CHIEF OF THE DEFENCE FORCE COMMISSION OF INQUIRY INTO THE DEATH OF PRIVATE JACOB LEE LAZARUS

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PTE LAZARUS COI REPORT

EXECUTIVE SUMMARY

Private Jacob Lee Lazarus, a 20 year old member of 6 RAR, died at the Sherwood Arboretum Forest, Brisbane, on Wednesday 19 January 2011, as a result of hanging. A Queensland Police Service investigation concluded that his death was not suspicious.

The Australian Defence Force Investigative Service (ADFIS) also commenced an investigation into the death of Private Lazarus. In mid April 2011, the Brisbane Coroner, Mr. John Lock, Office of the Queensland State Coroner, informed the ADFIS Director of Operations that he (Coroner Lock) supported ADFIS continuing as the primary investigative agency in support of the coronial investigation into the death of Private Lazarus.

Coroner Lock is yet to determine if he will conduct a formal inquest, having 'suspended' that decision until the Commission of Inquiry completes its Report.

On 12 October 2012, the Chief of the Defence Force appointed a Commission of Inquiry to inquire into the circumstances of Private Lazarus' death, essentially to determine if there was a nexus between Private Lazarus' service and his death.

Private Lazarus entered the Australian Army on 9 November 2009, with high expectations of military life, most particularly the prospect of operational deployment to Afghanistan. Those expectations were initially satisfied through his postings as a Recruit, and subsequently as a member of Training Support Platoon at the Royal Military College, Duntroon. In both postings, he was immersed in well organized, consistent and predictable military environments.

In September 2010, Private Lazarus transferred to 6 RAR at Gallipoli Barracks in Brisbane.

Private Lazarus marched into the Rear Element of a deployed Infantry Battalion, and into a Company that was atypical in its structure and disorganized, with a restricted and inexperienced leadership. In broad terms, the Rear Details Company was twice the size of a normal Company with half the complement of NCOs.

The 6 RAR Rear setting did not meet Private Lazarus' expectations, either in terms of his prior experience of military organization or his career aspirations. In particular, his hopes of deployment on operations with the Battalion were effectively diminished, as it arrived home from Afghanistan in September 2010.

Within a very short time in 6 RAR Rear, Private Lazarus was the subject of a number of potentially antagonistic incidents.
The chain of events started with his attendance at what was effectively his first 6 RAR activity – an AIRN weapons qualification practice – where he attended affected by alcohol. Private Lazarus was subjected to a rigorous physical training session to determine his fitness to continue participation in the practice, after which he successfully satisfied the required competency. It is apparent that Private Lazarus accepted responsibility for his inappropriate behavior on that occasion.

However, Private Lazarus was then subject to a confusing and inconsistent response by his Company chain of command. Firstly, he was counseled about his behavior by his Acting Company OC and Acting CSM who advised him that the matter was then ‘closed’. Later that day, Private Lazarus was tasked by his Platoon Sergeant to undertake weekend guard duty under ambiguous circumstances as to whether the tasking was a form of punishment or not for his earlier irresponsible behavior at the AIRN practice.

Acting on the belief that the weekend guard duty was not a punishment because he had been earlier told by the Acting OC and Acting CSM that the matter was now ‘closed’, Private Lazarus ‘sold’ the guard duty to a peer; an apparently accepted convention within his Unit.

Private Lazarus was subsequently the recipient of a “beasting” by a junior NCO who was under the erroneous impression that the member had inappropriately sold a punishment. The beasting was administered in a public setting in the presence of a number of Private Lazarus’ peers.

On Wednesday 22 September 2010, Private Lazarus was one of 14 soldiers who allegedly failed to salute the Acting OC B COY 6 RAR Rear. The group was then subjected to an inappropriate and illegal punishment regime, involving the imposition of guard duties and the loss of leave just prior to deployment on Exercise Hamel. However, there is no evidence that this incident had any significant adverse impact on Private Lazarus, in contrast to several of his peers who were significantly disadvantaged with respect to their leave arrangements. When the Acting CSM B COY 6 RAR became aware of the matter, it was investigated and remedied expeditiously by the Acting CO of 6 RAR Rear.

At the conclusion of Exercise Hamel in late October 2010, a confrontation allegedly occurred between Private Lazarus and another soldier who had apparently taken it upon himself to play a de facto section commander role. While the facts of the incident are not altogether clear, the incident appears to have been minor, and inconsequential from Private Lazarus’ perspective.

In summary, while Private Lazarus was involved in a number of adverse occurrences in the period following his march in to 6 RAR Rear, and whilst there is some evidence that this may have impacted on his morale and self esteem, there is no credible evidence that these occurrences, either singly or in combination, contributed to Private Lazarus’ decisions, firstly to attempt suicide, and then subsequently to end his life.
It is apparent from the evidence that Private Lazarus generally enjoyed his military service, and conspicuous by its absence in his lengthy notes, written to his family and friends the day before he died, is any indication that his military experience was a significant factor contributing to his fatal decision. Similarly, his verbal comments to family and friends, both civilian and military, did not evidence his well planned intent to take his own life.

The Commission was tasked with identifying and gathering evidence, and making findings with respect to the circumstances surrounding PTE Lazarus’ overdose on pharmaceuticals on 24 Nov 10, and his subsequent management by Army medical practitioners and others, up until the date of PTE Lazarus’ death by suicide on 19 January 2011.

At approximately 0900 hours on 24 Nov 10, PTE Lazarus was found at his parents home in Brisbane in an unconscious state and covered with blood from superficial lacerations to both his forearms. He had attempted suicide by initially ineffectually cutting his anterior left and anterior right forearms, and subsequently overdosing on proprietary pharmaceuticals.

PTE Lazarus was subsequently admitted to the Wesley Hospital and then transferred to the Royal Brisbane and Women’s Hospital (RBWH). On 25 Nov 10, he was admitted to the Gallipoli Barracks Health Centre (GBHC) and was admitted into the Mental Health Unit (MHU) of GBHC. Medical notes indicate PTE Lazarus had a depressive illness.

On 26 Nov 10, PTE Lazarus was re-admitted to RBWH because of a toxicology concern arising from the overdose on pharmaceuticals. On 1 Dec 10, he was re-admitted to the MHU where he remained until 4 Dec 10.

On 26 Nov 10, 6RAR undertook a Quick Assessment. In accordance with DI(G) PERS 16-26 - Management of a suicidal episode in the Australian Defence Force, the Commanding Officer (CO) established a Risk Management Team (RMT). Essentially, the RMT could not discharge its function properly. Reasons for this included the non-timely passage of information.

The Commission’s Report describes why DI(G) PERS 16-26 is problematic. Essentially, the rhetoric and the reality do not match; certainly, the rhetoric and the necessary resourcing required by DI(G) PERS 16-26 are problematic.

Particular ADF policies give rise to mutually exclusive interests. DI(G) PERS 16-26 vests responsibility for the welfare of ADF members in command, whereas the civilian contract health services essentially operate independently of the chain of command.

At the time in question, 6 RAR had just returned from Afghanistan; the tempo of the battalion was high. 6 RAR commenced block leave on 4 Dec 10.

The CO directed that Rear Details 6 RAR was to be involved with convalescence leave approval for PTE Lazarus. The CO considered there was sufficient medical
support to allow PTE Lazarus to be discharged into the care of his family. However, the CO had no visibility of PTE Lazarus' medical circumstances, once PTE Lazarus was effectively discharged from GBHC on convalescence leave on and from 4 December 2010.

On 2 December 10, PTE Lazarus was reviewed by a clinician. He saw a Consultant Psychiatrist that day and on the following day. He was prescribed the anti-depressant drug Effexor XR and recommended convalescence leave from 4-6 December 2010.

The Consultant Psychiatrist provided a report, dated 6 December 2010, indicating that Private Lazarus had a major depressive illness and that he was 'not fit for work'.

On 7 December 2010, the Consultant Psychiatrist again reviewed PTE Lazarus, declaring him 'not fit for duty'. Private Lazarus continued to be reviewed by the Gallipoli Barracks MHU until 9 December 2010. He was to be reviewed again at GBHC on 14 December 2010, but did not attend the appointment. The MHU and 6 RAR were unaware of this absence and consequently neither followed up this matter.

Private Lazarus' convalescence leave that effectively commenced on Saturday 4 December 2010, continued. At his appointment with the Consultant Psychiatrist on 23 December 2010, PTE Lazarus was clearly told by the Psychiatrist that he was not returning to the Army unless and until the Consultant Psychiatrist said he was fit to return. PTE Lazarus consented to his father attending the 23 December 2010 appointment with the Consultant Psychiatrist, and his father's recollection of what was said mirrored that of the Psychiatrist, said that his son was given a 'blunt' message in that regard.

It is possible that PTE Lazarus had a mistaken belief that he had to return to duty at 6 RAR on the end of block leave. On the day of his death, PTE Lazarus had medical appointments at the GBHC. His convalescence leave also needed to be extended beyond that day, requiring PTE Lazarus to visit the 6 RAR Duty office.

Private Lazarus was last seen by the Consultant Psychiatrist on 23 December 2010. The Consultant Psychiatrist was to see PTE Lazarus again on 11 January 2011 and/or 15 January 2011; however, PTE Lazarus was unable to attend because of the occurrence of the Brisbane Floods.

The Commission's Report examines PTE Lazarus's interaction with GBHC and MHU staff and their effective oversight of PTE Lazarus, together with the operation of relevant ADF policy. The Report also considers the use of contract medical practitioners and their relationship with the ADF; suffice it to say, those relationships may be problematic regarding issues of medical-in-confidence material.

There was no case manager for PTE Lazarus.
The Commission’s Report shows that there is a need for ADF policy to sensibly balance the requirement for the provision of a medical prognosis to commanders, against the professional obligations of doctors to adhere to a doctor’s duty of confidentiality; well reasoned policy development is required on this aspect.

The Commission’s Report considers how medical services are provided to ADF members. RAPs and RMOs have been removed from units. ADF members now access the ADF medical health system by direct presentation to a centralised garrison support ‘clinic’ or ‘hub’, staffed by contracted civilian general practitioners. To all intents and purposes, an individual ADF member is no longer the beneficiary of organic Unit based health care. Hence commanders have no direct command or control over civilian managed general practitioner hubs or clinics, or over outsourced health service providers.

The Commission’s Report considers the adequacy and responses of particular ADF policies and their effective application, with particular emphasis upon DI (G) PERS 16-26, “Management of a suicidal episode in the Australian Defence Force,” and its linkages to other policies.

It is arguable that particular ADF policies are mechanical and lack flexibility. Ultimately, a policy is just that - a policy. Policy cannot be applied in a blanket fashion. Arguably, rigid adherence to policy produces rigid thinking. Policy is not a substitute for professional judgment and emotional intelligence. In that sense, mandatory requirements for compliance with Defence Instructions is counter-intuitive and dogmatic.

The Commission’s Report shows that the complexity and burden of the ADF policy framework creates resource and compliance difficulty.

Overall, the Commission’s Report aims to respectfully shape the future provision of medical care for ADF personnel who have attempted suicide. In one sense, complex medical problems created by a suicide attempt are akin to complex military operations requiring multiple lines of operation. Coordination and detailed planning are key to the successful provision of complex medical services. Similarly, the tenets of success for the provision of professional medical services in the ADF include flexibility and responsiveness.

Before the Commission of Inquiry commenced, three persons were identified as Potentially Affected Persons, and each was separately represented at the hearings, unless earlier discharged. No adverse finding was made by the Commission against any of those persons, or indeed, any other person.
PTE LAZARUS COI REPORT

SECTION 1 – THE COMMISSION OF INQUIRY

Instrument of Appointment

1.1 By Instrument of Appointment dated 12 October 2012, General D.J. Hurley AC, DSC, Chief of the Defence Force (CDF), appointed this Commission of Inquiry for the purpose of inquiring into the circumstances surrounding the death of Private (PTE) Jacob Lee Lazarus, as specified in that document and its attached Terms of Reference.

1.2 The Commission of Inquiry (referred to in this Report as “the Commission” or “the COI”) is constituted by [Redacted], as President, and [Redacted], as Members.

1.3 The Commission, convened by the CDF as its Appointing Authority, is empowered pursuant to the Defence (Inquiry) Regulations 1985 (“the Regulations”). The Regulations are made under the Defence Act 1903, the Naval Defence Act 1910 and the Air Force Act 1923.

1.4 Pursuant to Regulation 51 of the Regulations, the CDF appointed legal practitioners [Redacted] as Counsel as the lead counsel. During the course of the COI, [Redacted] was promoted to Colonel.

Terms of Reference

1.5 The Terms of Reference (TOR) of the Commission contain nine paragraphs of background information, namely:

"On 19 January 2011, PTE Lazarus was found deceased at the Sherwood Arboretum Forest, Brisbane, Queensland. He appeared to have taken his own life by hanging himself from the branch of a tree. PTE Lazarus left a suicide note in the form of a written message to his family and friends. Initial reporting and inquiries already made suggest the existence of the following background circumstances.

At the time of his death PTE Lazarus was a member of the 6th Battalion, The Royal Australian Regiment (6 RAR). 6 RAR is based at Gallipoli Barracks, in Brisbane – which was PTE Lazarus’ ‘home town’.

[Redacted]
PTE Lazarus enlisted in the Australian Regular Army on 9 Nov 2009. A short time after completing his initial employment training, PTE Lazarus was posted to 6 RAR. There is evidence suggesting PTE Lazarus marched in to that posting on or about 16 September 2010.

On the evening of the day he marched in to 6 RAR, PTE Lazarus went drinking with friends and, upon reporting for duty the following morning, he appeared to be affected by alcohol, or to be suffering a hangover. He failed a weapons test, and was then immediately required to undergo a strenuous individual physical training session.

Subsequently on that day, PTE Lazarus was dressed down by an NCO in front of members of B Company. He was also counselled by his Company Commander and the Acting Company Sergeant Major.

It has been suggested by his parents that, after the events of that day, PTE Lazarus may have experienced difficulty in establishing a good reputation with his peer group and immediate superiors.

On 24 November 2010, PTE Lazarus engaged in an episode of serious non-fatal suicide behaviour by overdosing with non-prescription pharmaceuticals. He was hospitalized for approximately one week, after which he was granted convalescence leave and, while on convalescence leave, continued to undergo psychiatric assessment and receive care.

On the day of his death, PTE Lazarus had been due to attend an appointment with a psychologist at Gallipoli Barracks. There is evidence suggesting it may have been PTE Lazarus' belief that, following his medical appointment, he would be required to return to duty with 6 RAR. PTE Lazarus' parents and his treating psychiatrist assert that PTE Lazarus did not want to return to duty with 6 RAR, and was anxious at that prospect.

PTE Lazarus was a member of the Australian Regular Army when he died and his death appears to have arisen out of, or in the course of, his service in the Australian Regular Army. Accordingly (the CDF) decided to appoint the Commission pursuant to Part 8 of the Defence (Inquiry) Regulations 1985."

1.6 The TOR specifies the inquiry task, namely:

(Para 11) "The essential purpose of the Commission is to obtain information to inform military decision-making as to whether there are any systemic or isolated failures in terms Defence actions or in terms of Defence policy that may have contributed to PTE Lazarus'
death, and whether there are any actions that reasonably might be taken by Defence to reduce the chance of a similar occurrence.

(Para 12) Subject to the preceding paragraph, the Commission is to obtain evidence and provide (the CDF) with a report detailing the findings of the Commission as to:

a. **General.** The circumstances surrounding the death of PTE Lazarus, including:

   (1) the date, time and place of his death; and

   (2) the manner and cause of death.

b. **Specific background.** Incidents or actions the Commission considers may have contributed to PTE Lazarus’ attempted suicide and ultimate suicide, including:

   (1) the physical training session said to have been conducted immediately after PTE Lazarus failed his weapons test, and any other action taken in response to the failed test, whether formal or otherwise;

   (2) the circumstances in which PTE Lazarus may have been counselled for allegedly ‘trading’ guard duty responsibilities;

   (3) an incident in which PTE Lazarus may have been accused of failing to salute the Officer Commanding B Company, and the consequences of being so accused, if any; and

   (4) interactions between PTE Lazarus and members of his Unit, including any events that may have occurred in the course of Exercise HAMEL.

c. **Previous attempt at suicide.** Circumstances surrounding PTE Lazarus’ overdose on pharmaceuticals on 24 November 2010, and his management subsequently by 6 RAR, medical health practitioners and others.

d. **Communication between Commanding Officer (CO) 6 RAR and medical professionals.** Whether, prior to commencing his leave in December 2010, CO 6RAR was apprised of a psychiatric diagnosis and prognosis provided by (Doctor 8); if not, why he was not so apprised, and if so, whether his response to that information was appropriate.

e. **Assessment for suicide risk.** Whether PTE Lazarus was formally assessed for suicide risk in accordance with applicable policy
and whether that suicide risk assessment identified the appropriate level of risk.

f. The Unit approval procedures for convalescence leave. Whether actions taken were adequate, appropriate and consistent with applicable policy in all the circumstances relating to the role of the Unit in PTE Lazarus’ convalescence leave approval.

g. Adequacy of current ADF policy. Whether, at material times, the applicable policy was adequate, particularly with respect to:

(1) The effectiveness and practicability of Defence Instructions (General) PERS 16-26-Management of a suicidal episode in the Australian Defence Force and related Health Directive 294 – Suicide Risk Assessment and Management in the Australian Defence Force for Primary Care Providers, and related administrative and health policies and specifically:

(a) Whether the mechanism of a Risk Management Team to establish a Crisis Management Plan is appropriate;

(b) What role the treating medical officer should have in the policy process;

(c) Whether a CO has a discretion to vary the membership of a Risk Management Team;

(d) The mechanism for triggering the applicable policies where an ADF member is initially in the care of a civilian health facility prior to his or her Unit or the ADF becoming aware of a non-fatal suicide episode;

(e) The operation of the applicable policy where there are multiple ways in which a member may interact with the ADF medical system; and

(f) The operation of the applicable policy where medical staff are not engaged or available upon a full time basis.

(2) The obstacles to medical health practitioners and medical health professionals disclosing medical information to the chain of command in the event of non-fatal suicide episodes.

(3) Whether the risk assessment criteria for determining whether a person is at a ‘low’, ‘medium’, or ‘high’ risk of a further suicide attempt are appropriate and suitable in light of the
demands of military service and the expectations of command in the management of a member of the ADF who has engaged in non-fatal suicide conduct.

(4) Whether, and if so, at what point, a person who has engaged in non-fatal suicidal behaviour should undergo a medical classification review in accordance with Defence Instructions (General) PERS 16-15-Australian Defence Force Medical Classification System.

(5) Whether the processes for approving convalescence leave in accordance with Defence Instructions (General) PERS 16-21-Sick Leave and Convalescence Leave – Defence Members are appropriate and adapted for an ADF member who is undergoing medical assessment and treatment following non-fatal suicide conduct.

(6) Whether applicable policy ensures the effective interface between civilian and military health facilities in the management a ADF member who has engaged in non-fatal suicide conduct.”

Recommendations

1.7 Under Regulation 110 of the Regulations, the Commission is empowered to make recommendations from its findings. The TOR provide that the Commission is to make such recommendations, including but not limited to:

(a) “Whether the conduct of any person or the occurrence of any event in relation to the death warrants further investigation by service or civilian police or any other authority;

(b) Whether any immediate action is required to prevent the occurrence of a similar happening; and

(c) Any action that should be taken to correct or improve training, orders, instructions, policies or publications which, while they may not be causal factors themselves, is action which is considered should be subject to attention by the Appointing Authority.”

Non-public Inquiry

1.8 Pursuant to Regulation 117 of the Regulations, the Appointing Authority has directed that the Commission must not conduct its inquiry in public but that persons who are, in the opinion of the President, immediate family members or close friends of PTE Lazarus may attend the Commission hearings. The parents and brother of PTE Lazarus, together with a family friend, attended the hearings from time to time.
Non functions of the Commission

1.9 Amongst other things, the TOR direct that the Commission:

- "is not to conduct a criminal or disciplinary investigation nor to conclude or find that a disciplinary offence has been committed by any person," and

- "is not to inquire into the circumstances of PTE Lazarus’ enlistment."

1.10 Further, the TOR state:

"If the Commission becomes aware of matters personal to the deceased that appear not to have arisen out of or in the course of his service, but which may have had a bearing on his death, or on the state of his mind prior to his death, the Commission is to note these matters in its Report. The Commission is not to explore such matters in detail."

The purpose of the Commission

1.11 The essential purpose of the Commission is stated in paragraph 11 of the TOR restated in paragraph 1.6 herein.

1.12 The purpose of the Commission is not to name and shame, but to obtain evidence to enable it to elicit the truth, as best it can. That is not to say that the Commission should avoid criticism where criticism is warranted.

The assistance of counsel

1.13 The Commission was fortunate to have had the services of three Counsel Assisting with varied legal and military experience. Amongst other things, it fell to them to identify and assess potential evidence and, when necessary, to test or challenge the evidence of various witnesses.

1.14 All three Counsel Assisting have performed their duties with diligence and professionalism. Each has gone that extra mile in the performance of their duties.

1.15 Given the inquisitorial nature of the COI and the role of Counsel Assisting in these proceedings, including the drafting of the TOR for this inquiry, it was proper that Counsel Assisting had a real input into the preparation of the Commission’s Report. That involvement has been extensive and the contribution made by all three counsel in the Report’s preparation is appreciated and duly acknowledged.
Experience and independence of the Commission

1.16 The military members of the Commission have brought their very considerable experience to the COI, including regimental (infantry) and specialist corps (psychology) experience.

1.17 The President was appointed because he is a civilian with judicial experience. Such an appointment creates a healthy degree of separation from the normal chain of command, thereby promoting public confidence in the COI process.
PTE LAZARUS COI REPORT

SECTION 2 – THE HEARINGS

Pre-Hearing Practice Note

2.1. On 9 November 2012, the President of the Commission issued Practice Note 1 in order to facilitate the reasonably expeditious and efficient discharge of the task assigned to the Commission. A copy of the Practice Note is at Annexure A to the Report.

Potentially affected persons – Counsel Representing

2.2. The record or reputation of a person may be affected by the conduct of a COI. In effect, the Regulations provide that the President of a COI must form a view as to whether a person is a “potentially affected person” (PAP) entitled to legal representation. When so notified by the President, Counsel Assisting arranged for the CDF COI Directorate to advise the Director of Defence Counsel Services (DCS) to arrange for Counsel Representing.

2.3. Whilst the CDF COI Directorate is responsible for administering the COI, the abovementioned process was at arm’s length from the COI.

2.4. On the material available to Counsel Assisting prior to the commencement of the hearings, and with the assistance with their advice, the President formed the view that three (3) persons associated directly or indirectly with the deceased soldier, were potentially affected by the conduct of the COI. Those three PAPs were:

- Officer 21, CO 6 RAR at the material time, now Officer 21, CO 6 RAR at the material time, now
- Officer 6, Officer Commanding (OC) B Company, 6 RAR Rear at the material time; and
- SNCO 2, Acting Company Sergeant Major (CSM) of B Company 6 RAR Rear at the material time.

Accordingly, the following legal practitioners were granted leave to appear on behalf of those duly notified PAPs:

- Representing Officer 21;
- Representing Officer 6;
- Representing SNCO 2.

2.5. The President of the COI also considered that the record or reputation of PTE Lazarus might be affected by the inquiry conducted by the Commission. In
such a situation, Regulation 121 (3) of the Regulations provides that a “single representative” of the deceased is entitled to legal representation before the Commission.

2.6. Accordingly, a legal practitioner, _, was granted leave to appear on behalf of the single representative, _, the father of the deceased soldier.

2.7. In such matters, where Counsel Representing are legal practitioners who are legal officers in the ADF, their appearance is at Commonwealth expense.

2.8. All Counsel Representing brought to the Commission their very considerable legal experience including, in some cases, extensive military experience.

Natural Justice

2.9. Persons who may be subject to adverse findings in an inquiry such as this are entitled to natural justice. It will be afforded to them.

2.10. The provision of Counsel to Represent PAPS is indeed part of that process. For persons not present or represented before the Commission when evidence is given that, in the opinion of the President of the COI, may affect that person, the requirements of Regulation 122 (2) ensure that natural justice will be afforded to any such person.

Access to information

2.11. Whilst a CDF COI under Part 8 of the Regulations is defined as a “Court of Inquiry” in Regulation 3 (1), the Commission is in no way a court of law. Its process is inquisitorial and not adversarial, and its procedure is informal. Both the Commission generally, and the President specifically, may inform itself, or himself, on any matter relevant to the inquiry in such manner as it, or he, thinks fit.4

Assessment of evidence

2.12. Credibility is a matter of impression. In filtering the evidence and assessing the witnesses, the Commission was mindful that human evidence shares the frailties of those who give it. It is subject to many cross-currents such as partiality, prejudice, self-interest and above all, imagination and inaccuracy.5 Even honest witnesses may not be reliable, or fully reliable, in their testimony because of faulty recollection or faulty reconstruction. The passage of time and intervening events may also impact upon the memory of an honest witness.

2.13. In assessing the evidence and making its findings, the Commission has applied the civil standard of proof, namely, the balance of probabilities.

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4 See Regulations 50 (e) and 116.
5 R-v- Toohey (1965) AC 595, per Lord Pearce at page 608.
2.14. However, as the High Court of Australia pointed out some 75 years ago, proof of a matter on the balance of probabilities does not mean it can be achieved as a result of a mere mechanical comparison of probabilities independently of any belief in its reality. In applying the civil standard of proof, a fact finder must be “reasonably satisfied” of the occurrence or existence of the matter, and reasonable satisfaction should not be arrived at by “inexact proofs, indefinite testimony or indirect references.”

2.15. Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequences of the fact or facts to be proved. In short, the more serious the matter or allegation and the consequences flowing from a particular finding, the higher the degree of probability required.

Venue

2.16. The Commission convened at Victoria Barracks, Brisbane, and conducted hearings during the period 3 December 2012 to 19 December 2012 (including a view at Gallipoli Barracks, Enoggera, on the afternoon of 13 December) and also during the period 4 February 2013 to 21 February 2013.

2.17. The venue for the hearings was a long training room which was adequate for that purpose. The COI support staff were accommodated in an adjoining room. Separate accommodation was provided for Counsel Assisting and the Commissioners.

Witnesses

2.18. Seventeen (17) witnesses gave oral evidence on oath or affirmation, and sixteen (16) affidavits were tendered on their behalf. Three (3) of the key witnesses gave evidence for more than one day.

2.19. The affidavits of a further seventeen (17) witnesses were also tendered without the deponents being called by Counsel Assisting.

2.20. Before each witness gave oral evidence to the Commission, the witness was made aware of his or her rights and obligations with respect to answering questions. The same applied to all affidavit deponents.


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6 See Briginshaw v Briginshaw (1938) 60 CLR 336, per Dixon J. at page 361.
7 ibid. at page 362.
Exhibits

2.22. Seventy eight (78) exhibits were tendered. The Exhibits List is Annexure C to the Report. The exhibits themselves should accompany the Report if they have not already been sent to the CDF COI Directorate.

Transcript

2.23. The transcript of the Commission hearings consists of 1033 pages. An electronic record of the entire transcript and scanned exhibits is provided in compact disc form (CD) in Annexure D to the Report.

2.24. Any reference to the transcript in the Report is prefaced by the letter “T”, followed by the relevant page and line number: for example, T340.45 represents a reference to the transcript at page 340, line 45.

The two phases of the COI

2.25. In a general sense, the Commission had two principal tasks pursuant to its TOR: firstly, to explore the circumstances of PTE Lazarus' death, described by Counsel Assisting as "the behavioural factors" and secondly, to consider the adequacy of current ADF medical management policies, described as "the doctrinal factors".

2.26. It was therefore convenient to conduct the COI in two phases. Evidence concerning "the behavioural factors" was given mainly during phase 1 in December 2012, and evidence with respect to "the doctrinal factors" was given during phase 2 in February 2013. Some aspects of phase 1 were completed in phase 2, it being inevitable that a degree of crossover occurred.

The end of the COI hearings

2.27. The hearings of the Commission concluded on Thursday 21 February 2013, when proceedings were formally closed after Lead Counsel Assisting, [c], made submissions to the Commission. Those submissions were settled by all three Counsel Assisting and the views expressed were unanimous.

Written submissions

2.28. Written submissions were invited from Counsel Representing, addressing the issues identified by Counsel Assisting and issues that are relevant to the TOR.

2.29. Counsel Assisting reserved the right to respond to those submissions if necessary.

2.30. Copies of the submissions from Counsel Representing are Annexed to the Report. Those submissions are as follows:
• Submissions on behalf of the Next of Kin of PTE Lazarus, dated 11 Mar 13 – Annexure E

• Submissions on behalf of Officer 21, dated 7 March 2013 – Annexure F

• Submissions on behalf of Officer 6, undated. - Annexure G

• Submissions on behalf of SNCO 2, dated 8 Feb 13 – Annexure H

Identification of personnel

2.31. In their final submissions, Counsel Assisting proposed that in the case of all 6 RAR personnel, with the exception perhaps of Officer 21, the Commission’s final report should apply a pseudonym or nom de plume. Counsel Assisting continued:

“We would welcome suggestions from Counsel Representing as to how this best be achieved. In the case of Officer 21, the adoption of pseudonym would seem pointless.”

2.32. None of the Counsel Representing still involved at that time, and so invited, made any submission or provided any suggestion in this regard.

2.33. The views of the Commission have oscillated on the submission of Counsel Assisting that the Report should use pseudonyms for all 6 RAR personnel other than Officer 21. The use of pseudonyms is less essential where, as in this case, the Commission makes no adverse finding against any such member or former member.

2.34. As a matter of prudence, the Commission has adopted that submission of Counsel Assisting and used pseudonyms. Members or former members of 6 RAR, be they still serving in the ADF or having returned to civilian life, have been allocated a number after their general description as an Officer, Senior NCO or Soldier. “Officer” includes the ranks of Lieutenant (L.T) to Major (MAJ) inclusive, “Senior NCO” includes the ranks of Sergeant (SGT) to Warrant Officer Class 1 (WO1) inclusive, and “Soldier” applies to the ranks of Private (PTE) to Corporal (CPL) inclusive.

2.35. Because it is a matter of public record that Officer 21 was the no pseudonym has been used in his case. The same applies to his predecessor, the former Officer 22.

2.36. In its use of pseudonyms, the Commission has gone beyond the initial
submission made by Counsel Assisting and has used pseudonyms for essentially all witnesses who have given evidence and others who are named in the Report. This approach has been adopted in the interests of consistency and fairness. The Commission has also received advice from Counsel Assisting to the effect that it is more likely the Report will be provided to the Coroner if pseudonyms are used throughout.

2.37. The identification of persons for whom pseudonyms have been used is found in Annexure K to the Report.

2.38. Because pseudonyms have been used, the Commission is of the view that access to relevant Annexures should be restricted in the event that the Minister decides to publish the Report pursuant to Regulation 63 (3) of the Regulations.

2.39. The Commission has identified such Annexures by adding “Restricted Access” after each one in its Index of Annexures to the Report.
A pre-planned death

3.1. The evidence indicates that the decision by PTE Lazarus to take his own life on Wednesday 19 January 2011, was not a decision made on the spur of the moment. It was planned.

3.2. With the advantage of hindsight, his parents believe that the fatal decision was made two or three weeks beforehand. Unknown to his parents at the time, PTE Lazarus took out a personal loan of $5000 with the Commonwealth Bank on 7 January 2011. By the time of his death, all of that money had been spent. It is not known how much was won or lost gambling at the Brisbane Casino, but it is known that PTE Lazarus spent a large proportion of that money wining and dining his family and close friends, of whom he had many, at good restaurants. PTE Lazarus camouflaged his intentions very well: neither his family, nor his friends were given any indication of what lay ahead.

3.3. During that time, in the words of his mother, [redacted] PTE Lazarus "...reconciled with everyone from his past and he took everyone in his life out for a good time." As previously mentioned, neither family nor friends picked up on what PTE Lazarus was doing or had any cause for concern.

3.4. When PTE Lazarus left the family home for the last time at approximately 1130 hours on Wednesday 19 January 2011, wearing casual civilian clothes, he told his father that he was catching the train to Enoggera to attend a medical appointment at Gallipoli Barracks at 1300 hours, and to get a hair cut at the base. In fact, PTE Lazarus was to report back to the Hospital Office at 2HSB/GBHC at 1120 hours that day for a medical review with Doctor 12

3.5. The body of PTE Lazarus was found hanging from the branch of a tree in parkland at Sherwood shortly before 1250 hours that day. His shoes were found about five metres away from his body and a single set of footprints indicated that he had walked from where he had left the shoes to the tree. Mud was found on his feet during the autopsy.
3.6. When the body of PTE Lazarus was found, his shirt was open and his chest exposed. On his left upper chest, PTE Lazarus had written, with a felt pen that he had taken from his home, “ORGAN DONER (sic) B+”.

3.7. Clearly PTE Lazarus had opened his shirt so that whoever found his body would know that he was an organ donor. That generosity was replicated in the decision of PTE Lazarus’ father giving his consent to the Lazarus family being contacted by the Australian Institute for Suicide Research and Prevention for research purposes.

**Suicide Notes**

3.8. PTE Lazarus left extensive suicide notes to his family and friends in a black book which he left on his bed on the morning of his death. That book was found by his father about 1230 hours and, after reading several pages, he became very alarmed. He phoned Gallipoli Barracks and spoke to a female at 2 Hospital Support Battalion (2 HSB) who informed him that his son had not attended his medical appointment that day. He then contacted the QPS and reported his son as a missing person. He was not to know that his son was deceased until officers from the Sherwood Police Station attended his residence at about 1500 hours. The mother of the deceased soldier, Mother, was in Canberra at the time, on a social visit.

3.9. The night before PTE Lazarus’ death, his father had taken him and his brother to dinner at an Indoooroopilly restaurant. Afterwards, they played “Trivial Pursuit” with family friends and consumed alcohol. When the father went to bed, at about midnight, PTE Lazarus was out on the back deck of the family residence. He was smoking and writing in the black book previously mentioned. Father had never seen his son write in such a book before and assumed that it was a journal that his son’s psychiatrist, Doctor 8, had encouraged him to write.

3.10. What PTE Lazarus wrote were not journal entries, but notes to his family and friends before he ended his life. The notes consisted of some 21 pages.

3.11. The notes were “very positive goodbyes” to family members and close friends including ex-girlfriends. The names of those persons are in the notes themselves and mentioned in the statement given to the QPS by Father on 6 April, 2011.

3.12. The extensive suicide notes were “very personal”. What was written could not be said to be negative, apart from seeking reconciliation and forgiveness.
3.13. As his mother stated "he reconciled with ex-girlfriends and people from his past as if to say goodbye". In effect, PTE Lazarus said he was sorry to all the people who had supported him so strongly and apologized for letting them down.

3.14. The notes also contained a list of PTE Lazarus’ debts. There was no mention of the Commonwealth Bank loan, but three debts totalling $790 were mentioned. PTE Lazarus asked his brother, [redacted], whom he made executor of his estate, to re-pay those amounts if sufficient funds were available.

A conspicuous feature of the suicide notes – no reference to the ADF

3.15. One will search in vain for any reference in the suicide notes, direct or indirect, to the ADF or PTE Lazarus’ army service and/or experiences. As his parents have pointed out on a number of occasions there is simply no reference to the Army in their son’s final thoughts.

3.16. The Commission considers the complete lack of reference to the ADF or PTE Lazarus’ army service and/or experiences, in the extensive suicide notes, to be most telling. There is plenty of evidence that PTE Lazarus enjoyed the Army and the total silence within the suicide notes concerning his Army service may well reflect that reality.

The ADF and suicide investigations – background

3.17. In October 2003, the Senate referred the matter of the effectiveness of Australia’s military justice system to the Senate Foreign Affairs, Defence and Trade References Committee, for inquiry and report.

3.18. On 2004, the then Chief of Army, Lieutenant General Leahy, in giving evidence to that Senate Committee", explained that some years ago, the Army, at times, would be happy for the Coroner to report on a suicide and that Army would not investigate it. He indicated that that was not good enough and Army now wanted to go beyond the Coroner’s process and have a suicide investigated “through a board of inquiry with terms of reference." He added:

“What we want to do now is try to determine the reasons behind the suicide. We want to try to figure out whether there are other things that we could be doing, whether there is something in the environment or something that we are doing wrong.”

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21 See The Senate Foreign Affairs, Defence and Trade References Report into the effectiveness of Australia’s Military Justice System, June 2005, Chapter 9 Administrative inquiries into sudden death. Page 189, paragraph 9.34.
22 See the Senate Committee Hansard, 5 August 2004, page 18.
23 ibid, pages 18 and 74.
3.19. The Senate Committee tabled its report on 16 June 2005, and the Government’s response to the 40 recommendations was tabled on 5 October 2005. Whilst the Government did not agree to Recommendation 34, it undertook to amend legislation to create a mandatory CDF Commission of Inquiry into suicide by ADF members and deaths in service. To promote or demonstrate the independence and impartiality of such an inquiry, it was to be presided over by a civilian with judicial experience. Such an inquiry was to be in addition to existing arrangements for the appointment of Investigation Officers and Boards of Inquiry.

3.20. As a result of that undertaking, Part 8 of the Regulations (Regulations 108-124) – Chief of the Defence Force Commissions of Inquiry – was inserted in 2007.

3.21. As previously stated, those Regulations apply to this Commission of Inquiry. The COI is service-specific and its TOR strictly determine its function. It has no jurisdiction outside its TOR.

3.22. Australian Defence Force (ADF) documents which are relevant to a COI include:
   - DI(G) PERS 20-6 Death of ADF Personnel
   - CDF Directive 12/06 Interim Arrangements for CDF Commissions of Inquiry into ADF suicides and deaths in service, 30 May 06
   - CDF Directive 4/10 Interim Arrangements – Quick Assessments and Administrative Inquiries, 23 Apr 10

**Investigations**

3.23. On the day of PTE Lazarus’ death, the Australian Defence Force Investigative Service (ADFIS) immediately commenced its investigation.

3.24. The ADFIS investigation was conducted in conjunction with the Queensland Police Service (QPS), and it was ascertained that the death of PTE Lazarus was not suspicious. It was a death by suicide.

**Protocol**

3.25. Since mid-2007, a Protocol has existed between the ADF and the Queensland State Coroner (QSC) concerning the investigation of deaths of ADF members within the jurisdiction of the QSC. Mutual support and co-operation are features of that Protocol.
3.26. A copy of the Protocol is located in [Redacted].

**Coronial Inquests**

3.27. The function and scope of a Commission of Inquiry are not the same as those of a Coronial Inquest.

3.28. As regards the suicide of a civilian in Queensland, it is very rare for a coronial inquest to be held, unless it is a death in custody.

3.29. The Annual Report of the QSC for 2011-12 indicated that 4,461 deaths were reported to his office during the past year. Approximately 600 of those deaths resulted from suicide.

3.30. During 2011-2012, only 81 coronial inquests were conducted into deaths in Queensland and some of those inquests related to deaths in earlier years. Of the 81 inquests conducted, only five (5) involved death by suicide. Four (4) of those suicides were deaths in custody and the other one a triple murder and suicide event. Under the *Coroner's Act* 2003 (Qld), it is mandatory for the QSC to conduct an inquest into all deaths in custody, including suicide.

**The Brisbane Coroner**

3.31. By letter dated 15 April, 2011, the Office of the QSC, per Mr John Lock, Brisbane Coroner, informed the ADFIS Director of Operations in Canberra that he (Coroner Lock) confirmed his support for ADFIS continuing as the primary investigative agency in support of the coronial investigation into the death of PTE Lazarus.

3.32. Coroner Lock provided ADFIS with copies of various documents in the possession of the Office of the QSC, and indicated a willingness to provide ADFIS with any relevant coronial investigation information that became available. Coroner Lock’s letter to the Director of Operations of ADFIS further stated:

"At this stage I have requested that the police obtain statements from Private Lazarus’s mother and father concerning issues regarding his depression, self-harming, alcohol and drug abuse, any previous suicide attempts and any issues related to the Army such as concerns regarding bullying. I will provide copies of those statements when they are received.

I look forward to hearing from you with respect to the progress of your investigation and whether or not a “Commission of Enquiry” (sic) is to be held.”
3.33. Amongst the material provided to ADFIS by Coroner Lock were copies of a Toxicology Certificate dated 15 March 2011, and the Autopsy Report dated 5 April 2011.

3.34. Prior to the autopsy on 20 January 2011, the Coroner had made an order for Toxicology tests to be conducted. Consequently, five (5) samples including blood and urine were taken for full testing.

3.35. The test results indicated that no alcohol or drugs (less than 10mg/100ml) were detected in the blood and urine samples. Further, the testing for anti-psychotic drugs was carried out and found to be negative.

3.36. The Autopsy Report gave the cause of death as “Hanging”.

3.37. Although the ADFIS investigation revealed that PTE Lazarus’ death was not suspicious, it did reveal a potential service nexus in relation to the death, namely, several work-related incidents that may have contributed to the soldier taking his own life.

3.38. The final ADFIS report was completed in July 2011. That report recommended that a Commission of Inquiry be conducted to determine the extent of the service nexus, if any, that may have contributed to the suicide of PTE Lazarus.

3.39. In the spirit of the 2007 Protocol, the Office of the QSC was provided with a copy of the final ADFIS Report.
3.43. However, as Lead Counsel Assisting pointed out in his opening address, that preclusion does not mean that the Commission should not be cognisant of the evidence concerning the enlistment process. There is evidence, for instance, in the form of a pre-entry psychiatric report noting that PTE Lazarus had experienced an episode of self-harm when he was 15 years of age. It noted that he was a heavier than usual drinker who did not tolerate frustration and had a tendency to be impulsive. The report also stated that if the applicant became a soldier, he may have some difficulty tolerating the discipline associated with the military.

3.44. The pre-entry psychiatric report was requested by PTE Lazarus' General Practitioner (GP), who, it seems, was concerned that the episode of self-harm when his patient was about 15 – cigarette burns on his arms – would prejudice his enlistment in the ADF. The GP noted that his patient was keen to join the military and, as part of the process, he had been going through interviews and disclosed the circumstances of his cigarette burns. A psychiatric report was requested to determine his suitability to join the ADF.

3.45. Doctor 2, psychiatrist, spent about one hour with the 19 year old potential soldier, with whom he had had no previous contact, and also had the chance to talk briefly with his mother. There was no known family psychiatric history. The psychiatrist concluded his report as follows:

"In summary, there was no evidence of any major psychopathology in Mr Lazarus. He has a past history of slight discipline problems at school as well as train fare evasions. His episode of cigarette burns does not appear to represent a self-harming attempt. I would not attach great significance to this. He does appear to have some difficulty tolerating frustration and he was impatient to proceed into the military. On balance, he may have some slight tendency to being impulsive and may have some difficulty tolerating the discipline associated with the military. However, he does express a strong willingness to do so and appears to have made a conscious effort to change his previous behaviours."
The Commission will make no direct inquiry into the circumstances of PTE Lazarus’ enlistment. As pointed out by Lead Counsel Assisting, whether or not the applicant should have been accepted. Although not apparent from the TOR, Counsel Assisting suggested that there was a sound reason behind that stipulation:

"The recruitment process as it is, logic suggests that from time to time, individuals who may not be apparently ideally suited to service, will nonetheless enter the ADF, and, in particular, soldiers will enter the Australian Army."

Appointment of an Inquiry Officer

By Instrument of Appointment, dated 23 October 2011, the CDF appointed an Inquiry Officer to determine whether PTE Lazarus’ death appeared to have arisen out of, or in the course of his service, and to assess whether the appointment of a COI was warranted in all of the circumstances.

Specifically, the Inquiry Officer’s Terms of Reference referred to his “scoping inquiry” and stated:

"The Scoping Inquiry is not intended to be a substitute for a COI."

On 17 July 2012, the Inquiry Officer presented his report. Amongst other things, his recommendation was that a COI was not warranted. The CDF did not accept that recommendation.

For reasons stated by Lead Counsel Assisting in his opening address on 3 December 2012, the report of the Inquiry Officer has not been tendered in these proceedings. However, all material appended to the Inquiry Officer’s report has been placed into evidence during the hearings.

The principal reason why Counsel Assisting did not introduce the Inquiry Officer’s report into evidence was because Counsel Assisting, unanimously, formed the view that the Commission of Inquiry should not be influenced by whatever findings, opinions, beliefs or inferences the Inquiry Officer might have drawn from the evidence.

Recommendation – Unredacted Report to the Brisbane Coroner

It is the view and strong recommendation of the Commission that an unredacted copy of the Commission’s Report be provided to Coroner Lock, as soon as practicable. That recommendation has the unanimous support of Counsel Assisting.
3.53. The Commission is also of the view that the Coroner should not be burdened with all the Annexures to the Report, most of which have "Restricted Access" status. If it is necessary for the Coroner to access any of that material, he may so apply.

3.54. Disclosure of the Report, or any part of its associated records, is a matter for the Minister, and not the Commission, to authorise.
4. **PART A – CHRONOLOGY OF EVENTS**

4.1. This Chronology or Timeline of Events is constructed from information available to the Commission. Some comments from the Commission have been included. No footnote references have been included in Part A.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>Pre-enlistment</td>
<td></td>
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<tr>
<td>8 Apr 90</td>
<td>Date of birth of Jacob Lee Lazarus in Brisbane</td>
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<tr>
<td>Nov 07</td>
<td>Mr Jacob Lazarus successfully completed Year 12 at St. Joseph’s College, Gregory Terrace, Brisbane (OP score of 16).</td>
</tr>
<tr>
<td>24 Jan 08</td>
<td>Mr Jacob Lazarus’ first application to join the ADF, namely, the Australian Regular Army. (ARA). That application was not proceeded with.</td>
</tr>
<tr>
<td>20 Feb 09</td>
<td>Mr Jacob Lazarus’ second application to join the ADF. Job Preferences listed as: ARA – Rifleman (RFN) ARA – Soldier (ECN 500) The employment history given by Mr Jacob Lazarus mentioned labouring, dishwashing, kitchen hand/waiter and other casual jobs.</td>
</tr>
<tr>
<td>9 Apr 09</td>
<td>Mr Jacob Lazarus was assessed by a member of the Defence Force Psychology Organisation as having the aptitude for RFN and ECN 500, and recommended him for both.</td>
</tr>
<tr>
<td>9 Apr 09</td>
<td>The Examining Medical Officer Doctor 1, noted that in the circumstances, extra information was required, namely, a current psychiatric report, and a Medical Fitness Determination (MFD).</td>
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</table>
28 Apr 09  Date of the report by Doctor 2, Psychiatrist, Brisbane, to the Lazarus family GP concerning the suitability of Mr Jacob Lazarus joining the military. The report was supportive.

11 Jun 09  After a request by the Defence Force Recruiting Centre (DFRC), Brisbane, (per Doctor 1) for a MFD by the Chief Medical Officer (CMO), Defence Force Recruiting (DFR), in Canberra, the Deputy CMO (Doctor 3), having regard to the supportive report from the Brisbane psychiatrist, made a MFD that supported the application for Mr Jacob Lazarus to enlist in the ARA as a Rifleman (RFN). As regards the problem or issue that triggered the request for the MFD determination, the Deputy CMO stated “Waiver would be supported by CMO: N/A”.

**Recruit and Infantry Training**

**Recruit training**

9 Nov 09  Mr Jacob Lazarus enlisted in the ARA and marched into 1 Recruit Training Battalion (1RTB) Kapooka, NSW, to commence his training.

The evidence is that Recruit (REC) Lazarus performed well and enjoyed his training at Kapooka, and later at Singleton. His parents reported that he was probably happier at those times than throughout all of his high school years.

Whilst at 1 RTB, REC Lazarus decided to become an infantry soldier.

21 Dec 09 to 4 Jan 10  Christmas leave from 1RTB in Brisbane.

Fri 19 Feb 10  REC Lazarus successfully completed his training as a member of 3 PL, A COY, 1 RTB and his parents were present to see him march out from 1 RTB as Private (PTE) Lazarus.

**School of Infantry**

23 Feb 10  PTE Lazarus marched into the School of Infantry (SOI) Singleton, NSW where he commenced his Royal Australian Infantry (RA Inf) Initial Employment Training (IET).

2 Apr 10 to  Easter leave from SOI in Brisbane. It is clear
from the evidence that PTE Lazarus enjoyed his recruit training and his IET as an RFN. His parents told the Investigation Officer that while their son was at Kapooka and Singleton, he was "dead keen" to deploy to Afghanistan. To prepare himself in that regard, PTE Lazarus began voluntary study of the Afghan language by means of CDs his mother obtained for him.

**Detachments and postings**

15 Jun 10 From the SOI, PTE Lazarus was detached, as were some of his RA Inf IET cohort, for 3 months to the Training Support Platoon (TSP) at the Royal Military College (RMC), to participate in exercises (as enemy) in the training of RMC Officer Cadets. Various exercises were conducted in the ACT Training Area, the Wide Bay Training Area in Qld and the Land Warfare Centre (LWC), Canungra, Qld.

**Posting to 6 RAR**

Jul 10 Whilst a member of the TSP at RMC, PTE Lazarus was notified of his posting to 6 RAR, Gallipoli Barracks, Brisbane, in Sep 10.

Just prior to his march in to 6 RAR, PTE Lazarus and others from the TSP were billeted at the LWC.

**March in to 6 RAR**

Thu 16 Sep 10 The B Company (B COY) 6 RAR Rear Roll Book indicated that PTE Lazarus was a "NEW MARCH IN" on 16 Sep 10, together with 8 other soldiers.

At that time, B COY was the Rear Echelon Company of 6 RAR, and was designated as 6 RAR Rear. All other companies in 6 RAR were then deployed to Afghanistan as part of the 6 RAR Battle Group, namely, Mentoring Task Force 1 (MTF-1).

There is some evidence to indicate that PTE Lazarus and the 8 other soldiers from the LWC, arrived at Gallipoli Barracks in the late afternoon of Wednesday 15 Sep 10. Unfortunately, that evidence cannot be verified. If that date is correct, there is no evidence as to what PTE Lazarus and the other "new march ins" did on Thursday 16 Sep, within 6 RAR Rear, on that day.

PTE Lazarus (whose home town was Brisbane) was
provided with live-in accommodation at the base, namely:

*Building N6, Room 1.02,*  
*Long Tan Lines,*  
*Gallipoli Bks, Enoggera.*

**The WTSS Incident and its aftermath**

**Fri 17 Sep 10**  
**Morning** – Whatever his arrival date at B COY 6 RAR Rear, this day was PTE Lazarus’ first full day of duty in B COY 6 RAR Rear.

PTE Lazarus had stayed out late the night before, partying with civilian friends, and arrived for duty hung-over or affected by alcohol.

PTE Lazarus attended the Weapons Training Simulation System (WTSS) complex at Gallipoli Barracks, for a weapons training test. Smelling of alcohol, he failed his initial test on the Rifle 5.56mm Steyr. This resulted in an individual physical training (PT) session with a Combat Fitness Leader (CFL).

PTE Lazarus passed his 2nd attempt at the WTSS test at approximately 0954 hours, after his individual PT Session with the CFL.

**Afternoon** - PTE Lazarus was taken before, and counselled by, both the Acting OC and the Acting CSM of B COY about his attending the WTSS test affected by alcohol, earlier that day.

Given that the WTTS serial was not a live-fire exercise, no safety issue was involved. In effect, PTE Lazarus was told to improve his performance. No disciplinary action was taken and no written record of the counselling was made. PTE Lazarus was told that was the end of the issue, and no further action would be taken.

Later that afternoon, PTE Lazarus was asked by another soldier to perform that soldier’s guard duty at 6 RAR over the coming weekend. (18/19 Sep). PTE Lazarus had made other plans for the weekend and refused.

PTE Lazarus’ name was then entered onto the 6 RAR Rear Guard Duty roster for that weekend.

**Selling of the Guard Duty**
Fri 17 Sep 10  PTE Lazarus subsequently sold or traded that guard duty, because of his pre-existing commitment. He paid another soldier to perform the duty.

The evidence is that such a procedure, within 6 RAR Rear at the time, was an acknowledged informal practice, even if not condoned by higher authority.

The Monday morning “beasting” incident

Mon 20 Sep 10  The dressing down or “beasting” that PTE Lazarus received from a Lance Corporal (LCP) on the edge of the B COY 6 RAR Rear parade ground, after PT that morning was erroneously applied. The LCP had been informed by the B COY 6 RAR Rear Guard Commander during the weekend (his brother), that PTE Lazarus had “sold off” his guard duty punishment. As a result, PTE Lazarus received a loud dressing down from the LCP within the hearing and sight of other B COY 6 RAR Rear soldiers.

Failing to salute the Acting OC B COY and its consequences

Wed 22 Sep 10  At approximately 1300 hours, an incident occurred involving 14 soldiers from 4 PL B COY 6 RAR Rear. PTE Lazarus was one of those 14 soldiers. They were assembled outside the B COY HQ building, completing administrative paperwork. The Acting OC exited the side entrance of that building and approached the soldiers. The Acting OC took offence when the soldiers were not quick enough to brace up and pay him compliments including saluting.

At approximately 1600 hours that day, the 14 soldiers were notified by their PL SGT that double punishments of “2 extra duties” were to be performed by each of them, as a result of that incident.

The 14 soldiers were divided into two groups of 7 and informed by their PL SGT that one of the extra duties had to be performed, by each of them, during the weekend of 25/26 Sep. That punishment effectively negated the 4 day leave previously granted to all of those soldiers prior to their forthcoming deployment on Exercise (EX) Hamel.

The “extra duties” were, in fact, unlawfully imposed.

Sat 25 Sep 10  PTE Lazarus lost his leave for that day, performing
guard duties in 6 RAR Rear as a result of the non-saluting incident and the extra duties imposed.

On the same day, the Acting CSM of B COY 6 RAR Rear, SNCO 2, first became aware of the incident involving Officer 6 and the 14 soldiers on the previous Wednesday.

SNCO 2 took statements from the soldiers, arranged for them to have time away from work on 27 Sept 10 as token compensation for their cancelled leave, compiled the documentation necessary to have their leave re-credited (and, in two cases, had money lost on travel arrangements reimbursed), and submitted a written report to the 6 RAR Rear Adjutant, Officer 8.

Mon 27 Sep 10  SNCO 2 sent a Minute to Officer 8 concerning the loss of leave incident.

Quick Assessment

Fri 1 Oct 10  On this date, the 6 RAR Rear ADJT completed a Quick Assessment (QA) into the cancellation of leave incident for the 14 soldiers. The ADJT made a number of recommendations with which the Acting CO of 6 RAR Rear concurred, on the same date. The Acting CO noted that certain actions were to be taken as a result of the incident including "Administrative Action to be taken against (Officer 6) to address the systemic issue regarding the imposition of illegal punishments" and "administrative action to be taken against (SNCO 3)."

Exercise Hamel and the incident that occurred after its conclusion

Wed 29 Sep 10 to Sun 31 Oct 10  PTE Lazarus was one of 57 members of 6 RAR Rear who participated in EX Hamel, at the High Range Training Area (HRTA) outside Townsville. During that time, he and the other 6 RAR Rear members were at the HRTA until the end of the Exercise.

After the conclusion of EX Hamel, PTE Lazarus and the other deployed soldiers from 6 RAR Rear were accommodated at Lavarack Barracks, Townsville. On the last night before returning to Brisbane, leave was granted with a midnight curfew. Late that night, another soldier, Soldier 9, allegedly punched PTE Lazarus in the tent lines at Lavarack Barracks. The incident was alcohol related.

It was further alleged that the other soldier involved in
that incident, had threatened PTE Lazarus that he (PTE Lazarus) would be “done over” by members of 6 RAR when they returned from Afghanistan. This was because of PTE Lazarus’ poor performance in his short time with 6 RAR Rear.

Unit records indicate that PTE Lazarus performed to a satisfactory standard during EX Hamel.

**Post EX Hamel leave**

**Wed 3 Nov 10 to Mon 8 Nov 10**

Post Exercise leave was granted to 6 RAR Rear members who participated in the Exercise. PTE Lazarus spent his leave in Brisbane.

**Dearth of evidence**

**Tue 9 Nov 10 to Wed 24 Nov 10**

Apart from the B COY 6 RAR Rear Roll Book records and the like, there is a dearth of evidence concerning PTE Lazarus during the period of his return from post-exercise leave, and his non-fatal suicide attempt early on Wednesday 24 Nov 10.

Apart from the Telstra Call Charge Records for PTE Lazarus’ mobile phone (Exhibit 52), the Commission heard no evidence concerning personal and/or family issues which may have impacted upon PTE Lazarus during that period. In any event, even if there was such evidence, paragraph 15 of the TOR limits the ability of the Commission to explore, in depth, matters personal to the deceased that appear not to have arisen out of, or in the course of, his service but which may have had a bearing on his death, or on the state of his mind prior to his death.

**Loss of initial enthusiasm**

The evidence is clear that PTE Lazarus enjoyed his recruit training at 1 RTB, his IET at the SOI, and his 3 month posting to the TSP at RMC.

As his parents told the Investigation Officer, PTE Lazarus was “dead keen” on deployment to Afghanistan as a RFN. PTE Lazarus’ father also told the Investigation Officer that as soon as his son arrived at Enoggera, PTE Lazarus was “disappointed” to find out that there would be a “long wait” before his new Unit would deploy to that area of operations. The bulk of 6 RAR was then in Afghanistan, having been so deployed for approximately 5 months. In the words of PTE
Lazarus' father, "that dropped his morale enormously because he had built himself up and he was so fired up to go and all of a sudden, bang, big disappointment, brick wall".

PTE Lazarus didn't feel accepted in his new Unit. He felt that he had failed, and his personality rejected failure. He recognised that he had "stuffed up" on his first day in the Battalion, and that impacted on his pride. PTE Lazarus thought that he had lost his reputation and that his fellow soldiers regarded him as an "arsehole".

PTE Lazarus also found his duties at 6 RAR Rear "dead boring", "routine" and "mundane". He also described his deployment on Exercise Hamel as "very boring" and of no benefit to his training as an RFN.

Return of 6 RAR Battle Group to Australia

Oct-Nov 10 The 6 RAR Battle Group, MTF-1, returned to Australia from Afghanistan during the period Oct-Nov 10. The last MTF-1 personnel returned in the first week of Dec 10.

Upon its return to Gallipoli Barracks, 6 RAR was reorganised. Amongst other things, the Acting CSM of B COY, SNCO 2, was made the PL SGT of the 6 RAR Rehabilitation Platoon, a demanding role that was performed by him with distinction.

Sat 20 Nov 10 On this day, 6 RAR and other elements of 7 Bde, upon their return from active duty in Afghanistan and other deployments, were honoured with a Welcome Home Parade in Brisbane.

6 RAR Records confirm that PTE Lazarus was not on duty during the weekend of the Welcome Home Parade.

Mon 22 Nov 10 Upon the restructuring of 6 RAR, PTE Lazarus remained in B COY.

Telstra Call Charge Records

23 Nov 10 The Telstra Call Card Records disclosed that on this date, PTE Lazarus received 24 SMS messages and 4 very short phone calls on his mobile phone. The last SMS and use of his phone that day was at 2252 hours.
Non-fatal suicide attempt

Wed 24 Nov 10 At about 0730 hours that day, PTE Lazarus was found by his mother unconscious in a pool of blood on a couch in the family room at the Lazarus' Graceville residence. His parents did not know that he was at home, or that he had spent the night at their residence. Empty packets of Panadol and Codral were scattered next to a medicine chest on the kitchen bench. PTE Lazarus had consumed 48 Panadol and 48 Codral tablets, and had also endeavoured to cut his wrists.

PTE Lazarus' mother and brother, after phoning, at work, drove PTE Lazarus immediately to the Wesley Hospital at Auchenflower. endeavoured to keep his brother awake in the car.

After being admitted into the Emergency Department of the Wesley Hospital, PTE Lazarus regained consciousness and remained on a drip under observation. On the same day, he was transferred to the Royal Brisbane and Women's Hospital (RBWH). PTE Lazarus was assessed by the RBWH Psychiatric Registrar, Doctor 4, who recommended his discharge to the Gallipoli Barracks Health Centre (GBHC), with treatment recommendations.

PTE Lazarus' absence at the 6 RAR Rear roll call that morning was noted, and enquiries were made in an endeavour to locate him, including a call on his mobile phone. Unknown to 6 RAR Rear at the time, PTE Lazarus' father had called the 7 Bde switchboard in an attempt to notify 6 RAR of the incident. However, that call was diverted to the 6 RAR Rear orderly room which was not manned at the time and the call was not received. Contact was in fact made with PTE Lazarus' father later that morning, and the father explained what had happened to his son.

Telstra Call Charge Records

Wed 24 Nov 10 On Wednesday 24 Nov 10, PTE Lazarus' phone received one SMS message at 0701 hours, and between 0953 and 2238 hours that day, some 18 calls were received on his phone. One of those calls was from a mobile number that had phoned him on the previous day at 0907 hours for 13 seconds and again at 1452 hours for 4 seconds. That number phoned again on 25 Nov 10, at 0809 hours and at 2003 hours, sent an SMS message at 2027 hours and phoned him at the GBHC at
2046 hours for approximately 12 ¾ minutes.

It is possible that there may have been underlying personal issues that may have contributed to the non-fatal suicide attempt. However, in the absence of evidence, that is mere speculation.

**Hospital transfer**

**Thu 25 Nov 10**

PTE Lazarus was discharged from the RBWH and taken by Officer 10, then the temporary Regimental Nursing Officer with 6 RAR, back to the GBHC where he was admitted as an inpatient. PTE Lazarus’ mother accompanied him and Officer 10 to the Army hospital.

The Duty Medical Officer (Duty MO) at the GBHC, Doctor 5, noted that PTE Lazarus reported no suicidal ideation.

Some 6 weeks later, PTE Lazarus told an Army psychologist, Officer 18, at the Mental Health Psychology Section (MHPS) at GBHC, that he had been feeling disconnected, lonely, stupid and hopeless after EX Hamel. He mentioned that he had felt like that for some 3 years, but his feelings became sharper after the Exercise, which he described as “very boring”, and of no benefit to his training as an RFN.

PTE Lazarus told the psychologist that on the night of his attempted suicide, he was drinking at a friend’s house and then left to go home. However, he stopped at a park and cut himself with a razor. He said that he then went home and took two packets of Panadol, woke up and then took another two packets.

PTE Lazarus also told the psychologist that there was no reason that he should have the feelings he described, and told her he was unable to identify a trigger for his symptoms to have worsened.

**Fri 26 Nov 10**

Defence civilian 3, a civilian clinician at GBHC with mental health responsibilities, recorded that PTE Lazarus had been drinking with friends prior to the attempted suicide incident. PTE Lazarus indicated that he “had been feeling lonely since joining the Army and had increasing feelings of self-harm over the previous week”. Defence civilian 3 reported that PTE Lazarus denied any suicidal ideation, and felt embarrassed about his behaviour.
Doctor 6, a civilian GP at GBHC on short term contract, reviewed PTE Lazarus that day and found him to be polite, interactive, and not displaying any suicidal ideation.

Re-admission to RBWH

Fri 26 Nov 10

PTE Lazarus was readmitted to the RBWH the same day because of his abnormal liver function resulting from the non-prescription overdoses.

The RBWH was better placed or equipped to monitor PTE Lazarus' liver enzymes.

Quick Assessment

Fri 26 Nov 10

In accordance with Defence Instructions (General) Personnel 16-26, a Quick Assessment (QA) of the non-fatal incident was completed by Officer 7 of 6 RAR on the same day. The QA found no evidence indicating that the suicide attempt was related to any work incident or the conduct of PTE Lazarus' duties. It was assessed that there may have been underlying personal or family issues that may have contributed to the incident.

Risk Management Team

Fri 26 Nov 10

The CO 6 RAR convened a Risk Management Team (RMT) to identify any possible failings and to confirm future actions for PTE Lazarus. The RMT did not formalise or promulgate a Crisis Management Plan (CMP) due to PTE Lazarus' then treatment and management being handled by GBHC.

Re-admission to GBHC

Wed 1 Dec 10

PTE Lazarus was discharged from the RBWH and readmitted to the GBHC, into the General Ward. He was assessed that day by the Duty MO and observed to be co-operative, not depressed and not anxious.

Thu 2 Dec 10

PTE Lazarus was reviewed again by Defence civilian 3, who noted that the member reported no suicidal ideation. The Duty MO at GBHC, Doctor 7, also reviewed PTE Lazarus on the same day and reported him to be settled and co-operative with no suicidal or self-harm ideation.

After his readmission, PTE Lazarus was visited by his good friends Soldier 12 and Soldier 17, also members of
6 RAR and part of his recruit course cohort. They did not know at the time the reason for his hospitalisation. PTE Lazarus then told them that he had attempted to take his own life. He told them that he had been out somewhere and was drunk and depressed.

PTE Lazarus said that he had attempted to catch a train to get home to Enoggera, but missed the train. He said that after missing the train, he knew he would be late for work which pushed him over the edge and made him more depressed. He attempted to cut his wrists but it became too painful and he stopped. He said that he then went to his parents house where he took as many tablets as he could find in their medicine cabinet. When Soldier 12 asked “Why?”, PTE Lazarus responded simply by saying “Why not?”.

PTE Lazarus’ friends formed the view that he was depressed or stressed out about something. He told them that he wouldn’t do it again, recognizing that suicide was “the easy way out and that the people around him are the ones that suffer.”

PTE Lazarus asked his friends not to tell anyone else that he had attempted to commit suicide, but to say that his “liver was stuffed”. He also told his friends that he wasn’t being “kicked out of the Army”, and seemed somewhat relieved about that.

**Review by Psychiatrist**

Thu 2 Dec 10 It seems that on this day, Defence civilian 3 at the GBHC, arranged for PTE Lazarus to be reviewed by Doctor 8, Psychiatrist, Brisbane, and Consultant to the ADF for some 20 years.

Fri 3 Dec 10 PTE Lazarus was reviewed by Doctor 8 at the GBHC, who noted symptoms of major depression. The Psychiatrist also noted minor conduct difficulties and binge drinking by the soldier. He prescribed Effexor XR. He also recommended that PTE Lazarus go on leave over the weekend with his parents with a review after the weekend.

**6 RAR Rear Details**

Sat 4 Dec 10 Block leave started for 6 RAR and during that leave period, 6 RAR Rear Details operated.

Rear Details was managed by a skeleton staff not on any
type of leave. Officers and NCOs were to return from their block leave on Mon 24 Jan 11, and 6 RAR soldiers were to report back for duty on Mon 31 Jan 11.

At all times when he was on convalescence leave, PTE Lazarus was, in effect, a member of Rear Details because his convalescence leave was only for 2 weeks at a time. At the end of each convalescence leave period, he was required to attend GBHC for medical review. If further convalescence leave was recommended, it had to be approved by the OC Rear Details, as the CO's delegate.

During the period Fri 3 Dec 10 to Fri 13 Jan 11, SNCO 2 assisted the CSM of Rear Details. From Sat 15 Jan 11 to Sunday 30 Jan 11, SNCO 2 was Acting CSM of 6 RAR Rear Details.

**Weekend Convalescence Leave**

Sat 4 Dec 10 to Mon 6 Dec 10

PTE Lazarus was reviewed by the Duty MO at GBHC, Doctor 9. He was found to be well and his medication regime (Effexor XR [redacted]) was confirmed.

Doctor 9 recommended that PTE Lazarus be placed on convalescence leave for the weekend, going home to his parents. Doctor 9 noted that PTE Lazarus was to be reviewed by the Mental Health Unit (MHU) at GBHC at 0800 hours on Monday 6 Dec.

The convalescence leave recommendation was approved that day by the 6 RAR Rear Details Duty Officer, SNCO 2, and PTE Lazarus went home to his parents for the weekend.

**Return to GBHC as an inpatient**

Mon 6 Dec 10

The Duty MO at GBHC, Doctor 10, duly reviewed PTE Lazarus that day and made no specific comments regarding ideation.

Psychiatrist, Doctor 8, provided a written report that day to the MHU at GBHC. His report concluded as follows:

"**SUMMARY AND ASSESSMENT**
I thought this young man had a major depressive illness. I have started him on Effexor [redacted] I do not think he is fit for work though. I do think that I am happy for him to stay at home in the care of his parents and we will just see how that goes. I am organising to
review him early next week and will let you know of his ongoing progress."

Tue 7 Dec 10  PTE Lazarus had his second consultation with Doctor 8 at the GBHC. Doctor 8 found him to be stable and fit to go home to his parents. Doctor 8 also arranged another appointment to review PTE Lazarus two days later.

Following the review by Doctor 8, the Duty MO at GBHC, Doctor 11, noted that PTE Lazarus had no suicidal ideation and felt much better than before his overdose.

Doctor 11 recommended convalescence leave for PTE Lazarus with his parents, with a review of that leave on 14 Dec 10.

PTE Lazarus was discharged from the GBHC that day and commenced, what was to become, extended convalescence leave with his family.

Thu 9 Dec 10  Further consultation with Doctor 8, this time in Doctor 8’s private rooms in the city.

A review of PTE Lazarus by the Gallipoli Barracks MHU was scheduled for this day, but PTE Lazarus missed that appointment.

Tue 14 Dec 10  Further consultation with Doctor 8 in his private rooms in the city.

Fri 17 Dec 10  Further consultation with Doctor 8 in the city.

Wed 22 Dec 10  PTE Lazarus was reviewed by the Duty MO at GBHC, Doctor 12.

Doctor 12 noted that Doctor 8 had been regularly seeing him during the preceding period. PTE Lazarus denied any thoughts of self harm or suicide and reported some improvement to the doctor, in that his moods were more even.

Doctor 12 noted that PTE Lazarus was staying with his parents over Christmas. Doctor 12 arranged to have PTE Lazarus attend a psychologist at MHPS-GBHC on 5 Jan 11.

**Back-dating convalescence leave**

Wed 22 Dec 10  Doctor 12 also noted that the last convalescence leave
appointment had been missed on 9 Dec, due to a conflict of appointments. PTE Lazarus missed his appointment that day because double appointments had been booked. In the circumstances, Doctor 12 obtained permission from Officer 16, OC MHPS-GBHC, to backdate the convalescence leave. Doctor 12 recommended convalescence leave to 5 Jan 11, backdated to 14 Dec 10. The leave recommendation stated that PTE Lazarus was to report to the Hospital Office at 2 HSB/GBHC between 1000 and 1100 hours on 5 Jan for a medical review.

After leaving the GBHC that day, PTE Lazarus went to the 6 RAR Rear Details Duty Room to have his leave approved. His attendance at the Duty Room caused him distress.

The back-dated convalescence leave recommendation was then signed by the 6 RAR Rear Details Duty SGT, SNCO 2, and duly approved by Officer 2, OC 6 RAR Rear Details.

Thu 23 Dec 10  PTE Lazarus attended his sixth consultation with Doctor 8. With PTE Lazarus’ consent, his father was present throughout the consultation in Doctor 8’s rooms.

Both Doctor 8 and PTE Lazarus’ father have a very clear memory that PTE Lazarus was told that day by Doctor 8 that the only way PTE Lazarus was going to return to duty with the Army was if Doctor 8 “signed off” to the effect that PTE Lazarus was “fit” to return to duty.

Mon 27 to Wed 29 Dec 10  Lazarus family holiday at Coolum, a tradition for some 15 years. The evidence is the family had a “fabulous time.”

Wed 5 Jan 11  PTE Lazarus had a consultation with MHPS-GBHC psychologist, Officer 18.

That was the first, and indeed only, consultation PTE
Lazarus had with an Army psychologist, six weeks after the non-fatal suicide attempt.

Officer 18 had been posted to the MHPS-GBHC in Nov 10. Although a qualified psychologist, Officer 18, at that time, was not a fully qualified Army Officer, not having attended a Special Service Officer’s (SSO) course or a Regimental Officer’s Basic Course (ROBC).

Time constraints did not permit Officer 18 to complete relevant information gathering at that session with PTE Lazarus. At the time of the interview, Officer 18 did not have access to the member’s medical file believing, at that time, she could not access medical-in-confidence material. Officer 18 did have PTE Lazarus’ psychology file, and believed that it may have contained a copy of Doctor 8’s report dated 6 Dec 10.

Contrary to usual practice, the MHPS administrative staff had not arranged for PTE Lazarus to complete the pre-screening questionnaire prior to his interview.

During the assessment, it appeared to Officer 18 that PTE Lazarus was not listening to what she was saying. As far as any risk assessment was concerned, PTE Lazarus admitted to some fleeting thoughts of suicide by overdose, but denied any immediate thoughts or plan.

Officer 18 discussed a suicide-safe plan with PTE Lazarus, but no written plan was prepared. PTE Lazarus agreed that he would contact the MHPS or present to the RAP if he felt at risk. Officer 18 noted that whilst PTE Lazarus denied any immediate risk of suicide, his previous suicide attempt which included self-harming behaviour and the use of alcohol, increased the future risk.

Officer 18 recommended that PTE Lazarus continue his sessions with Psychiatrist, Doctor 8, and scheduled a follow-up session with MHPS-GBHC for continued counselling and monitoring of his safety. That session was booked for 1300 hours on Wed 19 Jan 11.

After the consultation with Officer 18 that day, PTE Lazarus was reviewed by Doctor 12, the Duty MO at GHBC. She noted that he had attended with the psychologist earlier that day and noted his next appointment with Doctor 8 later that month. It seems there was no direct liaison between the psychologist and
Doctor 12 that day. In short, Doctor 12 had no visibility with respect to the psychologist's assessment and, it seems, did not have access to PTE Lazarus Army psychology file.

Officer 18 did not think it necessary to back-brief Doctor 12 because the psychologist's assessment of PTE Lazarus did not value add to the information that Doctor 12 had provided Officer 18 in the medical referral. The psychologist understood that Doctor 12 was the case manager handling all relevant information.

At the review, Doctor 12 noted that PTE Lazarus reported that he was currently happy and had no current self-harm or suicide thoughts. The doctor gave him another prescription for Effexor XR.

Doctor 12 also noted that a Plan was in place, highlighting the need for continuity with a Doctor (referred to as the “RAP Dr”), and the need for PTE Lazarus to follow up his continuation of Convalescence Leave with Doctor 12.

There was to be a review at the 2 HSB RAP on 19 Jan 11 by Doctor 12, after the next appointment with the Psychiatrist, Doctor 8.

Doctor 12 recommended the continuation of Convalescence Leave from 5 Jan to 19 Jan 11, with PTE Lazarus to report back to the Hospital Office at 2 HSB/GBHC at 1120 hours on 19 Jan for a medical review by herself.

PTE Lazarus then took that Convalescence Leave recommendation to the 6 RAR Duty Room that day, where it was signed by the 6 RAR Rear Details SGT, SNCO 2. The Convalescence Leave was duly approved by Officer 12, the then OC 6 RAR Rear Details.

**Bank loan**

**Fri 7 Jan 11**

Unknown to his family, PTE Lazarus applied for a $5000 personal loan from the Commonwealth Bank of Australia (CBA). Those funds became available within days and were totally spent at the time of PTE Lazarus' death.

It appears that the loan monies were totally expended by PTE Lazarus in the wineing and dining of his friends and family and gambling at the Brisbane Casino.
Tue 11 Jan 11

PTE Lazarus missed an appointment with his Psychiatrist, Doctor 8, because of the Brisbane Floods. He phoned Doctor 8’s office after 1700 hours that day to obtain an appointment time for Friday, 14 Jan 11.

Doctor 8’s office was unaware of the missed appointment because the computer system was switched off apparently because the flood caused power loss in the area.

Mon 17 Jan 11

Doctor 8’s office endeavoured to contact PTE Lazarus to rearrange an appointment, but there was no response from PTE Lazarus. The Telstra Call Charge Records suggest that two phone calls were made, and an SMS message sent, by Doctor 8’s office at 1125 hours that day.

Sometime that day, Soldier 12 spoke to PTE Lazarus using the mobile phone network. PTE Lazarus told his friend that he had been having fun, going out with his mates. He also said that it was good having nothing to do with the Army and that he wasn’t looking forward to coming back to work. Soldier 12 thought that PTE Lazarus had to be back at work in the following week because of the way he was talking. That was the last time they spoke.

Tue 18 Jan 11

PTE Lazarus’ mother was in Canberra on a 5 day social visit. That evening, Father took both his sons to dinner at an Indooroopilly restaurant. Afterwards, PTE Lazarus played “Trivial Pursuit” with family friends.

At home, Father went to bed at about 1100 hours, having observed PTE Lazarus out on the back deck having a drink and a smoke. He was also observed writing in a black book. Father incorrectly assumed that this was a journal kept at the request of Doctor 8. In fact, his son was writing the 21 pages of suicide notes found by his father at approximately 1230 hours the next day on his son’s unmade bed.

Telstra Call Charge Records

Fri 14 Jan 11 to Wed 19 Jan 11

The Telstra Call Charge Records indicate that during that 5 day period, PTE Lazarus made 67 calls on his mobile phone, and 9 attempted calls. He also sent 58 SMS messages and received 7.

At 2123 hours on Tue 18 Jan 11, PTE Lazarus sent an
SMS message to a particular mobile number, and received no immediate reply. At 2251 hours he sent another SMS message to that number, and received a reply seconds later. That was the last use of PTE Lazarus’ mobile phone.

Wed 19 Jan 11

Father observed his son departing from the residence in casual civilian clothes, between 1100-1130 hours, supposedly to catch a train to Enoggera for a medical appointment on the base at 1300 hours and a hair cut at the base.

At about 1230 hours, Father found the black note book containing the suicide notes on his son’s bed. He then phoned the QPS expressing his concerns.

PTE Lazarus failed to report for his appointment with Officer 18 at the MHPS at Gallipoli Barracks at 1300 hours. As a result, a Failure to Report Form was completed by the MHPS staff, and an attempt was made to contact PTE Lazarus. Clearly, PTE Lazarus also failed to attend earlier that day for his medical review by Doctor 12, which would have involved a further review of his convalescence leave.

At approximately 1400 hours, the GBHS Director of Nursing Services, Defence civilian 2, received a phone call from PTE Lazarus’ father, indicating that his son was missing and last seen about 1100 hours that day. Father informed her that he had found a suicide note and had contacted the QPS. Defence civilian 2 then advised the OC MHPS, Officer 16, who in turn notified the ADJT 6 RAR Officer 3, at 1437 hours.

At 1438 hours, the S11 HQ 7 Bde, Officer 19, received a phone call from the QPS stating that PTE Lazarus had been found hanging by his neck from a tree. The QPS contacted the Army because an ADF ID Card had been located at the scene.

The body of PTE Lazarus was found hanging from the branch of a tree at the Sherwood Arboretum Forest. The QPS attended the scene at 1250 hours approximately.

Officer 19 conducted a PMKeys search and established that PTE Lazarus was a member of 6 RAR. He informed the Chief of Staff, Officer 13, at 1442 hours, and Officer 13 informed the COMD 7 Bde. At 1445 hours, the COMD 7 Bde directed that the CO 6 RAR was to be informed and that the ADJT 6 RAR was to
draft a FATALCAS, both of which occurred.

At 1538 hours, the CO 6 RAR received an email from Defence civilian 1, a member of ADF Media Operations, stating that approximately 20 minutes before, a female called Lucy had phoned the public enquiries line concerned about the whereabouts and health of PTE Lazarus.

At approximately 1531 hours, the QPS attended the Lazarus family home at Graceville and informed Father his son was deceased. The QPS officers took possession of the black note book containing the suicide notes.

At 1812 hours, the QPS notified the Army that PTE Lazarus’ father had identified his son’s body at approximately 1710 hours.

At 1820 hours, the QPS informed Officer 19 that the body of PTE Lazarus was taken to the John Tonge Centre – Queensland Institute of Forensic Technology, and that an autopsy was planned for the next day. At 1827 hours, a FATALCAS was released and at 1859 hours, an Initial Incident Report was released, via AIMS.

Earlier that day, ADFIS commenced an investigation into the sudden death of PTE Lazarus, assisted by the QPS on behalf of the Coroner.

That night, Mother returned home from Canberra.

Thu 20 Jan 11

Prior to the commencement of the autopsy that day, the Brisbane Coroner had ordered that certain tests be conducted, namely, a CT scan and toxicology analysis. During the autopsy, five (5) specimens were taken for analysis.

At 1000 hours that day, the CO 6 RAR, together with a Chaplain, the 6 RAR Nursing Officer and the RSM, visited Parents at their home. They were well received by the family.

Quick Assessment

Fri 21 Jan 11

As directed by the Chief of Staff HQ 7 Bde, the ADJT 6 RAR, Officer 3, completed a Quick Assessment (QA) into the death of PTE Lazarus. On the same date, the CO
6 RAR, **Officer 21**, concurred with the QA, noting that the recommendations therein were to be passed to the COMD 7 Bde.

The CO 6 RAR made four (4) notations with respect to the incident.

**Memorial Service**

Fri 28 Jan 11

A Memorial Service in celebration of PTE Lazarus life was conducted at the Centenary Memorial Gardens, Sumner Park. The service was listed in the *Courier Mail*.

In lieu of flowers, the family requested that donations be sent to "Beyondblue", an Australian organisation which provides information and support about depression to the public and health professionals.

Fellow soldiers acted as coffin bearers during the service. In addition to PTE Lazarus' soldier friends from 6 RAR, other soldiers that he had trained with attended the service from other infantry Battalions, namely, five soldiers from 1 RAR and 2 RAR, two from 5 RAR and two from 8/9 RAR. The CO of 6 RAR, **Officer 21**, also attended and spoke at the Service.

During the funeral, PTE Lazarus' father told the soldiers that he didn’t blame the Army for what had happened to his son. **Father** said that the Army was the best thing that happened to his son, but when he came back to his old life in Brisbane, the two lifestyles didn’t fit.

After the Service, **Father** invited his son’s soldier friends back to the family home for a wake. They spent the afternoon with the family and PTE Lazarus' civilian friends. Stories were told and the soldiers found their deceased mate's family and friends polite and friendly. There was no discussion about the deceased's depression or anything negative to do with the Army, but only "good stuff".

As painful as their loss is, PTE Lazarus’ parents have always acknowledged that their son’s decision to end his own life was not a sudden decision made by him on 19 Jan 11. The evidence is clear that the tragic event was planned well in advance and was very well camouflaged from his family and many close friends. None had any reason to believe that PTE Lazarus would take his own
life.

PTE Lazarus’ parents do not blame the Army for the tragic loss of their son. When interviewed by the Investigation Officer on 28 Nov 11, the parents spoke about the "excellent response" by the Army after their son’s death. Father stated:

"......they were great. We've had no complaints about the Army whatsoever, just all praise basically."

Whatever personal or other factors caused PTE Lazarus to fear returning to the ranks of 6 RAR, the reality is that he loved the Army. That is the evidence of his close soldier friends.

**Mon 31 Jan 11**

COMD FORCOMD, sent a Minute to the Chief of Army (CA) concerning the death of PTE Lazarus. COMD FORCOMD recommended that "a CDF Commission of Inquiry (COI) be initiated to investigate the military health and welfare support provided prior to PTE Lazarus’ death" and that "the CDF COI assists the Queensland Coroner to determine the cause of the fatality".

**Thur 24 Feb 11**

Doctor 13, ADF Regional Health Director, Queensland, Regional Health Service Queensland, Gallipoli Barracks, Enoggera, completed a 5 page review of medical documents pertaining to PTE Lazarus and his treatment. In his SUMMARY, Doctor 13 noted amongst other things:

"The stand-down period over the Christmas and New Year saw PTE Lazarus attend several different General Practitioners at GBHC".

The Regional Director of Health, Doctor 13 further opined:

"Whilst it was not ideal that he was reviewed by different medical officers over the stand-down period, it is not uncommon within any facility to have different duty medical officers during leave periods. (Doctor 8), Psychiatrist, however, continued to manage him and review him regularly”.

**Tue 15 Mar 11**

A Toxicology Certificate was issued by Queensland Health Forensic and Scientific Services and Toxicology Laboratory. In effect, no alcohol or drugs were detected in the specimens provided. As a result, it may be
reasonably inferred that, PTE Lazarus did not drink to
excess the night before his death, nor did he take his
prescribed medication, Effexor XR—at least on a
regular basis.

Fri 15 Apr 11  The Office of the Queensland State Coroner (QSC) per
Brisbane Coroner J. Lock, informed the ADFIS Director
of Operations in Canberra, that the Office of the QSC
supported ADFIS continuing as the “primary
investigative agency” in support of the Coronial Inquiry
into the death of PTE Lazarus.

July 11  The final ADFIS Report was issued. The Report
recommended that a COI be conducted.

Fri 2 Aug 11  The Office of the QSC, per Coroner Lock, informed the
ADFIS Director of Operations that he (the Coroner) was
"suspending any decision regarding the holding of an
inquest until the completion of the CDF COI Report and
receipt of a copy of that report."

23 Oct 11  The CDF appointed an Investigation Officer to conduct
a Scoping Inquiry into the death of PTE Lazarus.

17 Jul 12  The Investigation Officer presented his report
recommending that a COI was not warranted.

Fri 12 Oct 12  The CDF appointed this Commission of Inquiry.

3-19 Dec 12 and
4 - 21 Feb 13  During those periods, the COI hearings were conducted
at Victoria Barracks, Brisbane.

Thu 7 Mar 13  Written Submissions from Counsel Representing
Officer 21 and Officer 6 were to
be provided to Counsel Assisting, in electronic form, no
later than COB that day.

At the request of those Counsel Representing, an
extension was granted to COB, Mon 11 Mar 13.

(Submissions on behalf of SNCO 2 had been received
from his Counsel on 8 Feb 13.)

Wed 17 Apr 13  Having regard to unfortunate delays in the preparation
of the COI Report and paragraph 20 of the TOR, the
President contacted Director CDF Commissions of Inquiry,
was advised

that the completion date for the Report could be delayed
for up to one week. Permission was given to extend the
completion date if necessary, without further
notification to the CDF's Office. On Fri 19 Apr, circumstances dictated that the completion date for the Report would in fact be further delayed.

Thu 2 May 13 Date for the completion of the Report was extended to Fri 31 May 13: see Annexure L to the Report.

PART B - THE ESSENTIAL ISSUES

The behavioural and doctrinal factors

4.2. The TOR assign two principal tasks to the Commission of Inquiry: one is to explore the circumstances of PTE Lazarus' death, the second is to consider the adequacy of current ADF Medical Management Policies. Accordingly, it was convenient to conduct the COI in two phases, as an inquiry into relevant "behavioural factors" and "doctrinal factors,"

The six (6) issues.

4.3. In his final oral submissions to the Commission, [redacted] identified six issues upon which the Commission has been tasked to inquire into, make findings upon, and provide recommendations. Those issues are:

1. The physical training session conducted on the occasion PTE Lazarus attended the WTSS Session and the events that followed it including the circumstances in which PTE Lazarus was awarded guard duty ("the WTSS incident and its aftermath").

2. The circumstances in which PTE Lazarus came to be counselled for allegedly trading his guard duty ("the Monday morning beasting").

3. The incident in which PTE Lazarus had been accused of failing to salute Officer 6 and the consequences that flowed from that event ("the non-saluting incident").

4. The interactions between PTE Lazarus and other members of his Unit, including but not necessarily limited to, the incident that occurred at the conclusion of Exercise Hamel ("the post EX Hamel incident").

5. The circumstances surrounding PTE Lazarus' attempted suicide on or about 24 Nov 16 and his management in the wake of that event, both in the command sense and by way of medical treatment ("the non-fatal suicide attempt"). These are the issues raised in paragraphs 12 c. to 12 f. in the TOR.

6. The adequacy and the application of the various policy, instruction,
guidance and other doctrine dealing with the ADF’s medical services, and particularly matters of mental health ("the application and adequacy of ADF policy"). These are the issues raised in paragraph 12 g. of the TOR.

4.4. Clearly, issues 1 to 4 inclusive come under the umbrella of the so called "behavioural factors", whilst issues 5 and 6 relate to the so called "doctrinal factors".

PART C – NATURE OF THE EVIDENCE

Documents

4.5. The Exhibits List identifies those documents that were placed in evidence before the Commission.

Witnesses

4.6. Amongst other things, the Witness List gives the name and description of each witness who gave evidence on oath or affirmation.

4.7. As regards other persons, the Commission has received into evidence one or some of the following:

- A statement made to ADFIS in the course of its inquiry into PTE Lazarus’ death;

- A transcript of an interview conducted by the CDF appointed Investigation Officer; and/or

- An affidavit, sworn or affirmed.

Cohort members

4.8. As regards issues one (1) to four (4) inclusive, there was evidence from the following members of B COY 6 RAR Rear, described as PTE Lazarus’ cohort:

- Soldier 5

- Soldier 6
Evidence from Officers, NCOs and non-cohort members

4.9. Evidence was also given from the following persons with respect to issues one (1) to four (4) inclusive:

- **Officer 21**, CO 6 RAR at the material time
- **Officer 6**, Acting OC B COY 6 RAR Rear at the material time
• Officer 7, a Platoon Commander in B COY 6 RAR (Oct 10 - Jan 12), after his return from deployment with MTF-1
• SNCO 2, Acting CSM of B COY 6 RAR Rear at the material time
• SNCO 3, PL SGT B COY 6 RAR Rear at the material time
• SNCO 4, SGT 6 RAR Rear at the material time
• Soldier 1
• Soldier 2
• Soldier 3
• Soldier 4
• Soldier 7 and
• Soldier 9

Evidence with respect to issues 4 - 6 inclusive

4.10. The Commission has received evidence from the following personnel with respect to issues four (4) to six (6) inclusive:

• Officer 21 CO 6 RAR at the material time.
- Officer 14, Chief of Staff, HQ 7 Bde.
- Officer 20, former CO 2HSB and currently SOI Health Governance, Directorate of Army Health.
- Officer 16, OIC of the Mental Health and Psychology Section (MHPS) at Gallipoli Barracks Health Centre (GBHC) at the material time.
- Officer 3, ADJT 6 RAR and author of the QA into the death of PTE Lazarus, dated 21 Jan 11.
- Officer 4, Welfare Officer for MTF-1 at the material time.
- Officer 18, Army Psychologist.
- Officer 10, Nursing Officer 6 RAR at the material time.
- Officer 7, OC 4 PL B COY 6 RAR and author of the QA into the non-fatal suicide episode on 24 Nov 10.
- Officer 11, Platoon Commander C COY 6 RAR (Jan 10-Dec 10) and Assistant ADJT 6 RAR (Jan 11-Dec 11)
- SNCO 1, RSM 6 RAR at the material time.

**Doctors who gave oral evidence to the Commission**

- Officer 9, former Regimental Medical Officer (RMO) 6 RAR.
- Doctor 8, treating Psychiatrist.
Evidence from PTE Lazarus' parents and one of his best friends

4.11. The Commission was assisted by documentary evidence from the parents of PTE Lazarus, [Father] and [Mother], as well as a very good civilian friend of the deceased soldier, [Friend]. The friendship of [Friend] and PTE Lazarus commenced in their early school days and remained very strong thereafter.
5. The physical training session said to have been conducted immediately after PTE Lazarus failed his weapons test, and any other action taken in response to that failed test, whether formal or otherwise.

5.1. The Roll Book for B COY 6 RAR Rear records that PTE Lazarus was a “New March In” as were 8 other soldiers, on 16 Sep 10.

5.2. The new arrivals had come from the LWC at Canungra where they had completed their temporary duties with the TSP at RMC.

5.3. It seems that the arrival of the 9 soldiers at 6 RAR Rear was unexpected. One soldier said that they experienced a “stuff around” obtaining the keys for their live-in accommodation and that the keys were not at 6 RAR Rear HQ, but at the Gallipoli Barracks front gate. The new arrivals were told to go to 5 PL B COY, which was to be their platoon.

5.4. The evidence is that following their arrival at 6 RAR Rear, PTE Lazarus and the other new march ins went to the Regatta Hotel at Toowong, sometime between 5-6 pm when it was still light for a few drinks.

5.5. It is uncertain when the group left the hotel, but according to Soldier 12, it was “pretty early”, and certainly before 1:00 hours, because,

“...we were new to the Battalion and didn’t want to rock-up – you know, didn’t want to have too big a night.....”

5.6. PTE Lazarus, however, did not return to Gallipoli Barracks with his mates that night. He told them he was going to join civilian friends, with the implied suggestion that he would continue drinking.

5.7. Although PTE Lazarus was present at the Roll Call at 0730 hours on Fri 17 Sep 10, there is conflicting evidence whether he was then drunk or hungover. What was clear is that he looked tired and “smell of alcohol”.

5.8. Soldier 12, one of PTE Lazarus’ cohort, told his friend that he was “an idiot”
for staying out so late. As Soldier 12 said:

“I wanted us all to stay under the radar considering that we were new to the Unit”.

5.9. Following the marking of the roll book, members of B COY were advised to report to the WTSS facility at the back of Gallipoli Barracks, after breakfast, to participate in an Army Individual Readiness Notice (AIRN) range practice.

5.10. Instead of going to breakfast or doing individual Physical Training (PT), or even taking a shower, it seems PTE Lazarus went to his room and it appears that he went to bed before the WTSS practice.

5.11. The WTSS practice was listed to commence at 0900 hours and conclude at 1500 hours. Some 57 soldiers were listed for the practice.

5.12. It appears that PTE Lazarus was in the first group to participate in the WTSS practice. Soldier 3 was the practice NCO or security officer at the WTSS facility. He did not have a very good recollection of events that day, but remembered a soldier failing the practice “5 or 6 times” before the NCO went and sat next to him. That soldier was PTE Lazarus. Soldier 3 asked what was going on. PTE Lazarus informed the LCPL that he had “a big night and that he had a bit of a hangover”.

5.13. Soldier 3 said that PT “cleared” his head in times of trouble and he told PTE Lazarus that he (PTE Lazarus) was going to do some PT with Soldier 2, a combat fitness leader (CFL).

5.14. Soldier 3 was pretty sure he told the CFL to take PTE Lazarus for a run “to get a bit of a sweat up and clean him out”. Essentially, Soldier 2 was tasked to ascertain PTE Lazarus’ fitness to continue with the weapons test. PTE Lazarus was taken out of sight and out of the hearing of the remaining members of the detail that were present, and this is relevant only in the fact that other than for Soldier 2, no-one can give direct evidence of what then occurred.

5.15. Whatever happened during the PT session/assessment, the evidence is that PTE Lazarus returned to the WTSS and shot again. On that, his second attempt, he passed the test at 0954 hours.

5.16. In his affidavit, Soldier 3 mentioned Soldier 19 being present at the WTSS practice that day:
“There’s a lot I can’t remember, but I definitely would have spoken to (Soldier 19) who might have reported up the line. I don’t recall any disciplinary action being taken against the digger. Normally, the way it would have worked is, if we’d taken them for a run and it was dealt with. We would have said ‘Look, we are not going to do you in for having a hangover mate, you can go for a run and come back to do the shoot, but don’t do it again’.

5.17. Soldier 3 said that if a person was shooting at the WTSS with a hangover, that would not be a problem so long as the person was safe and not doing anything which involved the use of live ammunition.

The Assessment PT session

5.18. As previously mentioned, the PT session to clear PTE Lazarus’ head, and give him a further opportunity to pass the WTSS practice was conducted by Soldier 2. He had completed a CFL course in 2010, and became a qualified CFL in or about September 2010. Soldier 2 is now a Physical Training Instructor (PTI) elsewhere in Australia helping to train infantry soldiers. His first year as a PTI was 2012, and the first platoon he instructed achieved a 100% fitness assessment. As he said, if he wasn’t an “enthusiastic” PTI and former CFL “I wouldn’t be where I am today.” The evidence is that Soldier 2 runs his PT sessions in a “regimented” fashion.

5.19. Soldier 2 could not recall which NCO tasked him to do the PT session with PTE Lazarus at the WTSS facility that day. Clearly, it was Soldier 3. Like PTE Lazarus, Soldier 2 was one of the 57 soldiers listed to do their WTSS shoot that day.

5.20. The evidence is that the only time that Soldier 2 had exposure to or direct contact with PTE Lazarus was that day, and the interaction was in the nature of a more-senior soldier (CFL) mentoring the other.

5.21. Soldier 2 recalled that the tasking NCO was concerned that PTE Lazarus was affected by alcohol:

I was asked to take PTE Lazarus aside and see if he was going to be okay handling a weapons system. I cannot recall precisely what instructions or directions were given to me but it was to the effect ‘take him out around the back in the shade and see if he is good to go for the WTSS shoot, or words to that effect.”

5.22. The assessment PT exercise was tasked because PTE Lazarus was affected by alcohol. It was uncertain whether he was fit to shoot. In effect, the CFL was to exercise PTE Lazarus to assess his “fine and gross motor skills”.
5.23. There is nothing unusual or blameworthy about the practice of conducting a PT session for a soldier who is hung over or suffering the effects of alcohol. So long as such a soldier is assessed as being safe in the circumstances, there is nothing unsatisfactory or unsafe about that practice.

5.24. To the CFL, PTE Lazarus “looked fine but smelt of alcohol”. PTE Lazarus was questioned to determine whether there were any issues why the PT assessment should not proceed. There were none. PTE Lazarus was told to fill his two issue water bottles (each holding a litre) and “have a slow sips, and not to skol” before a warm up session was conducted. The CFL observed that PTE Lazarus “was a very fit looking young lad and he had no dramas with the warm up.”

5.25. Soldier 2 described the PT session intensity as “low to medium” requiring a constant sustainable output.

5.26. The PT session involved DEP (demonstrate, explain and practice) activities, and a range of movements to assess PTE Lazarus suitability to perform the WTTSS shoot requirements. PTE Lazarus was also required to do a “leopard crawl” for approximately 20 metres to assess if he could go to and from necessary fire positions.

5.27. During the PT session, the CFL observed PTE Lazarus drinking from his water bottle. Because it was an Army issue water bottle, the CFL was unable to estimate how much water PTE Lazarus had consumed.

5.28. Whenever it happened, PTE Lazarus threw up during the PT session. In his affidavit, Soldier 2 stated:

“At the end of the session (PTE Lazarus) started to feel a little bit ill. We stopped and sat down in the shade. He must have drunk a little too much water because he threw up. I saw him throw up and noted that the vomit was clear. I saw the expelled fluid go on the grass”.

5.29. In his evidence to the Commission, Soldier 2 said that PTE Lazarus threw up during the leopard crawl phase and that he then immediately ceased the session. His assessment was that PTE Lazarus had vomited probably from having drunk too much water. PTE Lazarus was told to hydrate himself and told the CFL that he was feeling much better after having thrown up.

5.30. The inconsistency between the oral testimony of Soldier 2 and his affidavit, as to when PTE Lazarus became ill, is explained by Counsel Assisting mistakenly putting to the witness that his affidavit indicated that PTE Lazarus
had thrown up while doing the leopard crawl.

5.31. Soldier 2 categorically denied that as regards hydration, PTE Lazarus was told that he couldn’t sip water from his canteen, but had to drink a litre at a time to make him throw up.

5.32. Soldier 2 was asked if it was possible he told PTE Lazarus to drink an entire water bottle at a time. His response was that such behaviour could possibly cause over-hydration and vomiting which causes further dehydration, which, in effect, would be self-defeating.

5.33. The CFL described PTE Lazarus as looking the worse for wear when they returned to the WTSS facility. It is clear from other evidence that PTE Lazarus had vomit on the front of his Disruptive Pattern Camouflage Uniform (DPCU) at that time. Soldier 12 said that when the CFL and PTE Lazarus returned, he could smell PTE Lazarus: “yes, booze mixed with vomit, you could smell it a mile away”.

5.34. The CFL could not recall the weather conditions that day, however, whilst it was hot and humid, it wasn’t a very hot day.

**The tree incident**

5.35. Soldier 17 stated that upon the return of PTE Lazarus to the WTSS facility area, PTE Lazarus was “smashed” by the CFL for holding onto a tree.

5.36. The CFL could not remember telling PTE Lazarus to stop holding on to a tree when they returned to the WTSS facility. Others who were present said that the CFL said something to the effect “that tree has been there for 10 years – it doesn’t need you to hold it up”.

5.37. Whilst the CFL could not recall actually using those words on that occasion, he readily conceded that he said such things to soldiers sometimes during PT. He said that if PTE Lazarus was holding on to a tree, it would have been logical for him, (the CFL) to tell him not to and to: “stand up straight, because when your body is in that position, it makes you want to throw up even more”.

5.38. The CFL agreed with Counsel Representing the deceased soldier and the next-of-kin, that in that context, the CFL was still in charge of the soldier, directing
him what to do. "Yes, hands on hips, stand up, open up the airways etc."  

5.39. Soldier 2 could not remember if he used "robust language" that day, but in effect, agreed, that such language could be used by him in PT "fault correction", be it whole group or individual fault correction. In the context of the tree incident, the CFL was asked by Counsel Representing the deceased soldier and the next-of-kin if he "yelled" to then attract his attention. The CFL replied:

"Speaking in a loud and clear voice; I'm in the military. It could have been interpreted as yelling. I'm (a) PTI and that's my normal voice".

A "smash" PT session?

5.40. Some of PTE Lazarus cohort, who didn’t witness the PT session that day, referred to it as a "smash" PT session. Clearly, they were relying on what PTE Lazarus had told them.

5.41. Soldier 2 was asked about his understanding of such a session. In his view, "a smash" session was a "good" or "hard" session; one where you generally:

"...walk away feeling you have earned that lesson, that you have done a good day’s PT, reached your goals, and gone above and beyond. I do not recall the session I was conducting with PTE Lazarus as a "smash" PT session; it wasn't long enough to be at that level and wasn't conducted past medium intensity. It was nowhere near that level."

5.42. When asked to expand upon the idea of a "smash PT session", being part of the "overall curriculum", Soldier 2 replied:

"Not as part of the overall curriculum; as part of someone's interpretation of what the sessions in the curriculum are."

5.43. The CFL could not recall how long PTE Lazarus' assessment PT session took, but his best estimate was no longer than fifteen to twenty minutes, having regard to the warm up phase and the shorter skills assessment phase.

5.44. As previously stated, the evidence is that the WTSS program commenced that day at 0900 hours. PTE Lazarus was in the first serial, failed, and was tasked to do PT because of Soldier 3's concern. The assessment PT session occurred and on his second attempt, PTE Lazarus passed his WTSS shoot. That was at 0954 hours.
5.45. The evidence is that the PT session was an assessment for WTSS fitness, given PTE Lazarus’ circumstances. It was not a punishment.

5.46. Essentially, Soldier 2 said he regarded his task that day as helping a junior soldier (just as he had been) who could have been in some strife, by helping him to do what had to be done that day.

5.47. Counsel Representing the deceased soldier and the next-of-kin has submitted that the Commission should prefer the evidence of PTE Lazarus’ cohort members, and family, where it conflicts with that of the Soldier 2.

5.48. On page 8 of his submissions, Counsel Representing urged the Commission not to ignore the consistent recollections and evidence of persons at the same level as PTE Lazarus, namely his cohort, and to those persons PTE Lazarus spoke to about the nature of the PT session to which he was exposed.

5.49. Counsel Representing further submitted that the more realistic or reliable view of the evidence was that PTE Lazarus was physically run into the ground (called a PT smash session or otherwise) by Soldier 2, as directed by Soldier 3, such action being “punitive” in nature.

5.50. Counsel Representing has submitted that a consistent theme emerges through the evidence, namely, that PTE Lazarus was made to crawl through his own vomit, in addition to being required to consume water one litre at a time by Soldier 2. It is submitted, from the perspective of the next-of-kin that the exercise was not one designed to enhance physical training or the performance of PTE Lazarus, but had an underlying and consistent punitive theme.

5.51. The Commission has no doubt that the PT assessment session conducted by Soldier 2 was robust. There is also no doubt that PTE Lazarus returned to the WTSS facility area with vomit on his DPCU and was spoken to in a loud voice by the CFL with respect to the “tree incident”.

5.52. There was no lack of candour in the evidence given by Soldier 2. It is the view of the Commission that Soldier 2 was an honest and generally reliable witness, doing the best he could to recall events more than two years ago. As Counsel Representing Officer 21 observed in his submissions, Soldier 2 was not evasive or reticent in his answers to Counsel Assisting or Counsel Representing.

5.53. It is beyond doubt that PTE Lazarus suffered considerable discomfort during
the PT assessment session. Given the reason for the assessment session, that is not surprising. The PT session was physically demanding. Witness testimony certainly attests to PTE Lazarus telling others that he had been subjected an arduous physical workout. However, viewed objectively, the evidence does not support the view that PTE Lazarus was forced to participate in a "smash" PT session.

5.54. The Commission finds that the assessment PT session was not conducted in any excessive or unsafe way. Indeed, it achieved its purposes: PTE Lazarus was proved to be fit to retry his WTSS shoot, and he succeeded on his second attempt.

5.55. The submissions made by Counsel Representing the deceased soldier and his next-of-kin, referred to in paragraphs 5.47 to 5.49 herein, are, with respect, not accepted by the Commission.

5.56. Given the circumstances, the Commission finds that PTE Lazarus had nothing to complain about as regards the PT assessment exercise, other than his blameworthy conduct in reporting for duty, effectively on his first day in his new Unit, affected by alcohol.

5.57. It should be noted that at no time did PTE Lazarus seek to contest that he had done the wrong thing by attending for duty on 17 Sep 10 whilst hung-over or suffering the ill-effects of the night before. Indeed, PTE Lazarus told his parents he had done the "wrong thing" by going out partying just after arriving at Enoggera, and racing to work at 6 a.m. obviously hung-over.

5.58. **Mother** commented to the Investigation Officer that her son felt that he had failed the first weekend, and that the Unit was never going to give him another chance. As she said "This particular CPL who kept riding him just never gave up, just kept riding him."

5.59. **Father** commented to the Investigation Officer that because his son had "stuffed up" in that regard, that would have been a "big blow to his son's pride."

5.60. Both parents were strongly of the view that their son would not have been "embarrassed" arriving for duty hung-over on his first day in the infantry Battalion. They said that their son took responsibility for his actions and knew what he did was wrong. Embarrassed or not, the Commission is confident that PTE Lazarus regretted his behaviour which, because of unfortunate consequences, was to continue to trouble him.

5.61. Embarrassment aside, PTE Lazarus had clearly demonstrated an error of judgment. He was a new member of an infantry Battalion most of whose members were then deployed on operations in Afghanistan.
5.62. The Army is no ordinary workplace and high standards are expected to be observed. In the circumstances, PTE Lazarus was dealt with at the WTSS in a way that reflected both commonsense and fairness. He was, after all, a soldier and shortly after the PT assessment session successfully completed his WTSS shoot.

5.63. As previously stated, contrary to the views expressed by his parents, the Commission is of the view that the behaviour of PTE Lazarus did cause him embarrassment and remorse. However, there is simply no evidence that the subsequent PT assessment session had any lingering or long term adverse effect upon him. Indeed, the evidence is to the contrary:

- Soldier 5 said that although PTE Lazarus was "a bit upset", PTE Lazarus made a joke about it;
- Soldier 13 observed that PTE Lazarus did not appear to have taken the incident too badly, and didn’t appear angry;
- Soldier 15 said that he spoke to PTE Lazarus the next day about the matter and he didn’t seem bothered by it; and
- Soldier 17 stated with respect to the incident, that PTE Lazarus "felt pretty good after he recovered from the session and he made a bit of a joke about it".

5.64. Given his circumstances, the Commission is of the strong view that PTE Lazarus was dealt with in a proper and professional manner with respect to the WTSS incidents. Disciplinary action was neither contemplated nor warranted in the circumstances

Counselling by the Acting OC and Acting CSM

5.65. Later on the day of the WTSS incident, the Acting CSM of B COY 6 RAR Rear, SNCO 2, became aware of the incident. Given that no safety issue was involved, the Acting CSM did not regard the incident as overly serious. However, the Acting CSM was of the view that PTE Lazarus had:

"...demonstrated a severe lack of judgment in choosing to report for his first full day of work in a full-time infantry Battalion in a state that he was unable to shoot properly."

5.66. The Acting CSM spoke to the Acting OC, Officer 6, about the matter. In the
early afternoon, PTE Lazarus was brought into the Acting OC's office. In short, both Officer 6 and SNCO 2 counselled the soldier for about 5 minutes.

5.67. Officer 6 spoke to PTE Lazarus about the importance of establishing a reputation as a competent and professional soldier and told him he had let himself down as a result of his behaviour. Professionalism in the Army was important and PTE Lazarus needed to improve his performance.

5.68. Amongst other things, the Acting CSM said in his evidence:

"I said to PTE Lazarus words to the effect that full-time military service is not a normal day job but a lifestyle requiring commitment. I went on to say words to the effect that he needed to demonstrate dedication to the Army, the Battalion and his fellow platoon members by performing to a high standard at all times while at work."

5.69. SNCO 2 told PTE Lazarus that no written record would be made of the counselling conversation with the Acting OC and himself, and no such record was made.

5.70. It is clear from their evidence that the Acting OC and the Acting CSM told PTE Lazarus that “that was the end of the matter”. It was made plain that once PTE Lazarus left the Acting OC’s office, the matter would be closed and would not be raised again. The Acting OC told PTE Lazarus that he did not want to see PTE Lazarus in his office again. That was the first time either Officer 6 or SNCO 2 had any direct dealing with PTE Lazarus.

5.71. In the circumstances, PTE Lazarus was perfectly entitled to believe that no punishment, in any shape or form, would be imposed by any person or would result in any way from his earlier error of judgment. In effect, his company “bosses” had told him so.

**Intervention by SNCO 3**

5.72. Sometime later that afternoon, after the completion of the counselling session with the Acting OC and the Acting CSM, PTE Lazarus was required to go to the office of his PL SGT, SNCO 3, who had been made aware of the WTSS incident.

5.73. The circumstances as to how PTE Lazarus ended up being further “fronted” by SNCO 3 are unclear. SNCO 3’s own specific recollections of events and personnel involved were admittedly hazy and at times contradictory. That is not a criticism, but an observation, no doubt consequent upon the passage of
time.

5.74. What is not in dispute is that at some point after the counselling session with
the Acting OC and the Acting CSM, SNCO 3 further counselled PTE Lazarus
as to his presentation at the WTSS, with words to the effect:

"Mate, you have screwed up. Deal with it. Bang. Clean slate.
That’s the situation done with. Hopefully, you learn from it, don’t do it
again."

5.75. Prior to that fronting in his office, the only involvement SNCO 3 had had with
PTE Lazarus was marking the 6 RAR Rear roll book that morning.

5.76. It is relevant and important to note that SNCO 3 was not privy to what the
Acting OC and Acting CSM had earlier said to PTE Lazarus about the WTSS
incident. PTE Lazarus did not tell SNCO 3 that he had been advised by them
that that was “the end of the matter”.

5.77. SNCO 3 told PTE Lazarus he was on guard duty that weekend.

5.78. The evidence of SNCO 3 was that the guard duty given by him to PTE
Lazarus was not imposed as a result of any form of disciplinary action under
the Defence Force Discipline Act (DFDA), but given as “retraining”.

5.79. In effect, the retraining was to make PTE Lazarus more soldier like in the
performance of his duties and:

“To take away the ability for (PTE Lazarus) to actually do that
(consume alcohol) on the weekend for one night.”

5.80. The reason for the guard duty was clear: “the guard duty was as a result PTE
Lazarus’ intoxicated condition at the WTSS.”

Guard Duty

5.81. Guard duty is a fact of regimental and garrison life for soldiers and NCOs in a
full-time infantry Battalion. The 6 RAR Guard Room is manned by a section
every day. Clearly, weekend guard duty is required but obviously not as
popular as weekday duty. Saturday duty is mounted between 0700-0730 hours
and dismounted at the same time on Sunday. Members of the guard take turns
to sleep in the guard room.

5.82. Soldier 4 was posted to 6 RAR in early February 2010. His evidence was to
the effect that because B COY 6 RAR Rear was so undermanned when the bulk of the Battalion deployed that year, guard duty was "pretty frequent" and "maybe twice a week".

5.83. In his affidavit evidence, Soldier 4 recalled having done three guard duties in a row at one stage and then being listed for guard duty on the next Saturday. Although he was not sure when that was, the evidence establishes that the "next Saturday" was Saturday 18 Sep 2010.

5.84. The evidence is to the effect that Soldier 4 approached PTE Lazarus and others in his cohort and asked if anyone could do his Saturday guard duty. As Soldier 4 stated: "everyone had an excuse and I just left it at that". About an hour later, Soldier 4 received a call on his mobile phone from a CPL or LCPL who was the guard commander for that Saturday. Soldier 4 was then told that he was no longer on guard duty. No reason was given. In his affidavit one of PTE Lazarus’ cohort, Soldier 13, spoke of an unnamed soldier who, it seems, was Soldier 4.

5.85. That soldier told PTE Lazarus that he was on guard duty on the coming Saturday because his name was now on the guard duty list for the day.

5.86. When told that he was now rostered for the Saturday duty, PTE Lazarus told the unnamed soldier that he couldn’t do the duty because he had a birthday party to attend. PTE Lazarus was then told that he had to do it because his name was now upon the guard roster.

5.87. Soldier 13 said that the other soldier then walked away then leaving PTE Lazarus upset and angry. PTE Lazarus said "I’m not doing it, I’ve got to go to this thing”.

5.88. In the circumstances, it is reasonable to assume that the name of PTE Lazarus was substituted for that of Soldier 4 on the duty guard roster with the approval of the B COY PLSGT, SNCO 3, given that he had placed PTE Lazarus on guard duty that weekend. As SNCO 3 said:

“When giving the guard duty, I would have said to him ‘you’re on duty’; obviously to make sure that you can turn up to work in a sober state”.

5.89. Indeed, in his evidence to the Commission, SNCO 3 effectively conceded that he swapped PTE Lazarus for Soldier 4 on the guard duty roster.

5.90. Notwithstanding the description of the guard duty as “retraining”, it was in effect a punishment and unjustified in the circumstances. Earlier that
afternoon, the Acting OC and Acting CSM had told PTE Lazarus that the earlier alcohol-related incident was now "closed" and that no further action would be taken concerning it.

5.91. The direction to report for guard duty to retrain or correct such behaviour, flew in the face of the contrary direction of higher authority and PTE Lazarus had every right to be angry and aggrieved. In the circumstances, PTE Lazarus remedied the unjust imposition by availing himself of a then 6 RAR Rear practice of selling the guard duty.

5.92. Given that the guard duty in question had not been imposed as any form of punishment, lawful or otherwise, and given the then prevailing practice in 6 RAR Rear of selling such duties, there was nothing improper or blameworthy about PTE Lazarus selling the guard duty in question.

5.93. Soldier 1 was the 6 RAR Rear guard commander for Saturday 18 Sep 10. As was his usual practice, the guard commander warned-out beforehand those soldiers whose names appeared on the duty roster for the next day. Soldier 1 did that on the Friday afternoon, presumably at a time after PTE Lazarus' name had been substituted for that of Soldier 4 on the Saturday guard roster. In his affidavit, Soldier 1 said that he heard PTE Lazarus trying to sell his duty which was "a common thing for a weekend guard".

5.94. Soldier 1 could not remember if he specifically told PTE Lazarus that the duty was a punishment guard, but said something like "due to the reasons you have been put on this guard, you must attend." Soldier 1 also said that he had no idea if PTE Lazarus' guard duty for the Saturday resulted from a formal process. He could not recall if he was told why PTE Lazarus was on guard duty or who prepared the guard duty roster. His evidence was to the effect that the guard lists were usually prepared by the sergeants and warrant officers.

5.95. It is not clear from the evidence which NCO substituted the name of PTE Lazarus for that of Soldier 4 on the duty roster on Friday afternoon. Given that the duty was imposed effectively as a punishment by SNCO 3, it is likely that SNCO 3 substituted the name on the duty roster. However, PTE Lazarus' good friend, Soldier 12, although not sure, thought Soldier 1 was responsible for swapping the names.

5.96. After telling PTE Lazarus that his guard duty was "not negotiable" and that he could not sell it, Soldier 1 walked away. In the circumstances, it seems clear that the junior NCO was made aware that the duty had been imposed to punish PTE Lazarus with respect to the WTSS incident.

5.97. The evidence is that PTE Lazarus sold his guard duty to Soldier 8, a soldier who marched into 6 RAR Rear some four months before him. Both soldiers
got on well together and got to know each other better during EX Hamel.

5.98. PTE Lazarus asked others in his cohort if anyone would perform his duty. Soldier 8 was short of money at the time and PTE Lazarus offered him $200 to perform the Saturday duty because he planned to attend a weekend social event on the Gold Coast.

5.99. At the time, Soldier 8 was unaware that PTE Lazarus had been tasked with the guard duty. He simply thought PTE Lazarus name had been randomly selected as a matter of routine. As Soldier 8 stated:

“Had it been a normal guard duty, the practice at the time was such that it would have been perfectly fine to ask another member of the Unit to perform the guard duty. With it being a punishment guard duty, there is no getting out of it.”

5.100. When Soldier 8 mounted the guard duty on Saturday 18 Sep 10, SNCO 4, who was the Duty SNCO for 6 RAR Rear that day, said:

“Where is Lazarus, what are you doing here?” He obviously expected PTE Lazarus to turn up at the guard duty. I explained what had happened. SNCO 4 went on to explain that PTE Lazarus had been awarded the guard duty as a punishment. He was unhappy that PTE Lazarus had avoided a duty as he had been given it as a punishment.

5.101. It was obvious to Soldier 8 that when PTE Lazarus had been trying to find someone else to do the duty, PTE Lazarus had not understood that the guard duty had been imposed upon him as a punishment.

5.102. At no time on Friday afternoon before the commencement of that duty was PTE Lazarus told by any NCO that it was imposed as a punishment guard and therefore he could not avoid it.

5.103. SNCO 4 is no longer a member of 6 RAR, having been posted interstate. His 10 page affidavit is in evidence. Whilst the affidavit helps to put in context the dysfunction and disjointed nature of 6 RAR Rear at the time, his memory of specific events is “a bit lacking”.

5.104. As SNCO 4 stated:

“I did not know PTE Jacob Lee Lazarus. Although his name sounds familiar, I am unable to put a face to the name. I cannot recall if there were particular incidents associated with PTE Lazarus’ name, nor do I recall an incident that might have occurred at the WTSS in or about September 2010.”
5.105. In effect, SNCO 4 is unable to remember the guard duty matter on Saturday 18 Sep 10 and comment upon it.

5.106. The Commission finds that the Saturday guard duty imposed on PTE Lazarus on the afternoon of Friday 17 Sep 10, was in effect, if not in name, a punishment imposed by SNCO 3, as a result of the WTSS incident that morning. SNCO 3 was unaware that the Acting OC and the Acting CSM of 6 RAR Rear had earlier counselled PTE Lazarus and told him in no uncertain terms that the matter was now at an end and no disciplinary action would result.

5.107. The fact that a type of punishment was imposed by a senior NCO after higher authority had clearly indicated that the matter was “closed,” evidences a lack of communication within the command structure, and perhaps typifies the dysfunction and chaos within 6 RAR Rear at the time.

5.108. Notwithstanding the blameworthy behaviour of PTE Lazarus reporting for duty that morning whilst still affected by alcohol, the newly marched in soldier had every reason to be aggrieved by the imposition of a punishment guard duty by a SGT shortly after his OC and CSM had spoken to him about the matter and said that no further action would be taken.

5.109. The Commission finds that the imposition of the guard duty, described as “retaining” but in effect “punishment”, was both unwarranted and unjust in the circumstances. As regards PTE Lazarus’ reporting for duty affected by alcohol that morning, the soldier had been counselled in the early afternoon by both the Acting OC and the Acting CSM of 6 RAR Rear. He was told by them that the matter was now closed.

5.110. When SNCO 3 intervened later that afternoon, he was unaware of what the Acting OC and the Acting CSM had said to PTE Lazarus. In his affidavit, PTE Lazarus’ good friend, [redacted] said about his friend “If he thought a wrong had been done to him, he would stand up for himself.”

5.111. Given that characteristic, it is somewhat surprising that PTE Lazarus said nothing to SNCO 3 when the latter intervened later that afternoon. Perhaps PTE Lazarus remained mute in that regard because he realised that he made a significant error of judgment.

5.112. PTE Lazarus was not the first nor indeed the last soldier to report for duty still affected by alcohol. He was dealt with in a robust way that resulted in his successful completion of the WTSS shoot on the second occasion. Later that day, he was counselled by his senior chain of command and told that the matter was no longer an issue. Subsequent to that a SNCO took it upon himself to make it an issue.

5.113. The Commission is of the view that even an experienced soldier would be
somewhat confused and rightly aggrieved at what happened.

5.114. Viewed objectively, given the then common practice of selling guard duties within 6 RAR Rear and PTE Lazarus having been told by his senior chain of command that no further action would be taken against him for his error of judgment earlier that day, PTE Lazarus did nothing wrong in selling his Saturday guard duty to Soldier 8. Whatever he may have been told by SNCO 3 and Soldier 1, PTE Lazarus was perfectly entitled to believe that the guard duty was not a punishment.

A matter of discipline

5.115. In the context of the guard duty imposed, SNCO 3 was not informed of any conversation to the effect that the alcohol related incident had otherwise been put to bed. If he had known that, the matter would have been left by him then and there.

5.116. It cannot be disputed that as a senior NCO in the ARA, SNCO 3 was responsible for the discipline of his soldiers. As regards PTE Lazarus, he said "I disciplined one of my soldiers".

5.117. In his oral evidence, SNCO 3 conceded that what he regarded as "retraining" could reasonably viewed by others as "punishment".

5.118. Discipline is an extremely important feature of military life. Indeed, it has been said that "Discipline is the soul of an army. In his submissions, to the 2005 Senate Committee tasked with reviewing the effectiveness of Australia’s military justice system, the then CDF, General Cosgrove AC, MC had this to say about discipline:

"Establishing and maintaining a high standard of discipline in both peace and on operations is essential for effective day-to-day functioning of the ADF and is applicable to all members of the ADF....Discipline is much more an aid to ADF personnel to enable them to meet the challenges of military service than it is a management tool for commanders to correct or punish unacceptable behaviour that could undermine effective command and control in the ADF. Teamwork and mutual support of the highest order are essential to success. Obedience to lawful direction is an intrinsic requirement expected from the most junior to the most senior members of the ADF."

152 George Washington, commander in chief of the colonial armies in the American Revolution (1775-83) and subsequently 1st US President (1785-97). See his Letters of Instructions to the Captains of the Virginia Regiments, 29 July 1759.
153 See Submission P16, pages 5-6, by General Peter Cosgrove, then CDF, made to the Senate Foreign Affairs, Defence and Trade References Committee in 2005.
5.119. Given the importance of discipline, it is important that breaches of discipline be corrected in an appropriate and lawful manner.

5.120. Lawful punishments can only be awarded to personnel under the *Defence Force Discipline Act 1982* (DFDA). There is no place in the ADF today for any form of punishment which is outside the military justice system.

5.121. In Section 7 of the Report, the Commission considered the unlawful punishments imposed by Officer 6 and SNCO 3 upon 14 soldiers of 6 RAR Rear, including PTE Lazarus, with respect to the non-saluting incident on Wed 22 Sep 10 and the subsequent determinations that administrative action be taken against both Officer 6 and SNCO 3.

5.122. Those determinations were made by the Acting CO of 6 RAR, Officer 5, after the incident had been brought to his attention and a QA had been conducted after the intervention of SNCO 2.

**Findings**

5.123. In relation to the WTSS incident, the Commission finds that PTE Lazarus appears to have accepted that any adverse outcome was of his own making, in that he attended his first 6 RAR activity affected by alcohol. PTE Lazarus was subjected to a rigorous PT session to determine his fitness to continue his participation in the weapons practice, but there is no evidence to suggest that this session was excessive or inappropriate in terms of its goals or conduct.

5.124. The Commission also finds that there is no evidence that PTE Lazarus was immediately or subsequently adversely affected by this incident.
PTE LAZARUS COI REPORT

SECTION 6

THE MONDAY MORNING “BEASTING”

6. The circumstances in which PTE Lazarus may have been counselled for allegedly ‘trading’ guard duty responsibilities.

Saturday guard duty: expectation and non-attendance

6.1. As previously mentioned, the 6 RAR Rear guard commander for Saturday, 17 Sep 10 was Soldier 1. Clearly, the guard commander had an expectation that PTE Lazarus would perform the Saturday guard duty. He had told PTE Lazarus the previous afternoon that the guard duty was “non-negotiable” and that the duty could not be sold because it had been imposed upon him given his circumstances.

6.2. PTE Lazarus did not attend Gallipoli Barracks to perform the guard duty because he had sold it to Soldier 8 the afternoon before. At the time, Soldier 8 was unaware that the duty had been imposed as a punishment upon PTE Lazarus and that he was not to sell it.

6.3. The guard commander’s brother, Soldier 7, also a member of 6 RAR Rear at the time, visited his brother for a chat during the Saturday guard duty. Both brothers have had extensive military experience, including operational deployments.

6.4. When the guard commander told his brother that the new arrival, PTE Lazarus, had not reported for the Saturday guard duty and had sold it to Soldier 8, Soldier 7 said that that was simply “unacceptable.”

6.5. The guard commander then asked his brother to check whose section PTE Lazarus was in. It was established that PTE Lazarus was in fact in Soldier 7’s section, although he had not met him. Soldier 7 then told his brother that he (Soldier 7) would deal with PTE Lazarus “on Monday.”

6.6. The guard commander was clearly upset by the non-attendance of PTE Lazarus

“...he disobeyed a lawful command by not turning up to guard, but he had also agreed with me and then went behind my back. So really his integrity was shot, and for a new soldier, its just something that is unheard of. It is never like that. I’ve never seen a soldier who just has
absolute or complete disregard for authority or for the way the Army has run and continues to run."

6.7. On Monday 20 Sep 10, the first parade for 6 RAR Rear was the roll call at 0730 hours. Prior to that, it seems that Soldier 7, if not other NCOs, received a verbal dressing down from the Acting OC, Officer 6, for not sufficiently "gripping" his or their soldiers. The evidence is that there were ongoing problems with discipline within 6 RAR Rear at the time. Indeed, as was stated by Soldier 1:

"We had quite a few disciplinary issues throughout the entire platoon due to the fact that many members didn't go overseas for disciplinary reasons."

6.8. Immediately after the initial parade was held that Monday, Soldier 7 called PTE Lazarus to the side of the 6 RAR parade ground. Other members of B COY, estimated to be between 20 and 40 in number, were then getting ready for PT at the rear of the B COY building and could hear and observe what then happened.

6.9. There is no dispute that the initial dressing down by Soldier 7 was reasonably quiet but it gained momentum and resulted in Soldier 7 yelling loudly at PTE Lazarus. As one soldier observed "When there is yelling like that, everyone hushes down and listens in."

6.10. There is evidence that PTE Lazarus was yelled at or "beasted", about his going out and drinking the night before the WTSS session. Soldier 6 had this to say about the disciplining of PTE Lazarus by the junior NCO (Soldier 7):

"He was referred to as a piece of shit because of his actions and that he needed to lift his game if he didn't want to be a piece of shit soldier for the rest of his career."

6.11. That oral evidence by Soldier 6 is not found in his affidavit. In his oral evidence, Soldier 6 described the language used as "demeaning."

6.12. Soldier 7 gave his evidence the day before Soldier 6. He was not recalled to be questioned about the specific language alleged by Soldier 6.

6.13. Whilst the Commission found the evidence given by Soldier 6 to be generally reliable, he was not personally well disposed towards the Army, especially because of the loss of leave incident on Wed 22 Sep 10 and its consequences.
for him. That was a relevant consideration for the Commission in assessing
the weight of Soldier 6’s evidence.

6.14. In any event, whatever language was used by Soldier 7 in his disciplining of
PTE Lazarus on the edge of B COY parade ground on the morning of Mon 20
Sep 10, the Commission is satisfied that the language used was robust.

6.15. Soldier 7 asked PTE Lazarus why he had swapped the Saturday guard duty
when he was told not to. The soldier was told that it wasn’t a good start to his
time in 6 RAR and that the Platoon Sergeant wanted to see him. The
evidence of Soldier 7 was as follows:

“I asked did he swap his guard after he was told not to; he said ‘yes’.
I said, ‘Did you know that you weren’t supposed to do that due to a
punishment? He said ‘yes’. He said that he realised he had made a
mistake.’

6.16. Soldier 7 said that the sole source of his information about the WTSS incident
and the subsequent guard duty came from his brother, the Saturday guard
commander. Soldier 7 said that he took it upon himself to “grip up” PTE
Lazarus and that no one told him to do so. However, the NCO at least knew
that SNCO 3 wanted to speak to PTE Lazarus. His understanding was that
SNCO 3 was going to give PTE Lazarus a second “gripping up” and thought
that any conversation between SNCO 3 and PTE Lazarus was destined to be
an “arse-kicking”.

6.17. Soldier 7 estimated that his “gripping up” session with PTE Lazarus lasted for
no more than one minute, although there is evidence from some members of
PTE Lazarus’ cohort that the period was considerably longer. For example,
Soldier 6 said that the session was demeaning and estimated that it lasted “up
to 5 minutes” or in earlier evidence “5 to 10 minutes”.

6.18. Soldier 7 told the Commission that there is a difference between a “gripping
up” and a “beasting”. He said that the former was when a soldier is told that
he has done the wrong thing and his behaviour is disappointing, whereas a
beasting “is just a full gripping, which goes for a prolonged period and may
include swearing”.

6.19. Soldier 7 agreed that he was “agitated” and “angry” with PTE Lazarus
when he conducted the “arse-kicking session with him”. He said that “PTE
Lazarus spoke freely to him during the session" and admitted that he had made a mistake in selling his guard duty. There is other evidence to the effect that it was more a one way conversation and, given the circumstances, that was probably correct.

6.20. The NCO agreed that it was a case of a cranky junior NCO balling out one of his soldiers before taking him to his SGT to be further balled out.

6.21. When Counsel Representing the next-of-kin put it to Soldier 7 that "A beasting means someone is getting told they have stuffed up", Soldier 7 agreed that was in fact what happened.

6.22. Clearly, the parade ground session conducted by the then Soldier 7 was a "beasting" as defined by Soldier 7, and the Commission so finds.

6.23. After that beasting, PTE Lazarus was quick marched into SNCO 3's office. Soldier 1 was then in that office. Both Soldier 1 and Soldier 7 brothers then left SNCO 3's office without hearing or observing what took place. As previously mentioned, it was anticipated that the PL SGT would give PTE Lazarus a second "arse-kicking".

6.24. SNCO 3 said that he had not spoken to Soldier 7 prior to his dressing down of PTE Lazarus on the parade ground. He heard the dressing down from his office and said it was a bit of a one way conversation:

"I think then PTE Lazarus might have learned the errors of his ways really quick, as to where he went wrong, and he checked himself."

6.25. SNCO 3 said that what Soldier 7 did wasn't a beasting, but simply "an NCO doing his job". He further stated:

"That sort of thing is a problem that we have within the Defence Force at the moment. As soon as someone yells at someone, everyone has a knee-jerk reaction and its bastardisation. I don't think it was. If I had believed it stepped over the line, I would have been one of the first people to go out and stop it. I've been on many deployments and lost good mates, so I would quickly stop that sort of shit. It was an NCO disciplining and speaking to a junior soldier, as an NCO had to in that scenario."

6.26. The evidence of SNCO 3 was to the effect that there was no point in dragging
out the matter. He said he could have charged PTE Lazarus with being intoxicated on duty, but that would be a mark on his record for a silly mistake and that "we've all done it".

6.27. As regards the guard duty following the WTSS incident, SNCO 3 stated that "it probably was a punishment and retraining". It was not a legal punishment and if he had to deal with the same situation again, SNCO 3 said that he would probably ask for advice and inquire whether there was a Discipline Officer around. He also conceded that he may follow the same path again.

6.28. It seems clear from the evidence of SNCO 2 that SNCO 3 intended to take further action against PTE Lazarus concerning the incident.

6.29. On either 20 or 21 Sep 10, during a conversation with SNCO 3 in his office, SNCO 3 informed the Acting CSM of B COY 6 RAR Rear, SNCO 2, of what had happened. SNCO 3 informed the Acting CSM that he felt that PTE Lazarus had done the wrong thing by paying another soldier to stand guard for him, and accordingly, SNCO 3 had allocated PTE Lazarus an additional three extra guard duties.

6.30. The Acting CSM expressed the view that PTE Lazarus had done nothing wrong in paying another soldier to stand his guard duty, because the guard duty had not been awarded as a result of any disciplinary action.

6.31. SNCO 3 was instructed that PTE Lazarus was not to be assigned any extra guard duties and was directed by the Acting CSM to reallocate the extra guard duties as he normally would, on an equitable basis amongst his platoon. In due course, the Acting CSM reviewed the guard duty roster and noted that SNCO 3 had done as he was instructed.

6.32. The evidence does not reveal whether PTE Lazarus was told he was given 3 extra guard duties. He may not have been told. Alternatively, he may have been told and then told he did not have to stand the guard duties. Certainly, none of the witnesses interviewed recall PTE Lazarus complaining about having been given extra guard duties.

6.33. The "beasting" of PTE Lazarus on the parade ground was clearly intimidating and probably demeaning. Whilst members of the ARA do not belong in a kindergarten, less intimidating means of correction were available. The disciplining could have been done in private and not in front of PTE Lazarus' peer group.

6.34. The beasting or disciplining of a soldier must not descend into bullying. There is a fine line between "beasting" and "bullying".
6.35. When the former CDF Air Chief Marshal Houston AC, AFC, commenced his watch as CDF in mid 2005, he, in effect, declared war on bullying and harassment in the ADF. His “declaration of war” – to term a phrase - was reported in The Australian under the heading “No place for bullies on my watch: Houston”. The article stated in part:182

“The Chiefs and I will not tolerate any form of abuse in our system. We will eliminate bullying and all forms of harassment and we take that very, very seriously.”

6.36. Commanders, at all levels, in the ADF know that there is zero tolerance for any form of bullying or harassment in the ADF. They have been put on notice that harassment and/or bullying have no place in service life today and that perpetrators will be dealt with seriously.

6.37. The profession of arms is a tough and demanding profession. However, that does not mean that it should be a demeaning profession that tolerates, or turns a blind eye to, bullying or harassment within its ranks. As the House of Commons stated in 1989:183

“Bullying has no place in the training of tough soldiers.”

6.38. On the morning of Mon 20 Sep 10, a lack of communication resulted in a form of punishment being imposed upon PTE Lazarus which was not warranted in the circumstances.

6.39. However, there is no doubt that PTE Lazarus’ behaviour in reporting for duty whilst still affected by alcohol, was blameworthy and warranted appropriate action. That action was satisfied by his being “counseled” by his senior chain of command and then being told that no further action would be taken.

6.40. One can imagine the dismay of PTE Lazarus in what followed, and his sense of injustice in having the guard duty imposed upon him, by relatively junior ranks, for the same behaviour.

6.41. The Commission finds that the Monday morning beating of PTE Lazarus by Soldier 7 was predicated upon his erroneous belief that PTE Lazarus was to have performed the guard duty as some form of punishment.

6.42. In the circumstances, Soldier 7, having been motivated no doubt by what Officer 6 had said to him and other NCOs earlier that day, took it upon himself to point out the error of his ways to PTE Lazarus. That was a disciplinary judgment call made by an experienced junior NCO who found the alleged conduct of PTE Lazarus simply “unacceptable”.

6.43. Hindsight is a wonderful thing. The “correction” or “retraining” – by

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182 See The Australian, Tue 5 July 2005, Article by Trudi Harris.
183 See “Battling Bullying in the British Army” 1987-2004” by James K. Wither, the Journal of Power Institutions in Post Soviet Societies, Issue 1, 2004, at page 1
whatever badge it was given – of PTE Lazarus could have been done man to
to man and not in public. Soldier 7 believed he was doing the right thing
especially when PTE Lazarus admitted that he had made a mistake.

6.44. Counsel Assisting have submitted that it would not be possible, on balance, to
conclude to the requisite standard that the “beasting” went beyond the bounds
of what would have been appropriate, had the circumstances been understood
by Soldier 7 that morning.

6.45. Whilst the correctional session was in fact robust, the Commission agrees with
the submission made by Counsel Assisting.

6.46. The Commission is unable to find, on balance, that the “beasting” session
exceeded the bounds of what would normally have been considered
appropriate in the context of soldier discipline.

6.47. The Commission makes the observation that in performing the very necessary
task of disciplining soldiers, when and where appropriate, care needs to be
taken to ensure that the language used achieves its purpose and is not
demeaning or offensive by today’s standards.

6.48. Such language should help the soldier to improve his or her performance and
not destroy his or her confidence and self-esteem. In the context of this COI,
that is an observation made by the Commission in a general sense and not a
criticism of what occurred, or may have occurred, on that day.

6.49. It is not acceptable in the ADF today for the disciplining of soldiers to involve
verbal abuse, bullying or any form of harassment. There is no satisfactory
evidence that any such conduct occurred in the case of PTE Lazarus.

6.50. That being said, the Commission has no doubt that the “beasting” session
impacted upon PTE Lazarus’ morale and self esteem. In a very public way, it
also impacted upon PTE Lazarus’ reputation within 6 RAR Rear, and made
him known within the Unit then or soon after, but for the wrong reason.

6.51. Whilst the discipline metered out by Soldier 7 was indeed robust, the
Commission is of the view that no adverse finding should be made against him
with respect to such conduct.

6.52. That conduct was witnessed by SNCO 3 in the sense that he heard part of the
“beasting” from his office.

6.53. As previously mentioned, in Section 7 of the Report the Commission
considered in some detail the actions of Officer 6 and SNCO 3 in the
disciplining of the 14 soldiers, including PTE Lazarus, involved in the non-
saluting incident on Wed 22 Sep 10, and the consequences of those actions.
PART A – THE NON-SALUTING INCIDENT
PART B – DIFFICULTIES WITHIN 6 RAR REAR

7. An incident in which PTE Lazarus may have been accused of failing to salute the Officer Commanding B Company, and the consequences of being so accused, if any, and

Part A - The non-saluting incident

7.1. On the afternoon of Wed 22 September 10, 14 soldiers from B COY, including PTE Lazarus were assembled outside the B COY HQ building completing administrative paperwork.

7.2. At about 1300 hours, the Acting OC B COY, left the side entrance of the B COY building and approached the group of soldiers. Versions differ as to exactly what happened, but the Acting OC took offence when the soldiers were not quick enough to pay him compliments.

7.3. Without going into detail, the essential thrust of the evidence from the soldiers involved was that no-one saw Officer 6 until it was too late, hence no-one saluted him.

7.4. The non-saluting of Officers in 6 RAR Rear was but one of a number of ongoing disciplinary issues within the Unit during 2010. It was certainly an issue before PTE Lazarus and 8 other soldiers marched into the Unit in 16 Sep 10. According to SNCO 3, the incident was not a one-off occasion and was 'about the fourth or fifth time it had actually happened.'

7.5. As a result of the non-saluting by the soldiers, the Acting OC tasked the SNCO 5 to supply him with the names of the 14 soldiers present who failed to pay him compliments.

7.6. Officer 6 then informed SNCO 3, the PL SGT of the 14 soldiers of the incident, and after discussing Platoon policy it was agreed that a minimum of two extra duties would be imposed on each soldier.

7.7. The 14 soldiers were departing the following Wednesday (29 Sep 10) to participate in EX Hamel. Officer 6 had earlier approved leave for them from 23 to 26 Sep 10, returning to work on 27 Sep 10.

7.8. As a result of the non-saluting incident, the leave of each of the 14 soldiers
was cancelled and they were each ordered to perform two extra guard duties between 23 Sept and their deployment on EX Hamel on 29 Sep 10. SNCO 3 notified the 14 soldiers of their leave cancellation and extra duties at approximately 1600 hours on the day of the incident, Wed 22 Sep 10.

7.9. Clearly, the cancellation of leave and the imposition of the extra guard duties were in fact, and meant to be, punishment for each of the 14 soldiers involved.

7.10. Two of the 14 soldiers had made airline bookings some days before the cancellation of their leave. Indeed, the bookings were made without prior leave approval. One of those soldiers was Soldier 6, who had booked a return flight to Rockhampton. As a result of the leave cancellations, both soldiers were financially disadvantaged by losing the cost of the air fares.

7.11. At the final parade on Wed 22 Sep 10, the names of the 14 soldiers were read out and they were told to form up separately from the rest of B COY. The Company was then stood down but for the 14 soldiers who were told by Soldier 7 that their leave was no longer approved and that they had to perform guard duties over the next 5 days. Prior to the final parade, 3 of the soldiers, including then Soldier 6 endeavoured to complain to SNCO 3, but their plea fell on deaf ears.

7.12. Former Soldier 6 had this to say:

"As soon as we knocked off, the Guards commenced. I was on that night and PTE Lazarus was also one of the Guard Members that night. It was utterly depressing. There were blokes in tears on the phone to their parents, wives and children, telling them that they weren't able to come home as planned. Everyone was in a state of shock and was feeling quite depressed, and no one was really talking to each other. It was the worst experience of my career. For me personally, my family had organised a surprise birthday party, and family members had travelled interstate for it, so it was really horrible to have to tell them I wasn't coming home. PTE Lazarus, like everyone else, was pretty quiet. As the night progressed, everyone started trying to make light of the situation and joke about what happened. PTE Lazarus was pretty good for morale, because he and I were just taking the piss out of the situation and trying to have a laugh. I would say that PTE Lazarus was shattered and depressed about what happened, but no more so than any of the other guys." (emphasis added)

7.13. All 14 soldiers, including PTE Lazarus, having lost their leave, duly performed the extra guard duties. PTE Lazarus performed his second guard duty on Sat 25 Sep 10.

The intervention of SNCO 2
7.14. The Acting CSM of B COY SNCO 2 was not at work on Thu 23 Sep 10. In his capacity as Acting CSM, he was totally unaware of the incident and its outcomes until Sat 25 Sep 10. During that weekend, SNCO 2 was the 6 RAR Rear Duty Officer.

7.15. At approximately 2100 hours on Sat 26 Sept 10, SNCO 2 was approached by Soldier 6, one of the 6 RAR Rear guard members. Soldier 6 had received the worrying news and the soldier told the 6 RAR Rear Duty Officer he wished to travel to Rockhampton the next day. The soldier also told SNCO 2 about his cancelled flights resulting from the non-saluting incident. This was the first time that SNCO 2 had heard anything about the incident and the resulting punishments.

7.16. When informed of what had happened, SNCO 2 formed the view that the cancellation of leave and the awarding of extra guard duties was simply wrong. In his capacity as Duty Officer, he interviewed 7 of the 14 soldiers on Saturday night and the other 7 soldiers on Sunday morning. He also located 13 of the 14 leave applications, being unable to locate that of Soldier 20.

7.17. On Mon 27 Sep 10, SNCO 3 submitted a Minute to the 6 RAR Rear ADJT, Officer 8, concerning the cancellation of leave incident. The Minute contained some 35 enclosures, and was signed by SNCO 2 in his capacity as: "CSM B COY" and "Unit Rehab Liaison Officer 6 RAR".

7.18. As a result, Officer 8 conducted a Quick Assessment (QA) into the cancellation of leave for the 14 B COY soldiers. The QA was dated 1 Oct 10.

7.19. Amongst other things, the 6 RAR Rear ADJT assessed that the two extra guard duties were unauthorised and that a sub-unit commander within 6 RAR had no authority to instigate a punishment policy that contravened ADFP 06.1.1. Vol 3, Chap 5, Discipline Officer Scheme – Minor Disciplinary Infringements.

7.20. The ADJT was also of the view that:

"(Officer 6) failed in his command responsibilities to ensure that the soldiers chain of command was informed of the pending punishment and that the correct notification and withdrawal of leave was undertaken;"

7.21. The ADJT made 6 recommendations in the QA including that:

"Commanders at all levels be reminded that punishments can only be awarded to personnel under either the DFDA or ADFP".
7.22. The Acting CO of 6 RAR Rear, Officer 1, on the same day, concurred with the views and recommendations of the ADJT. The Acting CO stated that the following actions were to be taken as a result of this incident:

1. "Administrative action to be taken against (Officer 6) to address the systemic issue regarding the imposition of illegal punishments.

2. RSM to conduct training for all NCOs, WO, and officers on the requirements for imposing punishments under the DFDA & the discipline officer system.

3. All soldiers to be reminded of the requirement to have an approved leave application prior to booking flights.

4. CCLK to review the leave approval time lines and process to ensure leave is processed in a timely manner.

5. CCLK to look into the process required to ensure soldiers are reimbursed for any financial loss they are entitled to.

6. Soldiers to be re-credited with any leave lost due to duties conducted.

7. Administrative action to be taken against (SNCO 3)."

7.23. Clearly, the 14 soldiers including PTE Lazarus were dealt with unfairly and in a way that was subsequently established to be wrong and unlawful.

7.24. In addition to what has already been stated, the Commission has heard and read a lot of evidence about the "non-saluting incident". The plethora of detail must not distract the Commission from its primary focus. The essential issue for the Commission is to determine what impact, if any, that unfair and unlawful action had upon PTE Lazarus.

7.25. One will search the evidence in vain for any proof, even suggestion, that this event, by itself, had a deleterious effect upon PTE Lazarus. Indeed, it is not unreasonable to speculate that given the events of Fri 17 Sep 10, and Mon 20 Sep 10, that PTE Lazarus was comfortable with the fact that he was one of a group of soldiers who seemingly were in trouble and that he was not again the star attraction.

7.26. PTE Lazarus' friend Soldier 12 was also one of the 14 soldiers involved. Amongst other things he said

"We basically just took this on the chin, did the duties and got on with it. I don't think it really bothered Laz too much as it was a punishment given to a large group and he hadn't been singled out."
7.27. The intervention by SNCO 2 was both timely and proper in the circumstances. Clearly, SNCO 3 was not of that view. In effect, he was upset about the lack of courtesy in not receiving at least a phone call before the Minute was raised by SNCO 2, and he felt that he was being "undermined" by the other senior NCOs. A "heated" discussion took place between the two senior NCOs. The reality is, that SNCO 2 was the Acting CSM and even Officer 6 admitted his mistake in not informing his CSM as soon as possible.

7.28. The intervention by the Acting CSM of B COY resulted in appropriate action being taken by both the ADJT and the Acting CO of 6 RAR Rear. Without going into detail, the evidence is that all of the matters identified for action by the Acting CO were indeed addressed, the only exception being that for whatever reason, no administrative action was taken against SNCO 3.

7.29. The recommendations made and the actions taken by the Acting CO of 6 RAR Rear were deemed appropriate and duly confirmed by the then CO 6 RAR, then Officer 21, upon his return from operations in Afghanistan in early Nov 2010.

Part B - Difficulties within 6 RAR Rear

Expectations and the reality

7.30. The evidence indicates that when PTE Lazarus marched into 6 RAR Rear, he joined a Unit quite unlike his previous and positive ARA experiences, and this setting was characterised by a variety of dysfunctions.

7.31. As one of at PTE Lazarus' cohort stated "everyone talks up Battalion life at Singleton and Kapooka and how good it is; but when you got there, it wasn't special at all."

No induction

7.32. Induction into B COY 6 RAR Rear appears to have been an informal process as reflected in the comments of junior NCOs and soldiers:

"I don't know whether the new soldiers who'd come from IET were given any induction program or a specific training regime. I don't know if that happened, but it is supposed to." and

"New soldiers were not given additional guidance or instructions. We were simply told about our room keys for our new rooms on base, and
then instructed 'to be at this Company at this time of day... ...I don't think there was an induction program for the new soldiers'.

**Fluid structure**

7.33. Witnesses provided varying estimates of the posted strength of 6 RAR Rear (B COY) during 2010, the highest estimate being approximately 320.

7.34. One of the Unit’s NCOs stated:

> "I couldn't guess how many members were in Rear Details. It was changing throughout the year... It was all over the shop."

7.35. Two of the junior NCOs of 6 RAR Rear offered the following views regarding the Unit’s structure:

> "So far as the structure of Rear details were concerned, it was roughly based upon the traditional Company appearance (that is, of section and platoons), but there were so many guys who were injured, transitioning out of the Army, and otherwise coming and going, that the section-structure was very loose." and

> "There was no formal company structure: it wasn't a structure you would get at A Coy, or (the current) B COY. It was more of on the lines of 'Righto, we're all together', and more of just, 'Everyone's a platoon, we'll call it a makeshift platoon and we'll go on like that'."

7.36. The perception of an ambiguous and fluid structure was also reflected in the comments of private soldiers:

> "I cannot remember if there were separate platoons - we were all in together." and

> "I cannot recall the names of any NCOs. It (B COY) was all chopped up and changed around that time - from my point of view, there wasn't really separate platoons and sections, it was the Rear Details mob... At the time, B COY was Rear Details. By the books, it might have been structured as a normal company, but by memory, it was all over the shop."

7.37. Ambiguity regarding postings directly impacted upon PTE Lazarus. His Section Commander, Soldier 7, had no direct involvement with PTE Lazarus
until he dealt with him on Mon 20 Sep 10. Until his brother had mentioned
the non-appearance of PTE Lazarus for guard duty on Sat 18 Sep 10, and they
checked on the Defence Restricted Network (DRN), that was the first time
PTE Lazarus’ section commander had heard of his name.

7.38. Similarly, PTE Lazarus’ Platoon Sergeant, SNCO 3, acknowledged that he
had only limited awareness that he was a member of his Platoon:

“I believe that (PTE) Lazarus was in my platoon. I had quite a large
platoon. He was one of those grey sorts of guys. There are only a few
things that actually stick in my head with him and there are only one
or two things that actually remind me that he was in my platoon.”

The difficulties of the CO upon deployment

7.39. Whilst Officer 21 was posted as the CO 6 RAR in...it was in
effect only to the Battalion rear element at that stage, as the bulk of the
Battalion was to be deployed to Afghanistan as MTF-1, under the previous
CO, Officer 22.

7.40. In May 2010, Officer 21 and his key staff deployed to Afghanistan whilst retaining technical command of
the Battalion. The local command of 6 RAR Rear fell to his Executive
Officer, Officer 5.

7.41. From May 2010, until his return in late October or early Nov 2010, Officer 21
had no direct day to day management of 6 RAR Rear. The
Commission heard evidence of the high tempo of operational activity in
Afghanistan that otherwise occupied Officer 21 in his role as the
Commander of MTF-1.

7.42. Additionally, as submitted by Counsel Representing Officer 21, the
Commission heard evidence of the CO’s continuing oversight of 6 RAR’s
activities and to offer guidance and counsel to Officer 5 by not infrequent
video conferencing.

7.43. Because of the operational demands placed upon the Commander of MTF-1,
and the fact that MTF-1’s tempo was the highest for the ARA since the
Vietnam war, the Commission acknowledges the almost super-human task
placed upon Officer 21 at the time.

7.44. Given the increasing demands of compliance placed upon commanders, the
Commission is of the view that it is unfair for a commander to be responsible
for his rear echelon whilst deployed on operations. Apart from anything else,
such an ongoing responsibility is a distraction from the commander’s primary
function.
7.45. The Commission is of the view that it is not an answer to say that such ongoing responsibility goes with the appointment of a Battalion Commander when the bulk of his Battalion is deployed on operations.

7.46. The dual responsibility imposed on Officer 21 had the real potential to distract him from full operational alertness and efficiency. Fortunately, that did not occur. That does not mean that such distraction might not occur to another Battalion Commander in the future, if so deployed.

7.47. With respect, the Commission is of the strong view that the issue of dual responsibility is something that the CDF should address. That being said, there is no evidence, or even suggestion, that this issue had anything to do with the decision of PTE Lazarus to take his own life.

7.48. The Commission also notes that its strong view about dual responsibility was arrived at independently. There was no evidence, or even suggestion, from Officer 21 that such a situation was unfair.

The Acting CO and Acting OC 6 RAR Rear

7.49. Counsel Assisting did not think it necessary to call the Acting CO 6 RAR Rear, Officer 5 as a witness, or provide affidavit evidence. The only documentary evidence from him is his Personal Assessment Report (PAR) of Officer 6 during 2010, and his reply to the representation made by Officer 6 in that regard. It may be noted that Officer 6’s PAR was subsequently amended after the intervention of the Brigade Major.

7.50. Officer 5 was a Officer 21. He was posted to 6 RAR in early 2010 until he retired in September of that year. At that point, Officer 21 redeployed the Unit XO and XO MTF-1, Officer 1, to undertake the duties of XO 6 RAR Rear. After Officer 21 deployed to Afghanistan, in late April to early May 2010, Officer 5 was in contact with him on a routine basis via telephone and where possible, VTC.

7.51. When Officer 6 was appointed the Acting OC B COY, he had every reason to believe that it was only a short-term acting appointment. Just before Officer 21 deployed to Afghanistan to take over from Officer 6 RAR met with Officer 6 and told him that he (Officer 6) had his support and that he would try to get people back to help him, including a CSM.

7.52. When the OC B COY deployed to Afghanistan, he was supposed to be replaced but wasn’t. As a result, Officer 6 ended up being the Acting OC B COY for most of the time 6 RAR Rear existed.
7.53. The evidence is that originally B COY had about 320 soldiers. This included the administrative company, Q-Store, PMV drivers, new recruits, march ins and those who were returning from Afghanistan, discharging, including the mentally and physically injured. There was an Acting CO, an Acting OC and CSM, 2 Platoon Commanders, (one of whom was removed back to Singleton) and about 12 NCOs. 6 RAR Rear had "many weird and different issues to deal with." 

7.54. Whilst the numbers of personnel within 6 RAR Rear fluctuated, the evidence is that the rear element comprised about one third of the Battalion.

7.55. The evidence is that 6 RAR Rear was heavily understaffed. It had a fluid membership and Officer 6 agreed that the description given by a soldier who gave evidence to the Commission to the effect that B COY was a mixture of "odds and odds", was a "very apt description."

7.56. It is clear from the evidence that the sheer volume of soldiers in 6 RAR Rear, and their differing needs, together with the lack of supervising personnel, made the Unit extremely difficult to manage. As Officer 6 stated, the management of a Unit twice the size of a normal infantry company with half of the normal allocation of NCOs, created an "enormous problem".

7.57. Officer 6 said that there was a need for three (3) times the number of NCOs in a normal company because of the constant arrivals and other unusual features of 6 RAR Rear. Indeed, he said that it seemed to him that B COY was:

"a dumping ground for non-deployable individuals. To keep the battalion properly manned, we were receiving a lot of new recruits, however, many of the new soldiers would arrive without any adequate or any paperwork. Often times, we just did not know who they were or from where they had come."

7.58. Counsel Representing Officer 6 made extensive submissions on his behalf. In the circumstances, there is no need for the Commission to address all of the matters raised.

7.59. 

7.60. Subsequently, Officer 6 was
7.63. As previously stated, Officer 6 became Acting OC Rear Detail 6 RAR. His understanding was that he would be looking after B COY by himself for only a short period of time. That was not to be.

7.64. As submitted by Counsel Representing Officer 6, there is little, if any, information available to the Commission that demonstrates the extent to which Officer 6 was "brought up to date" or trained with matters in respect of which he had material control when occupying the position of Acting OC, 6 RAR Rear.

7.65. Counsel Representing further submitted that Officer 6 found himself in the position of OC one of the most difficult commands that would challenge even the most experienced Major.

7.66. The reality was that Officer 6 did in fact inherit a "poisoned chalice" as had been mentioned by the then Brigade Major, Officer 17, and referred to in Officer 6's affidavit.

7.67. Whilst Officer 21 expressed the view that a Captain nominally should be able to step into an OC's position, the circumstances in 6 RAR were not normal and it was "a very invidious situation for anyone to take on". Officer 21 also stated in his affidavit that both the Acting CO and Acting CSM...
of 6 RAR Rear.

"...were given clear guidance on how to assist Officer 6 to the best of their ability before I deployed. To be fair to (Officer 6), the challenges of inheriting an organisation as large as B Company as a Rear Details element would be daunting to any officer, but it was apparent that he was more suitable as company 2IC and would need close supervision as an OC."

7.68. Officer 6 was left behind to command a Unit that was inflated in size and without sufficient junior level command support, amongst other things. Also, as early as May 2010, Officer 6 had spoken to the then Brigade Major, Officer 17, about his personality clash with the Acting CO of 6 RAR Rear, Officer 5. In the view of Officer 6, the relationship between the Acting CO and himself became "volatile".

7.69. Counsel Representing Officer 6 also submitted that it was inappropriate to visit the ill's of B COY 6 RAR upon Officer 6. With respect, there is merit in that submission so far as all 6 RAR Rear ill's, or problems, were concerned.

7.70. Counsel Assisting made the important submission that the "circumstances" in which Officer 6 were operating cannot be easily overlooked. It was also submitted that on one view, the Commission might think that Officer 6 was "destined to fail", because of his invidious position.

7.71. Amongst the difficulties that Officer 6 had experienced in managing B COY were ongoing alcohol related problems within the ranks and personnel issues involving soldiers. The evidence is that at the B COY parade preceding the award of punishments to the 14 soldiers for the non-saluting on the afternoon of Wed 22 Sep 10, the Acting OC cracked the disciplinary whip to the approximately 250 soldiers and NCOs then on parade.

7.72. The Acting OC reminded the parade that discipline was important and that included saluting officers and paying attention to recognizing the hierarchal structure of commissioned and non-commissioned officers alike. He informed the parade that there were too many alcohol related incidents occurring within 6 RAR Rear and that saluting and paying the professional courtesies were mandatory. The parade was advised that "extras" would be awarded for those who fail to maintain discipline.

7.73. As regards the awarding of extras, the evidence of Officer 6 was to the effect that he had received many extras during his service career and his belief that the use of extras:
"was a system that was in regular use in the Australian Army and I am aware that extras are still handed out."

7.74. The Acting OC said he didn’t know at the time that the 14 soldiers punished had been tasked to attend Exercise Hamel the following week. He said that the reason for this was because the Acting CSM, SNCO 2, was not at work.

7.75. It is surprising to say the least that SNCO 3 did not then advise Officer 6 that the 14 soldiers were shortly to depart for Ex Hamel. SNCO 3 was the only SNCO who was accompanying those and other soldiers on the Exercise.

7.76. In any event, the Acting OC said that had he known of the soldiers’ pending exercise deployment, he would not have administered extras to the soldiers at that time, the inference being the punishments would have been effected after their return from Ex Hamel.

7.77. Officer 6 stated that the punishments were imposed because the soldiers’ behavior was seen by him “as a flagrant breach of discipline.” Personally, he did not like giving extras as a punishment, and said that the non-saluting incident was the only time in his career that he had, or has, given extras. He had received many extras himself in the course of his career as an Officer.

7.78. Surprisingly, one of the matters which Officer 6 said he was unaware of when he commenced was the Discipline Officer System (DOS). He said that he had not been made aware of certain changes that had taken place within the ARA, particularly the introduction of the DOS. He said, in effect, that he was not instructed on the DOS as a new system to replace the giving of extras. He further said that he had not been released to undergo training whilst at 6 RAR and would have found such training most useful, particularly with respect to amendments to the DFDA process.

7.79. The Discipline Officer System came into effect on 1 Nov 1995, and has increased in importance and scope since then.

7.80. A Discipline Officer (DO) may deal with acts or omissions that are otherwise capable of being charged as Service offences under the DFDA. A DO may impose one of the punishments listed in para 5.37 of ADFP 06.1.1-Discipline Law Manual, Volume 3, Summary Authority and Discipline Officer Proceedings.

7.81. The DOS allows for the expeditious handling of minor infractions committed

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by non-commissioned rank and officer cadets, and applies where the member
admits the misconduct and there is no dispute as to the facts. There is no
appeal against a DOS outcome.

7.82. Punishments imposed by a DO take effect immediately. In the case of a
punishment for a specific period, the DO may delay commencement of a
"minor punishment" for up to 14 days after the day it is imposed.

7.83. "Minor punishments" are defined as restriction of privileges (for a period not
exceeding 2 days), stoppage of leave (for a period not exceeding 3 days), extra
drill (for no more than 2 sessions of 30 minutes each day for a period not
exceeding 3 days) and extra duties (for a period not exceeding 3 days).

7.84. Minor disciplinary infringements are dealt with at the Unit level by CO-
appointed Discipline Officers. If an ADF member does not admit to having
committed the infringement or does not elect to be dealt with by a DO, or the
DO considers the infringement too serious, the member may be charged and
tried by a Summary Authority.

7.85. Under the DOS, records of infringement notices do not form part of a
member’s conduct record, but are kept on a Unit register for 12 months before
being destroyed.

7.86. The report of the Judge Advocate General (JAG) for the ADF for the period 1
January to 31 Dec 2010, indicates that within that period a total of 3,792 Army
disciplinary matters were dealt with. Service Tribunals conducted 56 hearings,
Summary Authorities conducted 1,287 hearings and Discipline Officers dealt
with 2,461 matters. Accordingly, some 65% of all Army disciplinary matters
(almost 2 out of 3) were dealt with by Army Discipline Officers in 2010.

7.87. Given his position and function within 6 RAR and then 6 RAR Rear, Officer 6
should have been aware of the 6 RAR Routine Orders. (RO)

7.88. The CO 6 RAR, Officer 21 issued 6 RAR RO 1/10 on 4 February
2010. Those ROs cancelled all ROs for 2009, and stated, amongst other
things:

"All members posted or attached to this unit are to read and comply
with 6 RAR Routine Orders, 6 RAR Standing Orders and Gallipoli
Barracks Standing Orders.

7.89. Amongst other things, the CO of 6 RAR appointed Discipline Officers in
paragraph 6 of RO 1/10. The appointments were made pursuant to Section
169B of the DFDA and appointed the following as Discipline Officers

"Majors holding the appointment of Executive Officer and Officer
7.90. Clearly, the XO/Acting CO of 6 RAR Rear, Officer 5, was such a Discipline Officer. However, as previously stated, the Commission heard no evidence from him.

7.91. It is clear from the documents relating to the Course at the LWC that Officer 6 attended and passed that course. Service Discipline Law and Military Justice issues were dealt with and examined upon. For example, in the Service Discipline Law Section of the Military Justice System exam, Officer 6 correctly circled the answer "YES" to the question:

"Is the following statement correct
'The Discipline Officer framework is not a service tribunal and the rules of evidence do not apply.' "

7.92. Whilst the discipline law component was a "very small part" of that course, the reality is that Officer 6 had received some training with respect to the DOS and, quite reasonably, was expected to be knowledgeable about that important aspect of discipline law.

7.93. The Commission is unable to accept the evidence of Officer 6 that at the time, he had no knowledge of the DOS. It is the view of the Commission that Officer 6 was simply mistaken in that aspect of his evidence and was not attempting to mislead the Commission.

7.94. It is the assessment of the Commission that Officer 6 was an honest witness in his lengthy testimony, but a mistaken witness with respect to the DOS aspect.

7.95. As mentioned in paragraph 2.12 herein, even honest witnesses may not be reliable, or fully reliable, in their testimony because of faulty recollection or faulty reconstruction, given the passage of time.

7.96. With the advantage of hindsight, Officer 6 readily admitted to the Commission that he had made a mistake in punishing the 14 soldiers as he had, and it is something that he will look back upon with regret. He agreed that the soldiers were denied natural justice. Administrative action was taken against him in that he was formally counselled by the XO, Officer 1, on 6 Oct 10, and acknowledged by him in writing the next day. Officer 6 did not seek redress against such action.
7.97. Officer 6 also admitted that he had made a mistake in not informing his Acting CSM, SNCO 2, as soon as possible. SNCO 2 was clearly upset by what happened. However, following a "full and frank" discussion between the Acting OC and the Acting CSM, they then settled the issue.

7.98. Excluding the "illegal punishment" imposed on the 14 soldiers for the non-saluting incident on Wed 22 Sep 10, which Officer 6 candidly admitted to the Commission as being unfair, and for which he was formally counselled by Officer 1, Counsel Representing Officer 6 submitted to the Commission, that considered objectively, considering the entirety of Officer 6's service as Acting OC B COY, it can be seen "that he handled the (H)erculean tasks of looking after that company with significant skill and expertise given the extent of his training...."

7.99. As regards "the circumstances" in which Officer 6 operated as Acting OC, Counsel Assisting has rightly observed that the fact that Officer 6 struggled in that Acting role was, or ought to have been obvious to those who placed him in that role. Officer 6 said in evidence that he was aware of the issues affecting Officer 6's performance prior to his departure on deployment.

7.100. After the CO 6 RAR returned to Australia, he was made aware that his XO, Officer 1, had "formally counselled" Officer 6 with respect to the cancellation of leave of the 14 B COY soldiers in the so called non-saluting incident. The then Officer 21 was so informed as part of his re-orientation upon his return.

7.101. Officer 6's CFTS expired in Nov 2010, which coincided with the post deployment reorganisation of 6 RAR. Given the extent of Officer 6's training, there is merit in the submission of his Counsel that Officer 6 faced "(H)erculean tasks" in his role of Acting OC 6 RAR Rear for the bulk of the period the Battalion was deployed. Given the circumstances, the Commission agrees that even an experienced Major would have found the Acting appointment very challenging.

7.102. As previously stated, the Commission makes no adverse finding against Officer 6, or indeed any other member, or former member, of 6 RAR Rear or 6 RAR.

A "systemic" issue?

7.103. Counsel Representing PTE Lazarus and his next-of-kin has submitted that the issue of illegal punishment, as "extrav" rebadged as "retraining", is a serious problem that the Commission needs to address.
7.104. It is fair to observe that the evidence before the Commission disclosed a lack of knowledge of implementation of the Discipline Officer Scheme (DOS) within the ranks of B COY 6 RAR Rear.

7.105. It is the view of Counsel Representing that the regular use, acceptance of and attitudes towards “extras” from junior NCO to Officer level within 6 RAR Rear, indicates that the bad habits or practices involving illegal punishments and extras disclosed within A COY 3 RAR some 15 years ago in the Burchett Report246 have crept back into use, and constitute a significant risk to the system of military justice.

7.106. Counsel Representing is critical of the fact that such problems within 6 RAR “were not detected by the regular audits by IGADF.”

7.107. Upon the evidence before it, the Commission does not share the concerns of Counsel Representing with respect to those issues.

7.108. Whilst it is clear from the evidence that the use of “extras” as illegal punishments did occur within B COY 6 RAR Rear, once that problem or issue was identified within the sub-unit it was promptly and properly addressed by the Acting CSM, the Adjutant, and the Acting CO.

7.109. It is the view of the Commission that the problem was “systemic” only in the sense that it occurred within a sub-unit, namely B COY 6 RAR Rear, which at the time was beset with a number of system issues peculiar to its rear details function and resourcing issues, including the lack of sufficient and experienced personnel.

7.110. There is simply no evidence before the Commission that the illegal punishment issue extended beyond B COY 6 RAR Rear, let alone any suggestion that it was, or is, prevalent within 6 RAR, or indeed the ARA.

IGADDF audits

7.111. As regards audits by the Office of the Inspector General of the Australian Defence Force (IGADF), the only evidence in that regard received by the Commission was the evidence of... Such an audit of 6 RAR was conducted in March or April in 2011 by a team of 4 or 5 headed by a legal officer with the rank of Colonel...

7.112. The IGADF was established by the CDF in 2003 to “provide a means for review and audit of the military justice system independent of the ordinary chain of command.” In addition, the IGADF provides “an avenue by which failures of military justice may be exposed and examined so that the cause of

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246 See the Report of an Inquiry into Military Justice in the Australian Defence Force, July 2001, conducted by Mr J.C.S. Burchett QC.
any injustice may be remedied. The IGADF reports directly to the CDF and advises him on the health and effectiveness of the military justice system.

7.113. It is clear from the evidence of Officer 21 that the RSM of 6 RAR conducted training in January 2011 and January 2012 for all NCOs, Warrant Officers and Officers on the requirement for imposing lawful punishments under he DFDA and the DOS. The evidence is that such training conducted by the RSM was:

".....a matter of refocusing, talking about the discipline officer scheme so they understood what their specific responsibilities and left and right of arcs were."

7.114. As Officer 21 pointed out, the QA resulting from the stoppage of leave/illegal punishment issue in September 2010 was "focused on a particular situation" and the corrective action taken by the XO after the exposure of the circumstances was absolutely correct. Those issues were looked at by the IGADF audit team and Officer 21 recalled that one of the things the audit team told him was that "the QA process that was done on the unit and the implementation seen was spot on."

7.115. In the IGADF’s Military Justice Statistics Catalogue for Calendar Year 2011, it was noted that Discipline Officer scheme Infringement Notices continued to increase at 5306 compared to the 2010 total of 5066. It was also noted:

"It is clear that formal charges dealt with by the summary trial process are on the decline, replaced by more frequent recourse to the Discipline Officer scheme and adverse administrative action."

7.116. Contrary to the submission by Counsel Representing PTE Lazarus and his next-of-kin, the Commission finds that it is not necessary to recommend corrective action or retraining to remind ADF personnel at all levels on the use of the Discipline Officer scheme and of the unacceptability of illegal punishments.

7.117. Simply stated, the evidence before the Commission did not disclose a culture of widespread or systemic avoidance of due disciplinary process. On the contrary, the evidence disclosed the prompt and proper correction of disciplinary issues within B COY 6 RAR Rear, once such issues were identified.

7 Brigade recognition of difficulties

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253 See the Executive Summary of the Catalogue, para 5.

254 ibid para 12.
7.118. The current Chief of Staff, Headquarters 7 Brigade (HQ 7 Bde), Officer 14, gave evidence to the Commission. He was not posted to HQ 7 Bde in as he was then a UN military advisor. However, he was well and truly aware of the difficulties experienced by 6 RAR Rear in 2010. He was aware that the arrangements for 6 RAR Rear were not as "robust" as they could have been.

7.119. In planning for the rotation deployment of 8/9 RAR to Afghanistan, the Bde Commander did not want to repeat the experiences incurred by 6 RAR Rear in 2010. Accordingly,

"It was decided to appoint a fulltime officer and basically to direct (the) CO (of) 8/9 RAR that one of his competent majors was actually to stay behind as basically CO (of) 8/9 RAR Rear..."

7.120. Not only did 8/9 RAR Rear have an ARA Major as CO (it was in fact the experienced Bn XO); it was also resourced with an Adjutant, a full Rehabilitation Platoon with a Captain, a CSM, at least three Platoon Commanders. There were also at least 8 Platoon Sergeants and quite a number of junior NCOs as well as an Acting Chief Clerk. 8/9 RAR Rear also had significant support from the 7 Bde Welfare Cell, and direct access to the Chief of Staff. That was a significant contrast to the resources available to 6 RAR during 2010.

7.121. The Rehabilitation Platoon in any Rear Details element of a deployed infantry Battalion is a very important part of Rear Details, and very demanding for those who run it. The welfare of wounded and injured soldiers should always be paramount. That suggests a fulltime commitment for and from the person running the platoon.

7.122. By way of contrast to the 8/9 RAR Rear Rehabilitation Platoon resourcing, the 6 RAR Rear situation was a poor cousin. Not only was SNCO 2 the Acting CSM of 6 RAR Rear, he was also identified to fill the role of PL SGT of the then named Long Tan Platoon, the Battalion's Rehabilitation Platoon. As he said, "The Platoon at that time had no commander or sergeant. The Platoon strength was around 50 members, and my Platoon staff comprised 1 LCPL."

7.123. Lessons had indeed been learned by the time when 8/9 RAR deployed.

7.124. It cannot be said that the staff and other problems confronting 6 RAR Rear were unknown by the Bde at the relevant time. As Officer 21 stated in his evidence, his predecessor as CO of 6 RAR, the then Officer 22 had asked the Directorate of Career Management-Army (DOCM-A) for more officers.
before the deployment of 6 RAR as part of MTF-1. Unfortunately, that did not occur. Officer 21 also sought further assistance for 6 RAR Rear before the departure of the bulk of 6 RAR on deployment. The evidence is that approximately one third of the Battalion remained at Gallipoli Barracks.

7.125. As Officer 21 said in his affidavit:

"I tried to get more Officer augmentation for B COY through my brigade commander channel at DOCM-A. This was unsuccessful and the only augmentation we could gain was a RAEME WO who was employed as a Company OPSO to assist (Officer 6) and the CSM in lieu of additional officers."

7.126. In his affidavit, Officer 21 observed that the problems arising in the degradation of quality supervision at the junior levels and the lack of experience at the residual sub-unit and Unit level, occurred whilst 6 RAR was deployed. As he stated:

"It is apparent to me that the prevalence of these incidents appears to have commenced after the deployment of the selected and qualified sub-unit and unit level command teams and then appear to have, in the main, ceased upon their return. While this can be seen as both a systemic issue and command failures in a deployment period, the factors surrounding the manning of the units within the Bde at the time, cannot be understated. The other, hitherto undiscovered factor in this equation is that 6 RAR was engaged in the most intense deployment (including casualties) that the conventional Army has engaged in since the Vietnam War."

7.127. Clearly, the former COs of 6 RAR, Officers 21 & 22, whilst their Battalion was deployed in Afghanistan as part of MTF-1, had their primary focus on operational and associated issues in that country. That does not mean they neglected their 6 RAR Rear responsibilities in Australia. They did the best they could given their circumstances and resources.

7.128. As the Chief of Staff HQ 7 Bde observed, such Officers are given field rank for a good reason. Officer 14 had no doubt that when 6 RAR deployed, its then CO, and his successor, "would have been quite comfortable with what they put in place". With respect, the Commission shares that view.
LAZARUS COI REPORT

SECTION 8

PART A – THE POST EX HAMEL INCIDENT
PART B – THE REPUTATION OF PTE LAZARUS

8. Interactions between PTE Lazarus and members of his Unit, including any events that may have occurred in the course of Exercise HAMEL.

Part A - Exercise Hamel

8.1. As previously stated, the Commission makes no adverse finding against Officer 6.

8.2. Between 29 Sep 10 and 3 Nov 10, PTE Lazarus was one of 49 Privates from 6 RAR Rear, who participated in Exercise Hamel at the High Range Training Area, Townsville. The PL had one LT, one SGT (SNCO 3), one CPL and four LCPLs.

8.3. The Acting CSM, SNCO 2 did not participate in the exercise. However, he later asked someone (whom he couldn’t remember) how PTE Lazarus performed during the exercise and was told that PTE Lazarus “Did a good job”.

8.4. Members of PTE Lazarus’ cohort who participated in the exercise reported that he seemed to enjoy himself. Indeed, Soldier 12 observed that his friend “seemed to be in much better spirits up there at Hamel”.

8.5. PTE Lazarus was observed maintaining a fitness regime, and appeared to mix well.

8.6. Whilst others formed the view that PTE Lazarus enjoyed Exercise Hamel, he told the Army psychologist, Officer 18, on 5 Jan 11 that he found the exercise “very boring” and of “no benefit to his training as a RFN”.

The Post EX Hamel Incident

8.7. After the conclusion of the exercise, PTE Lazarus and the other deployed soldiers from B COY 6 RAR Rear were accommodated in tents at Lavarack Barracks, Townsville. On the last night before returning to Brisbane, leave was granted with a midnight curfew. After the soldiers returned to their lines late that night, PTE Lazarus was allegedly punched by another soldier from B
COY 6 RAR Rear, Soldier 9. Conflicting evidence was given about what happened and the Commission finds it unnecessary to descend into detail regarding the conflicting evidence. What is clear is that towards midnight, anger flared in the tent lines, no doubt aided by the heavy consumption of alcohol by the soldiers when they went into the city earlier that night.

8.8. In his statement to the ADFIS investigator, signed on 21 Mar 11, Soldier 17 referred to the incident. He said that when the soldiers returned to the tent lines that night, the NCO who had been put in charge of the PL that evening went to bed immediately upon returning to the lines. Soldier 9 then took it upon himself to try to get everyone to bed. Soldier 17 said when soldiers got up, Soldier 9 asked them where they were going, but would not stop them. When PTE Lazarus got up to make a phone call and go to the toilet, Soldier 9 told him that he couldn’t. An argument resulted about 20 minutes later and a fight apparently broke out between Soldier 9 and PTE Lazarus. The fight was broken up and shortly after, PTE Lazarus was restrained from having a “go again”. Soldier 17 continued:

“I thought Soldier 9 had been unreasonable, as he should have just let PTE Lazarus just go to the toilet. However, PTE Lazarus could have diffused the situation by just asking to go to the toilet, and not asking for the phone call as well and not pushing the situation.

The following morning, PTE Lazarus tried to apologize to Soldier 9. Soldier 9 told him to go away and that he didn’t want anything to do with him. PTE Lazarus didn’t really seem to care about this incident and didn’t mention it again”.

8.9. In his evidence before the Commission, Soldier 9 had no recollection of punching PTE Lazarus. He could only recall “getting physical” with the former Soldier 6. Soldier 9 didn’t think that PTE Lazarus hit anyone but simply threw drunken punches at others, which missed their mark.

8.10. The only NCO in the immediate vicinity was asleep at the time and, whatever happened, the incident was not reported.

8.11. In assessing the credibility of Soldier 9, the Commission formed the view that he was neither devious nor deceptive in his evidence.

8.12. Whilst PTE Lazarus’ good mate Soldier 12 was present at the time, and was aware of an altercation between Soldier 9 and PTE Lazarus, he didn’t think that there was a scuffle or fists thrown, “just up - in - your face yelling”.

8.13. Also, as Soldier 12 observed:

“I don’t think PTE Lazarus held a grudge towards Soldier 9 for what happened on Exercise Hamel. I think that was water off a duck’s back”
8.14. Of more concern is what Soldier 5 stated in his Record of Interview with Counsel Assisting, [REDACTED] on 31 October 2012. Soldier 5 said that:

"...Soldier 9 told (PTE Lazarus) a lot of times how when everyone got back from Afghanistan, that he, (PTE Lazarus), would get bashed a lot and threatened (PTE Lazarus) with this as well. (PTE Lazarus) was upset about this and seemed to take this seriously. This did not happen though, once everyone got back and (PTE Lazarus) seemed to be okay."

8.15. Whatever may have been said, there is simply no evidence, direct or indirect, that PTE Lazarus was in any way victimised, bullied or bastardised about anything that had previously happened, or at all, by members of 6 RAR who returned from Afghanistan in the following months.

8.16. What Soldier 9 may have previously told him, which initially caused concern and upset to PTE Lazarus, simply did not materialise.

**Part B - Reputation**

8.17. Reputation was very important to PTE Lazarus. As one of his very good civilian friends, [REDACTED], stated:

"It mattered to (PTE Lazarus) what people thought of him; including the trivial things. If he thought a wrong had been done to him he would stand up for himself."

8.18. According to his parents, PTE Lazarus felt he wasn’t accepted within 6 RAR because he failed the first weekend and he wasn’t to be given another chance. Their son’s personality was such that he hated to fail. The initial “stuff up” was a “big blow” to his pride.

**A soldier’s reputation.**

8.19. A soldier’s reputation is very important within an infantry Battalion. As former Soldier 7 said “you need to prove yourself and not draw the heat”.

8.20. Soldier 12 who joined the ARA on the same day as PTE Lazarus and also came from Brisbane, gave evidence to the effect that a new soldier in an infantry Battalion wanted to avoid being a “heat seeker” because reputation is so important. A “heat seeker” is one who draws the attention of, or heat from, the chain of command because of his performance or non-performance.
8.21. In the view of some members of his cohort, PTE Lazarus became a "heat seeker" until Exercise Hamel. For example, it was said by his good friend, Soldier 12, that PTE Lazarus became a "heat seeker and everyone knew him for the wrong reason."

8.22. Soldier 17 said that after the WTSS incident, and the sewing of the guard duty incident, PTE Lazarus "copped a lot of heat". He just "stood out" because of his troubles, and everyone was watching him after that.

8.23. The evidence of Soldier 6, a good friend of PTE Lazarus, did not lack candour. He left the ARA after four years service, for family reasons, and had no disciplinary action taken against in his entire army career, apart from the unlawful cancellation of leave incident. Soldier 6 readily conceded that his disposition towards Officer 6 was coloured because of the unfair treatment he and other soldiers received as a result of the non-saluting incident and subsequent cancellation of leave.

8.24. Amongst other things, Soldier 6 gave evidence that a soldier's reputation within a Battalion is highly valued. He said "Reputation in 6 RAR is a massive thing". By definition, infantry is a society of tough soldiers and it is part and parcel of a soldier's life to have discipline because it will help survival during deployment. In the oral testimony of Soldier 6, there are numerous references to the word "stigma", and there is no need to footnote all of those references.

8.25. In his affidavit, Soldier 6 spoke of the reputation of PTE Lazarus:

"It was a reputation that stuck with him. It would have taken an incredible feat like an act of valour overseas, or something like that to reverse a bad reputation. There was nothing in PTE Lazarus' power that would have taken away the stigma associated arising from the WTSS incident."

8.26. Soldier 6 also stated, in effect, that if he had been PTE Lazarus, he (Soldier 6) would have probably left the Army.

8.27. It is abundantly clear from the evidence that PTE Lazarus was very upset that he had created a bad name for himself in 6 RAR Rear, virtually as soon as he marched into the Battalion.

8.28. A number of witnesses painted a picture of PTE Lazarus as being "a heat seeker", or being "on the radar" or being on a "shit list". However, as Counsel Representing Officer 21 correctly submitted, there is no
evidence of consequence that PTE Lazarus had any adverse interaction with 6 RAR members. Certainly, none spoke despairingly of him in their evidence to the Commission, and none related incidents of hostility or deliberate isolation of him by the Unit members.

8.29. PTE Lazarus blotted his own character with the WTSS incident, but other than that incident, there is no reason to believe that he was not accepted as a regular member of 6 RAR. Indeed, the evidence is to the contrary.

8.30. There is certainly no evidence that PTE Lazarus was perceived by any NCO or Officer as a "heat seeker". However, that is not to say that PTE Lazarus did not himself fear that he had, or would, become the target of close scrutiny, or indeed that he would be shunned by his peers because of that risk.

8.31. The reality is that PTE Lazarus blotted his own character and standing within 6 RAR as a result of the WTSS incident. It is also unfortunate that through lack of communication, a chain of events was unfairly and inadvertently set in motion that further impacted upon PTE Lazarus' reputation within 6 RAR Rear.

8.32. As Counsel Assisting have correctly submitted, PTE Lazarus had marched into the exacting and robust culture of an infantry Battalion where soldiers are expected to perform to standards that are not easily reconcilable with a civilian workplace. The life of an infantry soldier is an austere and a demanding one. However, the perception of army life by a young infantry soldier may not always be matched by the harsh reality.

8.33. A soldier's reputation is extremely valuable. A good reputation is hard to win and may be quickly lost.

8.34. It would be difficult, therefore, to conclude otherwise than that the events experienced by PTE Lazarus so early in his life within the Battalion would have had a deleterious affect upon his self esteem.

8.35. As Counsel Assisting have correctly observed, it is possible that those events contributed to his state of mind, and ultimately, to his attempt to take his life and, later, his suicide. A pointer, perhaps, to this comes in the evidence of the statements made by PTE Lazarus after his attempted suicide wherein he referred to the trouble he anticipated if he were to be late to work.

8.36. Importantly, there was nothing in the subsequent behaviour of PTE Lazarus, or in his suicide notes, to indicate that his perception of military expectations, or his military reputation, was in any way a contributing factor to the decision to take his own life.
Command and control issues

8.37. In paragraphs 7.39 to 7.48 herein, the Commission has referred to the difficulties of the CO 6 RAR upon deployment.

8.38. In relation to 6 RAR command and control issues, the Commission finds that two principal factors contributed to the difficulties mentioned.

8.39. The first of these factors was the inadequate staffing of 6 RAR Rear at both the Officer and NCO level while the majority of the Unit was on operational deployment, and the inexperience of some of the key personnel left to fill those roles. These problems occurred despite the best efforts of both CO 6 RAR and his predecessor to proactively address those staffing deficiencies.

8.40. The second factor was the almost Herculean task presented to CO 6 RAR to effectively remote command the Rear Element of the Battalion, whilst simultaneously attempting to focus his energies on the command of his Unit during high tempo operations in Afghanistan.

8.41. The first factor appears to have received appropriate recognition and remedial action by the revised staffing arrangements during the subsequent deployment of 8/9 RAR.

8.42. The Commission is of the view that the second factor continues to demand urgent attention. The dual responsibility imposed on the CO 6 RAR had the real potential to distract him from full operational alertness and efficiency. Fortunately, that did not occur. That does not mean that such distraction might not occur to another Battalion Commander in the future, if so deployed.
PTE LAZARUS COI REPORT

SECTION 9: TOR 12 (c) Previous attempt at suicide

9. The COI was tasked with identifying and gathering evidence, and making findings with respect to the circumstances surrounding PTE Lazarus’s overdose on pharmaceuticals on 24 November 2010, and his subsequent management by Army, medical practitioners and others.

Summary of Facts from 24 Nov 10 – 19 Jan 11

The overdose on 24 Nov

9.1. At approximately 0900 hours on 24 Nov 10, PTE Lazarus was found at his parent’s house in an unconscious state, and covered with blood from superficial lacerations to both his forearms. It was routine for him to reside with his parents when not at his room in the Long Tan Lines at Gallipoli Barracks.

9.2. It transpired that PTE Lazarus had taken an overdose of over-the-counter pharmaceuticals at about 0300 hours that morning. Mrs Lazarus and her other son, drove PTE Lazarus to the Wesley Hospital, where he was admitted immediately. PTE Lazarus was later transferred to the Royal Brisbane and Women’s Hospital (RBWH).

9.3. On 25 Nov 10, PTE Lazarus was released from the RBWH and admitted to the Gallipoli Barracks Health Centre (GBHC), where he was seen by duty Medical Officer (MO), Doctor 5.

9.4. Doctor 5’s medical notes indicate that PTE Lazarus had been admitted to the Mental Health Unit (MHU), located at Ward 1, GBHC. The notes also indicate PTE Lazarus had a depressive illness, and was to be referred to a psychiatrist and to a psychologist. Doctor 5 recorded that PTE Lazarus “currently has no suicidal ideation” and feels “embarrassed”.

Note: The MHU later became the Mental Health Psychological Section (MHPS), but it was the MHU at the time PTE Lazarus was an in-patient at the GBHC.
**Gallipoli Barracks Health Centre (GBHC) response 26 Nov 10 – 4 Dec 10**

9.5. On 26 Nov 10, MHU MO, Doctor 6, saw PTE Lazarus. The medical notes indicate Doctor 6’s concern that PTE Lazarus required re-admission to a civilian hospital over toxicology concerns arising from the overdose of pharmaceuticals. That same day PTE Lazarus was re-admitted to the RBWH.

9.6. On 1 Dec 10, PTE Lazarus was re-admitted to the MHU. The duty MO medical notes indicate that PTE Lazarus was not currently suicidal or exhibiting suicidal ideation. The notes record that PTE Lazarus was to be reviewed by a psychiatrist and a psychologist.

9.7. On 2 Dec 10, PTE Lazarus was reviewed by clinician, Defence civilian 3. His Continuation Notes indicate that PTE Lazarus denied any present risk of self-harm or suicide. An appointment was made for PTE Lazarus to see Consultant Psychiatrist, Doctor 8, at 1500 hr that day.

9.8. On 3 Dec 10, the Continuation Notes completed by Doctor 6 indicate a further appointment with Doctor 8 at 1500 hr that same day.

9.9. Also on 3 Dec 10, Doctor 8 provided his Specialist Report on Form PM 526. Doctor 8 noted that PTE Lazarus was suffering major depressive symptoms, but that he was more settled. Doctor 8 prescribed Effexor XR and recommended PTE Lazarus be granted convalescence leave from Saturday (4 Dec) – Monday (6 Dec 10), with a review by Doctor 8 on 7 Dec 10. Doctor 8 stated that PTE Lazarus was “not fit for duty”.

9.10. The Continuation Notes made by the duty MO on 4 Dec 12 state that Convalescence leave was discussed with PTE Lazarus, and that the 6 RAR Duty Room was contacted to arrange the convalescence leave.

**Convalescence leave as an outpatient of the GBHC 4 Dec 10 continuing**

9.11. Block leave for 6 RAR commenced on 4 Dec 10 (which meant the Battalion effectively stood down, safe for a Rear Details element).

9.12. On 4 Dec 10, Dr 9 completed the 2 HSB/GBHC Convalescence Form, recommending that PTE Lazarus be approved convalescence leave from 4 – 5 Dec 10 inclusive. PTE Lazarus was to report to Doctor 6 at the MHU at 0800 hours on 6 Dec 10.
9.13. PTE Lazarus completed an ADF leave application (AD 097) on 4 Dec 10. The application was for convalescence leave for the period 4 – 5 Dec 10, with a return to duty on 6 Dec 10. The "recommending officer" section of the AD 097 was not completed. The leave was authorised by SNCO 2 Duty Officer, 6 RAR on 4 Dec 10.

9.14. As required, PTE Lazarus reported to duty MO, Doctor 10, on 6 Dec 10. Doctor 10's Continuation Notes make no mention of a suicide risk assessment. He noted Doctor 8 was to review PTE Lazarus on "27.12.10".

9.15. Also on 6 Dec 10, Consultant Psychiatrist, Doctor 8, provided a written opinion.

9.16. Doctor 8 reported that PTE Lazarus "described the development of depressive symptoms over the last few months, but with background symptoms of dysthymia over several years". Doctor 8 opined that PTE Lazarus had a major depressive illness, and stated that PTE Lazarus was "not fit for work" and that he was "happy for Private Lazarus to stay at home in the care of his parents.

9.17. In fact, Doctor 8 saw PTE Lazarus the next day, 7 Dec 10. In his Specialist Report provided on the Form PM 526, Doctor 8 stated that PTE Lazarus was settling, and can “go on con leave to parents”. Doctor 8 stated that PTE Lazarus was not fit for work, and was to be reviewed in one week's time.

9.18. PTE Lazarus also saw duty MO, Doctor 11, on 7 Dec 10. Dr noted Doctor 8's recommendations as to convalescence leave. He also noted that PTE Lazarus denied any suicidal or self-harm ideation, and recommended convalescence leave, with review on 14 Dec 10, and a review by Doctor 8 on 9 Dec 10. PTE Lazarus did not complete a form AD097 leave application for convalescence leave.

9.19. There are no further GBHC/MHU records until 22 Dec 10.

9.20. PTE Lazarus did not attend for the scheduled review appointment at the MHU on 14 Dec 10. The MHU was unaware that PTE Lazarus had failed to attend

301 'Dysthymia': A mood disorder characterised by chronic mildly depressed or irritable mood often accompanied by other symptoms such as eating and sleeping disturbances, fatigue, and poor self-esteem. Merriam-Webster's Medical Desk Dictionary, Revised Edition (2002). See also Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth edition, Text revision, at pages 376-381.
9.21. the MHU review appointment. 6 RAR was also unaware that PTE Lazarus had missed the appointment.

9.22. PTE Lazarus' "Inpatient Medical Record" discloses no further record of any further consultations with Doctor 8 until 22 Dec 10.

9.23. Doctor 8's evidence to the COI was that he continued to see PTE Lazarus regularly, and last saw him on 23 Dec 10 which was the last working day before Christmas 2010. His further evidence was that he regarded PTE Lazarus as his private patient on referral from the ADF on 3 Dec 10.

9.24. On 22 Dec 10, PTE Lazarus reported to duty MO Doctor 12 at GBHC, for a review of the convalescence leave. Doctor 12's Continuation Notes indicate that Doctor 8 had been seeing PTE Lazarus twice weekly. Doctor 12 noted that PTE Lazarus denied any thoughts of self-harm or suicide. She also noted that the longer-term plan was for PTE Lazarus to see a psychologist at the MHU on 5 Jan 11. PTE Lazarus was to remain on convalescence leave until the end of stand down. Doctor 12 recommended convalescence leave until 5 Jan 11, with a review to be conducted on that day by the 6 RAR Regimental Aid Post (RAP).

9.25. Doctor 12 also noted that it was necessary to back-date the convalescence leave to 14 Dec 10. She completed a 2 HSB/GBHC Convalescence Form, recommending leave for the period 14 Dec 10 – 5 Jan 11, with review at the sick parade on 5 Jan 11, 1000-1100 hr. She also completed a PM101 Form, recommending convalescence leave for the same period.

9.26. Also on 22 Dec 10, PTE Lazarus completed an AD 097 leave application for convalescence leave, backdated to 14 Dec 10, for the period 14 Dec 10 – 5 Jan 11. SNCO6, Platoon Sergeant, Rear Details recommended the leave that same day. The convalescence leave was authorised by Officer 2, OC Rear Details.

**Events from 23 Dec 10 to 5 Jan 11**

9.27. The treating Psychiatrist, Dr. 8, last saw PTE Lazarus on 23 Dec 10. Dr. 8 was due to see PTE Lazarus again on 10 Jan 11 and 15 Jan, but
PTE Lazarus was unable to attend because of the Brisbane Floods.

9.28. On 5 Jan 11, PTE Lazarus attended the MHU for an appointment with psychologist, Officer 18. He also had an appointment with duty MO, Doctor 12, for the review of his convalescence leave.

9.29. Officer 18 reported that PTE Lazarus presented with a bloody eye. He lacked eye contact throughout the session, was in a flat mood, and non-talkative. Officer 18 reported that answering questions appeared to be an effort, and PTE Lazarus often stared into space and asked for questions to be repeated.

9.30. As to his work situation, PTE Lazarus told Officer 18 he was second-guessing his enlistment in the ARA and did not know what to do about seeking discharge or improving his situation. Officer 18 recorded:

"he was quite anxious about the conclusion of his conv leave and having to return to work as he believes other members of 6 RAR know that he was in hospital after overdosing. He believes he will not be chosen for courses or for potential deployments because of the incident."

9.31. Officer 18 also noted that PTE Lazarus admitted some fleeting thoughts of suicide by overdose but denied any immediate thoughts/plans. An intervention safety plan was agreed and no written plan was developed. Officer 18 said the suicide plan was an agreement between PTE Lazarus and himself only. Officer 18 recommended PTE Lazarus continue the sessions with psychiatrist, Doctor 8, and a follow up session with a psychologist. Officer 18 did not access PTE Lazarus’ entry medical records, which would have revealed pre-entry risk conduct and a history of an ongoing mood disorders.

9.32. After seeing Officer 18, PTE Lazarus was reviewed by the duty MO, Doctor 12. She also noted the bloody eye. Doctor 12 recorded that PTE Lazarus was ‘happy’ with the appointment with the psychologist, that he disclosed no current self-harm or suicide thoughts, and that there was a safety plan in place. Doctor 12 noted that PTE Lazarus ‘needed continuity with RAP Dr’, and recommended convalescence leave continue, for review by the 2 HSB RAP at 1300 hours.

9.33. Doctor 12 completed the 2 HSB/GBHC convalescence form, indicating that
PTE Lazarus was to report to the Hospital Office at 1120 h on 19 Jan 11 for a medical review with Doctor 12. Doctor 12 also completed a Form PM101RE, recommending 15 days convalescence leave from 5 Jan 11–19 Jan 11.

9.34. Also on 5 Jan 11, PTE Lazarus completed a Form AD097, Leave Application, for convalescence leave from 5 – 19 Jan 11. PTE Lazarus did not sign the form. Rear Details Sergeant, 6 RAR, SNCO 2, recommended the leave. SNCO 2 marked the form with a notation ‘discussed with member’ and signed the form as recommended. OC 6 RAR Rear Details, Officer 12 approved the leave.

**The personal loan**

9.35. On Friday 7 Jan 11, PTE Lazarus applied for a personal loan from the Graceville Branch of the Commonwealth Bank. The loan was for $5000.00 repayable on a fortnightly basis over a period of two years.

9.36. **Mother** states that PTE Lazarus obtained the loan without advising her, as she controlled his bank-book. She states that from the time he took out the loan, he reconciled with everyone from his past and took everyone in his life out for a good time. **Mother** said that she found out after PTE Lazarus had died that he had changed his bank account password, which she assumed because he did not want her to know about the personal loan. She found out about the loan after PTE Lazarus’ death when she received the Commonwealth Bank correspondence in the mail.

**Tue 18 Jan 11**

9.37. **Father** reported that he had heard it either from his son, or from PTE Lazarus’ friends, that PTE Lazarus had it in his mind that he was to go back into the Army the next day. **Mother** was in Canberra playing in a [redacted], On the evening of 18 Jan 11, **Father** took his son, and PTE Lazarus out to dinner. **Father** said there was:

"no question that when we went out to dinner he (PTE Lazarus) was anxious about the next day. It was like he was on edge."

9.38. Later that evening, **Father** saw PTE Lazarus writing in a journal. **Father** assumed PTE Lazarus was doing something he had been asked to do by the psychiatrist.
Wed 19 Jan 11

9.39. \textcolor{red}{Father} last saw PTE Lazarus alive at approx 1100 hours on 19 Jan 11, when he heard his son leave the family home by the front door. \textcolor{red}{Father} reported that PTE Lazarus was out of bed reasonably early on the morning of the 19th, which surprised \textcolor{red}{Father} because he understood PTE Lazarus' medical appointments at Enoggera were not until 1300 h. PTE Lazarus told his father that he was going to the Base earlier to get a haircut, and he declined his father's offer to drive him to the Base, saying it would mean his father would have to wait around for over an hour.

9.40. \textcolor{red}{Father} recalls that he said to PTE Lazarus:

"Jake, I've heard this story about the thought, that you think you are going back into the Army... That's not true. You are not going back into the Army until that psychiatrist says you're fit."

9.41. According to \textcolor{red}{Father}, it was:

"like he wasn't hearing any of that, it was just going right past him. It was not sinking in at all."

9.42. The Queensland Police Report to the Queensland Coroner notes that at about 1250 hours on Wed 19 Jan 10, a passer-by found PTE Lazarus hanging by a rope from a tree at the Sherwood Arboretum. The Autopsy Report records the cause of death as 'hanging'. The time of death is recorded as being between 1130 h and 1300 h on Wednesday 19 Jan 11.

**CO 6 RAR's response to PTE Lazarus' suicide attempt on 24 Nov 10**

9.43. A QA was undertaken on 26 Nov 10, following receipt of the advice on 24 Nov 10 that PTE Lazarus had been admitted to the Wesley Hospital (then transferred to the RBWH) following a drug overdose.

9.44. On the same day as the QA was conducted, in accordance with D1(G) PERS 16-26, the CO 6 RAR established a Risk Management Team (RMT). CO 6 RAR stated 'due to hospital tempo', no GBHC medical representatives were available. The RMT comprised CO 6 RAR; RSM 6 RAR; Adj MTF 1, and Nursing Officer. The RMT noted that, at the time the RMT met on 26 Nov 10, PTE Lazarus...
was still an in-patient at the RBWH. The CO 6 RAR directed that:

"Rear Details 6 RAR is to be involved in any convalescence leave approval for PTE Lazarus over the course of block leave. No leave is to be approved without visibility of the next appointment or review by treating medical professionals....a unit welfare board will be conducted early in 2011 to determine any further unit action informed by medical treatment in the intervening period."

9.45. CO 6 RAR held the view that it was satisfactory for Nursing Officer Officer 23 to liaise between the GBHC and the Unit. He considered there was sufficient medical support to allow PTE Lazarus to be discharged into the care of his family on convalescence leave. He commented that in making his decision, he was aware Mother was a registered nurse.

9.46. CO 6 RAR noted that, at the time of PTE Lazarus’ suicide attempt, MTF 1 had only just returned from Afghanistan. There had been a welcome home parade in Brisbane on Sat 20 Nov 10, and block leave was to commence on Sat 4 Dec 10.

Findings of fact

9.47. PTE Lazarus was seen by eight different duty MOs over eight days during the periods 25-26 Nov 10, 1-7 Dec 10, and on 22 Dec 10;

- The Continuation Notes for 25 Nov 10 state that the RMO 6 RAR, Officer 9, “was aware of the patient”;
- RMO, 6 RAR, Officer 9, had no medical oversight of PTE Lazarus once he was admitted to the MHU GBHC on 25 Nov 10;
- All duty MOs were civilian contractors;
- PTE Lazarus was admitted to the MHU at the GBHC;
- None of the duty MOs at the GBHC had specialist training in psychiatry or psychology;
• The MHU MO, Doctor 6 worked at the MHPS for the period Nov – Dec 10 only;

• Doctor 6, MHU MO was a GP with no mental health specialisation;

• All duty MOs apparently proceeded on the basis that PTE Lazarus' risk of a further suicide attempt was "low";

• With the exception of Officer 18, no duty MO evidenced a systematic approach in a written risk assessment of PTE Lazarus;

• PTE Lazarus' risk assessment of "low" would not activate a MEC review;

• Doctor 8 expected PTE Lazarus to be downgraded to MEC J31 because he had been hospitalised and prescribed antidepressants;

• Continuation notes disclose that the assessment of PTE Lazarus further risk of suicide was largely based on PTE Lazarus' self-disclosure in response to questions of the duty MO;

• No duty MO acted on Doctor 8's Specialist Reports PM 526 of 3 Dec 10, and 7 Dec 10, provided to the MHU at the time, and placed on PTE Lazarus' Inpatient Clinical Record, to the effect that PTE Lazarus was "not fit for duty";

• No duty MO placed PTE Lazarus on sick leave as being "not fit for duty" as identified by Doctor 8 (rather than convalescence leave);

• No duty MO's Continuation Notes record any follow-up medical treatment of PTE Lazarus in light of the toxicity affecting his liver arising out of the drug overdose;

• No duty MO referred PTE Lazarus for a MEC review arising from his hospitalisation at the Wesley Hospital/RBHW for the drug overdose, or for his being held on the MHU at the GBHC for the issue of depression and suicide risk;

• PTE Lazarus' failure to attend a convalescence review appointment on 14 Dec 10 was not noted or followed up by either the MHU GBHC, or Rear Details, 6 RAR;
• On 26 Nov 10, the CO 6 RAR caused a Quick Assessment to be conducted; and

• On 26 Nov 10, the CO 6 RAR established a Risk Management Team (RMT) in accordance with DI(G) PERS 16-26, *Management of a suicidal episode in the Department of Defence*.

9.48. The above circumstances, when combined, point to an inadequacy in terms of continuity of medical care between the time of PTE Lazarus' attempt to take his life on 24 Nov 10, and his suicide on 19 Jan 11.

**Relevant policies**

**Introduction**

9.49. Defence Instructions (DI) are made pursuant to s 58B of the *Defence Act 1903*. They are legislative in character, being sub-delegated legislation. Their terms can be mandatory or directory, depending both on the terms of the Instruction, and the policy topic. They are issued under the authority of the CDF and the Secretary of Defence in accordance with their powers under s 9A of the *Defence Act 1903*.

9.50. DI take precedence over other policy documents within the ADF.

9.51. Health Directives are policy directives. While the application of Health Directives may be considered to be mandatory, Health Directives are not legislative in character, and do not override DIs.

9.52. In the event of inconsistency between DI and a Health Directive, the terms of the DI prevail.

9.53. Depending on their terms, DI will apply to members of the ADF and/or to the wider civilian elements of the wider Australian Defence Organisation.

**Policies governing risk assessment of ADF members at risk of suicide**

9.54. The risk assessment of an ADF member who is at risk of suicide is governed by:

• Health Directive 294, 11 February 2010 – *Suicide Risk Assessment and Management in the Australian Defence Force for Primary Care Providers* (HD 294);

• DI(G) PERS 16-26 – *Management of a suicidal episode in the Department of Defence*;
• DI(G) PERS 16-20 — Sick leave and convalescence and

• Peripherally, DI(G) PERS 15-16 Australian Defence Force Medical Employment. In 2010, the extant policy was promulgated in AMDT 2 to the DI(G).

9.55. HD 294 is addressed to Mental Health Professionals and Mental Health Specialists.

9.56. Mental Health Professionals are those with tertiary qualifications who provide mental health services. The definition includes MOs, Nursing Officers, Psychologists and Social Workers.

9.57. Mental Health Specialists are those practitioners who have post-graduate qualifications and who provide complex mental health services to ADF members. This includes psychiatrists and psychologists with post-graduate qualifications.

9.58. It is pertinent to note that the definition of ‘Mental Health Professional’ does not mandate that the person have a mental health specialisation.

9.59. HD 294 provides that a suicide risk assessment is one component of a comprehensive clinical mental health assessment. Any member who has engaged in non-fatal suicidal behaviour, has reported suicidal ideation, or who is suspected of being at increased risk of suicide must receive a thorough suicide risk assessment, in accordance with prescribed guidelines, risk assessment guidelines, and procedures at Annex B to the Directive.

9.60. The prescribed guidelines refer to Treatment Protocol Project (2004). Management of Mental Disorders (fourth edition, Sydney, World Health Organization, Collaborating Centre for Evidence in Mental Health Policy, Chapter 1, section 1.1.3.

9.61. The Directive further provides that an ADF member who is assessed as being at medium or high risk of suicide must be referred to a MO for an assessment and review of the member’s medical employment classification (MEC).

9.62. HD 294 does not mandate a timeframe for the conduct of the risk assessment. However, HD 294 provides that at-risk members are to be managed in accordance with DI(G) PERS 16-26.

9.63. DI(G) PERS 16-26 mandates that the ‘at risk’ member is to be presented to a Medical Officer (MO) who is to immediately refer the member to a Mental Health Professional for a comprehensive suicide risk assessment. In the absence of an MO, the ADF member is to be referred immediately to a Mental Health Professional using Form PM008.
9.64. Where the Mental Health Professional’s assessment indicates the individual is at risk of suicidal behaviour, the relevant Commanding Officer is to convene a Risk Management Team (RMT) within 24 – 48 hours of the suicide attempt. The RMT is to include the ADF member’s ‘treating Mental Health Professional and treating MO’.

9.65. The RMT is to establish a ‘Crisis Management Plan’ (CMP). The ‘treating MO’ is to act as the liaison between the RMT and the ADF member for the purpose of communicating the intentions of the CMP. The treating MO is to complete the CMP on behalf of the team following each RMT review meeting, and is also to finalise section 3 of the CMP when the case closes.

9.66. The term ‘Mental Health Professional’ is defined by reference to DI(G) PERS 16-24 Mental Health Provision in the Australian Defence Force. DI(G) PERS 16 – 24 provides that a Mental Health Professional is the same as that prescribed in HD 294.

9.67. DI(G) PERS 16-21 relevantly provides that convalescence leave for ADF members who have mental health conditions may only be recommended to the ADF member’s commanding officer by a MO, using Form PM101 “Medical or Dental Fitness Advice”. The leave approving authority is the member’s Commanding Officer.

9.68. Convalescence leave must only be recommended if the ADF member remains under active medical treatment, and the treating MO considers the ADF member is not fit to live independently (that is, the member cannot live alone). An ADF member on Convalescence leave is considered to remain under the health management of the ADF Health Facility. That aspect notwithstanding, the administration of an ADF member on convalescence leave remains the responsibility of the ADF member’s parent Unit.

9.69. Convalescence leave is not an automatic entitlement following hospitalisation. Defence members on approved convalescence leave must
not return to duty until formally discharged from inpatient care.

9.70. DI(G) PERS 16-21 provides that sick leave (as opposed to convalescence leave) for a period greater than four continuous weeks, is a trigger for a MEC review and a rehabilitation assessment by the ADFRP. The sick leave policy also provides that an ADF member who has been absent on sick leave for more than four weeks must have a MEC review before returning to work.

9.71. Significantly, it is not clear whether or not the policy on sick leave also applies to convalescence leave. The relevant distinction between convalescence leave and sick leave is that the former is defined as a gradual recovery to health and strength after an illness where as ‘sick leave’ is defined as an approved period of absence from duty when a Defence member is too ill or injured to work. Convalescence leave implies that the ADF member is no longer ill, but is yet to regain perfect health and strength.

9.72. Accordingly, any absence on convalescence leave of greater than four weeks may not necessarily trigger a MEC review.

9.73. DI(G) PERS 16-15 relevantly provides that, as a general principle, the MEC (and any associated employment restrictions) is to be assessed as part of an ADF member’s health care, and should be considered when an ADF member is hospitalised.

9.74. In accordance with DI(G) PERS 16-21, an absence from duty on sick leave for 28 days would trigger a MEC review. It is not clear whether an absence from duty on convalescence leave for 28 days would trigger a MEC review.
PTE LAZARUS COI REPORT

SECTION 10: TOR 12 (d)

COMMUNICATION BETWEEN
COMMANDING OFFICER (CO) 6 RAR
AND MEDICAL PROFESSIONALS

10. The COI was tasked with identifying and gathering evidence, and making findings as to whether, prior to commencing his leave in December 2010, the CO 6 RAR was apprised of a psychiatric diagnosis and prognosis provided by Doctor 8, and if not, why he was not so apprised, and whether the response by the CO 6 RAR was appropriate.

Findings of fact

CO 6 RAR's knowledge of Doctor 8's diagnosis and prognosis

10.1. The CO 6 RAR was not apprised of Doctor 8's diagnosis or prognosis when he commenced his leave in Dec 10.

10.2. The CO 6 RAR's knowledge at the time block leave commenced (on Sat 4 Dec 10) was that PTE Lazarus had consulted psychiatrist, Doctor 8, and that he was to continue to consult with Doctor 8 over the coming weeks. The CO 6 RAR stated:

"I knew that a psychiatrist had been engaged, that he'd been for his initial appointments, and I knew it was highly likely that the member would be discharged to his family, because his family were in Brisbane, and I also knew from my interaction from my nursing officer that the member's mother was a qualified, I think, a registered nurse."

10.3. CO 6 RAR had no visibility of PTE Lazarus' medical circumstances once PTE Lazarus was discharged from the GBHC on convalescence leave on and from 7 Dec 10.

The appropriateness of CO 6 RAR's response

10.4. On being advised of PTE Lazarus' suicide attempt on 24 Nov 10, CO 6 RAR caused a Quick Assessment to be conducted.

10.5. In accordance with DJ(G) PERS 16 – 26, CO 6 RAR established a Risk Management Team (RMT) within the mandated period of 24 – 48 hours after PTE Lazarus' suicide attempt.
10.6. The RMT was, however, non-compliant with the mandated policy in that:

a. The membership of the RMT did not accord with the policy in that it failed to include PTE Lazarus' treating Mental Health Practitioners and his treating MO. The RMT was unable to establish an effective relationship with the treating Mental Health Professionals.

b. The membership of the RMT reflected administrative needs of the Unit rather than establishing a communication mechanism between the Unit and GHBC.

c. The CO 6 RAR had no visibility of PTE Lazarus from 26 Nov until 1 Dec, when PTE Lazarus was an in-patient at a civilian hospital, and therefore the RMT could not properly fulfil its function.

d. The CO 6 RAR was unable to obtain information from GBHC medical staff on PTE Lazarus' re-admission at the MHU GBHC on 1 Dec 10 because the GBHC did not to pass on medical information to the member's Unit, and therefore the RMT could not properly fulfil its function.

10.7. On the information available to him, the response of CO 6 RAR was practical, attentive, and the best he could achieve in the circumstances. In some respects, the response did not reflect the purpose to be achieved by Dl(G) PERS 16 – 26, but this was beyond the control of CO 6 RAR.

**Background**

10.8. On 25 Nov 10, PTE Lazarus was admitted as an in-patient at the MHU GBHC. On 26 Nov 10, he was re-admitted to the RBWH for the stabilization of toxicology problems arising from the pharmaceuticals overdose.

10.9. On 26 Nov 10, CO 6 RAR caused a Quick Assessment to be conducted following receiving advice of PTE Lazarus' suicide attempt.

10.10. On 26 Nov 10, CO 6 RAR established a Risk Management Team (RMT) in accordance with Dl(G) PERS 16 – 26.

10.11. On 1 Dec 10, PTE Lazarus was discharged from the RBWH to the MHU GBHC. PTE Lazarus remained at the MHU until Sat 4 Dec 10, when the duty MO recommended he be granted convalescence leave for the weekend, for review at the GBHC on 6 Dec 10. PTE Lazarus remained on convalescence leave from 7 Dec 10 until his death on 19 Jan 11.
**Diagnosis and prognosis**

10.12. The CO 6 RAR was not apprised of Doctor 8's diagnosis and prognosis because the information was not available to him.

10.13. Doctor 8 provided his first form PM 256 “Specialist Report” on Fri 3 Dec 10, stating little more than that PTE Lazarus was “not fit for work”. Doctor 8 provided a second form PM 256 on 7 Dec 10, also stating that PTE Lazarus was “not fit for work”. These PM 526 reports were provided to the MHU GBHC. There is no evidence, and it is unlikely, that this information was ever passed to 6 RAR.

10.14. On 6 Dec 10, Doctor 8 provided a written report, addressed to the “Mental Health Unit, 2 HSB”. He opined that PTE Lazarus had “major depression” and “background dysthymia over several years”. There is no evidence, and it is unlikely, that this information was ever passed on to 6 RAR.

10.15. Doctor 8’s affidavit asserts that he was very confident that the medical people at Enoggera had a very clear view that PTE Lazarus was not going back to 6 RAR, but that the prognosis for PTE Lazarus was more uncertain. Doctor 8 stated that he had formed the view that PTE Lazarus would ultimately discharge from the Army, but he had not yet written to the MHU (GBHC) about that prognosis.

10.16. PTE Lazarus’ death on 19 Jan 11 foreclosed on Doctor 8 formally reporting his prognosis.

**Membership of the Risk Management Team**

10.17. DI(G) PERS 16-26 requires a commanding officer to establish a Risk Management Team (RMT) within 24-48 hours of a relevant incident. The RMT is mandated to include treating Mental Health Professionals and the treating Medical Officer.

10.18. Membership of RMT in the present matter was non-compliant with the policy. The RMT did not include PTE Lazarus’ treating Mental Health Professionals or his treating MO. CO 6 RAR stated that ‘due to hospital tempo, there were no GBHC representatives’ (available). The RMT comprised CO 6 RAR, the RSM 6 RAR, the ADJT MTF 6 RAR and Nursing Officer.

10.19. CO 6 RAR especially noted the need for 6 RAR Rear Details to have oversight of PTE Lazarus’ convalescence leave approvals, and the need to establish a Unit Welfare Board in 2011.
10.20. On including Nursing Officer, Officer 23 in the RMT to liaise with GBHC medical representatives, CO 6 RAR states:

“(I)n practice and in actuality, my nursing officer, who had been involved with the 2HSB and MHBS as, if you like, the link between the unit was effectively used for that purpose. I was satisfied, after she had briefed me, that there was sufficient knowledge and interaction. Noting that MHB/2HSB were also quite busy (at) that point in time so I was quite satisfied that I had the right contacts and the right information flow between us at that point in time”.

10.21. In contrast, Officer 23 evidence was that she assumed 6 RAR was taking care of the normal administrative actions that follow an attempted suicide, but she did not know if any member of 6 RAR had been appointed to a RMT. She stated that 6 RAR understood what had happened to PTE Lazarus because she reported back what she knew. Officer 23 said she was not made aware of an RMT, nor was she part of it.

10.22. RSM 6 RAR, SNCO 1, was similarly unclear as to his role in the RMT. He stated he had been appointed to a “crisis management group”, but he was unsure of its role and the membership of the team. He recalled being told by CO 6 RAR that he wished to be informed of any change in circumstances for PTE Lazarus.

10.23. The “treating MO was not included” in the RMT. The collective evidence is that there were differing views as to who was or should be the ‘treating MO’ – a term not defined in the policy.

10.24. The evidence is that the “treating MO” is pivotal to the efficacy of the successful operation of the RMT. This issue is discussed further at TOR 12(g).

10.25. One view was that the RAP RMO was the “treating MO”. However, for reasons that are not clear, the RMT for PTE Lazarus did not include the 6 RAR RAP RMO, Officer 9. CO 6 RAR’s recollection is that Officer 9 was either attending a course or was already on leave. Officer 23 evidence was that the RMO was at the Unit on 24 Nov.

10.26. Regional Health Director, Doctor 13 observed that Officer 9 was running a very busy RAP, and whenever Doctor 13 saw Officer 9, ‘he was flat out, absolutely flat out’.
10.27. Officer 9's name does not appear on any of PTE Lazarus' Inpatient Clinical Records as the treating duty MO undertaking a clinical role.

10.28. Officer 16 stated that a RMT was not established for PTE Lazarus. He states;

"Generally, it can be somewhat difficult to establish a RMT. This is due to the way things were done at the MHPS, where significant cases are medicalised and managed by the MO, psychiatrists, and clinicians. The outcome in this matter was to remove the person from their immediate stressors and try and resolve the situation."

10.29. Officer 16's view was also reflected by psychologist, Officer 18, who stated that she was not aware whether a RMT had been established for PTE Lazarus. Officer 18 said that she understood PTE Lazarus 'was being heavily medically managed by Medical at the time'. She also stated that she did not have any dealings with 6 RAR.

**Flow of information**

10.30. CO 6 RAR stated that the Nursing Officer, Officer 10, experienced difficulty obtaining accurate medical information from the civilian hospital, other than that PTE Lazarus had taken "a large quantity of aspirin".

10.31. Officer 10 liaised with duty MO, Doctor 5 on PTE Lazarus' admission to the GBHC late on 25 Nov, until PTE Lazarus was re-admitted to a civilian hospital.

10.32. Officer 10 stated that when PTE Lazarus was re-admitted to the GHBC after spending some days in the Royal Brisbane Hospital, she "was no longer in the loop". She said:

"That's the way it works, unfortunately: once the soldier was a patient at the Enoggera Health Centre, 6 RAR RAP was no longer this treating team. So we were not given updates, and not sent through information as to what is happening. His treating team was the Enoggera Health Centre and there is no formal mechanism for any feedback, as such, on a day to day basis as to what is happening with the member. Once Private Lazarus had been transferred to the Royal Brisbane, I lost visibility of him..."

10.33. Officer 10 also opined that in a lot of cases, where ADF members are treated
by a non-uniformed MO, they are told not to go back to the Unit. She said:

"The non-uniform MOs often do not understand the military system – and we can't get information as to what's going on because the MO treats it as medical-in-confidence', and does not speak to the unit."  

10.34. Examination of PTE Lazarus’ Inpatient Clinical Records discloses no notation of any communications with 6 RAR concerning PTE Lazarus, other than a observation in the Continuation Notes for 25 Nov 10 by duty MO, Doctor 5, that Officer 9 was aware PTE Lazarus was at the GBHC.  

10.35. The SNCO 1, said that the (poor) flow of information was probably why the Risk Management Team could not function. He said:

"...two things probably didn’t work; firstly, to my understanding, there was no medical advice direct from the MHU to input into any of our meetings or discussions. Secondly, to my knowledge, there was a failure somewhere to inform the CO that PTE Lazarus had been released.

On the whole, the unit CO is responsible for his personnel. At the moment, the CO is being taken out of the loop to a large degree. A CO won’t get hold of information so he can make a proper informed decision."

6 RAR’s loss of visibility of PTE Lazarus

10.36. SNCO 2 was 2IC of 6 RAR Rear Details when PTE Lazarus commenced convalescence leave. He was responsible for approving extensions to PTE Lazarus’ convalescence leave. He said that PTE Lazarus only attended 6 RAR when he required approval for extension of his leave.

10.37. In his oral evidence, SNCO 2 made the point that PTE Lazarus had not been “internally posted” to the Rear Details element because he had not been, MEC downgraded, nor had he had not been referred to an ADF Rehabilitation Program. That being the case, there was no “trigger” to bring PTE Lazarus to SNCO 2’s attention within Rear Details – beyond the fact SNCO 2 was administering his convalescence leave.

10.38. CO 6 RAR confirmed that, ‘as a rule of thumb’, a soldier had to be downgraded to MEC J31 to be moved into the reinforcement platoon for
rehabilitation purposes.

10.39. SNCO 2 observed that the Unit loses all visibility of a member if there is no case manager. He said that it would have been very helpful if PTE Lazarus had had a case manager.
PTE LAZARUS COI REPORT

SECTION 11: TOR 12 (e)

ASSESSMENT FOR SUICIDE RISK

11. The COI was tasked with identifying and gathering evidence, and making findings as to whether PTE Lazarus was formally assessed for suicide risk in accordance with the applicable policy, and whether that suicide risk assessment identified the appropriate level of risk.

Findings of fact

Primary findings

11.1. PTE Lazarus was not formally assessed for suicide risk in accordance with applicable policies within the timeframe of 24-48 hours after admission to the MHU GBHC.

11.2. CO 6 RAR is not correct in his belief that a suicide risk assessment had been conducted by the GBHC Mental Health Professionals. The referral of PTE Lazarus to Doctor 8 did not constitute a suicide risk assessment in accordance with the relevant policies.

11.3. In the absence of a comprehensive suicide risk assessment, the RMT established by CO 6 RAR was unable to promulgate a ‘Crisis Management Plan’ (CMP).

11.4. Officer 18 had only been commissioned in the Army in Nov 10. She had been granted provisional registration as a psychologist in 07 and full registration in 09. Accordingly it is arguable that Officer 18 was not sufficiently experienced to undertake the risk assessment of PTE Lazarus on 5 Jan 11.

11.5. On 5 Jan 11, Officer 18 did not ascribe a level of risk to PTE Lazarus.

Supplementary findings

11.6. No single MO can be regarded as PTE Lazarus’ ‘treating MO’ or ‘case manager’, with the result that no MO can be said to have been responsible for carrying out the suicide risk assessment upon PTE Lazarus’ admission to the MHU GBHC.
11.7. The categorisation of risk of suicide as 'low' appears to lead to an assumption that PTE Lazarus was no longer at risk of a further attempt at suicide and therefore did not warrant the development of a risk management plan.

11.8. It is not certain that either the DI or HD 294 are legally binding on contract health practitioners, therefore it cannot be established that any MO had an obligation to conduct the suicide risk assessment of PTE Lazarus.

11.9. Each and every duty MO who treated PTE Lazarus while he was an in-patient at the MHU GBHC, was qualified, in accordance with the relevant policies, to conduct a comprehensive suicide risk assessment of PTE Lazarus.

11.10. No MO who treated PTE Lazarus conducted a comprehensive suicide risk assessment in accordance with the relevant policies.

11.11. The assessments actually undertaken by the duty MOs did not constitute a comprehensive suicide risk assessment as envisaged by the relevant policies.

11.12. No duty MO attributed a level of risk of suicide to PTE Lazarus during his time as an in-patient at the MHU GBHC.

11.13. PTE Lazarus appears to have been assumed to be at a 'low' level of risk of a further suicide attempt, based entirely on his self-disclosure.

11.14. The relevant policies do not appear to permit a Mental Health Professional to delegate the responsibility to conduct a comprehensive suicide risk assessment to a consultant psychiatrist.

11.15. PTE Lazarus’ In-patient Clinical Records do not include a copy of the referral notes to consultant psychiatrist, Doctor 8. It is therefore not possible to ascertain whether Doctor 8 was requested to conduct a comprehensive suicide assessment of PTE Lazarus on behalf of the GBHC.

11.16. On PTE Lazarus being referred to Doctor 8 on 3 Dec 10, PTE Lazarus became Doctor 8’s private patient. Any clinical notes made by Doctor 8 were not made available to the MHU.

11.17. Doctor 8’s diagnosis, provided to the MHU GBHC on 6 Dec 10, was that PTE Lazarus was suffering a "major depressive disorder". Doctor 8 did not disclose whether he made a formal assessment of PTE Lazarus.

11.18. PTE Lazarus’ admission to Ward 1, GBHC, after his discharge from the RBWH on 1 Dec 10, was in the nature of a "stop-gap measure," pending Doctor 8’s further directions. Duty MOs do not appear to have exercised any
independent case management of PTE Lazarus (such as placing him on sick leave, or initiating a MEC review arising out of his hospitalisation from the pharmaceutical overdose.

11.19. Officer 18 undertook the first comprehensive suicide risk assessment of PTE Lazarus, consistent with the relevant policies, on 5 Jan 11.

11.20. Officer 18 did not consult with the referring MO, (Doctor 12), on the outcome of her suicide risk assessment as she did not believe her assessment would add value to PTE Lazarus’ medical management.

**Policy requirements**

11.21. DI(G) PERS 16 – 26 provides that where an ADF member has engaged in a suicide attempt, the ‘at risk’ person is to be presented to a MO who is to refer the member to a Mental Health Professional for a comprehensive suicide risk assessment. Where a MO is not available, an ADF member can be referred directly to a Mental Health Professional by means of a Form PM008.

11.22. A RMT is to be established to develop a Crisis Management Plan (CMP) for the case management of the “at risk” member. The RMT is required to monitor and case manage an ADF member who has attempted suicide until the member is deemed by the RMT to no longer be at risk.

11.23. HD 294 provides that any ADF member who has engaged in a suicide attempt must receive a thorough suicide risk assessment in accordance with Chapter 1, section 1.1.3 of Treatment Protocol Project (2004). Management of mental disorders (fourth edition), Sydney, World Health Organisation, Collaborating Centre for Evidence in Mental Health Policy. However, the guidelines together with comprehensive clinical mental health assessment procedures, are then provided in Annex A to HD 294.

11.24. The Annexes to HD 294 set out the factors to be taken into account when conducting a suicide risk assessment.

11.25. The directive provides where an ADF member is assessed as being at medium risk, a risk assessment is to be conducted by the member’s case managing MO within 24 – 48 hours of discharge from an in patient facility.

11.26. An ADF member assessed as being at a medium or high risk of suicide may be
admitted to a health facility or a civilian hospital. A further risk assessment should be conducted within 24 – 48 hours of the initial assessment, with face-to-face assessment conducted at least twice weekly.

11.27. Any member considered to be at a medium or high level of suicide risk must be referred to an MO for a further assessment and review of the member’s MEC. Members assessed as being at a medium or high risk must be assessed and clinically case managed by the MO, with specified clinical records to be retained in the member’s UMR.

11.28. Where an ADF member is assessed as being at a low risk, the member is to be managed as an out-patient. The policy particularly notes that the member does not require admission to a health facility. An ADF member assessed as being at a ‘low’ risk of a further suicide attempt must undertake a review risk assessment on a weekly basis.

11.29. Further, where a member considered to be at low risk, Mental Health Professionals and Specialists are to provide specified clinical records to the MO, including the comprehensive initial assessment report to the MO for inclusion in the member’s UMR.

11.30. Di(G) PERS 16-21 provides that a MEC review must be undertaken where an ADF member has been absent on sick leave for 28 days.

11.31. Di(G) PERS 16-15 requires a MEC review to be undertaken where an ADF member has been admitted to an ADF Health Facility, or has been hospitalised.

**Extent of the duty MOs suicide risk assessments of PTE Lazarus on his admission to the MHU GBHC**

11.32. 25 Nov 10: Doctor 5 recorded that PTE Lazarus “was feeling OK now, no suicidal ideation, feels ‘embarrassed’”.

11.33. 26 Nov 10: Clinician Defence civilian 3: “Denies self-harm/suicide/ aggression... now embarrassed”.

11.34. 26 Nov 10: Doctor 6: “Patient denies any current suicidal thoughts/intent; polite, co-operative”.

11.35. 1 Dec 10: duty MO: “Nil suicidal thoughts currently; co-operative; not feeling down...Denies any depressive or anxiety feelings.”
11.36. 2 Dec 10: Clinician Defence civilian 3: "Denies any further/present risks of self-harm / suicide / aggression".

11.37. 2 Dec 10: Doctor 7: "No suicidal / self-harm ideation/plans".

11.38. 3 Dec 10: Doctor 6: "Denies any suicidal thoughts".

11.39. 4 Dec 10: Doctor 9: "Con leave discussed with patient".

11.40. 7 Dec 10: Doctor 11: "Member denies any suicidal or self-harm ideation and feels much better than before his polypharmacy overdose on 24 Nov 10".

11.41. On 7 Dec 10, PTE Lazarus commenced convalescence leave at this parent’s home.

11.42. All duty MOs relied entirely on PTE Lazarus self-disclosure, coupled with references to PTE Lazarus being in the care of Consultant Psychiatrist, Doctor 8. (The Commission observes, that in the circumstances, this may not have been unreasonable, given Doctor 8’s extensive experience.)

11.43. No duty MO ascribed to PTE Lazarus a level of risk vis-à-vis a further suicide attempt.

11.44. Further, no duty MO undertook any process to identify whether PTE Lazarus was vulnerable to any risk factors not disclosed by PTE Lazarus himself. Present risk factors included a diagnosis of major depression and a recent suicide attempt, associated with having consumed excessive alcohol.

11.45. HD 294 lists factors that are indicators of a significant risk of suicide. In that regard, there is no evidence that any duty MO considered PTE Lazarus’ entry medical records, which disclose risk factors identified by HD 294, namely, self-applied cigarette burns, consumption of excessive alcohol at age 15, impulsiveness, and frustration when bored. However, Psychiatrist, Doctor 2, in a report dated 28 Apr 09, prepared to ADF Recruiting, stated:

"There was no evidence of any major psycho pathology in... his episode of cigarette burns does not appear to represent a self-harming attempt. I would not attach great significance to this."

11.46. Finally, no duty MO referred PTE Lazarus to a psychologist for a comprehensive suicide assessment.

**Medical staff knowledge of relevant policies**

11.47. The MOs who had contact with PTE Lazarus were not called to give oral evidence, so the Commission is unable to make a finding as to their individual level of knowledge and understanding of obligations pursuant to DI and ADF policies.
11.48. As outlined, it is unclear whether, as civilian contractors, they would be bound by DI and policy in any event.

11.49. Based on the duty MO’s medical notes, it is open to infer that no duty MO was aware of the need to conduct a risk assessment where an ADF member has attempted suicide.

11.50. The Regional Director of Health, Doctor 13 made the general point that the duty MOs at the GHBC were not mental health specialists. Doctor 13 also talked about MOs generally wanting to avoid dealing with mental health cases.

11.51. The Regional Director of Health said:

"Again, it’s a difficult thing when you are dealing with contractors, and I’ve got to say its against my own profession, that doctors are like herding cats; they’re difficult to get to do things, and they’re very independent thinkers... and you can reiterate and reiterate the requirement for appropriate documentation and sometimes, a lot of the time, they continue to do what they want to do."

11.52. In the case of Doctor 6, who was the MO at the MHU at the time of PTE Lazarus admission on 25 Nov 10, she was employed as a contract locum GP for a period of six weeks only, during Nov - Dec 10.

11.53. The Regional Director of Health Doctor 13, stated that Doctor 6 was not the treating MO for PTE Lazarus, but had acted in a liaison role in referring in MHU patients to other Mental Health Professionals or Specialists. Doctor 13 agreed that Doctor 6 would not have had an opportunity to become familiar with relevant DI during her short period of employment.

11.54. Doctor 13 also said that Doctor 6 was meant to be the person who provided the continuity of care for the mental health aspects of a member’s overall health, on the basis that the GP who referred the person to a specialist was the appropriate case co-ordinator.

11.55. However, as Regional Health Director, Doctor 13 observed, MOs within MHU were not mental health specialists, and, by circumstance of their being a GP, they became proxy GPs in the MHU, but separated from frontline GP practice. Doctor 13 said that a circumstance had developed where some GPs became ‘quite belligerent’, and something of a law unto themselves, about how a person with a mental health issue was handled. The MO position has
since been removed from the MHU, so the GP can now be the case co-
ordinator.

The role of the GBHC Army psychologists

11.56. Officer 16 and CAPT Officer 18 were aware of and did seek to apply the
relevant policies.

11.57. Officer 16 was the OIC, Mental Health and Psychology Section (MHPS) at the
time PTE Lazarus was an in-patient at the MHU. 440 He is a generalist
psychologist 441 who has been registered since 2004.

11.58. Officer 16 was not involved in the case management of PTE Lazarus on his
admission to the MHU. He stated that, at the relevant time, two civilian MOs,
Doctor 6 and Doctor 14 shared the one MHU duty MO role. He said that both
doctors had since left Defence.

11.59. Officer 16 had read the relevant DI and Health Directives. He was aware of
their nature and function, and their relationship to each other. He stated that
he is not aware of Treatment Protocol Project (2004). Management of mental
disorders (fourth edition), Sydney, World Health Organisation, Collaborating
Centre for Evidence in Mental Health Policy prescribed by HD 294. Officer
16 said that any risk assessments he has conducted at the MHPS have
followed the guidelines set out in HD 294 and the DI.

11.60. Officer 16 was of the view that PTE Lazarus’ referral to Doctor 8 satisfied the
policy obligation of DI(G) PERS 16-26, because Doctor 8 conducted a
"psychiatric" assessment of PTE Lazarus. He opined that there was limited
use in conducting another psychological assessment, and that because PTE
Lazarus’ management:

"was being driven by medical...his MO and consulting psychiatrist", it
was very difficult for other allied professionals to argue against the
treatment, given that a psychiatrist has a lot more influence in the
medical hierarchy that a psychologist".

440 Note: At some point in 2010, the MHU became the MHPS. Colloquially, the
section is still known as the MHU.

441 Note: For the purposes of this Report, a “generalist psychologist” is one holding
general registration with the Psychology Board of Australia (PBA), but not
endorsement in a PBA–approved specialist area of practice such as clinical,
organisational or health psychology, at the material time.
11.61. Officer 18 had only been commissioned in the Army in Nov 10, and was posted to the Psychology Unit at the GBHC. Her supervisor was Officer 16. Officer 18 is a generalist psychologist, who had been granted provisional Registration in 2007, and full Registration in 2009. At the material time, she was a relatively inexperienced Psychology Officer.

11.62. Officer 18 was aware of the relevant DI and Health Directives. She stated that she did not see any clients for the first few weeks after her arrival at the MHPS. She spent that time "reading big chunks of information without applying what I was reading to situations". She said she still refers to the policies as they have a depth of information in them. Officer 18 did not fully understand the relationship of the DI to the Health Directives.

11.63. Officer 18 conducted a psychological assessment of PTE Lazarus on 5 Jan 11, some six weeks after he had attempted suicide, on 24 Nov 10.

11.64. Officer 18 commenced practice as a generalist psychologist in 2007. She stated that, in her civilian employment prior to joining the Army, she had dealt with 'maybe one or two' cases where a client was at significant risk of suicide or self-harm. She said that PTE Lazarus was the first case she had encountered since joining the ADF (only weeks earlier to the events in question). PTE Lazarus was allocated to Officer 18 by being 'booked in my calendar by the administrative staff'.

11.65. Officer 16 stated that Officer 18 was selected to conduct the suicide risk assessment:

"because she was the only resource available at that time, and because she was a uniformed psychologist who would understand how the case would fit into overall management in Defence...She had also been ASIST trained, and ASIST was our primary method of conducting a risk assessment at that time".

11.66. The Regional Director of Health, Doctor 13, made the point that Officer 18 was an organisational psychologist doing what is clinical work.

11.67. Officer 18's Psychological Assessment Report suggests that she systematically canvassed pertinent issues raised by the policy guidelines in her risk assessment of PTE Lazarus. She noted specific risk factors.

11.68. In the conclusion to her Report, Officer 18 stated concerning PTE Lazarus:

"Whilst he has denied immediate risk of suicide at this time, his
previous attempt/self harming behaviour and use of alcohol increases the future risk.

However, Officer 18 did not attribute a specific level of suicide risk.

11.69. Amongst other things, PTE Lazarus told Officer 18:

"...that he was quite anxious about the conclusion of his con leave and having to return to work as believes other members of 6 RAR know that he was in hospital after overdosing. He believes he will not be chosen for courses or for potential deployments because of the incident."

11.70. Finally, Officer 18 stated that she never had a role in MEC reviews, and had not thought of referring PTE Lazarus for a MEC review. She said that "at the time I was still getting my head around all the policies and the terminology."

11.71. On the general issue of recognising potential risk triggers, Doctor 8 opined:

"Ultimately, it depends hopefully on the skill of the treating mental health practitioner and if that person is more experienced, hopefully that practitioner can pick up on things a less experienced practitioner may miss. It's not a scientific task; warning bells may go off in my head that just don't go off in someone else's head. That makes the process very much dependent on the qualifications and experience of the treating practitioner...if people do not tell you the truth for whatever reason, at some point you've got to play your hunches."
12. The COI was tasked with identifying and gathering evidence, and making findings as to whether, in respect of 6 RAR’s role in approving convalescence leave for PTE Lazarus, the actions taken were adequate, appropriate and consistent with applicable policy in all the circumstances.

Findings of fact

12.1. The CO 6 RAR did the best he could in all the circumstances. In effect, CO 6 RAR, Officer 21, was handed a fait accompli by the GBHC, which he sought to manage reactively. He had no information available to him, and no mechanism to contribute to the options for PTE Lazarus’ management from a medical perspective.

12.2. The GBHC did not advise 6 RAR prior to placing PTE Lazarus on convalescence leave.

12.3. Contrary to his understanding and belief, CO 6 RAR, Officer 21, did not have sufficient relevant information for him to exercise his command responsibilities in an informed manner in granting of convalescence leave to PTE Lazarus on 7 Dec 10.

12.4. Had the RMT he had established been able to fulfil its function in accordance with the policy, it is likely it would have quickly become apparent (to the RMT and Officer 21) that PTE Lazarus should have been on sick leave rather than convalescence leave.

12.5. It is possible that CO 6 RAR, Officer 21, in direction, that the Unit must have visibility of PTE Lazarus by requiring his attendance at 6 RAR before any approval convalescence leave, was deleterious to PTE Lazarus. In any event, the Unit had no visibility of PTE Lazarus from 7 Dec 10 when he was granted ongoing convalescence leave.

12.6. There was no system in place to contemporaneously identify that PTE Lazarus had failed to attend the medical appointment, scheduled for 14 Dec 10, for the review of his convalescence leave.

12.7. 6 RAR’s administrative approval processes for convalescence leave otherwise
complied with the relevant policy.

12.8. Officer 21 first concern was that PTE Lazarus not be discharged from the civilian hospital, of his own volition, without reference to his Unit.

"The reason I assigned and directed Officer 23 to go to the (civilian) hospital in the first instance was (because) of my concerns based on prior experience ...that there needed to be an ADF point of contact, preferably from the unit, at the hospital, because what I was most in fear of, having seen this before, is that the hospital would discharge a soldier full stop once they believed that the immediate threat (of suicide) had dissipated... therefore I directed Officer 23 to go down there to make sure we could bring the soldier back to either the RAP, but preferably straight down to... the GBHC".

12.9. Officer 21, the CO 6 RAR, was aware that, on PTE Lazarus' admission to the GBHC on 25 Nov 10, the GBHC medical staff were focussing on concerns arising out of the pharmaceutical overdose, and that the GBHC did not conduct an assessment with a mental health practitioner at that time.

12.10. At much the same time, Officer 21 established the RMT in accordance with DI(G) PERS 16-26. However, the RMT had no medical information upon which to make a Crisis Management Plan, other than that provided by Officer 23 who "reported what she knew" back to the Unit.

12.11. Officer 10 lost track of PTE Lazarus after he was re-admitted to the RBWH on 26 Nov 10. She was unsure how long PTE Lazarus was back at the RBWH, or when he transferred back to the GBHC. Officer 10 said:

"At that time, I was no longer in the loop. That's the way it works, unfortunately. Once the soldier was an inpatient of the Enoggera Health Centre, 6 RAR RAF was no longer his treating team."

12.12. Officer 21 was of the belief that when PTE Lazarus was admitted to the GBHC the second time, the ADF or civilian Mental Health Practitioners assessed his level of suicide risk. In fact, this was not the case (see TOR 12(e)). PTE Lazarus remained as an inpatient of the GBHC from 1 – 7 Dec 10 until medical staff, on the recommendation of Doctor 8, arranged for his discharge on convalescence leave.
12.13. Officer 21 was entitled to rely upon GBHC conducting assessments of PTE Lazarus in accordance with the relevant policies. The evidence with respect to TOR 12(e) is that this did not occur. What did occur was something less than a comprehensive suicide risk assessment.

12.14. Of the RMT, Officer 21 conceded that it was “probably fair to say, (the RMT was) ad hoc”. This was because PTE Lazarus was being treated in a civilian hospital. SNCO 1, a member of the RMT, said:

“The team/group was not aware PTE Lazarus had been released on Convalescence leave. (When we convened, PTE Lazarus was in hospital and being managed as an inpatient). We then went on Basic Recreation Leave (BRL). Sometime during the BRL, PTE Lazarus was released from hospital, but no-one in the unit, to my understanding, was aware of that – they didn’t tell us .... the granting of convalescence leave was probably a medical decision. We never got told he was going to be released. I never knew he was going to be released”.

12.15. At the time Block Recreation Leave (BRL) commenced on Sat 4 Dec 10, Officer 21 stated that PTE Lazarus had consulted a Psychiatrist, and that PTE Lazarus was to continue to consult with the Psychiatrist over the coming weeks. Officer 21 stated:

“I knew that a psychiatrist had been engaged, that he’d been for his initial appointments, and I knew it was highly likely that the member would be discharged to his family, because his family were in Brisbane, and I also knew from my interaction from my nursing officer that the member’s mother was a qualified. I think, a registered nurse.”

12.16. On 29 Nov 10, Officer 21 gave the direction to 6 RAR Rear Details that the Rear Details was to be involved in approving convalescence leave over the BRL period, and that:

“No leave is to be approved without visibility of the next appointment or review by treating medical professionals”.

**Unit visibility of PTE Lazarus while he was on convalescence leave**

12.17. The evidence is that there was no system in place to contemporaneously identify that PTE Lazarus failed to attend medical appointments on 14 Dec 10 for review, and the extension on his convalescence leave.

12.18. Except for the duty MO’s medical notes for 22 Dec 10, which state “con leave
backdated; pt missed appt due to double appts booked”, there is no record in 6 RAR of PTE Lazarus having been required to attend the GBHC on 14 Dec 10, or who he was to see.

12.19. The Unit processed the necessary forms at the times PTE Lazarus attended 6 RAR, but they had no visibility of his schedule of appointments, nor a follow up system to ensure PTE Lazarus attended at the appropriate times.

12.20. The Unit saw its role to be largely limited to processing the paperwork. In his oral evidence, Officer 21 referred to the close attention he paid to ensuring compliance with his instructions concerning PTE Lazarus, noting that his recollection was that OC Rear Details, Officer 2, telephoned him on the Unit’s receipt of the first convalescence leave application. Except for some minor clerical errors, the paperwork for the grants of convalescence leave was efficiently completed and the processes applied were compliant with the policy and the CO’s instructions.

12.21. Of the Unit’s responsibility for PTE Lazarus, Rear Details CSM, SNCO 2, said that he made no inquiries about PTE Lazarus because “At the time, you could say it was none of my business” for the reason that PTE Lazarus had not been internally posted to Rear Details and he had not been medically downgraded. Nor indeed, had PTE Lazarus been referred to an ADF Rehabilitation Program, which would have provided a trigger for SNCO 2 to take a closer interest.

12.22. SNCO 2 made the further point that a Unit loses all visibility of a member on convalescence leave, unless the member has a case manager. His evidence was that PTE Lazarus did not have a case manager. He said:

“(It) (visibility) can be very difficult. You know, I can recall a couple of times where months would go by and, you know, other things take priority, and it would take quite a while to get to the bottom of exactly where someone was and what was going on. So the fact that the unit remained responsible, but not really empowered to enact, I suppose, that responsibility, is very difficult”.

12.23. It mattered that Officer 21 was not aware of the approval PTE Lazarus’ Convalescence leave

12.24. Officer 21 sought to achieve some visibility of PTE Lazarus during his absence on convalescence leave by directing that he attend the Duty Room at 6 RAR following each medical appointment at the GBHC for the extension of his leave.
12.25. Officer 21 was unaware:

a. A comprehensive suicide risk assessment of PTE Lazarus was not undertaken by the MHU GBHC until 5 Jan 11 (see TOR 12(e)), and

b. that PTE Lazarus had a pre-entry history of risk behaviours.

12.26. Even if PTE Lazarus’ suicide risk assessment determined that he was at a “low” risk of a further suicide attempt, that assessment was not a predictor of future conduct; it was only a snapshot in time. (In any event, Doctor 8’s view was that PTE Lazarus was very unwell, the prescription of anti-depressants being just the first step in his treatment of PTE Lazarus, which would be longer term.)

12.27. No MEC review had been initiated by the MHU GBHC or the Unit, as required by DJ(G) PERS 16 -15.

12.28. Mother had told Officer 10 that she had not nursed since she’d had children, and she was concerned about PTE Lazarus being placed in her care because she felt she could not keep him safe. (RMO, Officer 9 observed that, even if Mother had some sort of nursing experience, unless she was a mental health nurse or had some mental health training, being a nurse would not necessarily assist. He said that depression and suicide are very specialist fields.)

12.29. Doctor 8 had told the GBHC that he considered PTE Lazarus was “not a good fit for the Army” and that PTE Lazarus “would not be returning to 6 RAR” and that PTE Lazarus was “terrified of going back” to 6 RAR.

12.30. Doctor 8 was the only medical practitioner who had continuity of visibility of PTE Lazarus from 7 Dec 10 when he went on convalescence leave; that continuity was severed by the event of the ‘Brisbane Floods’ in Jan 11, a week prior to PTE Lazarus’ death. Officer 21 did not know these things and could not know some or all of these things, nor their significance, because the GHBC did not tell him.

12.31. Had Officer 21 been aware of Doctor 8’s view that PTE Lazarus was unsuited to regimental life, or of PTE Lazarus’ discomfort at visiting the Unit, he may well have not have required PTE Lazarus to attend 6 RAR personally.
for the renewal of his convalescence leave approvals. PTE Lazarus' found the requirement to attend 6 RAR to be stressful. His father's evidence is that when he took his son to 6 RAR on 22 Dec 10, PTE Lazarus found it highly stressful, saying to his father "I will get a hard time here."

12.32. PTE Lazarus' close friend, [redacted], drove PTE Lazarus to a review appointment for convalescence leave. He said that PTE Lazarus was reluctant to see the Sergeant who had to sign off on the convalescence leave. [redacted] said it was the Sergeant with whom PTE Lazarus had had some differences. (The Sergeant whose signature appears on the Convalescence leave forms dated 4 Dec 10, 22 Dec 10, and 5 Jan 11 is SNCO 2).

12.33. PTE Lazarus had told Doctor 8 that he was "petrified of (SNCO 2)."

12.34. As to the concerns that PTE Lazarus had expressed to others about SNCO 2, Lead Counsel Assisting has submitted that it is not possible to find that SNCO 2 acted in any inappropriate way towards PTE Lazarus. Indeed, the evidence strongly suggests to the contrary, namely, that SNCO 2 is someone who has a particular interest in pursuing fair outcomes for his subordinates. Why it was that PTE Lazarus may have apparently held a negative view of SNCO 2 is not clear. It may be the case that SNCO 2 was simply a figure of authority. As Counsel Assisting submitted, these are matters of conjecture.

12.35. With respect, the Commission shares the views of Counsel Assisting.
PTE LAZARUS COI REPORT

SECTION 13: TOR 12 (g)
ADEQUACY OF CURRENT ADF POLICY

13. The COI was tasked by TOR 12 (g) with identifying and gathering evidence, and making findings as to whether at material times, the applicable policy was adequate, particularly with respect to issues (1) to (6) therein. Those issues are dealt with in seriatim.


**Primary findings**

13.1. The policies give rise to mutually exclusive interests: DI(G) PERS 16 – 26 vests responsibility for the welfare of ADF members in command, whereas the centralised garrison support model vests responsibility in a fragmented ‘consumer driven’ civilian contract health delivery service which operates independently of the Chain of command.

13.2. There is a gap between the needs of ADF members with respect to mental health care, and the availability and suitability of services and facilities available in the wider civilian community.

13.3. The evidence has disclosed a degree of failure by the Enoggera Health Centre and civilian contract duty Medical Officers at the MHU GBHC to adhere to ADF policies and practices designed to protect ADF members who have attempted suicide or are engaging in suicidal ideation, specifically:

- The failure of the MHU GBHC to undertake a comprehensive risk assessment of PTE Lazarus within 48 hours of PTE Lazarus’ admission to the GBHC on 1 Dec 10 after his discharge from the Royal Brisbane and Women’s Hospital; and

- Proceeding on an assumption that PTE Lazarus’ risk of suicide was “low”. However, as outlined in paragraph 12.27 herein, any assessment was not a predictor of future conduct, it was only a snapshot in time.
**Supplementary findings**

13.4. The evidence identified by the COI suggests that, while responsibility for the welfare of ADF members vests in Command, current arrangements are such that Command no longer ‘owns’ or controls the capability necessary to deliver the policy outcome.

13.5. Civilian health contractors do not appear to be legally bound to apply ADF mental health policies, or if they are legally bound, are not applying ADF policies designed for the protection of ADF members who have attempted suicide or are engaging in suicidal ideation.

13.6. Contract medical practitioners treat the individual ADF member as a private ‘consumer’ of medical services.

13.7. Civilian health contractors’ professional rules of medical confidentiality have the effect that the health practitioners do not consider that they have any obligation of disclosure to the ADF about an ADF member in their care.

13.8. The complexity and burden of the policy framework creates its own resource and compliance difficulties for the ADF.

**Commentary**

13.9. Regional Health Director, South East Queensland, Doctor 13, told the COI that the ADF is struggling to deal with mental health issues. He said there is presently disengagement between the medical system and ADF Units.

13.10. According to Doctor 13’s evidence, there is a need for a holistic Defence-wide approach to the issue of mental health issues, covering recruiting, resourcing and the structure of the mental health services.

13.11. The Regional Director of Health, Doctor 13, said people are being accepted into the ADF who have pre-existing psychiatric, psychological and personality disorders, which the organization is unable to handle because there is *no one size fits all* response to each of the cases. Resourcing in mental health is at minimal levels.

13.12. The Regional Director of Health, Doctor 13’s evidence is that the GBHC has struggled with an increasing number of low to moderate psychiatric problems within a facility that does not suit. Doctor 13 said the expectation is that where a CO is concerned about a member’s mental state, the CO can refer the member to the Enoggera Hospital, and can expect the Enoggera Health Centre to admit the member.
13.13. The COI is aware that COMD HQ 7 BDE, sees a need for a small, properly designed mental health ward at Enoggera. However, Joint Health Command has directed the GBHC to provide outpatient mental health services only.

13.14. 6 RAR RMO, Officer 9, said the MHU at Enoggera was a very limited service, but he had occasion to refer high-risk ADF members to the GBHC (Ward 1). Officer 9 said he faced the difficulty that what the Army considers as high-risk does not accord with the civilian equivalent, yet the expectation is that Army looks after the soldier’s entire welfare. He said the issue with inpatient mental health care is that they need a higher level of supervision, and sometimes this requires locked wards so that soldiers at risk don’t self-discharge.

13.15. To demonstrate the difficulties he faces, the Regional Director of Health, Doctor 13, spoke of a situation in Townsville where a very sick young ADF member with mental health and drug and alcohol issues had assaulted a couple of people in the Townsville Hospital. The ADF member had to be removed from that hospital and put into the Lavarack Barracks health care facilities. Doctor 13 said he was concerned for the wellbeing of his own staff. He outlined his conversation with Joint Health Command as follows:

"(Doctor 13) I'm just letting you know, Ma'am, that this is the case that we've got at hand and he's in Lavarack (there being no private mental health facilities in Townsville).

Reply: What's he doing in that unit? What's he doing - I've told you that we don't admit any mental health patients (as) inpatients to our unit".

(Doctor 13) Well, Ma'am, he needs it because he's unwell and we've got nowhere else to put him".

Reply: What's he doing in our unit? I told you not to put any mental health patients in our unit.

(Doctor 13) Ma'am, he's actually quite unwell. We need to keep him in hospital.

Reply: 'But what's he doing in our ....'

13.16. With the assistance of the police and others, the Regional Director of Health, Doctor 13, managed to transfer the patient into the care of the patient's parents at The next day Doctor 13 received a telephone call from a caller who was concerned about the safety of the ADF member's family. The caller asked Doctor 13 what he was doing about maintaining a positive control
over the patient, to which Doctor 13 replied:

"Positive control over a guy who's a psychotic drug user? Are you kidding? No-one's got any positive control over him."

13.17. Doctor 13 said that mental health issues affecting ADF members are qualitatively different from the issues facing the wider community. Consultant psychiatrist, Doctor 8, agreed with Doctor 13.

13.18. Doctor 8 said that civilian mental health hospitals have no interest in treating ADF members because the State psychiatric systems are set up to treat people with chronic, severe psychiatric illnesses, like schizophrenia and bi-polar disorders. State facilities have no experience in dealing with military members.

13.19. Doctor 8 pointed to the circumstance where a person was not well enough to go home, yet the ADF's current solution (of admitting them to a psychiatric hospital):

"...is entirely inappropriate because, contrary to popular belief, if you go into a psychiatric hospital, you can actually learn bad habits, you can get worse, that's the real problem. So, that's the subtlety that's been lost."

13.20. Doctor 8 said the new outsourced health model does not and will not work, because an ADF member who is not sufficiently unwell to be admitted to a civilian mental health facility, may be discharged back into the wider community, or back to the lines at Enoggera and living by themselves, "and that's a real problem." While someone in the situation of PTE Lazarus might be placed in the care of his family, a member without family nearby has no place to go.

The complexity of the inter-related policy framework

13.21. The Chief of Staff HQ 7 Bde commented upon the complexity of the policy guidance, referring to the number of instructions, the fact that policies are not necessarily complementary, and that some policies do not give guidance on how to manage a situation on behalf of a CO.

13.22. To illustrate this point, the Chief of Staff HQ 7 Bde suggested that DI(A)
PERS 33-11 *Army Casualty Administration Support and Framework* may transition into a case of convalescence leave rather than a casualty, with resulting confusion as to how an ADF member with a health issue is to be managed.

13.23. Chief of Staff HQ 7 Bde also suggested one consolidated DI with annexures should be developed to cover all instances that might affect a member, rather than dealing with the issue by medical classification. For example, the issue may be *managing a seriously injured, ill or wounded ADF member*, rather than focussing on the nature or classification of the medical health or mental health issue the particular member is facing, including attempted suicide or suicidal ideation.

**TOR 12 (a) (1) (a):** The appropriateness of a Risk Management Team as the mechanism to establish a Crisis Management Plan.

**Primary finding**

13.24. The policy construct that requires a commanding officer to establish a Risk Management Team (RMT) to devise a Crisis Management Plan (CMP) within 24-48 hours of an ADF member attempting suicide cannot work in all circumstances. This is because the policy is inconsistent with the organisational arrangements for the delivery of medical services to ADF members who are suffering mental health issues.

**Supplementary findings**

13.25. The concept of a RMT to establish a CMP is generally appropriate, but is not easily adapted to the more complex cases.

13.26. The efficacy of a RMT is dependent upon the commanding officer having command and/or control over the medical capability to meet the policy obligations of DI(G) PERS 16 – 26.

13.27. The CO should have access to adequate medical information, particularly any relevant prognosis.

13.28. Organic first-line medical support is pivotal to an RMT being able to obtain timely and appropriate medical information.

13.29. The RMT process focuses on the ADF member’s suicidal episode in isolation of the member’s underlying mental health issues.

13.30. The policy is resource intensive.

13.31. The RMT process does not envisage an ADF member being hospitalised in a civilian hospital for emergency treatment for physical injuries arising out of
the suicidal episode.

13.32. There is a policy overlap between the role of Welfare Boards, and the RMT process outlined in DI(G) PERS 16-26. Within Army, Unit or Formation Welfare Boards provide an established, robust and mature process for the management of Army personnel with significant health issues, including mental health issues.

**Commentary**

13.33. Medical witnesses were positive about the policy. Doctor 8 considered the policy framework for managing ADF members who are suicidal to be appropriate, but believed that the policy needs to be better articulated. Mental health practitioners, Officer 16 and Officer 18, were of the view that the policy framework and intent are appropriate.

13.34. The Regional Director of Health, Doctor 13, also considered the policy to be sound if it is applied as intended, but in his experience he is not seeing RMTs being formed. Similarly, Officer 18 said the problem with the policy was that it was not being applied as often as it should. Officer 18 was of the understanding that RMTs were initiated and led by MOs, not realising the policy provides that commanding officers are to initiate RMTs. Doctor 13 also said the policy should be "driven by the Commanding Officer, as it's supposed to be.""

13.35. However, CO 6 RAR, Officer 21 observed that while the policy set out in DI(G) PERS 16-26 is laudable, 'it is hard to apply practically' for the reasons that the commanding officer does not own or control the policy levers. He submitted that policy sounds grand – 'a caring and sharing environment or the members' welfare' – but that it establishes a process but does not provide any semblance of a solution.

13.36. Officer 21's opinion is that the policy is more suited to low grade suicide ideation or less serious suicide attempts, where the ADF member has not been admitted to hospital and the Unit has the first contact with the member, thus the Unit "has the levers" to convene the RMT.

13.37. CO 6 RAR, Officer 21 observed that in PTE Lazarus' case, the RMT was difficult to achieve because the episode occurred on the cusp of the BRL Christmas stand-down, and concurrently with the Welcome Home Parade in Brisbane following the return to Australia of MTF1. He said it was
not possible to convene the RMT in the manner mandated by DI(G) PERS 16-26.

13.38. CO 6 RAR, **Officer 21** further submitted that, with the removal the Unit’s first line medical support Regimental Medical Officer (RMO), the policy now relies entirely in its operation on delivery by third party civilian medical practitioners who are not only not within a CO’s Chain of command, but also, not even within the ADF medical system’s direct control. He questioned how, under the contract arrangements, an RMT could be established within 24-48 hours of a suicide event.

13.39. Officer 16 agreed with CO 6 RAR, **Officer 21** saying that he considered the RMT process could not work because there were too many civilian contractors working on a part-time basis, making it difficult to bring treating practitioners into the risk management team.

**Individual or Unit Welfare Boards**

13.40. **Officer 21** considered that an Individual Welfare Board to be the more appropriate mechanism to consider a person in PTE Lazarus’ situation, because once PTE Lazarus had been re-admitted to the GBHC after spending time in a civilian hospital, the immediate crisis had passed. He was of the view that for the medium or longer term planning, the RMT and the IWB processes are very similar and the policies ‘begin to merge’. **Officer 21** focus was on the establishment of a Unit Welfare Board for PTE Lazarus after the Christmas BRL as being a more appropriate means of managing PTE Lazarus.

**Resources**

13.41. **Officer 21** submitted that the policy pre-supposes that the CO has been provided with the necessary resources to undertake the policy obligations. He noted that the OIC, 1 Psych Unit, Brisbane Detachment, Officer 16, had described his staffing levels at the time of PTE Lazarus’ suicide attempt as ‘inadequate’ or ‘under resourced’. Officer 16 expressed the view that the resourcing situation had not improved with the transfer of the psychologist functions to Joint Health Command, with emphasis being on clinical work at the expense of organisational referrals.

13.42. The Chief of Staff HQ 7 Bde said that the bulk of the work for the management of personnel in a Unit falls to the Adjutant, the Chief Clerk and
the RSM. In a Unit of 800 or more members, compliance with policy and reporting obligations (of the RMT) is a significant impost, which is over and above their other Unit responsibilities.

**TOR 12 (g) (1) (b)**: The role of the treating medical officer.

**Primary finding**

13.43. The role of the ‘treating medical officer (MO)’ is central to the efficacy of the policy, as the interface between the Unit and civilian mental health practitioners and specialists.

13.44. The extant policy assumes organic first-line medical support through a uniformed Regimental Medical Officer (RMO).

13.45. The extant policy does not define the term ‘treating medical officer (MO)’.

13.46. There is a multitude of views as to who is, or should be, the ‘treating MO’.

13.47. The ‘treating MO’ should be in a position to disclose relevant medical information about an ADF member to the Unit.

**Supplementary findings**

13.48. It was highly significant that:

- There was no single ‘treating MO’ to provide oversight and continuity of care at the Gallipoli Barracks Health Centre (GBHC), with the result that consultant psychiatrist, Doctor 8, became the default reference point for continuity of treatment; and,

- PTE Lazarus was not referred for a Medical Employment Classification (MEC) review, because he did not have one single treating MO with the clear responsibility for initiating the MEC referral.

**Commentary**

13.49. Regional Health Director, Doctor 13 stated that “In retrospect, (what went wrong for PTE Lazarus was) the lack of continuity of care, the general practitioners were changing around.” Doctor 13 agreed that continuity of care is the hallmark of a good health system. He made the point that the time of year (the cusp of the Christmas BRL) is always problematic, when:

“...we don’t have the same staff on the floor, we have different doctors around, we use what we can use, and do what we can do.”
13.50. Eight duty MOs attended to PTE Lazarus during his eight-day stay as an in-patient at the MHU GBHC. The documentary evidence is that none of the duty MOs at the GBHC considered him or herself to be PTE Lazarus' 'treating MO'.

13.51. The 6 RAR RMO, Officer 9, did not consider himself to be the 'treating MO'. Officer 9 said that once a patient is admitted to the GBHC, the patient becomes the responsibility of the admitting or treating doctor at that time.

13.52. Those who did have a role in the management of PTE Lazarus had differing views as to who was or should be the 'treating MO':

- Officer 9, considered the treating medical officer to be the civilian doctor, Doctor 15, because PTE Lazarus was admitted directly to the Mental Health Unit (MHU) at the GBHC and Doctor 15 was in charge of the MHU.

- Psychologist, Officer 18, considered the treating medical officer to be the 'duty MO' who referred PTE Lazarus to her for an appointment on 5 Jan 11 for the suicide risk assessment. The medical records indicate that the duty MO for 22 Dec 10 was Doctor 12, whose medical notes include a notation that a psychologist appointment should be arranged.

- The OIC 1 Psych, Brisbane Detachment, Officer 16, considered the 'treating mental health professional' to be consultant psychiatrist, Doctor 8, and the 'treating medical officer' to be the MHU duty MO, Doctor 6, as she received the initial referral of PTE Lazarus from 6 RAR.

- Regional Health Director, Doctor 13 considered the referring GP to be the treating MO, because that person has responsibility for the ongoing care of the member. In Doctor 13's view Officer 9 was the referring GP. He considered that MHU duty MO, Doctor 6 could not have been the treating medical officer because she was not the primary or first referral MO. Doctor 13 considered Doctor 6's role to be one of liaison. He held this view despite being aware that Officer 9's name
did not appear on any of the GBHC medical notes concerning the daily management of PTE Lazarus.

13.53. The Regional Director of Health, Dr. 13, said that the (management) directives he had received as the Director of Medical Services at Enoggera had said that the General Practitioner (RMO) was to be the case manager of the patient. However, Dr. 13 said that, in practice, the general practitioners found patients with mental health issues to be too difficult or time-consuming to manage, so they referred the patients to the MHU. He noted the MHU was not staffed by mental health practitioners, but by general practitioners with an interest in mental health issues.

13.54. The documentary evidence is that duty MO general practitioner, Dr. 5, was the first MO at the GBHC to see PTE Lazarus. Officer 10, 6 RAR Nursing Officer at the material time, said that she arranged for PTE Lazarus to see Dr. 5, and "it was quite a wait". It would appear from Dr. 5's medical notes that she did not consider herself to be the 'treating MO'.

13.55.Commenting on the new Joint Health Command garrison support "clinic" model, the Regional Director of Health, Dr. 13, considered it to be "a real problem that commanding officers have lost a medical person in their units".

TOR 12 (g) (1) (c): Discretion to vary the makeup of a Risk Management Team.

Finding

13.56. The efficacy of the extant policy is dependent on it not being open to a CO to vary the membership of the Risk Management Team (RMT).

13.57. The policy is not sufficiently flexible to accommodate circumstances where the staff mandated by the policy either are not available, or are not available within the timeframe mandated by the policy.

13.58. The Commission is of the view that, ultimately, the function of an RMT is to essentially assess and mitigate risk; the means by which it does so should be a discretion for the commanding officer.

Supplementary findings

13.59. The policy design is such that it is only with the participation of the designated mental health professionals and the treating MO, in conjunction with the Unit, that the policy is viable and effective in communicating relevant information in one forum, to that extent it is inflexible and unrealistic.
13.60. The policy does not address the role of the Unit in the RMT process.

13.61. The policy does not take into account that medical stakeholders external to the Unit are not necessarily available, or available within the mandated policy timeframe of 24 – 48 hours after the ADF member has attempted suicide, to attend an RMT.

13.62. The policy does not take into account reduced availability of medical staff and the treating MO during reduced tempo or stand-down periods, or in the absence of the treating MO (assuming the treating MO is the RMO).

13.63. The policy is not compatible with the (new) centralised garrison support civilian health practitioner contractor model.

Commentary

13.64. The Co 6 RAR, Officer 21 said that in providing for a multidisciplinary team, the current policy incorrectly assumes all stakeholders will be available within the mandated timeframe, and also incorrectly assumes the availability of resources and facilities. He said that current Joint Health Command contract arrangements made the process even more problematic.

13.65. In PTE Lazarus’ case, the only person who had relevant information to pass on to CO 6 RAR about PTE Lazarus’ circumstances was the off-base civilian Consultant Psychiatrist, Doctor 8. However, Doctor 8’s participation was not mandated by the policy. Moreover, Doctor 8 indicated he sent the MHU a written report about PTE Lazarus, and had attended clinical meetings at Enoggera. However, in the absence of a designated treating MO, no GBHC duty MO performed that function for PTE Lazarus for the purpose of the policy. Doctor 13 confirmed that the Christmas BRL is a difficult time for the GBHC because of reduced staffing – that ‘it’s very hit and miss about who’s around’.

13.66. The CO 6 RAR, Officer 21 said the policy is not prescriptive of the role of individual members of the RMT, nor does it offer any suggestions as to the role of individual members of the RMT. He also said the policy is not prescriptive about the role a Unit can play in the process, as opposed to the role of medical staff. He said the Unit is important, because the soldiers are well known to command. He recounted a circumstance where he, as CO, successfully mentored soldiers who had been suicidal who had sought his personal assistance, and to demonstrate that the Unit has a real and meaningful role to play in the process.

13.67. The Regional Director of Health, Doctor 13, expressed the view that
commanders should drive the RMT.

13.68. The Chief of Staff 7 Bde observed that every Unit, including HQ 7 Bde, will promulgate a reduced tempo or a stand-down instruction, and rely on the Duty Officer system where there is a need to respond to an incident in the stand down period. He stated that the Unit can always draw together the key (Unit or military) staff or stakeholders, but the same cannot be said for external (civilian) stakeholders.

**TOR 12 (g) (1) (d):** The situation where an ADF member is initially in the care of a civilian health facility prior to the ADF becoming aware of a non-fatal suicide attempt.

**Finding**

13.69. The policy wrongly assumes the Unit has immediate visibility of the relevant conduct.

13.70. The policy wrongly assumes the Unit is notified of the attempted suicide.

13.71. A Unit is in danger of losing visibility of the member who is admitted for treatment to a civilian hospital.

**Supplementary finding**

13.72. The policy does not accommodate the circumstance of an ADF member initially being in the care of a civilian health facility in relation to a health matter, of which an attempted suicide is but one aspect.

13.73. The policy does not accommodate the circumstance of a civilian hospital releasing an ADF member back into the community on the member’s own recognizance, based on the civilian hospital’s own suicide risk assessment of the member.

13.74. The policy does not accommodate the situation that civilian hospitals are not under any obligation to report to the ADF where a member has attempted suicide.

13.75. The policy cannot operate where an ADF member is being treated as an inpatient of a civilian hospital or by a non-ADF civilian contract doctor.

**Commentary**

13.76. The policy trigger is the non-fatal suicide behaviour. (A commander is then
obliged to convene an RMT within 24-48 hours of the behaviour.)

13.77. It was submitted on behalf of Officer 21 that he was ‘essentially blinded’ from further involvement with PTE Lazarus’ welfare management from 26 Nov 10, when PTE Lazarus was re-admitted to the RBHC. Amongst other things, the submission stated that said that the transfer and re-admission of PTE Lazarus to the RBWH for medical treatment of toxicology issues arising from his overdose:

“removed PTE Lazarus from the military medical system and essentially blinded Officer 21 from further involvement at this time because when PTE Lazarus returned to the GBHC there was no flow of information back to the Unit”.

13.78. With respect, the submission that the re-admission of PTE Lazarus to a civilian hospital on 26 Nov 10 caused Officer 21 to lose sight of PTE Lazarus, is not accepted.

13.79. Rather, it is the opinion of the Commission that what caused Officer 21 to lose sight of PTE Lazarus was, on the one hand, the loss of the RMO’s role as co-ordinating ‘treating MO’ in liaison with the MHU GBHC, and on the other, the GBHC’s apparent policy of not providing the Unit with relevant medical information concerning PTE Lazarus.

13.80. As to the latter aspect, Officer 21 was totally reliant on his Nursing Officer, Officer 10, being able to glean as much information from the GBHC as she could so she might assist the CO.

13.81. Officer 21 was confronted with the practical difficulty that PTE Lazarus’ first admission was to a civilian hospital. Officer 21’s evidence was that his initial concern on being advised that PTE Lazarus had been admitted to a civilian hospital on 24 Nov 10 was that there is no obligation upon a civilian health facility to advise the ADF that an ADF member has been admitted to a civilian health facility. Furthermore, the civilian hospital is not obliged to advise the ADF if the hospital intends to discharge the ADF member on that member’s own recognisance if the civilian hospital assessed the ADF member’s risk of suicide to be low. In this instance, it was critical for Officer 21 to quickly locate the whereabouts of his soldier.

13.82. To ensure he had visibility of PTE Lazarus, Officer 21 directed his Nursing Officer, Officer 10, to go to the civilian hospital to establish an ADF point of contact. Officer 10 accompanied PTE Lazarus from the RBHC for
his admission to the GBHC on 25 Nov 11. Officer 21 said he made sure Officer 10 "was a follower" of the changing circumstances that occurred at the time of PTE Lazarus re-admission to the RBHC.

13.83. Officer 21 faced this dilemma twice. The first occasion was when PTE Lazarus was admitted to a civilian hospital's emergency department on 24 Nov 10. The second was his re-admission to a civilian hospital on 26 Nov 10.

13.84. Officer 21 predicament was compounded because, following PTE Lazarus re-admission to the RBWH, the GBHC did not keep the Unit apprised of PTE Lazarus situation. RMT member, Officer 23 said she was unaware of when PTE Lazarus was re-admitted to the GBHC following his treatment in a civilian hospital for toxicology issues.

13.85. No issue arises from an ADF member having been admitted, or re-admitted to a civilian hospital, provided the Unit has the visibility and continuity of the member's management. Command can refer an ADF member for a comprehensive suicide assessment, either of a CO's own motion (by Form PM008), or through an RMT (in accordance with DI(G) PERS 16–26), on the member being admitted to an ADF Health Care Facility.

13.86. Where an ADF member has attempted suicide away from the base, it is absolutely critical to the efficacy of the policy that the Unit quickly identify and locate the member – preferably before the member is released by the civilian hospital back into the community.

13.87. In PTE Lazarus' situation, Officer 21 action in immediately dispatching Officer 10 and Officer 11 to the civilian hospital avoided the mishandling of PTE Lazarus in the civilian hospital processes.

13.88. In contrast, PTE Lazarus' situation was mishandled in the Enoggera 'military' health facility, and this resulted in the failure to undertake a comprehensive suicide assessment within 24–48 hours of PTE Lazarus' re-admission to the GBHC on 1 Dec 10.

**TOR 12 (g) (1) (e):** The multiple ways in which a member may interact with the ADF medical system.

**Primary finding**

13.89. DI(G) PERS 16-26 is unworkable in the absence of a formally designated 'treating MO' who is legally capable and obliged to report medical information about an ADF member to a military commander.
Supplementary findings

13.90. The extant policy is evidently based on a construct whereby ADF members access the ADF medical health system by presentation to an RAP staffed by uniformed medical support (the RMO).

13.91. RAPs and RMOs having been removed, ADF members now access the ADF medical health system by direct presentation to a centralised garrison support ‘clinic’ or ‘hub’, staffed by contract civilian general practitioners, or directly to the Mental Health and Psychology Section (MHPS).

13.92. The hub/clinic may refer a member on to a civilian health care facility or an off base service nominated by the outsourced health solutions provider.

13.93. Under current arrangements, the individual ADF member is the ‘consumer’ of medical services provided by centralised garrison support hubs/clinics, and outsourced provider. The individual ADF member is no long a beneficiary of organic health care deemed necessary by the institution of the ADF as the consumer of medical health services.

13.94. Hence, commanders have no command or control over the civilian managed general practitioner hubs or clinics, nor service providers engaged under the auspices of the outsourced health solutions provider.

13.95. Senior officers who gave evidence to the Commission do not consider the removal of RMOs to be sound policy.

Commentary

13.96. The Regional Director of Health, Doctor 13, explained the new arrangements introduced by Joint Health Command. He said those arrangements are a refinement of what was already in place at the time PTE Lazarus was an inpatient at the MHU in Dec 2010.

13.97. The Regional Director of Health, Doctor 13, advised that, under the Joint Health Command arrangements, the general practice (GP) area of the Enoggera Health Centre was ‘hived off’, to effectively become a civilian staffed RAP, called the Enoggera Clinic. The Clinic is a ‘hub’, or a stand-alone general practice.

13.98. The new arrangements allow ADF members on base a choice of MO. If the member has no preference, he or she is directed to a particular MO. Doctor 13 said he has briefed his staff as follows:

“We’ve got to make our health service attractive for these people. We’ve got to treat them like you would in a commercial practice. They’ve got to want to come and be served like genuine customers.”
13.99. In the case of a mental health issue, a soldier will see a GP (at a hub) for an initial risk assessment, and if necessary, the ADF member will be referred to the Mental Health and Psychology Section (MHPS – formerly the MHU) where the soldier will be assessed by an intake clinical registered nurse. The MHPS registered nurse is a mental health nurse.

13.100. The soldier may then be assigned to a MHPS psychologist, or referred off-base to the Veterans’ and Veterans’ Families Counselling Service (VVCS), or mental health specialist psychiatrist nominated under the outsourced provider model; or in an extreme case, admitted to a civilian facility under the Queensland Mental Health Act 2000.

13.101. Regional Director of Health, Doctor 13 also said that the soldier could voluntarily present directly at the MHPS (formerly MHU): “It’s the same as in the community.”

13.102. The difference between the new arrangements and those operating at the time of PTE Lazarus’ presentation, is that his admission to the GBHC was directly from a civilian hospital on the basis of a telephone discussion between Officer 9 and the Registrar of the civilian hospital.

13.103. The Regional Director of Health, Doctor 13, acknowledged there is now a gap in the system.

13.104. Recognising that Units no longer have organic medical staff, the Regional Director of Health, Doctor 13, said he has sought to establish a system where civilian hub GPs (MOs) are informally aligned with Units, so that a civilian MO can establish a relationship with a CO/Unit.

13.105. The Regional Director of Health, Doctor 13, acknowledged that he is trying to meet the concerns arising out of the removal of the RMOs. The GP/MO would be a civilian contractor who is the COs point of contact. The aligned civilian GP/MO would also attend Welfare Boards. However, the civilian contractor MO is not under the direct command or control of a commanding officer, as was the case with the uniformed RMOs.

The military response to the centralised garrison support model

13.106. The Chief of Staff HQ 7 Bde said the Army should:

"(D)o away with the Joint Health restructuring and give SMOs back to
13.107. Of the centralising of garrison health support in 2012, Officer 21 called it:

"(A) train smash, and the train was rapidly falling out of the station and heading off the cliff last year with the centralisation of uniformed medics within Forces Command into 17 CSSB, under the Close Health Company construct, at the same time as moving to a contracted garrison health support model."

13.108. Officer 21 expressed concerns about the administrative burden a CO carries where there are significant numbers of medical downgrades, let alone soldiers with on-going mental health issues, which for CO 6 RAR involved some 19 soldiers in late 2010:

"This illustrates a very heavy administrative burden for the unit all round and demonstrates to me why the Army’s APAC model of centralising clerical staff at the same time as centralising uniformed medical staff (into 17CSSB) and taking them away from a first line unit as tantamount to destroying a CO’s ability to carry out their command responsibilities to their soldiers."

The military response to the removal of RMOs

13.109. Officer 21 stressed the significance of a RMO to a command officer. He said that he does not believe civilian contracted health practitioners working for Joint Health Command actually understand, or are even interested in gaining an understanding, of the Unit perspective. He said the value of the RMO was that the uniformed medical practitioner straddled two worlds, the medical world and the battle rhythm and operational life of the Unit. He said the RMO could provide “health intelligence”, and knows when and what to report back to the chain of command, both generally and in particular cases.

13.110. Officer 21 said the RMO was the “family GP” for the regimental family. He commented that his RMO for MTF 1 shared the CO’s own battle legacy of responding to those killed in action, something which cannot be shared by a civilian contact practitioner.

13.111. Officer 21’s view is that the RMO and the RAP were his first line of medical support, with the Enoggera Health Centre being his second line of support. He said the centralised garrison support has caused the first and second lines of support to be blurred. It is his view that while there are benefits in centralised garrison clinics, the system should be complemented if
RMOs were re-introduced to Units.

13.112. Officer 21 said he is very firmly of the view that the Army needs to return uniformed Unit MOs and clerical staff to first line Units as a matter of priority. Without that support, COs will face increasing difficulty in managing complex medical and administrative obligations. Importantly, Officer 21 said that garrison support civilian hub contract practitioners only partially fill the gap. He said that the long-term effectiveness of a Unit relies upon uniformed medical staff to live, work and train with the soldiers they support.

13.113. The evidence of the Chief of Staff HQ 7 Bde was also to the effect that the removal of the RMO has resulted in a CO being without a trusted medical practitioner in his chain of command who can "go and talk the medical talk" to the mental health and medical health practitioners, and then back brief the CO.

13.114. Chief of Staff HQ 7 Bde considers the uniformed RMO to be a critical member of staff who is involved in a commander's planning group for operations. He stated that the loss of the RMO in the Unit means the CO is at the "beck and call" of a medical organization that is not cognisant of how a Unit works, or the nature and scope of a CO's remit.

13.115. This Senior Officer said the medical organization has no direct relationship with the Unit or the CO. The CO now has a reduced ability to be informed, and make decisions, with the result that a CO now has to spend time actively building a relationship with the medical fraternity. The Chief of Staff HQ 7 Bde further stated that a uniformed RMO is fully conversant with the pressures, that a CO and his chain of command come under, in the exercise of the duty of care towards their soldiers.

13.116. The Chief of Staff HQ 7 Bde was aware that the removal of RAPs has made the administration of training programs more complex. He gave evidence of an episode that has already arisen, where a commanding officer conducted a risk assessment and identified the level of medical support necessary for a training exercise, only to find 17CSS Brigade second-guessing command. For the training exercise to proceed, it was necessary, for what was an otherwise simple request, for medical support to be elevated to a command-to-command level to ensure appropriate support.

13.117. In the opinion of the Commission, this is an unsatisfactory outcome.
Provision of health services to the ADF under the new arrangements

13.118. The Chief of Staff HQ 7 Bde's evidence was that the relationship between 7 Bde and the ADF medical facilities at Gallipoli Barracks is presently "fairly fractured, bordering on non workable".

13.119. He said the result of a number of different restructuring initiatives, including the removal of the RMOs, is that the Army now has medical practitioners who probably do not have any understanding of the obligations of a commanding officer for the duty of care to their soldiers, and who do not keep the chain of command informed, specifically in the area of mental health.

TOR 12 (g) (1) (f): Part-time medical staff.

Findings of fact

13.120. Defence has an obligation to ensure that the standard of care provided by its contractor/health practitioners is appropriate; otherwise Defence is potentially at risk of exposure to legal liability.

13.121. There is no current mechanism to retain oversight of the ADF member to ensure continuity and coordinated health care management for the member.

13.122. PTE Lazarus had no continuity in his treatment while an inpatient at the GBHC; he was seen by a procession of civilian contract duty MOs working on a job share or locum basis.

13.123. The Enoggera Clinic and the Enoggera Health Centre continue to be staffed by contract medical practitioners on a part-time and/or locum basis. Accordingly, it is arguable that the situation which confronted PTE Lazarus will be repeated.

13.124. It is not clear whether civilian contract medical staff at the Enoggera Clinic or the Enoggera Health Centre are contractually bound and legally obliged to apply any ADF medical management policies.

13.125. The centralised garrison approach to the provision of health services at Enoggera has undermined a commanding officer's capacity to fulfil his or her command function of being responsible for the welfare and administration of the members of his or her Unit.

13.126. Staffing on a part-time or job share basis is a significant problem for the management of files and the development of relationships.

13.127. The model based upon the outsourced civilian contracting on referral from a GP hub located on base is inconsistent with the way complex psychiatric
cases are managed in the non-ADF mental health fraternity.

13.128. The evidence presented to the COI suggests that the outsourced model lacks oversight and coordination for the treatment of ADF members suffering complex mental health issues.

Summary of the evidence

13.129. The evidence pointed to chaotic staffing arrangements at the GBHC at the time of PTE Lazarus’ admission to Ward 1. Both the Regional Director of Health, Doctor 13, and Officer 16 described ongoing changes in organisational structures, commencing in 2009 and continuing throughout 2010 (including the period when PTE Lazarus’ was an inpatient at Ward 1 of the GBHC), and continuing to date.

13.130. The evidence is that the delivery of medical and mental health services by on-base contract medical practitioners has been, and continues to be, unsatisfactory.

13.131. No witness heard by the Commission considered the current outsourced health model capable of delivering the requisite level of mental health care for ADF members.

13.132. There is evidence that the local mental health delivery model which grew out of the apparent need for on-base delivery of mental health care to soldiers at Enoggera has been replaced by an unworkable model. This has resulted in loss of the goodwill and expertise of private practice medical and mental health care specialists who have provided services to Enoggera for many years. The Commission observes that this considerable corporate medical knowledge and expertise now appears to have been lost to the ADF.

13.133. The evidence suggests that the current health services model is ill-adapted to the delivery of mental health care to ADF members because it provides inadequate oversight, co-ordination or continuity of treatment. The model adopts a ‘consumer’ approach to the provision of medical services to the ADF member, with no means of providing command with any visibility of the member.

Staffing arrangements at the time of PTE Lazarus’ admission to the GBHC and after

13.134. PTE Lazarus’ medical notes at the time of his admission to GBHC in Nov 10, disclose that his care was provided by eight different contract medical
practitioners during his eight-days as an inpatient at the GBHC. None of those duty MOs considered themselves to be PTE Lazarus treating GP for the purposes of Di(G) PERS 16 – 26.

13.135. The Regional Director of Health, Doctor 13, confirmed that, at the time, contract medical practitioners, Drs 6 and 14, were sharing one MHU MO position on two/three days each with one day overlap at the time PTE Lazarus’ was an inpatient immediately following his suicide attempt. Doctor 13 also confirmed that the MHU MOs were not specialist trained in psychiatry or psychology, “so we do the best we can.” Doctor 13 said Doctor 6 was a short-term engagement, and that neither Doctor 6 nor Dr 14 are now employed by the GBHC.

13.136. Throughout his evidence, the Regional Director of Health, Doctor 13, lamented the difficulties he faces concerning staffing. He noted that one GP doing a 40-hour week is no longer the norm – that the workforce is about job sharing and flexibility. He said “It’s really difficult to get full-time medical practitioners”.

13.137. The Regional Director of Health, Doctor 13, also commented that contract health practitioners have set hours and do not get paid to be on call, as compared to GPs in the “real world”. He said the Christmas BRL stand-down period is always a problem:

“We don’t have the same staff on the floor, we have different doctors around, we use what we can, we do what we can do. This is far different from most general practitioners, who are all there all the time, apart from their four weeks leave a year. So, we often have problems at this time of year, where we have different care. In practice, difficulty filling contracted positions, doctors on leave, the whole gamut of HR issues that we’re going through, particularly now, in the transition process...”

13.138. Officer 16 made a similar point. He advised that, while the number of cases to be considered at the weekly clinical meetings had increased because of soldiers returning from deployment, it was not possible to increase the number of hours to meet the additional workload. He said:

“(It) came down to a contracting issue, so again, it was difficult to get all treating practitioners in the same room at the same time due to the part-time nature of their jobs.”
13.139. Doctor 13 also explained his difficulty in getting contract health practitioner staff to comply with documentary requirements:

"Again, it's a really difficult thing dealing with contractors, and I've got to say..., it's like herding cats; they're difficult to get to do things, they're very independent thinkers and you can reiterate and reiterate and reiterate the requirement for appropriate documentation and... a lot of the time, they continue to do what they want to do."

13.140. On a related issue, the COMD 7 Bde, Officer 24, mirrored the Regional Director of Health, Doctor 13's concerns. In June 12, Officer 24 sent a letter to Doctor 13 complaining about the continuing failure of on base contract medical practitioners to apply ADF policy concerning sick leave and convalescence leave. Officer 24 said:

"I raise this with you because this is an enduring issue with contracted MOSs and Specialists operating out of the Enoggera Health Centre. As a rule either they do not understand their responsibilities or they deliberately fail to comply with (the policy). They continue to administer leave as if they are the approving authority..."

13.141. The Regional Director of Health, Doctor 13, agreed that the same lack of continuity of treatment of PTE Lazarus could re-occur, even under the new arrangements.

**The current model is no solution**

13.142. Consultant psychiatrist, Doctor 8, is scathing of the current health services model. He said the model does not work for psychiatry.

13.143. Doctor 8 said the current model does not meet the needs of mentally ill ADF members who have very complex issues. The model of a GP referring an ADF member to a private practice psychiatrist, who sends a letter back to the GP after the session, can work where the ADF member has a simple problem, such as an anxiety disorder. However, the model cannot work in complex cases; the norm in the psychiatric environment is that once a GP has referred a person to the psychiatrist, that person may undergo a long period of treatment without reference back to the GP for a considerable time.

13.144. Doctor 8 said, for psychiatry in the wider medical world, the focus of the management of treatment shifts from the GP to the psychiatrist. The current health services model does not allow for the way mental health specialists in the wider community practice. He said:
"Psychiatry is not like orthopaedics, it's not like general surgery; it's very different and, with all due respect, the fact that I'm sitting here this afternoon, is testament to that fact, because, if it was an orthopaedic matter, you wouldn't be having a board of inquiry (sic)."

13.145. Doctor 8 said the consultative and co-ordinated model of mental health care at Enoggera has 'broken down' with the cessation of the weekly clinical meetings between MHU staff at Enoggera, and the visiting consultative specialist psychiatrists. He said:

"(C)ome 30 June last year, that stopped. So whatever system that was in place has been destroyed, and I use the word 'destroyed' with a degree of emphasis."

13.146. Doctor 8 said under the present centralised garrison arrangements, there is no coordination; that no-one in the system has control of what is happening to mentally ill ADF members.

13.147. Doctor 8 said that under the current arrangements, ADF members he had been treating had been sent to other psychiatrists without any consultation with Doctor 8, and without any feedback to, or control over, the situation. On this point, Doctor 8 said that if what had happened to him had happened to a surgeon, "there'd be a riot."

13.148. Regional Health Director, Doctor 13 said that the Enoggera Health Centre is expected to refer ADF members to private practice specialists from a list of specialists who, in his opinion, do not have the expertise in the areas the Enoggera Health Centre requires. He said he tried to put an on-base capacity back in place, even though it was contrary to Defence Service Group instructions, but he was not able to achieve that outcome. He said he would like to bring the original arrangements back, but now it cannot happen because "we've hubbed everything."

**Dissatisfaction with the current medical services arrangements**

13.149. Doctor 8 said he became a contractor, with the new health services provider on a 30 per cent reduced fee, only because he felt he had a responsibility to a group of people he had treated for a long time.

13.150. The Regional Director of Health, Doctor 13, said that, under the current
arrangement, the Enoggera Health Centre no longer has the capacity to have private practice medical specialists attend on base. He said:

"(It) was a very definite instruction that we are not to have specialists on base .... We had (a range of specialists) coming on base. Very handy. So patients could come, be referred to these guys, park on base for no cost .... So we had this great working relationship (with the specialists). So with the change and the national model, no specialists on base, can't have them on base. So we've lost that - we lost that closeness".

13.151. Doctor 8 confirmed that he is no longer permitted to attend Gallipoli Barracks, and that his pass had been removed.

13.152. In effect, Dr 8 said he was "humiliated" by the way things were handled, especially after he had been attending Gallipoli Barracks for the past 15 years on a weekly or fortnightly basis.

13.153. Regional Health Director, Doctor 13 disputed that Doctor 8 had been "locked" out of the base, but acknowledged that the new provider arrangements had treated specialists arrogantly. He said specialists who had worked for the Enoggera Health Centre for many years were offered contracts on substantially less remuneration, and the anaesthetists had been particularly badly dealt with.

13.154. According to Doctor 13, one outcome from the new arrangements is that he has now lost the support of specialists who had given exceptional support to the ADF. Doctor 13 recounted losing the services of an ex-GSO, who had become an orthopaedic surgeon specialising in traumatic lower limb injuries. This practitioner, now no longer available to the ADF, was previously ready, willing and able to assist. As Doctor 13 stated:

"I could ring him at 2 o'clock in the morning with something that is coming back, he would have a team ready to go. He was just fantastic."

13.155. The Regional Director of Health, Doctor 13, said that the situation may be worse elsewhere, because much depends on specialist availability region to region. Whilst Brisbane may be well-served with private practice specialists, the same is not the case elsewhere.

13.156. The Commission observes that considerable corporate medical knowledge and expertise now appears to have been lost to the ADF.
TOR 12 (g) (2): The obstacles disclosing medical information to the chain of command.

Finding

13.157. The professional obligations of contract medical practitioners to the individual ADF member arising from the confidentiality of medical information do not, of themselves, pose an obstacle to the disclosure of medical information to the chain of command. Differentiation needs to be made between a diagnosis and a prognosis.

13.158. Contract medical practitioners appear to consider their obligation of medical confidentiality is to individual ADF members. If so, that could constitute a breach of their professional obligation to disclose relevant medical information about an individual ADF member to command.

13.159. It is not apparent that contract medical practitioners are bound to apply ADF health policies that, in some circumstances, require them to disclose medical information to the chain of command.

13.160. The optimal outcome is achieved when uniformed medical support mediates between contract medical practitioners and a commanding officer in the release of medical information about an individual ADF member, sufficient to meet a commanding officer’s decision-making needs.

13.161. The ADF policy is capable of being prescriptive as to the nature and extent of the medical information a commanding officer is entitled to be told about an ADF member. Past instances of inappropriate use of medical-in-confidence information, poor file management and the separation of a member’s medical files and psychology files have exacerbated policy difficulties.

13.162. It is arguable that a culture has developed where contract medical practitioners apply their own preferences, with instances where doctors have withheld medical information from commanding officers (albeit for well intentioned reasons).

13.163. Whether deliberate or otherwise, relevant medical information may not be available to be disclosed because of inadequate documentation and reporting and/or a practice having developed of ‘exception’ reporting of a change in an ADF member’s medical condition, with the result that there are significant gaps in the potential knowledge of a member’s medical condition and treatment regime.

13.164. The issue of disclosure of medical-in-confidence information is exacerbated under the centralised garrison support system which effectively removes the commanding officer’s organic first-line medical support.
Supplementary findings

13.165. Specific policy weaknesses arise by reason of:

- Contract medical practitioners not being specifically and clearly legally bound to apply ADF health policies.

- The practical application of the obligation of medical confidentiality at the point of the civilian/military interface.

- Differences between the different medical professional groups as to what medical information can be disclosed.

- The ability for contract medical practitioners (with the best of intentions) to effectively quarantine the member from the chain of command, and thereby circumvent the relevant Defence Instructions and Health Directive, thus preventing disclosure of medical information to commanders.

- Concerns that a medical practitioner may:
  
  o insist upon strict medical confidentiality, rather than the ADF member giving his or her willing and informed consent to release relevant medical information, as discussed between the doctor and the member as part of the case management process; or

  o assert the doctor’s own interests by not seeking an individual ADF member’s consent to the release of relevant medical information.

- the lack of articulation of exactly what information a commanding officer needs to know, as distinct from what a commanding officer might want to know, i.e. the distinction between a prognosis as as opposed to a diagnosis.

Commentary

13.166. On the issue of disclosure, the Regional Director of Health, Doctor 13, said:

"It's a huge problem. We are bound by the policies to be very pernicious with the information we provide to units and we will be found wanting if we divulge information...that is considered inappropriate."

13.167. Officer 16 considered that both civilian contractor and uniformed medical practitioners were bound by the same overarching ethical obligations with respect to their patients. However, Officer 16 considered the ADF to be his
primary client, because the ADF was paying for the medical services. He considered the patient to be the secondary client. He considered his role to be to negotiate between the primary and secondary clients' requirements and needs in relation to disclosure of medical information. Officer 16's approach was that the uniformed RMO was the mechanism to mediate between civilian health practitioners and commanders in relation to medical-in-confidence information.

13.168. Officer 18 was of a similar view to Officer 16. Officer 18 said that, unlike civilian doctors, uniformed psychologists are a part of the ADF organization, and as such, have a responsibility to report back to COs who are responsible for managing ADF members.

13.169. Officer 16 opined that medical-in-confidence was being used by contract medical practitioners as an excuse for withholding information from the chain of command. He said the information being withheld is, in fact, not necessarily medical-in-confidence, and gave the analogous example that of a Land Rover being broken. A CO does not need to know what has to be done to fix the Land Rover, but he does need to know when the Land Rover might be fully functional again. Officer 16 said a CO is not being told what he is entitled to know, such as whether a person has been medically downgraded, or whether the person is coming back to work or not.

13.170. Officer 18 said that different practitioners have different views about how much medical information should be passed on to the chain of command. Officer 18 was of the view that the ADF needs to know more about a person than a civilian employer would be entitled to know. Officer 18 said that between uniformed and civilian doctors, the tendency of the latter was to be more protective of medical information.

13.171. Evidence from the Chief of Staff 7 Bde was to the effect that the medical community would redefine an ADF member's reason for presenting at the medical centre as a means of avoiding any medical disclosures to the Unit. The medical staff would determine that a presentation was not, in fact, for a suicide ideation, and form the view that a member was of no threat to themselves, or that the threat was low, with the view to granting the member convalescence leave to remove the ADF member from oversight by the Unit.

13.172. Chief of Staff 7 Bde also opined that the issue of disclosure of medical-in-confidence information was "significant", but that it could be nullified by having a uniformed SMO or MO in the Unit as an intermediary between the contract medical practitioner and the CO. He said that as things currently
stand, the CO is having to make a personal call on the medical practitioner, with the medical staff probably seeing it as an affront to their medical and professional judgement when asked to provide more information.

13.173. **Officer 21** emphasised the critical importance of the RMOs to the medical disclosure process. He recounted a problem he had recently encountered that led him to seek the removal of a civilian contract doctor. He said the civilian doctor became an advocate for the soldier, and begrudged talking to him about the case. **Officer 21** said that uniformed RMO can straddle the medical issues in the context of the Unit’s operations and battle rhythm.

**What a commander is entitled to know?**

13.174. Doctor 8 identified the issue of the disclosure of medical-in-confidence information as being the distinction between what a person is entitled to know, and not entitled to know. He said he has no difficulty with the idea of releasing medical-in-confidence information to the RMO, because it is “not unreasonable to let people know what’s going on.”

13.175. The Regional Director of Health, Doctor 13, expressed the view that for the Units to work with medical staff, a certain amount of information must be provided to the Units to improve the outcomes for the individual. Doctor 13 recognised that commanding officers have “a whole suite of information” about a member that medical practitioners are not privy to, which, when there is an exchange of information, can change completely the understanding of a situation.

13.176. The Regional Director of Health, Doctor 13, called it “a beautiful split” when medical staff have medical-in-confidence information, and the commanders have staff-in-confidence information, with the result being that the division between the two is ripe for an ADF member “who wants to play the system”.

13.177. **Officer 21** said that commanding officers do need to understand the treatment path, but “not the ins and outs of the treatment.” **Officer 21** said that when he had a uniformed RMO, he knew “intimately” what was going on, though the RMO did not go into absolute medical detail. Instead, the RMO would give tips on how to manage a member.
13.178. **Officer 21** said that medical staff focus only on the medical issues, and therefore miss broader aspects of rehabilitation where, using a welfare board approach, command can set rehabilitation goals for a soldier. **Officer 21** said the contracted medical health staff working for Joint Health Command don’t actually understand, and “in some cases, don’t want to understand, or don’t care...for the ADF system and the broader aspects.”

**Consent to the release of information**

13.179. The Regional Director of Health, Doctor 13, said it has not been routine to ask a member to sign a form to consent to forego confidentiality, but when it happens it can be very helpful. The difficulty is that it is open to abuse. It has happened that a Unit has pressured ADF members to waive confidentiality, but if a doctor were to invite an ADF member to waive confidentiality, it could be construed as the doctor advocating for the Unit. The problem remains that medical practitioners, and especially contract medical practitioners, are vulnerable to being sued if medical-in-confidence information is deemed (by a disciplinary body) to have been wrongfully disclosed.

13.180. **Officer 21** said he has experienced welfare boards where the soldier was prepared to discuss medical-in-confidence information, because it was an appropriate forum.

**Inappropriate use of medical information which has been disclosed**

13.181. The Regional Director of Health, Doctor 13, indicated that, in his experience, commanding officers use medical-in-confidence information provided to them very well, but that the same cannot be said for the lower command ranks. Doctor 8 said much depends not only on what information is to be released, but how it is released. *His experience has been that information released has not been kept confidential, and that the system "leaks like a sieve."*

13.182. Like Doctor 13, Doctor 8’s experiences have been that some of those who are given medical-in-confidence information deal with it very badly, which can be disastrous for the management of a soldier.

13.183. Both Doctor 13 and Doctor 8 recognised as a problem that lower ranks provided with medical-in-confidence information did not always use it very well. Doctor 13 considered this to be an issue of education and training.
13.184. Officer 18’s role in the management of PTE Lazarus illustrates the danger of medical records being ‘stove-piped’ by record type.

13.185. When undertaking her assessment of PTE Lazarus’ risk, Officer 18 made a distinction between medical information, and mental health information. She said that at the time she saw PTE Lazarus, she was unaware that she could access his medical records, as she was of the understanding the medical records were medical-in-confidence, and therefore not available to her. She therefore did not access PTE Lazarus’ medical records.

13.186. As to the keeping of medical and psychological records on different files, the Regional Director of Health, Doctor 13, noted the impact of the historical circumstance. Continuation notes were once accessible by all treating medical practitioners, but concerns arose that notes were being inappropriately perused, leading the psychologists to create separate files. He said that Joint Health Command is currently addressing this problem.

13.187. Officer 16 made the point that the number of patients to be covered at the weekly clinical meetings attended by Doctor 8 and other consultant psychiatrists meant getting 60-80 UMRs to the meeting at one time. It was therefore difficult to record anything, other than by ‘exception reporting’ when there was a change in the treatment plan.

13.188. The Regional Director of Health, Doctor 13, also acknowledged that maintaining medical record keeping at the appropriate standard “is a persisting problem... an ongoing frustration” because the process is time consuming, and needs systems in place and administrative support. Without those mechanisms record keeping is ad hoc. Doctor 13 observed that the Defence health record keeping systems were at about the 1960s standard.

TOR 12 (g)(3): Appropriateness and suitability of risk management criteria for determining whether a person is at a ‘low’, ‘medium’ or ‘high’ risk of a further suicide attempt.

Findings

13.189. Heath Directive 294 is not meeting Command’s needs and expectations.

13.190. The function of a suicide risk assessment is inadequately explained in the policy, and is potentially misunderstood by commanders.
13.191. The criteria for determining an ADF member's level of risk of suicide is inadequately articulated in the policy.

13.192. The language of 'low', 'medium' and 'high' in the risk assessment process is potentially misleading, in that the lay-person may incorrectly impose a correlation between an allocated level of risk and the likelihood of suicide.

13.193. While mental health professionals and specialists across the ADF and wider community use the risk assessment language of 'low', 'medium' and 'high', the application of the risk assessment process does not yield consistent results between mental health practitioners who have specialist experience of ADF members, and mental health practitioners in the wider mental health community.

Supplementary findings

13.194. The evidence discloses that none of the duty MOs at the GBHC at the times of PTE Lazarus' admissions to that facility, was a mental health practitioner.

13.195. The Duty MO's risk assessment of PTE Lazarus during the period 25 Nov – 22 Dec 10 was perfunctory; no level of risk was recorded.

13.196. As a private practice Consultant Psychiatrist, Doctor 8 was not (and should not) be bound by the ADF policies to conduct the risk assessment (though he may have conducted such an assessment for his own purposes in his treatment of PTE Lazarus).

13.197. Contrary to the policy, the GBHC did not conduct a risk assessment of PTE Lazarus until he was referred to a uniformed psychologist on 5 Jan 11.

Facts

13.198. Officer 21's experience reflects a commanding officer's difficulties with operation of HD 294.

13.199. Of PTE Lazarus' situation, Officer 21's evidence was that he was satisfied he had sufficient visibility of PTE Lazarus' medical situation at the time the Unit commenced the Christmas BRL stand-down on 4 Dec 10.

13.200. In his affidavit, Officer 21 stated that, on 29 Nov 10, he understood that PTE Lazarus was to be reviewed by an ADF contracted MO and mental health professional before the Unit would authorise PTE Lazarus to commence any convalescence leave. Officer 21's evidence was that his expectations were that:

(PTE Lazarus') "medical review must encapsulate a medical risk assessment IAW Di(G) PERS 16 – 26" and
“That I expected that PTE Lazarus would for the immediate period, be engaged with a mental health professional and that, in time, he was likely to commence a return to work program” (emphasis added)

13.201. Neither of Officer 21’s expectations was met. PTE Lazarus did not undergo a risk assessment conducted by a GBHC mental health professional until 5 Jan 11, nor was PTE Lazarus in the care of a ‘mental health professional’ as that term is defined by the DI and HD 294, although PTE Lazarus was first placed in the care of a consultant medical health specialist psychiatrist, Doctor 8 on 3 Dec 10, some nine days after his suicide attempt.

13.202. Consultant Psychiatrist, Doctor 8’s evidence was that when he first saw PTE Lazarus (on 3 Dec 10), he thought PTE Lazarus’ risk of a further attempt of suicide “to be a bit higher than ‘low’, but certainly I thought it became low reasonably quickly”. Doctor 8’s assessment is not reflected anywhere in the contemporaneous duty MO medical notes at the time.

13.203. The relevant policies did not oblige Doctor 8 to conduct PTE Lazarus’ formal risk assessment. Doctor 8 was treating PTE Lazarus as his private patient, although PTE Lazarus attended Doctor 8’s rooms in Spring Hill, for treatment of a major depressive illness, for which, on 3 Dec 10, prior to 6 RAR’s Christmas BRL, Doctor 8 declared PTE Lazarus to be ‘not fit for duty’.

13.204. In the period 25 – 26 Nov 10, and from 1 – 7 Dec 10, no duty MO at the GBHC, nor any other ‘mental health professional’ as defined by HD 294, conducted a risk assessment of PTE Lazarus.

13.205. The evidence discloses that HD 294 was not a sufficiently mature or robust mechanism for medical staff to apprise CO 6 RAR of PTE Lazarus very tenuous situation when PTE Lazarus was released on convalescence leave into the care of his family on 7 Dec 10.

Commentary

13.206. Three issues become apparent from the evidence. The first is that the medical practitioners (duty MOs) at the GBHC did not apply Health Directive 294.

13.207. The second is that the policy itself is inadequate and confusing. The policy purpose and outcome are not clear, and the language of the policy is misleading to a commanding officer seeking to administer an ADF member who is at risk of attempting suicide, or suffering from suicidal ideation.

13.208. Issue 1: It is not clear from the evidence whether contract medical
practitioners are legally bound to abide by ADF policies in the management of ADF members who have attempted suicide or were suffering from suicidal ideation. Nor it is clear from the evidence that the duty MOs were actually aware of the existence of such policy, or understood what the policy entailed. The risk assessment undertaken by duty MOs during PTE Lazarus’ hospitalisation in GBHC Ward 1 was minimal and cursory, and without regard to the examination of particular risk factors or stressors identified by HD 294, even though the information was available to them in PTE Lazarus’ UMRs.

13.209. It is possible that the failure of the duty MOs to conduct a risk assessment of PTE Lazarus is explained by the Regional Director of Health, Doctor 13, who said that GBHC MOs were not specialist mental health professionals, and not trained in psychiatry or psychology. He said the GBHC staff were GPs with an interest in mental health. He also noted that patients with mental health issues were time consuming and often very difficult to deal with. Doctor 13 also said that he found it very difficult to get the contract medical practitioners to comply with ADF requirements.

13.210. Issue 2: Health Directive 294 and DI(G) PERS 16-26 are not integrated into a wider context of mental health management. The risk assessment policy does not address how the information gained from a risk assessment is to be used in the wider management of the ADF member, and how it fits into the process of the RMT.

‘What is meant by ‘low’, ‘medium’ and ‘high’?’

13.211. HD 294 does not make it clear that a risk assessment of either ‘low’, ‘medium’ or ‘high’ is not a predictor of whether the person will in fact commit suicide.

13.212. Regional Director of Health, Doctor 8’s evidence is that suicide is inherently an unpredictable event, and that the notion that suicide is predictable has no basis in psychiatric literature.

13.213. Officer 16 made a similar point. He was careful to stress the momentary nature of a risk assessment. The moment a person walks out of a consultation, the person could suffer an unknown significant event that will completely change the level of risk (and future conduct). Officer 16 said that previous behaviour is the best predictor of future behaviour.

13.214. Doctor 8 said the policy language of ‘low’, ‘medium’ and ‘high’ might lead a lay-person to assume that a risk assessment of ‘low’ means the problem has
gone away, and a person can be 'back on deck soon' after a suicide episode whereas, a person who is assessed at being at a 'low' risk remains very unwell and in need of treatment.

13.215. Officer 16 said that someone being at a 'low' risk of suicide "could mean just about anything to anybody". He said a person at 'low' risk might require an exhaustive management plan, where a person at a 'high' risk may only need a simple management plan.

13.216. Officer 16 said the issue is the communication of what the risk means rather than relying on the level of risk.

13.217. HD 294 provides guidelines to Mental Health Professionals regarding both the assessment and estimation of suicide risk, and the clinical management of members deemed to be at specific risk levels. However, in many areas, the guidelines are intentionally discretionary in recognition of the fact that suicide risk and protective factors are both unique to the individual and dynamic in nature. Unfortunately, this discretion may have unintended consequences, typically, a lack of rigor in the assessment of risk and in the development of an informed intervention strategy. This lack of rigor has been clearly evident in the case of PTE Lazarus. The difficulties with these documents have been exacerbated by fundamental changes in the delivery of ADF Health Services since the documents were first promulgated.

13.218. Accordingly, the Commission recommends a holistic review of DI(G) PERS 16-26 and HD 294 to better address those issues.

13.219. It is apparent that some practitioners have equated a "low" risk of suicide with a minimal risk. HD 294 defines Low Risk as follows:

"Low. Few risk factors are present and they are mild (e.g. mild suicidal ideation with no evidence of planning). Some protective factors would typically be at play. Members deemed to be at low risk of suicide will generally be managed on an outpatient basis (i.e. they will not require hospital admission)."

13.220. Clearly, the intent of the definition is that the member will still be the subject of active suicide risk management. To further clarify this intent, it is recommended that the Health Directive include a category of Minimal Risk, specifying the absence of factors of concern, and that no specific intervention is currently required.

- The function of a risk assessment
13.221. Officer 16's evidence is that a risk assessment is no more than a snapshot of a person at a particular time, focussing on the current factors that are causing a person to have a suicidal ideation. He said that to assume someone who is at a low risk today is going to be at a low risk for the week is a fallacy. He also said the actual conduct of a risk assessment in itself is changing risk. Officer 16 said the value of a risk assessment is that it provides a starting point for determining a treatment plan. The risk assessment gives a mental health practitioner a better chance of understanding the factors that may influence someone's suicidal behaviour, and what might be causing an individual stress. Similarly, Doctor 13 said the purpose of a risk assessment is to try to quantify the risk to give the medical practitioner an objective measure of the patient's "suicidality", and to provide a tool for the management of the patient.

13.222. All medical witnesses confirmed that the risk assessment process is largely dependent upon self-disclosure by the patient. Development of a rapport with the patient is useful in the assessment process.

13.223. The Regional Director of Health, Doctor 13, made the point that the risk assessment process is vulnerable to manipulation by those who have been exposed to mental health processes who know the "lingo" and say all the right things. He said some people are very good at giving the responses they wanted to give.

13.224. Doctor 8 said that, ultimately, the management of an at risk person is dependant upon the treating practitioner's qualifications and experience and the rapport the practitioner can establish with the patient and whether the patient is going to tell the truth.

13.225. The evidence suggests that DI(G) PERS 16-26, and HD 294, do not reflect the ephemeral nature of the risk assessment process, or the highly unpredictable nature of suicide. Nor does the policy explain the purpose of the risk assessment process, or where the assessment fits within the wider context of the management of an ADF member with a mental health illness (of which attempted suicide and suicidal ideation are but one manifestation).

**The risk assessment criteria**

13.226. The Regional Director of Health, Doctor 13, said that the policies espoused in DI(G) PERS 16-26 and HD 294 were not practical.

13.227. The Regional Director of Health, Doctor 13, gave evidence that in 2011, a
comment was made by a visiting Consultant Psychiatrist from New South Wales, to the effect that the risk assessments being conducted at Enoggera under HD 294 “were rubbish”, suggesting the Enoggera Health Centre apply the New South Wales hospitals’ risk assessment regime. Doctor 13 said the risk assessment criteria should be ADF specific.

13.228. The Regional Director of Health, Doctor 13, said that the Enoggera Health Centre now undertakes a more comprehensive risk assessment, and there is more guidance available because there is now a Directorate of Mental Health.

13.229. Officer 18 said that the risk criteria specified in HD 294 for a risk assessment are common across the mental health profession as a whole. Officer 16 said that while the criteria or practices may be the same between the ADF and the wider community, the ADF tends to be more conservative in its application of the risk assessment criteria compared to the wider community.

13.230. Both Officer 18 and Officer 16 noted that the application of the risk assessment process within Defence had recently been standardised with the recent introduction of a Suicide Risk Assessment Training Program. Officer 16 observed, however, that the allocation of a level of risk will never be completely consistent within the ADF because medical practitioners can vary on the significance of any risk factor, and that some practitioners are more conservative than others even within a standardised process. He said that, as much as possible, a collegiate approach is taken to the allocation of a risk level in a particular case.

**TOR 12 (g) (d):** At what point should a person who has engaged in non-fatal suicide conduct undergo a medical classification review in accordance with DI(G) PERS 16–15 Australian Defence Force Medical Classification System.

**Findings**

13.231. The MEC policy should be sufficiently robust to accommodate a number of contradictory policy objectives:

1. The maintenance of optimum fitness levels for the ADF as a whole, with emphasis on deployment capability.
2. Acceptance that an ADF member may suffer a mental health illness, including a suicidal episode, during his or her ADF career, but will recover full or sufficient health to remain a member of the ADF.

3. The streamlined redeployment of ADF members who may no longer be able to meet the employment requirements of one category or mustering, but meets the fitness requirements of another category or mustering;

4. The streamlined immediate discharge as a simple administrative decision, without fault, of a recently joined ADF member who is not suited to military life.

13.232. The MEC policy should place a meaningful emphasis on rehabilitation and reintegration of an ADF member (i.e. finding a way to continue to employ a member rather than finding a way to discharge the member, noting that a member’s training and experience may amount to a significant financial investment by the ADF)

**Supplementary findings**

13.233. The policy should articulate a requirement that an ADF member who has attempted suicide should be referred for a MEC review concurrently with the comprehensive suicide risk assessment mandated by DI(G) PERS 16 – 26.

13.234. In the absence of a MEC review contemporaneously with the suicidal episode, an ADF member who has attempted suicide is likely to end up in limbo, with the member having no certainty as to the his or her future treatment or future employment prospects.

13.235. The MEC system should adopt an approach that accepts that an ADF member can (and is likely to) recover from a mental health issue, and allow a member’s MEC to be upgraded after the completion of stabilising treatment, allowing the member to declared fit for duty/deployment.

13.236. The MEC policy is currently unnecessarily inflexible, specifically in its approach to the prescribed use of anti-depressants by an ADF member, whether or not that member has suicidal ideation or has attempted suicide.

13.237. The practical operation of extant MEC policies where a member is suffering from a mental health illness has the result that ADF members are seeking private medical treatment, often on referral from the VVCS. The consequence of this for the ADF is that it has no visibility of the nature and extent of mental health illness being suffered by ADF personnel (that is, there presently exists a sub-culture of members with mental health issues who have “gone underground”).

13.238. The MEC system should support the retention of trained ADF members by simplifying and streamlining the redeployment of members between categories or mustering as befits their actual fitness levels.
13.239. The MEC system is deleterious for the management of long term 'not fit for duty' soldiers.

13.240. The ADF lacks a streamlined means to achieve the 'without fault' discharge of recently-recruited ADF members (under two years) who suffer from mental health issues, where those members probably should never have been accepted to serve in the ADF.

The MEC policy and mental illness:

13.241. In the context that suicide is a pathology closely associated with depression, Doctor 8 said his experience of the ADF policy is that, as soon as a person is prescribed anti-depressants, there is an automatic MEC downgrade with a review in six months. Doctor 8 said that once the six months had passed it was difficult to reverse the MEC process and the ADF member is faced with the inevitability of discharge.

13.242. Doctor 8 said the pressure the MEC system places on the ADF member for whom the military has been his or her life, and who has few portable skills for civilian employment, is that they "try to hang on but (the ADF) does not provide a system where they can do other things"; the focus of the ADF being that everyone must be at a deployable fitness level.

13.243. Based on the operation of the MEC policies, the ADF member has the following options:

- To not seek treatment;
- To obtain treatment outside the ADF, and not tell the ADF — with the consequence that mental health issues in Defence go underground;
- To cease the treatment before the MEC mandated six months mark, to the member’s detriment (noting that the literature suggests a person with a significant depressive illness needs to remain on anti-depressants for at least nine months).

13.244. Doctor 8 said that because of the timeframes attached to MEC downgrades, a member with a mental health illness who can become well again, but not within the mandated MEC timeframes, faces discharge (which demonstrates the inflexibility of the MEC policy). The member having then reached the predicament and inevitability of discharge, it then takes a very
long time for the member to actually be discharged. Doctor 8 said he knew of a case where it took five years for a member to be discharged.

13.245. Doctor 8 said the ADF only finds out if a member is suffering a mental health issue if the member reports through the ADF reporting mechanisms. In terms of transparency, Doctor 8 called the VVCS 'a completely hopeless system', because, unless the person is at imminent risk to themselves or others, the VVCS does not report back to the ADF where an ADF member presents with significant psychological problems.

13.246. Doctor 8 said that an ADF member could go to the VVCS or see a private psychologist:

"and talk until the cows come home, you can drink yourself to death, but you won't be medically downgraded. But if a person is prescribed antidepressants in the ADF, within the ADF medical system, that's a flag. The further issue is that, under the new system, once someone is medically downgraded, it is very difficult to upgrade them."

13.247. Officer 21 agreed with Doctor 8, saying the VVCS option is particularly attractive to soldiers who want to continue in the ADF until they can leave on their own terms. Officer 21 says that this group poses a problem for the serving soldier where they undertake private medical treatment on referral from the VVCS, and the ADF medical system is unaware of the problem or the treatment.

Anti-depressants policy

13.248. Doctor 8 said the policies concerning the prescription and use of anti-depressants should be reviewed.

13.249. He said that the issue is not that an ADF member is on antidepressants per se, but that once the condition is stabilised, there is no reason why the ADF member cannot return to work. Doctor 8 had no qualms with the initial MEC downgrade of a person who is newly diagnosed and prescribed antidepressants. He said he was more concerned with ADF members who are suffering depression, but who have not been treated. Such persons are more dangerous handling weapons than those who are on anti-depressants and who are stable. Finally, Doctor 8 made the point that the US military routinely deploy people who are on antidepressants and are stable.

13.250. Again, Officer 21 agreed with Doctor 8. Officer 21 said that the ADF policy on the upgrade of ADF members on antidepressants "appears
very conservative, and out of touch with the practice with the US military at
least." Officer 21 saw no issue with the system accommodating a
medical upgrade of a soldier who had been prescribed anti-depressants.

Other management options

13.251. On the issue of current MEC policies forcing mental health issues
‘underground’, Doctor 8 suggested the MEC system should be sufficiently
flexible to accommodate the redeployment of ADF members who may no
longer be fit in their current category, but who have years of military training
and experience. He said the current policy does not address retention as an
option to the discharge of a member.

13.252. Doctor 8 also said the MEC system does not allow an easy discharge option
for a person like PTE Lazarus, a recent recruit who, in Doctor 8’s view,
should not have got into the Army in the first place. Once a person such as
PTE Lazarus has commenced the MEC process, there is no simple way out.
Where a person is not suitable for military service, Doctor 8 said of the
current policy:

"...once you have downgraded people, because you have placed them
on treatment, then the administrative discharge becomes very
difficult...in my experience I have suggested people should be
administratively discharged...but the unit (says) ‘I don’t agree with
you’ on the basis of no experience and no possible ability to judge it.

If someone is administratively unsuitable for service, then my view is
you get them out; let them get on with their lives."

13.253. Doctor 8 was clear to say the administrative discharge process unrelated to
MEC downgrading should apply only to those who, like PTE Lazarus, have
only recently joined the military, noting that it would probably result in a
Federal Court challenge if the ADF tried to discharge an ADF member on
the grounds the member is unsuited to military service after 14 years of
service.

13.254. Officer 21 evidence is that a medical discharge typically took 6-8
months to process after a Central Medical Employment Classification
Review (CMECR) and even where a MEC J5 has been confirmed, it still
takes 3-6 months to complete the soldier’s separation. The timeline of 10-12
months would come after any treatment for MEC J34 or J31. He said that
Doctor 8 having diagnosed PTE Lazarus with a depressive illness, the
standard timeline for discharge meant that PTE Lazarus was unlikely to be
discharged on medical grounds before mid-2012.

13.255. Officer 21 is of the view there needs to be a shorter time frame medical discharge model for soldiers who have no desire to continue to serve, and who seek discharge on medical grounds. He said such a process may assist with the management of soldiers who have pre-existing conditions who want to move to other employment quickly, or those not medically compatible with military service, where being held in the ADF is likely to exacerbate their condition. Officer 21 said this may have assisted PTE Lazarus had he not taken his life.

Alternative treatment models

13.256. Officer 21 raised as a related issue, that the ADF needs to examine other treatment methodologies for ADF members who are suffering a mental health illness, but want to remain in the ADF.

13.257. Officer 21 spoke of the experience of a Psychiatrist at the Toowong Hospital, Brisbane, whose preferred course of action was group therapy and clinical psychology for PTSD and similar mental health issues. Officer 21 said he had two Sergeants, who had undertaken the program, say to him that if they had undertaken the non-medical treatment in the first instance, they believed they would be returning to work, whereas they are now discharging “due to the antidepressants”. It has been Officer 21 experience that any long-term delay to returning to work delivers a sub-optimal result for the ADF. He said the vast majority who do not return to work in the shorter term end up discharging without ever coming back to work.

TOR 12 (e)(5): The process for approving convalescence leave.

Primary findings

13.258. Convalescence leave has become the medical profession’s default position for ADF members assessed as being at a ‘low’ or the low end of a ‘medium’ level of risk of suicide.

13.259. GBHC MOs effectively derogated their responsibilities to Doctor 8’s instruction to grant convalescence leave, on the basis that Doctor 8 was treating PTE Lazarus. In so doing, the GBHC MOs failed to exercise an independent judgement as to whether it would be more appropriate to recommend that PTE Lazarus be granted sick leave rather than convalescence leave.
13.260. It appears that Doctor 8 was unaware of any policy distinction between a grant of 'convalescence leave' and a grant of 'sick leave'. Doctor 8's expressed concern was to ensure an ADF member with mental health issues was not hospitalised, or required to attend the Unit when they had been classified MEC J52.

13.261. The GBHC did not initiate a MEC Review.

**Supplementary findings**

13.262. It was not, and is not, Doctor 8's role or responsibility to ensure the GBHC applies ADF policies to an in-patient at the GBHC.

13.263. The GBHC duty MO recommendation that PTE Lazarus proceed on convalescence leave had the effect that 6 RAR lost control of his overall management and welfare, at least until a welfare board was convened.


13.265. It should only be the exception for a commanding officer to grant convalescence leave to an ADF member who has attempted suicide. As a general statement, an ADF member who has attempted suicide should be granted sick leave rather than convalescence leave.

13.266. A commanding officer who is considering a grant of convalescence leave (as an exception) to an ADF member who has attempted suicide should be obliged to make inquiries as to whether it is necessary for that member to report to the Unit in person for the approval of the convalescence leave.

**Convalescence leave’, ‘sick leave’ and MEC**

13.267. D1(G) PERS 16-21, *Sick and convalescence leave – Defence Members*, was cancelled in Dec 12.

13.268. It would appear that, in allowing PTE Lazarus to proceed on convalescence leave after his suicide attempt on 24 Nov 10, GBHC did not appreciate the policy premise that convalescence leave is only granted where the ADF member is not suffering an illness or injury.

13.269. The policy distinguished between sick leave and convalescence leave, the latter being defined as ‘the gradual recovery of health and strength after an illness’. ‘Sick leave’ is an approved absence when a Defence member is too
ill or injured to work. An ADF member who attempts suicide is likely to be ill due to a mental health issue, of which suicide is a manifestation of the underlying illness, prima-facie, it would be inappropriate to grant convalescence leave.

13.270. The evidence is that on 3 Dec 10, Doctor 8 had clearly stated that PTE Lazarus “was not fit for duty”. He had also been hospitalised for approximately one week due to toxicology issues arising from the pharmaceuticals overdose. Both these factors should have triggered a grant of sick leave rather than convalescence leave. Furthermore, the hospitalisation should have immediately triggered a MEC review. Doctor 13 said PTE Lazarus should have been referred for a MEC review:

“This guy was unwell and really once the assessment of this guy’s level of wellness, regardless of the 28 day timeframe, it (the request for a MEC review) should have been in, it should have been done. So this guy had a significant pathology and as soon as practicable that MEC should have been done; simple as that. Timeframes are a guide. But if you see someone who is unwell, medically unwell, and should not be in that classification, is not going to get better. ... the sooner the system knows about it, the sooner we can act on it.”

13.271. As events transpired, Officer 21 was presented with a fait accompli in that the GBHC sent PTE Lazarus on convalescence leave without reference to 6 RAR.

13.272. Officer 21 had no opportunity to have input into the options for the management of PTE Lazarus. The evidence is that the MHU GBHC was not fully disclosing information to the Unit. Doctor 8 stated:

“I certainly communicated my view (to the medical people at Enoggera) that he was not suited to military life and would need to be discharged. I don’t know the answer to why 6 RAR appears to have virtually no knowledge of Jacob’s circumstances.”

13.273. The application of convalescence leave in the case of an attempted suicide may be viewed as a circumstance where a medical issue is redefined for the purpose of removing an ADF member from the reach of the chain of command. Officer 16, OIC 1 Psych, Brisbane Detachment said:

“Clinical management of a member (at the GBHC) kept on bordering on administrative management. ... Clinical management quite often ignored, or went beyond, the administrative management of the
individual. A protective culture developed, whereby an assumption was made that the Army was causing a lot of angst for the patient. The resulted in the design of a treatment plan to “protect” the member from the negativity of the Army.”

13.274. Similarly, the Chief of Staff HQ 7 Bde said:

“For a suicide ideation, there is a real reticence from the medical community and more importantly, the mental health community, to get the chain of command involved. In my opinion, this detracts from a unit being able to undertake its roles and responsibilities as dictated by the DI(A)......because the unit is not informed of what is going on with the soldier who has presented. I have witnessed that in the past two years, where the medical community thinks it is doing the right thing by the soldier, by granting convalescence leave. The medical community would determine that it’s not a suicide ideation and the member is no threat to themselves and it’s a low threat. However, we have argued that while such a view may be a medical assessment, a CO still has the overall responsibility for that soldier and needs to be informed. That’s an area that has to be gripped up.”

(emphasis added) and

“The CO is relying on interactions with civilian medical practitioners who are not from his unit; and those practitioners are dealing with the whole garrison...Now the unit Adjutant or the unit is not fully across what it is the soldier is getting convalescence leave for......”

13.275. The way the convalescence leave policy is operating in practice results in the Unit having a passive role in managing a member on convalescence leave.

13.276. Chief of Staff HQ 7 stated that in late 2011 – early 2012, there was a significant number of cases at Enoggera where the commanding officer concerned had lost positive control because the medical community was granting convalescence leave, and determining that soldiers were to have no contact with Units. He said the practical effect of that circumstance was that the right to grant convalescence leave was taken out of the hands of the CO.

13.277. [Officer 21] disagreed strongly with any suggestion that a long-term absence from the workplace on either sick leave or convalescence leave should only be at the MO’s discretion. His view is that only the Unit can determine the wider aspects associated with the management of a soldier. His experience is that an MO has no visibility of the complexity of some cases a Unit has to deal with, and particularly those cases where a soldier’s mental health condition has not stabilised.
Why the Enoggera hospital treats convalescence leave as a necessary and inevitable default position for ADF members at a ‘low’ or ‘medium’ level or risk

13.278. The Regional Director of Health, Doctor 13, highlighted the critical point that, if an ADF member is at a low or medium risk of suicide, the GBHC has no legal basis to insist the member remain at the MHU. It is irrelevant that the person being treated is an ADF member, or that the location of the treatment is an ADF Health Facility.

13.279. Doctor 13 said:

“The thing is, we cannot keep these people against their will.”

13.280. Accordingly, once PTE Lazarus left the GBHC on convalescence leave, he was on his own. As to PTE Lazarus’ circumstances, Doctor 13 said:

“PTE Lazarus, with his past, self-harm, recent serious attempt at suicide, and the best we could do at the moment would be (the) EHC, at least overnight” (emphasis added)

and then look at referring PTE Lazarus to the New Farm Clinic or some other off-base (non-ADF) mental health facility.

13.281. The GBHC duty MOs relied entirely on Doctor 8’s assessment that PTE Lazarus was sufficiently stable to not require inpatient care. The GBHC appears not to have paid any great heed to the relevant Defence policies, and the distinction between ‘sick leave’ and ‘convalescence leave’. PTE Lazarus’ discharge from the GBHC marked the end of the GBHC responsibility for PTE Lazarus. PTE Lazarus was not referred back to the 6 RAR RMO.

13.282. The situation is compounded by the fact the GBHC, according to the Regional Director of Health, Doctor 13, is not a suitable place to hold a person with a mental health illness. Doctor 13 said difficulty also arises where an ADF member is not sick enough to be an in-patient restricted to a ward bed, though not well enough to do their normal duties. These ADF members are admitted to the Enoggera Hospital (Ward 1) as the default solution.

13.283. An acute difficulty arises for the ADF. The practicality of the operation of the various policies leads to the conclusion that no great practical purpose is ultimately served in conducting a risk assessment for any ADF member whose risk is less than ‘moderately high’ to ‘high’. This is because an ADF member whose level of risk of a further suicide attempt is assessed at the higher end of the scale, is more likely to be admitted into a civilian mental health facility.
13.284. An ADF member whose risk is assessed as being 'low' or the low side of 'medium' is less likely to be accepted into a civilian psychiatric hospital. The situation is not assisted by the circumstance that civilian psychiatric hospitals are not equipped to deal with the unique nature of ADF presentations.

13.285. By default, the ADF members whose risk of a further suicide episode is at the lower end of the scale are likely to find themselves housed temporarily in the unsuitable facilities in the MHU at GBHC (Ward 1). The ADF member cannot be held involuntarily and could discharge him or herself from the hospital at any time.

13.286. For the GBHC, convalescence leave is a tool to get ADF members away from the environment of the hospital.

TOR 12 (g) (6): Policies to ensure effective interface between civilian and military health facilities in the management of an ADF member who has engaged in non-fatal suicide conduct.

Findings

13.287. The allocation of a level of risk of suicide to an ADF member by health professionals and health practitioners acting on behalf of the ADF carries the concomitant responsibility for the ADF to provide the level of care commensurate to the risk.

13.288. The determination of a level or risk of suicide bears no correlation to the capacity of ADF health facilities to provide the appropriate level of specialist mental health care to the ADF member who is vulnerable to suicide, particularly where the ADF member is violent.

Supplementary findings

13.289. If an appropriate mental health care facility is not available, the allocation of a level of risk to an ADF member, is not only nugatory, it also potentially invites legal liability if the necessary level of care commensurate with the risk assessment is not provided.

13.290. Mental health facilities in the wider community are inadequate to respond to ADF members' particular needs for mental health care.

13.291. There is no effective interface between civilian and military mental health facilities under the recently introduced garrison support arrangements (nor the previous arrangements), for the care of ADF members who are suffering from a mental health illness, including attempted suicide.

13.292. The ADF lacks a dedicated specialist mental health facility for the management of ADF members who suffer from mental health issues but who are not sufficiently unwell to be accepted for admission to civilian mental health facilities.
The different issues arising for ADF members compared to the wider community

13.293. The evidence is that, while the risk assessment criteria may be consistent across the ADF and wider community of mental health practitioners, the application of the risk criteria differs between the ADF and the wider community – to the detriment of ADF members. The result is that the ADF does not have the capacity or capability to provide the appropriate level of care to an ADF member who is at risk of suicide.

13.294. The ADF may determine that a member is at risk of a further suicide attempt that warrants the member’s admission to a community mental health care institution. However, the admission of an ADF member to any community mental health care facility is dependent upon that institution’s own risk assessment at the time of admission. The psychiatric registrar of the institution may determine that the ADF member’s level of risk is not such as to warrant the member’s admission to that particular civilian hospital. It is possible the psychiatric registrar will refuse the admission, and release the ADF member directly into the community, on his or her own recognizance and without further reference to the ADF.

13.295. Officer 9 explained the problem as follows:

"...the Royal Brisbane Hospital, the Princess Alexandra Hospital, they see very floridly psychotic people on drugs. They see very, very highly depressed people who have a very high intention to commit suicide and they see a vast array of patients. In the military setting we see patients who have from mild to severe depression, usually not floridly psychotic because the drug culture ...... isn’t accessible (to the ADF). And because we (the Army) are responsible for a patient’s welfare...for me to decide when I see a patient that they are not going to harm themselves or others, we tend to lower that threshold because we are wholly and solely responsible (for the member’s welfare)."

13.296. The Regional Director of Health, Doctor 13, said that it is much easier to manage a person whose risk of a suicidal episode is high, because civilian mental health facilities have systems in place for someone who is suicidal, psychotic or a danger to themselves. Doctor 13 said:

"...the real danger I believe is those people who are at moderate or low risk and the ones who are potentially time bombs that we can’t assess any other way than low risk (who) is sitting in our ward (at Enoggera) or (by) sending them home."

13.297. The Regional Director of Health, Doctor 13,’s remarks reflect the circumstances of PTE Lazarus. Officer 9 said of PTE Lazarus’ situation:
"I remember...... receiving a phone call from the registrar at the Royal Brisbane where I was informed of PTE Lazarus’ situation. At that time I would have made an assessment on what had been described to me......on the basis of that phone call, I would have suggested the PTE Lazarus be taken directly to the (Enoggera) health centre to be assessed and likely admitted and provided services down there."

13.298. The point Officer 9 made is that PTE Lazarus would not have been accepted for admission by the civilian hospital for his suicidal episode because, after his initial admission on 24 Nov 10, PTE Lazarus’ level of risk diminished, at least to the extent that his risk of a further suicide event was less than “high”. If, therefore, he had not been returned to the GBHC (Ward 1) PTE Lazarus would very likely have been released by the civilian hospital into the wider community (to his family), even though he may not have been well or out of danger of a further suicide event. It was only by the intervention of Officer 9, on behalf of 6 RAR, that PTE Lazarus was admitted to the GBHC, noting that PTE Lazarus might have otherwise been considered to be “Absent Without Leave”.

13.299. Officer 21 had a similar view. He said that until the ADF has a policy and facilities that allow ADF specific treatment for the mental health conditions that are prevalent in the ADF, the ADF cannot meet its duty of care to its soldiers. He said the gap is widest when an ADF member is in a crisis but does not meet the community model of acute mental health care.

The suitability of contract mental health facilities for ADF members

13.300. The Regional Director of Health, Doctor 13, confirmed that his experience has been that there is a need for an organic intensive psychiatric service with an in-patient capacity at Enoggera. However, he said Joint Health Command’s clear instructions to him are that the Enoggera hospital is to operate as an outpatient service only. Doctor 13 said that both the COMD 7 Bde, Officer 24 and the RANR Consultant Psychiatrist referred to in paragraph 13.227 herein, support an in-house psychiatric facility.

13.301. Both Doctor 8 and Doctor 13 said that the admission of ADF members to the MHU at the GBHC (or Ward 1) at Enoggera came about because of a demonstrated need not presently recognised by the ADF health system.

13.302. Doctor 8 said:

"I have said to Defence in the past that it is important that someone has control of what is happening to sick young men and women. I
would look after them and sometimes put them in a ward out there at the (Enoggera) hospital. The hospital is not a mental health facility, just a general hospital ward. I certainly put people in there on many occasions where I considered the person to be at low risk. The hospital had no specialised psychiatric care nurses.... I had already said to Defence that, given the problems they are having with unwell people, it would be a reasonable thing to have an on base facility, but my advice was not accepted....

13.303. Using examples, The Regional Director of Health, Doctor 13, posed the question of what to do with an ADF member who is angry and/or violent (whether or not suicidal), who is not accepted for admission to a civilian mental health facility, but who, for a multitude of social reasons, is not able to return to his or her own home.

13.304. The Regional Director of Health, Doctor 13, also pointed to the difficulty as to the suitability and/or availability of an external mental health care facility. Doctor 13 said he has had the experience of ADF members being admitted to an external facility only to find that because of the types of problems that ADF members present, the external facility will say they can't handle the patient.

13.305. The Regional Director of Health, Doctor 13, gave the example of angry and aggressive ADF members being admitted to the Greenslopes Private Hospital who “sorted that place out real fast”. Greenslopes Private Hospital had experience with Vietnam veterans. Over a period of about two weeks, ADF members vented their anger and aggression on the hospital’s gymnasium equipment, such that the hospital said to the ADF “you’ve got to do something with these people.”

13.306. Doctor 8 said that civilian mental health hospitals have no interest, and no experience, in treating ADF members because the State psychiatric systems are set up for people with severe psychiatric illnesses such as schizophrenia and bi-polar disorder (which are true diseases of the mind).

13.307. Both Doctor 8 and Doctor 13 point to the dangers of admitting ADF members to a civilian psychiatric hospital. Doctor 8 said:

"... contrary to popular belief, if you go into a psychiatric hospital, you can actually learn bad habits and you can get worse, and that's a real problem. So that subtlety seems to be lost. So putting people in hospital is not the be all and end all of the solutions."
13.308. The Regional Director of Health, Doctor 13, pointed to the another difficulty in that the Enoggera hospital is not a safe place to hold ADF members with mental health issues because there are more places:

"... to hang people than a butcher’s shop... It’s a high risk environment for even people we consider to be at a low or moderate risk. But on Friday afternoon or when it all happens and you have a patient who needs to be admitted, you cannot find a bed at the moment in Brisbane... So we would admit these patients into the Enoggera Health Centre to look after them. That’s not a model that Joing Health Command wants, we didn’t have anywhere safe to put them. And we’ve been banging this old drum for a couple of years now."
14. **Findings**

14.1. **With respect to Terms of Reference (TOR) 12 (a): “General: The circumstances surrounding the death of PTE Lazarus”, the Commission finds:**

1. Private Lee Lazarus died on Wednesday 19 January 2011, between 1100 and 1250 hours, at the Sherwood Arboretum Forrest, located at the intersection of Jolimont and Douglas Streets, Sherwood, Brisbane, in the State of Queensland.

2. Private Lazarus took his own life, the cause of his death being hanging by a rope from the branch of a tree.

14.2. **TOR 12 (b): “Specific background. Incidents or actions the Commission considers may have contributed to PTE Lazarus’ attempted suicide and ultimate suicide”, the Commission finds:**

**Overview of 1 to 4 below:**

Whilst PTE Lazarus was involved in a number of potentially adverse occurrences in the period following his march in to B COY 6 RAR Rear, there is no credible evidence that these occurrences, either singularly or in combination, contributed to PTE Lazarus’ decisions, firstly to attempt suicide, and subsequently to end his life. On the contrary, it is apparent that PTE Lazarus generally enjoyed his military service, and conspicuous by its absence in both his written and verbal comments to family and friends is any indication that his military experience was a significant factor in contributing to his suicidal behaviour.

1. In relation to the WTSS incident, the Commission finds that PTE Lazarus appears to have accepted that any adverse outcome was of his own making, in that he attended his first 6 RAR activity affected by alcohol. PTE Lazarus was subjected to a rigorous PT session to determine his fitness to continue his participation in the weapons practice, but there is no evidence to suggest that this session was excessive or inappropriate in terms of its goals or conduct.

The Commission also finds that there is no evidence that PTE Lazarus was immediately or subsequently adversely affected by this incident.
2. On the morning of Mon 20 Sep 10, PTE Lazarus was the recipient of a "beasting" by a junior NCO (Soldier 7), who was under the erroneous impression that PTE Lazarus had inappropriately sold a guard duty imposed as a punishment. Not only was the beasting based on a false premise, it was administered in a public setting in the presence of a number of his peers. However, Soldier 7 believed he was doing the right thing, especially when PTE Lazarus told Soldier 7 that he (PTE Lazarus) had made a "mistake".

3. PTE Lazarus was one of 14 soldiers subjected to an inappropriate and illegal punishment following the so called 'saluting incident' on Wed 22 Sep 10. However, there is no evidence that this incident had any significant adverse impact on PTE Lazarus, in contrast to a number of his peers who were significantly disadvantaged with respect to their leave arrangements. When the Acting CO of 6 RAR rear became aware of the matter, through the intervention of the Acting CSM, the matter was remedied expeditiously and appropriately.

4. PTE Lazarus was a proud and popular person who had many friends, civilian and military. In relation to the confrontation which allegedly occurred between PTE Lazarus and another soldier at the end of Ex Hamel, whilst the facts are not altogether clear, the incident appears to have been minor and inconsequential, and there is no evidence that this incident had any significant lingering affect on PTE Lazarus.

14.3. With respect to TOR 12 (c), "Previous attempt at suicide", circumstances surrounding PTE Lazarus' overdose on pharmaceuticals on 24 November 2010, and his management subsequently by 6 RAR, medical health practitioners and others", the Commission finds:

1. The circumstances, when combined, point to an inadequacy in terms of continuity of medical care between the time of PTE Lazarus' attempt to take his life on 24 Nov 10, and his suicide on 19 Jan 11;

2. PTE Lazarus was seen by eight different duty MOs over eight days during the periods 25 – 26 Nov 10, 1 – 7 Dec 10, and on 22 Dec 10;

3. The Continuation Notes for 25 Nov 10 state that the RMO 6 RAR, OFFICER 9, "was aware of the patient";

4. RMO, 6 RAR, Officer 9, had no medical oversight of PTE Lazarus once he was admitted to the MHU GBHC on 25 Nov 10;

5. All duty MOs were civilian contractors;

6. PTE Lazarus was admitted to the MHU at the Enoggera hospital;

7. None of the duty MOs at the Enoggera Hospital had specialist training in psychiatry or psychology;
8. The MHU MO, Doctor 6 worked at the MHPS for the period Nov – Dec 10 only;

9. Doctor 6, MHU MO was a GP with no mental health specialisation;

10. All duty MOs apparently proceeded on the basis that PTE Lazarus’ risk of a further suicide attempt was “low”;

11. With the exception of Officer 18, no duty MO evidenced a systematic approach in a written risk assessment of PTE Lazarus’;

12. PTE Lazarus’ risk assessment of “low” would not activate a MEC review;

13. Consultant Psychiatrist, Doctor 8 expected PTE Lazarus to be downgraded to MEC J31 because he had been hospitalised and prescribed antidepressants;

14. Continuation notes disclose that the assessment of PTE Lazarus further risk of suicide was largely based on PTE Lazarus’ self-disclosure in response to questions of the duty MO;

15. No duty MO acted on Doctor 8’s Specialist Report PM 526 of 3 Dec 10, and 7 Dec 10, provided to the MHU at the time, and placed on PTE Lazarus’ Inpatient Clinical Record, to the effect that PTE Lazarus was “not fit for duty”;

16. No duty MO placed PTE Lazarus on sick leave as being “not fit for duty” as identified by Doctor 8 (rather than convalescence leave);

17. No duty MO’s Continuation Notes record any follow-up medical treatment of PTE Lazarus in light of the toxicity affecting his liver arising out of the pharmaceutical overdose;

18. No duty MO referred PTE Lazarus for a MEC review arising from his hospitalisation at the Wesley/RBHW for the pharmaceutical overdose, or for his being held on the MHU at the Enoggera Hospital for the issue of depression and suicide risk;

19. PTE Lazarus’ failure to attend a convalescence review appointment on 14 Dec 10 was not noted or followed up by either the MHU GBHC, or Rear Details, 6 RAR;

20. On 26 Nov 10, the CO 6 RAR caused a Quick Assessment to be conducted; and

21. On 26 Nov 10, the CO 6 RAR established a Risk Management Team (RMT) in accordance with DI(G) PERS 16 – 26, Management of a suicidal episode in the Department of Defence.
14.4. With respect to TOR (d): “Communication between Commanding Officer (CO) 6 RAR and medical professionals. Whether, prior to commencing his leave in December 2010, CO 6 RAR was apprised of a psychiatric diagnosis and prognosis provided by (Doctor 8); if not, why he was not so apprised, and if so, whether his response to that information was appropriate”, the Commission finds:

1. On the information available to him, the response of CO 6 RAR was practical, attentive, and the best he could achieve in the circumstances. In some respects, the response did not reflect the purpose to be achieved by DI(G) PERS 16-26, but this was beyond the control of CO 6 RAR.

2. The CO 6 RAR was not apprised of Consultant Psychiatrist, Doctor 8’s diagnosis or prognosis when he commenced his leave in Dec 10.

3. CO 6 RAR had no visibility of PTE Lazarus’ medical circumstances once PTE Lazarus was discharged from the GBHC on convalescence leave on and from 7 Dec 10.

4. On being advised of PTE Lazarus’ suicide attempt on 24 Nov 10, CO 6 RAR caused a Quick Assessment to be conducted.

5. In accordance with DI(G) PERS 16-26, CO 6 RAR established a Risk Management Team (RMT) within the mandated period of 24 – 48 hours after PTE Lazarus’ suicide attempt.

6. The RMT was, however, non-compliant with the mandated policy in that:

   i. The membership of the RMT did not accord with the policy in that it failed to include PTE Lazarus' treating Mental Health Practitioners and his treating MO. The RMT was unable to establish an effective relationship with the treating Mental Health Professionals.

   ii. The membership of the RMT reflected administrative needs of the Unit rather than establishing a communication mechanism between the Unit and GBHC.

   iii. The CO 6 RAR had no visibility of PTE Lazarus from 26 Nov until 1 Dec, when PTE Lazarus was an in-patient at a civilian hospital, and therefore the RMT could not properly fulfil its function;

   iv. The CO 6 RAR was unable to obtain information from GBHC medical staff on PTE Lazarus' re-admission at the MHU GBHC on 1 Dec 10 because the GBHC did not pass on medical information to the member’s Unit, and therefore the RMT could not properly fulfil its function.
14.5. **With respect to TOR 12 (e): “Assessment of suicide risk”**. Whether PTE Lazarus was formally assessed for suicide risk in accordance with applicable policy and whether that suicide risk assessment identified the appropriate level of risk”, the Commission finds:

1. **PTE Lazarus** was not formally assessed for suicide risk in accordance with applicable policies within the timeframe of 24-48 hours after admission to the MHU GBHC and therefore no Crisis Management Plan was put in place. The only risk assessment undertaken was by Officer 18, a new and inexperienced army psychologist, on 5 Jan 11, some six weeks after the non-fatal suicide event. That risk assessment did not ascribe a level of risk to PTE Lazarus.

2. The CO 6 RAR was **not apprised of Consultant Psychiatrist, Doctor 8’s diagnosis or prognosis** when he commenced his leave in Dec 10.

3. **PTE Lazarus** was **not formally assessed for suicide risk in accordance with applicable policies within the timeframe of 24-48 hours after admission to the MHU GBHC**.

4. CO 6 RAR is **not correct in his belief that a suicide risk assessment had been conducted by the GBHC Mental Health Professionals**. The referral of PTE Lazarus to Consultant Psychiatrist, Doctor 8 did not constitute a suicide risk assessment in accordance with the relevant policies.

5. In the absence of a comprehensive suicide risk assessment, the RMT established by CO 6 RAR was unable to promulgate a ‘Crisis Management Plan’ (CMP).

6. Officer 18 had only **been commissioned in the Army in Nov 10**. She had been **granted provisional registration as a psychologist in 07 and full registration in 09**. Accordingly it is **arguable that Officer 18 was not sufficiently experienced to undertake the risk assessment of PTE Lazarus on 5 Jan 11**.

7. On 5 Jan 11, Officer 18 **did not ascribe a level of risk to PTE Lazarus**.

8. No single MO can be regarded as PTE Lazarus' ‘treating MO’ or ‘case manager’, with the result that no MO can be said to have been responsible for carrying out the suicide risk assessment upon PTE Lazarus’ admission to the MHU GBHC.

9. The categorisation of risk of suicide as ‘low’ appears to lead to an assumption that PTE Lazarus was no longer at risk of a further attempt at suicide and therefore did not warrant the development of a risk management plan.

10. It is not certain that either the DI or HD 294 are legally binding on contract health practitioners, therefore it cannot be established that any
MO had an obligation to conduct the suicide risk assessment of PTE Lazarus.

11. Each and every duty MO who treated PTE Lazarus while he was an in-patient at the MHU GBHC, was qualified, in accordance with the relevant policies, to conduct a comprehensive suicide risk assessment of PTE Lazarus.

12. None of duty MOs at the Enoggera Hospital had specialist training in psychiatry or psychology.

13. No MO who treated PTE Lazarus conducted a comprehensive suicide risk assessment in accordance with the relevant policies.

14. The assessments actually undertaken by the duty MOs did not constitute a comprehensive suicide risk assessment as envisaged by the relevant policies.

15. No duty MO attributed a level of risk of suicide to PTE Lazarus during his time as an in-patient at the MHU GBHC.

16. PTE Lazarus appears to have been assumed to be at a ‘low’ level of risk of a further suicide attempt, based entirely on his self-disclosure.

17. The relevant policies do not appear to permit a Mental Health Professional to delegate the responsibility to conduct a comprehensive suicide risk assessment to a consultant psychiatrist.

18. PTE Lazarus’ In-patient Clinical Records do not include a copy of the referral notes to consultant psychiatrist, Doctor 8. It is therefore not possible to ascertain whether Doctor 8 was requested to conduct a comprehensive suicide assessment of PTE Lazarus on behalf of the GBHC.

19. On PTE Lazarus being referred to Doctor 8 on 3 Dec 10, PTE Lazarus became Consultant Psychiatrist, Doctor 8’s private patient. Any clinical notes made by Doctor 8 were not made available to the MHU.

20. Doctor 8’s diagnosis, provided to the MHU GBHC on 6 Dec 10, was that PTE Lazarus was suffering a “major depressive disorder”. Doctor 8 did not disclose whether he made a formal assessment of PTE Lazarus.

21. PTE Lazarus’ admission to Ward 1, GBHC, after his discharge from the RBWH on 1 Dec 10, was in the nature of a “stop-gap measure” pending Consultant Psychiatrist, Doctor 8’s further directions. Duty MOs do not appear to have exercised any independent case management of PTE Lazarus (such as placing him on sick leave,) or initiating a MEC review arising out of his hospitalisation from the pharmaceutical overdose.
22. Officer 18 undertook the first comprehensive suicide risk assessment of PTE Lazarus, consistent with the relevant policies, on 5 Jan 11.

23. Officer 18 did not consult with the referring MO, (Doctor 12), on the outcome of her suicide risk assessment as she did not believe her assessment would add value to PTE Lazarus’ medical management.

14.6. With respect to TOR 12 (f): “the Unit approval procedures for convalescence leave, Whether actions taken were adequate, appropriate and consistent with applicable policy in all the circumstances relating to the role of the Unit in PTE Lazarus’ convalescence leave approval”, the Commission finds:

1. The CO 6 RAR did the best he could in all the circumstances. In effect, Officer 21 was handed a fait accompli by the GBHC, which he sought to manage reactively. He had no information available to him, and no mechanism to contribute to the options for PTE Lazarus’ management from a medical perspective.

2. The GBHC did not advise 6 RAR prior to placing PTE Lazarus on convalescence leave.

3. Contrary to his understanding and belief, Officer 21 did not have sufficient relevant information for him to exercise his command responsibilities in an informed manner in granting of convalescence leave to PTE Lazarus on 7 Dec 10.

4. Had the RMT he had established been able to fulfil its function in accordance with the policy, it is likely it would have quickly become apparent to the RMT and Officer 21 that PTE Lazarus should have been on sick leave rather than convalescence leave.

5. It is possible that Officer 21, in direction, that the Unit must have visibility of PTE Lazarus by requiring his attendance at 6 RAR before any approval convalescence leave, was detrimental to PTE Lazarus. In any event, the Unit had no visibility of PTE Lazarus from 7 Dec 10 when he was granted ongoing convalescence leave.

6. There was no system in place to contemporaneously identify that PTE Lazarus had failed to attend the medical appointment, scheduled for 14 Dec 10, for the review of his convalescence leave.

7. 6 RAR’s administrative approval processes for convalescence leave otherwise complied with the relevant policy.
With respect to TOR (g): “Adequacy of current ADF policy”, Whether at material times, the applicable policy was adequate, particularly with respect to”:


1. The policies give rise to mutually exclusive interests: DI(G) PERS 16-26 vests responsibility for the welfare of ADF members in Command, whereas the centralised garrison support model vests responsibility in a fragmented ‘consumer driven’ civilian contract health delivery service which operates independently of the chain of command.

2. There is a gap between the needs of ADF members with respect to mental health care, and the availability and suitability of services and facilities available in the wider civilian community.

3. The evidence has disclosed a degree of failure by the Enoggera Health Centre and civilian contract duty Medical Officers at the MHU GBHC to adhere to ADF policies and practices designed to protect ADF members who have attempted suicide or are engaging in suicidal ideation specifically:

i. The failure of the MHU GBHC to undertake a comprehensive risk assessment of PTE Lazarus within 48 hours of PTE Lazarus’ admission to the GBHC on 1 Dec 10 after his discharge from the Royal Brisbane and Women’s Hospital; and

ii. Proceeding on an assumption that PTE Lazarus’ risk of suicide was “low”. However, as outlined in paragraph 12.27 herein, any assessment was not a predictor of future conduct, it was only a snapshot in time.

4. The evidence identified by the COI suggests that, while responsibility for the welfare of ADF members vests in Command, current arrangements are such that Command no longer ‘owns’ or controls the capability necessary to deliver the policy outcome.

5. Civilian health contractors do not appear to be legally bound to apply ADF mental health policies, or if they are legally bound, are not applying ADF policies designed for the protection of ADF members who have attempted suicide or are engaging in suicidal ideation.

6. Contract medical practitioners treat the individual ADF member as a private ‘consumer’ of medical services.

7. Civilian health contractors’ professional mandate rules of medical confidentiality have the effect that the health practitioners do not consider that they have any obligation of disclosure to the ADF about an ADF member in their care.
8. The complexity and burden of the policy framework creates its own resource and compliance difficulties for the ADF.

14.8. With respect to TOR 12 (g) (1) (a), "Whether the mechanism of a Risk Management Team to establish to establish a Crisis Management Plan is appropriate", the Commission finds:

1. The policy construct that requires a commanding officer to establish a Risk Management Team (RMT) to devise a Crisis Management Plan (CMP) within 24-48 hours of an ADF member attempting suicide cannot work in all circumstances. This is because the policy is inconsistent with the organisational arrangements for the delivery of medical services to ADF members who are suffering mental health issues.

2. The concept of a RMT to establish a CMP is generally appropriate, but is not easily adapted to the more complex cases.

3. The efficacy of a RMT is dependent upon the commanding officer having command and/or control over the medical capability to meet the policy obligations of DI(G) PERS 16-26.

4. The CO should have access to adequate medical information, particularly any relevant prognosis.

5. Organic first-line medical support is pivotal to an RMT being able to obtain timely and appropriate medical information.

6. The RMT process focuses on the ADF member’s suicidal episode in isolation of the member’s underlying mental health issues.

7. The policy is resource intensive.

8. The RMT process does not envisage an ADF member being hospitalised in a civilian hospital for emergency treatment for physical injuries arising out of the suicidal episode.

9. There is a policy overlap between the role of Welfare Boards, and the RMT process outlined in DI(G) PERS 16-26. Within Army, Unit or Formation Welfare Boards provide an established, robust and mature process for the management of Army personnel with significant health issues, including mental health issues.

14.9. With respect to TOR 12 (g) (1) (b) : "What role the treating medical officer would have in the policy process", the Commission finds:

1. The role of the ‘treating medical officer (MO)’ is central to the efficacy of the policy, as the interface between the Unit and civilian mental health
practitioners and specialists.

2. The extant policy assumes organic first-line medical support through a
uniformed Regimental Medical Officer (RMO).

3. The extant policy does not define the term ‘treating medical officer (MO)’.

4. There is a multitude of views as to who is, or should be, the ‘treating MO’.

5. The ‘treating MO’ should be in a position to disclose relevant medical
information about an ADF member to the Unit.

6. It was highly significant that:

   i. There was no single ‘treating MO’ to provide oversight and
      continuity of care at the Gallipoli Barracks Health Centre (GBHC),
      with the result that Consultant Psychiatrist, Doctor 8 became the
      default reference point for continuity of treatment; and,

   ii. PTE Lazarus was not referred for a Medical Employment
       Classification (MEC) review, because he did not have one single
       treating MO with the clear responsibility for initiating the MEC
       referral.

14.10. **With respect to TOR 12 (g) (1) (e), “Whether a CO has a discretion to vary
the membership of a Risk Management Team”, the Commission finds:**

1. The efficacy of the extant policy is dependent on it not being open to a
   CO vary the membership of the Risk Management Team (RMT).

2. The policy is not sufficiently flexible to accommodate circumstances
   where the staff mandated by the policy either are not available, or are not
   available within the timeframe mandated by the policy.

3. The Commission is of the view that, ultimately, the function of an RMT
   is to essentially assess and mitigate risk; the means by which it does so
   should be a discretion for the Commanding Officer.

4. The policy design is such that it is only with the participation of the
   designated mental health professionals and the treating MO, in
   conjunction with the Unit, that the policy is viable and effective in
   communicating relevant information in one forum; to that extent, it is
   inflexible and unrealistic.

5. The policy does not address the role of the Unit in the RMT process.

6. The policy does not take into account that medical stakeholders external
to the Unit are not necessarily available, or available within the mandated policy timeframe of 24-48 hours after the ADF member has attempted suicide, to attend an RMT.

7. The policy does not take into account reduced availability of medical staff and the treating MO during reduced tempo or stand-down periods, or in the absence of the treating MO (assuming the treating MO is the RMO).

8. The policy is not compatible with the (new) centralised garrison support civilian health practitioner contractor model.

14.11. With respect to TOR (g) (1) (d), "The mechanism for triggering the applicable policies where an ADF member is initially in the care of a civilian health facility prior his or her Unit or the ADF becoming aware of a non-fatal suicide episode", the Commission finds:

1. The policy wrongly assumes the Unit has immediate visibility of the relevant conduct.

2. The policy wrongly assumes the Unit is notified of the attempted suicide.

3. A Unit is in danger of losing visibility of the member who is admitted for treatment to a civilian hospital.

4. The policy does not accommodate the circumstance of an ADF member initially being in the care of a civilian health facility in relation to a health matter, of which an attempted suicide is but one aspect.

5. The policy does not accommodate the circumstance of a civilian hospital releasing an ADF member back into the community on the member's own recognizance, based on the civilian hospital's own suicide risk assessment of the member.

6. The policy does not accommodate the situation that civilian hospitals are not under any obligation to report to the ADF where a member has attempted suicide.

7. The policy cannot operate where an ADF member is being treated as an inpatient of a civilian hospital or by a non-ADF civilian contract doctor.

14.12. With respect to TOR 12 (g) (1) (e): "The operation of the applicable policy where there are multiple ways in which a member may interact with the ADF medical system", the Commission finds:

1. Dl(G) PERS 16-26 is unworkable in the absence of a formally designated 'treating MO' who is legally capable and obliged to report medical information about an ADF member to a military commander.
2. The extant policy is evidently based on a construct whereby ADF members access the ADF medical health system by presentation to an RAP staffed by uniformed medical support (the RMO).

3. RAPs and RMOs having been removed, ADF members now access the ADF medical health system by direct presentation to a centralised garrison support ‘clinic’ or ‘hub’, staffed by contract civilian general practitioners, or directly to the Mental Health and Psychology Section (MHPS).

4. The hub/clinic may refer a member on to a civilian health care facility or an off base service nominated by the outsourced health solutions provider.

5. Under current arrangements, the individual ADF member is the ‘consumer’ of medical services provided by centralised garrison support hubs/clinics, and outsourced provider. The individual ADF member is no longer a beneficiary of organic health care deemed necessary by the institution of the ADF as the consumer of medical health services.

6. Hence, Commanders have no command or control over the civilian managed general practitioner hubs or clinics, nor service providers engaged under the auspices of the outsourced health solutions provider.

7. Senior officers who gave evidence to the Commission do not consider the removal of RMOs to be sound policy.

14.13. **With respect to TOR 12 (g) (1) (f),** “the operation of the applicable policy where medical staff are not engaged or available upon a full time basis”, the Commission finds:

1. Defence has an obligation to ensure that the standard of care provided by its contractor/health practitioners is appropriate; otherwise Defence is potentially at risk of exposure to legal liability.

2. There is no current mechanism to retain oversight of the ADF member to ensure continuity and coordinated health care management for the member.

3. PTE Lazarus had no continuity in his treatment while an inpatient at the GBHC; he was seen by a procession of civilian contract duty MOs working on a job share or locum basis.

4. The Enoggera Clinic and the Enoggera Health Centre continue to be staffed by contract medical practitioners on a part-time and/or locum basis. Accordingly, it is arguable that the situation which confronted PTE Lazarus will be repeated.

5. It is not clear whether civilian contract medical staff at the Enoggera
Clinic or the Enoggera Health Centre are contractually bound and legally obliged to apply any ADF medical management policies.

6. The centralised garrison approach to the provision of health services at Enoggera has undermined a commanding officer’s capacity to fulfil his or her command function of being responsible for the welfare and administration of the members of his or her Unit.

7. Staffing on a part-time or job share basis is a significant problem for the management of files and the development of relationships.

8. The model based upon the outsourced civilian contracting on referral from a GP hub located on base is inconsistent with the way complex psychiatric cases are managed in the non-ADF mental health fraternity.

9. The evidence presented to the COI suggests that the outsourced model lacks oversight and coordination for the treatment of ADF members suffering complex mental health issues.

14.14. **With respect to TOR 12(g) (2),** “The obstacles to medical health professionals and medical health professionals disclosing medical information to the chain of command in the event of non-fatal suicide episodes”, the Commission finds:

1. The professional obligations of contract medical practitioners to the individual ADF member arising from the confidentiality of medical information do not, of themselves, pose an obstacle to the disclosure of medical information to the chain of command. Differentiation needs to be made between a diagnosis and a prognosis.

2. Contract medical practitioners appear to consider their obligation of medical confidentiality is to individual ADF members. If so, that could constitute a breach of their professional obligation to disclose relevant medical information about an individual ADF member to command.

3. It is not apparent that contract medical practitioners are bound to apply ADF health policies that, in some circumstances, require them to disclose medical information to the chain of command.

4. The optimal outcome is achieved when uniformed medical support mediates between contract medical practitioners and a commanding officer in the release of medical information about an individual ADF member, sufficient to meet a commanding officer’s decision-making needs.

5. The ADF policy is capable of being prescriptive as to the nature and extent of the medical information a commanding officer is entitled to be told about an ADF member. Past instances of inappropriate use of medical-in-confidence information, poor file management and the
separation of a member's medical files and psychology files have exacerbated policy difficulties.

6. It is arguable that a culture has developed where contract medical practitioners apply their own preferences, with instances where doctors have withheld medical information from commanding officers (albeit for well intentioned reasons).

7. Whether deliberate or otherwise, relevant medical information may not be available to be disclosed because of inadequate documentation and reporting and/or a practice having developed of 'exception' reporting of a change in an ADF member's medical condition, with the result that there are significant gaps in the potential knowledge of a member's medical condition and treatment regime.

8. The issue of disclosure of medical-in-confidence information is exacerbated under the centralised garrison support system which effectively removes the commanding officer's organic first-line medical support.

9. Specific policy weaknesses arise by reason of:

   i. Contract medical practitioners not being specifically and clearly legally bound to apply ADF health policies.

   ii. The practical application of the obligation of medical confidentiality at the point of the civilian/military interface.

   iii. Differences between the different medical professional groups as to what medical information can be disclosed.

   iv. The ability for contract medical practitioners (with the best of intentions) to effectively quarantine the member from the chain of command, and thereby circumvent the relevant Defence Instructions and Health Directive, thus preventing disclosure of medical information to commanders.

   v. Concerns that a medical practitioner may:

      • insist upon strict medical confidentiality, rather than the ADF member giving his or her willing and informed consent to release relevant medical information, as discussed between the doctor and the member as part of the case management process; or

      • assert the doctor's own interests by not seeking an individual ADF member's consent to the release of relevant medical information.

10. The lack of articulation of exactly what information a commanding
officer needs to know, as distinct from what a commanding officer might want to know, i.e. the distinction between a prognosis as opposed to a diagnosis.

14.15. **With respect to TOR 12(g) (3),** "Whether the risk assessment criteria for determining whether a person is at a 'low', 'medium' or 'high' risk of a further suicide attempt are appropriate and suitable in light of the demands of military service and the expectations of command in the management of a member of the ADF who has engaged in non-fatal suicide conduct", the Commission finds:

1. Health Directive 294 is not meeting Command's needs and expectations.

2. The function of a suicide risk assessment is inadequately explained in the policy, and is potentially misunderstood by commanders.

3. The criteria for determining an ADF member's level of risk of suicide is inadequately articulated in the policy.

4. The language of 'low', 'medium' and 'high' in the risk assessment process is potentially misleading, in that the lay-person may incorrectly impose a correlation between an allocated level of risk and the likelihood of suicide.

5. While mental health professionals and specialists across the ADF and wider community use the risk assessment language of 'low', 'medium' and 'high', the application of the risk assessment process does not yield consistent results between mental health practitioners who have specialist experience of ADF members, and mental health practitioners in the wider mental health community.

6. The evidence suggests that none of the duty MOs at the GBHC at the time of PTE Lazarus' admission as an inpatient was aware of, or considered him or herself bound to apply any ADF policy applicable to an ADF member who is at risk of suicide, or suffering suicidal ideation.

7. The risk assessment of PTE Lazarus conducted by Duty MOs during the period 25 Nov-22 Dec 10 was perfunctory; no level of risk was recorded.

8. As a private practice Consultant Psychiatrist, Doctor 8 was not (and should not) be bound by the ADF policies to conduct the risk assessment (though he may have conducted such an assessment for his own purposes in his treatment of PTE Lazarus).

9. Contrary to the policy, the GBHC did not conduct a risk assessment of PTE Lazarus until he was referred to a uniformed psychologist on 5 January 2011.
14.16. **A respect to TOR 12 (g) (4):** “At what point should a person who has engaged in non-fatal suicide conduct undergo a medical classification review in accordance with Defence Instruction (General) PERS 16-15 Australian Defence Force Medical Classification System”, the Commission finds:

1. The MEC policy should be sufficiently robust to accommodate a number of contradictory policy objectives:
   
i. The maintenance of optimum fitness levels for the ADF as a whole, with emphasis on the deployment capability;
   
ii. Acceptance that an ADF member may suffer a mental health illness, including a suicidal episode, during his or her ADF career, but will recover full or sufficient health to remain a member of the ADF;
   
iii. The streamlined redeployment of ADF members who may no longer be able to meet the employment requirements of one category;
   
iv. mustering, but meets the fitness requirements of another category or mustering; or
   
v. The streamlined immediate discharge as a simple administrative decision without fault of a recently joined ADF member who is not suited to military life.

2. The policy should articulate a mandatory requirement that an ADF member who has attempted suicide should be referred for a MEC review concurrently with the comprehensive suicide risk assessment mandated by D(I(G) PERS 16-26.

3. In the absence of a mandatory MEC review contemporaneously with the suicidal episode, an ADF member who has attempted suicide is likely to end up in limbo, with the member having no certainty as to the his or her future treatment or future employment prospects.

4. The MEC system should adopt an approach that accepts that an ADF member can (and is likely to) recover from a mental health issue, and allow a member’s MEC to be upgraded after the completion of stabilising treatment, allowing the member to declared fit for duty/deployment.

5. The MEC policy is currently unnecessarily inflexible in its approach to the prescribed use of anti-depressants by an ADF member, whether or not that member has suicidal ideation or has attempted suicide.

6. The practical operation of extant MEC policies where a member is suffering from a mental health illness has the result that ADF members are seeking private medical treatment, often on referral from the VVCS. The consequence of this type of situation for the ADF is that it has no visibility of the nature and extent of mental health illness being suffered
by ADF personnel (that is, there presently exists a sub-culture of members with mental health issues who have ‘gone underground’).

7. The MEC system should support the retention of trained ADF members by simplifying and streamlining the redeployment of members between categories or musterings as befits their actual fitness levels.

8. The MEC system is deleterious for the management of long term ‘not fit for duty’ soldiers.

9. The ADF lacks a streamlined means to achieve the ‘without fault’ discharge of recently-recruited ADF members (under two years) who suffer from mental health issues, where those members probably should never have been accepted to serve in the ADF.

14.17. **With respect to TOR 12 (g) (5):** "Whether the processes for approving convalescence leave in accordance with Defence Instruction (General) PERS 16-21 – Sick Leave and Convalescence Leave – Defence Members are appropriate and adapted for an ADF member who is undergoing medical assessment and treatment following non-fatal suicide conduct", the Commission finds:

1. Convalescence leave has become the medical profession’s default position for ADF members assessed as being at a ‘low’ or the low end of a ‘medium’ level of risk of suicide.

2. GBHC MOs effectively derogated their responsibilities to Consultant Psychiatrist, Doctor 8’s instruction to grant convalescence leave, on the basis that Doctor 8 was treating PTE Lazarus. In so doing, the GBHC MOs failed to exercise an independent judgement as to whether it would be more appropriate to recommend that PTE Lazarus be granted sick leave rather than convalescence leave.

3. It appears that Consultant Psychiatrist, Doctor 8 was unaware of any policy distinction between a grant of ‘convalescence leave’ and a grant of ‘sick leave’. Doctor 8’s expressed concern was to ensure an ADF member with mental health issues was not hospitalised, or required to attend the Unit when they had been classified MEC J52 (not employable on medical grounds).

4. The GBHC did not initiate a MEC Review.

5. It was not, and is not, Consultant Psychiatrist, Doctor 8’s role or responsibility to ensure the GBHC applies ADF policies to an in-patient at the GBHC.

6. The GBHC duty MO recommendation that PTE Lazarus proceed on convalescence leave had the effect that 6 RAR lost control of his overall management and welfare.
7. Recommending PTE Lazarus proceed on convalescence leave delayed the initiation of the MEC Review process.

8. It should only be the exception for a commanding officer to grant convalescence leave to an ADF member who has attempted suicide. As a general statement, an ADF member who has attempted suicide should be granted sick leave rather than convalescence leave.

9. A commanding officer who is considering a grant of convalescence leave (as an exception) to an ADF member who has attempted suicide should be obliged to make inquiries as to whether it is necessary for that member to report to the Unit in person for the approval of the convalescence leave.

14.18. With respect to TOR 12 (g) (6): “Whether applicable policy ensures the effective interface between civilian and military health facilities in the management of an ADF member who has engaged in non-fatal suicide conduct”, the Commission finds:

1. The allocation of a level of risk of suicide to an ADF member by health professionals and health practitioners acting on behalf of the ADF carries the concomitant responsibility for the ADF to provide the level of care commensurate to the risk.

2. The determination of a level or risk of suicide bears no correlation to the capacity of ADF health facilities to provide the appropriate level of specialist mental health care to an ADF member who is vulnerable to suicide, particularly where an ADF member is violent.

3. If an appropriate mental health care facility is not available, the allocation of a level of risk to an ADF member, is not only nugatory, it also potentially invites legal liability if the necessary level of care commensurate with the risk assessment is not provided.

4. Mental health facilities in the wider community are inadequate to respond to ADF members’ particular needs for mental health care.

5. There is no effective interface between civilian and military mental health facilities under the recently introduced garrison support arrangements (nor the previous arrangements), for the care of ADF members who are suffering from a mental health illness, including attempted suicide.

6. The ADF lacks a dedicated specialist mental health facility for the management of ADF members who suffer from mental health issues but who are not sufficiently unwell to be accepted for admission to civilian mental health facilities.
PTE LAZARUS COI REPORT

SECTION 15

A MATTER OF CONCERN

and

RECOMMENDATIONS

15. **A Matter of Concern**

15.1. Although it is a matter beyond the remit of the Commission of Inquiry, at page 101 of the Report, the Commission mentioned the almost Herculean task presented to the CO 6 RAR to effectively remotely command the Rear Element of the Battalion, while simultaneously attempting to focus his energies on the command of his Unit during high tempo operations in Afghanistan.

15.2. This issue was not raised by Officer 21 in his evidence, but is a matter which caused concern to all three Commissioners.

15.3. The dual responsibility imposed on the CO 6 RAR had the real potential to distract from full operational alertness and efficiency. Fortunately, that did not occur. That does not mean that such a distraction might not occur to another Battalion Commander in the future, if so deployed.

15.4. With respect, the Commission is of view that this is a matter which demands urgent attention.

**Recommendations**

15.5. There is an urgent need to clarify whether the ADF considers the ultimate responsibility for the welfare and wellbeing of ADF members should rest with the members’ chain-of-command or with Joint Health Command.

15.6. There is an urgent need to clarify where legal liability is likely to vest in the event of systemic failure, such as occurred with PTE Lazarus, where commanding officers no longer have the capacity or capability to carry out their mandated responsibilities under the health care policies.

15.7. The aim of HD 294 is to provide ADF Mental Health Professionals and Specialists with clear guidance regarding the management of ADF members who are considered to be at risk of suicide. The Commission has identified inconsistency in the application of the term “low risk” of suicide. Low risk, as defined in HD 294 (Annex A 8b), is nevertheless a significant risk requiring active intervention as outlined in Annex C, paragraphs 1-7. However, the Commission has encountered examples where the term has been applied to
circumstances where no significant risk is apparent, and where no intervention by a Mental Health Professional is contemplated. It is the view of the Commission that the term ‘minimal risk’, rather than “low risk”, should be used to describe such circumstances.

15.8. Accordingly, the Commission recommends a holistic review of HD 294 to address that and other issues, and a similar review of DJ(G) PERS 16-26, to address the issues mentioned in Section 13 of the Report.

15.9. The Commission notes that DJ(G) PERS 16-21, dealing with “Sick Leave and Convalescence Leave – Defence Members,” expired on 21 Sep 12. This expired document should also be considered in the holistic reviews recommended by the Commission in the preceding paragraph, with the intent of achieving a seamless medical and administrative management of an ‘at risk’ ADF member, at least until that risk has been ameliorated.

15.10. As mentioned in paragraph 3.52 and 3.53 of the Report, the Commission strongly recommends that an unredacted copy of the Report be provided to the Brisbane Coroner, Mr John Lock, as soon as possible. That recommendation has the unanimous support of Counsel Assisting.

15.11. Disclosure of the Report, or any part of its associated records, is of course a matter for the Minister, and not the Commission, to authorise.

15.12. The Commission is also of the view that Coroner Lock should not be burdened with the Annexures to the Report, most of which have been given “Restricted Access” status by the Commission. Accordingly, the Commission does not recommend that Coroner Lock be provided with the Annexures.
PTE LAZARUS COI REPORT

SECTION 16

CONCLUDING COMMENTS

16. Concluding comments

16.1. The compilation of the Report has not been without difficulty and its completion has taken longer than anticipated. Accordingly, the CDF Commissions of Inquiry Directorate (the COI Directorate) granted an extension of time until 31 May 2013.

16.2. In Section 1 of the Report, the assistance of Counsel Assisting has been acknowledged and placed on the record. Further, the Commission acknowledges the role of Counsel Assisting in the preparation of the Report, and thanks them for their very significant contributions. In particular, the Commission wishes to thank [redacted], who was tasked with preparing the draft for that part of the Report dealing with the Phase 2 issues, namely, the “doctrinal” issues. Her contribution has been invaluable.

16.3. The Commission thanks the COI Directorate for its assistance and patience. In particular, the Commission wishes to commend Royal Australian Air Force [redacted] from the COI Directorate, for his services as Secretary to the Commission. Known throughout the hearings as ‘Mr Secretary’, he has performed his many duties most efficiently and has responded to the many demands made upon him by the Commission in a prompt and professional manner.

16.4. Within the context of its Terms of Reference, the Commission has endeavoured to inquire into the circumstances surrounding the tragic death of PTE Lazarus.

16.5. It is apparent from the evidence that PTE Lazarus generally enjoyed his military service, and conspicuous by its absence in both his written and verbal comments to family and friends is any indication that his military experience was a significant factor in contributing to his suicidal behaviour on Wed 24 Nov 10 and Wed 19 Jan 11.

16.6. The evidence established that the decision of PTE Lazarus to take his own life was not a sudden decision made on 19 Jan 11, but was planned well in advance and was well hidden from his family and friends, both civilian and military.

16.7. PTE Lazarus was a young man to whom reputation was important. He was a popular soldier: not only did soldier friends from 6 RAR attend his Memorial Service, but also soldier friends from four other infantry Battalions. As one of
his soldier friends, Soldier 17, said of PTE Lazarus “He loved the Army and was proud of himself. Everyone was proud of him.”

16.8. Whatever caused PTE Lazarus to attempt to take his life on 24 Nov 11, it may be that PTE Lazarus thereafter considered his reputation “damaged” in the eyes of the Army, with his mental stability being questioned and his military future in jeopardy. That indeed was the view PTE Lazarus’ closest civilian friend.

16.9. Clearly, mental health issues were involved. Sadly, a degree of stigma still attaches to such issues within the community at large and within the ADF.

16.10. Over the past four years, the ADF has undertaken a significant body of work to improve mental health services within the ADF and to better understand ADF members’ mental health needs. The CDF is committed to breaking down “the wall of silence” with respect to such issues, and leading a change in attitudes across the ADF.  

16.11. Counsel Assisting have correctly pointed out that there is no reasonable basis to questions the standard of clinical treatment provided to PTE Lazarus in the aftermath of his attempted suicide on 24 Nov 11. However, the same cannot be said of his non-clinical administration or medical management; that is, the events after his admission as an inpatient to the general ward at Enoggera Hospital, while he was in the care of the Mental Health Unit, and during his convalescence.

16.12. The reality is, that PTE Lazarus did not receive the continuity of case management that is expected. What continuity there was in the medical treatment of PTE Lazarus was that which was provided by the Consultant Psychiatrist, Doctor 8, and that continuity was broken by the advent of the Brisbane Floods in early Jan 11.

16.13. The parents of PTE Lazarus have a legitimate expectation that their son’s death would result in this Commission of Inquiry.

16.14. The Commission is unable to assuage the anguish of PTE Lazarus’ family and his many friends, resulting from his death, but it shares the sentiments of Lead Counsel Assisting, [redacted], when he said to the mother of PTE Lazarus at the conclusion of the hearings:

“[redacted], we can only try to understand your loss, but if any good has come from your son’s death it has been that we have been able to have this forum to shine a light upon our own processes.”

16.15. It is the hope of the Commission that any weaknesses within ADF processes and policies disclosed by that light will be addressed.

26 May 2013