Royal Commission into Defence and Veteran Suicide

ROYAL COMMISSION INTO DEFENCE AND VETERAN SUICIDE

TRANSCRIPT OF PROCEEDINGS

PUBLIC HEARING – WAGGA WAGGA DAY 3

09.00 AM WEDNESDAY, 30 NOVEMBER 2022

COMMISSIONER NICK KALDAS APM

COMMISSIONER JAMES DOUGLAS KC

COMMISSIONER PEGGY BROWN AO

CHAIR: Yes, good morning, Ms Bridgett.

MADELEINE BRIDGETT: May it please the Commission.

Commissioners, you will hear evidence today from Colonel Simon Dowse from the Defence School of Intelligence and Dr Robert Worswick, who is a medical doctor, Rural Generalist. Before you hear that evidence today, Commissioners, as you heard in the opening address on Monday, Kylie Reynolds, a lived experience witness, is giving evidence to this Royal Commission in the form of a written statement. Kylie Reynolds has made a redacted and unredacted statement. Before I tender those statements, I wish to say something about her evidence and the experiences Kylie Reynolds shares in her witness statement.

Kylie Reynolds is giving lived experience evidence, evidence of her subjective perceptions of her time in the Australian Army, her time living as a veteran in the community, and her dealings with the Department of Veterans' Affairs.

Kylie Reynolds gives evidence of how, at the age of 17, she enlisted in the Australian Defence Force Army Ready Reserves in Brisbane, on 11 January 1993. She gives evidence of how she was told at the time that this was the only way women could enter the Army. She says in her statement that the Ready Reserves needed female numbers, so recruiting would not accept women into the full-time Army and that was her way of getting into the Australian Army.

In 1993, Ms Reynolds completed the three-month recruit training here in Kapooka, and she was one of 32 female recruits out of 1,000 males at recruit training.

In her statement, Ms Reynolds says:

> *I had my 18th birthday in the corridors at Kapooka, Delta Company, 32 Platoon.*

On 12 October 1994, she transferred into the Australian Regular Army and was posted to 1 Field Hospital in Ingleburn, New South Wales. She had a long career in the Army during which she attained the rank of Warrant Officer Class 2 in Royal Australian Corps of Signals.

Her time in the Army, unfortunately, was marred with negative experiences that have impacted on both her mental and physical health.

In 1993, during her first posting, Ms Reynolds was sexually assaulted at Enoggera Barracks by one of her seniors. At paragraphs 34 and 35 of her statement, which can be displayed, it says:

> *I never reported the sexual assault. I could not believe it had happened at the time. I just sort of blacked it out. I still don't know why it happened. At the time, being a Private, I had no idea who to speak to or what to do about it. It*

was 1993. I had just turned 18. I was not even sexually active at that time. I was ashamed that I had let this occur and was not strong enough to stop it. I had been warned to keep your mouth shut. As a young soldier, I had already learnt to not make waves because if you make waves, even just to speak up for yourself or others, you are discriminated against and your life will be hell. You needed to learn and figure out your position in the Army. As a young female Private, I was the lowest of the low.

Despite this and the other difficulties she faced as a woman in the Army, Ms Reynolds quickly rose to the rank of Corporal and became a computer technician for the Royal Australian Corps of Signals. She refers to herself as a geek. Ms Reynolds gives evidence of what life was like being a woman in the Army at the time and her experiences of being a gay woman in the Army.

After 18 years and 5 months of serving the country, both in Australia and overseas on deployments, Ms Reynolds was medically discharged and is currently wheelchair-bound as a result of injuries sustained during her service.

She deployed in 2000 -- I will just briefly mention some -- her work in terms of -- her work in the service. In 2000, she deployed to East Timor and was promoted to Sergeant soon after in 2002. In 2006, Ms Reynolds was promoted to the rank of Warrant Officer 2 in Signals as Manager, Command Support Systems. In 2006, she was the youngest female Signal Corps Warrant Officer 2 at the time.

Whilst Ms Reynolds was excelling in her work in the Army and her career prospects were bright, in 2006 a friend of hers in the Army attempted suicide and it was Ms Reynolds who had to assist this person to ensure the person did not take their life. Following this incident, Ms Reynolds stated she was persecuted and harassed because of how she intervened to save her friend's life.

This event has had an impact on Ms Reynolds' mental health, as she evidences in her statement. Her mental health started to decline and she sought treatment in 2007. She had planned to take long service leave; however, she was then required to deploy to the Middle East to oversee the IT systems there.

Ms Reynolds gives evidence of how her mental health continued to decline to the point, and these are in her words, she "could not even make decisions about what I wanted to drink or have for breakfast".

In 2011, after 18 years and 5 months, she was medically discharged from the Army. Following her discharge, Ms Reynolds' transition to -- her transition to civilian life was difficult and challenging, and in her words she says:

I felt as if my world had been ripped out from under me.

She gives evidence of having suicidal thoughts and it was her service dog and her partner at the time that kept her safe during this period.

From her time of discharge until today, Ms Reynolds gives evidence of how she had to deal with the Department of Veterans' Affairs and continues to deal with them, and how this has had a serious and negative impact on her mental health.

She gives extensive evidence of her dealings with the Department of Veterans' Affairs in her statement and, for confidentiality reasons, I will not go into all the detail. I can, however, say that Ms Reynolds, in her statement, refers to 9 issues that she had with the Department of Veterans' Affairs.

The first one, getting timely reimbursements from DVA for her expenses; the second one, keeping track of reimbursements; the third one, decline of payment without explanation; the fourth issue, dealing with DVA to resolve an issue at the time it occurs; fifth issue, DVA declines payment unreasonably; sixth issue, lack of understanding of medical conditions; seventh issue, DVA approval of necessary equipment and modifications; eighth issue, lack of clarity around legislation used; ninth issue, difficulties with the use of MyGov.

Commissioners, I want to acknowledge Ms Reynolds' service in the Army and I want to acknowledge her courage to speak up today. I now tender both the redacted and the unredacted statement. The doc ID is KRE.0000.0001.0014. I tender the redacted statement as a confidential exhibit and the unredacted statement as a public exhibit. Apologies, I have just been told it is the other way around. Thank you very much.

CHAIR: Thank you, Ms Bridgett. They will both be accepted into evidence and allocated the next lot of consecutive numbers.

We just add our voice to yours in thanking her for her service and for coming forward. We know it is not easy to come forward and to talk about these things and to relive a lot of the trauma that people have been through. But it is invaluable and, in fact, essential for this Commission to hear from people like Ms Reynolds. We honour her. Thank you.

EXHIBIT #57-1 - REDACTED STATEMENT OF KYLIE REYNOLDS

EXHIBIT #57-2 (CONFIDENTIAL) - UNREDACTED STATEMENT OF KYLIE REYNOLDS

MADELEINE BRIDGETT: Thank you, Commissioners.

PETER SINGLETON: Good morning, Commissioners.

CHAIR: Good morning, Mr Singleton.

PETER SINGLETON: The next witness will be Colonel Simon Dowse, who is at the witness table, and the topic will be the ADF's Conduct After Capture, or CAC training. This topic is attended by some need for confidentiality. I believe that I can say that CAC training is directed at preparing some members of the ADF for the possibility that they might be captured in adverse circumstances.

Yesterday afternoon, those acting for the Commonwealth notified those assisting this Commission of a number of confidentiality claims, based on the public interest that national security should not be compromised. There is no question that national security should not be compromised. There is, however, some intricacy about the exact scope of the confidentiality that the public interest requires.

We therefore propose this morning to tender the material in the tender bundle in this session, a list of which has now been brought up on the screen, on the basis that the material, the subject of the Commonwealth's claims will be tendered confidentially for the time being. We are hopeful that the issues can be resolved between the parties or, if necessary, by written submissions for a determination in the coming weeks.

I should note that there has been a recent production of more material sought by production notice. Such productions occur by electronic secure link, and those acting for the Commonwealth then notify the office of the solicitors assisting you that that has occurred.

Last night, after receiving notice of the confidentiality claims, and the evidence provided in support of those claims, which occurred at 6.24 pm, those assisting the Commission noticed that the claim covered several documents, regarding which we had not been notified that they had been produced at all. At 7.29 pm, the solicitors assisting you raised this problem with those acting for the Commonwealth, and at 8.26 pm those acting for the Commonwealth advised that the documents in question had been produced "this evening", and they then provided the password needed to gain access to the documents.

That was too late for the purposes of this hearing and, in any event, the documents are the subject of confidentiality claims that will need to be considered and ultimately determined. We shall clarify the reason for the late production in due course.

The scope of some of the confidentiality claims does involve something of a late change to the approach to be taken to this examination, a change of approach that is unlikely to be implemented perfectly. There is a realistic possibility that the public hearing will reach the point that it becomes clear that the evidence thereafter should be taken in private.

Be that as it may, I shall ask a number of questions in an open way rather than a closed way that I might otherwise have done, and I shall, of course, attempt to avoid including in questions any information that is the subject of a confidentiality claim.

But the avoidance of mistake cannot be guaranteed. For this reason, more than on other occasions, counsel for the Commonwealth and the witness himself will be alert to make objections or even to call for a cut in the live feed of this proceeding, if need be.

Finally, I note the real possibility that we will need to hear further evidence from Colonel Dowse next year, not least because of questions that may arise from the documents received last night.

A final and quite distinct matter to note is that, once again, parliamentary privilege will impede your inquiry. The subject of this session has been examined by a Senate Committee, which has produced a report with recommendations. Of course, I make no comment on that material.

The Commonwealth has issued a written government response to the recommendations in the Committee's report, but that response was tabled in Parliament and we are advised by those acting for the Commonwealth that no version of the response has been independently published elsewhere. Accordingly, no version of the report or the response can be tendered into evidence before you.

We are grateful to those acting for the Commonwealth for their proper assistance in confirming the facts and the status of these documents. The effect is, however, that we are precluded from tendering not only the response but -- sorry -- the committee document, but also the response.

Although in due course we will try to explore what has been done in respect of the underlying issues that are touched by the recommendations, this will be an occasion on which the Executive Government is shielded from full scrutiny about whether or not the recommendations have been accepted or implemented. There being no evidence before you of what the recommendations were, or even what the Government thought they were, we will not be in a position to make a comparison between the recommendations and what the Government may have done in response to them.

Commissioners, before the witness is sworn or affirmed, I will pause for a moment to see whether you or Mr Free or anybody else have any matters to raise.

CHAIR: Mr Free?

STEPHEN FREE SC: Nothing to raise at this point, Commissions. I thank my friend.

CHAIR: Thank you.

PETER SINGLETON: Might the witness be sworn or affirmed.

COLONEL SIMON RICHARD DOWSE, AFFIRMED

EXAMINATION BY PETER SINGLETON

CHAIR: Thank you.

PETER SINGLETON: I will just ask that the tender list be brought up. Sorry, I will just introduce the witness.

Sir, what is your full name, rank and current posting?

A. My full name is Simon Richard Dowse. I'm a Colonel. I am in the part-time component of the Australian Army and I am posted to the Defence School of Intelligence.

Q. All right, we will come to more detail in a moment, but I will ask that the tender list be brought up.

Commissioners, in the usual style some documents are shaded blue and given a little circle to indicate confidentiality claims. As noted, we propose that those be received confidentially for the time being, pending more detailed resolution. I add that item 6, the biography, has this morning been made the subject of a claim of confidentiality as well, so notwithstanding the lack of blue, I tender that document on a confidential basis for the time being. I tender the other documents on an open basis.

CHAIR: Thank you, Mr Singleton. They will be accepted on that basis and allocated the next lot of consecutive numbers.

EXHIBIT #57-3 - TENDER BUNDLE FOR COLONEL SIMON RICHARD DOWSE (EXCEPT ITEM 6)

EXHIBIT #57-4 (CONFIDENTIAL) - TENDER BUNDLE FOR COLONEL SIMON RICHARD DOWSE - ITEM 6

PETER SINGLETON: Thank you, Commissioners.

Colonel, can you, in broad terms that can be mentioned in public, tell us what is Conduct After Capture training?

A. The ADF's Conduct After Capture training is a series of training activities, which encompasses theoretical and practical training for specified ADF personnel. Its function is to prepare those personnel to withstand the rigours of capture, to be able to resist exploitation by a capturing force, to allow them to consider ways in

which they can preserve military security and, importantly, to survive that process with dignity.

If I may add, that training is only conducted by authorised personnel and by the Defence School of Intelligence.

Q. Thank you. Operator, could you please display the document DEF.1081.0002.0145. Do you see on the screen, Colonel, this is the front page of the joint personnel recovery manual?

A. I do.

Q. Dated 2021. I'll ask the operator to go to page 0213. You will see that the technology allows us to expand particular paragraphs. Do you see there at 11.27 three different levels are mentioned?

A. I do.

Q. To the extent you can say -- I won't say this every time, but to the extent you can say in public, what are the purposes and objectives of the Level A training?

A. Noting this document is classified as official and sensitive, I'm happy to talk about Level A as being what I like to think of as the education part of ADF's Conduct After Capture training, in that it provides online an opportunity for authorised users to access the basics of the ADF's training and approach to Conduct After Capture.

As it says there, it is really designed for people who are at low or lower risk of detention. It gives the fundamentals of the approach, the types of captivity situations that people might find themselves in, and discusses the proposed and approved responses those personnel could take. Typically it takes about 60 minutes to complete that online module, the Level A training.

Q. All right. You've mentioned that the document was marked "Official: Sensitive". Just so you are on an even playing field with the rest of us, are you aware that this has become a public exhibit?

A. Yes, I am.

Q. Level B, what's the purpose of that as distinct from Level A?

A. It serves two purposes: the first is that it amplifies for those groups of personnel who are considered at higher risk of being captured. It gives them additional depth and detail about the types of experiences they may undergo. It includes a number of additional case studies and discussions with the learners over the period of, say, 3 or 4, maybe sometimes 5 hours. It's delivered by a qualified resistance trainer face to face with the target audience. So that its first purpose as a

higher level of awareness training for a different category of ADF personnel.

Its second purpose is to serve as a mandatory precursor for those groups of ADF personnel who are identified at being at the highest risk of capture and potential exploitation, and it gives them the theoretical basis that they then use when they go through to do the highest level, Level C, the immersive Conduct After Capture training. They must complete the Level B training within six months of undergoing the Level C training.

Q. We will have a greater focus on Level C and get to more detail, as much as we can. But what, in very brief terms, is the purpose of Level C, if it is a different purpose from the other two?

A. It does have a different purpose. If you think of Level A as being education, Level B, in a sense, is exposure and Level C is experience. It is immersive training. As you can see, it involves people being placed in situations which are generically similar to those which they may encounter in the course of their operations, were they to be captured, detained, questioned and so forth.

Q. You may be aware -- we have become aware -- that the ADF uses acronyms. For this one, is C-A-C or CAC commonly used?

A. Yes. It's an inelegant word but we use CAC within the community to describe it. But I will continue for the sake of, I think, trying to be less inelegant, to talk about Conduct After Capture.

Q. I'm going to be inelegant and use C-A-C or CAC, but I'm going to try with CAC. I wasn't expecting that answer. What is CAC's relationship to the concept of Resistance to Interrogation?

A. CAC is the term which has arisen from, essentially, the similar family of training. It evolved and it went from being Resistance to Interrogation, or RTI training, to being Conduct After Capture training. This was done in recognition, in about -- in fact, I won't give dates, but after certain operational events that ADF personnel were more likely than they had been to be detained, questioned, exploited, in what the military like to call asymmetrical environments, in other words not military force on military force, which is why concepts such as foreign government detention and hostage survival phases were brought into this capability. And, at the same time, it was more accurately renamed as Conduct After Capture to embrace the full range of learning strategies, coping mechanisms and skills that weren't necessarily covered under the Resistance to Interrogation heading.

Q. Is it your experience that some of the documents and maybe some of the oral discussions in your work sometimes use the terms interchangeably, particularly if they are comparing different times?

A. It is increasingly rare that that happens. It was some time ago that the

transition occurred. 90 per cent, I would say, of the time now, we inelegantly refer to CAC and not to RTI.

Q. What's the relationship between CAC and Resistance to Exploitation?

A. They are almost identical. Again, without going into detail, there are some definitional differences. If I may, the background is that Conduct After Capture training exists within what's known as the Survival, Escape, Resistance and Recovery, and so forth, the SERE continuum, and the R is the resistance. Within the SERE community, what we call Conduct After Capture is often referred to as Resistance to Exploitation.

In addition, some of our partners overseas use the term "RTE", that is Resistance to Exploitation. So, as you say, acronyms abound. The ADF term is Conduct After Capture, except in occasional documents, and we are in the process of trying to bring that together.

Q. So the acronym is SERE --

A. That's correct.

Q. -- and that stands for Survival, Evasion, Resistance, Escape?

A. Yes.

Q. CAC, RTI and RTE all fit into the resistance part of that spectrum?

A. That's correct.

Q. Operator, could you please bring up -- I'm not sure if it's the same document or not, but DEF.1081.002.0145 and then go to page 0213.

While that's being done, when did you first become involved with CAC or RFI training, if that's what it was at the time?

A. That was in 1984. I was trained as an ADF interrogator in 1984, and I have supported Resistance to Interrogation and Conduct After Capture activities in various ways since then.

Q. How recently have you been involved in actually running the training course or participating in a training course?

A. May this year.

Q. What was your role then?

A. I had two roles: in one of the two activities that were conducted this year, I

was a resistance trainer; and in the second of them, I was what's known as the conducting officer. I had overall responsibility, which I shared with another conducting officer, 24 hours a day while the activity ran for its safe, legal and effective conduct.

Q. Is the term conducting officer something in the nature of a chief instructor?

A. No. The chief instructor term is more applicable in a training establishment to an officer at a particular level with responsibility for the content and delivery of training more in an abstract sense, whereas the conducting officer is the person who has the direct responsibility for a practical activity such as a Level C.

Q. I don't know whether this is a permissible question, so be cautious, but does the conducting officer have instructors beneath him or her who are assisting to deliver the training, or do you -- are you the first and most direct contact with the trainee?

A. There's a hierarchy. As the conducting officer, an officer is not involved in the delivery of the individual sessions that constitute a Level C activity. However, going back to your earlier question, as a resistance trainer in the first of those activities, I was, so I had the two roles. But as a conducting officer, the idea is that you stand above and you control and monitor all aspects, and you do not get involved in the delivery of the training. There is one non-training exception to that.

Q. Which you're welcome to tell us or we can defer it till a closed session.

A. I'd prefer to defer that to a closed session, if I may.

Q. Yes. What's your -- turning away from the details of your training work, or your work in the role you just described, are you currently involved in a project or some other -- I'm trying to use a neutral term there -- a project relating to CAC training?

A. I am.

Q. What is the nature of that project?

A. I was requested by the training authority for the ADF's Conduct After Capture capability to produce what's known as a Performance Needs Analysis into the ADF's Conduct After Capture capability. I headed up a small team of subject matter experts to work on that report.

Q. What is the -- can you just give us a little bit more on what is the nature of a performance review evaluation, or whatever you just said?

A. A Performance Needs Analysis, a PNA, is part of what's known as the Army's or the Defence's Systems Approach to Defence Learning, or SADL, and it's a

way of looking at the degree to which customers for training are receiving the training that they require, determining if there is a gap between their requirements and the delivery of training, and then, once those findings have been considered and ratified and decisions taken, it can move to a next stage of the training process where gaps can be closed or addressed, whatever the decision may be.

Q. You mentioned that you are assisted by subject matter experts. What are the subjects in which those people are expert?

A. The people assisting me are ADF qualified resistance trainers of long standing and experience, and recognised as subject matter experts in that field.

Q. All right. So the subject of the expertise is resistance training?

A. Conduct After Capture training.

Q. Or CAC training?

A. Yes.

Q. How big is the team? Or, sorry, do they form a team or are they just resources to which you have access?

A. It's a team.

Q. How big is that team?

A. It's a team of three people.

Q. Plus you or --

A. Including me.

Q. -- including you. Do you have access to other professional assistance such as psychologists, medical practitioners, that type of people?

A. Yes, we do. However, the main focus of the Performance Needs Analysis is the efficacy of the training, and we have had considerable assistance from the ADF's training experts to ensure due process. We've also had considerable access to and assistance from ADF elements who are, for want of a better term, Conduct After Capture stakeholders. That is, their personnel are at particularly high risk of capture, either now or potentially, or they have other interests in the correct application of the ADF's Conduct After Capture training.

Q. But your focus is the efficacy of the training, isn't it?

A. It's training efficiency, yes, yes.

Q. To what extent, if any, are the effects, the deleterious effects, the non-educative effects, on the trainees a part of what you are looking at?

A. They are a part, because it goes to the efficacy. Our aim for the training is to build resilience, to build skills, to build faith by the people we train that what they experience, what they learn, will be of value and support them in the hopefully never event that they are captured and questioned.

Q. At least in theory, there's some prospect of physical injury -- I'm not suggesting any level or any type -- arising out of CAC training. Is there -- I'm not looking for a name, but is there a particular medical officer or general practitioner or other medical professional with whom you're working on this project?

A. We're taking advice from a range of ADF health professionals. Much of that aspect of the PNA is already very effectively covered, in terms of standing instructions and requirements and directions that pertain to the running of the Level C activities, and the staffing of medical, psychological and other support elements during each and every part of that training.

Q. Are you saying that there's a document that is about CAC training which describes how a review of the training -- sorry, a PNA would be conducted?

A. Let me try and break that apart. There is -- was, still is, a directive which was issued which detailed, essentially, the terms of reference for the Performance Needs Analysis which I'm leading, so there's that part of it. There's also documentation that applies to every Level C activity which details responsibilities, health arrangements, and so forth.

Q. Are the -- so do you have access to medical practitioners from within the ADF --

A. Yes.

Q. -- for your project? Do you have any access to medical practitioners who are independent of the ADF?

A. No.

Q. Same pair of questions regarding psychologists: you've got access to ADF psychologists; is that right?

A. Yes.

Q. But not, you're not calling on external psychologists?

A. At this point, yes.

Q. Is it contemplated that you will be having access to them as a part of this project, or is it merely a "it could be done if the need arises"?

A. I have no doubt it could be done if the need arises. We have a number of ADF psychologists who are familiar with Conduct After Capture training, who have supported it and, over the years, have provided, I think, very sound advice about its correct development and application.

Q. Did you complete an interim report on the project in September?

A. Yes, I did.

Q. And is there a final report due?

A. Yes, the final report is virtually complete. I provided that report to the key Conduct After Capture authorities about three days ago, with a caveat that there were minor adjustments to some of the supporting documents. The PNA process has a number of templated documents that are required to be filled out and, concurrent with my appearance here, my colleagues are working to complete that by the time I return.

Q. If you're able to say, what was the interim report about?

A. I'm going to go quite high in terms of my response, broadly speaking. It described progress; it described, as part of that progress, the stakeholders that we had interviewed; it drew some summary observations of those initial stakeholder comments; and developed some trends which we felt the commissioning authorities should be aware of so that they could comment on the first batch of work and provide guidance for the remainder of the PNA.

Q. Without revealing any actual substance, did the interim report go so far as to reach conclusions on changes that might be made to CAC training?

A. It did not, and deliberately did not.

Q. You mentioned that the final -- will it be a final report, the one that you've mentioned just circulated earlier this week?

A. Yes, it will.

Q. We'll call it that, if we may. Are you aware of the existence of a notice that required production to this Royal Commission of the current version of the final report in draft?

A. I was verbally briefed, as I recall, about 10 days ago at the Defence School of Intelligence about that requirement, so I was aware that it was an option that was

being discussed.

Q. Leaving aside the -- well let me withdraw that. About 10 days ago, did you become aware of a legal requirement to produce that draft document?

A. I was aware that a request had been made that the final version of the report be produced.

Q. Did you become aware of a requirement that the current draft be produced?

A. Yes. Yes.

Q. Did you create a copy of the final draft at that time?

A. No. I did not do anything other than, essentially, tell people where that draft was.

Q. And did you have the understanding that, having told them where to find the draft, your role in organising the production of the document was complete?

A. That was my understanding, yes.

Q. Yes. And in fairness to you, this notice wasn't addressed to you, it was addressed to a much higher authority who had the responsibility; is that your understanding?

A. Yes.

Q. No-one told – no-one suggested to you, you personally had to do it?

A. No, they did not.

Q. But they sought your assistance and you gave it?

A. Yes.

Q. About 10 days ago?

A. Yes, about that.

Q. Do you have any knowledge of why the document, the location of which you notified relevant people, has not yet been produced to this Commission?

A. I wasn't aware that it had not been produced.

Q. I take it it follows you don't know why it hasn't?

A. That's correct, if that's the case.

Q. You may have said as much as you can about the following question in your overview, but is there any more that you can tell us about the -- well, actually, I'll withdraw that. Even if there's a little overlap, don't worry about it. What is the need or the danger or the problem that Conduct After Capture training is designed to address?

A. It's the risk of ADF personnel being captured, and that risk has always existed and we'd only have to go back into World War II and subsequent military history to understand that. And as I mentioned earlier, the risk is now seen as multifaceted and could include ADF personnel being detained by foreign governments, it could include the risk of them being taken hostage by -- kidnapped for ransom or ideologically motivated groups, or it could include them being taken prisoners of war during a declared conflict.

Q. It follows -- correct me if I'm wrong, but it would appear the flip side of that is that the objective of the training is to prepare the trainees to be as ready as possible to cope with such an occurrence?

A. That's correct. The very worst thing that can happen to anybody when they're captured is that they're simply unprepared for that eventuality. And the three-tiered approach that the ADF takes to Conduct After Capture training gives people that grounding of what might lie ahead, it provides them with the fundamentals of coping strategies and skills. And as you go through that continuum, up to and including Level C, as I mentioned earlier, you get a chance to experience a taste of what that might feel like and to understand how you would apply those skills and strategies to both help you as a person and as a soldier withstand captivity, preserve military security, and survive with dignity.

Q. Just broadening the focus beyond the assistance that the training provides to the individual soldiers or sailors and aviators, are there organisational purposes for doing the training, or other purposes beyond what we've just described?

A. Well, I would argue that, from my perspective, they allow those senior commanders who control the ADF's operational assets to be confident that those assets, as part of their force preparation or force generation, have got that element of their, for want of a better term, operational readiness signed off. So there's that part of the equation. The second and, I think, equally important part is that it satisfies Defence's and the nation's duty of care to its service personnel, that it does give those service personnel identified as being at risk the skills, the grounding, the experience, which will allow them to survive what could be a very traumatic experience in the best possible way.

Q. Is another purpose of the training to help protect confidential information that the soldiers might hold?

A. Yes, it is, and I think I mentioned a couple of times this idea of preserve military security, resist exploitation. So there's the two-fold; the individual and the information that they are holding about whatever it might be.

Q. And is the protection of information and security an equally high purpose as preparing the soldiers for his or her individual welfare?

A. The -- it's a bit difficult to answer that directly. Could you potentially rephrase it? It's almost like apples and tractors at the moment.

Q. There are two purposes.

A. Yes.

Q. Which of them is the more important one from the point of view of the ADF?

A. From the ADF's perspective, and I'm speaking as an officer not a commander in the ADF, our people are the most important thing we've got. So the most important purpose, from that perspective, is that the training helps people cope with the rigours of captivity and survive with dignity, so they get through a traumatic experience in the best possible shape and they come home safe and as well as can be expected. Preservation of military security is, of course, important, but if you are asking me as Simon Dowse to place one above the other, that's the order I'd rank them in.

Q. You may have mentioned this a moment ago. I think you did but forgive me if I'm wrong. Did you suggest that the ADF considers there would be a public expectation, in effect, that this training would be done?

A. I do.

Q. And is a purpose of the training also to meet the public expectation and avoid public criticism of the ADF if it were not done?

A. I don't think that's considered in that way. I think it’s, as I said earlier, it's the duty of care. In the same way that we prepare personnel to be able to conduct rudimentary first aid and other self-care abilities, it's all about the person first. Rather than worrying about, you know, what might be thought of this, it's the right and the correct military thing to do.

Q. Have you seen it or heard it or read it suggested within the ADF ever that avoiding public opprobrium would itself be a sufficient reason for doing the training?

A. No.

Q. In meeting -- I withdraw that. Since 2001, how many ADF personnel have, in fact, been captured in the relevant sense, in the sense that the CAC training is

designed to address, including detention and other forms of hostile capture?

A. There are -- or there is a response to this. The answer is, in the sense of being militarily captured, my understanding is that there have been no ADF personnel captured. However, to broaden the aperture a little, there have been instances, which I don't intend to detail, where ADF personnel have been detained or otherwise questioned innocuously, perhaps with some other intent, in the course of their official travel, and they're factors which we need to consider as well.

Q. The -- I'm not asking about the detail of those examples but you've referred to examples just then. Are those cases where the training that was done proved to be beneficial, but it wasn't the kind of capture or detention that was actually the purpose of the training? Would that be a fair summary?

A. I'd answer that by saying that any training which has prepared people to understand what it's like to be detained in any of those three environments which I've discussed, and then to be questioned, which provides them with coping strategies and skills for responding appropriately during those detention and questioning experiences, I think any training like that is going to be worthwhile compared to somebody having nothing or trying to make something up on the spot.

Q. Yes. Well, the question actually presupposed that it would be helpful, but the actual focus of the question was that was, in effect, an incidental benefit. The purpose of the training is to address a certain category of capture and detention, as described in the papers, and the examples you've just referred to are not within that scope of capture or detention; correct?

A. I don't know if that is correct, and I'm sorry if I haven't been clear, but one of the three elements is foreign government detention. That can include anything from being drawn aside as you pass through a primary point at a border crossing, to being, perhaps, questioned by authorities for a particular purpose once in a country. That broad spectrum of foreign government detention is covered under ADF Conduct After Capture training.

Q. Alright. Although, depending on definition, the number of ADF people who have actually been captured is zero or a few, depending on definition, one would nonetheless accept that there's a risk of capture and even if there were no examples on the edge, there would still be the risk. Has anybody in the ADF or for the ADF conducted a study that attempts to in some way measure, describe or quantify the risk of capture?

A. The word "study" might be a little misleading here and please correct me if I'm on the wrong tangent, but if you're asking is the ADF assessing the likelihood of various elements being captured, the answer is yes.

Q. And you tell me if this can't be discussed, but an example of that would be in preparation for a particular deployment, at least hypothetically, one might expect the

Commander would take into consideration whether there was a high or low risk in that environment of a capture. I'm not talking about that kind of assessment. I'm wondering whether there has been a more global, perhaps even more academic assessment of the size of the danger, or the size of the risk generically, a review, perhaps, of the kind that you're doing, or of a different kind?

A. There's no review that I'm aware of that matches the definition you just gave. However, there are a number of studies going on which look both in particular areas, which I won't discuss, but also more generally about the broader environment that faces ADF personnel as they travel or they deploy for operational purposes, and the effects of such things as a much more significant and persistent digital footprint that we all leave, and the opportunities that provides for understanding more about somebody than was ever possible before. Those sorts of factors and their effect, not just on the likelihood or the risk of capture, but the way in which detention and questioning could occur, that is happening.

Q. Has the ADF received from any qualified expert who's independent of the ADF and independent of the Defence Department, any report or study, or similar, on whether or not CAC training is effective in meeting its objectives?

A. Some years ago, and I'd have to go back and confirm the date, but what was then I think called the Defence Intelligence Training Centre, DSI by another name, did work with the CSIRO to have some of their human factor specialists, if I've used the right term, consider that topic.

Q. And would it be fair to summarise that that study was done by DSI, calling on the resources of the CSIRO to assist?

A. Yes.

Q. Has there been a study that was actually conducted by an independent body or person of the effectiveness of CAC studies, CAC training?

A. No, I'm not aware of any independent study.

Q. It is the case, is it not, that there is no empirical evidence available to the ADF to establish the effectiveness of CAC training, only anecdotal evidence?

A. I don't know if I would agree with the premise to that question. If we take empirical as either experience or experiment, let me be very clear we are not experimenting, so it comes back to experience. And there are many case studies and there are links that the ADF Australia has with its partners, again which I choose not to discuss in this forum, that do give us an indication of where capture of various forms has occurred, it indicates that the training, similar to that which we provide, was effective for them. So I would suggest that there is some empirical basis as well as other bases for doing what we do when it comes to Conduct After Capture training.

Q. Do -- does the ADF have a study, report or whatever, that goes beyond looking at a selection of individual cases to try and study the population of captors, captees as a whole to try to get accumulated lessons on the whole, that kind of study?

A. ADF is looking at those accumulated lessons and recent experiences, for example where Australian persons have been detained in various South East Asian, Middle Eastern countries. That is the sort of material that's being constantly reviewed to get updated views of captors, tactics, techniques and procedures. Likewise the conflict in Ukraine.

Q. Is what you have just described a process of having a look at every individual case that comes to attention to see what lessons can be learned?

A. Yes.

Q. I'm asking whether there's been an academic, statistical or other broader based study that doesn't just look at the individuals -- it may well look at them -- but the purpose is to look at all of the cases and try and learne patterns? Is there a report, a document, that summarises any study of that kind that the ADF has?

A. Not to my knowledge, but I argue that the same analysis and key findings are being worked as a result of that other activity, the individual review of individual instances.

Q. Is there a central repository of the lessons that are being learned from these individual reviews that occur over the months and years?

A. The Defence School of Intelligence's Conduct After Capture wing is the ADF's Centre of Excellence for that material.

Q. And does it -- that might be the central repository for the ADF, but is there an actual place inside that unit which puts it all together, or is it really just a series of files around the filing cabinets of the office?

A. It's an ongoing process in the sense that it's their role to keep up to date with that. And for example, the Level B briefing that I referred to earlier, there is a regular review of that briefing to ensure that recent lessons learned and case studies are incorporated into that briefing as appropriate.

Q. Has somebody -- in the last year or so, let's just pick a time, has somebody sat down and said, "Right, now is the time to review the last 10 years' worth of these cases. We have looked at them as we went along, but now is the time to sit down and look at them all at the same time and try to pick the patterns"?

A. No, it's more of a continual than a waypoint process.

Q. A lot of the knowledge then would be in the minds of the people who are doing it, and perhaps recognising, when they read one individual case, "Oh, I remember I read another one recently", or --

A. Yes, it is in the minds, but it is also being recorded and there are write-ups, there are excerpts, there are all sorts of documents which are being collated to make sure that we do maintain that currency.

Q. When it's written up, is it ever written up in something in the nature of a register or a running log so that all those lessons are in the one document of whatever kind?

A. I honestly don't know.

Q. Has the ADF obtained from any qualified expert, external to or independent of the ADF and the Defence Department, on the subject of whether or not CAC training has adverse effects or increases risks for the trainee participants?

A. The ADF is certainly conscious that the nature of CAC training, particularly Level C CAC training, requires extraordinarily careful management and care in its application. And as such, when it's developed, it consults about the mental health and other effects that it may generate.

Q. Yes. I understand what that means, but could I just ask you to go to the question, which was: has the ADF obtained from any qualified expert, independent of the ADF and the Defence Department, any report on whether CAC training has adverse effects or increased risks for the trainees?

A. I'm not aware of any external advice being given on that.

Q. The same question, but in respect of the instructors: has there been any external or independent study of the effects on the instructors of this training?

A. Again I'm unaware of it, but I would make the point that the internal care arrangements for both learners and the resistance trainers are a constant and prominent part of that capability.

Q. You would accept the proposition, would you not, that no matter how caring and how experienced and skilled those running and supervising the training may be, and no matter how diligent they may be, from time to time there would indeed be benefit from getting an external expert, perhaps with psychological and/or medical expertise, to come in and take a fresh look from a different perspective?

A. It's a fair proposition, based on the presumption you would be able to find the right people, yes.

Q. Your concern -- perhaps the implication in that answer is that there would

need to be such a professional who was also expert in CAC training in some way? Is that the implication that you intend?

A. That's my lay take on it. I'll just make the point, if it needed to be made, that I'm not a psychologist --

Q. Yes.

A. -- and there may be any number of mental health professionals and psychologists who could turn their hand to that. But in my lay opinion, we need to understand the circumstances, the purpose and the environment in which the training occurs.

Q. Why would they need to understand the purpose of the training in order to determine what its adverse effects were?

A. Mainly because people look at particularly Level C CAC training, and they think of it as interrogation, but it's not. It's not designed in the way that interrogation is, to exploit people and get information from them. It's designed to establish a set of circumstances and conditions against which the learners can apply those coping strategies and those skills which they have been taught and discussed on Level B. More to the point, the aim of Level C, its purpose, is to give the learners the chance to successfully demonstrate their competence in applying those LOs under those simulated conditions, in order that they then leave confident that they have both got the internal psychological and physical means to deal with it, and they have got the skills to be able to assess and respond correctly to the particular environments, lines of questionings, whatever it might be.

And I just do think it is important to bear in mind that the purpose of Conduct After Capture training is not questioning and eliciting information; it's providing the settings in which ADF personnel can demonstrate, as realistically as we must, as we can, the right way in which to apply the skills they have learnt.

Q. Let me acknowledge that I too am not a psychologist or a psychiatrist, so you and I are grappling on a difficult matter of expertise where neither of us are experts and the room has many experts in it. But let me just press on a little bit anyway. What you've just said would be, I suggest, very relevant to getting a review of the effectiveness of the training. One could not assess the effectiveness of the training without knowing what its purpose was. But when it comes to the adverse effects on the trainees, I suggest to you -- and the question is, do you accept the logic of this point as at least worthy of consideration and study, rather than dismissal -- I suggest to you, it would be better that the psychologist or other expert did not know the purpose, that they just looked at what happened, interviewed the people after it happened and in any other ways inform themselves of the effects and just reported what the effects were? Do you see the validity of that proposition?

A. I see the proposition. What I do think needs to be taken into consideration is

that there's considerable difference between an interrogation attack on somebody and the mental and physical effects that would have, and what we are talking about, Conduct After Capture, and if I may, during Level C activities, and I'm going to choose my words carefully here, our aim is to help the learners become confident and competent in that training. And there are occasions where the trainer will, in one way or another, assist the learner if the learner is not demonstrating the correct learning outcomes. And there are a variety of ways that can be done, and I don't propose to talk about them here. But there is an element of -- and this may sound peculiar -- support for the learner during Level C at the same time as the resistance trainer is replicating an adversarial captor or questioner. Our job is to help them learn and apply. And because of that difference, I do think any independent psychological expert review would need to be taking that into account. It's not the same as directed interrogation.

Q. Yes, and I will finish off this bit of the discussion with a final bit of analysis for your comment and then we'll move on. There's a few parts to this, just for speed.

Firstly, the documents, including the confidential documents, describe a lot of what you've said, that there are protections and supports all the way through. I am suggesting that the decision on whether the harms or risk of harms to the trainees is worth the benefits is a balancing act that somebody in leadership has to do -- a commander, taking advice, the best available advice on what the harms are, and the best available advice on what the efficacy is; do you agree with that?

A. I do.

Q. And the best way to find out what the harms are is to try and assess them without being contaminated by knowing what the purpose is -- certainly know who has what role in the training, as the psychologist observes it, the psychologist would be told "these people are playing a role, these people are in a support role" that you just described, these people have whatever other role, so they understand what's happening in that level of sense, but that they don't take into account the purpose, they are just focused on the effect on the trainee. Is there any further comment you want to make as to whether that's a wrong analysis?

A. My only other comment is that the ADF psychologists, with whom I have worked since 1984 on this, I believe are both expert and dispassionate about their assessments of the effects that the training has on participants, both the learners and resistance trainers. That's where I will leave it.

Q. I did say -- one more on this. The fact that these experts, with all good conscience have been in it for so long, is surely a reason occasionally to bring in a completely independent person, to check that they have not become so much a part of the team that they have lost their objectivity. Do you agree with that?

A. I simply don't know about the basis for determining whether that's accurate or not, but I would say that while we do have some long-term psychologists and others

who have supported the capability, the ADF goes out of its way to make sure that there is a rotation of psychologists and, for example, the last couple of activities I have supported, there are new faces there, deliberately so, and while I don't know this for a fact, I suspect that the senior ADF health professionals are probably conscious of the need to rotate people through to bring fresh eyes to a particular problem.

Q. All right. Moving on -- we won't of course be able to avoid these issues for the whole day, but moving on a little bit -- when the training is being provided, speaking in general terms, would it be right to assume that the instructors and the trainees are present?

A. Yes, yes.

Q. I'm just stepping gently in towards matters of what happens, so I don't want to rush. You need to be on the alert not to go beyond the right point.

Who else is present during the conduct of the training, apart from the instructors and the trainees?

A. By present, can I just confirm you mean involved in the activity?

Q. Involved in the activity or present for some other reason, but in such proximity that they can see and hear what's going on, if anyone's there?

A. There are a lot of people there. Level C activities, in particular, are extraordinarily well supervised. There are many layers of oversight and neutral supervision. I mentioned that there is a conducting officer, there are other layers of command, that is the senior trainer, for want of a better term, who on a shift basis controls the allocation tasking and debriefing of trainers for particular activities. We have, as well as that, ADF medical technicians constantly attending -- that is, they are there. We have at least two psychologists, they are there. We have two neutral officers drawn from the ADF whose role it is to keep that dispassionate eye on what's happening and if at any stage they feel that something untoward is or is likely to occur, they are authorised to go and discuss that and other people have got roles which makes sure that if anything starts to occur, which it shouldn't, or they think that's likely, they can either, depending on their role, stop the activity or speak immediately to the conducting officer to discuss what's going on.

I should add, to give people clarity here, that every aspect of a Level C activity from the start to the finish is captured and recorded and monitored on CCTV systems. If those systems aren't working, the training stops.

Q. Let me try to get such detail as is appropriate. Firstly, who does the monitoring of the CCTV system?

A. That's done by a number of people. The only people authorised to watch what's going on, for very obvious reasons, I hope, of privacy and propriety, are

perhaps depending on staffing, the resistance trainer monitor, so there might be one resistance trainer conducting activity; a second actually watching it on the screen in a control area.

The senior trainer that I mentioned before, they are also watching what's going on on a wall of screens. The conducting officer has got a feed. The psychologists have got a feed as well and the neutral officers have got a feed as well.

It's very important that only authorised people for the right purpose have access to vision of the training.

Q. You will appreciate I'm newer to this than you are, so may I just clarify. I think you've used the terms "neutral observers", "neutral ADF officers" and "neutral officers". Are they three terms for the same people?

A. They are, yes.

Q. And there's two of them? For --

A. Yes, there are.

Q. Two psychologists?

A. Yes.

Q. Both ADF psychologists?

A. Yes.

Q. How many medical technicians?

A. There's usually one medical technician physically in the activity area on a rotating shift basis.

Q. What is a medical technician?

A. I think it's the new term for a medic. I just saw it for last time on the last activity. So it is an ADF person who is specifically trained to provide advanced medical care.

Q. So it's a relatively well-trained first aid officer?

A. I would say very well-trained.

Q. Yes. But not a medical practitioner? Or a nurse?

A. They have -- they may have their own views about that, but --

Q. From the point of view of the college, the Royal Australian College of Physicians, or some similar body to that, they are not medical practitioners who, by law, can call themselves medical practitioners, are they?

A. I'm not familiar with the legal term, but they are not doctors.

Q. I'm not critical, I'm just getting the detail. They may be perfect for the role --

A. Yes.

Q. -- I just wanted to understand it. You mentioned that the medical technician is -- I will insert the word "typically" -- but is present physically when the activities are occurring?

A. I can be definitive about that. They are present.

Q. Right. Does that mean that -- I haven't asked you how many trainees are doing it at the same time and I'm not going to unless you tell me I can -- but are there times when some of the trainees would not be directly visible to the technician? Because some trainees are in one spot and some are in another?

A. Medical technician is not required to maintain constant observation over all trainees in all locations during all the activities. What tends to happen is that if any of the staff observe what they think could be signs of possible medical issues, then they will let the medical person know. Importantly, at any point during the training, without fear of detriment, if one of the learners feels that they are experiencing a medical issue, they are instructed specifically on how to bring that to the attention of the conducting staff and as soon as that happens, the medic will go to that person and there are arrangements made for a neutral location where outside the boundaries of the scenarios and the activity, the medical person attends to the learner in the same way as if you were being consulted by a medic somewhere else.

Q. You mentioned one or both of the psychologists monitor the proceedings via the CCTV system. Is it both of them or just one of them that does it that way?

A. Normally both of them are watching the screens at the same time.

Q. And if you are able to say, how far away are their screens from the actual activity?

A. They are within five minutes walk, at the absolute outside -- I'm just going to rephrase.

Under the current circumstances, it is probably a two-minute walk away from the site, and they are within the activity area, it's not like they have to move from one building into another through a fence, a gate, et cetera.

Q. What's done with the recordings? The video recordings?

A. All video recordings of all ADF Level C Conduct After Capture activities are retained, and they are held in a suitably secure part of the Defence School of Intelligence.

Q. Do you accept that the decision -- I'm sorry when I get repetitive, but we often get ahead -- you accept, do you not, that the decision to conduct CAC training should be based upon an assessment that the need for the training, plus its effectiveness in meeting the need, are greater than the risks that the training poses to the participants?

A. Yes.

Q. Has the ADF conducted or commissioned a study of that balance?

A. Each ADF Level C activity is accompanied by a detailed risk assessment, which does go to the specifics of all the risk factors, likelihood, consequence, mitigation, and so forth, affecting that particular activity. In addition, the broader reviews that are conducted into the capabilities, such as the Performance Needs Analysis, provide an opportunity for stakeholders and others to comment on potential harm, benefit, requirements and so forth.

Q. Would this be fair: that balance is something that's borne in mind by many of the people involved, including yourself, all the time, or very often, and individual components have the risk assessments that you have just mentioned, and there are quite a lot of things that exist, or are done, that go to the balance, but there has not been, at least in any reasonably recent time, any single comprehensive review that tries, if you will, from a blank sheet to put it all together, with a fresh mind and see just how well that balance is being struck?

A. There have been regular reviews of the ADF's keystone doctrine products on this topic, and I'm not 100 per cent familiar chapter by chapter but my recollection of them is that each of those keystone documents does address the requirement, the risks and, therefore, the balance that goes into shaping and applying ADF Conduct After Capture training.

Q. I think that indicates that there is no study of the kind that I described?

A. Not what I would think of as a study.

Q. I want to turn to the selection of the trainees, or the identification of the trainees. We understand that risk assessments are used as a part of the process to screen people before they undergo Level C training. Is there such a process by whatever name?

A. Again being very broad here, the determination of which categories of ADF personnel require what level of ADF Conduct After Capture training, typically levels B and C, is a process conducted by operational elements of the ADF, working in conjunction with capability managers and others. So there are broad considerations about which groups of people need this training the most, and then additional processes are applied within those categories.

Q. The screening you've just mentioned is focused on the degree of risk that their work might lead them into captivity, and that, of course, would indicate, prima facie, a need to be prepared for that. Having identified a group or a person as being in that group, is there then any screening assessment, testing, or whatever, of the individual's personal circumstances or characteristics to check so that a person who might not fare well in the training is not subjected to it?

A. There are. I'm not completely conversant with a number of those, particularly the psychological screening elements, but I can say, for example, that they need to achieve a certain ADF medical standard before they are allowed to come on to the Level C Conduct After Capture activity. So that is assessed by medical people and, you know, forms are filled out and notifications are made. So that's a form of medical screening. They have to be, for want of a medical term, as fit as a drover's dog to actually come along and do this, not having ongoing medical issues, for example.

Q. You've used a bit of technical language there. "Fit as a drover's dog", is that also known as MEC level J1?

A. Yes, that would be another term for it.

Q. Is MEC level J2 sufficient, if you are allowed to say?

A. I don't know.

Q. You don't know the answer or you don't know whether you're allowed to say?

A. I know that I'm probably not allowed to say --

Q. I'll leave it at that. I don't know what questions are permissible, so please be careful.

A. Yes.

Q. You said that one of the possible screenings, pardon me for paraphrasing and maybe not even getting it quite right, but you said something to the effect that members are screened to make sure they are fit as a drover's dog, meaning MEC J1; are they screened around about the time they are going to go into the course, or does the ADF rely on their existing classification which may have been determined years before?

A. There are a number of answers to that. It's sequential. There's that pre-existing requirement, and then, speaking broadly, at the start of Level C, a process occurs whereby the conducting officer, accompanied by a medic, they receive each of the learners in a neutral environment and the learner is asked to do a couple of things. They are asked to confirm that they remain a volunteer for this training, which is, in a sense, a self-screening aspect, if you will.

Q. Yes.

A. The second part of that is once the conducting officer has had that brief too, and responses from the learner, the attending medic will then go through a number of questions which go directly to the current medical state of the learner, including their MEC status, and, for example, whether they are currently undergoing any treatment, on any medications and so forth, for obvious reasons.

Q. Any other screening that you're able to -- firstly, is there any other screening that you know of?

A. When learners are nominated for Level C, it's my understanding that elements of their psych records are made available only to qualified psychs, so that the psychs can then review and advise if there are any issues that could affect those learners' performance or capacity at that time to undergo the training.

Q. Those psychs are not independent, they know what the course is about?

A. Indeed they do.

Q. Yes. Anything else to add to this list of screening that you know of?

A. I'm limiting my answers at the moment to the inbound process, that is, what happens before people --

Q. Yes, that's what I'm asking about. And if there is a secret process that can't be mentioned, we'll deal with it later, but is there something I need to ask you later? Or is that the list that you know of?

A. That's the list.

Q. All right. Are there any personal, professional or other characteristics that the ADF uses as criteria or indicators upon which personnel are discerned as unsuitable for the training? So, for example, the psych might just report on the basis of the individual record, "This person may not be suitable", or the medic may ask, "What's your MEC level", and it's J3. I won't say this is right, but hypothetically the person is out. But a part from -- are there other specific criteria, categories of people, who have been identified, category-wise, as not suitable? That's a "yes" or "no" answer at the moment. Are there categories of people who are just not suitable, beyond

medical --

A. If we accept that we are looking at people who have been deemed as being at risk and therefore are needing to have the training, that they have gone through that screening process which we have just discussed, I'm not aware of any other reasons, other than the over-abiding factor of being volunteers or not.

Q. The medics are medical technicians?

A. Yes.

Q. The psychs have access to the psychological records. Do the medics have access to the medical records?

A. They can get them. My understanding, it's all online, so if required, if something popped up during that initial briefing that I discussed with the conducting officer and the medic, something arose, the medics are able to tap in to the relevant material.

Q. If you are able to say, are there people other than those who are deemed to be at high risk of capture who do the training?

A. I prefer not to talk any more in this forum about who does the training.

Q. That's all right.

Can doing the training assist a member's career? Say, by helping them get a promotion or a good role or good posting?

A. That's not its purpose, and I don't --

Q. I appreciate that. Can it help?

A. -- think there is a direct causal link between Level C and those factors or results that you mentioned. Proficiency, as recorded in the Army's, the ADF's personnel systems, of having completed Level C training in some trades and specialities, and I don't intend to go into any more detail, is a prerequisite for certain types of deployment.

Q. If a person -- if the training is a prerequisite for certain types of deployment, which we will not identify, and a person can't or won't do the training, is it right that generally, at least, they would not be deployed?

A. That would be a command decision, and I would say it would contribute to such a decision, but I won't speak for commanders or others about that.

Q. Speaking just from your experience, as a military officer or member, I don't

know -- I don't recall your full career, with no disrespect intended, but you've been there for 40 years nearly, 38 years?

A. Yes.

Q. You are very experienced. From that experience, are you willing to say whether or not there is likely to be a perception among many members that if they don't do this training when called upon, there's a very good chance they won't be deployed?

A. There might be that perception. That's all I'd say about that.

Q. There's also, is there not -- there are benefits for being deployed, appropriately so, because it's dangerous. For instance, there is more remuneration; correct? There is the possibility of a medal? You've nodded, but I will have to ask you to speak.

A. Yes, that's correct.

Q. There are, therefore, significant motivations for doing the training even if one feels reluctant to endure the experience; would you agree with that? Or at least would be perceived by many to be so.

A. You can make a case that there is that perception, but I keep coming back to everyone who does the training at Level C gives their well-informed consent, they do it as volunteers and they have the right to withdraw their volunteer status and leave the training at any point.

Q. Knowing -- I accept the formal position, that it is voluntary, and we'll come to the details of just what that means, but you accept, do you not, that there are significant factors that would compel many people to volunteer, even if reluctant?

A. There are factors. Personally I don't think it's probably about the medals and the money. I think for many -- and again I won't go into detail -- it's an important part of their chosen career path.

Q. But to be clear, let me suggest the most important factor is, that what's they joined up for. They joined up to serve, and to serve in that role, and they want to put their other training, their military skills training, to use in service of their country. That would be a very strong motivator to say, "I volunteer for this course if my commander has determined it is necessary for me to be deployed"; correct?

A. It's a statement which would apply to some people, yes.

Q. Most, in your experience, surely.

A. I'd agree with that.

Q. And the same -- although the balance might be a little bit different halfway through the course when a person is under stress, that same factor would still be there, the desire to serve and the other things perhaps peripherally, like medals and money -- the desire to serve, the desire to be well regarded by one's mates and colleagues, would be a factor that encouraged people to keep going with the training, even beyond the point of real discomfort; do you agree that that is a factor for some?

A. There's a lot to that question which falls both into areas I'm happy to discuss openly and areas which I'm not --

Q. Yes.

A. -- and revolves around the duration of the training, discomfort and a few other issues. Can I have that perhaps in a -- either broken down or a slightly different version, please?

Q. You've agreed that for most people there is -- the wish to deploy, if called upon to serve, is a factor that would motivate people to do the training even though reluctant. Do you make the same concession with respect to it being a motivator to continue the training, even though it's become very difficult?

A. It would be a factor. However, if people wished to leave the training, there are a number of options and there are cases where they have got the chance to talk with a neutral -- that is, for example, the conducting officer, who is clearly identified as a neutral person, because they are wearing a certain uniform, they have a white arm band, et cetera, about what's happening, and remembering that our aim is to give those people the best possible chance of getting through that training, having the confidence and the competencies. A discussion like that may enable the learner to regroup, reconsider and go back in. Or, if they are still of the mind that they wish to withdraw from the training, then no one will stand in their way.

Q. Can commanding officers, or other high-ranking officers, make a decision to refer members to CAC training?

A. Typically, that's how it happens. The unit will nominate a group of people by name to attend a course.

Q. Is any review then conducted to determine whether or not the member's future deployment is likely to put them at high risk of capture, or has that, in effect, already been decided by the commander?

A. That will already have been decided. So you are drawing individual names from an eligible prone-to-capture group.

Q. Is the process, so far as you are aware, one where the commanding officer calls for volunteers to be deployed and therefore to be given CAC training, or does

the commanding officer just refer people who are to be deployed and then they have to decide whether they volunteer for the training?

A. I think there's a lot of that, all of that, and other things as well involved in those processes, and I am un-sighted on the specifics of how, at unit level, or equivalent in other services, that occurs.

Q. All right. Let me put the general proposition: to the extent you are able to comment on it, if any, and the proposition is that when your commanding officer decides that you need the training to do the duties that are now going to be given to you, it very much undermines the notion that it's truly voluntary. Do you agree with that?

A. I don't know if I do, and let me explain why. For most of our Level C participants, the career path they have chosen, their military aspirations, they know going in that at some point this lies in their future. So I don't think it comes as a great surprise to the majority of people that they are going to be panelled for Level C ADF Conduct After Capture training at some point as part of an ongoing skills acquisition training development or other cycle.

Q. I will just ask the operator to bring up a document, if I may. It's DEF.1081.0002.0576. Colonel, when I do that, if I get the number right, it comes up. Do you recognise this as the first slide or page of a presentation that's given near the end or at the end of Level B training?

A. I do.

Q. I will ask the operator to -- well first I'll just ask this question, Colonel: a part of the Level B training is to give a description of the Level C training; is that right?

A. It can be.

Q. Can be?

A. Remember that Level B can be delivered to people who are sort of in the middle when it comes to their prone-to-capture status. So it's a standalone activity. It is also mandatory, within a six-month window, to do a Level B if you are going to do a Level C. In that latter case, then the Level B will conclude with what you're showing now.

Q. I'm pretty sure I understand, and thank you for that clarification. I will ask the operator to go to page 0589. It follows from what you've just said in your last answer that the people who are seeing this in the course of their Level B training are ones who are already on the path towards Level C, but they have not yet had to make a decision as to whether they volunteer? Is that a fair summary?

A. They have not yet formally volunteered. I would argue there is a case to be

made in turning up for the Level B, knowing it's the stepping stone to the Level C, they are, in a sense, indicating they are likely to volunteer. Otherwise they may well go, "Okay, at this point I would rather not".

Q. That's very fair, and thank you for the detail. Another way of looking at it would be they have provisionally volunteered but they have the right to withdraw once they know what it's about?

A. Yes, although we don't accept provisional voluntary status --

Q. Small p, small v?

A. Yes, it is important for us to get the actual signatures on paper and confirm it right at the start of the Level C.

Q. Yes, and the signatures come after this slide presentation?

A. Yes, they do.

Q. You will see that the first of the points to remember is that you are undergoing this training because it is a requirement of your trade. Do you see that that might be construed in a way that undermines the proposition that it's really voluntary?

A. I'd look at it as a motivation rather than a constraint or a direction. That is my interpretation of it.

Q. Do you -- I don't cavil with that being your interpretation, but do you see that others might think that the word "requirement" meant requirement?

A. Yes, in the same way that for some of our customers, "specialist skills" are other requirements. So this would be one of those many other requirements that some of our key customers have to undergo to obtain full competency in their trade.

Q. And one can't take the next step in one's career unless one does it?

A. Couldn't take particular steps towards a particular part of a career.

Q. It's also a bit like saying it is a requirement of this job that you arrive at the office by 9 o'clock. That's another phrase with the word "requirement". Why wouldn't that -- why wouldn’t a person read this dot point as being in that nature?

A. I agree; however, I wouldn't say that "requirement" and "compulsion" are synonymous here. They are being reminded it is a requirement for their job, but in no way takes away their right to volunteer or not for that training.

Q. At the very least it could cause confusion in the minds of some?

A. I haven't observed that.

Q. Let me just find my spot. Volunteers, participants, trainees -- I think you called them learners?

A. Yes.

Q. Is that the term that is preferred?

A. Yes.

Q. I will attempt to conform.

A. Me too. Yes.

Q. Learners do have the right to withdraw at any point during the training; is that right?

A. Yes.

Q. Again, be careful, I may not know where to draw the line. There is a -- they are taught from the beginning, or before the beginning, how to communicate that desire?

A. Yes.

Q. How many do withdraw during the training?

A. Very few. My apologies for not having the detail to hand. The figure in my mind, and I stand to be corrected here, is around about 25 or so over the period under review.

Q. I'll just be very slow in case there is an objection because I don't know --

A. Yeah.

Q. -- what numbers are in or out of the public sphere. What is that as a percentage, or a proportion? You've said very few, and I'm not certainly going to hold you to an exact number, but if -- as best you are able to give us some indication of the proportions, it would assist.

A. It's a low percentage. I'm referring to a table which talks about the numbers who have gone through Conduct After Capture training. Those numbers indicate to me that since --

Q. I'll just stop you there. I think that we are guessing. That may be a document

over which confidentiality is claimed --

A. Yes.

Q. -- and I'm sure there will be something in there that can be disclosed, but let's not --

A. I think it's fair to say that it's an unusual and small percentage of the training audience who voluntarily withdraw.

Q. Yes. Now, my next question is how many -- my language, I'm afraid -- but how many, in effect, pause the training? Correct me if I am wrong, a person doesn't have to make a decision to withdraw before giving the signal, whatever it may be. Can they, in effect, pause the training and get some support to then carry on?

A. Yes.

Q. How many do that?

A. Again, I honestly don't know that we have those numbers. If I may, when I was the conducting officer in the most recent activities, from memory there were two people who required what we call a re-briefing, because they were not clear in their own minds and their behaviours indicated this about correct responses, and once I'd spoken with them and reminded them of the key learning outcomes and expected behaviours, they both chose to go back into the training and completed it successfully.

Q. Yes. Is this right: a relatively small number do pause the training?

A. It's a very small number.

Q. You don't have the figures, and my impression was nor do you have the figures back at the office, it's just an impression that it's a small number overall from your own experience?

A. Yes.

Q. I take it, then, that the ADF does not keep data on when people withdraw from the course and/or seek a pause, to use my language?

A. We keep -- the ADF keeps data in the sense that the conducting officer for Level C activity keeps a log. For example, those two people that I spoke with on the last activity, as soon as I'd spoken to them, I went back and I wrote up on the log what happened, what it meant and a couple of comments, so there is a record kept of those issues. Likewise -- and again not going into full detail -- but the reporting regime attached to Level C is extensive and it includes not just individual reports into each aspect of the Level C, but also other situations, be they medical, or issues such

as we have discussed, where someone has either asked for or been given realignment during the training.

Q. Does anybody from time to time -- it might be annually, quarterly, biannually -- but does anybody from time to time sit down, review all of those records, in order to look for patterns that might be used to improve the training?

A. It is done regularly in the sense that after each of the Level C activities, the officers responsible and the group of trainers and key support staff get together and have a review, under what the military likes to call the "sustained improve fix matrix", and essentially it's what it says on the tin, so you talk about things we keep doing, those things we need to improve, tweak, those things which need fixing. And those post-activity reviews are, to the best of my knowledge, consolidated into a rolling review of particularly Level C.

Q. By rolling review, do you mean that it's done after a particular course, but reviews the experiences of all the previous courses?

A. Yes, it aggregates that and then at a certain point, normally by command direction, somebody will say, okay, let's look at how this has progressed for all sorts of reasons, and either recommend or otherwise what might change or be a slight adjustment.

Q. And are these reviews documented?

A. I think they would be documented. That's not as definitive as I would like, but it's my understanding that when they are done, there's correspondence within the system that would both inform and seek decision from appropriate delegates, senior officers, and so forth.

Q. Would those sorts of reviews be relevant to the project you've been doing in the last few months?

A. They are a factor. Our focus has been on the customer and also reviewing data from learners.

Q. If there was a particular point in the training that triggered an unusually large proportion of those who ask for a pause, or actually withdrew, the only way that would be picked up would be effectively through the memory of the trainers and other people who do these debriefs after each course; is that right?

A. Yes, and also potentially through the individual debriefs that are conducted with each learner as part of a post-activity cycle, because -- to explain, each learner goes through a number of debriefs, including one with a resistance trainer, and issues such as those are covered. They are asked, you know, were there particular points of the training which didn't quite seem right, or you think could be improved, and so forth. Those reports are written reports, and then they are reviewed. There is -- and

I'm not going to go into detail in this environment -- a particular aspect of the Level C which has actually improved the efficacy of this approach, where, over the last little while, it has become apparent that a part of the training isn't being as clearly applied as other parts. People have thought about the reasons, and there are now adjustments being proposed that will ideally overcome that inconsistency, or that lack of clarity about expectation and performance.

Q. And did it become apparent because an instructor or a course conductor, or somebody else involved, happened to notice it because it was happening within his or her experience, or did it become apparent because someone had actually sat down and done a review of all of these debriefs with the trainees and systematically looked for problems and issues?

A. It's a bit of both. In that particular case, it was commented on and recorded by individual trainers after debriefs and during the post-activity wash-up, the "sustain improve fix" activity. And then more senior officers running the capability drew those comments in and went, "Okay, we do have a pattern, we do have an issue, and we'll need to look at what are our options", and so forth.

Q. It wasn't the result of a study that specifically had the purpose of reviewing the experiences of a number of courses looking for the patterns; it was more the luck or the acuity of the staff, including the higher-up staff, who noticed it?

A. Yeah, I dispute luck. I don't think there was any luck; it was astute judgment by the trainers and supervising staff that this isn't working as we would like it to, and we need to do something about it. But I agree it was not a separate study that is designed to look at that part of the program.

Q. The example you've mentioned, whatever it may be, did that end up in a document that set out all the learnings from whatever was going on, so that that corporate knowledge was captured for future use?

A. I don't know. I suspect it's in informal correspondence which has worked its way through the trainer management and capability management channels.

Q. We have a break in five minutes, so we will see if we can see something. Could I ask the operator to bring up another document, DEF.9999.0038.0114. Do you recognise -- tell us if you don't -- but do you recognise this is a response prepared by Defence to a notice seeking information?

A. I do recognise it.

Q. I ask the operator -- I apologise, I haven't worked out the exact number -- to go to page 6 of this document. A little further to paragraph 18, we are looking for.

Do you see paragraph 18 there, Colonel?

A. I do.

Q. Do you see that the last four lines of this paragraph refer to a volunteer declaration form?

A. Yes.

Q. I'm going to bring up another document to see if you recognise it to be the same thing.

Operator, could you bring up DEF.1081.0002.0728.

I don't know how good your eyes are, Colonel, but do you -- is this the form mentioned in the previous document?

A. Yes, it is.

Q. Do you know who prepared this form and who approved it?

A. My best answer to that -- and I'm pretty sure this is right, but I don't know for a fact -- is that it would have been prepared by the DSI Conduct After Capture wing, and it would have been approved by the CO of DSI as the authority for such matters.

Q. Do you know whether or not any of the participating medical technicians mentioned previously contributed to the preparation of this document? In other words, put their expertise into it?

A. I don't know that.

Q. What's your understanding of the term "informed consent"?

A. My lay understanding is that it's someone agreeing to a suggestion, a course of action, in this case, attendance on training, with a full and appropriate understanding of what's involved, in terms, in this case, of the treatment, the monitoring, their rights to withdraw and so forth. So my lay approach to it is that informed consent essentially means there are no surprises, you know what you are up for going in.

Q. As far as you are aware, does this form a part of giving the information to make sure the consent is informed?

A. It is part of it. The other part is, as you discussed earlier, Counsel, the addition to particular Level B briefs, which are the Level C prep brief.

Q. Yes. Has any study, review, measurement been undertaken to find out just how well informed the learners actually are? They receive all of this material, they get the briefing, they read the form, one could imagine that later on there's an exam

of a sample, and they are asked questions in different ways and you find out whether they actually did understand it. Has anything like that been done?

A. Yes, there are activities which go to that purpose. Part of it is the individual learner debrief with an RT where the resistance trainer asks the learner to comment on specifically -- if I get the wording right -- how effectively did the Level B briefing prepare you for Level C? So, in other words, were there any surprises, was there anything that you didn't expect? So there's that particular part of it. And most of the comments where we have captured those comments from recent learners have suggested that there haven't really been any surprises because of the combination of the Level B and the Level C pre-brief, in particular.

And I have to say, if I may, that 20 more years ago when I started doing this, things like shock of capture were a part of it, but these days, the idea is that it's a course, people know what to expect, the idea is to get people competent and confident, and that -- what we can do to prepare them for this and get the best learning out of the activity is important.

Q. Two of the matters on the screen were:

> *I shall be subjected to a close simulation of the type of treatment I might expect to receive as a Prisoner of War ...*

And so on. Another was:

> *Nudity is an authorised stressor in the context of CAC training and it may be required I remove my clothing.*

Are there -- without telling us what they are, but are there potentially more severe or more distressing aspects of CAC training than the two I have just mentioned?

A. I'm not going to talk about the details of stressors --

Q. No, it's a yes/no question. Maybe that's not permissible, but I think it is?

A. My only qualification to that is that what is found to be distressing is often quite an individual experience, and that while we may think that something is especially or most distressing in that environment, that may not be the case for each individual learner. So it would be very hard to categorise what are the more disturbing or most disturbing elements for individuals.

PETER SINGLETON: Commissioners, I note that it is 11 o'clock.

CHAIR: Thank you. We will adjourn for 15 minutes for morning tea.

PETER SINGLETON: Thank you, Commissioner.

ADJOURNED **[11.01 AM]**

RESUMED **[11.18 AM]**

CHAIR: Yes, Mr Singleton.

PETER SINGLETON: Commissioners, before the break I had asked questions about a document that identified a number of things that might be experienced in the training. I read out a couple, one referable to nudity and the other referable to conditions of capture. I will proceed from there.

Colonel, you made the point that there is an element of subjectivity as to what is a worse or more horrible thing, and minds might well differ on that. In your opinion, without telling us what they are, are there any parts of the training that are likely to cause some of the trainees greater shock or discomfort or surprise than the ones that are on that form?

A. With respect, I would not want to answer that in this forum, on the grounds that revealing those particularly effective characteristics would reveal elements about the training's effectiveness, that could give adversaries an unfair advantage.

Q. I'm not going to cavil with you beyond this: I just want to make sure you understand the question as a yes/no one. In your opinion, is there anything worse. What those might be will definitely be a matter for the confidential session. Are you able and willing, without harming the public interest, to say whether your opinion is that there is or isn't something worse?

A. There are more effective --

Q. I'm not asking about whether they are effective, I'm just --

A. "Worse" is such a value judgment.

Q. That's right. I'm asking for your value judgment.

A. If you are asking now if I was detained, are there things which I would find worse than those you have just listed, the answer is yes.

Q. To the extent that we can in the public forum, can you point to a good reason why those potentially worse things are not part of the disclosure of what's going to happen before people consent?

A. I'd prefer not to answer that in this environment.

Q. Very well. We'll come back to it, if we remember. I want to turn to a different but centrally important topic, and that is the fact that a number of people who have done this training have later died by suicide. You are aware of that?

A. Yes, I am.

Q. I will ask the operator to bring up a document number, which I will have to read slowly, DEF.9999.0038.0114. Do you recognise this? I'm not sure if it's the same one as before or a different one, but do you recognise that to be a response to a notice?

A. I do.

Q. I'll now ask the operator to go to the tenth page, which is 0124 and I'll just ask the operator to expand paragraph 30. We won't be going to the table but the broad figure, 45 Defence members or veterans who have undertaken CAC training have, or are suspected to have, died by suicide, five of whom had been trained at Level C, by arithmetic, 40 who had done the other levels. Has any study by anybody been done to see whether or not CAC training creates an additional risk factor for suicide?

A. I'm not aware of any such study.

Q. Has anybody -- let me preface these questions with an acknowledgement: it's generally a very complicated matter and there is no one single factor that leads to many such deaths, and you would appreciate that, I trust, but has anybody done a study on just the simple question of whether statistically that's a higher rate than for other members of the ADF?

A. I'm not aware of any such study.

Q. Although if it were a different subject this might be considered a small number, given the very serious nature of people dying by suicide, does it not occur to you or your colleagues or the ADF as an institution that that's a sufficiently high number to warrant an inquiry of some kind? I'm not saying this kind, but an inquiry into whether or not CAC training creates risk factors for suicide?

A. For me, you know, the numbers start at 1 when it comes to being tragic, they really do. The issue that you mentioned, counsel, of the multiplicity of factors and the lack of yet defined distinctions between causality and correlation have played into this aspect of the discussion. All I can say for sure is that during Level C activities, the emphasis on the learner's mental health and the debriefing that occurs with individual psychologists for individual learners afterwards, and the ADF's broader ability and responsibility to provide after care, are significant mitigating factors.

Q. Yes. The actual question was, in your opinion, would it be worthwhile to actually do some kind of review or study to see whether, at least on a statistical basis

or any other basis, there might be a correlation between CAC training and suicide risk?

A. Anything that helps us address this awfulness, of course, would be worthwhile.

Q. But it hasn't been done?

A. Not to my knowledge.

Q. Let me ask some more specific questions and, again, we'll try and be careful, you especially, if I may say so, not to transgress. Do trainees ever become -- sorry. There is a series of questions I want to ask about what is observed about the effects on trainees in the course of doing the training. So many people are observing, including the course conductor. Certain behaviours, to use a loose term or a general term, may occur among the trainees that are not planned or expected. I'm going to go through some of those to see whether they have ever been identified. Do trainees ever start talking in an incoherent manner, suggestive of stress, or at all?

A. Trainees can/have talked to themselves. It's not common. Often it's found to be people singing, although it's not songs as we know it, but it is, as we have talked to them afterwards, part of their coping mechanism, trying to think of every song they ever heard from year 4 and sing it, just to help deal with the environment they find themselves in. That's in line with what we suggest by way of coping strategies.

Q. Have hallucinations ever occurred, as best, of course, as best an observer can tell or in the learner reports?

A. Can I ask for clarification? Are we talking about the period under review or in my personal experience of all of this training that I have supported?

Q. Whether from your own observation, experience as a trainer, a course conductor or otherwise, or from your research and study for the current project that you are doing, or from any other source of information, is it known to you that on occasion, a learner has apparently hallucinated during the training?

A. Yes. Sorry, if I may, and apologies for interrupting, on two grounds: the first is research has shown this happens; and, second, my own experience, and this is over 30 years ago, when the training had a different format, hallucinations were known to occur.

Q. The former, does that apply to the current training? That is, your research as distinction from your observation?

A. Research indicates that after a certain amount of time, which varies, hallucinations will occur under certain circumstances. It's an unusual aspect. People will talk about what they imagine and, again, it's part of coping strategies. Prisoners

of war in World War II -- I have spoken to a gentleman who designed, in his mind, while in solitary under Japanese captivity, his perfect house, and he was in solitary confinement for three years. He came out of that captivity, he was repatriated and he built that house. It was just an example of just being very clear about the difference between hallucination and self-care, self-visualisation.

Q. It's good to have that clarity in mind. I'm definitely talking about hallucination, not a constructive mind exercise. Your experience under the old form of training was that hallucinations occur?

A. Yes.

Q. Have you personally observed hallucinating to occur under the current CAC training model?

A. Not as I would understand the term hallucination. There are moments of disorientation and slightly off-balance. And again without going into detail, when people move from one situation into another, those initial couple of minutes, you can see that there is a period of adjustment going on, and we do what we can to make that work for them.

Q. All right. One can see the distinction you've made as a significant one. Let me just try another, bearing in mind English is a limited language, except for all the others which are more limited, of course. Do trainees ever become delusional? Do you see a distinction between that and hallucination and, if so, do trainees become delusional?

A. I haven't seen delusions. No, I haven't seen delusions.

Q. Have you, in your research, come across that proposition as something that has been occurring under the current model of CAC training?

A. No.

Q. Panic attacks, is that known to be something that, without going into any detail, occurs under the current model of CAC training?

A. It can occur under some circumstances, yes.

Q. And has occurred?

A. Again, I'm relying on my definition of a panic attack. Again, not a psychological definition, but where a learner either demonstrates or subsequently reports during a debrief that they found it difficult to focus, that it's hard for them to get a grasp on things. If that's a working definition of a panic attack, an overwhelming fear, of anxiety, for example, associated with that, then occasionally you will hear of or observe what you think is a panic attack.

Q. But using that definition, that happens sometimes?

A. Yes.

Q. A vaguer term, but do trainees ever break down, whatever that may mean, whether it's simply saying, "I can't go on", or crying or anything like that? It's a loose term but perhaps one we well know the meaning of.

A. I'm going to answer that in two ways. The first is to give you the answer directly, which is yes, but I'm not going to talk in any more detail about circumstances in this environment.

Q. Of course, yes.

A. The other point is, again without going into detail, to explain that one of the strategies that we do teach might lead people to suspect that that's going on, even if it's not, but I would prefer not to go into any more detail.

Q. The last of this particular series of questions -- indeed, my time is running out, so we are near the end for this segment -- have trainees become unconscious during CAC training under the current model?

A. I can't remember anyone becoming unconscious. They have gone to sleep, but they haven't been unconscious.

Q. Yes, and there's a clear distinction.

A. Yes.

Q. You don't recall it and you don't recall reading about it or seeing reports of it?

A. No.

Q. There are, as you've mentioned, a number of observers, some of them described as neutral observers, of the training. Are they briefed on what the official course content is, including what's allowed and what's not?

A. Yes, they are. And, indeed, to expand on that for the Royal Commission's information, the guards and/or what you might call the ancillary staff also go through a level B briefing, so they understand clearly what the purpose and limitations are of the training.

Q. "Guards", that's not a term you've used before, I think, today. Are they guards around the perimeter of the training facility or are you talking about participants in the training?

A. No, they are participating in the training. Their role is to provide the replicated adversarial guard force, but, more importantly, to safely and correctly move learners from one area to another when the learners are subject to certain limitations.

Q. You mentioned white armbands before.

A. Yes.

Q. Do the guards wear white armbands?

A. No, no.

Q. All right. I think that gives us an idea. I won't attempt to tread any more lines like that. Are those participants, guards, trainers with white armbands and anyone else involved --

A. Sorry, just to be very clear, trainers do not have white armbands.

Q. Thank you. So with or without armbands, are those participants who are not learners, they are volunteers as well; would that be right?

A. They are not required to formally volunteer in the same way that learners are.

Q. Well, can they decline a direction to take the post? If --

A. I have not seen that happen.

Q. You've not seen them decline --

A. Yes.

Q. -- or you've not seen a declination refused?

A. Neither, to be honest. They are arranged through the school, who liaises with the supporting unit, and then they turn up. They're given a comprehensive briefing about their duties, they sign confidentiality agreements, as we all do, and then if at any time during the activity any of that support staff element do have concerns, they are encouraged to raise them with either a resistance trainer, the conducting officer, the senior trainer, whoever it might be.

Q. Just in the broad, do the people who are a part of the teaching infrastructure, with or without white armbands, get the same briefings and go through the same consent process that the learners do, or something similar?

A. I'm sorry, I'm confused. The teaching staff don't have white armbands. So you've got resistance trainers --

Q. No, the people who are there. The learners, we can understand, are going to be subjected to stressors, it's part of the learning.

A. Yes.

Q. But there are people there who are, for want of a better phrase, inflicting those stressors or watching it happen who themselves may become distressed by having to do it or see it. Do they have the same protections before and after the training that the learners have?

A. They are not precisely the same in that, for example, a member of the guard force will not go through an individual series of debriefs afterwards. But the briefing given to them, the explanation about why this happens, the reinforcement that this is a learning activity and not an interrogation activity, the opportunity to talk to trainers or others about what they see and have it explained to them, and then afterwards, if they wish to talk either in a group or individually to a trainer like myself or the conducting officer about their experiences, all that goes toward helping them understand and put in context what they are supporting.

Q. How often do the observers intervene?

A. If by "intervene" you mean stop an activity --

Q. Stop the activity or pull someone out of it?

A. It's never happened to me. That is, either as a resistance trainer or a conducting officer or a senior shift trainer, I have never been in a situation where a neutral officer has sought to stop something. They are at liberty and occasionally do ask for an explanation of certain activities and these days we go out of our way, if we are planning a particular aspect of the training, to let them know as soon as this is looking likely and to brief them on the what, why, when, who, how, where, so that they can be fully informed about what's going on and offer comment or intervene, as you put it, if they wish.

Q. So you haven't experienced such an intervention, but do they occur, even if you're not there?

A. Not to my knowledge.

Q. So in all the training courses in all the years, to your knowledge, there's never been an intervention by a neutral observer?

A. Not to stop the activity.

Q. To stop the activity?

A. That's correct. There have been questions raised, there have been discussions, but not to stop the activity, to my knowledge.

Q. I will ask the operator to bring up document DEF.9999.0038.0114. It's the NTG response, we will call it. We may have time to go to the detail. I just want to turn to the debriefing of learners. If we could -- I'm sorry I don't have the page, but if the operator could find the response to question 25? I do have the number, it's 0120, and the answer goes only to the bottom of the page, to a and b part answer.

The Commission understands that there are three different debriefs, being a group debrief, two individual debriefs, one with a CAC conducting officer and one with psychology. I'm not sure if that adds up to three or four, but is that correct?

A. Yes, it is.

Q. What are the purposes of the different stages of the debriefing?

A. The initial -- I'll take them in the order in which they generally occur, which is a group debrief, so that's all the learners being debriefed by the conducting officer. And that's to give a broad overview of what people have been through and to comment on any particular observed features of that training, to remind them of what the purpose of the training was and also to encourage those learners to reflect on what they experienced, in particular, seeing it's experiential learning, and offering ways in which, if they want to follow up particular aspects, they can seek professional support within the ADF to do that. So that's the group debrief.

Then they move into, concurrently, either an individual debrief with a resistance trainer, and that follows a form. The form itself is a compilation of every session that those learners have been through, which is written up and then summarised and recorded in one document, and they go through that so the learner has a chance to talk with the RT about how they did at this time, why this comment was made, what they were actually thinking when they behaved in this way. So they get direct feedback from an RT, normally someone they have had interaction with, and can build on the learning from that.

Then they go -- sorry. It also includes, as I mentioned earlier, comments about their view on the value, preparation and realism of the training and a confirmation they weren't hurt or harmed and they've got all their kit back. So all that usual admin stuff.

Then they go to an individual psychologist debrief and I'm not privy to that.

And the potentially fourth briefing that you mentioned is what's sometimes called the show of knowledge. Without going into a lot of detail, during the activity we see what's possible in terms of finding out information about people and that can be used in sessions. And at the end of the Level C, often general comments are made about the importance of operational security, digital hygiene, a whole bunch of other stuff,

which again is designed to help particularly high threat of capture personnel turn off a few things, shut down a couple of accounts, that sort of stuff.

Q. Are there occasions during the training when one trainee is abusive or disrespectful or in any other way inappropriate to another?

A. I'm searching for anything like that.

Q. In most workplaces eventually somebody's going to be rude to somebody else. And one might think that at a time of great stress, when perhaps they are in a situation which is meant to indicate what it's like to be in captivity with someone else -- and I'm not suggesting whether or not that happens, but to illustrate the question, one could imagine two people in captivity getting annoyed with one another for taking a different approach, or something like that?

A. I won't go into detail but the circumstances that are applied during the Level C don't allow people to necessarily be in that situation. And not being flippant but I think it's a genuine comment, they tend to have all of their angst directed at the authorities as opposed to their mates, because we do reinforce the importance of mateship and even little things like a nudge as you're going back into a particular area or a quick comment, you know, those things. So they're encouraged to respond and survive collectively as ADF personnel, so I think that also works against the likelihood of such things.

Q. Are the debriefs conducted by people who had been part of the instructing or observing staff, or is an independent group brought in?

A. All the debriefs are conducted -- the psych, the show of knowledge, the conno and the RT debriefs -- by people who have been in the activity, especially the RT briefs because, as I said earlier, you want someone who probably had a couple of interactions at pivotal moments to be able to sit down and talk with that learner about what it was, what it looked like, what it meant, good, bad, indifferent, how to improve.

Q. I don't know whether this is a realistic question, so any disclosure of a secret would be a pure accident, but you would be alert to this: does that mean that a learner who is being debriefed might be being debriefed by someone who a short time ago had been in the role of an enemy, or a bully, or something like that?

A. I take issue with the word "bully", but adversarial.

Q. Leave that aside. An adversarial, pretend adversarial position?

A. The answer is yes.

Q. Has the appropriateness of that form of debrief been studied to see whether that's good for either party?

A. I don't know if it's been studied. In my experience, and I would have done hundreds of these debriefs over the years, if not more, it's never been an issue. In fact, and this will sound a bit strange, it's almost a bonding thing, a peculiar experience which you shared. Bearing in mind, if I may explain, that the debriefs happen after the activity has concluded, after the learners and the trainers have had a chance to sleep, to eat, to wash, and come back the next morning, so to speak, so everyone's in Australian uniforms and that helps take some of the steam out of that particular risk.

Q. Finally, to give others a chance to ask some questions, I will ask the operator to bring up DEF.1081.0002.0145. You will recall we looked at the recovery manual earlier.

A. Yes.

Q. I will now ask the operator to take us to page 0212. When we get to 0212, I will ask the operator to expand 11.18 and 11.19 so that we can bear that in mind. We see here a recognition by Defence that CAC Level C training is “dangerous, complex and extremely sensitive”. Further, in summary, Defence acknowledges -- in a summary there is an acknowledgement that there is a risk, if the training is not conducted properly, of injury to an unacceptable level. Can you please tell the Commission what safety measures are in place -- don't reveal secrets but as best you can in a general, public way -- for trainees while they are within the immersion of Level C training, so as to enable them to be observed and make sure that the safety practices are actually carried out?

A. I might tackle this in three ways. The first is attitudinal. Way back in the day when I did this early, we used to have signs all around the various facilities we used which said "These are our colleagues", and the whole idea was to remind people that this is not an adversarial relationship, that these are fellow ADF men and women who are going through extraordinarily demanding training and it's our job to help them. So by reminding people that you are there to help your mates achieve a result from this training, that's the first step, the attitudinal step in the safety.

The second is, I guess, the documentary. There are exhaustive and very well written and clearly briefed orders, instructions, duty statements, which point to everyone's responsibility for safety, regardless of rank or function, and constantly this admonition that if you see something going wrong, just bring it to someone's attention. Don't worry about the training. If someone is about to fall over or whatever, we look after the person first.

The third is the application. At every stage and particularly once trainees, without going into detail, are no longer free to move on their own steam, they are escorted every step, every step of the way, everywhere they go, under approved control measures, so that they are not at risk of tripping, bumping into something or whatever else might happen.

Likewise, the use of restraints and other material is only done in accordance with what has been approved broadly and specified and approved specifically by the conducting personnel at the time. It is just a complete and pervasive safety overlay which attaches to this activity from the initial point all the way through to the release.

Q. Quite a bit of emphasis goes into making sure that people speak up or are protective of one another, if I could summarise it that way. Have unacceptable behaviours occurred during the training?

A. I'll need more specific focus on that, please, because "unacceptable behaviours" across all of the training -- if you're talking about, you know, guards not looking after people, or are you talking about RTs not treating people the right way?

Q. Well -- just excuse me for one moment. Just have a look at paragraph 19. You'll see that it first refers to certain sensitivities in the first sentence and then it says in the second:

> *Claims of inappropriate behaviour, unwarranted training methods, and physical and mental abuse could be difficult to refute without compromising the security issues associated with RTE training.*

RTE training is a comparable concept to CAC training?

A. Yes, Resistance to Exploitation.

Q. There appears to be a recognition here, firstly, that there could be inappropriate behaviour, certainly claims of it, and also that it could be rather difficult to know whether or not it's happening.

A. Yes.

Q. Do you accept there is a risk, in a broad term -- let me preface it also with this: we have heard evidence of much work being done by the ADF to explain to its members what unacceptable behaviour is, and why it should not occur and to deal with it when it does. I take it you yourself would have had training of that nature, of trying to learn what unacceptable behaviour is?

A. Yes.

Q. So just bringing all that training to bear, it's a very general question, I acknowledge, and I'm not seeking any details, but does it occur during the training and is it recorded when it does occur?

A. I'm going to answer by talking about "inappropriate" because it's obviously a different definition during an immersive Level C activity. What is done there clearly would not be acceptable in any way, sense or form in a workplace. So if I may, I

would talk about claims of unauthorised behaviour, because everything that is done by way of generating the simulated adversarial environment is authorised, and as an RT or a guard, you do not do anything that hasn't been signed off. And that includes how you move people, how you interact with people, how you conduct an individual session, what you might use during that session.

Unauthorised behaviour is countered by constant observation. You are on camera the whole time, whether you are a guard or a learner or a trainer in a session, and I think it's important to recognise as well as that the military's power of discipline, in that we are getting orders and we are told under the *Defence Force Discipline Act* and everything that goes with rank and so forth, "You will not do this. This is as sensitive as it gets. This is a capability that's important, but sensitive. You are to behave exactly as you are ordered, otherwise there are risks for our mates, there are risks for the capability, and so forth."

So that combination of discipline and a very clear understanding of what is permissible, the fact that only trained people act as RTs and RT supervisors. Usually we put trained resistance trainers in charge of the guard force as well, and the guards are under extraordinarily close supervision and they know that they are in a world of hurt if they even start to think about not doing exactly as they are told.

Q. I will accept the use of the term, in this very special context, unauthorised behaviour. You have given a description of why there are measures to combat it or prevent it, but I will come back to the actual question I asked, which was has it occurred in the training?

A. Unauthorised behaviour?

Q. Yes.

A. I've never seen an example of unauthorised behaviour.

Q. Have you seen reports of it, records of it, other information that it occurs?

A. No, no, I haven't.

PETER SINGLETON: Commissioners, I have intruded into your time slot. I apologise, but those are the questions I have for this session.

Thank you, Colonel.

QUESTIONS BY THE COMMISSION

CHAIR: Thank you. Commissioner Brown?

COMMISSIONER BROWN: Thank you. Can I just ask a few questions. On the page we had which was out of the Level B training, but the activity brief for Level C, there was something that said "don't sanitise yourself too much". What is that supposed to mean?

A. Commissioner, what it means is that when trainees/learners come to us, because they'll come to us, again, talking broadly, under a certain scenario, ideally, to give them the best chance of realistic and immersive training they would actually turn up as if they were in that scenario. So they would have the relevant material in their pockets, the relevant clothes, the relevant weapons, equipment, documents, comms kit, whatever it might be, consistent with what they are portraying to be, so that this gives them a chance to understand what it's like to have an adversarial interrogator go, "Ah, this bit of kit, that's, for example, a signature item, that only belongs in certain parts of the ADF, yet you're saying you're something different, so how does that all reconcile?"

If they sanitise themselves, in other words, turn up in a bright, fresh new uniform smelling of fresh coffee and nothing in their pockets, the ability to have them understand and apply resistance strategies and coping mechanisms consistent with reality is reduced. So we encourage them not to sanitise themselves.

COMMISSIONER BROWN: Okay, thank you. You talked about the fact that there is a screening process -- medical, psychological screening, et cetera -- pre-existing and then prior to the activities. I guess I'm just wondering what is the risk of an individual not disclosing at any of those screening points potential, say, mental health issues, vulnerabilities, et cetera, because we hear this all the time, that people tell us they just lie, basically, they don't reveal what they are going through or what they have been through because they want to keep pressing on?

A. I don't know what the risk is, Commissioner. I'd have to speak with psychs about that, other than during the Level Bs that I have delivered in the past, we do, you know, encourage people to be clear about such things because it's important that those are known so that accurate risk assessments be made before they come to the training.

COMMISSIONER BROWN: The same applies to the psychological screening pre and post-deployment, but it doesn't seem to change the outcomes.

A. Yes.

COMMISSIONER BROWN: Along the same lines, do you have any awareness of whether that screening actually goes into details of past traumas that the person may have experienced? Not -- I'm looking, therefore, not just at particular mental health diagnoses, but actual past traumas.

A. My understanding, based on conversations with some of the psych officers some of the time, is that it does, and there have been rare opportunities, or, I should

say, instances, where a psych has made known to the RTs in a suitably sensitive way that there are some areas attached to a person and their background which we ought to be aware of so that people can be mindful of that when we are designing the training for that particular person.

COMMISSIONER BROWN: So with that in mind, do you have any awareness of whether there's a threshold beyond which a person would not be considered appropriate? Again, you talked about mental health diagnoses, et cetera, but I'm just thinking there about past traumas. Is there a particular kind of cutoff or threshold where there might be a decision made, this might be too much for this person because of what they have experienced earlier in their life or their career?

A. I imagine there is, but that's my assumption. I don't know how it's determined or applied because I just don't have the insight into the psychological process.

COMMISSIONER BROWN: Thank you. The observing officers, so the neutral officers and the psychologists, what rank would they be?

A. The neutral officers are drawn from a band which is a Warrant Officer Class 1 or equivalent, to Major or equivalent. What that means they are normally quite experienced of people typically, I would imagine, between 15 years and 20 years' experience. Importantly, they can't be drawn from DSI. They can't be drawn from the unit that is undergoing the training, and they must not be, or have been, resistance trainers or ADF interrogators.

COMMISSIONER BROWN: Is it -- and again, I don't want to cross any threshold here that I shouldn't be, but is it likely that they would be of a rank senior or junior to the persons being trained? I guess what I'm thinking about there is whether it's possible that the rank of the neutral observers might make it harder for the trainee to actually put their hand up and say "I need a break" or "I want to withdraw"?

A. In my experience, Commissioner, that's never, ever played a role. It's the position rather than the rank, bearing in mind that the trainees are not requesting to see a neutral officer when they do that; they are requesting to see one of the neutral ADF control officers. There's a distinction between the two. But the same answer would apply. For example, as a Colonel, and the conducting officer for the last activity, there was a junior rank who just asked to see the Colonel, and when I went to introduce myself, "I'm Colonel Dowse", et cetera, it made no difference at all to what they wanted to say to me about what was going on.

Q. So then what would be the consequence if a trainee did say that they wanted to pause or that they wanted to declare a medical issue? You said that there might be a pause or a discussion, they might choose to go on -- presumably they can choose to end it as well -- if they chose the latter and chose to cease the activity, is there a consequence to that in terms of are they allowed to have a second attempt at the training, is it likely to impact their capacity to be deployed, you know, in their role?

A. It may affect -- depending on their role, it may affect their role and ability to do certain jobs, achieve certain qualifications or deploy. So the answer to that is yes, it may.

COMMISSIONER BROWN: Is repeat training allowed?

A. You only ever do the Level C once.

COMMISSIONER BROWN: Okay. So if you withdraw, you don't get another opportunity? Okay.

A. I'm sorry, "yes", for the record.

COMMISSIONER BROWN: Yes. How long are the CCTV recordings kept for? You said they are kept securely. Are they kept forever?

A. They are kept in accordance with the *Archives Act* and I'm sorry I don't know what that means in terms of duration, but that's what they are kept, and -- we have VHS, gen 1 locked away in the vault somewhere all the up to contemporary storage methods.

COMMISSIONER BROWN: And I do have some questions about informed consent, which I think we'll probably come to later this afternoon, but I did just want to note on this public record that from my perspective, discussion of risks is as important as discussion of understanding what will happen. And I think we'll come to that later. Thank you.

CHAIR: Thank you. Commissioner Douglas?

COMMISSIONER DOUGLAS: Thanks, Colonel. If I'm transgressing beyond boundaries, please tell me. Mr Singleton asked you about independent evaluation of the program and, from recollection, you were a bit sceptical about the ability to get people who are experienced in the delivery of programs such as this. Is it possible to do so with cooperation of our allies?

A. Yes.

COMMISSIONER DOUGLAS: And does that happen?

A. Yes.

COMMISSIONER DOUGLAS: Thank you. My next and last question relates to the delivery of the training to an individual. If the trainer perceives during the course of the training that this individual is perhaps particularly resilient or not resilient, does that vary the content of the training?

A. It does, Commissioner, and I would be happy to elaborate on that in other

circumstances.

COMMISSIONER DOUGLAS: Thanks. Thank you.

CHAIR: Thank you. I don't have any questions in this forum.

Mr Free, are there any questions you wish to raise?

STEPHEN FREE SC: Not at this stage, thank you, Commissioner.

CHAIR: Mr Fraser?

IAN FRASER: No, thank you, Commissioner.

CHAIR: Mr Singleton?

PETER SINGLETON: I have one directly arising. One unasked question that was re-inspired and, with leave, one important one that I didn't get to before.

CHAIR: Yes, go ahead. We have time.

FURTHER EXAMINATION BY PETER SINGLETON

PETER SINGLETON: I see we have eight minutes. May I -- thank you for the leave.

Commissioner Brown asked you about particular risk, and your answer was "I don't know what the risk is, I'd have to speak to the psychs about that". Have you spoken to the psychs about that?

A. Not specifically. I have had broad conversations over the years, but to their great credit, and I hope to my sense of discretion, I don't pry into their methods and the specifics of individuals, but it is always useful to get a sense of generally how they are folded into the process.

Q. If you don't pry into their methods, who does take the steps necessary to find out what their methods are in order to give assurance to the ADF or the CDF that the methods are appropriate?

A. It probably happens at three levels. The OC of the CAC wing itself, the CO of the school, the fact that DSI has its own psych, and so I think between those three people and then up the chain of command into Defence, health and other areas, I think there is a strong but hidden to me discussion about those very factors.

Q. Is it not a topic that would be relevant to the review that you have been

conducting and have nearly completed?

A. Again, the Performance Needs Analysis really is looking at the gap and solutions to that gap between customer requirements and capabilities that are being developed or applied at the moment, and while we recognise the fundamental importance of physical and psychological safety and so forth, under the way in which the PNA is shaped, at this point, in what's known as the analysis phase, they are not the preeminent considerations. At later points, when the Performance Needs Analysis starts to look for the design and development and delivery of recommended changes, those sorts of things start to fold in far more regularly and prominently.

Q. When you speak of the customer, in practical terms, is the customer the commanders of the units who may be deployed and therefore need their personnel to be trained?

A. The customers are the capability and component commanders, writ large, so that's across all services and other areas. It varies. The stakeholder list is quite large and varied. So that's a wave. I think unit level is probably a bit low because the big decisions are taken at much higher levels about which categories under which operational constructs are considered most at risk, and then decisions as we discussed earlier are taken from there about individual panelling.

Q. Do you accept that when a trainee -- sorry, a learner is having a debriefing with the instructor who did the instructing, and with the psychologist who did the observing, the trainee will, in most cases at least, realise that both of those people thought that what had occurred was appropriate because the first person did it and the second person didn't intervene?

A. I'm not quite sure what you're asking there.

Q. Insofar as a debrief might be an occasion for a learner to express some criticism or dissatisfaction with what had happened, the learner would know that the very person conducting the debrief either did it or observed and failed to intervene and, in that sense, approved of it. Is that not an impediment to the learner giving full feedback in the debrief?

A. It hasn't been, in my experience, both watching other debriefs and conducting debriefs. If what you're asking is if I had behaved in an unauthorised manner to a learner and then debriefed them, would they be intimidated by the fact that all of a sudden I have gone from being a role player to a Colonel, and therefore feel they shouldn't say it or can't say it because no one else has said it, that doesn't seem to have been a factor. Mainly because people aren't behaving in an unauthorised manner.

Q. Well, firstly, is it not the case that the typical learner is not going to have a detailed knowledge as to what exactly is authorised and unauthorised?

A. Well, they will, in the sense that in the individual learner debrief form there is a question -- forgive me if I don't get this verbatim, but I'm pretty sure I got the gist of it -- "Bearing in mind the circumstances of CAC Level C training, were you unduly or inappropriately dealt with at any time during the activity?" What the RTs tend to do is explain exactly what that means in the context of Level C.

Q. And even assuming a good explanation, what I suggest to you is no explanation could be good enough to bring the trainee or learner to the level of knowledge and expertise that the conductor of the course, or the instructor, already has?

A. I agree with that. One other thing that is done is that if -- you know, the very rare circumstances where there's been a particular type of interaction between an RT and a learner, then normally what would happen is when the senior shift trainer allocates the individual debriefs, then you'll put in an RT with that learner who wasn't involved at all in that particularly sensitive or different interaction. So there is that element of neutrality brought to bear during the debrief which would allow the learner to go, "Well, see that guy over there? This is what I think".

Q. At the beginning you expressed the view that you'd never seen a problem that I'm attempting to address in this little set of questions. Has there ever been a study or survey done, perhaps taking just one course, and saying, "Pick this one, we'll drill in carefully", once the whole process including the debrief is over, a new group of people will come in and say, "Look, we have chosen you to be part of a special project to find out if it was really any good. Forget about all you've been told about what's appropriate or inappropriate, just give us your views", some way of testing whether the usual process is eliciting adequate feedback?

A. I think we have done something similar. Counsel, you mentioned empirical evidence before. One of the ADF psychs, I think in 2017, conducted a review of learner feedback from Level Cs and produced a report which, amongst other things, 93 per cent of the respondees said the training improved their confidence to resist interrogation and survive captivity. Now, that psych wasn't involved in those activities directly. They went and asked and looked at the reports that had come from the learner debriefs, and that's the sort of positive response in terms of the training's efficacy which they came up with.

Q. All right. Well I won't go into the detail about that, due to time. We'll chase up the report in due course.

My last effort in this inquiry, this segment, is involving a document. I will ask the operator to bring up DEF.1081.0002.0722. When it comes up -- there it is. You will see it is headed "Activity Commencement Brief for Learners". Just have a look at it. Is this a document which is, on this page, effectively a script for an instructor -- sorry, for the conducting officer to in effect read out to explain things to a learner?

A. Yes, it is.

Q. I will ask the operator then to go to the next page of the document. Do you see this is headed "Declaration". There is an explanation that learners are to provide a verbal response to each question, and you will see, 12. Do you see at 10, the question is asked:

Is this your volunteer declaration form? (Learner to sign)

A. Yes, I see that.

Q. Is this, in effect, a continuation of the script that the conducting officer follows in that the conducting officer will ask the learner these 12 questions?

A. Yes, it is.

Q. And when question 10 is asked, the learner is shown a document?

A. Yes.

Q. Which the learner is then invited to sign?

A. Yes. Just briefly, what happens is that typically at the end of Level B, for those doing Level C, they give the Level C brief. At that point, particularly in some cases if there is a very short gap between the end of Level B and Level C, they are shown the voluntary declaration form and fill it out, but do not sign that form. So they know what they are getting themselves into. A short time passes, they start the activity, they end up being briefed by the conno who then, as you say, takes them through the script, asks and records their answers to those questions, then places in front of them their volunteered declaration form and, to formalise the process, confirms it is theirs and asks if they are willing to sign.

Q. And this is the, if you like, critical point, the signature point?

A. Yes.

Q. I think we earlier said you, in a sense, had volunteered at an earlier stage, but this is the moment --

A. Yes.

Q. -- when the signature goes on the page?

A. Yes.

Q. Who is present when this script is read out and these questions are asked?

A. It is the learner, the medic and the conducting officer in a room.

Q. Not the psychologist?

A. No.

Q. Is there any other person ever present for this process?

A. No.

Q. The learner would have to say to the medic, who is not a medical practitioner, "We have discussed that". You may have to say "yes" in the presence of that person to wanting to speak to a psychologist?

A. Yes.

PETER SINGLETON: Those are my questions for the open session.

CHAIR: Thank you.

Are there ny issues, Mr Free?

STEPHEN FREE SC: No, thank you, Commissioner.

CHAIR: If there are no other issues, we will adjourn for lunch and reconvene in one hour.

THE WITNESS STOOD DOWN

ADJOURNED **[12.19 PM]**

RESUMED **[1.17 PM]**

CHAIR: Good afternoon, Mr Gray.

PETER GRAY: Good afternoon, Commissioners. I call Dr Robert Worswick. Dr Worswick is already in the witness box. I will just explain some housekeeping issues and then in a moment I'll ask that he be administered the affirmation or oath.

Firstly, there is a tender list in respect of Dr Worswick's evidence. I will ask the operator to display that. Commissioners, there are a number of items in the first part of that list which you see before you, on the first two pages.

There are three items, items 2, 12 and the attachment to 12, that are being tendered on a confidential basis. They are the unredacted version of Dr Worswick's statement. A redacted version has already been tendered by Mr Connor and it appears later in this document. It is item H of the documents previously tendered. Item 12 is email correspondence of November 2022. It is being tendered on a confidential basis. Most importantly, an attachment, referring to certain individual matters, to that email is being tendered on a confidential basis.

We will be seeking a non-publication direction to ensure that there is enduring protection for those documents. It is not intended that they are going to be published. There will be some questioning relating to those documents in a closed session in due course.

On that basis, could I first tender the documents in the list appearing on the first two pages of the document displayed before you.

CHAIR: Certainly, thank you. That will be accepted on that basis, and allocated the next lot of consecutive numbers.

EXHIBIT #57-5 - TENDER BUNDLE FOR DR BOB WORSWICK (EXCLUDING ITEMS 2, 12 AND ATTACHMENT TO ITEM 12)

EXHIBIT #57-6 (CONFIDENTIAL) - TENDER BUNDLE FOR DR BOB WORSWICK - ITEMS 2, 12 AND ATTACHMENT TO ITEM 12

PETER GRAY: Thank you, Commissioner. The next item of housekeeping is that you, as you know, Commissioners, have made a non-publication direction and an order in respect of a closed session later today for examination of Dr Worswick. Can I just indicate to the public what our plans are in this respect.

For the next 90 minutes or so we are going to have a public examination of Dr Worswick. Dr Worswick is a medical doctor. He's a rural generalist. He is currently a Senior Contracted Clinician contracted to Defence and he provides medical services to Defence, including in Wagga, and in that respect he provides medical services to recruits at RAAF Base Wagga and at Kapooka. He does so as part of the services that are provided by BUPA to Defence.

Previously, in 2021, he was Senior Medical Officer for New South Wales South and he had similar responsibilities or similar -- he provided similar services, including services to recruits at the bases. Before that, for a couple of -- not immediately before that, but in a period before that, he was a Medical Officer in the Army and before that, he had a long career in the Army, a couple of decades of experience in the Army.

His evidence today is not about his experience as a soldier, it is focused on his concerns arising from knowledge he has acquired in the course of his duties as a Medical Officer, Senior Medical Officer and Senior Contracted Clinician.

We are going to hear from him in public session for 90 minutes, as I say, and then just before 4.00 pm, as far as the public is concerned, the webstream will cease at that point. Commissioners, after a brief technical adjournment, we will be asking that you conduct a closed hearing to hear the balance of Dr Worswick's evidence. That's necessary because of sensitivities around some of the details that Dr Worswick will be telling you about.

Then Dr Worswick's evidence will come to a close just before 4.00 pm. I beg your pardon, I think I got the time wrong a minute ago. Dr Worswick's public evidence will finish at about 2.50 pm. Then at that point, as far as the public is concerned, the webstreaming of proceedings today will come to an end and the public webstreaming will recommence tomorrow.

During the period from about 3.05 pm to just before 4.00 pm, we will hear from Dr Worswick in closed session. Then there will be a short adjournment and from 4.00 to 5.00 pm you will continue to hear from Colonel Dowse in closed hearing.

CHAIR: Thank you, Mr Gray.

PETER GRAY: You have already made a non-publication direction in respect to the closed hearing that will take place from 2.50 pm.

DR ROBERT WORSWICK, AFFIRMED

EXAMINATION BY PETER GRAY

PETER GRAY: Dr Worswick, I will ask that a redacted version of your witness statement be displayed, and that is at H of the documents previously tendered. I will read into the transcript the document number that appears; it is RWO.0000.0001.0006_R. Do you recognise that to be the first page of the statement you have prepared in response to a notice from the Royal Commission, Dr Worswick?

A. I do.

Q. To the best of your knowledge and belief are the contents of the statement true and correct?

A. Yes, it is.

Q. Thank you. I should have asked you whether there were any corrections you needed to make to the statement?

A. No, there are not.

Q. Thank you. Dr Worswick, I won't ask you questions about your couple of decades in the Army and we'll skip straight to your career as medical officer. You were a medical officer in the Army in 2017 and 2018; is that right?

A. Yes, that's correct.

Q. You had a stint in Joint Health Command with responsibility in the area called MECARS in 2020; is that right?

A. Yes, that's correct.

Q. What's that about?

A. MECARS is the Military Employment Classification and Advisory Review Service. It provides advice to the service MECRBs on the suitability for employment and deployment of ADF members.

Q. Thank you, and after that stint in MECARS in 2020, did you become the Senior Medical Officer for Southern NSW, covering both Kapooka and RAAF Base Wagga, and was that in 2021?

A. Yes, that's correct. I was posted as the Senior Medical Officer for the Joint Health Unit of Southern NSW, which covers both the ACT and the Wagga region.

Q. Thank you. In the course of your role as Senior Medical Officer, were you intended to be providing frontline medical services to recruits, or was that just something that occurred as needed?

A. So, it wasn't intended I would provide frontline medical services to recruits. In fact, we have some wonderful medical officers who have been at Kapooka for a long time who shoulder the burden of that responsibility. My role was more so in the capacity of providing advice to them in relation to how injuries or illnesses affecting those recruits might affect their Military Employment Classification and whether that might need a referral to the service MECRBs, whether that may require them to be medically separated or simply just rehabilitated to return back to training.

Q. But on occasion, did you have to step into the frontline?

A. I have seen a very small number of recruits directly on a doctor/patient basis. I have done more work with some of the staff at RAAF Wagga and RAAF Kapooka.

Q. Thank you. Could you just tell the Commissioners a bit about your current

role since mid-2022. You are a Senior Contracted Clinician, employed by BUPA, providing services to Defence; is that right?

A. That's correct. As a Senior Contracted Clinician, my role is to provide -- is to undertake a number of tasks. It's a clinical supervisory role and it's an advisory role. So I provide some clinical supervision and clinical advice to the other medical officers in the Joint Health Unit Southern NSW area on how best to manage some of the complex cases that they might be managing and specifically on advice of the application of the Military Employment Classification System.

Some of the other responsibilities I have are in the approvals of particular treatments or investigations. ADF members get a very good level of healthcare, but there are some interventions and/or investigations that require that next level of approval and that's, again, one of my responsibilities.

Q. I'm just going to ask the operator to display from your redacted statement -- in this public session we'll only be referring to that document -- paragraphs 17 and 18 on the break of pages 0009 and 0010. In those paragraphs, Dr Worswick, you refer to some of the matters you just explained to the Commissioners concerning your role as SCC, Senior Contracted Clinician. You talk about military medicine being unique in a certain respect because of the need to take an organisational perspective. Can you expand on that, please?

A. It is a unique environment being a doctor working for Defence because you owe an obligation or responsibility to two masters, for want of a better term. A first priority, of course, is to provide patient-centred care to ADF members. But we also have a responsibility to meet and provide advice to the ADF on the ongoing employability and deployability of those members. Sometimes those two responsibilities can clash because, on the one hand, your priority is to look after the health and wellbeing of the individuals, but sometimes the clinical conditions, injuries or illnesses that might arise from their service may result in them being not fit for further service, and that's when you have an obligation to provide advice to the Australian Defence Force as to whether their ADF member is suitable for continued service. And that has some significant implications.

As the Commissioners are aware, medical separation is a big deal and it can be challenging dealing with both of those responsibilities because, on the one hand, you're looking after the patient's welfare, the ADF member's welfare and, on the other hand, you're also obliged to tell them that you are required to potentially refer them to Service MECRB and the outcome of that referral may be a recommendation for their separation from Defence.

Q. You mention, and this is in paragraph 18, the particular importance of continuity of care in that context and how, where there isn't a continuity, there can be a losing sight of the occupational element. Can you expand?

A. So, continuity of care is important for a number of reasons. Firstly, from a

patient-centric care perspective, it's important for the doctor to know the patient well so that they can work with them towards their -- on their journey towards wellness. But it's also important from the occupational perspective because, as I said earlier, there is a requirement for the treating clinician to be able to provide advice to the services, the ADF, on the ongoing employment and deployment suitability of the member.

Where there is a lack of continuity of care, sometimes the treating clinician can get lost in the here and the now, that is the medical conditions. In my experience, I've seen a number of cases where ADF members have had very, very good clinical care provided by clinicians but because of a lack of continuity of care, they haven't necessarily seen the bigger picture, understood the implications from an employability and deployability perspective. As noted in my statement, certainly one of the roles of an SCC is to have that sit back and look from afar perspective and understand the bigger picture. I think that's what counsel's referring to there.

Q. Doctor, at paragraphs 22 and 23, this is again on the break of the page, pages 10 and 11, operator. In those pages you refer to the role of welfare boards. You refer in quite approving terms, I think it's fair to say, to the opportunity they provide for a meeting of minds or a collaboration between Command and medical staff. Are they working as they should? Is there room for improvement?

A. Oh, I think the welfare board is a wonderful tool that's used by Defence to manage members who have questions arising about their suitability for continued service. I have quite considerable experience in welfare boards. I would conservatively say that I have discussed around about 2,000 ADF members in welfare boards in the last 18 to 24 months. I think, by and large, welfare boards work very, very well.

It's important to recognise that a welfare board is actually a command responsibility, it's not a medical responsibility. We are a contributor to that. In terms of improvement, I would suggest that -- I think sometimes the medical officers may have a better understanding of the welfare and Military Employment Classification System than commanders do, but we are a joint team. So, as counsel indicated, the welfare board provides the opportunity for all of the people involved in the patient's care and welfare to come together to make sure that we are working to the interests of the member.

Q. Dr Worswick, we have been asked to slow down a little. I'll try, and I'm sure you'll try, thank you. You mentioned Army and the Royal Australian Navy having welfare boards. What about the Royal Australian Air Force?

A. Sure. I have participated in welfare boards for all three services. From my experience, it is a very well embedded process in Army. It is a quite good process embedded in Navy. Navy have recently written some new doctrine on welfare boards. They wrote that last year. I provided some input into the development of that policy.

I have had some participation in Air Force welfare boards, less so than the other services. My sense, from my personal experience, is that the Air Force welfare boards are perhaps not as mature, but that's only from my experience. I haven't had as much experience in dealing with welfare boards for Air Force, as much as I have the other services.

In speaking with one of the Air Force officers from Air Force headquarters last year and asking about a welfare board policy, I was advised that it was in the process of being written or rewritten, but I have no further detail around the current policy. I know there is a previous policy from around about 2013, but I don't know whether that has been rewritten.

Q. Dr Worswick, thank you for those background and contextual matters. I'm now going to ask you some questions about some concerns you express in your statement. We'll start with a reference you make to the recruiting challenges that are facing the ADF, and they are well known and have been traversed in earlier hearings of the Royal Commission as well.

The point you make is that the recruiting challenges, you think, are resulting or have resulted in a relaxation or a lowering of recruiting standards relating to fitness, in an effort to increase the pool of candidates for recruitment. You mention that in paragraph 25 of your statement. You are concerned, as you say, that the lowering of entry standards could perpetuate or will perpetuate, if not increase, the rate of veteran suicide. You go on to provide reasons why you are concerned that may be so, and we'll come to those in a minute.

I just want to start with displaying what the Chief of the Defence Force, General Campbell, wrote in his statement on this issue in response to a notice from the Royal Commission earlier in the year. This is at document N -- DEF.9999.0011.0344. This is at page 89 of that document, please, operator, paragraph 313 at page 0432, thank you, operator:

> *Given current economic circumstances and the low employment rate, the ADF's risk appetite in recruiting has increased.*

Doctor, I won't yet ask you about your views on that statement concerning risk appetite, but I will come to that. Going on and reading the Chief of Defence Force's paragraph:

> *As an example, the Services have slightly reduced the standards of their preliminary fitness assessments for the majority of employment groups and been prepared to consider candidates with a marginally higher psychological risk indicator for certain roles. The Services are taking more considered risk against a candidate's chance of success at initial military and employment training; as a result there is likely to be an increase in those risks being realised in initial training, but it is too early to understand this impact.*

Just pausing there, Dr Worswick, you, in the course of the duties that you've outlined to the Commissioners, have formed some views about what those impacts appear to be; is that right?

A. That's correct.

Q. You've referred to an impact which you've called Impact 1 in your statement between paragraphs 26 and 27 on page 0011. Impact 1 is trainees with poor levels of physical fitness. Now, perhaps the best way to start with this topic is to refer to a study that you mention in your statement. It's previously tendered. It's document RWO.0000.0001.0001, a study by Rodney Pope, *Predicting Attrition in Basic Military Training*. What was the study about?

A. Sir Rodney Pope was a physiotherapist who was working at Kapooka in the early to mid-1990s. I was posted to Kapooka at the same time. The study was looking at the attrition rates through training. When I was posted to Kapooka, I served in the role as the agent, so I was working directly with the Commandant, and one of the chief concerns of the Commandant was the attrition rate. If I recall correctly -- and it was quite some time ago, 1996/97 -- the attrition rate was around about 17 or 18 per cent and the majority of the attrition rate was attributable to musculoskeletal conditions and particularly lower limb injuries.

Rodney Pope and his colleagues looked at identifying risk factors that might increase the risk of a recruit being injured through training and, through that study, also identified that the increased risk of injury led to an increased risk or increased likelihood of medical separation. So the study -- Rodney Pope and his team used a surrogate measure for measuring pre-enlistment fitness. It was called the -- well, colloquially known as the beep test. It was called a 20-metre shuttle run test, or something like that, but colloquially known as the beep test. They used that as a surrogate measure to establish or determine what pre-enlistment fitness was, and then their study using about -- or looking at about 1400 recruits, examined the effect of recruits' achievements on that shuttle run test, the beep test, and their likelihood of injury. The key finding was -- I beg your pardon.

Q. Thank you. If we go to page 00 -- sorry, 0004, under "Discussion", the report of the study says:

> *The results of the study indicate that the 20 metre shuttle run test score measured before commencement of training is a strong predictor of attrition in basic military training. In both injured and non-injured subjects, recruits who scored poorly were about 25 times more likely to fail to complete training than the fitter recruits who scored highly.*

Those two expressions were defined as -- by reference to brackets in an index of results of the shuttle run test; is that right?

A. Yes, that's correct.

Q. There's detail on the previous page under the heading "Results", previous page 0003, right-hand column. There is detail there about the relative risks or relative likelihood of injury and risk of attrition or failure to complete training by reference to various brackets of results. That appears right at the foot of the right-hand column, thanks operator. Right at the of the right hand of that page. Thank you very much:

> *Subjects who had sustained an injury in training were 10 times more likely to fail to complete training ...*

Then there's similar risk factors identified for the least fit subjects. People who had a score of only 3.5 on the test, they were 25 times more likely to fail. There were less extreme risks faced by people who were somewhat low in their results on the shuttle run tests. What was the outcome of the study? Do you recall what occurred after this study had been done at Kapooka?

A. I do. So, Rodney Pope made a recommendation that we should implement the beep test at Kapooka, and it was. It was made a pre-enlistment requirement and certainly a requirement for recruits to start training. So when a recruit came to Kapooka, they were made to do the beep test before they started training.

Those that scored above 7.2 -- and I believe it was 7.2. It may be 7.5. I note from the information provided by Colonel Deacon yesterday that the cut-off they are using at the moment is 7.5, so my memory from 25 years ago may be a bit hazy. But certainly we established -- the Commandant established the beep test as a prerequisite to start recruit training.

The implications of that were very quickly realised and were significant. So, again from my recollection -- I don't have the exact figures to hand -- prior to the beep test, the attrition rate was around about 17 to 18 per cent, and upon the implementation of the beep test, the attrition rate dropped to between 12 and 14 per cent, if I recall correctly, and that's quite statistically significant. It's about a 30 to 40 per cent reduction in attrition of trainees at Kapooka.

Q. What's the current -- I beg your pardon -- What’s the current status of the shuttle run test or the beep test in the pre-entry fitness assessment, to the best of your knowledge?

A. So my understanding, and I will admit that I'm not an expert, but my understanding and certainly based on the information that was provided yesterday by Colonel Deacon, is that the shuttle run test is still used as a means of assessing the fitness of recruits, but there are now different standards applied, based on the different training opportunities that are provided and, specifically, that they have delineated between a standard of 7.5 for combat and combat-related roles and a standard of 6.1 for non-combat related roles. They then have a lower standard which

would be used as a means of allowing entry into the Army Pre-Conditioning Program.

Q. I'll just ask for a slide presentation entitled "Recruiting Levers and Opportunities" to be displayed for you, that's in the tender list at number 8, DEF.1062.0001.0216.

Dr Worswick, this is a document that appears to have been prepared in about February 2021, and it refers to the Army Pre-Conditioning Program, this is on page 0130, and Colonel Deacon has explained where that program fits in the programs that are being conducted at Kapooka. What do you draw from the table at the top right-hand quadrant of this slide?

A. So what that tells me is that there are about 850 people who, during the reporting period there that commenced the pre-conditioning program, and 30 per cent of them did not complete it. It doesn't give me any information as to why they did not complete it, but it says that 30 per cent of the individuals who commenced the APCP, who entered the APCP, with a lower cut-off mark on the beep test, 30 per cent have not graduated from APCP to -- sorry, have not graduated from the recruit course, so about 21 per cent committed the APCP and then some did not graduate from the recruit course.

Q. If we can go now to a document that predates this slide pack. It's a document in 2016. It's a decision brief to the Chief of Army, and there's a similar -- I beg your pardon, it's a decision brief to the Chief of Air Force and there's a similar document in existence in the documents previously tendered in relation to the Chief of Army. We will go to the Chief of Air Force document. It's at tender list number 4, it's entitled "Removal of unnecessary barriers", DEF.0017.0001.0001, please operator.

A. May I make one final comment about that slide?

Q. Yes, please. Please do, doctor.

A. The other comment I'd make, if you are looking at the bottom right of the graph, is that there are an increasing number of people who are not meeting the current entry standard, and that are coming in through the APCP. It's the red line there for the female candidates. It's close to 50 per cent, which I suggest may predispose them to injuries through recruit training, that there may be a disproportionate impact on our female trainees.

Q. You're drawing from the shape of the red curve, are you?

A. That's right, the red line there that's labelled "percentage of female general enlistment inflow" that shows a bit over 45 per cent, so nearly half of the female trainees that come into Kapooka come in via the Army Pre-Conditioning Program, and they come in at a lower standard of fitness, and my suggestion is that that lower standard of fitness, based on the study from Rodney Pope, means that they are more

likely to be injured in training. And based on the graph there in front of us, that, in fact, a larger burden of injury may in fact be for female trainees compared to males.

Q. Thank you. We'll go now to the 2016 document on removal of unnecessary barriers, DEF.0017.0001.0001.

Brief for [Chief of Air Force]: Removing unnecessary barriers in the entry medical recruiting process.

This is a document that has been provided to you in the course of preparation for your evidence; is that right?

A. Yes, that's correct.

Q. And you had access to a similar document in the course of your duties in relation to the Army; is that right?

A. That's correct.

Q. Are you familiar with the fact that in 2016, there were various changes made to the recruiting entry standards for both Army and, as this document suggests, the Air Force? Is that right?

A. Yes, I am.

Q. And you've only been performing your duties as Medical Officer, then Senior Medical Officer, and now SCC in the period after 2016, so you can't compare the provision of medical services before 2016 with your experience since, can you?

A. I can provide some anecdotal evidence because I was posted to Kapooka for two years during the period 1996/97, but the bulk of my experience is more contemporary.

Q. Alright. Subject to that qualification, is it a fair summary of the concerns you are raising before the Royal Commission that since 2016, there's been a lowering of fitness standards and you're concerned that there hasn't been a commensurate series of adaptations down the line to protect the interests of the recruits who might have entered as a result of the lowered standards?

A. My concern is that with the lowering of entry standards, and as noted in that document, they identify that a key risk associated with lowering of entry standards is a potential for increased injury rates, and that a risk mitigation strategy would be for the provision of increased health services at the ab initio training establishment, so specifically at Kapooka and the other services. And my concern is that during this timeframe, so certainly since this brief was written in 2016, in addition to the lowering of entry standards, there has also been an increase in the trainee throughput because the Defence Force has been growing over the last years, so the net effect of

that is that you have an increasing population, patient population, of recruits who -- generally, not all -- some who have a lower physical fitness standard, and those two factors result in a considerable increase in the burden on clinical healthcare that's required for them, and that there has not been a commensurate increase in the resources to provide that care.

Q. Thank you. Let's just go to some of the detail which I believe you wish to comment on and is of concern to you.

Operator, please go to page 0009. This is an attachment to that brief to the chief of Air Force, Dr Worswick. It's titled "Attachment 2". It is comments and feedback from stakeholders. The Navy has provided quite a lot of comment on the first page and over to the second page. If we go to the second main paragraph commencing "Is this consistent with the current Navy strategy to improve resilience?", you wish to make a point, I believe, concerning the expectation at the time in 2016 as to what conditions would be the subject of potential changes in standards and which wouldn't be?

A. So the brief did identify a number of conditions which would be included in the trial, and certainly some of them made sense to me as a clinician, and I agreed with the intent that there would be low risk in allowing those conditions to be waived and for entry into the Defence Force.

Q. Perhaps I will just stop you there.

Operator, please go to 0005, which also goes -- contains a table in the bottom half of the page and goes over to page 0006. If we can just expand that table.

Dr Worswick, are these the conditions that you consider were logically and sensibly the subject of consideration for relaxation?

A. Some of them. As it turned out, for some of those that seemed quite simple or trivial on that list, some of them have actually caused some concern for us, and I can speak to that later.

Q. All right.

A. The key issue from the earlier comment that was brought up, the second paragraph --

Q. We'll go back to that, please, operator, on 0009.

A. The key issue from my perspective -- the two key issues from my perspective is the comment that mental health and musculoskeletal have been excluded from the strategy. I acknowledge this is a 2016 document. That is not my contemporary experience, that there are mental health and musculoskeletal conditions that are being waived on entry. And we are -- we, the clinicians in the Wagga region, are seeing

what I believe are detrimental impacts from a health and certainly we are seeing some recruits being medically separated from Defence, or separated from Defence but with a non-deployable MEC as a result of the pre-existing mental health and musculoskeletal conditions.

The second part of that statement, that I don't have visibility of, per se, but is of concern to me, is the last sentence that says:

> *Tracking of these individuals through into Service is possible and could provide some evidence of whether this was borne out in practice.*

I do not know whether that tracking has occurred. I don't -- or I can say that we have not seen a change in the way that the waivers are being applied. In fact, we have seen a change, that there are more waivers being applied and for more conditions. So I can't determine whether we have -- we -- sorry, please forgive me, I keep saying "we" because after 35 years in the Defence Force, it's hard to stop saying "we". I can't determine whether the Defence Force has learnt lessons from this trial and what they have done to implement or change things as a result of those lessons.

Q. Dr Worswick, can I draw your attention to the fifth paragraph as well. I don't know whether this is the same point that you just addressed concerning tracking of members. Do you care to comment about that statement, reading:

> *Any flow-on effects on later-in-life standards need to be considered.*

Et cetera?

A. Again, I have no visibility of having worked for Joint Health Command for the last nearly two years, with oversight of two ab initio training establishments, I have no visibility of a systemic approach to tracking the outcomes of people who are given a waiver to enter recruit training.

Q. All right. I don't think we -- I mean, there are many other things here that we could discuss but I think we had better keep going because we'll run out of time. I'll now go back to 2021, to a discussion paper relating to that presentation slide pack that I asked you about a short time ago. It is tender list number 9, Chief of Army's CAC addendum paper, "Recruiting Levers and Opportunities", that's DEF.1062.0001.0123.

This is a document that you've been shown in preparation for giving your evidence, but which you hadn't come across in the course of your duties as either Senior Medical Officer or SCC; is that right, Dr Worswick?

A. Yes, that's correct.

Q. This document appears -- and I invite the inference, Commissioners -- it's a discussion paper relating to that presentation. It has various elements that you wish

to comment on, doctor. The first is, I understand, paragraph 5(b), where there's reference to the lowering, or lower entry standards being trialed, and this is a comment that relates to the APCP.

The APCP had been in place since, when, 2016, for women?

A. I'm not sure when it was implemented.

Q. If we take that as correct, we'll stand to be corrected by our friends from the Commonwealth if it isn't, and if we also note the fact that in more recent times, perhaps from about 2020, it has been opened up to some men. This document in 2021, February 2021, indicates there is consideration being given to further changes which might affect the APCP, amongst other matters. Do you agree with that?

A. I do. I take that to read that up until financial year 19/20, that it was predominantly for female candidates, but I also take the second part of that sentence to mean that the cut-off for the APCP, as I understand it, was a beep test score of 5.5 and there are cut-offs for some other physical activities, such as push-ups, but they are now trialing a lower entry standard, so I should take that to mean lower than a 5.5 cut-off for entry into the APCP.

Q. Thank you. If we just go over the page to paragraph 8, there is the beginning of a discussion about one of three concepts that are discussed in this proposal, and it's called "Concept 1 - Indexed Entry Standards". This is actually a phrase that Colonel Deacon used yesterday, suggesting that perhaps since February 2021, there's been at least some degree of implementation of this idea. Do you know anything to the contrary of that interpretation? Does that interpretation sound reasonable to you?

A. I know nothing to the contrary, but I am aware of the index entry standards, but I wouldn't profess to knowing a lot about it.

Q. It says in paragraph 8:

DFR [Defence Force Recruiting] advises the Physical Fitness Assessment ...

Is that also called the pre-entry physical?

A. Pre-fitness.

Q. Beg your pardon, pre-entry fitness assessment, PFA. Do you know of anything else, any difference between the so-called physical fitness assessment and the pre-entry fitness assessment?

A. I believe they are one and the same.

Q. Thank you. It says:

... the largest barrier to increasing Army's inflow.

And then there's reference to the development of the ACPC[sic], and relevant to an increase in the use of the APCP as an inflow avenue. What are your comments on this paragraph and the discussion that follows?

A. I think my first comment is that the pre-fitness assessment, however it may be referred to now, was established back in the mid-1990s for a very good reason, and I think, broadly speaking, people in the room would understand that in the last couple of decades there has been a general reduction in fitness among the youth of Australia, so what we are seeing, I suggest, is affliction of society, is that young people perhaps aren't as fit as they once were when they're coming to join the Australian Defence Force, and that in contemporary times, a standard of 7.5, the standard that was established when I was at Kapooka in the mid-1990s, is proving a significant barrier to getting the number of recruits through the door into the ADF. This is about now trying to mitigate or to remedy that risk, and by also applying the risk mitigation strategy, which is the APCP. So lower the standard, but have a risk mitigation strategy, such as the conditioning program, to try to bring them to a standard -- to the standard that we know reduces their level of, or their risk of being injured in training while they are in the service, to then start training.

Q. I just want to provide an anchor for some of the fitness levels that you've referred to in the course of your evidence over the last few minutes.

Operator, please display DEF.1048.0004.6104. That's an instrument entitled "ADFRI032", "Pre-entry fitness assessment (PFA)". It states on the front cover, with a date some time in May 2022, that:

This ADFRI is issued for use by all DFR staff and is effective forthwith.

If we go to page 6114, you drew some significance from table 6, I believe; is that right, doctor? Can you just explain table 6 to the Commissioners?

A. So my understanding, based on the evidence provided by Colonel Deacon yesterday, is that whilst the shuttle run standard of 7.5 will remain for the general enlistment combat personnel, the shuttle run standard for the non-combat personnel has been reduced to, I believe he says 6.1, and as noted there, the APCP standard of 5.5 per the previous document we looked at, I believe that that is now being reduced or waived, so that recruits are able to be enlisted with a lower level of fitness and for the non-combatant recruits, they are able to commence recruit training with a lesser score on the shuttle run, which myself and Rodney Pope and his colleagues would suggest means with a lower level of fitness.

Q. Can I ask you to clarify an element of paragraph 30 of your statement.

Operator, if you please display paragraph 30 for Dr Worswick.

You r

efer to the reduction in cut-off scores for the beep test as part of the PFA. You also say that Army has now removed the beep test as a barrier to enlistment. Can you explain what you mean by that?

A. So by that I mean -- and again I refer to Colonel Deacon's testimony yesterday -- is that the beep test is no longer a barrier, so it's no longer a prerequisite to pass the beep test to be enlisted. What the ADF are doing, as I understand it, Army in particular, is that they are enlisting recruits and bringing them to Kapooka in order to provide them with this pre-conditioning to bring them up to a physical standard where the risk of injury is lesser so that they can then commence training.

Q. You also referred to the removal of some of the physically arduous activities from the recruit course. Can you expand on that?

A. Sure. I'm not an expert on the recruit course curriculum, but one of the changes to the recruit course that I am aware of is the removal of an activity called "The Challenge". When I was on staff at Kapooka, and until recently, I think perhaps within the last 12 months or so, the recruits at -- the penultimate activity for them as part of their training program was that they would complete a route march with backpacks on and they would do some activities along the route; perhaps obstacle course, or perhaps some fire and movement, those sorts of activities.

My recollection -- because as a staff member at Kapooka in 1996, as part of the induction I had to do The Challenge -- my recollection is it's a 15-kilometre activity. At the end of the activity, there is this sense of achievement, that it marked the recruits' graduation from Kapooka, and shortly thereafter they would have their marching out parade.

I believe, as a risk mitigation strategy, with the lowering of entry standards, they have removed The Challenge from the curriculum as a way of mitigating some of the potential risk of injury.

Q. Do you know of any systematic analysis done to determine whether the fitness of recruits leaving the Army Recruit Course has deteriorated as a result of changes of that kind?

A. I do not know if there has been a study into the flow-on effect of this. My understanding of the logic and the logic, I think, is reasonable, is that it's not that this is a requirement to be physically robust and to be able to do these sorts of activities. It's not as if this disappears. The Army's intent is that they will move that sort of training to further along in the training continuum. So these sorts of activities would be done at the initial employment training schools, I assume. What I don't have any visibility of is whether shifting the more arduous training to the right has also shifted some injury patterns to the right.

Q. When you say shifted to the right, you mean shifted to a later stage in the overall training program for a person who has entered the ADF?

A. That's correct.

Q. So if we take the employment categories relating to combat arms, are you saying that it would be important to systematically analyse whether the state of fitness at the end of the ARC, Army Recruit Course, is sufficient for the people who are going into initial employment training for combat arms, and to ensure that any deficit at the end of the ARC is properly catered for and addressed and results in appropriate adaptations at the combat arms IET training level?

A. I think there definitely does need to be some study. My understanding of Army is that, you know, Army appreciates that the training continuum is a system, and that a change at one point will have impacts at another point; downstream effect. So I am reasonably confident, but I do not know, but I am reasonably confident that the Army will have adapted its training at the subsequent next schools, at the IET schools, to make up for changes in training at the recruit training school, but I have no visibility of that.

Q. All right, thank you. At paragraph 31, you say -- and this is perhaps specifically relating to the Army Pre-Conditioning Program -- that you've made many referrals of recruits for medical discharge. I just want to ask you about that. Firstly, you heard Colonel Deacon's evidence yesterday. Did you want to make any comment about that?

A. I would like to make two comments. The first comment I would like to make is that Colonel Deacon provided some statistics on medical separation. I believe that the numbers that he provided for the last two years, so this year and last year, when I have personal knowledge, may have understated the actual number, and I would invite the Commission to ask Army. Army MECRB staff would be able to clarify that for you. I'm unable to do so.

The second comment I would make relates to my statement there, and again to Colonel Deacon's statement that medical separation rates haven't increased. That's probably reasonably accurate. The number of recruits who are referred for medical separation, i.e. referred to the Service MECRB to be medically separated, may be around about the same over the last few years. But the number of recruits who are injured in training and are separated with a MEC, Military Employment Classification, of MEC J31, has certainly increased. That's where perhaps my perspective as a Senior Clinician and Colonel Deacon's perspective as a Commander may differ, in that he has the visibility of the medical separations, because it's a formal process and as a Commander it is his requirement to deliver the MECRB determination to the trainees, whereas for recruits who are separated with a MEC of MEC J31, that MEC can be assigned by a confirming authority such as myself, on advice from the clinicians, the very experienced clinicians at the recruit training schools who are managing the health and welfare of the trainees.

Q. Are there -- In the course of your role as SMO in 2021, and now SCC, are

you aware of discharges that really are attributable to injury or aggravation of pre-existing conditions, but that aren't formal medical discharges?

A. We do that quite often. Early on in my tenure as the SMO, I took a very doctrinal approach, identifying if a recruit had an injury that was not compatible with their continued service in the Defence Force, then we would seek a medical separation for them. But it became -- the work associated with that on the clinicians at Kapooka, less so at RAAF Wagga, but the work associated with that, we were making a rod for our own back, almost, so my approach changed such that if someone was being separated for a condition that they had arrived at Kapooka with, and had been granted a waiver for, then rather than put the recruit and put the medical staff through the rigmarole, the stress of potentially referral to the MECRB -- because, remember, many of these recruits typically were recruits who had come to Kapooka, had been injured in training, and after they'd been injured they had decided that they didn't want to be there any more. So a lot of them were managed as a discharge at own request. But the discharge at own request didn't reflect the fact that, in fact, the MEC that was assigned to them on their separation from the Defence Force was MEC J31, that they were medically, physically or psychologically not at a deployable standard, and they were separated with that MEC.

Q. Dr Worswick, we are probably not going to have enough time to delve into it deeply, but in addition to identifying the lowering of the fitness standards as a cause for concern, you've also made a point in your statement that screening has a second purpose, at least a second purpose to identify people who should be screened out because of pre-existing conditions, so it is not just a matter of general fitness, but they have some sort of pre-existing condition or potential for an underlying condition to be aggravated. You also have concerns that there has been a more relaxed approach taken to such conditions; is that right?

A. I certainly do, and that's something that I would hope to be able to discuss with the Commissioners in the closed session so that I can provide more detailed description just to be able to illustrate the nature of my concerns. But for the public forum, there have certainly been a number of cases where ADF service, as brief as it may have been, has either exacerbated or the condition has manifested such that it became evident to all, including the trainee that, unfortunately, that they are not suitable to continue to training. And this is, if I may make the comment -- this is a real challenge for clinicians at Kapooka. Because we have a bunch of young, enthusiastic men and women, young Australians, who had come to Kapooka with hopes, aspirations and ideals, and the clinicians at Kapooka are the ones who are unfortunately having to either break the news to the recruit that their hopes, aspirations and dreams are now not realisable, and also to provide them with a dignified exit, to help them on that journey.

Q. You've referred to firsthand experience of people feeling stigmatised and distressed when they have had to discharge early; is that right?

A. Yes, definitely. As I said, as a senior clinician, sometimes I deal with the more complex cases, and what we are talking about is not necessarily complex. A lot of these are routine. And by routine, I mean they occur commonly, and these are cases that the clinicians, the doctors at Kapooka, manage on a day-to-day basis. But for some of the recruits, they are more complex and they are brought to my attention, and occasionally I deal with them personally.

Q. Dr Worswick, time permitting, there should be an opportunity in the closed session for you to go into a little more detail on that. Just sticking at the general level for the time being, can I just ask you about a further fact you identify that's causing you concern, and that is that DFR, Defence Force Recruiting, seems to be applying a somewhat less stringent ADF-wide standard, even for people who are coming into the Army, where more stringent standards apply; is that right?

A. That's correct. So there are different standards of fitness, both medical and psychological, across the Defence Force. There is an overarching standard which is a joint standard, but each of the services are different. The service in the Navy is very different to service in the Army, and both are very different to service in the Air Force. So the services have developed their own medical policies to reflect the exigencies or the specific nature of serving in that service.

In the Army's case, it has a very detailed policy. In the Army Standing Instructions, part 8, chapter 3, which details the effect that a medical condition may have on an Army member's suitability to serve, and what their MEC might be if they would have this condition. And the challenge that we experience at Kapooka is that the Defence Force recruiting a recruit to the joint standard, which is a different standard to the Army, so a recruit may arrive at the Army barracks with a Military Employment Classification assigned by the Defence Recruiting, or suggested by Defence Recruiting of MEC J22, so suitable to train but with some restrictions. But when we apply the Army standard to them when they arrive at Kapooka, in the Army they are MEC J3, so they are not suitable for training.

Now, in some cases, the policy is -- Army policy is quite strict, and we work around that. We use commonsense. So, for example, there are some medications that are commonly used to treat acne which make someone MEC J31, and our doctors will write on a restriction form that's provided to the commanders, "MEC J31 by policy but suitable to continue training." However, there are other people who arrive with conditions that by Army policy make them MEC J5, so for medical separation, and we start that separation process as soon as they get off the bus. Not every time -- that doesn't always result in the separation of the trainee, because the military -- the clinicians, our role is simply to apply the policy as it is written. The decision, it's a personal management decision. It's made at the Service MECRB based on the advice that the clinicians will provide at Kapooka, and based on advice that the clinicians at MECARS and at Joint Health Command will provide.

Q. Doctor, in wrapping up on Impact 1, the impacts of the lower standards or the poorer levels of physical fitness that you are seeing in the recruits, you have taken

issue, I think it's fair to say, with the statement that it's the ADF who is taking on more risk or who has increased their risk appetite. I will ask the operator to display paragraphs 38 and 39 in this respect. Can you explain to the Commissioners, perhaps in brief terms, because time is short, what you mean by that?

A. So from a clinical perspective, when we look at a -- when we look at providing an intervention, and so in this case the intervention is allowing somebody to commence training, we ensure that they do so with informed consent. So, as a clinician who quite frequently works in an emergency department, sometimes I have to perform procedures on patients, and I explain to them what the procedure is, what the benefit of the procedure is, what the alternatives are and what the risks are, and I get their informed consent before I do anything.

My concern is that the services have indicated that they have a broader risk appetite, but really it's not the services accepting the risk, it's the individual. The individual is at risk of being injured, being medically separated from the Defence Force. And that's my concern in the context of this, that I don't believe that trainees who are coming to Kapooka with a lowered entry standard are provided informed consent, are provided with advice that, for example, "You're going to commence the APCP, there is a 30 per cent chance that you won't complete recruit training". I don't believe those sorts of -- that sort of advice is provided to trainees, and I don't think that we gain consent from them in these certain circumstances where we acknowledge or they acknowledge that they are at increased risk of injury and that they are willing to accept it.

Q. Doctor, I'll just lead, if I may. You've pointed out then, by reference to the AIHW reports, that the veterans most at risk of suicide are those who are less than 25 years of age, who have served for less than 12 months and who are involuntarily separated. That has caused you the moral and philosophical concerns you have expressed in your statement on this issue?

A. That's correct.

Q. As well as your personal experience of people expressing feelings of stigmatisation and shame in circumstances where they involuntarily separate shortly after coming to Kapooka?

A. It's not just the involuntary separation, you know, it's the recruits who are injured and withdraw at their own request but they do so because of their injury.

Q. Thank you. We'll go now to the second impact, Impact 2, increased burden on the provision of healthcare, and this is a real focus of the recommendations that you wish the Commissioners to consider and of much of the rest of your statement, isn't it? Perhaps before I do that, though, I should ask: have you and other clinicians in the Wagga area attempted to explain to Defence Force recruiting the concerns you've expressed so far to the Commissioners?

A. We have on a number of occasions over the last couple of years.

Q. Should we come to them in detail in the closed session. Is that more appropriate, or do you wish to refer to them now?

A. I'd like to go into detail in the closed session, but just to say that the first time I have been involved in raising this was while I was working at MECRB, so at Headquarters Joint Health Command, when myself and my boss started to see a number of recruits being medically separated for reasons that were apparent before they started training. So it wasn't such that they'd been injured by their training at Kapooka per se, they'd arrived with conditions that very quickly resulted in their medical separation. When we saw a number of these come through, we arranged a meeting with DFR to discuss these concerns.

Subsequently, in 2021, there has -- I have been either initiating or an addressee, cc addressee on correspondence with various people involved in this. As the SMO, last year I sent emails directly to DFR about some of the candidates that we were having to manage and causing difficulty for the recruit themself and difficulty for the clinicians trying to manage them. And again in 2020. I'd be very happy to speak to those in the closed forum.

Q. Thank you. In short, outside those attempts you've made on those occasions, are we to infer that there isn't a systemic feedback framework for medical officers to make observations of this kind in the hope of improving matters?

A. I'm not aware of a formal or systematic approach that allows the feedback from the training institutions and the clinicians at the coalface to allow changes in process or practice.

Q. Perhaps it's obvious, but if there isn't such an avenue, to your knowledge, presumably it's likely that there is no such avenue? You would know about it if there was such an avenue, wouldn't you?

A. I would agree with your statement that it would seem obvious that if the clinicians at Kapooka and RAAF Wagga who deal with recruit training every day, if the senior clinicians who oversee, particularly, the confirmation of recruits being sent to the MECRB, if they are not aware of it, then it probably doesn't exist.

Q. Should it exist?

A. Most definitely so.

Q. How would it look? How would it be different from those occasions when you have sent emails and sought meetings? Have you given thought to that? Should there be, in effect, a regular gathering together of Command, Defence Force recruiting, the training institutions and the medical officers, for example?

A. Most definitely so. I mean, the basis of this is -- it's not a witch-hunt, it's certainly not punitive. This is about understanding that part of our role as clinicians and really part of the role of the ADF, also, is that when you bring recruits into the organisation, the first priority should be to not do harm. And we are seeing that we are -- for some of the recruits, we are doing some harm to them. So it's about learning. It's about learning and doing things better, because I have been in the ADF -- I was in the ADF for nearly 35 years and there is no higher priority for our nation than the defence of Australia. Times are difficult, it's difficult to get trainees into the Australian Defence Force, so we need to do things differently. But if we are going to do things differently, we need to make sure that appropriate supports underpin that.

Q. In the course of your duties as SMO and then as SCC, and including in your duties as medical officer, were you made aware of any studies analysing injuries in the Australian Recruit Course or the Army Recruit Course or the Army Pre-Conditioning Program? Were the results of any studies on injuries in those programs shared with you?

A. I must profess, I've only been in this role for nearly two years, but I'm not aware of any studies that have been done. I was talking to -- I beg your pardon.

Q. If there had been any such studies analysing injuries in those recruit courses or pre-conditioning courses, should they be shared with the medical officers?

A. Oh, most definitely so, because those studies would do two things. Firstly, they would inform changes to training, which is outside my area of responsibility, but it would also inform the nature of care that we need to provide to trainees. If there are particular injury patterns, it might influence, for example, particular specialisations that we might need to refer trainees to. If we don't have ready access to those, then it might change our referral patterns.

Q. We heard from Colonel Deacon about reports he receives regularly, I think he said weekly, on the workplace health and safety CENTINAL incident reporting system. Should you, as a Senior Medical Officer, Senior Contracted Clinician, be receiving some sort of intelligence about what is learned from workplace health and safety reporting? Do you receive anything like that?

A. I don't receive it but, again, I would note from my statement that I am a locum, so I'm not permanent. There may be some advice provided to clinicians who are permanent there, but I'm unaware that it is. We certainly would not need to be involved to the level of detail that Colonel Deacon is. We would not need a weekly update, but quarterly or half-yearly we would be interested in trends and patterns, so that we could act upon it to preserve the force.

Q. Can I go now to Impact 2. At paragraphs 42 and 43 of your statement, you begin your discussion of your concerns about the increased burden on the provision of healthcare that you believe has occurred over recent years and which are

attributable, in your view, to lower entry standards. What are your observations in this regard, doctor, and what are your concerns?

A. I make a number of observations. The first is that we get handed over a trainee, a recruit. From a medical perspective, we get handed over a patient and the patient requires care before they start training. So the DFR medical officers, who do a wonderful job -- I know a number of the medical officers who work for DFR and they are great clinicians -- they do a very thorough job of identifying conditions that will require care after the trainee has joined the Australian Defence Force, but that care comes with a burden.

My first concern is that the care that is required, the resource burden associated with that has not been transferred to the clinical schools. As an example, I would say the document that was shown previously to the Commissioners, the brief on removing barriers to entry --

Q. Can we, in this regard, go to your consideration of the Chief of Army decision brief. That's on page 0015, please, operator, paragraph 45. You address certain aspects of the Chief of Army version of the decision brief on removal of unnecessary barriers?

A. Yes. So in the decision brief it established some criteria and identified the requirement to provide additional health resources. In the decision brief, one of the things -- one of the estimates it made was that there would be an additional four hours per candidate --

Q. That's 45(e), please, operator.

A. In the document itself it talks about an estimate of four hours per candidate of additional clinical care. Our experience has been that it is a lot more than four hours. If we use the number four hours arbitrarily, as the estimate -- as it was, and if I may quickly refer to a note, for this year, 2022, all of the candidates who arrive at a health centre in the Wagga region with a MEC of J22 are referred to the Senior Contracted Clinician for review, because it's a clinical handover and it requires a clinician to review the DFR documentation to identify what care the patient needs.

Now, the clinical handover itself isn't that great, and I'll talk to that later, but what I specifically wanted to mention was that from Kapooka, there were 411 recruits who came with MEC J22, and that number may be a couple out, and at RAAF Wagga there was 139. So that's 550 recruits at four hours a recruit, let's call it an eight-hour day. 550 divided by two is 275, so that's 275 working days of clinician time. That's almost a year's worth of clinician time, based on an estimate of four hours per recruit.

Q. Were they annual figures, 411?

A. That's for this year only.

Q. Oh, this year to date?

A. For 2022 to date. I don't believe there are any more platoons coming through Kapooka or RAAF Wagga at the moment. So that's the first issue, that in terms of the transfer of care, it was underestimated and not resourced. But it's not expected to be required more often than four-weekly during that time. For many of them that's not the case; for some it is.

If you would like me to speak to the other criteria there that you've got echoed --

Q. We'll probably have to leave it there and your written evidence stands.

A. Sure.

Q. So the Commission will give it full consideration, but thank you. You refer also to while there's been underestimation of the increased burden that would be entailed by the lowering of the standards, you also refer to hollowness in the workforce. Colonel Deacon himself referred to an aspect of this relating to mental healthcare. Do you wish to add to what Colonel Deacon said?

A. I would like to. There is hollowness across the workforce. A key issue for the training establishments is hollowness in the mental healthcare workforce. As noted by Colonel Deacon, we have some part-time psychologists, one for each of the bases at Wagga and Kapooka, and they are wonderful psychologists, marvelous experience in dealing with recruits, but they are part-time. There are two positions for psychologists at Kapooka. Only one of them is filled and it's filled on a part-time basis.

More generally, though, from a concept of hollowness, and this is now, again, looking more broadly at my remit for the Southern NSW region, we also experience hollowness at the ACT Health Centre. We might talk to the ACT Health Centre and the demographics there a little bit later, but there are ab initio trainees there because the cadets at Duntroon and ADFA -- they number around about 1,000 in the Canberra region -- and the key issue for us is, whilst we have a workforce establishment, if the doctors are not there, then you can't provide continuity of care and you have longer wait times and care is -- from my perspective, I have not seen care compromised, but it is not optimised.

Q. In paragraph 48, you are concerned about potential impact on continuity of care, leading to a compounding effect, no doubt, because of the importance of continuity of care that you underlined earlier? That's right, isn't it?

A. That's correct. I mean, the most important thing here is, you know, everybody here in the Commission room will probably have their own GP and you see your GP and your GP knows you and understands what's going on and you don't have to explain yourself every time you go and see a GP because they know what's going on. One of the great challenges that we have -- not in all locations -- is that in

some locations, and most notably in the ACT, continuity of care is a real challenge and it creates frustrations for the ADF members, some of whom have very complex medical problems and at each consultation, that may only last 20 or 30 minutes, they need to spend the first 20 minutes re-describing what their situation is.

Q. You refer in that regard to a resort to local GPs in Wagga Wagga?

A. That's right. So there have been occasions where there has not been a clinician at the Wagga Base and we have had to refer some of our ADF members to civilian GPs. I'm sure the Commission is aware that there is a GP crisis going on in Australia and that transferring the care of ADF patients into the civilian community potentially displaces the care of some of the civilians in the community, it has an impact on the community.

I must say that things are looking a bit brighter at the RAAF Wagga and certainly in the Wagga region. We have just recently recruited a new permanent SCC, who is a wonderful doctor, and I understand there are one or two GPs potentially starting early next year. So, you know, my statement is correct as and when it was written. It may be that things will look up.

Q. Dr Worswick, I will leave it there and I will just ask you briefly about the AIDP, the Army Indigenous Development Program. You address the AIDP from paragraph 55 of your statement in some detail, and you do have some concerns about some aspects of the program. Are you able to give a very brief overview of those concerns and leave the detail to the closed session?

A. So the AIDP is a wonderful initiative but, as noted in the Chief of Army's directive that governs its implementation and it's noted a number of times in that directive, the AIDP brings with it a number of challenges and a number of risks. The key, in my opinion, the key requirements to ensure the success of that program are to mitigate the risks that have been identified. I don't think that that has occurred.

I think -- whilst the AIDP is a wonderful initiative, I think that there are some lessons that can be learned from its implementation, because it would seem that the Army is changing the way it recruits. It's doing the pathways, indexed entry standards, et cetera, which are different to the norm. I think some of the lessons that can be learnt from the AIDP that would be relevant to the potentially new recruiting and training methods could include the way that they select candidates, expectation management of candidates, communication with the enabling agencies, particularly with Joint Health Command, the possible problems of overreach and scope creep and, lastly and most significantly, is the resourcing, particularly -- swimming within my lane -- the resourcing of Joint Health Command, to be able to provide the clinical support that is tailored to meet the specific needs of the AIDP or any other program that may be implemented.

PETER GRAY: Thank you. I will leave my questions for the public session there. I will have some further questions in the closed session.

Thank you, Commissioners.

CHAIR: Thank you, Mr Gray. Commissioner Brown? I note the time and I note Mr Free, I think, has raised some questions he will have to ask before we go into the private session.

I think we should go first.

PETER GRAY: Perhaps we might be able to extend the public session and take ---

CHAIR: I think we will have to, 15 minutes or so.

PETER GRAY: Yes.

CHAIR: Thank you.

QUESTIONS BY THE COMMISSION

COMMISSIONER BROWN: Perhaps if I pick up on the last point, the concern you mentioned about the AIDP. You talked about possible overreach and scope creep. Do you want to just expand on that?

A. Commissioner, if you don't mind, I would prefer to speak to that in the closed forum?

COMMISSIONER BROWN: Okay, thank you. You did say that you thought that perhaps Colonel Deacon may have understated the medical separation rates, and I'm just wondering on what basis you have that thought.

A. So my -- because I have -- I am intimately involved in nearly all of the medical separations, because a role of the SCC is to provide that second tier review, my understanding is that the number that he quoted is less than what I believe to be the true number -- not significantly less, but less than.

COMMISSIONER BROWN: That's obviously something we might have to follow up with the agents, as you mentioned. Can I just ask, in terms of the MEC standards, and I'm just wanting to be clear here what I mean, do the MEC standards actually differ between the services, or is it what's actually acceptable to the services?

A. So it's the latter, Commissioner. So MEC is a common terminology. I understand the Commission has been -- the MEC has been discussed previously, but the services may grade a particular condition a different MEC depending on what service you are. I will give you an example. If you are in the Army, you have a mental health problem and require anti-depressant medication. Then you will be

assigned MEC L27 in accordance with Army policy. In the Air Force, you may be assigned MEC J23, or MEC J22, as an example.

COMMISSIONER BROWN: The issue -- You talked about informed consent and again I appreciate we may have an opportunity to talk about this a little more this afternoon, but you appear to be conveying that you think that any enlistee or recruit, in signing up to join the Defence Force, should be informed about risk of injury and, potentially, increased risk of medical separation or separation at own request. In your view, does that extend to informing them about the risk of suicide? I'm just curious about your thoughts?

A. My personal view is no, that that wouldn't be necessary, and to elaborate a little bit more on what I said earlier, it's not every recruit I think that needs to be given this brief. It's just those that for whom we have waivered the standard, so if they have come in at the current normal standard, so with a MEC of J1, and, you know, having met pre -- current pre-entry standards, then to me they are the normal population, that they would not need to be given informed consent. We would not need to get informed consent from them. But for those who we are potentially exposing or are predisposed to a greater level risk of injury, I believe that they may not be aware of that and I believe that we should be providing them with that information so that they enter into their journey in the ADF with a full understanding of what could possibly lie ahead.

COMMISSIONER BROWN: Those figures you gave from 2022 to date for Kapooka and RAAF Wagga, were they the general enlistee recruits or were they including the pre-conditions program recruits? Because it seemed to be a large number of J22s.

A. Yes.

COMMISSIONER BROWN: More than I guess I would have anticipated if it was not pre-conditioning.

A. It's certainly more than the pre-conditioning. I'm sorry, I can't break them down by general enlistment and APCP, but certainly I would suggest that -- for the Air Force I can -- all of the Air Force numbers, all 139, they were all normal recruits. The majority of those numbers that I have provided to you would have been general enlistees.

COMMISSIONER BROWN: So is the issue that -- I'm just trying to get the different stages of this. Is the issue with the change in the standards, is there an issue there about -- are you making any statement about the performance of DFR in this process? No?

A. No, no, I'm not. DFR are marching to the tune that the services have provided them. They are provided -- their role is to identify conditions that may or may not -- may be affected by service and may or may not preclude entry, identify

those and then see whether a waiver is appropriate, and then make recommendations around a waiver. So if I have given the impression I'm being critical of DFR, I don't mean to do so. My concern is that there's a system here that I think has some problems.

COMMISSIONER BROWN: So the system is changing the entry standard for an understandable reason?

A. Yes.

COMMISSIONER BROWN: There is a risk attached to that if they don't change the training requirements?

A. Yes.

COMMISSIONER BROWN: I guess the -- but we heard, I think over the last couple of days, that they are changing the training requirements.

A. Yes.

COMMISSIONER BROWN: And I think you articulated some of those today. The question is, I guess whether -- in my mind anyway -- is whether the training requirements are what's actually required to complete the mission or whether, you know, potentially, because the nature of the modern military is changing, whether in fact it's okay to change that, so long as we change the training? It's okay to change the entry standard, so long as you change the training and don't injure people through it and you provide the supports required? Is that essentially in line with what you are saying?

A. Commissioner, I look at the end state and I do so because I'm informed by my experience over 34 years in the ADF, almost 20 years as an infantry officer, having had the privilege of commanding soldiers, as a platoon commander, as a company commander, and having had the misfortune of having to write letters to parents whose children are not coming home from Afghanistan, is that war is enduring. The nature of war is enduring. And we need to -- we as an organisation, I think we need to keep that in perspective. Whilst we might change some training standards and, as I have said earlier, I think the changes are logical, and we have -- and they are about risk mitigation, we haven't removed all of the risk. And the fact that we haven't removed all of the risk is demonstrated in some of the discussion that we have had today, and some of the information that we will discuss around -- in the closed session, that I have been discharging recruits.

COMMISSIONER BROWN: But the implication of that is either that you don't change the standard or that you do more to mitigate the risk.

A. Right.

COMMISSIONER BROWN: And which side are you sitting on?

A. I think it's the latter. But I think we also need to agree here, and this is the role of the Commission, ultimately, you can't remove all risk. Joining the ADF is a risky business, and we need to mitigate and/or remove risk, and there are a number of ways that we can do that. And I think my statement and some of the documents that I have been speaking to show that we haven't got that right yet.

COMMISSIONER BROWN: Okay, thank you.

CHAIR: Commissioner Douglas? I don't have any questions either and neither does Commissioner Douglas.

We just want to clarify, Mr Free, your views about your examination, whether you would prefer that to be in the public forum or in a closed hearing.

STEPHEN FREE SC: Thank you, Commissioner. I think it is appropriate that it be dealt with in the open forum, and I'm reasonably confident that most of it can be dealt with in the open forum, and if there is any left over for the closed session, it will be very limited.

CHAIR: Thank you. Please go ahead.

EXAMINATION BY STEPHEN FREE SC

STEPHEN FREE SC: Thank you. Dr Worswick, I just wanted to start with asking you about your responsibilities as a Senior Contracted Clinician. So you are effectively engaged BUPA as part of a contract BUPA it has with the ADF to provide services, is that right?

A. That's correct.

Q. Part of your role is to back-fill short-term vacancies when people are on leave and the like?

A. That's correct.

Q. You in fact do some equivalent locum work as part of your other professional work at the moment?

A. Yes, I do.

Q. So, to the extent that you are personally constrained in your ability to provide continuity of care, that's somewhat a function of the arrangement that you are acting in the nature of a locum?

A. That's right, but also in the nature of my role, so as a Senior Contracted Clinician, typically a senior contracted clinician for BUPA would not have a heavy patient load because the other work that they do is quite time-consuming in itself.

Q. To the extent that there is a clinical role seeing patients, and there's a concern to ensure continuity of care, you need to take advantage of things like e-health records and the like?

A. That's right. We have access to the Defence electronic health system, so we are able to look at the ADF members' medical history on the Defence health system.

Q. All right, and that's a system available to any medical officer treating members of the ADF?

A. That's right.

Q. Now, the contract with BUPA, dealing with it from your perspective, you're retained by BUPA and receive fees according to the work that you do for them; is that right?

A. That's correct.

Q. The fee that governs particular services is a matter effectively between you and BUPA?

A. For my service?

Q. Yes.

A. Yes, that's correct.

Q. So when you provide a service, there's a system that identifies the work done by reference to the MBS item numbers -- that is, the Medical Benefits Schedule?

A. That's not for me.

Q. Right?

A. It's when we get support from specialist clinicians outside of the Defence Force, they will provide a bill to us. And more often than not, their bill will be linked to the MBS, of course, and then any additional charge that they might put on top of that.

Q. Okay, so the services they have provided are identified by the MBS item numbers. And I think you gave some evidence in your statement that you thought the fee they are paid is linked to the MBS fee; is that right?

A. To my understanding, and this arises from personal discussions that I have had with a particular type of clinician, so clinicians, mental health clinicians, psychiatrists, is that the BUPA fees are in some way or another linked to current MBS rates. Of course, there is -- access to mental healthcare for all Australians is challenging, access to psychologists and access to psychiatrists. So when demand exceeds supply, supply has the liberty to set their own fee. One of the challenges that I elaborate on in my statement is that if you set a fee that's higher than Defence is willing to pay, then that service is not available to Defence and in some locations, we have very limited access to service.

Q. When you say a fee Defence is not willing to pay, you are actually talking about a fee that BUPA pays those specialists?

A. I believe so, yes. So, BUPA pays the specialists and that's through the Defence contract.

Q. Yes, all right, but it's -- to the extent you are talking about supply and demand, it's effectively between BUPA and the clinicians it's trying to retain to get those services, what fees they pay?

A. That's right.

Q. You also make some mention in your statement of the difficulty you had on one occasion obtaining some emergency services that were needed for a particular ADF member. Now, emergency services aren't ordinarily governed by the services provided under the BUPA contract?

A. No, that's right. So in the case of an emergency, we would refer someone -- in this case, in that example I was using, it was a mental health emergency -- we would refer someone to the local hospital, and that's exactly what happened, was that this person was referred to the local hospital, in fact was in the local hospital, but what I needed was very quick assessment from a professional -- from a psychiatrist, in this case --

Q. Yes.

A. -- on diagnosis, treatment and prognosis. Because of the -- as I have mentioned, there is a limited supply, particularly mental health clinicians, the wait times can be quite long at times. In this case, you know, a standard wait time of maybe two weeks to an appointment, it wasn't appropriate.

Q. So that was an emergency scenario and you used what would be the ordinary emergency resources?

A. I used two things. The first thing I did was this patient was under the care of the civilian health system, but the patient was being discharged, and we, the ADF,

had to take over this patient's care, and it was not appropriate for this person to wait for two weeks or so to be seen, through our normal referral process. So I reached out to a clinician who has done some work for Defence and asked if he could support me. And he very kindly -- as is always the case, this was at 5 o'clock on a Friday afternoon, and he came into the ADF Health Centre and saw that person at 10 o'clock the next morning.

Q. Thank you. Now, you've given some evidence a little earlier today about some recent improvements in the local workforce and new medical officers and psychologist supports that have been made available. To the extent that there is still some unfilled positions, is it your understanding that that's a difficulty of filling the positions rather than the resources being available to fund those positions?

A. It's both. So I would suggest, if I may quickly refer to my notes again, if I can use Canberra as an example, so Canberra has a patient dependency of around about 8,000 people. The dependency is quite complex, it ranges from initial trainees at ADFA and Duntroon all the way up to the Chief of Defence Force, and everybody in between. A lot of those patients, majority of those patients tend to be older and the majority tend to have some complex -- not majority, a number have complex health issues, and a number of them are ready tabled at a MEC of J42 which makes them non-deployable but are they retained in the Defence Force because of the corporate knowledge and experience that they have.

Now, when I was a young infantry officer, every infantry battalion had its own doctor, and every unit had a unit doctor. And the rough rule of thumb was that for a unit of 500 people, you had a doctor.

Now, these were all young, fit, infantry soldiers, and so the doctor's load wasn't particularly large. So on a ratio of 500 people to 1, with 8,000 people you would expect that there would be 16 doctors. On a ratio. Now, again, that assumes that everybody's fit, well and healthy. Some of the ADF patients are not, they are more complex, so I would suggest that maybe a ratio of 500 or 450 might be appropriate. Suffice to say, on a ratio of about 1 to 500, which was a figure provided to us by Joint Health Command when we asked last year, we would have a workforce of 16 FTE. I believe the current workforce is 13, so the -- I think there are not enough clinicians, and of the 13 FTE that we have, I think we are achieving around about 9 to 10. That's the work force hollowness that I talk about.

Q. So the difference between the 9 or 10 and the 13 is a product more of the difficulty recruiting people with the appropriate qualifications?

A. Yes.

Q. Thank you, Dr Worswick. Now, you gave some evidence about physical fitness requirements and I just wanted to clarify, you were asked about the evidence you give in paragraph 30 of your statement where you talk about removing the beep test as a barrier to enlistment. Now, do I understand from your answer that you are

there referring to being able to enter the Army Pre-Conditioning Program rather than the recruit course?

A. Yeah, that's right. So a person is enlisted into the Army, and then they commence the APCP.

Q. All right.

A. So it's no longer a barrier to enlistment.

Q. Are you aware there is still a beep test requirement to enter the APCP but at a lower level of 5.5?

A. My understanding is that the level of 5.5 has been waived, based on the previous document that was tendered up on the screen there, about the trial that was looking at a lower standard. I'm very happy to be corrected on that.

Q. Your knowledge in that regard is just based on your reading of that document, is it?

A. Correct.

Q. Thank you, Dr Worswick. Now, the APCP is intended and I think you gave some evidence to this effect, to assist people who might not otherwise reach the entry fitness standard, to improve their physical fitness condition, and ideally then graduate the APCP which enables them to meet the entry requirements. Is that right?

A. That's right. Colonel Deacon said as much yesterday as well, I think.

Q. So it is itself a risk mitigation scheme to assist those people in achieving the necessary fitness levels to enter recruit training?

A. Yes, it is.

Q. It also has the benefit of broadening the base of people who can become eligible through recruitment, through that program, that might not otherwise be eligible. Do you agree with that?

A. I agree.

Q. We have seen, I think, particularly women have benefited from it and the rates of proportion of women entering recruit training has in fact gone up substantially in association with them doing the APCP?

A. Yes, that's a wonderful outcome of the APCP.

Q. Now, in terms of the introduction of that measure and also the adjustment of

the entry standard for non-combat roles, would you agree that that has the benefit of expanding the pool of people who can come into the Army -- we are focusing on the Army, but take that as the example -- which is beneficial from a recruitment perspective but also for those potential candidates?

A. I agree that it is beneficial because it does increase the number of potential candidates.

Q. And as I think you described it, it reflects a philosophical adjustment that you are then, during the training course, hoping to increase the fitness and capability of people who might have a slightly lower, to take the non-combat role example, level of fitness on entry, but an appropriate level upon completion of training? That's the basic philosophy of the approach as you understand it?

A. For the APCP?

Q. Yeah -- no, for adjusting the entry standard for non-combat roles.

A. Yes.

Q. And you -- sorry, I withdraw that. I take it you heard Colonel Deacon's evidence yesterday?

A. Almost all of it. I was online and I missed a couple of things.

Q. All right. Did you hear him describe the tailoring of training techniques to deal with the fact that some recruits will have a lower level of entry fitness than others?

A. Yes, I did.

Q. You'd agree that's an appropriate measure to deal with that variability in fitness levels?

A. Oh, I think you need to tailor everything, so not just the training, but also the support that you provide to them through -- while they're at Kapooka.

Q. Okay, and did you also hear Colonel Deacon say there's been some higher level of physiotherapy that he has discerned, but aside from that, no evidence of an increased injury rate?

A. I did hear him say that.

Q. Is that consistent with your experience?

A. No, it's not.

Q. You've seen cases of injury that you would attribute to a lower level of physical fitness, have you?

A. I have. I routinely receive feedback from the clinicians at Kapooka. I would note one of the doctors who is serving at the recruit clinic at Kapooka has been serving there since 2005, and the other one has been serving since 2016. So these two doctors, I think, have a significant amount of corporate knowledge, and they are able to provide informed advice on the trends in injury rates and patterns and numbers. So I'm basing my advice -- my answer on the advice that I'm getting from my clinicians who are working at the coalface.

Q. I think you indicated earlier you're not aware of any data or analysis that has considered in a more comprehensive way than that whether there is any differential injury rate?

A. I'm not aware, no.

Q. And your own clinical experience is from 2017, is that right, when you qualified as a doctor?

A. So my initial ADF clinical experience is whilst serving in Townsville with the Army Brigade in Townsville.

Q. That was in the Army Brigade, and your role as a Senior Contracted Clinician is only since May of this year; is that right?

A. So I commenced my role as a Senior Contracted Clinician in May of this year and commenced my role -- and was the SMO from January of last year.

Q. Thank you. So for the entirety of your time working as a medical officer, either in Townsville or in Kapooka, the arrangements that applied, for example, in relation to the standing waiver for J22 on entry, that's been in place?

A. Yes, it has.

Q. All right. So you personally don't have a before and after comparison that you can draw on?

A. Not as a clinician.

Q. Thank you. Now, you gave some evidence about the numbers of people -- I think you were talking about in the last year -- who were at Kapooka with a J22 and I think you'd said it was around 550. And there's some evidence in an email you sent of instances of people you've encountered through the medical system who had a J22 classification and then experienced some medical issues, some of which led to discharge. But you'd accept that's a relatively small proportion of the 550 that end up in that scenario?

A. So just to clarify, the 550 was the total between Kapooka and Wagga. For Kapooka itself it was around about 411. The rate of medical separation is a low proportion. I don't have the exact numbers but I would suggest that for every one that we medically separate, there may be three or four who discharge with a MEC of J31 at a local level, rather than referring to the MEC -- but I don't have the numbers. Please don't hold me to those, I don't have the numbers. They could be reviewed but I don't have them to hand.

Q. Thank you, Doctor. You also give some evidence in your statement about the waiver process. I understand, just to confirm we are reading your statement correctly, where you talk about this is from paragraph 68 or so of your statement. You got that, Doctor?

A. I do, yes, thank you.

Q. You're talking there about individual waivers rather than the standing delegation that relates to J22?

A. I include that in the process and the reason I include the standing delegation is because I have seen evidence where it's been not applied in accordance with the policy. So in the Defence Health Manual it talks about J22 will be applied and here are the restrictions. I have seen examples where additional restrictions have been added that impact on the recruit's ability to undertake training.

Q. We'll just take it one step at a time. The Defence Health Manual talks about, effectively, a standing delegation that says if Defence Force recruiting identifies someone as falling into a particular MEC J22 category, they can be waived through?

A. Yes.

Q. But you're saying you've encountered examples where they have been inappropriately classified as falling into that when they shouldn't have?

A. That's correct.

Q. And that's a matter that depends upon, effectively, a case-by-case assessment. In those cases, they have been wrongly assessed?

A. Correct.

Q. So is it fair to say your concern there is with the application of those criteria rather than the existence of the arrangement per se?

A. Yes, that's correct. Yes.

Q. And then were you also intending in this part of your statement to deal with

individual waivers outside of that procedure?

A. I -- They are all encapsulated in my statement, so waiver, whether it be as part of a standing process or whether it be individual.

Q. I see, but where you express some concern, if that's a fair description, about liaison officers who aren't medically qualified, are you talking there about just the J22 waiver?

A. So they are individual waivers and they come in at J22 or sometimes at another MEC.

Q. All right.

A. Or sometimes without a MEC.

Q. But you're aware under the Defence Health Manual, aside from that J22 exception, if it's an individual waiver, it should only be happening if a medical officer has carried out a risk assessment?

A. That's right, and I have seen evidence that the medical officers do provide a risk assessment. In the closed session we can talk about a particular case where a risk assessment was done and the decision to proceed was based on medical advice -- sorry, the decision to proceed was taken, having considered medical advice but decided not to accept it.

Q. Perhaps we'll come back to the individual example.

A. Sure.

Q. But just again dealing with it in the abstract, your concern there is about a misapplication of the criteria rather than --

CHAIR: We may have to take a short break because there is an issue with the two-hour capacity for transcription.

STEPHEN FREE SC: Certainly. Understood.

CHAIR: We'll take a short break and then return.

ADJOURNED **[3.16 PM]**

RESUMED **[3.27 PM]**

CHAIR: Thank you, Mr Free.

STEPHEN FREE SC: Thank you, Commissioner.

FURTHER EXAMINATION BY STEPHEN FREE SC

Q. Dr Worswick, you probably don't remember the question I was asking, but I was asking about the different types of waivers that could be granted and asking you to focus on the individual waiver process, not the J22. I think in response to that question you talked about an example where you had disagreed, in effect, with the approach that had been taken at the recruiting stage.

The question I was asking you was dealing with it in the abstract rather than the particular circumstances of that case. That was an instance of misapplication of the criteria and the risk assessment process. From your perspective, you disagreed with the risk assessment, rather than necessarily you thinking the procedure is itself inappropriate?

A. My understanding is that -- it was the way the individual waiver was applied that I had a concern with. So it wasn't a procedure per se, it was a decision made to overrule medical advice.

Q. I see. And I take it you've got less insight into the process by which psychologists might be involved in providing advice about waivers when it is to do with psychological issues?

A. I have almost no visibility of that. Certainly when we receive a candidate's enlistment medical documents, the mental health aspects of that are not included in there, other than, say, for a few dot points.

Q. Thank you. Now, you make a statement in paragraph 73 of your statement about a liaison officer being incentivised to get as many people into the ADF as possible. I just want to ask you to explain what you mean by incentivise there.

A. By that I mean the ADF strives to recruit as many people as we possibly can. Sorry, again I said "we". The ADF strives to recruit as many people as it possibly can because it needs people. There is -- what I'm suggesting there is there's a little bit of potential for people to have too much focus on meeting the numbers without due regard to possible implications of lowering the entry standard or providing a waiver, and the risk that that might provide to the individual.

Q. So you're not talking about personal incentivisation?

A. No, no, no. It's about an organisational -- you know, the liaison officer is acting on behalf of the organisation and is, as far as I understand it, trying to get as

many possible people as they can into the ADF.

Q. You used the words there "lowering entry standard". Would you agree, to take the fitness standards, for example, which we've been talking about, they could more appropriately be described as changing the entry standards and changing the approach to how one deals with fitness issues through the continuum of recruitment and training?

A. No, I wouldn't agree with that statement. I'm very comfortable with my assertion that this is a lowering of standards not a changing of standards.

Q. You are talking about lowering at the entry point, are you?

A. Correct, yes.

Q. In relation to the AIDP, which I understand you support as an initiative, but your concern is about the resource impact; is that a fair description?

A. That's one of the concerns that I have.

Q. What's your other concern, or other concerns?

A. So, as I indicated previously, I think there are concerns around the selection of appropriate candidates, noting, of course, that the services have a higher degree or are willing to accept a higher risk -- which, as I have previously said, is actually transferred to the individual -- around about the expectation management for the people that join the program.

Importantly, a key criteria is about communication between the services and Joint Health Command, and communication has been poor. I can talk to a specific example, I think, in an open forum if you're happy for me to do so. Part of that is the Chief of Army's directive talks about the need for good communication with enabling agencies and it talks about the need for a board. So this is a discussion between the recruiting people and Army Headquarters and Joint Health Command and the clinicians at Kapooka or wherever else it may be conducted, so that before the candidates arrive at Kapooka, those who are providing support to them have a good understanding of what healthcare needs they might meet.

We don't get that. I have -- in my 22 months or so now, I have participated in one board where there was forewarning of who was coming and we were able to discuss the potential care requirements. But there have been other AIDP during this timeframe where there has not been that open forum discussion and forewarning so that we could make appropriate arrangements to provide tailored care for the candidates.

Q. All right. Are you aware that there is a handover process that occurs between recruiting and the gaining organisation, whether it be 1RTB or other organisations?

A. I expect that there probably is. I'm not -- I assume that there probably is, or I expect that there is. I'm not personally aware of it occurring because I have not been a participant in that process.

Q. But what you would like to see in that regard is greater engagement with the health providers in relation to health issues with the participants; is that what you are emphasising?

A. What I would like to see is what the Chief of Army has directed; that is, that the health providers are engaged early so that we can provide optimal care.

Q. Thank you. You mentioned expectation management. Are you talking about managing expectations of participants in the program?

A. That's right, yes.

Q. Is that to do with making them appreciate that it's not necessarily a path to entering the recruit course proper?

A. That is part of it and, if the Commissioners are happy, I would like to speak to that in the closed forum.

STEPHEN FREE SC: Thank you. Alright just excuse me for a moment, doctor.

Thank you, doctor.

Commissioners, those are our questions.

CHAIR: Thank you. Mr Fraser, any questions?

IAN FRASER: No questions, thank you, Commissioner.

RE-EXAMINATION BY PETER GRAY

PETER GRAY: Two points by way of re-examination, very briefly if I may, Commissioners?

CHAIR: Yes.

Q. Thank you. Dr Worswick, in a response to a request from Mr Free you referred to the psychological assessment material from Defence Force Recruiting not being provided to you, or not being accessible by you and you not having visibility of it save for some dot points, should you be provided, in your view, as the medical officer or senior medical officer responsible for care of the recruits in question with

the medical -- the psychological assessment material that DFR has collected?

A. I think that's absolutely essential because, in effect, we know that -- certainly there is evidence from my perspective, that there are -- people join the ADF who have a history of mental health concerns, and/or illnesses and potentially diagnosis. And it is important for us as clinicians who are accepting care of these people to understand their medical history and what treatment they have had, what the nature of the illness may be, if they are medicated or not, how long that was for. So it requires a proper clinical handover so that we can assume care and, more importantly, if it's a condition that may have -- that the individual may no longer have present, but relapses while they are at Kapooka, again it's about our capacity to provide care for them.

So, at the moment, there is a separate psychology file, and for the majority of candidates, that's largely about their aptitude. But for those that do have a history of mental health issues, it's important that the clinicians have visibility of this. I'm not saying that we necessarily need access to the entire file, but it would be useful to get a nice summary as a clinical handover, as what we would normally do as a courtesy between doctors, provide a clinical handover. At the moment the clinical handover we receive for every trainee ranges from 60 to 100 pages of notes. It takes a little while to work your way through that. Ideally, if we could get a nice, succinct summary, as we would normally do as a general practitioner who writes to a specialist to say, "Thank you very much for seeing our patient, they are a 27-year-old person who has the following illnesses and injuries and/or medications and this is what I suggest is the care that is required", that's not part of the process at the moment.

Q. Thank you. The second issue is the requirements of the Chief of Army you referred to in response to the last set of questions you were asked by Mr Free. I'll just ask you to identify the requirements in question by reference to Chief of Army Directive 821 titled "Army Indigenous Development Program". That's document J in the documents previously tendered, DEF.1048.0005.1333, thank you, operator.

If we could please go to the heading "Chief of Army's intent" on page 1334, in the paragraph beginning "Method" in bold, the last sentence reads:

> *Clear and early communication of Army's accepted risk with Training Establishments ... and Defence enabling agencies will ensure health and welfare support are tailored and provided to AIDP trainees.*

Was that part of what you were referring to?

A. That's correct, yes.

Q. Was there anything else that jumps out at you in this document you wish to refer to in that respect? If you have it handy?

A. No, that's fine, thank you.

PETER GRAY: That was it, thank you.

No further questions, thank you.

CHAIR: Thank you, I understand we have to have a short break now.

For the purposes of our viewers, we will adjourn until 8.30 tomorrow morning, but we will return obviously for a closed hearing. Thank you. We will adjourn now.

[HEARING TO BE CONTINUED IN IN-CAMERA SESSION 1 - REFER TO SEPARATE TRANSCRIPT]

PUBLIC HEARING ADJOURNED AT 3.39 PM (AEDT) UNTIL THURSDAY, 1 DECEMBER 2022 AT 8.30 AM (AEDT)

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