REPORT OF THE COMMISSION OF INQUIRY INTO THE DEATH OF

CORPORAL JORDAN LEIGH TALAY

NUMBER 3 SQUADRON
ROYAL AUSTRALIAN AIR FORCE

ON 15 JANUARY 2008
INDEX

INTRODUCTION 4

BACKGROUND 7

General Background and Royal Australian Air Force Service 7

Events Leading to Death 8

Mental Health 10

TERMS OF REFERENCE 13

Circumstances Surrounding the Death (TOR Paragraph 5(a)) 13

 Sufficiency of any Actions and Decisions taken by Defence Personnel (TOR Paragraph 5(b)) 14

(i) Administrative and Operational Management 14
    a. Workplace Bullying/Harassment 14
    b. Ammunition Incident 14

(ii) Medical Treatment and Management 15
    a. 2ATHS 15
    b. Dr Nicholas 16
    c. Dr Henry 20

Any Substantial Weaknesses or Deficiencies (Isolated or systemic) in Defence Systems, Policies, Equipment, Practices, Procedures and Training 24

(i) Medical Record Keeping 24
    a. System 24
    b. Auditing 27
    c. ADF Military Liaison Officer 27

(ii) Training: 28
    a. Suicide Awareness Training in the ADF 28
    b. Suicide Awareness Training Coordinator 28
    c. Self-harm Risk Assessment Training for ADF Health Providers 28
    d. Communication between ADF Health Providers and Commanders 29

(iii) Policy: 30
    a. ADF Commanders Duty of Care 30
    b. Authority to Direct the Formation of a Crisis Management Team 31
(iv) Privacy
   a. ADF Medico/Legal Hotline

(v) Contracted Health Professionals
   a. Standardised Health Practices in the ADF
   b. ADF Military Liaison Officer

FINDINGS

RECOMMENDATIONS

ANNEXURES:
A. Instrument of Appointment and Terms of Reference
B. Inquiry Volumes 1 – 7
C. Exhibit List
D. Timeline of Medical Treatment
E. Counsel’s Submissions
INTRODUCTION

1. Corporal (CPL) Jordan Leigh Talay, an Aircraft Technician with Number 3 Squadron (3SQN), located at Royal Australian Air Force (RAAF) Base Williamtown, was found hanged in his bedroom at his private residence on the evening of 15 January 2008.

2. For sometime CPL Talay had been suffering from, and undergoing treatment within the Australian Defence Force (ADF) Health System for, major depression. At the time of his death, he was facing a serious criminal charge under the New South Wales Crimes Act.

3. The circumstances surrounding CPL Talay’s death were initially investigated by New South Wales Police who subsequently prepared a report for the Coroner. The Coroner dispensed with the holding of an Inquest into CPL Talay’s death. I have had the advantage of having his Report before me in the evidence and also hearing from the investigating police officer.

4. On 27 January 2008, the Chief of the Defence Force (CDF) appointed an Inquiry Officer (IO) to inquire into the circumstances of the death of CPL Talay and, inter alia, make a recommendation as to whether a Commission of Inquiry (COI) should be established.

5. The IO completed her Report on 28 March 2008 and made a number of recommendations, including the establishment of a COI.

Appointment of Commission of Inquiry

6. On 24 July 2009, the Acting Chief of the Defence Force, Lieutenant General David Hurley, AO, DSC, appointed a COI, under the Defence (Inquiry) Regulations 1985 (the Regulations), constituted by myself for the purpose of inquiring into the circumstances surrounding CPL Talay’s death on 15 January 2008, in accordance with the Instrument of Appointment and its associated Terms of Reference. Lieutenant Colonel (LTCOL) Craig McConaghy and LTCOL Craig Barker were appointed as Counsel Assisting (CA) the COI.

7. The Coordination Instruction for the COI was signed by CDF, Air Chief Marshal Allan Grant Houston, AC, AFC, on 6 September 2009. Prehearing preparation commenced following my first meeting with CA on 8 September 2009.

Terms of Reference

8. The Terms of Reference (TOR) require the COI to obtain evidence and to provide the CDF with a report detailing, with reasons, the findings of the COI as to:

   a. the circumstances surrounding the death of the deceased including, without restricting the generality thereof:
(i) the date and place of the deceased’s death; and

(ii) the manner and cause of the deceased’s death.

b. the sufficiency of any actions and decisions taken by Defence personnel which are materially relevant to the deceased’s death, both prior and immediately subsequent thereto.

c. any substantial weaknesses or deficiencies (isolated or systemic) in Defence systems, policies, equipment, practices, procedures and training proximately associated with the deceased’s death.

Potentially Affected Persons

9. During pre-hearing preparation, CA identified two persons, who were involved in CPL Talay’s medical management, as being potentially affected persons (PAP). Doctor (Dr) (then Flight Lieutenant) Hayden Henry, an ADF Medical Officer, was CPL Talay’s Primary Health Care Provider and Dr Anthony Nicholas, was CPL Talay’s treating Clinical Psychologist. I considered that both doctors were PAP and accordingly they were so advised. I considered CPL Talay’s reputation or record may be affected by the inquiry conducted by this COI. Accordingly, pursuant to Regulation 121 (2), I authorised CPL Talay’s wife, Mrs Suzanne Talay, to appear before the Commission as his single representative. Arrangements were then made for their legal support in accordance with Regulation 121 (3) and they were represented throughout the COI by experienced ADF Reserve legal officers of their choice.

COI Hearings

10. The COI sat in both open and closed sessions at Defence Plaza - Sydney between 19 October 2009 and 3 December 2009. In closed session the COI heard evidence concerning the nature and detail of the criminal offence with which CPL Talay had been charged, but had not been determined through the New South Wales criminal justice system. Lieutenant Commander C. Needham, SC, RANR, appeared as Counsel Representing on behalf of the Deceased’s Single Representative. Two additional Counsel Representing appeared before the COI for the PAP. Major Nigel Gabbedy, on behalf of Dr Henry, and Lieutenant Commander Alister Abadee, RANR, on behalf of Dr Nicholas.

11. Evidence (based in the main on witness statements obtained by CA and interviews conducted by the JO) was received orally from 36 witnesses. In addition, 113 documents were tendered as Exhibits. The Exhibits were divided into categories and placed into separate volumes. Some volumes have more than one part. The volumes are contained in Annex B and titled:

a. Volume 1 - Reports;

b. Volume 2 - Personnel;
c. Volume 3 – Medical;
d. Volume 4 – Witness Statements;
e. Volume 5 – Policy;
f. Volume 6 – Transcripts; and
g. Volume 7 – Miscellaneous.

12. A separate list of all exhibits is contained in Annex C. A timeline of CPL Talay’s relevant medical treatment is contained in Annex D. Written submissions were submitted by all Counsel before the COI, and are contained in Annex E.

Scope of the COI Inquiries

13. The COI hearings were broken into three broad phases. During the first phase evidence was taken regarding CPL Talay’s personal history as well as his service within the RAAF. The second phase was primarily concerned with CPL Talay’s working and social environments between 2005 and his death. In this phase evidence was taken from CPL Talay’s superiors and work mates from 3SQN. The last phase of the hearing concerned medical issues, which involved the taking of evidence relating to CPL Talay’s medical management and treatment. This phase also included evidence regarding the broader systemic issues relating to mental health management within the ADF that were, and remain, proximately associated with CPL Talay’s death.

14. These systemic weaknesses and/or deficiencies are considered in the Report under the following headings:

a. Medical Record Management;
b. Training;
c. Health Policy;
d. Privacy and Communication; and
e. Contracted Health Professionals.

Applicable Law

15. The COI is an administrative inquiry and is not bound by the rules of evidence. It is however governed by the Defence (Inquiry) Regulations 1985, the TOR and subject to general administrative law principles, such as procedural fairness. The standard of proof that has been applied is that evidence must be established on the balance of probabilities. Further, I have followed the principles expressed in the comments made by Dixon J in Briginshaw v Briginshaw (1938) 60 CLR at pages 361 and 362.
16. The two PAP have participated in the COI. They have been present in person and/or been represented by their legal counsel. Each PAP has given evidence and also has been given the opportunity to call additional evidence. Before making any finding or comment which may adversely affect either of them, I must be satisfied that the evidence supports such finding or comment in accordance with the principles set out in Briginshaw.

BACKGROUND

General Background and RAAF Service

17. CPL Jordan Leigh Talay was born at Albury, New South Wales, on 23 December 1981. He died at Raymond Terrace, New South Wales, on 15 January 2008. CPL Talay married Suzanne Louise Talay in 2005 having lived in a recognised de facto relationship since 11 August 2004. Their only child, was born on 9 January 2007. CPL Talay was quiet and reserved, but well liked and respected by his close work mates and immediate superiors. He carried out his ADF duties to a very high standard and was considered to be a 'great worker'.

18. Before joining the ADF CPL Talay attended the Secondary College, Victoria, graduating in 1999. CPL Talay was a high achieving and motivated student. In Year 11, he received an Academic Excellence Award 'in recognition of outstanding achievement across the curriculum'.

19. On 26 October 1998, CPL Talay applied for entry to the Australian Defence Force Academy (ADFA) seeking to become a pilot in the RAAF. CPL Talay had been taking private flying lessons, having completed 17.5 hours at the Albury Airport. The recruiter noting that 'I can tell by the enthusiasm in Jordon’s voice that he has a real love of flying.' CPL Talay made his way through to the Selection Board, however was unsuccessful as the Board felt he was, amongst other things, 'Very under confident...'. He did however show potential and was encouraged to reapply.

20. On 17 September 1999, CPL Talay sought to join the permanent RAAF as an Aircraft Technician. On 22 December 1999, he was advised that his application was successful. On 2 February 2000, CPL Talay enlisted in the RAAF for an initial period of six years service. CPL Talay completed his recruit training and was posted to the RAAF School of Technical Training in Wagga Wagga, New South Wales, on 17 April 2000. Four days after passing his Aviation Technician's course (interim) on 21 May 2001, CPL Talay was posted to Number 75 Squadron at RAAF Base Tindal, near Katherine in the Northern Territory. At this base he progressed in his trade knowledge by undertaking a number of courses and developing his skills.
on the F/A-18 Hornet aircraft. On 21 May 2003, CPL Talay was reclassified as a fully qualified aircraft technician.

21. On 13 January 2004, CPL Talay was posted to 3SQN, Workshops, RAAF Base Williamtown, where he commenced his duties in the Module Bay rebuilding Hornet engines. He was then relocated to the Wheels, Brakes and Tanks section of the Workshop. CPL Talay had a good Service record, and was well liked by his peers. On 21 May 2004, he was provisionally promoted to the rank of CPL, which was made substantive on 24 May 2006. CPL Talay was awarded the Australian Defence Medal on 17 April 2007.

Events Leading to Death

22. CPL Talay’s Unit first became aware that he had a health problem at about the time when he was sent on leave to visit his parents in [redacted] in late April 2007. The Unit’s Commanding Officer (CO), Wing Commander (WGC) Vincent Iervasi, now promoted Group Captain, was notified of an unspecified health problem by his Administrative Officer (ADMINO), Flight Lieutenant (FLTLT) Tim Ferrell in May 2007. Although the ADMINO was not initially aware of the actual health issue, he was advised that CPL Talay needed to take some time off work. Subsequently, FLTLT Ferrell was notified that CPL Talay was to be admitted to a hospital in Melbourne. Following that he was authorised by his CO to make the necessary Australians Dangerously Ill Scheme (AUSDIL) assistance in order for the member’s father, wife and child to travel to Melbourne.

23. CPL Talay returned to work on 16 July 2007 and was placed in charge of the Tools Store of the Workshop. This was ordered by his command chain, in consultation with medical authorities. The reason for the move was to place him in an environment that was not only less demanding and where he could be more closely supervised, but also did not require him to exercise his skills as a trade supervisor in a safety critical area. Shortly after this move, however, CPL Talay’s command chain became aware that he was the subject of an investigation into his alleged use of the Defence Restricted Network (DRN) to access inappropriate Internet sites. Some of these sites contained child pornography and some of these images were allegedly downloaded by CPL Talay.

24. The investigation was conducted by the Australian Federal Police (AFP) with the Australian Defence Force Investigative Service (ADFIS) acting as the ADF point of contact. For operational security reasons CPL Talay was never informed of the investigation. The investigation ultimately led to the CPL’s Raymond Terrace home being searched by the AFP under execution of warrant on 11 January 2008. That same day CPL Talay was arrested and charged with an offence relating to the possession of child pornography. Following his being charged, CPL Talay was granted bail, after which he returned to his home at Raymond Terrace. One of CPL Talay’s bail conditions was that he could ‘not access the Internet for any purpose
other than work'. On the same day, CPL Talay spoke on the telephone to a solicitor, Ms Margaret Wells, and arranged an appointment with her for the afternoon of 15 January 2008.

25. At about 1200 hours on 11 January 2008, the 3Sqn ADMINO telephoned CPL Talay and inquired after his well being. During this conversation, the ADMINO offered both CPL Talay and his wife the support of the Defence Community Organisation (DCO) and the Chaplaincy service, which they declined. The ADMINO then provided CPL Talay with his contact telephone number and arranged to meet with him on the following Monday morning. On Monday, 14 January 2008, CPL Talay had a meeting with the ADMINO followed by the CO. In both meetings, CPL Talay, a licensed firearms owner, stated words to the effect "I'm glad they took my firearms away" or "It was lucky they took my weapons off me". Both the CO and the ADMINO recall that the words were said in a flippant manner, however, given CPL Talay's medical history the CO ordered that he be medically examined, and an appointment was made for him to be seen at Number 2 Air Transportable Health Squadron (2ATHS) at RAAF Base Williamtown later that day. Subsequently on that day CPL Talay saw Dr Henry at the Base. At the conclusion of this consultation, CPL Talay agreed not to harm himself.

26. The next morning he was seen by his treating Clinical Psychologist, Dr Nicholas, after which he returned to work and in the afternoon went to his solicitor's appointment. The last involvement that his Unit had prior to CPL Talay's death was via the telephone between Dr Henry and the 3Sqn ADMINO. That conversation took place in the late afternoon of 15 January 2008 during which Dr Henry sought CPL Talay's telephone contact details. The ADMINO asked after CPL Talay, but was informed by Dr Henry that it was 'medical-in-confidence'.

27. Following this conversation, Dr Henry went to CPL Talay's home where he spoke to Mrs Talay, as CPL Talay had not as yet arrived home. At about 1800 hours, Dr Henry spoke by telephone to CPL Talay, and re-affirmed his earlier oral contract that he would not self-harm. At this time Mrs Talay was not 'really concerned for his welfare as [sic] was not in a bad mood and seemed quite his normal self.' CPL Talay then had dinner with his family, after which he was spoken to by his wife following his accessing the internet on their home computer. Mrs Talay said to him words similar to: 'If you're not going to take this serious. We may not be together after all this is over.'

28. CPL Talay then took over looking after their son, , while Mrs Talay used the computer. After a time she checked on and found that he was asleep in his cot. At about 2040 hours, Mrs Talay went looking for CPL Talay and found him hanging by a rope attached to the ensuite door in their bedroom. This was the same rope that she had seen in his bag before he left for work that morning, and about which he commented 'you never know when your going to need a
Mrs Talay cut her husband down and attempted to revive him. She called 000 and both New South Wales Police and the Ambulance Service arrived. All attempts to revive CPL Talay failed.

29. On the night of the death, Mrs Talay told Police that CPL Talay had said to her on a number of occasions following his arrest that he wanted to commit suicide.

Mental Health

30. At the time of his death, CPL Talay was suffering from endogenous depression, for which he was being treated within the ADF Medical Health System. He reported to one psychiatrist that he believed that he 'always had periods of depression', but that it had gotten worse as time went by. He also believed that he had a family history of depression on his father's side.

31. ADF medical authorities first became aware of CPL Talay's mental health condition on 8 September 2005 when he reported as an outpatient to 2ATHS. There he was examined by a medical officer, FLTLT Lee Drury, and during the consultation disclosed that he was suffering from depression and had attempted to commit suicide by hanging two years earlier. This information was written in note form by FLTLT Drury on a PM105 Outpatient Clinical Record and attached to CPL Talay's Unit Medical Record (UMR) at folio 22. In his evidence to the COI, the now Dr Drury explained that entry as follows:

"The notes detail a history of what CPL Talay told me about, so it says that he'd had depressive symptoms over a couple of years, which had been getting worse over six months or so prior to him seeing me and that he had never consulted a Dr or other health professional about it in the past. He said that his mood was up and down, so it was - he got very low and also quite normal. And when he was down, he had typical symptoms of depression, which were poor sleep, with what we call early morning awakening, which is the "EMW", poor appetite, poor concentration. "HHW" means helplessness, hopelessness and worthlessness. These are, you know, typical symptoms of what we call major depression.

...There was a possibility of a family history of depression on his father's side, although the question mark there probably means that he wasn't quite sure, but he obviously thought that. It also details - he told me that he had tried to commit suicide two years prior to him seeing me, and only his fiancée had actually known about that attempt, but he had no plans to do similar at that stage when he saw me on this day and that he wasn't using alcohol or other drugs."
32. CPL Talay was started on a course of medication and referred to a Clinical Psychologist, Dr Nicholas. Over the next 12 months CPL Talay received treatment from medical officers at 2ATHS, as well as Dr Nicholas.

33. On 30 November 2005, Dr Nicholas reports that CPL Talay had a marked reduction in depression; that his medication was agreeing with him; and that he felt calm and in control of his life. On 7 September 2006, CPL Talay had improved to the extent that he was taken off his anti-depressant medication. He was reclassified at the highest medical employment classification (MEC1) following a review on 12 October 2006.

34. In late April 2007, about four months after he was born CPL Talay returned home and was seen by Mrs Talay to be standing in the front doorway “...white and shaking. He was crying” after apparently having “...just lost it at work”. His wife managed to calm him down and they then went to bed. The following morning Mrs Talay noticed that he was not in bed and on investigation found him lying on the lounge “...just crying and shaking”. After trying to obtain assistance through ADF medical resources, Mrs Talay was advised via the ADF medical assistance hotline to take him to a civilian doctor. This she did, and later that day on Saturday, 28 April 2007, CPL Talay was taken by his wife to a General Practitioner (GP) at Maitland. The GP, Dr Raj Joshi, recommenced CPL Talay on medication. CPL Talay then proceeded on convalescence leave to his parent’s home in the [redacted] area. He was ordered to present to the Albury-Wodonga Medical Centre (AWMC) where he was seen on 2 May 2007 by Dr Allan Platts.

35. On 3 May 2007, CPL Talay represented at the AWMC and was again seen by Dr Platts who completed a PM528 Specialist Referral to a psychologist. In his evidence to the COI, Dr Platts stated:

“Well the member presented in the early hours of 3 May to the nursing staff at Latchford with an acute anxiety attack this morning - that morning at 0500; unable to settle, anxious and stressed. He seemed to be over ventilating and the ward staff appeared to try to tranquilise him without medication, to breathe deeply and slowly and try, try and relax. I saw this member that same morning, Jordan stated he'd had poor sleep quality the night of the 2nd/3rd May '07, he was tearful and anxious, he's had nausea and he'd vomited, he'd vomited the day before on the 2nd; that he was still nauseas. Eye contact remained appropriate, there was no obvious tremor or sweating. I suggested that we give him an anti-nausea medication called Maxalon Metoclopramide 10 mg, to carry on with his Effexor 75 mg once daily, and I suggested a tranquiliser, Dicapeam 5 mg three times a day. And I intended to speak with Dr Cronin the same day for his advice as a psychiatrist.”
36. Dr Platts spoke to Dr John Cronin, a consultant psychiatrist, following which arrangements were made to have CPL Talay admitted to a mental health hospital, the Victoria Clinic, in Melbourne on 7 May 2007. He remained an inpatient until his discharge on 18 May 2007, after which time CPL Talay returned to RAAF Base Williamtown. Whilst at the Victoria Clinic, CPL Talay appeared to respond well to treatment. As his discharge date approached it was noted by Dr Cronin that “...he has felt some mild anxiety relating to the uncertainty of his future but has coped reasonably with this. He is keen to spend the weekend with his parents in Wodonga before returning to his wife and child in Newcastle next week.” A period of convalescence was recommended with a gradual return to work. It was also recommended that he return to the care of his psychologist and that his medication was to continue. Dr Cronin further recommended psychiatric review, particularly in relation to determining the length of anti-depressant treatment, which he opined was likely to be at least two years.

37. On his return home CPL Talay received further and ongoing treatment for his depressive illness at 2ATHS. For the majority of the period May 2007 to January 2008 his Primary Care Provider was Dr Allan Sacco, an employed medical officer and a WGCDR in the RAAF Specialist Reserve. Dr Sacco facilitated the continuation of his treatment by Dr Nicholas and also referred the member to Dr Pavan Bhandari, a consultant psychiatrist.

38. Dr Nicholas saw CPL Talay on 10 occasions between 5 June 2007 and 15 January 2008. On his penultimate consultation on 6 December 2007, Dr Nicholas described CPL Talay as ‘progressing well’ and was confident in his outlook. CPL Talay was going to be reviewed in 2008 with a view to reducing his medication. Dr Bhandari also saw CPL Talay on a number of occasions over the same period. In his Report, dated 5 December 2007, Dr Bhandari noted that although he would need anti-depressant therapy for a further 12 months that: ‘His improvements suggest there will be full resolution of his depressive symptoms over the next three months.’ None of CPL Talay’s treating health professionals were aware however of the ongoing criminal investigation, or of the planned search of his home.

39. CPL Talay was last reviewed by Dr Bhandari on 8 January 2008, at which time it was noted that ‘Jordon has been well with no significant deterioration of his emotional state.’ The psychiatrist further noted that his prognosis was positive.

40. Following his arrest by the AFP, medical authorities within the ADF became aware of CPL Talay’s arrest at about 0900 hours on 11 January 2008 when ADFIS investigators spoke to Dr Henry at 2ATHS. They requested the contact details of CPL Talay’s treating mental health specialist in order to provide them to the AFP. Dr Henry took legal advice following which he advised the ADFIS investigators to put their request in writing via email; which was done. Dr Henry did not raise the inquiry by ADFIS with any other health professional. CPL Talay died before ADFIS received any response to their request.
TERMS OF REFERENCE

Circumstances Surrounding the Death (TOR Paragraph 5(a))

41. CPL Talay was born at Albury, New South Wales, on 23 December 1981. He died between 2020 hours and 2043 hours on 15 January 2008, at his home at Raymond Terrace, New South Wales. His death was by hanging which was self-inflicted. There were no suspicious circumstances. At the time of his death CPL Talay was not performing any military duty.

42. The searching of his home by the AFP and the subsequent criminal charge, with its associated stigma, was a very significant stressor for CPL Talay. The evidence from Dr Lambeth, a clinical psychiatrist and called as an expert in the COI, is that historically a person suffering from severe depression is at real risk of taking his/her life within six months of a significant stressor. Dr Lambeth gave further evidence to the effect that even a minor negative event within that period may be sufficient to cause a person to take their own life.

43. In his evidence, Dr Lambeth was asked to consider the events as they unfolded after CPL Talay had spoken with Dr Henry on the telephone on 15 January 2008:

"The evidence that is currently before this hearing and I'll be taking you back, relating back as we have reached this point, I'll just ask you to turn your mind to this now, is that CPL Talay went and saw his solicitor in the afternoon of his death. He then went home. He was contacted by his medical officer at that time, a conversation was had between them, that his mood was at that time described by his wife in these terms, 'Jordan seemed pretty happy with the support from work with this.' And following the conversation with Dr Henry, the medical officer, his wife describing his mood as, 'I was not really concerned with his welfare as he was not in a bad mood and seemed quite his normal self.' Then following that there seems to have been a further communication between them. What happened there was this, that during that evening CPL Talay informed his wife that he was going to check their emails and that in so doing he may have been in breach of certain bail conditions that he was on as a result of the charge that he was facing. His wife then said to him words similar to, "If you're not going to take this serious we may not be together after all this is over." Those words, could they have any impact on his state of mind?---Upon someone who was in what was presumably a very highly aroused state of mind, given the recent events, those words may have indicated a severe loss and, yes, they would have impacted quite seriously, in my opinion.

Could they be enough to tip him over into making suicide attempt?---They could be enough, yes."
Sufficiency of any Actions and Decisions taken by Defence Personnel (TOR Paragraph 5(b))

Administrative and Operational Management

Workplace Bullying/Harrassment

44. There is no evidence before the COI which in my view supports a finding of any material deficiency by any persons in 3SQN in respect of the administrative and operational management of CPL Talay. Counsel Representing CPL Talay’s Single Representative raises one matter of concern in relation to 3SQN not putting in place any plan of action to support CPL Talay during the search of his home by the AFP. I address this submission in my Findings below. The only matter of real concern before the COI related to the very serious allegation of workplace bullying or harassment.

45. In 2005, CPL Talay had disclosed to Dr Nicholas, that he had a problem at work with a Warrant Officer who was ‘giving him a hard time’. At this time 3SQN was having difficulty maintaining it operational readiness at the required level, as the individual readiness of squadron members was well below the minimum standard. Improving the individual readiness status fell on the warrant and non-commissioned officers within 3SQN. On the evidence before the COI, the only Warrant Officer in CPL Talay’s chain of command was Warrant Officer (WOFF) Kulij. Each of the witnesses called from 3SQN was asked about WOFF Kulij, and in particular his relationship with CPL Talay.

46. There is no evidence before the COI, save what was said by CPL Talay to Dr Nieholas, that either directly or indirectly, that supports the contention CPL Talay was being singled out, or mistreated in any way. There is evidence that points to CPL Talay not liking WOFF Kulij, and of the WOFF’s perceived, in some quarters at least, poor management style. On the other hand WOFF Kulij was well regarded by the command chain within 3SQN. I had the opportunity of seeing WOFF Kulij give his evidence before the COI. I found him to be an impressive witness and I accept the evidence he gave, in particular his evidence concerning his relationship with CPL Talay. The evidence supports the view that WOFF Kulij was both conscientious and even-handed in his duties.

Ammunition Incident

47. The COI heard evidence about CPL Talay bringing firearm ammunition to his workplace on 26 October 2007. Counsel Representing CPL Talay’s Single Representative, in her written submissions, makes reference to the ‘ammunition incident’ at paragraphs 72 to 78 and 106 to 107. It is convenient to address the evidence concerning this incident before moving on to consider CPL Talay’s medical management and treatment as Counsel attempts to draw a link between them.

48. Group Captain (GPCAPT) Iervasi, Squadron Leader (SQNLDR) Lloyd Sellick and WOFF Kulij all have given evidence to the effect that CPL Talay brought the civilian ammunition to work in order to show his mates. They all took the matter seriously as in so doing
CPL Talay was in breach of ADF regulation and practice. After interviewing and counselling CPL Talay, all three formed the view that this was an honest mistake on CPL Talay’s part. None believed there was anything further to the incident.

49. CPL Talay was however sent to 2ATHS and seen by Dr Vincent Duffy to determine whether his mental health was a factor. Dr Duffy reviewed his handwritten notes during his evidence to the COI and read onto the record the following:

“Reviewed at ADMINO’s request. The member has a shooters licence outside Defence and today brought live ammunition to work which he left on his desk. Member states that this was due to stupidity and lack of insight rather than with any sinister intent.”

50. Dr Duffy formed the opinion that the ammunition was not brought onto Service property with any homicidal or suicidal objective in mind.

51. Matters became confused when during his evidence, Dr Nicholas was asked to review Dr Duffy’s handwritten notes and instead of reading the word ‘sinister’ believed the word to be ‘suicidal’. It is against this background that Dr Nicholas’ evidence of this act ‘being a cry for help’ needs to be considered.

**Medical Treatment and Management**

2ATHS

52. From September 2005 until his death in January 2008, CPL Talay was under the general health management of 2ATHS. His UMR was maintained by 2ATHS and save for a short period of time in May 2007, his primary care providers were health professionals posted or contracted to 2ATHS.

53. The oral evidence given before the COI, and supported by the various written medical reports, is that CPL Talay appeared to be responding well to the treatment he was receiving, either directly or indirectly, by health professionals associated with 2ATHS. One of the systemic issues, which was explored during the COI, was the apparent high turnover of medical officers at 2ATHS and the impact that this may have had on CPL Talay’s medical management and treatment. This issue and the closely related issue of record keeping within the UMR will be considered in further detail under the last TOR.

54. In the last six months of his life, none of his treating health professionals were aware that CPL Talay:
a. Had in September 2005, disclosed to Dr Drury that he had attempted to take his life in 2003, by hanging. This is notwithstanding the fact that the disclosure remained on a PM105 Outpatient Clinical Record (PM105) within his UMR.

b. Had been accessing ‘suicide’ sites on the internet on a regular basis both before and after his return from the Victoria Clinic;

c. Had been accessing ‘child pornography’ sites on the internet;

d. Was under criminal investigation concerning his internet usage; and

e. Following the search of his home, on 11 January 2008, made of number of statements to his wife that he wanted to commit suicide.

55. The searching of CPL Talay’s home and his being subsequently charged with an offence relating to child pornography introduces a clear and obvious point of division in his medical management and treatment. There is nothing in the evidence before me that raises any substantive issue regarding sufficiency of any actions and decisions taken by members of, or associated with, 2AHTS which are materially relevant to the deceased’s death up to 11 January 2008.

56. On the other hand, both Drs Nicholas and Henry were directly involved in the medical management and treatment of CPL Talay between 11 January and 15 January 2008, and accordingly their actions require careful consideration.

Dr Nicholas

57. Dr Nicholas provided clinical psychological services to CPL Talay on at least 16 occasions from September 2005 until the day of his death. Apart from seeing him in person, Dr Nicholas also spoke with CPL Talay on various occasions over the telephone. Dr Nicholas says that he had an ‘excellent relationship’ and a ‘very good rapport’ with CPL Talay. It was to him that CPL Talay raised his problems in the workplace with a Warrant Officer. Initially, their sessions together ended by mutual consent. Dr Nicholas’ recommended his treatment of CPL Talay’s after his return to RAAF Base Williamtown following his discharge from the Victoria Clinic.

58. Notwithstanding the perceived excellent relationship between them, it was only on the morning of 15 January 2008 that CPL Talay told Dr Nicholas of his obsession with pornography, including child pornography. Dr Nicholas described CPL Talay’s state at this time as being ‘extremely upset’ and recalls CPL Talay remarking ‘Now the whole world would just see me as one of those low lifes.’
59. During the consultation, Dr Nicholas says that he explored the pornography issue with CPL Talay. In his statement to the IO, he expressed this conversation in the following terms:

"Now, what is important here is that in the process of Jordan’s discussions here with me that morning I said to him “Jordan, whenever we’ve talked about your depression I always felt that there was an element about you that was sort of very secret and separate, and I’ve picked that up. Is this what it is? Is this what it has been?” and he said “Yes”. He said “I’m sick of it.” [Comment by Inquiry Officer: Are you referring to him looking at child pornography?] All pornography across the board."

When CPL Talay left Dr Nicholas he was in a state of agitation, but relieved, wanting to go back to work and then to his solicitor’s appointment.

60. The evidence before the COI clearly supports the view that CPL Talay was guarded in his disclosures to other people, which also included his treating health professionals. Evidence has also been presented to the COI from which the only reasonable inference to draw is that CPL Talay accessed and downloaded images of child pornography. A file containing child pornography was located on CPL Talay’s home (H) drive on the Defence Restricted Network system. He told Dr Nicholas that he accessed child pornography, but did not disclose the downloading of same. Before the COI, Dr Nicholas was asked for his opinion of CPL Talay’s personality against that background:

"What does it tell you?---That he was a very disordered young man, but was not mentally ill.

What do you mean by disordered?---That he was dysfunctional.

What do you mean by dysfunctional?---Dysfunction meaning that he created situations whereby he provided some of - he would have provided some information some of the time selectively because he was - now in retrospect I can say this, but at the time I wouldn’t have known that, although I suspected that something was going on, that in fact he was aware that what he was doing was very, very wrong, but he couldn’t help himself. The shame and the enormity of what happened, which was blown wide open on the Friday morning when the police arrived, he could no longer hide behind, "No, I’m not going to say anything about it. I’ll just put up firewalls". His firewalls had been broken down. Jordy was very skilled at putting up firewalls. My rapport with him was such that I was able to break through a lot of those firewalls but, having said that, clients can still be very, very skilled at putting up firewalls in order to protect themselves about issues that they are acutely ashamed of, and this is what is in fact has transpired. That’s why he came to me in a state of acute stress disorder on that Tuesday morning and looked as if, as I said, he’d been hit by a - by someone by a baseball bat, that he, you know, he’s all of a sudden there’s nowhere to hide. But at the same time, from what you’re saying now, he still in fact did hide. He said, "No, I didn’t do anything with it" when in fact he did; but I didn’t know that."
61. CPL Talay’s ability to put on a ‘public face’ can be seen in the evidence given by a close friend. Sergeant (SGT) Matthew Long recalls a conversation that he had with CPL Talay on the day of his death:

“Tuesday lunchtime he seemed as normal, you know, as any other day and we even had a laugh together during our conversations. Nothing seemed unusual at all.”

62. This conversation took place between CPL Talay’s medical consultation, with Dr Nicholas, earlier that day and the meeting he was to have with his solicitor that afternoon. In this regard Mrs Talay’s observations about his demeanour referred to in paragraph 27 above are also highly relevant.

63. Dr Nicholas’ evidence is that CPL Talay had settled by the time he left the consultation. That he wanted to return to his Unit and then proceed to his solicitor’s appointment. Dr Nicholas was ‘comfortable’ with both of these courses of action. Nevertheless, he had a meeting with Dr Henry immediately after the consultation, during which he expressed his opinion that there was a ‘Twelve out of ten’ risk that CPL Talay would self-harm. Dr Henry does not recall this expression being used by Dr Nicholas in their meeting. In his evidence, Dr Nicholas explained that this expression was one that he used from time to time to focus attention to a serious problem in the broad context of a person’s well-being, rather than meaning that it was the actual level of risk of self-harm.

64. The ‘twelve out of ten’ expression first appears in Dr Nicholas’ statement to the IO, and is couched in terms of a twelve out of ten ‘problem’. Later in that statement the IO specifically addresses the issue of self-harm, and Dr Nicholas repeats the expression in those terms. Dr Nicholas is then asked by the IO to explain what conclusions he and Dr Henry reached during their discussions about how to manage CPL Talay. The answer provided by Dr Nicholas appears to be consistent with a high level of concern, but not a 120 percent assessment of his risk of actual self-harm. It is also consistent with his evidence before the COI.

65. The Crisis Management Plan agreed to by both doctors comprised of the following:

a. CPL Talay would be allowed to return to his Unit;

b. CPL Talay would be encouraged to attend the solicitor’s meeting;

c. CPL Talay would be re-assessed by Dr Henry following the solicitor’s appointment;

d. CPL Talay was provided with the contact details of both doctors and encouraged to contact them if needed; and

e. CPL Talay was to have another consultation with Dr Nicholas on 17 January 2008.
66. The treating health professionals did not, between themselves, discuss the option of voluntary self admission of CPL Talay to a care facility. The Plan did not include the following features which were raised in the evidence before the COI:

a. Back-briefing CPL Talay’s Unit concerning his potential for self-harm;

b. Arranging for someone to accompany CPL Talay to the solicitor’s meeting;

c. Raising the possibility of voluntary self admission with CPL Talay;

d. Advising CPL Talay that Dr Henry would be contacting him after the solicitor’s appointment; and

e. Briefing the next of kin.

67. LTCOL (Dr) Andrew Cohn is a clinical psychologist and was called to give expert evidence to the COI. He was asked to comment on the Plan and said in his evidence:

“I believe that the management plan from Dr Nicholas’ perspective was above the minimum required for the management of CPL Talay.”

68. LTCOL Cohn also gave evidence to the COI on some of the additional features, which were not part of the actual Plan, but were the subject of lengthy probing by various Counsel:

“...It may have been reasonable to advise the unit that he was going to the solicitor’s office and that maybe a close friend of his from the unit may have wanted to go along with him to provide support in the case that there was bad news, and maybe contact the doctor from the solicitor’s office once CPL Talay was leaving the office so that the doctor could have made another assessment at that point in time. But as I said, this is over and above what I consider to have been the appropriate course of action that they took based on what they knew at the time. I believe that they did not consider that when CPL Talay left the solicitor’s office that afternoon or that morning, that that was going to escalate him to the point where he was going to suicide.

And further added:

Well, based on the material that you've read, do you consider that at the time they made that plan, that that was a reasonable assumption for them to make?---Yes, I do.

Now, the plan that was put in train effectively left, it would seem - because there wasn't support provided by the unit or elsewhere, there wasn't anyone accompanying CPL Talay - for if the solicitor’s meeting had gone badly, and so that he left not in a buoyant state but less than that, the plan, it would seem, called for CPL Talay to initiate contact with either Dr Henry or Dr Nicholas. Would you agree with that?---Yes, I do.
What do you say about that?—Based on what they considered to be the level of risk that he presented, I believe that was an appropriate course of action for them to take.

69. Dr Lambeth’s evidence generally accords with that of LTCOL Cohn. He was however critical of some of their actions, or more correctly lack of action, in relation a number of the courses of action available to them. These are canvassed below.

Record Keeping

70. An additional matter that was the subject of inquiry was Dr Nicholas’ clinical note keeping. The evidence is that Dr Nicholas did not make clinical notes other than those contained in the various PM528 Specialist Referral forms contained in Exhibit CA009. These notes were not extensive, and would not provide an adequate base line of information from which another clinical psychologist could proceed without significant back-tracking.

71. There is no evidence however, that supports a view that this lack of adequate clinical note keeping on the part of Dr Nicholas impacted negatively either directly, or indirectly, on CPL Talay’s mental health management. Also Contracted Health Professionals (CHP) such as Dr Nicholas were in 2007/2008, and are currently, not tied to the same reporting requirements as an employed or uniformed psychologist in the ADF. This issue is considered more fully under the TOR relating to systemic issues.

Dr Henry

72. Dr Henry first became involved with the management of CPL Talay on 11 January 2008, as a result of a request by the ADFIS to provide to them information concerning the member’s mental health providers. Dr Henry responded that he needed to seek legal advice; which is what he did. Dr Henry did not attempt to contact either of CPL Talay’s mental health providers, nor did he pass on any information concerning CPL Talay’s situation to other health professionals or his Unit. At this stage, Dr Henry considered that he was not in a direct doctor–patient relationship with CPL Talay. The course of action adopted by Dr Henry, on advice by a legal officer, was to wait until a formal written request was made in relation to the information sought by the ADFIS. The consequence of this action was that no-one associated with CPL Talay’s mental health care was to see him until four days later on 15 January 2008.

73. CPL Talay was however seen by a health professional on the afternoon of 14 January 2008, as a consequence of the referral by his CO as set out earlier. As it turned out, he was seen by Dr Henry, as Dr Drury, who had originally agreed to see the member, was not available.

74. Although Dr Henry first examined CPL Talay’s medical file on 11 January for administrative purposes relating to the ADFIS request on 14 January 2008, he became the
member’s treating medical officer as a result of the risk of self-harm consultation. Dr Henry made the following entry in the PM105 concerning the consultation that day:

Review of member’s mental health status due to situational crisis. Member facing ADFIS/AFP investigation and charges. Appropriate reaction and brief episode of "overwhelming helplessness at time of being charged. Has since discussed with wife, parents, CO & ADMINO and has reduced his sense of helplessness in situation. Contracted verbally that he would not harm himself or others. Although reluctant to disclose details of charges or events surrounding, he displayed normal mental state including reactive affect, emotional stability, normal insight and judgement. Safe to remain in duties".

75. Dr Henry did not consider that CPL Talay was in immediate risk of self-harm, and was also aware that he was seeing Dr Nicholas the next morning and therefore took no further direct action. The following morning, Dr Henry had a meeting with Dr Nicholas and a crisis management plan was agreed. Dr Henry does not accept that he simply agreed to Dr Nicholas’ plan, but that after discussion the plan was adopted as the appropriate course of action. Dr Henry does not however recall Dr Nicholas’ twelve out of ten comment. He also was of the belief that CPL Talay was heading directly to his solicitor’s meeting following his consultation with Dr Nicholas.

76. As to Dr Nicholas’ ‘twelve out of ten’ comment, it is clear from the evidence that both doctors held similar opinions in relation to CPL Talay’s level of risk of self-harm, regardless of whether the comment was made or not. Neither believed that he could be scheduled (involuntarily made an in-patient of a mental health facility). Both believed that attending the solicitor’s meeting was an important step in creating a ‘safety net’ around CPL Talay.

77. Accepting Dr Henry’s evidence that he believed that CPL Talay was going directly to his solicitor’s meeting means, that from Dr Henry’s perspective there would have meant the passing of a number of hours between when the member would have left the meeting, to when Dr Henry first attempted to contact him by telephone. Further, CPL Talay was not told that he would be contacted by Dr Henry following his solicitor’s appointment. Both of these matters were put to Dr Henry by CA:

“Do you consider that that might have been a flaw in the plan, if the Member hypothetically was not aware that you were going to be the person who was going to be contacting him?---In retrospect, yes.

That would you also consider that it was another floor [sic] to your plan that on your timeline he may have had some hours in which he would have been the one who had to take the initiative to contact yourself or to contact Dr Nicholas for assistance if the advice he had received from the solicitor wasn’t good?---In retrospect, yes.”
78. In his Report and confirmed in evidence before the COI, Dr Lambeth opined that:

“CPL Talay suicided following his arrest by the AFP on charges of a sexual nature. He faced the possibility of dismissal from the RAAF, severe public embarrassment, embarrassment to his family and confinement to prison. He had a long history of depression with a previous suicide attempt and a period of voluntary hospitalisation. He was being treated by a Consultant Psychiatrist, a Clinical Psychologist and a General Practitioner.

There is a reasonable possibility that, with a comprehensive risk assessment for suicide and a comprehensive suicide management plan, he may have been dissuaded from his course of action.”

79. In his evidence before the COI, Dr Lambeth was asked to consider the actual plan agreed to by Dr Henry:

“Well what appears to have been done is that the member was allowed to go back to his unit, a place that he wanted to go to; that he was allowed to go to see his solicitor, and that Dr Henry would conduct an assessment, another risk assessment of him, later that day?—Yes.

What do you say about that plan?—Well I don’t think it was a bad plan. I certainly would have still suggested the voluntary admission to hospital, but other than that not a bad plan, because he’s been seen, he knows he’s going to the solicitor, whether or not he has some hope of a positive outcome of that, and then contact him later in the day to see how he is feeling seems to me to be a reasonable plan; maybe not the perfect plan, but a reasonable one.

I left out, inadvertently, that both Drs had provided to him their contact details?—Yes, well again that would have been very useful provided that the provision of the contact details was accompanied by some idea of when he should contact them and so on. And that an arrangement had been made for CPL Talay to see Dr Nicholas on the Thursday, Thursday morning, that is essentially two days forward?—Yes, I think I would have made an arrangement for him to see someone the next day, but again that would depend on availability. And when I say someone I mean someone with a clinical background in mental health; so for me that would be a clinical psychologist or a psychiatrist.”

80. ADF policy refers to ‘best practice’ in the mental health treatment of its members. When asked what he understood the term to mean when answering questions by Counsel Representing CPL Talay’s Single Representative, Dr Lambeth said that it was the standard that he should attain:
"When you came to answer the questions posed by her to you, what was your understanding of the term ‘best practice’?---Best practice is the kind of practice that someone of my training would or should adhere to. So basically the gold standard.

So someone of your training, your experience and it’s the gold standard?---Yes."

81. Another experienced ADF medical officer, SQNLDR Collette Richards, also expressed the opinion that ‘best practice’ was the ‘gold standard’ and should be contrasted with the minimum standard below which a medical officer would be considered to have performed negligently.

82. On Dr Lambeth’s interpretation, that high standard is obviously one in excess of the training and experience of someone in Dr Henry’s position in January 2008.

83. Dr Lambeth did however express the opinion that some of the actions, or lack of action, on the part of Dr Henry (and Dr Nicholas) were less than ‘prudent’. When asked what he considered the word ‘prudent’ to mean in the context in which he was being asked to give his opinion, Dr Lambeth explained it in these terms:

"Is that word - when you came to answer the questions is that associated with best practice or some other practice?---No, prudent - a good idea, a sensible thing to do. Yes, best practice would certainly include that. Reasonable practice may well have."

84. In his evidence before the COI, Dr Lambeth considered the less than prudent inaction on the part of both Drs as follows:

a. It would have been a good idea if they had organised for someone to escort CPL Talay to the meeting with the solicitor;

b. Dr Henry should have asked CPL Talay about any previous suicide attempts;

c. They should have contacted the ADMINO;

d. They should have contacted CPL Talay as soon as he finished with the solicitor; and

e. They should have mentioned the potential risk of self-harm to CPL Talay’s next of kin.

85. In not doing so, however, neither Dr Nicholas nor Dr Henry fell below what either LTCOL Cohn or Dr Lambeth considered to be the minimum necessary crisis management plan for CPL Talay’s particular circumstances.
Any Substantial Weaknesses or Deficiencies (Isolated or Systemic) in Defence Systems, Policies, Equipment, Practices, Procedures and Training (TOR Paragraph 5(e))

86. In her Report, the IO identified a number of potential systemic weaknesses which have been explored during the course of the COI. Additionally, during the course of pre-hearing preparation other potential weaknesses were identified by CA. I note other COI have examined some of these and appropriate action has been taken by ADF authorities. Since CPL Talay’s death there have been significant developments into the framework of the delivery of mental health medical support to members of the ADF. One example is the commissioning of a report into the issue of privacy of medical information in the ADF. This COI has concentrated, to its knowledge, on issues that have not been examined, or examined in detail, by other COI or Boards of Inquiry (BOI). In so doing, the COI has received evidence from a number of witnesses, including senior officers from within Joint Health Command (JHC), who have identified residual substantial weaknesses or deficiencies in Defence systems, polices, practices, procedures and training, and suggested improvements to remedy same.

Medical Record Keeping

System

87. The COI has taken a significant amount of evidence from various sources concerning the maintenance of health records in the medical management of ADF members. Almost universally the evidence has been that the current paper management system of UMRs is far from best practice. One senior medical practitioner described the current system as ‘abominable’. Although it is intended that this system will be wholly replaced by an electronic record keeping and management system, the current paper system will be continued for a significant period of time. Accordingly, it is necessary to ensure that it is as efficient and effective as such a system will permit.

88. The most significant failing identified in the evidence relates to the management of ‘critical information’. CPL Talay’s disclosure in 2005 to Dr Drury of a previous suicide attempt was, and remained, critical information. Such information should have always been taken into account in the medical management of CPL Talay’s mental health problem. The fact that it wasn’t can be put down to a number of factors that are, for the most part, systemic in nature.

89. The structure of the UMR has meant that busy health professionals have not had the time to plough through often extensive files in order to find relevant information. The COI has also heard evidence from a number of medical practitioners of their reluctance to record sensitive information on a summary sheet within the UMR. Critical information could also not come to the attention of the treating health professional by reason of misfiling and missing documents on the UMR.
90. Dr Michael O’Donaghue’s evidence highlighted the limitations of the current system, particularly with respect to important information held within the paper record:

“It has major shortcomings. There have been some improvements over the last 25 years that I’ve been as a medical officer, but there are still major shortcomings. The chronological filing of the PM105s and not having any way of bringing information to attention is one shortfall. The fact that all the other reports have been stored in the second part of the folder and with quite often no separation, depending upon the nature of that material, normally involves a hunting process through what could be quite thick records to finding a needle in a haystack or the particular information that you’re seeking.”

91. Simply because information is recorded in a PM105 does not of itself mean that critical information will be brought to the attention of a treating health professional. The unread or ‘hidden’ disclosure made by CPL Talay is a good example of this problem.

92. The COI has heard evidence from LTCOL Helen Murphy who is responsible for the strategic level oversight of the extant medical record management system. Steps have been taken to try to make the UMR a more user-friendly historical record. For example, dividers have now been introduced to create separate areas for the various categories of information that is held in a UMR. Additionally, LTCOL Murphy has overseen the creation of a new Health Summary sheet (PM510) which is to be placed on the front of the first filed documents within the UMR. She stated:

“There is currently a form of PM510 in the system called a problem list. So this form of document is already in the system but currently not well used. And that has been the impetus to create a new form in collaboration with the clinicians to provide them with something that they will use. However, it is possible that we can produce a directive from Commander Joint Health Command that there will be - that there is a requirement to use this document; a reminder, if you like.”

93. Critical information can be entered onto the updated PM510 and therefore alloy, at least to some extent, the privacy concern on the part of medical practitioners.

94. Air Commodore (AIRCDRE) Tracy Smart told the COI that there are currently two electronic systems used in the delivery of health services which operate across the ADF. The first is Health Key Solutions (HealthKeyS) which has been used for some time, but which has significant limitations. In order to overcome the limitations another electronic record management system called Medical Information Management Index (MIMI) was used in some local areas, but is not available across the ADF. The other system is the Electronic Psychology Record Information System (EPRIS). This system was introduced and rolled out from July 2009. It contains organisational psychology records, but also can be utilised for clinical psychology recording keeping as well.
95. AIRCDRE Smart gave evidence of the proposed ADF’s electronic record management system called the Joint E-Health Data and Information System (JEHDI) which will eventually replace the existing paper management system. It will be implemented over the next few years and is a framework within which electronic modules can operate and link into one another. It will be also capable of linking with the National E-Health Transition Authority that will be implementing a national e-health system over the next four to five years, as well as potentially with an e-health system being contemplated by the Department of Veteran’s Affairs.

96. The essential issue, however, is one of compliance. Currently record keeping within the ADF health environment is not consistent. There are varying interpretations as to what is to be recorded within in the UMR; as well as where such information should be recorded. There is no requirement to record critical information from a PM105, or other source within the UMR, to the summary contained in the PM510. While there is no clear agreement as to what constitutes an exhaustive list of critical information which should be captured, all relevant witnesses expressed the opinion that a disclosure of the type made by CPL Talay would be included:

"Yes. That sort of information should be recorded on the health summary that would sit at the very front of the file as a quick reference for the general practitioner to note. It would also be recorded in the PM105 section in more detail about the consultation with the member. Any previous assessments made by a psychologist as in a POPS, a post-operational assessment or return to Australia assessment, psychological assessments, would be recorded in the mental health section."

97. Medical practitioners generally support the proposed electronic record management system. It will go a long way to ensuring that recorded information is readily accessible by health practitioners. The current system will however be continued for all existing ADF members until their separation. It is not envisaged that there will be a complete transfer on the records currently contained within the paper UMRs.

"We’re not resourced to transfer all content of the current paper systems into the new system, but it is aimed that all significant data, such as their ongoing vaccinations, et cetera, will be transferred across."

98. Every current ADF member will however have an electronic record that will supplement the existing paper record. There is support for limited transfer of information from the paper record to the electronic system.

99. Transfer of critical information from the PM510 to the electronic record could then be reasonably conducted, as the volume of work would be significantly reduced.
Auditing

100. Regardless of whether the system is paper or electronically based, it will still require maintenance by medical and administrative staff. Accordingly, it is reliant upon the skill and commitment of those persons entering the information, and is therefore subject to error. The only way to ensure compliance and accuracy is with a system of auditing. Such a system is being implemented by Joint Health Command (JHC). The proposed system will use an audit tool that will examine key risk areas against civilian and Defence standards. One module of the tool will specifically examine medical documentation. The first such audit is due to commence in February 2010.

ADF Military Liaison Officer

101. The COI has heard that the ADF’s high tempo of operations has had a knock on effect in the delivery of health services within Australia. This situation is reflected in the number of health professionals involved in treating CPL Talay over the years 2005 to 2008. Since about 2000, the military workforce in ADF health sectors has been focusing on deployable health assets with the consequence that health care facilities have been backfilled by a contracted civilian workforce. The appointment of Dr O’Donaghue (formally the uniformed CO of 2ATHS) is an example of how JHC is attempting to remedy the situation. Another is the introduction of a standardised introduction pack for all newly contracted CHP across the ADF.

102. Not all CHP have Dr O’Donaghue’s extensive clinical and military background. LTCOL Murphy has identified the problem and explained in her evidence:

“So that the - there wasn’t a transition period to transfer the knowledge to the contracted workforce. So the contracted workforce have come into Defence health facilities without necessarily any prior knowledge of the health environment, the military environment.”

103. One additional proposal is to have ADF military liaison officers to bridge the experience gap. These ADF military liaison officers would have a clinical or administrative background and can, ‘assist the contracted workforce with the military information that they need to do their job’. From LTCOL Murphy’s perspective, this role would be quite important in order to ensure that ADF members receive the appropriate level and quality of health care.
Training

Suicide Awareness Training in the ADF

104. The COI has heard from a number of witnesses as to the benefits of suicide awareness training being delivered at Unit level for ADF personnel. Defence Instruction (General) Personnel – Mental Health Provision in the Australian Defence Force (DI(G) PERS 16-24) recognises the stressors at play within the ADF working environment and the need for preventative training. The DI(G) specifically refers to the delivery of such training in the workplace.

105. At the time he gave his evidence, Captain (CAPT) Dustin Cleverley was the Suicide Prevention Coordinator within the Directorate of Mental Health. His evidence concerned the development and availability of mental health training programmes within the ADF. He told the COI that the ADF Suicide Prevention Program (SPP) was introduced as part of the ADF Mental Health Strategy (MHS) in 2002. Since its inception, the SPP has been primarily focused on the provision of suicide awareness training and basic intervention skills training to ADF members.

106. Unfortunately only the Army actually delivers such training on a yearly and mandatory basis. Navy and Air Force have no such requirement. It is somewhat ironic that CPL Talay was one of the few members of 3SQN to have undertaken such training. His CO, at the time, said in his evidence to the COI that such training should be provided on an annual basis. If Army is capable of conducting such training, then there would appear to be no valid reason why the other two Services ought be so able. The intent of the policy appears to require such training; however the relevant provision is couched in non-mandatory language.

Suicide Awareness Training Coordinator

107. The importance of the delivery of such training has been recognised in the creation of a specific appointment within JHC to co-ordinate its delivery on a Tri-Service basis. Unfortunately that position is not going to be maintained, for at least the next 12 months. Given the importance of the delivery of this training across the ADF environment there is a strong argument for the permanent establishment of the position on a Tri-Service basis.

Self-harm Risk Assessment Training for ADF Health Providers

108. The evidence before the COI supports risk assessment tools as being very important in assisting a health professional in assessing the level of someone’s risk of self-harm. LTCOL Cohn and LTCOL Stephanie Hodson gave evidence of the development of a standardised risk assessment tool to be included in an as yet to be released Health Directive.

109. While the evidence is clear that a standardised risk assessment tool would be very useful to health practitioners, it can not be the only indicator of self-harm; clinical judgement is vital. It
has been observed that medical officers in the ADF do not have a ‘great knowledge’ of mental health. LTCOL Cohn held the opinion that junior medical officers in particular would benefit from a standardised risk assessment tool.

110. Such training was seen as the key to greater success in this area. Dr Lambeth was of the opinion that all ADF medical officers and mental health professionals should undertake specialised training in suicide risk assessment.

Communication between ADF Health Providers and Commanders

111. Another matter that was canvassed at some length before the COI was the passage of information between health professionals and command. Dr O’Donagheue, who has had the benefit of his experience as both a medical officer and a CO, in his evidence spoke about the difficulties of command managing a member who is undergoing a health crisis:

“It is extremely difficult. I perhaps stand in a position to my own advantage simply because I’ve been at Williamstown for so long a period of time and knowing most of the individuals on the base there, most of the commanding officers and they know me and I think I’ve established a professional relationship with them, if for no other reason than I’ve been there for 12 years, they know me and I know them and I think we have a professional relationship between the two of us. But again I’m also hindered by the disclosure of information that I’m allowed to disclose.”

112. GPCAPT Iervasi told the COI that:

“So there is no mechanism currently that would enable either the commanding officer or in fact anyone within the chain of command to have more generalist in-depth knowledge from various agencies about how things are going. So it generally is a means of operating around various levels of vagueness and you give some responses and might be the case that the response is, ‘Yes, that sounds about right.’ So certainly there are a number of other circumstances of other things I’ve had to deal with on the unit that access to more in-depth knowledge certainly would have assisted me and my chain of command earlier in the process to come to what has ended up being in most of them the same end state. So it’s a case of not only duty of care, but the best type of support when it’s required.”

113. The core difficulty identified by GPCAPT Iervasi is the inability on the part of command to have access to all relevant information when making decisions concerning the welfare of an ADF member. Evidence before the COI shows that this situation is not just limited to command, but has historically also been the case between various health providers.

114. LTCOL Hodson, the ADF Director of Mental Health, gave evidence about the barriers in the sharing of information between psychologists and other health professionals. Her evidence
focused on the development of ADF Mental Health Policy since 2000 and the introduction of the ADF MHS. She also provided evidence to the COI relating to Professor David Dunt’s Review of Mental Health Care in the ADF and the Transition through Discharge, commissioned by the Australian Government and delivered in January 2009. She also gave evidence regarding the Government’s Response to the Review, dated 1 May 2009.

115. One of the recent developments to enhance the delivery of mental health within the ADF and create an information sharing environment is the creation of regional health teams. All of the senior command staff at JHC who gave evidence before the COI believed that the creation of health teams will break down the ‘stove pipe’ mentality and assist in the passage of information between health providers. The same however still can not be said of the commander vis-à-vis health professionals. Training would assist in developing a culture where all relevant information which can be shared, is indeed shared.

Policy

ADF Commander’s Duty of Care

116. The COI took evidence concerning a Commander’s duty of care for the mental health of those under his/her command. Extant ADF policy states:

“All ADF commanders have a moral obligation and duty of care to monitor and protect the health and welfare of personnel. The command responsibility includes mental health.”

117. GPCAPT Iervasi saw his responsibility under this DI(G) PERS 16-24 as follows:

“At the time of CPL Talay’s death they meant to me that as I have a responsibility and accountability for all people in my chain of command in accordance with the first line of that paragraph, I’m after and ensuring their general health and welfare, so I’m working in my capacity as commanding officer and through all support networks feasible to ensure that I’m not going to put individuals in a position where they are either at physical risk to their own safety or in a position where they may be caused to self-harm.”

118. However, it is well recognised that notwithstanding the imposition of this duty of care on the part of ADF commanders, other Defence policy restricts their access to information that would assist them in its fulfilment. Medical-in-confidence and general privacy considerations may in fact positively hinder a commander in the fulfilment of this obligation. As GPCAPT Iervasi commented:
"...if I am dependent upon non-specific and more general information and if I'm dependent upon intuition and gut feeling. At times intuition and gut feeling might not actually be correct. I don't have and didn't have and no unit is equipped to have specialist professional mental health staff or the unit that can actually provide me with independent advice as to whether the courses of action we are taking to maintain a duty of care are actually at the correct level."

119. Commanders will continue to have a crucial role to play in the provision good mental health within their commands. The issue is whether they should have the primary responsibility in circumstances where the actual management of ADF member with a mental health problem may never in fact be brought to the attention of the command chain. The existing tension between policy, on the one hand, and practicality on the other is recognised at very senior levels within JHC. AIRCDRE Smart said in her evidence to the COI:

Do you see that there's a tension between the two?---I do. I do believe there is an ongoing tension between the two, particularly when it comes to mental health issues because we all know that in the community in general, and no less so in the military, there is a stigma associated around mental health conditions which is very unfortunate and something obviously that both Defence and civilian world is trying to overcome. So I think, you know, if you have to make a judgment call as to when there is a risk associated, when there is a problem, because if you don't draw the line in the right place you may tell the CO something about a member who has already got a diagnosed condition but is under treatment and is not at risk and they actually may be treated differently by the work environment, by the CO and perhaps because of their mental condition, so I think a lot of it is to do with the stigma surrounding this and also some sensitive medical conditions which makes it very difficult. As you say there is a tension between the two, and it is an area of grey, I agree."

Authority to Direct the Formation of a Crisis Management Team

120. Extant policy relies upon good and effective working relationships between health professionals and command in relation to the crisis management of members at risk of self-harm. Evidence before the COI supports a conclusion that such relationships generally work. There will, however, be the occasional situation where the interpersonal relationships do not result in a positive outcome. All command and medical witnesses who have given evidence on the issue are in agreement that medical officers and Commanders should be given the power to direct the establishment of a crisis management team.
Privacy

ADF Medico/Legal Hotline

121. Privacy of health information has been a recurring theme throughout the COI. The ADF’s mental health policy refers, and complies with, the Privacy Act requirements. Commander JHC, Major General (MAJGEN) Paul Alexander provided the following evidence in relation to a report, which was commissioned to specifically address the privacy of Defence Health Information:

“As far as I’m aware, the report was prepared at the direction of the CDF’s office, and it was in relation to findings of previous BOIs and COIs, in fact, not dissimilar to, I’m sure, you know, the current Board of Inquiry, in that many of the findings were in relation to - or many of the BOIs were in relation to mental health-related incidents and many of the findings were in relation to poor information sharing, lack of clarity in relation to direction as to what information should be shared, and therefore it was taken forward in that regard and recommendations made to the COSC, as you’re aware, that there should be further work done to ensure that there was greater clarity in relation to release of information.”

122. Given the requirement for Defence to adhere to the civilian privacy standards, and with which ADF policy is for the most part compliant, there is unlikely to be, without the informed consent of the member, free passage of medical-in-confidence information to the command chain. That is not to say however that the current environment facilitates the full passage of information that is not in breach of privacy provisions. On the contrary, the evidence before the COI supports the view that health professionals err on the side of caution in the release of information. For example, the following exchange between CA and Dr O’Donaghue concerns disclosure following a member’s consent:

“I’m not about to provide you with a legal opinion in these circumstances, but the writing appears to be quite clear, though, isn’t it, that personal health information can be used or disclosed to others for purposes other than that described in paragraph 7 if the Defence personnel concerned have consented to the use or disclosure or a number of other circumstances arise?---That’s what it says, yes.

So, notwithstanding what I would submit to you are fairly clear words, you’d still be concerned about not having sufficient coverage to disclose information in a critical situation?---I think particularly - this has come from experience - with any issues, particularly those relating to mental health, what I would consider to be adequate consent I’d have some concerns about.

What do you mean, informed consent?---Informed consent, sorry. Also, the fact that a person’s opinion may change and wane over the course of a period of disclosure, and how long they have given me their consent for and for what parts of information and things like that, and the fact that if this thing were to turn around, a breach of privacy attracts a lot of attention across a wide circle of things. I would like my supervisors,
my chain of command, to be aware of this before I ventured down what can be seen as a very torturous path."

123. Dr O’Donaghue was by no means unique in his conservative approach. Evidence from other medical officers clearly establishes the level of concern held by ADF practitioners and the need for support in this area.

124. One proposal being explored by JHC is the creation of ADF dedicated medico/legal hotline via which health professionals can seek advice on disclosure of personal/medical information. Such a resource, if adopted, would assist in the flow of relevant information between health practitioners and command. It would not be a complete answer to the restricted regime currently experienced by commanders. Extant ADF policy does not clearly identify and acknowledge this continuing inconsistency.

**Contracted Health Professionals**

*Standardised Health Practices in the ADF*

125. Another issue explored by the COI relates to record keeping by, and the professional standards of, CHP. It became clear during the evidence of LTCOL Cohn that the information recorded by Dr Nicholas and held within CPL Talay’s UMR would have been insufficient for another clinical psychologist to step in and continue with his treatment without significant backtracking. LTCOL Cohn was of the view that CHP should have the same reporting requirements as uniformed and civilian psychologists employed within Defence. Currently CHP are bound to deliver the outcomes which are specifically set out in their contact with Defence. The intention is to tie the CHP to the relevant ADF policies and instructions.

*ADF Military Liaison Officer*

126. The passage of information could be further facilitated through the introduction of ADF Military Liaison Officers, as discussed earlier.
FINDINGS

127. In making my findings, I shall deal with the TOR in order. In so doing I shall deal, as I believe necessary, with the submissions made by CA, Counsel Representing CPL Talay’s Single Representative and the two Counsel who appeared for the PAP.

TOR Paragraph 5(a)(i) and (ii)

128. The evidence in relation to this TOR is clear and uncontroversial. Accordingly, my findings are:

a. CPL Jordon Leigh Talay died on 15 January 2008 between 2030 hours and 2100 hours at his home at Raymond Terrace, New South Wales; and

b. His death was caused by hanging, using a nylon rope for this purpose, and was self inflicted. There were no suspicious circumstances and he was not on duty at the time.

TOR Paragraph 5(b)(i) – Administrative and Operational Management

Workplace Bullying/Harassment

129. In her submissions, Counsel Representing CPL Talay’s Single Representative, attempted to draw a link between the treatment of the deceased by WOFF Kulij and the deceased’s action in suiciding. There is no doubt that in his lifetime the deceased had made complaints to his wife about this matter. However, when WOFF Kulij gave evidence before the Commission he was not cross examined by Counsel Representing CPL Talay’s Single Representative. Nothing emerged in his evidence that suggested this contention.

130. The major single complaint made by the deceased about his treatment by WOFF Kulij concerned the WOFF’s insistence that following the deceased having failed a mandatory physical fitness test he retake the test earlier than the relevant policy required him to do.

131. There was no issue that this was the case, however, WOFF Kulij’s evidence which was effectively unchallenged was that in so doing he was merely following orders given to him by 3SQN’s CO. The reason why WOFF Kulij was so insistent was that the number of personnel available for operational duty had fallen to 58 percent, well short of the 75 percent required to allow 3SQN to be operational.

132. 3SQN is at the forefront of Australia’s defence, operating as it does F/A18 Hornet Jet Fighters. While CPL Talay may have resented being directed to do something earlier than policy required him to do, the WOFF’s directions to him could in no way be classified as being bullying or oppressive. What the WOFF was doing may be simply expressed as ‘doing his job’. Furthermore, no valid criticism can be made of the command chain for its proper desire for 3SQN to be operational.

133. Also a suggestion is made that WOFF Kulij’s management style was in some way unfair or oppressive. Here, there is simply no evidence to suggest this contention.
134. Accordingly, I find there is no substance in the allegation that there was a link between WOFF Kulij’s treatment of the deceased and the deceased’s suicide.

3SQN

135. Counsel Representing CPL Talay’s Single Representative also submitted that insufficient steps were taken by 3SQN to implement a contingency management plan for the deceased upon the execution of the search warrant. As I understand this submission, it means that 3SQN should have had at least a responsible member present at the deceased’s home at the time of the execution of the warrant. This submission fails to take into account that both of the ADFIS and AFP did not, for operational reasons, advise 3SQN of the time or date the search warrant was to be put into effect. When advised that the search had been conducted, the 3SQN response was both proper and in the deceased’s best interests.

136. My finding is that 3SQN did not fail in its duty of care to the deceased in this respect.

137. At this juncture, I believe it appropriate to refer to the question of suicide awareness training. The evidence discloses while this training is mandatory for appropriate members of the Army, this is not so for the Navy or the RAAF. In this case, the absence of such training is not important because, as paragraph 25 reveals, both FLTLT Ferrell, the 3SQN ADMINO, and its CO, the now GPCAPT Jervasi, were both astute enough to recognise that CPL Talay was at risk and required medical attention.

138. I find the absence of such mandatory training in the Navy and RAAF to be a matter of concern.

TOR Paragraph 5(b)(ii) – Medical Treatment and Management

2ATHS

139. Two matters emerged in the evidence in relation to this Unit:

   a. Record keeping; and

   b. The need for a liaison officer having regard to the regularly changing of medical officers and civilianisation of health facilities at medical Units due to the Services’ operational requirement.

140. As to paragraph 139.a., my findings here will be the same as those under TOR Paragraph 5(c), so I shall deal with this matter later in my findings. The same consideration applies to paragraph 139.b.

Dr Anthony Nicholas

141. Both Drs Nicholas and Henry were subjected to considerable criticism of their treatment of the deceased. As far as both were concerned, the major criticism raised by Counsel Representing CPL Talay’s Single Representative was they should have realised that the deceased’s situation called for voluntary admission to a psychiatric hospital where he could be monitored and treated.
142. I should note that the evidence clearly established that in view of the deceased’s insistence on 15 January 2008 that he had no intention of self-harm, involuntary admission pursuant to the New South Wales Mental Health Act was not an available option.

143. There is no doubt that voluntary admission was an available option. In this regard it is of importance to bear in mind that the deceased had been voluntarily admitted as an in patient at the Victoria Clinic in Melbourne. In this regard it is equally important to have regard to the history of how the deceased presented at the time as detailed in paragraphs 34 to 36 above.

144. The contrast between his presentation of symptoms in May 2007 and January 2008 is critical in my view in dealing with the submissions of Counsel Representing CPL Talay’s Single Representative. While CPL Talay was plainly very distressed at the outset of his consultation with Dr Nicholas on the morning of 15 January 2008 (see paragraphs 58 and 59 above) he was calm at its end. He then returned to his duties where he was observed by a workmate to be acting in a normal fashion.

145. Later he attended upon Ms Margaret Wells, his solicitor, in Newcastle. When his interview with her commenced she observed that he was apprehensive. Having regard to the charge CPL Talay was facing I do not find this to be surprising. At the end of the interview, she observed that he seemed in good spirits (my understanding of her evidence).

146. I regard Ms Wells’ observations to be of great value in determining the facts. She was no mere lay observer because her long involvement as a Mental Health advocate plainly would have given her a relevant capacity to make informed observations of the presentation of persons such as CPL Talay.

147. CPL Talay then returned home. His wife’s statement to New South Wales Police reveals that he was in good spirits on his arrival, after which the events detailed in paragraph 27 above occurred.

148. As I have said, the contrast between the manner in which CPL Talay presented before his admission in May 2007 to the Victoria Clinic and his presentation:

a. At the end of his consultation with Dr Nicholas;

b. As it appeared to his workmate shortly thereafter;

c. At the conclusion of his interview with Ms Wells;

d. On his arrival home; and

e. In his telephone conversation with Dr Henry;

are indeed significant.

149. As at the time of CPL Talay’s conversation with Dr Henry at 1808 hours, had Dr Nicholas been aware of the deceased presentation at that time and earlier as I have detailed above, he, no
doubt, would have been satisfied that the plan composed by Dr Henry and himself outlined in paragraph 65 above was working.

150. I turn then to the medical evidence. As far as the crisis plan itself is concerned its principal medical critic was Dr Lambeth. I refer to the extracts from his evidence which are to be found in paragraphs 78, 79, 80 and 83 above. In this regard, LTCOL Cohn’s evidence is similar (see paragraphs 67 and 68 above).

151. Accordingly, I find that while the plan may have fallen below what Dr Lambeth describes as the “Gold Standard” it was clearly a reasonable plan and one which clearly exceeded minimum standards.

152. I should also note neither Drs Henry and Nicholas were aware (nor could they have been) of CPL Talay’s use of the Service computer to access images relating to suicide by hanging or the fact that he was carrying the very nylon rope which he used to kill himself in his bag. Had they known (as they deposed) these facts their crisis management plan may have changed.

153. Accepting, as I do, LTCOL Cohn’s evidence (as I do the evidence of Dr Lambeth) the recriminatory discussion between CPL Talay and his wife, as set out in paragraph 27 above, was the last straw for a person suffering from CPL Talay’s mental condition and he soon afterwards took his own life.

154. I should add that the principal cause of CPL Talay’s decision to suicide was his arrest and being charged with an offence relating to the downloading of child pornography.

155. Counsel Representing CPL Talay’s Single Representative submitted that an incident which involved CPL Talay bringing sporting ammunition onto the Williamentown base “was a danger signal of which Dr. Nicholas should have been aware”. In evidence, a misreading of Dr Duffy’s note of his review of CPL Talay caused some unfounded evidence to be given with this submission. Dr Duffy’s translation of his own handwriting invalidates the evidence so given and accordingly this submission.

156. In the light of the evidence, I have referred to above, I am of the view that Counsel Representing CPL Talay’s Single Representative’s submission is not sustainable. I thus make no finding adverse to Dr Nicholas.

Dr Hayden Henry

157. It follows that in relation to his treatment and care of CPL Talay, I make the same finding in relation to Dr Henry. Indeed, the fact that he went to the deceased’s premises on the fateful evening to monitor his patient’s condition and his subsequent consultation with him by telephone are entirely to his credit.

158. There is one other matter raised in respect of Dr Henry. It is this. On Friday, 11 January 2008, following CPL Talay’s arrest ADFIS contacted Dr Henry requesting he provide them with the names of the mental health practitioners treating CPL Talay.

159. Dr Henry then sought advice from a legal officer at RAAF Base Willington. There is no evidence as to the precise nature of the advice and the reasons behind same. I make no findings
as to its correctness or otherwise. Suffice it to say that Dr Henry acted on such advice and believed that considerations of medical-in-confidence prevented such disclosure. Following that advice, Dr Henry refused the oral request and required that it be put in writing for further consideration.

160. Unfortunately, in my view he should have acceded to the ADFIS request for the simple reason that the disclosure of the treating health professionals was to CPL Talay’s benefit. Having, however, regard to the fact that Dr Henry was a very junior medical practitioner at the time, I make no adverse finding against him for following such advice nor taking any other steps to inform other health professionals of the request.

161. In short, I find that no criticism of Dr Henry has been sustained.

TOR Paragraph 5(c)(i) – Medical Record Keeping

System

162. The chronological system of medical record keeping was described by Dr Lambeth in his evidence as ‘abominable’. In essence, his criticism was that important information can be buried in an extensive file when a busy medical officer does not have the time to read the file from cover to cover when carrying out his normal clinical duties. While the Commission received evidence that the Single Services will ultimately have an electronic system, such a system is some way off arriving. The introduction of the amended PM510 Health Summary (PM510) into the existing system will, I believe, create a better mechanism for the capture of critical information. It will however, (and so I find) be important for health practitioners to be required to use the PM510 for the recording of such information.

163. Furthermore, the evidence suggests that regular audits of UMRs should be made by JHC. I find that this would assist, interalia, to monitor both the recording of critical information in the PM510, and information transfer from the present paper system to the proposed electronic system.

TOR Paragraph 5(c)(ii) – Training

Suicide Awareness Training Coordinator

164. CAPT Cleverley, the then holder of this position, gave evidence of his role. Unfortunately, his position terminated shortly after he gave his evidence and he will not be replaced in the forthcoming 12 months. In my view (and I so find) there are strong grounds for the establishment of this position on a Tri-Service basis. I so find because I believe the importance of this training is such as to require proper coordination between the three Services.

Self-harm Risk Assessment Training for ADF Health Providers

165. Evidence was given by LTCOLs Cohn and Hodson of the proposed issuing of a Surgeon General Health Directive on Suicide Risk Assessment for health providers within the ADF. The draft Directive (Exhibit CA090) includes a suicide risk assessment guide which is intended for
use as a tool by ADF Health Providers when confronted with a member who may be at risk of self-harm.

166. In my view (and so I find), junior medical officers should be given specific training in such risk assessments as suggested by LTCOL Cohn and Dr Lambeth. The proposed Surgeon General Health Directive appears to clarify the role of health providers in the ADF when dealing with such situations.

**Communication between ADF Health Providers and Commanders**

167. In evidence, GPCAPT Iervasi pointed to the difficulties he encountered as CO 3SQN in obtaining access to relevant medical information when he was required to make decisions relating to the welfare of RAAF members under his command.

168. Indeed, LTCOL Hodson pointed to a problem between psychologists and other health professionals when information is sought to be shared.

169. I find that training should be initiated so that a culture is developed that where relevant information can and should be shared, it is indeed shared.

**TOR Paragraph 5(c)(iii) – Policy**

**ADF Commanders Duty of Care**

170. The relevant current DI(G) PERS 16-24 imposes a duty of care upon CO to monitor and protect the mental health and welfare of their personnel. However, as GPCAPT Iervasi pointed out, (and so I find) medical-in-confidence and privacy considerations seriously inhibit the capacity of a CO to fulfil the duty of care imposed by the DI(G).

171. In this regard the concept of sharing of information as outlined above would assist in breaking down the obstacles confronting COs as outlined by GPCAPT Iervasi.

**Authority to Direct the Formation of a Crisis Management Team**

172. While evidence before the Commission indicated that the present system relies upon good and effective working relationships between command and health professionals in relation to crisis management, all witnesses were of the view that both medical officers and COs should be empowered to direct the establishment of a crisis management team. As this suggestion is plainly not only common sense, but also appropriate management practice, I find it should be instituted.

**TOR Paragraph 5(c)(iv) – Privacy**

**ADF Medico/Legal Hotline**

173. In dealing with the actions of Dr Henry on 11 January 2008 involving CPL Talay, I observed that he should have disclosed the names of the treating psychologist and psychiatrist to ADFIS. Furthermore, other evidence before the Commission (particularly that of
Dr O’Donaghue) is indicative that medical officers would seek a clearance from their medico/legal insurer before making a disclosure of an ADF patient’s medical information.

174. To an extent this matter is similar to the difficulties that exist between COs and medical officers, which I have dealt with above.

175. One solution currently being considered by JHC is the creation of an ADF dedicated medico/legal hotline through which ADF health officials can obtain advice on the disclosure of personal/medical information. While not a perfect solution, I am of the view (and so find) that a trail of such a hotline should be carried out.

**TOR Paragraph 5(c)(v) – Contracted Health Professionals**

**Standardised Health Practices in the ADF**

176. A problem that emerged in evidence before the COI is the standard of record keeping by CHP. In particular, the evidence of LTCOL Cohn was that that the notations made by Dr Nicholas and found within CPL Talay’s UMR would be insufficient for another clinical psychologist to take over his treatment without significant backtracking. I agree with LTCOL Cohn’s view that CHP should have the same reporting conditions as uniformed and civilian psychologists employed within the ADF, i.e. to tie CHP to relevant ADF policies and instructions, and so I find.

**ADF Military Liaison Officers**

177. The current high temp of ADF operations has meant that uniformed health professionals are being redeployed at a rate not seen outside of World War II. The result has been the necessity for the employment of civilians to backfill for the vacancies created by such deployments.

178. LTCOL Murphy deposed that a problem has arisen involving such contractors. It is that such persons enter the Defence health facility without any prior knowledge of health provision within a military environment.

179. LTCOL Murphy suggests that a way of overcoming this problem is the appointment of ADF Medical Liaison Officers with appropriate clinical or administrative backgrounds that could assist the contracted workforce with the military information they need to do their job. LTCOL Murphy regards such appointments as important in ensuring that ADF members receive appropriate health care. I agree with LTCOL Murphy and I find that the appointment of such liaison officers in the present operational mode of the ADF would be beneficial to ADF personnel.

180. In making these findings, I have made reference only to submissions made on behalf of the CPL Talay’s Single Representative. I have not mentioned the submissions of the other Counsel simply because my findings are, by and large, in accordance with their submissions.
RECOMMENDATIONS

181. The following are my recommendations.

Medical Record Management

182. JHC conduct regular audits of UMR to monitor both the recoding of critical information in the PM510, and information transfer from the present paper system to the proposed electronic system.

183. JHC ensure that:
   a. Critical medical information is recorded on the PM510 Health Summary,
   b. Critical medical information is transferred from the UMR to the PM510 Health Summary, and
   c. Critical medical information is transferred from the paper UMR to proposed electronic medical record system within 12 months of its establishment.

Training

184. All full-time ADF members are to undertake suicide awareness training annually.

185. All ADF medical officers and mental health professionals to undertake specialised training in suicide risk assessment.

186. The establishment of a Tri-Service Suicide Awareness Training Coordinator within JHC at the Major equivalent (04) level and such person should have an appropriate level of military training and experience.

187. JHC to provide training to ADF health professionals and command with respect to the passage of medical information between one another.

Policy

188. JHC and Defence Legal to audit extant ADF health policy with a view to addressing the inconsistencies that currently exist pertaining to commanders and others with respect to their ‘duty of care’ responsibilities.

189. Amend DI(G) PERS 20-16 to provide for the authority of Medical Officers and COs to direct the establishment of a Crisis Management Team.

Privacy

190. JHC to continue to work towards the establishment of an ADF medico/legal hotline for use by health professionals and command.