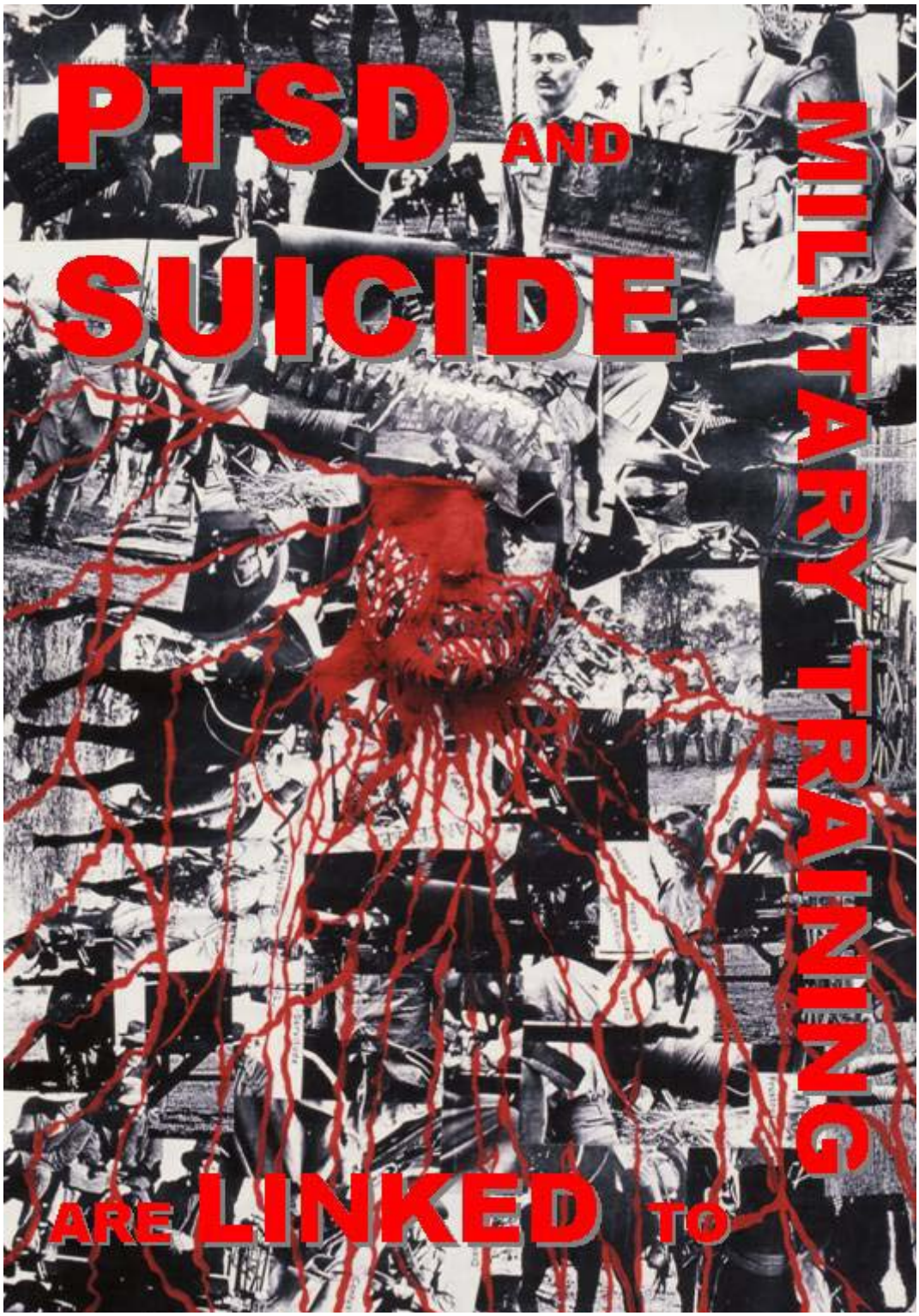
John Lawler

Submission to:
Foreign Affairs Defence and Trade References Committee

Suicide by Veterans and Ex-Service Personnel



PTSD AND SUICIDE ARE LINKED TO MILITARY TRAINING

The evidence, as supplied in this submission, shows that Australian Defence Force training is a major contributor to suicide of veterans and ex-service personnel, in that, to ensure they react automatically in a war like situation, their stress levels are raised to **9 out of 10**, where they remain for the rest of the individual's life.

A minor incident can easily push a veteran's stress levels to 11 out of 10.

11 out of 10 equals suicide.

This submission is being made to ensure that the matters it raises are placed on the public record and subject to public scrutiny.

This submission contains important evidence concerning the physical brain injury of PTSD sustained by Australia's young men and women going through Basic and Corps Training in Australia's Defence Force.

The Australian Federal Government is knowingly subjecting up to fifty percent of young recruits to training that will be devastating to their lives, if not kill them.

I believe that it is of utmost importance that this matter be dealt with immediately before more young people are subjected to ongoing criminal abuse by the Australian Federal Government.

I hope you understand that while you are reading this submission a number of Australia's recruits are being brainwashed to the extent that up to fifty percent of them will become physically brain damaged, some for the whole of their lives. This terrible condition not only affects those that are brain damaged but also those close to them.

I say to you again, it is of utmost importance that this matter be dealt with immediately and there is no time to waste in bringing this matter to the nation's attention.

A film which also forms part of this submission can be viewed on YouTube at:

https://www.youtube.com/watch?v=ckneovhcx-Y

PTSD is linked to Military Training
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Introduction

I am a veteran of the Australian Army and suffer from PTSD and other medical conditions.

My PTSD and other medical conditions are the result of an assault upon me where I was bashed unconscious by five Australian soldiers when I attempted to stop them from raping a female soldier at Randwick Barracks in Sydney in 1976.

Although I reported the assault immediately to an officer at the time, and was later interviewed by a sergeant from the Military Police, no action was taken by the Army regarding the assault or my injuries.

I felt betrayed by the Army personnel who covered up the incident and did nothing to obtain justice for me. I was horrified that the Army had allowed this to happen and continued to cover up and deny the assault.

I have evidence that I have suffered from PTSD since immediately after the assault, but I was not formally diagnosed with the condition until 2011, when, on my own initiative I sought help from Vietnam Veterans Counselling Service (VVCS) and my GP, and was referred to a private psychiatrist for assessment. I then commenced private psychiatric treatment in 2012.

As part of helping myself to understand my condition and to bring some meaning to what happened to me I have been undertaking personal research and, attempting to raise awareness of the link between army basic and corps training and PTSD. My concern is that young Australians, who are currently undergoing military training, are being exposed, by the Australian Government, to an undeclared risk of getting PTSD.

In making this submission I hope to bring this matter to the attention of people who may have the compassion and courage to bring this matter to the nation's attention and to act to bring about changes that will minimise the risk to young men and women who may ultimately be called upon to lose their lives in wars incited by politicians.

This submission comprises six written sections, and a film. The first section details the assault upon me, the second describes the impact the assault and subsequent events have had on my life, the third sets out some of the appalling experiences I have had with DVA, the fourth describes some of the things I have done to stay sane and alive, the fifth section is a call to action and includes information as well as important questions that need to be answered. The sixth and final section introduces the documentary film I have made about this shameful behaviour that will result in 1 in 3 serving or veteran personnel acquiring PTSD. The film can be viewed on YouTube at: https://www.youtube.com/watch?v=ckneovhcx-Y and I have submitted a copy on DVD.

The assault

I joined the Royal Australian Army on 3 June 1975 as a corps enlisted Architectural Draftsman. I completed 12 weeks basic training at Kapooka and then transferred to

Casula for corps training with the Royal Australian Military Engineers. I remained at Casula until January 1976 when I was transferred to the Chief Engineers' Office, Victoria Barracks in Sydney.

While at this posting, in mid-1976, I was assaulted by a group of male soldiers. I was beaten about the head and body and rendered unconscious while attempting to prevent the imminent sexual assault (rape) of a female soldier.

I was returning to my accommodation block at Randwick Barracks in the evening, when I noticed a female soldier whom I worked with at the C.E.'s office. She was with a group of male soldiers (approximately 5, who all appeared sober). One of the male soldiers was a corporal.

I said hello as l was passing and noticed that was intoxicated. While I was talking to , the corporal said that his car was next to us and that I could "go first". I believed that may have been at risk of assault or possibly rape, so I sat in the car and talked to her for about twenty minutes in an attempt to allow her to sober-up.

While I was sitting in the car with her, the car door opened and I was pulled out of the car and onto the ground by the corporal who was infuriated and who, with at least one of the other soldiers, began to beat me to unconsciousness about the head and body with their fists while I was on the ground. I woke up twenty minutes later and found , the car, and the soldiers gone.

I was extremely concerned about welfare and immediately went to the officer's married quarters at the barracks and raised the alarm to a male officer. I was advised to return to my accommodation block by the officer.

The next day I attended work with abrasions and black eyes. I was interviewed that day by a sergeant in the Military Police. He stated to me that I must have had an involvement with to be so concerned. I replied to him that I was in a committed relationship with a woman in Adelaide and was about to be married. The sergeant discontinued the conversation. I heard nothing of the incident following the interview.

I did not attend the RAP for treatment of the physical injuries that had been inflicted on me during the assault.

arrived at work two days later and thanked me for my help that evening. She told me that the Military Police had asked her to change corps to the Military Police, and that she could be transferred to Recruiting, and that maybe there was a promotion in the offering.

My record of service sheet shows a charge against me in early November 1976. This incident occurred at Singleton Army Base where I had been sent overnight to design a new dental surgery. After work I went to the mess and became drunk. Returning to the accommodation I was disorientated and walked through an 'off limits' area. I was challenged by a civilian whereupon, unfortunately, I told him to 'piss off', and I was subsequently charged.

Around the same time I was detained overnight at a police station at Darlinghurst in Sydney for being drunk. I phoned the CE's office the next morning from the Darlinghurst lockup, and was subsequently picked up from the lockup and taken to work. There are no details of this on my army record and I have no personal records of this event.

Not long after this I was called to a meeting with the Chief Engineer , who said that things did not seem to be going too well for me, and that he would make it possible for me to get out of the Army if I wanted to. I did not accept the offer, telling the CE that I had signed on for six years and was prepared to meet that commitment.

I discharged from the Army on 2 June 1981.

The impact

Currently I am receiving treatment from a Doctor, and a Psychiatrist. My Psychiatrist has diagnosed me as suffering from Post-traumatic Stress Disorder, Generalized Anxiety Disorder, Alcohol Dependence (in remission), Nicotine Dependence (in remission).

I sustained injuries from the incident, which were physical/psychological and long term. I suffered black eyes, abrasions, concussion, and neck and back injuries from the incident. I have suffered for 38 years from anxiety stress and depression. This manifested for a number of years as alcoholism, for which I spent three months in an Alcohol and Drug Treatment Unit in the Darwin Hospital. In 1989 I attended a psychiatrist to help with problems. I continue to suffer from PTSD, depression, anxiety, stress, headaches and back and neck pain.

My relationships with family and friends have suffered and continue to do so. I married in August 1976 and had a marriage breakdown in 1979, primarily due to my alcohol dependence. I remarried in 1999. I have current marriage issues with my wife suffering from depression and requiring treatment due to my ongoing mental and physical issues caused by the assault.

My career in the ADF suffered because of my alcoholism, medical issues and loss of faith and trust in the Army system which had failed to deliver justice, left me disinclined to pursue promotion or to further re-enlist.

My career in commercial architecture also suffered because of my psychiatric problem.

After leaving the Army, I worked for the Commonwealth Department of Housing and Construction in Darwin for two and a half years. It was while I was in Darwin that I underwent a three month voluntary detoxification program. However, after leaving Darwin I moved to a rented shack at Mannum (country South Australia) and essentially isolated myself there for the next six months to continue my recovery.

I then returned to Adelaide and gained employment with a number of large commercial architectural firms, but I have essentially only held short term or contract jobs since my return from the Northern Territory.

The last full-time permanent position I held was as the Housing/Building Coordinator with AP Services, in the Anangu Pitjantjatjara Lands in South Australia. My symptoms became extreme during this period of employment and I actually started abusing alcohol again. When this happened I realised I needed to remove myself from this situation and resigned in 1996.

My PTSD stopped me from working because I am unable to work with other people, I have difficulty concentrating, I am quickly exhausted, and easily overwhelmed by even the simplest challenges.

I received a Centrelink Disability Support Pension in December 2000 for my psychological and physical injuries.

Nevertheless I had previously successfully completed Bachelor of Visual Arts and a research Masters of Architecture in Aboriginal housing and in 2007 I enrolled as a PhD candidate, also in Aboriginal housing, with Queensland University of Technology.

I felt I would be able to undertake this further study because the solitary nature of research meant I was able to work at my own pace when I felt well enough, and with minimal contact with other people. It meant I did not feel completely useless and was able to make an important contribution to society. Except for scholarships my research and study has been unfunded.

I had to withdraw from my candidature when my PTSD symptoms again escalated after I was exposed to media reports of the ADFA Skype affair in 2011.

My PTSD means that I live my life in a constant state of stress and anxiety. I see catastrophe all around me and always expect the worst. I do not trust anyone and I find it impossible to see any good in people, events and life overall. I live in a constant state of irritation and anger, finding fault and wrongdoing in almost everything around me. I find social contact with people physically and emotionally draining. There is next to nothing in my life that gives me pleasure.

My significant relationships with other people are gravely affected. I am unable to relate to anyone other than my grandchildren, my wife (most of the time), and my son (some of the time).

My relationship with my son is strained and fractious because he reacts badly to my PTSD symptoms of irritability, anger and negative outlook. He has had to live with it all of his life. He thinks I am a hypochondriac and a loser.

My relationship with my wife is also strained and riven by conflict. My wife tries to support me, but her own mental health has suffered and she is also receiving psychiatric treatment. I find fault with much of what she does and we argue

frequently. My wife lives on tenterhooks in anticipation of my next angry outburst. We live perpetually on the brink of separation.

My relationship with my two sisters is distanced, as was that with my mother until her passing in 2013, and I have maintained these relationships primarily through a strong sense of moral obligation.

I find it extremely testing to mix socially with people. I find it impossible to cope with large groups and or to engage socially with individual people for any more than about half an hour. I have difficulty following the flow of conversations and I am unable to remember much of what is said. I am suspicious of people and their motivations and am unable to form friendships.

Since the onset of my PTSD immediately following the assault I have always found it hard to make long term meaningful friendships. My ability to socialise casually with people has gradually diminished over the ensuing years. My suspicions and distrust of others increased significantly immediately after the assault. Over the last 15 years or so I have been unable to do much more than stay at home, or spend time with my wife.

My medication gives some relief from my symptoms so I can at least attempt to maintain my relationships with my grandchildren, son, wife, and sisters, and feel that there is a reason to continue living.

I have no motivation or energy to do anything and when I do manage to find a little bit of energy I am easily exhausted and overwhelmed, especially if things do not go right.

The number of activities I engage in has been greatly reduced due to my PTSD. I mainly watch television or browse the internet, neither of which is very satisfying. The only satisfying activities I undertake are riding my motor bike, and sailing, for which I rely very heavily on my wife for organising the outing and the physical tasks involved. I only do these activities very occasionally now.

I rely on my wife totally for completion of all domestic tasks, financial matters and other activities associated with daily living.

I have suffered financially from the loss of a substantial farm property following my first marriage breakup (over a million dollars).

I have suffered and continue to suffer from the loss of access to my son and grandchildren.

I have suffered and continue to suffer because my PTSD damages the relationship between my wife and I, and constantly puts our marriage at risk.

Since the Skype incident I have suffered from the inability to continue my PhD in architecture at the Queensland University of Technology.

I felt betrayed by the Army personnel who covered up the incident and purposely did nothing to obtain justice for me. I was horrified that I had been attacked by men who were meant to be covering my back, that the Army had allowed this to happen, and has continued to cover up and deny the assault.

I still find it incredibly painful to talk about the assault, and the deterioration of my mental health in the years that followed.

My PTSD means I have no desire or capability to pursue any meaningful activity, whether that is physically, mentally or emotionally and this fills me with despair and self-loathing.

My condition has been worsened by shortcomings in the DVA Claim process which I describe in the following section.

An analogy to what has happened to me since the assault in 1976 is that I had attempted to save another Australian soldier's life by running onto the battlefield under fire. Myself and the other soldier were seriously wounded. I lay in the battlefield for 38 years wounded. When I called out for help I was fired at with no hope of repatriation.

The incredible truth here is that the enemy who seriously wounded myself and the other soldier were other Australian soldiers, who bashed and raped their fellow soldiers.

The absolutely incredible truth here is that when I called out for help and was then fired upon, it was by my own country (DVA).

So much for the mythology of the Australian digger, who looks out for his mates, used so often by Australian Governments for their own benefit.

My grandfather, who fought at Hill 60 with The First Australian Tunnelling Company RAE against the Germans in WW1, and my father, who defended Australia's airfields against the Japanese in WW2 in the 43 Battalion AIF, would be dumbfounded, and if they were alive today would be appalled to find Australian Governments that did not care about the welfare of its service men and women, only about its own "hip pocket" and reputation. Consecutive Australian Governments' have lost their moral compasses.

It is deplorable that the Australian Government, the Australian Army and the Department of Veterans' Affairs have failed in their duty of care because they failed to act on the report of serious criminal assault and rape on three occasions over a thirty six year period; and they also failed to offer treatment for my PTSD injuries on those same three occasions.

The nightmare of DVA

My experiences with DVA have been extremely unsatisfactory, unhelpful, distressing and they have exacerbated my PTSD symptoms and consequently had a detrimental

effect on my physical health. My dealings with DVA have been marked by misrepresentations, misleading or incorrect information, obfuscation and outright lies.

In 2001 I lodged a claim with Department of Veterans' Affairs for a disability pension. During that claims process I advised the Veterans' Review Board of the assault, but no action was taken regarding the assault or my injuries.

As part of assessing my 2001 claim, I was seen by DVA medico-legal psychiatrist psychiatrist (in 2002) who diagnosed me with a Generalised Anxiety Disorder. In his report he noted that if I did not receive treatment immediately my condition would become permanent.

My records show that I told the VRB about the assault and possible rape in 2003. However, what is not shown in my records is that my testimony was summarily dismissed by one member of the VRB with a flippant comment to the effect of: "I suppose you want to claim for **that** now" (a Brigadier). No further evidence or action concerning the assault was taken.

DVA eventually denied my 2001 claim, saying that my injuries were not service related.

My mental illness also meant I did not have the capacity to pursue the matter of my 2001 DVA claim any further.

I did not receive any treatment until 2006 when, on my own initiative, I sought help from my GP who prescribed anti-depressant medication.

In 2011, my condition worsened considerably following media reports of the SKYPE affair, and I sought additional treatment. It was then psychiatrist diagnosed my condition as PTSD.

In August 2011 I again lodged a claim with DVA for a disability pension for "depression, anxiety and stress" which the DVA acknowledged.

As part of the claims process, I again attended . prepared two reports following that consultation. In his first report, requested additional information prior to offering an opinion on diagnosis and causation.

The DVA Claims Officer dealing with my case, never asked me for the information held by me that requested.

In his second report states he was unable to make a clear diagnosis because critical information he had requested from DVA was not forthcoming. The information requested from DVA contained important information concerning the criminal assault upon me, the rape of the female soldier, the subsequent effects on my mental health and the eventual diagnosis of my PTSD by . Despite advising that his diagnosis was offered in the absence of this information, she chose to determine my claim on the basis of an incomplete assessment.

I was subsequently refused my application for "anxiety disorder and alcohol dependence" (DVA had changed the basis of my application without notifying me) on the grounds that my condition was not service related.

I appealed the decision to the Veterans' Review Board.

Part of the appeals process under the Veterans' Entitlements Act is that DVA has the opportunity to review all claims, prior to referral to the VRB. My file indicates that DVA did not take the opportunity within this part of the process afforded them to take further evidence or to conduct further investigation. Instead they abdicated their responsibility in this regard by choosing not to review my case and referring it to the VRB.

The correspondence I received seemed to indicate DVA had made this decision by relying heavily on the reports prepared by in 2002, and 2011, and the absence of any record of the assault in my army personnel and medical records.

I decided I would need to find my own evidence and set about trying to locate . In doing so I contacted a former colleague who had worked with me at the CE's office in Sydney, whose wife had been friendly with . He told me he remembered the time I had been assaulted, and provided a statutory declaration to this effect. However, I was unable to locate until late in 2012 when I discovered (via a Google search) that she had passed away earlier that year.

As part of my preparations for my appeal to the VRB I gained access to documents on my file through a Freedom of Information request. It was then I discovered that had requested information which had not been obtained from me. This caused me great distress, particularly as reports clearly qualified his findings as being incomplete in the absence of this information.

I tried to ascertain how I could submit this information in support of my claim. This led to several confusing and distressing phone calls with Claims Office , asking when DVA/VRB would request the additional information I held. My distress reached such a point that my wife had to eventually speak to a supervisor, who advised her it was appropriate for me to submit whatever additional evidence I held to support my claim, at this stage of the process. He also acknowledged that the Application for Review form was misleading and confusing in that it did not provide information to this effect. apologised for the manner in which I had been treated and commented that the form needed to be amended

Also, at no time did DVA request that I complete an Alcohol Questionnaire, although I have since been told this should be standard procedure. It was not until my 2011 claim was appealed to the Veteran's Review Board that I was asked to complete this document. At no time have I been asked to complete a Smoking Questionnaire.

Further, despite the outstanding information requested by subsequently being submitted by me, DVA did not seek to have him revisit his diagnosis.

The other matter causing me acute distress was that, from where I stood, DVA had changed my claim (by changing how it was described) without advising me or explaining why and this was incredibly confusing, and distressing.

I raised this matter with the Minister for Veterans Affairs (2 May 2013) and was advised by his office that, on the basis of reports, DVA had determined, "generalised anxiety disorder and alcohol dependence" was the appropriate medical diagnosis for my claim

At no point during the claims process did DVA advise me why they had changed the description of my condition, and, hence, the basis of my claim.

I first saw my treating psychiatrist, , in January 2012, following a referral from my GP. It was who advised me I was eligible to apply for a DVA White Card which would help pay for my treatment. He assisted me with making an application for a white card on the basis of his diagnosis of PTSD.

I was subsequently issued a white card for Anxiety.

A letter I received from DVA dated 16 March 2012 stated that "Approval has been given for you to receive treatment for anxiety disorder at the expense of the Department with effect from 20 May 2001," and that a White Card would be forthcoming.

Again, I could not understand why the card had been granted for a condition other than that which had been applied for. I was gravely concerned and distressed that DVA's records were not reflecting the diagnosis of PTSD, given by my treating psychiatrist.

Clearly, DVA had ignored the PTSD diagnosed by and chosen to privilege the diagnosis of , made on the basis of one consultation, and, on his own admission, offered in the absence of significant and crucial information, over that of who has had numerous consultations with me since I started seeing him in February 2012.

I raised this question with the Minister (3 August 2013) and received a response from DVA advising that:

> Although consultant psychiatrist had provided a brief statement that you suffered from PTSD, DVA held three detailed reports from suggesting otherwise.

This explanation seemed unlikely because completed the DVA form **Application for Health Care in Respect of Post Traumatic Stress Disorder (PTSD)** in its entirety, providing the information specified, and submitted it to DVA. The section of the form **Diagnostic Report – Report Detail** is specific and succinct about the information required from the treating Psychiatrist. It asks a question requiring a "Yes" or "No" answer and provides four lines for the treating Psychiatrist

to add further details and "specify ICD codes where possible". Nowhere on this form is the treating Psychiatrist asked to provide any further information. Further, the form requires the diagnosis and application to be made by the ***treating*** Psychiatrist. was not, and is not, my treating psychiatrist.

The above explanation seemed even more unlikely when, after ( ) submitted the same DVA form as had done (**Application for Health Care in Respect of Post Traumatic Stress Disorder (PTSD))**, I was advised I had been accepted for treatment for PTSD.

I further challenged the privileging of diagnosis over that of my treating psychiatrist in further correspondence with the Minister (2 October 2013).

The questionable nature of this matter was reinforced when the Minister subsequently advised (13 January 2014) that a report from (which I understand to be the same form as that submitted by) meant it had been "accepted that the weight of evidence favoured a diagnosis of post traumatic disorder (PTSD)".

I appeared before the VRB in October 2013. The VRB accepted diagnosis of PTSD, Generalised Anxiety Disorder, and Alcohol Dependence, and recorded that my claim was for those conditions. The VRB took detailed evidence from me regarding the particulars of the assault, the subsequent events, and the impact of the assault on my life. The VRB found that further evidence was required before it could make a determination on my case and adjourned the matter. The VRB requested DVA to provide an historical report on the circumstances surrounding the assault.

DVA subsequently commissioned a report from which was conducted by It is my understanding the researcher contacted my colleague who had provided evidence (by was of statutory declaration) on my behalf. At no time did he contact me directly for any information or seek to interview me.

The VRB advised DVA that purpose of obtaining an historical report was to provide contemporaneous evidence to the assault. The board advised DVA that they were seeking: statements from a wider group of personnel; MP files, investigative notes, or reports; the service documents (including the medical file) of . However, the report author did not access the documents sought by the VRB.

The researcher who prepared the report on behalf of DVA did not make any reference to having made any attempts to contact any other personnel, specifically my CO, , thereby suggesting he did not do so. Also he relied on advice from third parties as to what records could be expected to be found, and then relied on advice from Defence that such records did not exist. (I subsequently tracked down , but he had recently passed away).

The researcher was DENIED access to service records by Defence and relied on advice from Defence that her service records contained no reference to any incident. He did not obtain or inspect her files for himself.

Further, in its findings of 11 July 2014 the VRB noted:

> The report contains suppositions and opinions based on the report author's military service. … Regrettably the report author was, in effect, substituting his service knowledge for 'evidence'.

And

> Accordingly, the author's suppositions are not substantiated by any evidence. They follow the form of "had event A occurred, what should have happened was x, y, and z". Such conclusions are unhelpful to the Board.

I understand DVA have since discontinued using the services of , whose reports had been the subject of considerable controversy for some time.

In July 2014, the Veterans' Review Board reconvened my matter and advised that they found, on the balance of probabilities, the assault had occurred and my injuries were service related, and I was entitled to compensation under the Veterans' Entitlements Act. They referred my case to DVA for assessment of the rate of benefit payable.

I have since been assessed by DVA as eligible to receive 80% of the General Pension Rate because of my service related injuries.

This assessment was made in the absence of me completing a necessary Lifestyle Questionnaire. However, Claims Officer, had assigned a lifestyle rating of 3. I raised the fact that I had not been asked to complete a Lifestyle questionnaire with my RSL advocate who said that it did not matter because it would not make any difference to my disability rating. I was unsatisfied with this response and raised the matter with DVA, in a personal attendance upon . She subsequently wrote confirming that I had not been requested to complete the Lifestyle Questionnaire and sent a form for me to complete and return. I elected to complete the self assessment option, which indicated a lifestyle rating of 5.

I have since received a letter from Ian Allison, advising that DVA had reviewed my case and the disability rating of 3 used in their assessment of my level of disability was appropriate. No mention was made of the fact that the form I completed indicated a different impairment rating.

I am currently appealing this assessment. It is the opinion of my psychiatrist that my injuries are total and permanent and were the sole cause of my cessation of work.

Trying to stay sane and alive

As well as commencing psychiatric treatment and counselling, I decided I could take some action of my own to challenge the institutional processes that were making my life hell, to seek additional treatment that would help me manage my condition and to gain a better understanding of what had happened to me by conducting some research. All of this had to wait for those short periods when I felt strong enough to quell some

of the distress and anger, and was able to concentrate sufficiently to undertake these tasks. I relied heavily on my wife to complete most of them.

Writing to the Minister(s)

Despairing and angry at the treatment I was receiving through the lack of information, and misleading advice, I sought help from within the political process.

Throughout 2012 and 2013 I wrote numerous letters to Prime Ministers, Ministers, Senators, and the Commonwealth Ombudsman outlining my concerns about the shortcomings in DVA's processes.

Most of these letters went unacknowledged, or unanswered. Those answers I have received appeared to merely regurgitate information provided by DVA as incontestable fact, or ignored the questions I had asked. I even have evidence that some of the information contained in the letters was completely untrue.

Copies of these letters are attached – see Annexures 1 to 5). Three major concerns I raised in these letters are discussed below.

DVA's false promises that cost me money

On two occasions I approached DVA for treatment of physical conditions related to my PTSD and anxiety as part of my psychiatric treatment, under the white card system.

The first was for some dental treatment related to teeth grinding arising from my anxiety and stress. The DVA said that if I went to my dentist for an examination they would reimburse the money that I had spent and then would follow up with further treatment. When DVA were asked to pay for the consultations and further treatment, they refused.

When I raised this matter with the Minister (2 May 2013), DVA told the Minister that they had no record of me having requested assistance with dental treatment.

The claim that DVA holds no record of me seeking assistance with dental treatment is not true. My enquiries about assistance with dental treatment started on a date I did not record, and with a member of DVA staff who did not offer her name, and whose name I did not request. I was told that DVA would contribute an amount, which I recall as being $61, toward the cost of a dental examination. I was also told that if that examination revealed damage to my teeth arising from my mental health condition, for example damage caused by tooth grinding due to stress, DVA would cover the cost of the treatment. On the basis of this advice I attended , who completed an examination. then wrote to DVA on 6 June 2012 seeking approval of the cost of his proposed treatment. DVA denied this request in a letter dated 21 June 2012 from , Medical and Allied Health Services, to . Following this I personally paid account for the examination.

The second occasion was with regard to obtaining a CPAP machine for treatment of sleep apnoea. A staff member of DVA told me, over the phone, that DVA would pay for the costs of a CPAP machine if I obtained a letter from my doctor confirming that I needed one. wrote a letter to DVA outlining my need for a CPAP machine, and forwarded it to DVA on my behalf. The request was made on the basis that it was **part of my treatment for my mental health condition** because sleeping well is a crucial aspect of improving mental health. In fact, a number of brochures published by DVA attest to this fact.

When I contacted DVA (Adelaide office) to follow up on Dr Short's request, they denied all knowledge of having received his letter, which had been sent by facsimile transmission to , RAP Division. I contacted office and they obliged by sending the letter again. I waited in the DVA office until they confirmed it had been received. In the meantime, the staff member at the reception desk had given me a Claim for Disability Pension form and told me to complete that as part of my request. I tried at length to explain to him that I did not want to claim sleep apnoea as a service related injury and had no intention of wasting everybody's time by doing so. Rather, I wanted to be able to claim treatment for sleep apnoea as part of my mental health treatment, for the reasons stated above.

The situation became increasingly distressing and frustrating and I eventually had to leave the office, leaving my wife to deal with the matter. She asked to speak to a supervisor and was eventually seen by (a manager) and . She had a lengthy conversation with and , explaining my situation and reiterating the point that the request was being made on the basis that it was part of the treatment for my accepted condition and **not** as a claim for a service related condition. and acknowledged this point of view, but said it was highly probable that any request in this regard would be denied because the staff involved would not be able to see the correlation. gave my wife a form for completion by my sleep physician and made the offer that if I were to bring the completed form into her, she would forward it to the relevant division with DVA, with a supportive comment as to why it should be approved.

In the meantime, letter of 3 May 2012 appeared to have been forwarded to RAP Queensland. , Client Services, replied most promptly on 16 May 2012 declining the request. Her letter did not advise that was not an approved prescriber for CPAP machines. She did, however, cite the National Schedule of Equipment as specifying "which prescribers are eligible to prescribe the items listed". If DVA believes this constitutes advising and I that he is not considered eligible to prescribe CPAP as a treatment then they are sadly mistaken. I was not given a copy of that Schedule, nor was I told where I might be able to access a copy. I was also, once again, given what now appears to be the stock standard response that I should lodge a claim to have sleep apnoea recognised as service related. As I have said previously, this would have been a futile exercise, because it is not service related.

In this matter of the CPAP machine, as with the dental treatment DVA seemed intent on deliberately missing the point of the request. Further letters received from the

Minister and DVA conflict and contradict each other as to whether a claim for a CPAP machine would be accepted as part of my psychiatric care plan.

Given the state of my mental health and the increased distress these specific matters was causing me, both my wife and I decided this particular battle should be deferred and pursued at a later date.

DVA's lack of action exacerbated my condition

Prior to being assisted by I was not advised by DVA and did not know about the DVA White Card. told me that it had taken him five phone calls to DVA to ascertain whereabouts on the DVA website he could access the application form.

I was extremely distressed that I had not been advised by DVA or my RSL advocates that, even though my 2001 claim had been denied, I had been diagnosed with a psychiatric condition for which I would have been eligible for treatment under a White Card (Specified Condition).

I did not receive any treatment until 2006 when, on my own initiative, I sought help from my GP who examined me, read 2002 report and prescribed anti-depressant medication. He also wrote a letter of referral for me to see but when I rang to make an appointment to see I was told he only saw DVA clients. Disgusted and dejected I decided I would get by on my own.

As noted previously, when I was seen by in 2002 he noted that if I did not receive treatment my condition would become permanent. He also stated that:

> I would recommend that Mr. Lawler attend a Psychiatrist for psychotherapy and psychotropic medication. …"

Despite this recommendation DVA did not provide me with the assistance for treatment provided by the White Card facility.

I raised this matter with the Minister (2 May 2013), and the response I was given was that:

> It was indeed open to DVA in 2002 and again in 2011 to have extended eligibility to you for treatment of your anxiety disorder, and it is regrettable that this was not done. This was noted in March 2012 when determining your formal application for this treatment, and it was in view of this that your eligibility was backdated to 20 May 2001, three months prior to your original claim.

The statement that "it is regrettable" DVA failed to advise me of my eligibility for treatment of my condition under the White Card facility is trite and offensive. In my view it is has been extremely detrimental to my physical and mental health and in this regard DVA have been exceptionally negligent.

When I received the letter from DVA regarding the grant of the White Card I took the

date of 20 May 2001 noted therein to be a typographical error, as it made no sense otherwise. Even though DVA's letter confirms that this date is indeed correct, it remains unclear as to what effect the back dating of my eligibility for a White Card is intended to have, as it is clearly not possible for me to retrospectively seek treatment and, as I have not been able to afford to seek treatment in the past, I had no expenses to claim.

I have sought clarification from the Minister on two further occasions regarding the purpose or intended effect of back dating the White Card but have received no comment in this regard.

If DVA had advised me that they could assist with treatment, I would have taken it. However, they did not, and my mental health has deteriorated further and my quality of life has reduced accordingly.

In accordance with prognosis, in the absence of treatment, my disability continued and is now permanent.

Alteration of my medical records

The documents I received under my Freedom of Information request also revealed a discrepancy between the copies of my army medical records I had received in November 2001 and those which had been sent to me as part of my DVA file. The discrepancy was that Items 49, 50 and 51 of my final medical examination had not been completed on the copies I held, but those from my DVA file had been. It was most concerning that these Items were for 49 Other, 50 Emotional Stability; and 51 Mental Capacity.

The alteration of my records was incredibly distressing and I was very angry because they had been altered in a way that supported DVA's claim that 'I did not have a service related injury'.

I raised this with the Minister (2 May 2013) and was advised that Defence had been asked to investigate. Defence had subsequently advised that the copy of my file at Central Medical Records held a letter dated 18 May 1981 to the effect that the items had not been completed and had been returned to the medical centre for completion. However, there is no indication as to why these items had not been completed at the time of my examination. Defence advised the Minister that returning the documents was in keeping with policy at the time. The Minister also claimed that:

> …the completion appears to have been undertaken by the same medical officer undertaking the final medical board, and within a timeframe to make this completion accurate and appropriate.

The copies of my medical and dental records which I now hold were forwarded to me on 9 November 2001 by *Australian Defence Force Health Records – Army*. The covering letter described these documents as:

> your Unit Medical Record (UMR) which is a duplicate copy of your Central Medical Record (CMR).

These documents do not contain a letter dated 18 May 1981 concerning boxes 49 to 51. It seems strange that if my file had been returned to the medical unit for completion that the unit records were not also amended. Also, the ticks that have been placed in those boxes ***are noticeably different*** from all of the others on the sheet of paper.

I have had legal advice that, considering the items were not completed at the time of my final medical examination, I cannot be considered to have been properly examined, even though the document was subsequently amended so it was complete.

By 2014 I was tired of writing letters. I was also very frustrated, angry, and distressed that no-one from DVA had taken the time to speak to me directly about the facts of my claim. I decided to travel to Canberra and protest. I took to the steps of Parliament house with a megaphone. I also called upon the offices of DVA and the Prime Minister in Woden. This resulted in a two hour interview with and (DVA), who, while making all the right empathetic noises, were more interested in how information from me might help them in their job, rather than how they might help me.

I have repeatedly contacted Senator Nick Xenophon since May 2011, as he notes on his website that he supports the underdog. For example, in 2013 onwards he has advocated for residents of a council owned caravan park that had been served notice to vacate. He has supported a fish and chip shop owner who was about to be fined by the local council for illegal signage, and is currently in Hong Kong, advocating on behalf of a local sports shoe business which has lost its supply contract with ASICS shoes. The owner paid for his airfare.

In all of these cases Nick Xenophon was to be seen on television supporting these causes, and he has had a strong media presence on behalf of these people.

I had contacted Senator Xenophon, hoping he would take up this important cause and, as he has done for others, bring my concerns about DVA, ADF abuse, and the link between PTSD and military training to the attention of the media. The outcome after almost five years is that in April 2015, a member of the Senator's staff started to draft a series of questions to be put to DVA at the Senate Estimates Committee. The Senator has advised that he will put six questions only to the Senate Committee. The other numerous issues I have raised with him will be directed to the current Minister for Veterans' Affairs, Senator Ronaldson, by way of a (yet another) letter.

Ward 17 at Daw Park Repat

In 2013, I was at a very low point and seriously contemplating self harm. I realised this was not a good place to be and told I needed more help. He referred me to the PTSD program run by the staff of Ward 17 at the Daw Park Rehabilitation Hospital.

My wife and I attended this outpatient program for eight weeks at the end of 2013.

As part of the Daw Park PTSD program I saw two films which helped me considerably. The first was "You're Not in the Forces Now", produced with Australian Government approval, and which included funding to the VVCS for its production,. This film describes the training the Army delivers to new recruits in order to prepare them for combat. A key point made within this lecture is that basic and corps training raises the stress levels of recruits to the point where, by being "battle fit" they already have PTSD and it is a matter of then being exposed to a stressor for the illness to manifest to a diagnosable level. The lecture specifically mentions that it is not the effects of war which ex-service personnel are struggling to overcome, it is the training they have receive. The second film was the documentary "The Unforgettable Experience" which provided scientific evidence that PTSD is actually a physical brain injury. Now after seeing these videos I fully understood what had happened to me.

I also had some understanding of what had happened to cause the men who attacked me and raped to act the way they did. They had been trained (brainwashed) into an aggressive and bullying culture of domination and subordination and, with their personal stress levels at 9/10, had lost sight of where the boundaries were in a non-combat situation. They might have had PTSD too. But, it must be said that these men would\could rape women in a warlike situation. Not a good look for Australia's Defence Force.

Personal research

Since finishing the program at Daw Park I have continued to read widely about current research into PTSD.

This research has revealed the following statistics on the prevalence of PTSD in veterans and serving personnel.

The 2010 ADF Mental Health Prevalence and Wellbeing Study Report by Professor Sandy McFarlane stated that the 12 month prevalence rate of PTSD amongst all ADF members is approximately 8.3%.[1] and the Royal Australian Army claims that 2% of Australian soldiers who have engaged in operational service suffer from PTSD[2]. This suggests that 6.3% of ADF members suffer from PTSD, even without having engaged in operational service. One very important point arising from these figures is that acquiring PTSD is ***not*** contingent upon having been in combat.

US figures[3] indicate that 12 month prevalence rates (such as those provided by ADF) are significantly different from whole of life rates. That is, the number of veterans who will suffer from PTSD over the course of their entire life.

A 1995 study from the United States reported that 30% of military personnel who spend time in a warzone experience PTSD.[4]

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[1] http://www.defence.gov.au/Health/DMH/Docs/4MHPWSreport-Section1.pdf
[2] http://www.army.gov.au/army-life/wounded-injured-and-ill-digger/support-to-wounded-injured-and-ill/soldier-recovery/mental-health
[3] http://www.veteransandptsd.com/PTSD-statistics.html
[4] http://www.military.com/benefits/veterans-health-care/ptsd-frequently-asked-questions.html

US studies also show that: firstly, rates of PTSD shortly after personnel return from deployment are 9% but this rises to 31% a year after deployment; and, secondly, only 50% of those with PTSD seek treatment. [5]

Following from this it is worth noting that if 31% of veterans are recorded as having PTSD, but that amount is only 50% of sufferers, then that would suggest it is actually 60% of veterans that have PTSD. This 60% figure supports the figure of 56% for Australian Vietnam veterans cited by Picking Up the Pieces[6].

More recently, Prof. McFarlane states that the percentage for current serving members with PTSD (Lifetime Rating) is 16.9%. [7]

The Australian Defence Force currently has a total of 103,380 trained personnel, comprising current active personnel of 57,982, reserve active of 23,232, and reserve standby of 22,166[8]. 16.9% of 103,380 equals 17,471. However if only 50% of those suffering seek treatment, that means another 17,471 are unreported but suffering with PTSD. Therefore, there are 34,942 men and women ***currently*** serving in Australia's Defence Force that are suffering with PTSD. All of these men and women have endured Basic and Corps Training.

These figures ***do not*** account for veterans that have been discharged. That is information that DVA should be able to advise if, in fact, they have those figures. But of course, many veterans want nothing to do with DVA, so the real figures may never be known unless some significant and genuine action is undertaken.

Research has also revealed evidence regarding the significant changes in brain structure associated with PTSD. The key brain structures affected are the frontal lobes, amygdala and the hippocampus, which leave suffers in a state of hyper-arousal and emotional detachment.[9]

Further, there is considerable evidence of the detrimental impact of PTSD on the physical health of individuals affected. The attached journal article by Professor Alexander McFarlane provides a useful overview of these impacts (see Annexure 6).

My research and my personal experiences have led me to conclude that the reason the ADF, DVA, Repatriation Commission and successive Federal Governments have hidden this abuse is because if the abuse became public it would reflect badly on the ADF. It would cost the ADF money and reputation and would damage their recruiting efforts.

If the assault upon me whilst attempting to prevent the rape had been put in the public domain, I most likely would have received an award like the Cross of Valour for "an

[5] http://www.veteransandptsd.com/PTSD-statistics.html
[6] http://www.pickingupthepeaces.org.au/post-traumatic-stress-disorder-statistics
[7] Personal correspondence 2 July 2015
[8] https://en.wikipedia.org/wiki/Australian_Defence_Force
[9] http://vvaveteran.org/33-5/33-5_reidlyon.html

act of conspicuous courage in circumstances of extreme peril", but the ADF could not afford to let that happen, the ADF's reputation was at stake.

It is the appalling behaviour of the ADF in the past that has caused the mental illnesses of veterans like me, and it is the current appalling behaviour of the DVA that is continuing and exacerbating the abuse under the umbrella of the Australian Governments. The stonewalling and delaying tactics the DVA engages in deny and delay our claims until we give up, die of old age or commit suicide.

A need for change

Gaining an understanding of what had happened to me was beneficial but it also kindled the simmering rage I had inside me about the injustice of what had happened. I am also incensed at the thought of young recruits incurring significant harm that they may remain unaware of for ten, twenty or more years. They sign on knowing they may be called upon to fight. They do not get told they may suffer a lifelong brain injury from Basic Training and Corps Training.

I feel a moral obligation to use my understanding to bring about change. It is part of who I am.

The information that needs to be made public is set out below.

PTSD and abuse in Australia's Defence Force is linked to military training and the Government and ADF know this to be the case.

There is a link between Military Basic and Corps training, and PTSD and Abuse in the Australian Defence Forces.

- Defence training predisposes personnel to PTSD, and gives them PTSD.
- When Defence Force recruits participate in Basic and Corps training their stress levels are purposely raised from level 3, to level 9 out of 10 to ensure they respond automatically in combat.
- They are trained to act on their "Fight" response rather than their "Flight" response when confronted with a threat.
- Basic and Corps training ensure that this high level of stress is maintained and becomes the "norm".
- When the soldier returns to civilian life, their level of stress is still at 9 out of 10. Scientists claim that people cannot live normal lives at this stress level.
- The Australian Government has known about this for decades.
- The Australian Government and VVCS produced the DVD 'YOU'RE NOT IN THE FORCES NOW' in 2001 which shows this.
- The DVD also states that the Defence Force attempts to keep the soldiers stress levels under 10 by supplying them with free or cheap alcohol and cigarettes, turning some of them into alcoholics and chronic smokers.
- It is my belief these high stress levels are also the cause of much of the abuse in the Defence Force (DART) that goes back to the 1950's that has been reported in the media recently.
- This heightened level of stress places defence personnel and veterans at a higher

risk of suffering PTSD both during and after service.

PTSD is a physical brain injury and can become permanent if not treated early.

- PTSD is a recognised physical brain injury.
- This is supported by the top 3 researchers in the world into PTSD, including Professor Sandy Macfarlane of Adelaide University, who is the advisor to DVA.
- PTSD is a physical injury because research has shown that the Amygdale and Hippocampus are reduced in size. Other areas of the brain are also affected leaving chronic sufferers with permanent changes to the brain.
- 30% (according to American statistics) of defence personnel suffer PTSD.
- Early diagnosis and treatment can prevent the injury from becoming chronic and permanent.
- The Australian Government does not wish the Australian public to know that 1 out of 3 recruits will receive and suffer brain injury by joining the Australian Defence Force. Recruiting would suffer enormously.

The Australian Government does not wish to treat veterans suffering from PTSD because it would cost too much money.

- The Government does not wish to advertise to service personnel that they are suffering from PTSD due to their time in the services, because it would cost the Government time and money to provide these veterans with the care they need.
- Those they do treat within the 30 days of it beginning to becoming permanent are the SAS and Australian Air force pilots, because the Government has spent large sums of money training them and cannot afford to have F18 jets not being used.
- Treatment that is available is inadequate. For example: treatment for alcoholism at Daw Park Repatriation Hospital (Ward 17) consists of only 6 days' admission to detox, or a maximum of 10. It is proven that treatment for alcoholism is 3 months. Daw Park is unable to provide 3 months treatment because of lack of funding by the Federal Government. Another example is that although good sleep is crucial to good mental health, DVA won't cover treatment for sleep disorder as part of a psychiatric treatment plan.
- Successive Australian Governments have until now knowingly labelled PTSD or shell shock as a non-injury, and by adopting this stance have denied their responsibility of due care towards injured veterans.
- The Government would say that they are doing something about it, but servicemen who have recently returned from Afghanistan say they are told to keep their eyes on their mates for unusual behaviour, and that is all.
- Because a great number of veterans are suffering, but do not know why, the Government must contact all current and past service personnel to determine the extent of PTSD and to offer treatment, to them and their families.
- A national advertising campaign is needed so current and ex service personnel can recognise the symptoms of PTSD, and how to get help.
- The problem is that PTSD can affect you for the first time forty years after the event, and because the Government is not educating the veterans as to what PTSD is, the veterans do not understand what is wrong with them.

Up to 30% of existing and past veterans suffer from PTSD.

- Research shows that it may be 30% of existing and past Australian Defence Force veterans suffering from PTSD. The Australian Government states that it is 8.3%, (but American evidence states that it is 30%.
- Research shows that 65% of Vietnam Veterans have PTSD.
- The true number of PTSD sufferers has to be ascertained within the forces and among those that have left the forces and are now in the community.
- The issue is that there are tens if not hundreds of thousands of current and ex service personnel suffering from PTSD unknowingly and who do not understand that it is PTSD that is ruining their lives.
- I estimate that up to 500.000 of Australian veterans have suffered and continue to suffer with PTSD from, and including WWII, if we use the 30% American figure.

A Royal Commission is required into ADF, DVA. DART Taskforce and their management and treatment of PTSD veterans.

- The current situation is a National Disgrace and requires a Royal Commission.
- Men and women have put their hands up to defend Australia, but when they become injured, the governments have turned their backs on them.
- Why should men and women join Australia's Defence Forces if the Government is not willing to look after them when they become sick due to service injury? Or worse, when they are attacked by their fellow soldiers and develop PTSD.
- The PTSD information has been there since the 1st World War. But Australia's military forces and Governments have done nothing about it
- The evidence is there, it just takes someone with the courage and strength to stand up to the Government and to say they know what the truth is, and that the governments are going to be held to account for their appalling lack of due care for veterans.
- There needs to be a Royal Commission into the action of the governments, ADF, DVA, and the DART Taskforce, concerning their avoidance of their responsibility – their lack of due care over the decades.
- Changes are needed in the legislation and policies governing DVA and the ADF, the methods of training, and minimising harm to serving personnel, and the methods of caring for and assisting veterans post service.

Questions need to be asked

- Why is there such a large disparity between Australian Government and US figures on PTSD rates?
- What is the true percentage in the Australian Forces, past and present?
- Will the ADF and DVA admit that PTSD is a physical brain injury?
- Will the ADF accept evidence that defence training causes physical changes in each recruit's brain that predisposes them to, and/or causes PTSD?
- Will the ADF provide a program of similar length and intensity to basic and corps training (6 months) to counter these changes in the brain when personnel discharge.
- Will the ADF declare PTSD is an occupational hazard for ***all*** defence personnel, not only those who have operational service?
- Why do the ADF and DVA only wait for serving personnel and veterans to self-

report when evidence shows PTSD sufferers, are unlikely to seek help, because they do not understand that they are suffering from PTSD? 50% goes unreported

- Why do the ADF and DVA deny ex-service organisations the opportunity to proactively contact veterans to monitor their mental health?
- Why does DVA not inform GPs, counsellors, psychologists etc. about treatment available to veterans?
- Why does DVA not tell veterans claiming for benefits for a psychiatric condition about treatment available?
- Considering the well documented "ripple effect" of PTSD, why does DVA not cover treatment for veterans' families?
- Why does DVA not acknowledge that psychological health has an impact on physical health, and allow treatments for relevant physical conditions as part of a veteran's psychiatric condition?

A documentary

I have combined the information set out above, with my story and the evidence provided in the two films "Your Not in the Forces Now" and "The Unforgettable Experience" into a documentary film.

This film also contains art work, which I created as one way of coping with my PTSD. This artwork reflects my own personal journey of trauma, horror, betrayal and suffering.

In further support of the importance of this issue I refer to the report on Tuesday 7 April, which the ABC ran a report on the 7:30 program revealing that a significant number of navy personnel suffering with ice addiction had committed suicide.

The information in the DVD explains why these young people in the navy and other sections of the defence forces are using ice and other drugs.

The reason is that they are suffering from PTSD and because the ADF is attempting to reduce the intake of alcohol and cigarettes by veterans, they have turned towards illicit drugs.

The DVD explains how defence training causes PTSD and explains how PTSD is a physical brain injury.

When people with PTSD do not receive help and treatment for their PTSD injury, they self-medicate with alcohol and other drugs, and as the report on 7:30 discussed, this frequently leads to suicide.

Defence training gives them PTSD, and PTSD causes them to suicide. The DVD I have put together provides proof of this.

As the ABC's investigations have shown so far, this is a very important issue, and I hope you will take the time to watch this DVD and consider the information it contains.

PTSD is linked to Military Training
John Lawler

Remember, while you have been reading this submission and are watching the DVD, young Australians, who are now undergoing military training will be contracting PTSD, which is a permanent physical brain injury.

This will affect not only their lives, but the lives of everyone they love.

THE AUSTRALIAN GOVERNMENT KNOWS THIS!

IT IS AUSTRALIA'S NATIONAL DISGRACE.

THERE ARE 34,942 MEN AND WOMEN ***CURRENTLY*** SERVING IN AUSTRALIA'S DEFENCE FORCE THAT ARE SUFFERING WITH PTSD

Annexures

1. Correspondence with Minister for Veterans' Affairs
2. Correspondence with Minister for Defence
3. Correspondence with Commonwealth Ombudsman
4. Correspondence with Prime Minister
5. Correspondence with Minister for Mental Health and Ageing
6. Article by Prof. Alexander McFarlane

John Lawler

2 May 2013

Stephen Smith, MP
Warren Snowdon, MP
Ann McEwen, Senator
David Johnston, Senator
Michael Ronaldson, Senator

Dear Ministers and Senators,

I am a veteran of the Australian Army and suffer from PTSD and other medical conditions relating to an assault upon myself where I was bashed unconscious by five Australian soldiers when I attempted to stop them from raping a female soldier at Randwick Barracks in Sydney in 1976.

On the 18/6/2011 I applied for a Disability Pension for "depression, anxiety and stress" which the DVA acknowledged. I was then refused my application for "anxiety disorder and alcohol dependence". DVA had changed my claim without advising or consulting with me and my claim was forwarded to The Veterans Review Board.

On two occasions the Department of Veteran's Affairs had told me to spend my money to be tested for sleep apnoea and to have an inspection of my teeth by a dentist. I hold a DVA white card.

The DVA said that they would refund the money that I had spent and then would follow up with further treatment. When DVA were asked to pay for the consultations and further treatment, DVA refused.

As you are probably aware under Promissory Estoppel it is illegal for the Government to tell a person to spend money and then advise them the Government has changed its mind about a refund and further treatment.

I am currently seeing a psychiatrist and psychologist, both of which are being paid for by DVA under my white card. My wife is also seeing a psychologist because of my illness. I first saw my psychiatrist in January 2011, following a referral from my GP. It was my psychiatrist who advised me I was eligible to apply for a DVA White Card which would help

pay for my treatment. He assisted me with making an application for a white card on the basis of his diagnosis of PTSD. I was subsequently issued a white card for Anxiety.

In 2002 I was seen by a DVA psychiatrist who diagnosed me with a Generalised Anxiety Disorder. In his report he noted that if I did not receive treatment my condition would become permanent. I was not advised by DVA that I would have been eligible for treatment under a white card. I did not receive any treatment until 2006 when, on my own initiative, I sought help from my GP who prescribed anti-depressant medication.

My mental illness has left me unfit for general employment and I receive a Centrelink disability pension.

I have undertaken academic research in Aboriginal Housing as a PhD candidate in architecture at QUT as a Research Scholar with the Australian Housing and Urban Research Institute and in the past have been a Research Fellow with the Aboriginal Research Institute (UniSA) in Aboriginal housing and health. The solitary nature of research meant I was able to research at my own pace when I felt well enough, and it meant I did not feel completely useless and was able to make an important contribution to society. Except for scholarships my research has been unfunded.

The recent SKYPE affair has seriously reactivated the memories of the assault against me in 1976. Over the past two years I have been overwhelmed and unable to continue with my PhD because of the increase of my PTSD.

Six weeks ago, my professor contacted me and offered to send a post-graduate researcher from QUT (Brisbane) to the Barossa Valley to assist me to complete my thesis. I said that although I wished to finish my PhD, my current mental and emotional state prevents me from doing so.

Since the SKYPE affair two years ago I have been on sick leave from my PhD research. Four weeks ago I sent an email to my professor advising him that I was unable to complete because of my mental/emotional illness and that I was withdrawing from my PhD candidature.

Evidence has shown that the Government Authorities have:

- Fraudulently altered my official documents;
- Behaved illegally and criminally towards me;
- Hidden serious criminal assault and rape on three occasions over a thirty six year period;
- Miserably failed in their duty of care both legally and morally towards me.

The reason the ADF, DVA, Repatriation Commission and successive Federal Governments' have hidden this abuse is because if the abuse became public it would reflect badly on the ADF. It would cost the ADF money and reputation and would damage their recruiting efforts.

If the assault upon myself whilst attempting to prevent the rape had been put in the public domain, I most likely would have received an award like the Cross of Valour for "an act of conspicuous courage in circumstances of extreme peril", but the ADF could not afford to let that happen, the ADF's reputation was at stake.

It is the appalling behaviour of the ADF in the past that has caused the mental illnesses of veterans like myself, and it is the current appalling behaviour of the DVA that is continuing and exacerbating the abuse under the umbrella of the Australian Governments. The stonewalling and delaying tactics the DVA engages in deny and delay our claims until we give up, die of old age or commit suicide.

Yours sincerely,

John Lawler

In 2003 I informed The Veteran's Review Board the criminal assaults had taken place as indicated.

VETERANS' REVIEW BOARD

Mr Lawler described to the Board an incident in 1975, (sic) when he was assaulted at Randwick Barracks and severely beaten. He said that he believed that his back was injured in the assault and the later march aggravated his spinal injuries. The Board was unable to find any record of medical treatment following the assault in 1975. (sic)

The Repatriation Commission, The DVA and the ADF did not further investigate the criminal assault upon myself or the rape of the female soldier that I was attempting to protect. The assault and rape were reported at the time to the authorities in 1976, in 2002 and in 2011 with no result.

VETERANS' REVIEW BOARD

Decisions under review:

The Repatriation Commission decisions of 3 May 2002, which refused claims for thoracic spondylosis, cervical spondylosis and anxiety disorder.

Decisions of the Board:

On 29 January 2003 the Veterans' Review Board decided to:

- **AFFIRM** the decisions under review in relation to thoracic spondylosis, cervical spondylosis and anxiety disorder. This means that the Repatriation Commission's decisions are unchanged in relation to those matters.

This is part of a report from to the DVA in 2002. is the DVA psychiatrist.

Given that Mr. Lawler has yet to receive the benefit of psychiatric treatment I would take a conservative approach and rate his current mental state as *"temporary"*. Should there be no change with eight to ten months of psychiatric treatment I would consider his psychiatric state to be *"permanent"*.

Although DVAs' psychiatrist has stated that my psychiatric condition was service related and will become permanent without treatment, the DVA did not offer me any treatment and refused my claim. My psychiatric impairment has now become permanent.

Commonwealth Department of
Veterans' Affairs

Telephone: 133 254
Country Calls: 1800 555 254
Facsimile: (08) 8290 0498

3 May 2002

Dear Mr Lawler,

This letter is to advise you of my decision on the disability pension claim you lodged on 20 August 2001.

DECISION

I have decided that thoracic spondylosis, cervical spondylosis and anxiety disorder are not related to service.

Australian Government
Department of Veterans' Affairs

On two occasions the Department of Veterans' Affairs told me to spend my money to be tested for sleep apnoea and to have an inspection of my teeth by a dentist. I hold a DVA White Card. The DVA said they would refund the money I had spent and then follow up with further treatment. When asked to pay for the consultations and further treatment, DVA refused. Under Promissory Estoppel it is illegal for the Government to tell a person to spend money and then advise them the Government has changed its mind about a refund and further treatment.

Dear

I write with regard to your request for DVA to fund dental treatment for Mr Lawlor.

Unfortunately, Mr Lawlor is not currently covered under his White Card for dental treatment.

Dear Mr Lawler,

I am writing to you in response to a request received in this office on the 14th May 2012, from your Psychiatrist for the supply of a CPAP machine and consumables.

In examining the request it is noted you are a white card holder and you do not have an accepted disability (sleep apnoea) that relates to a clinical need for the supply of a CPAP machine. Based on this information it has been determined that you currently do not meet the Department's criteria for the supply of CPAP equipment and I therefore must advise that the request for the supply of CPAP equipment has been declined. An advice letter has been forwarded to

Australian Government
The Repatriation Commission

On 31 August 2011, Mr Lawler, the veteran, lodged a claim for 'depression; anxiety and stress'.

I am satisfied that the appropriate medical diagnoses for the claim are:

- Anxiety Disorder; and
- alcohol dependence.

The Repatriation Commission had changed my claim without my knowledge or authority.

Australian Government
Department of Veterans' Affairs

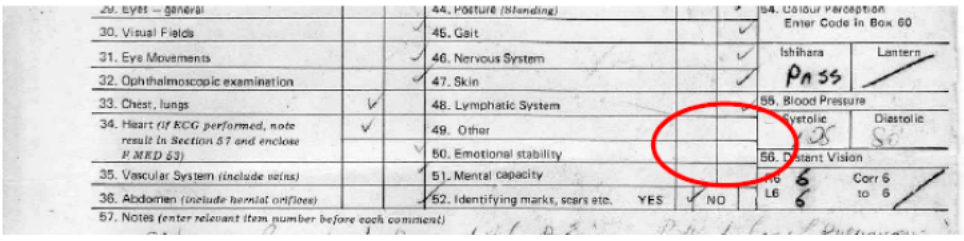
Dear Mr Lawler,

This letter is to advise you of my decision on the disability pension claim you lodged on 31 August 2011.

DECISION

I have decided that Anxiety Disorder and alcohol dependence are not related to service.

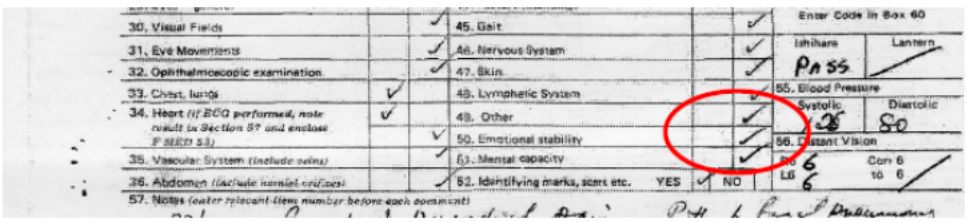
Veterans' Affairs had made a decision against me on a claim that the Department had concocted.



30. Visual Fields		✓	45. Gait		✓
31. Eye Movements		✓	46. Nervous System		✓
32. Ophthalmoscopic examination		✓	47. Skin		✓
33. Chest, lungs	✓		48. Lymphatic System		✓
34. Heart (if ECG performed, note result in Section 57 and enclose F MED 53)	✓		49. Other		
		✓	50. Emotional stability		
35. Vascular System (include veins)		✓	51. Mental capacity		
36. Abdomen (include hernial orifices)		✓	52. Identifying marks, scars etc.	YES ✓	NO
57. Notes (enter relevant item number before each comment)					

54. Colour Perception — Enter Code in Box 60
Ishihara: PASS — Lantern: ✓
55. Blood Pressure — Systolic: 125 — Diastolic: 80
56. Distant Vision — R6: 6 — L6: 6 — Corr 6 to 6

An image of the carbon copy of my Army medical discharge certificate.



30. Visual Fields		✓	45. Gait		✓
31. Eye Movements		✓	46. Nervous System		✓
32. Ophthalmoscopic examination		✓	47. Skin		✓
33. Chest, lungs	✓		48. Lymphatic System		✓
34. Heart (if ECG performed, note result in Section 57 and enclose F MED 53)	✓		49. Other		✓
		✓	50. Emotional stability		✓
35. Vascular System (include veins)		✓	51. Mental capacity		✓
36. Abdomen (include hernial orifices)		✓	52. Identifying marks, scars etc.	YES ✓	NO
57. Notes (enter relevant item number before each comment)					

Enter Code in Box 60
Ishihara: PASS — Lantern: ✓
55. Blood Pressure — Systolic: 125 — Diastolic: 80
56. Distant Vision — R6: 6 — L6: 6 — Corr 6 to 6

An image of my Army medical discharge certificate that the Government has fraudulently altered to prevent me from receiving a disability pension for PTSD and other injuries.

Office of the Hon Warren Snowdon MP

Minister for Veterans' Affairs

Ref: M13/1222

Mr John Lawler

Dear Mr Lawler

Thank you for your email of 2 May 2013 to the Minister for Veterans' Affairs and other addressees, concerning your dealings with the Department of Veterans' Affairs (DVA). This matter falls within the portfolio responsibilities of Minister Snowdon, who has asked me to respond on his behalf. I apologise for the delay in replying.

For compensation to be payable under the *Veterans' Entitlements Act 1986* (VEA) there must be an injury or disease as defined under the Act. Only when it has been established that an injury or disease is present can the relationship of the claimed signs and symptoms to service be considered.

Whether or not an injury or disease is present in a particular case and, if it is, the appropriate diagnosis of that injury or disease, is a matter for medical opinion. As it was the opinion of consultant psychiatrist that the conditions you claimed in 2011 as "depression, stress and anxiety" were generalised anxiety disorder and alcohol dependence, they were from that point onwards referred to in that way by DVA.

I understand that you hold a White Repatriation Health Card for Specific Conditions – also known simply as a White Card – that entitles you to treatment for your anxiety disorder only. I have been advised that you have no eligibility for dental treatment and that DVA has no record of you seeking such treatment at DVA's expense at any time.

In May 2012, DVA received a request on your behalf from your treating psychiatrist, for a CPAP machine for treatment of sleep apnoea. This request was not approved because you do not have eligibility for treatment of sleep apnoea and because a psychiatrist is not an eligible prescriber of CPAP machines. I understand that both you and were advised in writing of this at the time.

It does happen from time to time that a veteran will seek treatment at DVA expense for a condition that has not been accepted as service-related. In such circumstances, the only way to extend eligibility is to lodge a claim for disability pension and medical treatment under the VEA in respect of that condition. Should the veteran not wish to delay treatment pending the successful outcome of such a claim, he or she will have no choice but to incur the expense and seek reimbursement from DVA at a later date.

It was indeed open to DVA in 2002 and again in 2011 to have extended eligibility to you for treatment of your anxiety disorder, and it is regrettable that this was not done. This was noted in March 2012 when determining your formal application for this treatment, and it was in view of this that your eligibility was backdated to 20 May 2001, three months prior to your original claim.

I understand that it was found on 12 December 2011 that your anxiety disorder and alcohol dependence were not service-related. I have been advised that an appeal to the Veterans' Review Board (VRB) was lodged on 19 March 2012 and that the VRB is awaiting your lodgement of a Certificate of Readiness before proceeding to a hearing.

The Minister has no power to influence decisions made by independent authorities such as the Repatriation Commission and its delegates, nor does he have any discretion to review or intervene in any individual case. The VRB is now the appropriate forum within which to resolve the matter of the relationship of your anxiety disorder and alcohol dependence to service.

In your letter you also refer to the alteration of your medical records, highlighting in particular variations in boxes 49 to 51 on copies of the final medical board form completed at the time of your discharge from the Australian Army. The Department of Defence was asked to investigate your concerns.

I have been advised that your Central Medical Record (CMR) has been reviewed. Boxes 49 to 51 have been completed on the copy of the final medical board form filed on your CMR, and the ticks appear to be similar in nature to the others on that form.

Defence has advised, however, that your CMR contains a letter from Health Records, dated 18 May 1981, stating that boxes 49 to 51 were not originally completed, and indicating that the documents were returned to the medical centre for completion of this section. This implies that this section was completed at a later date. There is no evidence to explain why these sections were not completed at the time of the original final medical board.

Defence has advised that returning your final medical board documentation to the medical centre for completion was appropriate and consistent with the policy of the time. In addition, the completion appears to have been undertaken by the same medical officer undertaking the final medical board, and within a timeframe to make this completion accurate and appropriate.

In view of this, it appears likely that the original copy you received as part of your discharge process was a true copy of the final medical board, before the board paperwork was returned in order to complete boxes 49 to 51.

Thank you for bringing your concerns to the Minister's attention.

Yours sincerely

Chief of Staff

26 JUL 2013

John Lawler

3 August 2013

The Hon Warren Snowden, MP
Minister for Veterans' Affairs
Parliament House
CANBERRA ACT 2600

Dear Minister,

I refer to a letter from your Chief of Staff, , dated 26 July 2013, responding to my letter to you dated 2 May 2013.

My responses to letter are set out below. To make it clear which element of his letter I am referring to, I have also incorporated the text of his letter herein, and make my comments below the pertinent sections.

> Thank you for your email of 2 May 2013 to the Minister for Veterans' Affairs and other addressees, concerning your dealings with the Department of Veterans' Affairs (DVA). This matter falls within the portfolio responsibilities of Minister Snowdon, who has asked me to respond on his behalf. I apologise for the delay in replying.

I note the apology regarding the delay in replying, but would like to bring to your attention, that until I received letter, I had not received any acknowledgement from your office that my correspondence had been received.

> For compensation to be payable under the *Veterans' Entitlements Act* 1986 (VEA) there must be an injury or disease as defined under the Act. Only when it has been established that an injury or disease is present can the relationship of the claimed signs and symptoms to service be considered.
>
> Whether or not an injury or disease is present in a particular case and, if it is, the appropriate diagnosis of that injury or disease, is a matter for medical opinion. As it was the opinion of consultant psychiatrist that the conditions you claimed in 2011 as "depression, stress and anxiety" were generalised anxiety disorder and alcohol dependence, they were from that point onwards referred to in that way by DVA.

As I claimed previously in the letter forwarded to you and others dated 2nd May 2013. "On the 18/6/2011 I applied for a Disability Pension for "depression, anxiety and stress" which the DVA acknowledged. I was then refused my application for "anxiety disorder and alcohol dependence". DVA had changed my claim without advising or consulting with me and (their) claim was forwarded to The Veterans Review Board.

The diagnosis in the report dated 14/10/2011 by (DVA psychiatrist) stated:

"17. DIAGNOSIS

Given the history Mr. Lawler gave to me on this occasion was quite different to what he gave me last time and given there appears to be quite a considerable amount of information which would assist me I would like to see the following information before offering an opinion on diagnosis and causation.

- The details and dates of his drink/driving offences.
- His military charge sheets and records of any disciplinary issues in the military (particularly related to alcohol).
- Mr. Lawler showed me a document which indicates a chronology of events and I would like to see this.
- His medical records from the army (he said he presented to the RAP in relation to symptoms which he attributed to the assault).
- His drug and alcohol questionnaire (from this claim and the last claim).
- report from 1983.
- Reports, notes or letters from .
- Any information from
- Mr. Lawler's various claim forms.
- The determination from the Veterans' Review Board in relation to Mr. Lawler's various claims."

The Claims Officer dealing with my case, never asked me for the information held by me that requested.

After I had lodged my application for appeal to the VRB, I had several confusing and distressing phone calls with Claims Office , asking when DVA/VRB would request the additional information I held. My distress reached such a point that my wife had to eventually speak to a supervisor, , who advised her it was appropriate for me to submit whatever additional evidence I held to support my claim, at this stage of the process. He also acknowledged that the Application for Review form was misleading and confusing in that it did not provide information to this effect. apologised for the manner in which I had been treated.

Further, at no time did DVA request that I complete an Alcohol Questionnaire, although I have since been told this should be standard procedure. It was not until my 2011 claim was appealed to the Veteran's Review Board that I was asked to complete this document. At no time have I been asked to complete a Smoking Questionnaire.

A following letter on the 23/11/2011 from claims:

"7. DIAGNOSIS

I preface my response by noting that you have forwarded some of the information to me that I requested to see but not all of the information and in particular I have not seen the following:

- The details and dates of his drink/driving offences.
- His military charge sheets and records of any disciplinary issues in the military (particularly related to alcohol).
- Mr. Lawler showed me a document which indicated a chronology of events and I would like to see this.
- His drug and alcohol questionnaire (from this claim and last claim).
- report from 1983.

- Reports, notes or letters from .
- Any information from

Further, on page 6. states:

> "When taking into account the factors I have just discussed, it is my clinical opinion, based upon a reasonable degree of medical probability that Mr. Lawler is suffering from a **Generalized Anxiety Disorder.** His **Alcohol Dependence** is in remission.
>
> 9. DISABILITY
>
> Given that the facts are currently unclear which means that issues of causation are far from clear I will defer a disability rating until the decision-maker advises me what are the facts in this case."

Clearly felt he was unable to make a clear diagnosis because critical information that he had requested from DVA was not forthcoming. The information that requested from DVA contained important information concerning the criminal assault upon me, the rape of , the subsequent effects on my mental health and the eventual diagnosis of my PTSD by . Despite advising that his diagnosis was offered in the absence of this information, she chose to determine my claim on the basis of an incomplete assessment.

> I understand that you hold a White Repatriation Health Card for Specific Conditions -also known simply as a White Card -that entitles you to treatment for your anxiety disorder only. I have been advised that you have no eligibility for dental treatment and that DVA has no record of you seeking such treatment at DVA's expense at any time.

The claim that DVA holds no record of me seeking assistance with dental treatment is not true. My enquiries about assistance with dental treatment started on a date I did not record, and with a member of DVA staff who did not offer her name, and whose name I did not request. I was told that DVA would contribute an amount, which I recall as being $61, toward the cost of a dental examination. I was also told that if that examination revealed damaged to my teeth arising from my mental health condition, for example damage caused by tooth grinding, DVA would cover the cost of the treatment. On the basis of this advice I attended , who completed an examination. then wrote to DVA on 6 June 2012 seeking approval of the cost of his proposed treatment. DVA denied this request in a letter dated 21 June 2012 from , Medical and Allied Health Services, to . Following this I personally paid account for the examination. Copies of these letters and account are attached.

The White Card was not forthcoming until my psychiatrist submitted a claim for treatment on my behalf on 3 February 2012 on the basis of his diagnosis for PTSD. Prior to the application by I was not advised by DVA and did not know about the DVA White Card. told me that it had taken him five phone calls to DVA to ascertain whereabouts on the DVA website he could access the application form.

A letter I received from DVA dated 16 March 2012 states that "Approval has been given for you to receive treatment for anxiety disorder at the expense of the Department with effect from 20 May 2001," and that a White Card would be forthcoming. The Department ignored the PTSD diagnosed by , even though, as stated in afore mentioned letter,

"Whether or not an injury or disease is present in a particular case and, if it is, the appropriate diagnosis of that injury or disease, is a matter for medical opinion".

It is interesting that DVA continue to privilege the diagnosis of , made on the basis of one consultation, and, on his own admission, offered in the absence of significant and crucial information, over that of who has had numerous consultations with me since I started seeing him in February 2012. Further, despite the outstanding information requested by subsequently being submitted by me, DVA has not sought to have him revisit his diagnosis.

> In May 2012, DVA received a request on your behalf from your treating psychiatrist, , for a CPAP machine for treatment of sleep apnoea. This request was not approved because you do not have eligibility for treatment of sleep apnoea and because a psychiatrist is not an eligible prescriber of CPAP machines. I understand that both you and (sic) were advised in writing of this at the time.
>
> It does happen from time to time that a veteran will seek treatment at DVA expense for a condition that has not been accepted as service-related. In such circumstances, the only way to extend eligibility is to lodge a claim for disability pension and medical treatment under the VEA in respect of that condition. Should the veteran not wish to delay treatment pending the successful outcome of such a claim, he or she will have no choice but to incur the expense and seek reimbursement from DVA at a later date.

With regard to the matter of the CPAP machine, DVA seems intent on, once again, deliberately missing the point of the request. The request was made on my behalf by on the basis that it was **part of my treatment for my mental health condition** because sleeping well is a crucial aspect of improving mental health. In fact, a number of brochures published by DVA attest to this fact.

When I contacted DVA (Adelaide office) to follow up on request, they denied all knowledge of having received his letter, which had been sent by facsimile transmission to , RAP Division. I contacted office and they obliged by sending the letter again. I waited in the DVA office until they confirmed it had been received. In the meantime, the staff member at the reception desk had given me a Claim for Disability Pension form and told me to complete that as part of my request. I tried at length to explain to him that I did not want to claim sleep apnoea as a service related injury and had no intention of wasting everybody's time by doing so. Rather, I wanted to be able to claim treatment for sleep apnoea as part of my mental health treatment, for the reasons stated above.

The situation became increasingly distressing and frustrating and I eventually had to leave the office, leaving my wife to deal with the matter. She asked to speak to a supervisor and was eventually seen by (a manager) and . She had a lengthy conversation with and explaining my situation and reiterating the point that the request was being made on the basis that it was part of the treatment for my accepted condition and **not** as a claim for a service related condition. and acknowledged this point of view, but said it was highly probable that any request in this regard would be denied because the staff involved would not be able to see the correlation. gave my wife a form for completion by my sleep physician and made the offer that if I were to bring the completed form into her, she would forward it to the relevant division with DVA, with a supportive comment as to why it should be approved.

In the meantime, letter of 3 May 2012 appears to have been forwarded to RAP

Queensland. , Client Services, replied most promptly on 16 May 2012 declining the request. Her letter did not advise that was not an approved prescriber for CPAP machines. She did, however, cite the National Schedule of Equipment as specifying "which prescribers are eligible to prescribe the items listed". If DVA believes this constitutes advising and I that he is not considered eligible to prescribe CPAP as a treatment then they are sadly mistaken. I was not given a copy of that Schedule, nor was I told where I might be able to access a copy. I was also, once again, given what now appears to be the stock standard response that I should lodge a claim to have sleep apnoea recognised as service related. As I have said previously, this would have been a futile exercise, because it is not service related. Copies of these letters are attached.

Given the state of my mental health and the increased distress this specific matter was causing me, both my wife and I decided this particular battle should be deferred and pursued at a later date. Several months latter, called and spoke to my wife. She told my wife she was leaving her current position within DVA, and was following up on outstanding matters prior to her departure. She asked if I had taken the matter further, and my wife said no. advised that if I wanted to proceed it would be best to contact either , National Manager of RAP, in Melbourne, or , the Assistant Director of R & C. Having no faith in any assistance DVA purports to offer, I have chosen not to do so thus far.

> It was indeed open to DVA in 2002 and again in 2011 to have extended eligibility to you for treatment of your anxiety disorder, and it is regrettable that this was not done. This was noted in March 2012 when determining your formal application for this treatment, and it was in view of this that your eligibility was backdated to 20 May 2001, three months prior to your original claim.

The statement that "it is regrettable" DVA failed to advise me of my eligibility for treatment of my condition under the White Card facility is trite and offensive. In my view it is has been extremely detrimental to my physical and mental health and in this regard DVA have been exceptionally negligent.

In 2002 advised DVA that:

> "I would recommend that Mr. Lawler attend a Psychiatrist for psychotherapy and psychotropic medication. … He would also benefit from seeing a Psychologist or attending the Vietnam Veteran's Counselling Service."

And

> "Given that Mr. Lawler has yet to receive the benefit of psychiatric treatment I would take a conservative approach and rate his current mental state a "temporary". Should there be no change with eight to ten months of psychiatric treatment I would consider his psychiatric state to be "permanent".

If DVA had advised me that they could assist with treatment, I would have taken it. However, they did not, and my mental health has deteriorated further and my quality of life is accordingly reduced and my disability is now permanent.

When I received the letter from DVA regarding the grant of the White Card I took the date of 20 May 2001 noted therein to be a typographical error, as it made no sense otherwise. Even though letter confirms that this date is indeed correct, it remains unclear as to what effect the back dating of my eligibility for a White Card is intended to have, as it is clearly not possible for me to retrospectively seek treatment and, as I have not been able to afford to seek treatment in the past, I had no expenses to claim.

discusses in his report of 23/11/2011 the criminal assault that took place upon me in 1976, and the consequences of the assault, and comments that the Veterans' Review Board knew of the assault in 2003. At no point has DVA mentioned, discussed or investigated the report of criminal assault and rape. did not raise the issue of the assault or rape in his interview, I did.

Following the letter from your Office and this response to it, the Government of Australia has now been notified on five separate occasions of the criminal assault against myself and the rape of (nee) in 1976, with no result for 36 years.

> I understand that it was found on 12 December 2011 that your anxiety disorder and alcohol dependence were not service-related. I have been advised that an appeal to the Veterans' Review Board (VRB) was lodged on 19 March 2012 and that the VRB is awaiting your lodgement of a Certificate of Readiness before proceeding to a hearing.
>
> The Minister has no power to influence decisions made by independent authorities such as the Repatriation Commission and its delegates, nor does he have any discretion to review or intervene in any individual case. The VRB is now the appropriate forum within which to resolve the matter of the relationship of your anxiety disorder and alcohol dependence to service.

As you are no doubt aware, part of the appeals process under the Veterans' Entitlements Act is that DVA has the opportunity to review all claims, prior to referral to the VRB. My file indicates that DVA did not take the opportunity this part of the process afforded them to take further evidence or to conduct further investigation. Instead they abdicated their responsibility in this regard by choosing not to review my case and referring it to the VRB. I am fully aware that, following DVA's decision not to review my case, a determination of my claim by the VRB is the next step in the claims process specified by the Act.

My previous experience with the VRB in 2003 has shown that the hearings granted to veterans are predicated on a significant imbalance of power. Firstly, the members of the VRB are serving or former high ranking officers, which is in itself intimidating, particularly for veterans like myself who suffer from mental illness. Secondly, the VRB also enjoys the benefit of legal counsel, as one member of the board is usually a legal practitioner, but veterans are denied similar equity in legal representation, by only being allowed to engage the services of volunteer, DVA trained, advocates.

My records show that I told the VRB about the assault and possible rape in 2003. However, what is not shown in my records is that my testimony was summarily dismissed by one member of the VRB with a flippant comment to the effect of: "I suppose you want to claim for **that** now". No further evidence concerning the assault was taken.

As Minister, perhaps you may be able to offer some assurances that, when and if I appear before the VRB in relation to my current claim, the VRB will consider all the evidence necessary to determine the matter fairly this time. You may also wish to consider how the considerable inequity in the power relationships present in the current process can be redressed.

Finally, the most important point I want you to understand, is that DVA seem intent on ignoring the fact that the assault I suffered, and the possible rape of are

beyond the scope of the VEA legislation, and that at least one, and quite likely two crimes occurred. In this regards, the Army, the VRB, DVA and now your office, have failed to act on the reporting of a crime and failed to act on their duty of care.

> In your letter you also refer to the alteration of your medical records, highlighting in particular variations in boxes 49 to 51 on copies of the final medical board form completed at the time of your discharge from the Australian Army. The Department of Defence was asked to investigate your concerns.
>
> I have been advised that your Central Medical Record (CMR) has been reviewed. Boxes 49 to 51 have been completed on the copy of the final medical board form filed on your CMR, and the ticks appear to be similar in nature to the others on that form.
>
> Defence has advised, however, that your CMR contains a letter from Health Records, dated 18 May 1981, stating that boxes 49 to 51 were not originally completed, and indicating that the documents were returned to the medical centre for completion of this section. This implies that this section was completed at a later date. There is no evidence to explain why these sections were not completed at the time of the original final medical board.
>
> Defence has advised that returning your final medical board documentation to the medical centre for completion was appropriate and consistent with the policy of the time. In addition, the completion appears to have been undertaken by the same medical officer undertaking the final medical board, and within a timeframe to make this completion accurate and appropriate.
>
> In view of this, it appears likely that the original copy you received as part of your discharge process was a true copy of the final medical board, before the board paperwork was returned in order to complete boxes 49 to 51.

I did not receive any copies of my medical records as part of my discharge process.

The copies of my medical and dentals records which I now hold were forwarded to me on 9 November 2001 by *Australian Defence Force Health Records – Army*. The covering letter described these documents as:

> "your Unit Medical Record (UMR) which is a duplicate copy of your Central Medical Record (CMR)."

These documents do not contain a letter dated 18 May 1981 concerning boxes 49 to 51. The ticks that have been placed in those boxes are noticeably different from all of the others on the sheet of paper.

If the claim that my final medical board documents were returned to the medical officer concerned shortly after my final examination is true, then I question why all copies of the documents were not returned for completion (the carbon copies). The original signature on the carbon copies I hold indicate these copies were to be considered as original copies also, therefore, if what Defence is claiming is correct, these copies should also have been completed.

It is my belief that the letter dated 18 May 1981 does not exist, and if a letter has been produced it will be a forgery. I ask for the original letter of 18 May 1981 to be produced so that it can be forensically examined.

An analogy to what has happened to me since the assault in 1976 is that I had attempted to save another Australian soldier's life by running onto the battlefield under fire. Myself and the other soldier were seriously wounded. I lay in the battlefield for 36 years wounded. When I called out for help I was fired at with no hope of repatriation.

The incredible truth here is that the enemy who seriously wounded myself and the other soldier were other Australian soldiers, who bashed and raped their fellow soldiers.

The absolutely incredible truth here is that when I called out for help and was then fired upon, it was by my own country.

So much for the mythology of the Australian digger, who looks out for his mates, used so often by Australian Governments for their own benefit.

My grandfather, who fought at Hill 60 with The First Australian Tunnelling Company RAE against the Germans in WW1, and my father, who defended Australia's airfields against the Japanese in WW2 in the 43 Battalion AIF, would be dumbfounded, and if they were alive today would be appalled to find Australian Governments that did not care about the welfare of its service men and women, only about its own "hip pocket" and reputation. Australian Governments' have lost their moral compasses.

This response from your Office continues the work of DVA in that it is geared toward maintaining the practice of providing false information, delays, denials and obfuscation. DVA and your Ministry appear determined to deny even the possibility that the assault of myself and the rape of actually occurred. In particular, they continue to focus on reports of me citing different years 1975/1976 for when the assault and rape occurred in an attempt to discredit my testimony, and, on the basis of these reports, seek to deny that the event took place.

This seems particularly officious and overly pedantic considering the effects that anxiety and stress can have on detailed memory. I admit I do not have a good memory for exact dates, however, I have always been able to locate the event within the chronology of my life. That is, it occurred shortly before I married my first wife, which was on 20 August 1976.

Also, there are elements of report which are inaccurate, but which have been relied on by DVA in determining my claim. For example, , Review Officer, stated that

> "medical service documents don't confirm a visit to medical officer for treatment after your assault."

Although claims in his report of 23/11/11 that I told him I sought medical treatment immediately after the assault, this is not true. At no stage have I ever said I sought treatment immediately after the assault. To the contrary I have always acknowledged that I **did not** seek treatment for my injuries immediately after the assault, nor was I ordered to do so. The attendance upon a medical officer that I told about was some months after the event, and this was told to during our interview.

The assault I suffered in 1976 at the hands of serving Australian soldiers constitutes a Category 1a stressor. My mental health has deteriorated since then.

The government's ongoing practices of obfuscation and denial have severely impacted on and added to the deterioration of my mental health and as I have said before, these practices perpetuate the abuse I have already suffered. The abuse has now been institutionalised.

The following artwork has been my attempt at trying to keep myself sane in the face of the continuous DVA and Australian Government onslaught against my claim of criminal assault and rape within the ADF since 1976.

My challenge to the Australian Government and its delegates is to fund this artwork in exhibitions throughout Australia. The Governments' involvement in this would go some way towards showing other ADF abuse victims and the rest of the people of Australia that the Australian Government is serious in its attempting to right the wrongs of the past.

If the Australian Government shows it genuinely cares about the well-being of veterans, by being involved in helping soldiers with PTSD to get back on track by expressing themselves through art, then it will perhaps find its' moral compass.

It is imperative that this matter is dealt with before 6 October 2013, the date of my 65th birthday. It is my understanding that after this date my ability to claim compensation is prejudiced.

I look forward to your response.
Without prejudice

John Lawler

cc: The Hon Kevin Rudd, MP
Prime Minister
Parliament House
Canberra ACT 26000

The Commonwealth Ombudsman
GPO Box 442
Canberra ACT 2601

Attachments:
1. Statutory Declaration/Witness Statement by – 11 June 2013
2. Report of – 6 May 2013
3. Letter from to , DVA – 3 May 2012
4. Letter from , DVA to John Lawler – 16 May 2012
5. Letter from to , DVA – 7 June 2012
6. Letter from to DVA – 6 June 2012
7. Letter from , DVA, to – 21 June 2012
8. Account from to John Lawler – 26 June 2012
9. Receipt from to John Lawler – 2 July 2012
10. Letter from ADF Health Records-Army to John Lawler – 9 November 2001

Australian Government
Department of Veterans' Affairs

Ref: M13/2085

Mr John Lawler

Dear Mr Lawler

Thank you for your further letter of 3 August 2012 to the Minister for Veterans' Affairs in which you express concern about your dealings with the Department of Veterans' Affairs (DVA) and the handling of your Defence records. Your correspondence was referred to DVA for response. The Defence matters that you have raised were referred to that Department for attention.

With regard to the diagnosis of your claimed conditions, you have stated that consultant psychiatrist felt that he was unable to make a clear diagnosis in your case. This is not correct. Having given diagnoses of generalized anxiety disorder and alcohol dependence, he stated that "issues of causation are unclear". He then declined on this basis to provide an assessment of incapacity.

The completion of alcohol and smoking questionnaires is not required in every case. An applicant for benefits will be asked to complete a questionnaire only if by doing so they will provide information that is necessary and otherwise unavailable. Details of your alcohol consumption were provided by in his 2002 report, and at no stage have you lodged a claim for a smoking-related condition.

Further investigations have revealed that DVA did receive a request to fund dental treatment from your provider l, dated 6 June 2012. I apologise for DVA's oversight and the subsequent advice in the Chief of Staff's letter of 26 July 2013.

Unfortunately I am unable to comment on the advice you received from a DVA staff member about your entitlement to dental treatment. If your dental issue is linked to your mental health conditions, then payment for dental treatment may be possible. For this to occur it would be necessary for you to have your mental health condition accepted by DVA as being caused by your service and your dental condition being subsequent to that condition.

The decision to extend eligibility for treatment in respect of anxiety disorder rather than post traumatic stress disorder (PTSD) appears to have been made on the basis of the weight of evidence before the delegate at the time. Although consultant psychiatrist had provided a brief statement that you suffered from PTSD, DVA held three detailed reports from suggesting otherwise.

It was clear that the request by for a CPAP machine was made with the treatment of your anxiety symptoms primarily in mind. Be that as it may, a CPAP machine can only be provided if an appropriate specialist recommends it as treatment for sleep apnoea. In such cases an appropriate specialist is a respiratory physician, a respiratory clinic or sleep centre, a physician or an ear, nose and throat specialist.

You have questioned why no action has been taken in relation to your allegation that you were assaulted during service. This is a matter for the relevant law enforcement authorities. The role of DVA and the Veterans' Review Board (VRB) in this matter is limited to that of considering your eligibility for benefits under the *Veterans' Entitlements Act 1986* (VEA).

There is no onus on the Repatriation Commission to review any matter prior to it being considered, upon appeal, by the VRB. When the Repatriation Commission does intervene, it is generally because compelling new evidence has become available.

I note your concern that some members of the VRB, an independent statutory tribunal, are former high-ranking officers and that this can be intimidating. The aim and purpose of the VRB is to provide a means of review that is fair, just, informal and quick in an environment which ensures respect for the service of applicants and dignity in the conduct of proceedings.

Members of the VRB have, through the Council of Australasian Tribunals, participated in training sessions concerning communication with vulnerable clients. Further training was provided to VRB members at a National VRB conference in August 2013. In addition, the VRB can also arrange all female or all male panels to hear sensitive cases. Advocates have been advised at advocates' forums that an applicant or representative can contact the registrar in their state to request such a panel.

The VEA does indeed prohibit people with legal qualifications from representing veterans at VRB hearings. This restriction was brought in to prevent appeal hearings becoming overly adversarial, technical and resource intensive. Applicants are of course permitted to consult lawyers prior to their hearing. Written submissions are accepted by the VRB for consideration as evidence.

It is important that applicants for benefits on the basis of a relationship between service and a particular medical condition be prepared for their claim to be carefully scrutinised. This is not because of any doubt with regard to the veracity of any individual claim, but in order that the integrity of the Repatriation system be maintained.

You have asked that consideration be given to an exhibition of your art works, copies of which were included with your letter. DVA does not administer any programs that could make this possible.

You have expressed concern that you will not be able to claim compensation after turning 65. This is not correct. Compensation in respect of incapacity arising from service-related disabilities can be claimed and paid at any age. It is certainly the case, however, that disability pension is not usually granted at the Special Rate or the Intermediate Rate to veterans who have turned 65. A DVA Factsheet with further information is enclosed.

Should your current appeal to the VRB be successful you will be considered for disability pension at these rates regardless of your age. This is because the claim before the VRB was lodged on 31 August 2011, at which time you were aged 62.

Yours sincerely

Rehabilitation & Support Division

10 September 2013

ENCL

2 October 2013

Senator The Hon Michael Ronaldson
Minister for Veterans' Affairs
Parliament House
CANBERRA ACT 2600

Dear Minister,

I refer to previous correspondence (two previous letters from myself) between myself and the office of the former Minister, the Hon. Warren Snowden, MP.

I have received a letter from , Rehabilitation & Support Division, Department of Veterans' Affairs, dated 10 September 2013, responding to my letter to the former Minister dated 3 August 2013. Copies of these letters are attached. I have also attached, for your information, a copy of a letter I have sent to the Commonwealth Ombudsman regarding these matters.

My responses to letter are set out below. To make it clear which element of his letter I am referring to, I have also incorporated the text of his letter herein, and make my comments below the pertinent sections.

> Thank you for your further letter of 3 August 2012 (sic) to the Minister for Veterans' Affairs in which you express concern about your dealings with the Department of Veterans' Affairs (DVA) and the handling of your Defence records. Your correspondence was referred to DVA for response. The Defence matters that you have raised were referred to that Department for attention.

I note the advice regarding referral of some matters to Defence, but request information as to what those matters are, and when I might expect a response. Further, I am astonished that a letter to an Honourable Minister has been responded to by one of the Departments about which I am expressing concern. The probability of an impartial response seems remote.

> With regard to the diagnosis of your claim conditions, you have stated that consultant psychiatrist felt that he was unable to make a clear diagnosis in your case. This is not correct. Having given diagnoses of generalized anxiety disorder and alcohol dependence, he stated that "issues of causation are unclear". He then declined on this basis to provide an assessment of incapacity.

This statement is inaccurate. qualified the findings of his final report of 23 November 2011 when he stated that he ***prefaced his response*** by noting much of the additional information he had requested had not been received from DVA, and further notes that his opinion was "based upon a reasonable degree of medical probability".

As I have previously noted, in his report dated 14 October 2011 requested:

> … ***the following information before offering an opinion on diagnosis and causation***. [emphasis added]
>
> - The details and dates of his drink/driving offences.
> - His military charge sheets and records of any disciplinary issues in the military (particularly related to alcohol).
> - Mr. Lawler showed me a document which indicates a chronology of events and I would like to see this.
> - His medical records from the army (he said he presented to the RAP in relation to symptoms which he attributed to the assault).
> - His drug and alcohol questionnaire (from this claim and the last claim).
> - report from 1983.
> - Reports, notes or letters from
> - Any information from
> - Mr. Lawler's various claim forms.
> - The determination from the Veterans' Review Board in relation to Mr. Lawler's various claims."

As I state in my previous letter, and as noted above, in his report of 23 November 2011 writes:

> "7. DIAGNOSIS
>
> I ***preface my response*** by noting that you have forwarded some of the information to me that I requested to see ***but not all*** of the information and in particular I have not seen the following [emphasis added]
>
> - The details and dates of his drink/driving offences.
> - His military charge sheets and records of any disciplinary issues in the military (particularly related to alcohol).
> - Mr. Lawler showed me a document which indicated a chronology of events and I would like to see this.
> - His drug and alcohol questionnaire (from this claim and last claim).
> - report from 1983.
> - Reports, notes or letters from
> - Any information from

clearly states the diagnosis he has provided has been given in the absence of significant information he requested about my mental health conditions.

I held this outstanding information which had requested, but, as I have previously advised, the Claims Officer dealing with my case, of DVA, never asked me for the information held by me, and had only provided with some of the information he had requested.

As I have previously noted, the information that requested from DVA contained important information concerning the criminal assault upon me, the rape of , the subsequent effects on my mental health and the eventual diagnosis of my PTSD by

And I state again, that despite advising that his diagnosis was offered in the absence of this information, she chose to determine my claim on the basis of an incomplete assessment, rather than taking the time and care to contact me and request that I provide the information had requested. In fact, she acknowledges she did not provide all of the information requested, on page 2 of her letter dated 12 December 2011 wherein she writes that:

> provided a second report, dated 23 November 2011, which was prepared ***without*** reference to particular information…" (emphasis added).

She further claims that this information "was unable to be obtained." I reiterate my previous statement that she was unable to obtain this information because ***she did not ask me for it***"

More importantly, I was not aware that required this additional information to make an informed diagnosis until I made a Freedom of Information Application for access to my DVA file, and was able to read a full copy of his reports and then forwarded the information through my RSL advocate to DVA.

> The completion of alcohol and smoking questionnaires is not required in every case. An applicant for benefits will be asked to complete a questionnaire only if by doing so they will provide information that is necessary and otherwise unavailable. Details of your alcohol consumption were provided by in his 2002 report, and at not stage have you lodged a claim for a smoking-related condition.

obviously thought alcohol questionnaires were necessary in my case as he made a direct request that he be provided with alcohol questionnaires from this claim ***and my previous claim.*** Further, the reference in relation to alcohol, made by in his 2002 report consists of two sentences, which cannot be considered to be "details" of my alcohol condition. Finally, an alcohol questionnaire was clearly required in my case because in a letter dated 11 July 2012, DVA eventually requested I complete one, which I did.

Also, the increase in my consumption of cigarettes increased significantly between enlistment and discharge and in particular in the year following the assault. This is evident in my discharge medical exam of 1981which notes consumption of 50+ cigarettes a day. This increase is evidence of the deterioration of my mental health.

> Further investigations have revealed that DVA did receive a request to fund dental treatment from your provider , dated 6 June 2012. I apologise for DVA's oversight and the subsequent advice in the Chief of Staff's letter of 26 July 2013.

I note the apology from DVA. Considering I provided the Chief of Staff, , with copies of the relevant correspondence, I believe comment that DVA have undertaken "further investigations" is inaccurate, and an overstatement. It claims credit for DVA's actions where none is due.

> Unfortunately, I am unable to comment on the advice you received from a DVA staff member about your entitlement to dental treatment. If your dental issue is linked to your mental health conditions, then payment for dental treatment may be possible. For this to occur it would be necessary for you to have your mental health condition accepted by DVA as being caused by your service and your dental condition being subsequent to that condition.

The point of my request regarding dental treatment was the same as my request regarding a CPAP machine, however, DVA are intent on making the same incorrect argument. That is, treatment is only available if the condition is service related. Which, based on the information provides further on in his letter, with regards to the funding of a CPAP machine, is not the case.

The request for assistance with dental treatment was made on the basis that it was ***part of my treatment for my mental health condition***. I grind my teeth because of my mental health condition, and my teeth have been damaged because I grind my teeth. Further my mental health deteriorates, because my anxiety levels increase when my physical health, including my dental health, is poor. If my teeth were treated my mental health would improve.

Therefore, dental treatment is part of treating my mental health condition, and treatment for my mental health condition is covered by the White Card and does not require to be service related. Treatment for my mental health condition is covered by the White Card regardless of whether or not it is service related. It is ***not*** contingent upon having my mental health condition accepted by DVA as being caused by my service, as claims in the paragraph cited above.

If DVA are genuinely interested in assisting veterans who suffer from mental health conditions then they need to change their approach and acknowledge that treatment of mental health disorders requires an holistic approach and is not confined to medication, or psychiatric counselling. They also need to train their staff accordingly, particularly those taking telephone or face to face enquiries.

> The decision to extend eligibility for treatment in respect of anxiety disorder rather than post traumatic stress disorder (PTSD) appears to have been made on the basis of the weight of evidence before the delegate at the time. Although consultant psychiatrist had provided a brief statement that you suffered from PTSD, DVA held three detailed reports from suggesting otherwise.

The statement that "The decision to extend eligibility in respect of anxiety disorder rather than post traumatic stress disorder" is ludicrous. The writer appears to be saying that if I suffered from anxiety disorder and post traumatic stress disorder that I would only be treated for one disorder and not both. It is not an and/or argument.

As I have stated previously, the White Card I have been issued was not forthcoming until my treating psychiatrist submitted an application for treatment on my behalf on 3 February 2012 on the basis of his diagnosis for PTSD. completed the form **Application for Health Care in Respect of Post Traumatic Stress Disorder (PTSD)** in its entirety, providing the information specified, and submitted it to DVA. The section of the form **Diagnostic Report – Report Detail** is specific and succinct about the information required from the treating Psychiatrist. It asks a question requiring a "Yes" or "No" answer and provides four lines for the treating Psychiatrist to add further details and "specify ICD codes where possible". Nowhere on this form is the treating Psychiatrist asked to provide any further information. Further, the form requires the diagnosis and application to be made by the ***treating*** Psychiatrist. was not, and is not, my treating psychiatrist. My treating psychiatrist is . A copy of this application is attached, for your information.

Further, total assessment was made on the basis of one consultation for forty minutes, which was undertaken in a ***medico legal context***, on behalf of his client DVA. As

notes, on page 6 of his report dated 23 November 2011:

> "There are significant differences between the medico-legal arena and a clinical setting that relate to formulating a psychiatric diagnosis."

Also, despite the outstanding information requested by subsequently being submitted by me (forwarded via my advocate), DVA has not sought to have him revisit his diagnosis. At that time I also forwarded correspondence from (letter dated 17 August 2011), my VVCS counsellor, (letter dated 28 June 2011) and my GP, (letter dated 29 July 2011), advising that I suffered from PTSD. A full and comprehensive report from dated 6 May 2013 confirming his diagnosis of PTSD has also been provided.

In addition, the diagnosis of PTSD has been further confirmed by PTSD psychiatrist, , and clinical psychologist , of the Repatriation General Hospital, Daw Park, South Australia. and confirmed this diagnosis during their assessment of me on 23 September 2013 for three hours, for inclusion in their Post Traumatic Stress Disorder Program. Clinical Co-ordinator has since advised by telephone that I have been accepted for the program which is to commence on 14 October 2013.

If, as suggests, it was diagnosis which determined my eligibility for treatment under a White Card (Specific Condition) why was I not issued with a White Card subsequent to his reports in 2002 or in 2011? Why was not it not until submitted his diagnosis that a White Card was issued, from his request?

I reiterate my previous observation that DVA have deliberately privileged a diagnosis by , over that of my treating psychiatrist, and other professionals. I believe DVA has chosen to issue a White card for anxiety disorder based on incomplete diagnosis because report is more favourable to their position of wishing to determine that my mental health condition is not related to service.

All of the other six professionals who have assessed me have stated that my PTSD is due to the assault upon me in 1976.

I also note that has chosen not to respond to my comment that the reasoning behind backdating my eligibility for a White Card is unclear. Minister, would you please ascertain and advise why my eligibility for a White Card has been back dated to 20 May 2001, and how that might be of benefit to me?

> It was clear that the request by for a CPAP machine was made with the treatment of your anxiety symptoms primarily in mind. Be that as it may, a CPAP machine can only be provided if an appropriate medical specialist recommends it as treatment for sleep apnoea. In such cases an appropriate specialist is a respiratory physician, a respiratory clinic or sleep centre, a physician or an ear, nose and throat specialist.

statement that it was "clear" the request for a CPAP machine was "made with the treatment of your anxiety symptoms primarily in mind" contradicts the statements made previously advising that I was not eligible for assistance with the supply of a CPAP machine because my sleep apnoea had not been accepted as a service related condition. It contradicts the statement by in his letter dated 2 May 2013, wherein he writes:

> "This request was not approved because you do not have eligibility for treatment of sleep apnoea …" [not service related]

and

> "It does happen from time to time that a veteran will seek treatment at DVA expense for a condition that ***has not been accepted as service-related*** [emphasis added]. In such circumstances, the only way to extend eligibility is to lodge a claim for disability pension and medical treatment under the VEA in respect of that condition."

It also contradicts the original letter I received from , DVA dated 16 May 2012, wherein she states:

> "In examining the request it is noted you are a white cardholder and ***you do not have an accepted disability (sleep apnoea)*** [emphasis added] that relates to a clinical need for the supply of a CPAP machine. Based on this information it has been determined that you currently do not meet the Department's criteria for the supply of CPAP equipment."

I am forwarding a copy of the report from my sleep study, conducted by on 28 October 2011, and a letter from , dated 25 June 2012, advising that a CPAP machine would assist with my mental health condition by improving my sleep. I did not forward these documents to DVA previously because, as I advised in my previous letter of 3 August 2013, I had been told that a CPAP machine would only be funded if my sleep apnoea was service related. Would you please arrange for the sleep study report and letter from to be forwarded to the relevant department and advise them that I seek approval of costs for treatment with respect for the sleep study (to determine the type of CPAP machine which would best suit me, and cost for the purchase of a CPAP machine, associated equipment, consultations and ongoing costs of associated consumables.

> You have questioned why no action has been taken in relation to your allegation that you were assaulted during service. This is a matter for the relevant law enforcement authorities. The role of DVA and the Veterans' Review Board (VRB) in this matter is limited to that of considering your eligibility for benefits under the *Veterans' Entitlements Act 1986* (VEA)

I am not surprised that has chosen to respond to my concerns by stating the purely legal obligations of DVA and the VRB. Even if pursuing the matter of a criminal assault was not within the jurisdiction of the VRB and DVA one might have thought the individuals who became aware of my situation may have felt some ethical or moral responsibility to refer me to the appropriate body or report the crimes. However, they chose to do and say nothing. The assault and rape were reported in 1976 to a superior officer and I was then interviewed by the Military Police the next day. The Military Police then hid the crimes. I believed that the DVA and the VRB should have reported the crimes when I reported them to those bodies. Instead DVA and the VRB have hidden the crimes as did the Military Police thirty seven years ago. DART has now taken up my case and will involve the Federal and State Police in the investigation of the assault and rape. The fraudulent alteration of my medical records, assault and rape has also been reported to the South Australian Police, and a statement recorded, and I have been referred to the S.A. Police Fraud Squad and the New South Wales Criminal Investigation Squad.

> There is no onus on the Repatriation Commission to review any matter prior to it being considered, upon appeal, by the VRB. When the Repatriation Commission does

intervene, it is generally because compelling new evidence has become available.

I note comments, and simply reiterate my previous statement that, ***even though a substantial body of additional evidence*** was submitted to DVA (which included most of the outstanding information sought by), DVA chose not to conduct a review. It is my view that the additional evidence should have been referred to for a review of his diagnosis, in light of the information he had requested having been received.

I note your concern that some members of the VRB, an independent statutory tribunal, are former high-ranking officers and that this can be intimidating. The aim and purpose of the VRB is to provide a means of review that is fair, just, informal and quick in an environment which ensures respect for the service of applicants and dignity in the conduct of proceedings.

Members of the VRB have, through the Council of Australasian Tribunals, participated in training sessions concerning communication with vulnerable clients. Further training was provided to VRB members at a National VRB conference in August 2013. In addition, the VRB can also arrange all female or all male panels to hear sensitive cases. Advocates have been advised at advocates' forums that an applicant or representative can contact the registrar in their state to request such a panel.

I note comments regarding communications training undertaken by members of the VRB. Nevertheless the power imbalance remains. In addition, Minister, I draw to your attention, the fact that the information has provided with regards to the VRB arranging all female or all male panels if requested was not provided to me when I lodged my appeal, nor does it appear on the VRB website.

The VEA does indeed prohibit people with legal qualification from representing veterans at VRB hearings. This restriction was brought in to prevent appeal hearings becoming overly adversarial, technical and resource intensive. Applicants are of course permitted to consult lawyers prior to their hearing. Written submissions are accepted by the VRB for consideration as evidence.

I state, again, VRB hearings are underpinned by a significant imbalance of power in that the Senior Member of the panel is a lawyer, thereby providing the panel, by default, with the benefit of legal counsel at the hearing, whereas veterans and their advocates are not.

It is important that applicants for benefits on the basis of a relationship between service and a particular medial condition be prepared for their claim to be carefully scrutinised. This is not because of any doubt with regard to the veracity of any individual claim, but in order that the integrity of the Repatriation system be maintained.

I do not have any problem with the facts of my case being scrutinised. My concern is that DVA did not take the time or care to consider all the facts of my case, chose not to obtain further evidence for me that would support my claim, and relied upon taking elements of report out of context in order to determine my claim as not being service related.

You have asked that consideration be given to an exhibition of your art works, copies of which were included with your letter. DVA does not administer any programs that could make this possible.

Despite advice that DVA does not administer any programs that would assist with staging an exhibition of my art work, which relates to my PTSD, my own investigations have revealed that, in collaboration with an Ex-Service Organisation, an application could be made for funding of an exhibition through a Veteran and Community Grant. This is something I will be investigation further, therefore, Minister, any additional information or assistance you could provide would be invaluable.

> You have expressed concern that you will not be able to claim compensation after turning 65. This is not correct. Compensation in respect of incapacity arising from service-related disabilities can be claimed and paid at any age. It is certainly the case, however, that disability pension is not usually granted at the Special Rate or the Intermediate Rate to veterans who have turned 65. A DVA Factsheet with further information is enclosed. Should your current appeal to the VRB be successful you will be considered for disability pension at these rates regardless of your age. This is because the claim before the VRB was lodged on 31 August 2011, at which time you were aged 62.

I note advice with respect to my pending 65th birthday.

Finally I note that letter does not address the matters raised in my previous correspondence with regards to the fraudulent alteration of my medical records. I would appreciate a detailed response regarding this matter.

I have found it appalling that DVA, the body responsible for the wellbeing of veterans, treats those with diagnosed mental health illnesses such as myself, with such contempt. Instead of assisting us, DVA continues to distort and misrepresent the facts of my case which shows the extent to which DVA will go to hide the evidence of criminal assault and rape within The Australian Defence Force. Nothing has changed.

DVA has never interviewed me.

I look forward to your reply.
Without prejudice

John Lawler

cc: The Hon Tony Abbott, MP
Prime Minister
Parliament House
Canberra ACT 26000

The Commonwealth Ombudsman
GPO Box 442
Canberra ACT 2601

Attachments:

1. Letter to Minister for Veterans' Affairs – 3/08/13
2. Letter from Department of Veterans' Affairs – 10/09/13
3. Letter to Commonwealth Ombudsman – 2/10/13
4. Application for Health Care in Respect of Post Traumatic Stress Disorder – 4/02/12
5. Sleep Study conducted 28/10/11: Report from – 10/11/11
6. Letter from – 25/06/12

Australian Government
Department of Veterans' Affairs

Ref: M13/2314

Mr John Lawler

Dear Mr Lawler,

Thank you for your email of 2 October 2013 to the Minister for Veterans' Affairs, Senator the Hon. Michael Ronaldson concerning your dealings with the Department. The Minister has asked that I acknowledge receipt of your letter on his behalf and for the matters you have raised to be investigated by the Department of Veterans' Affairs.

A response from the Minister will be provided to you once this investigation has been completed.

Thank you for raising this issue with the Minister.

Yours sincerely,

Assistant Secretary
Determination Support and Reviews

23 October 2013

28 November 2013

Senator The Hon Michael Ronaldson
Minister for Veterans' Affairs
Parliament House
CANBERRA ACT 2600

Dear Minister,

I am writing to you with disappointment that my previous correspondence concerning the following issues remains unaddressed since 2 May 2013.

- Fraudulent alteration of my official documents;
- Illegal and criminal behaviour towards me;
- Hiding of serious criminal assault and rape on three occasions over a thirty six year period;
- Miserably failing in their duty of care, both legally and morally, towards me on a continuous basis.

On the 2 October 2013 I again raised these issues for your information and action.

You replied on the 23 October stating that an investigation will commence concerning the issues noted above.

On the 14 November I contacted of DVA whom I understand is in charge of the investigation. I was informed by her that the investigation into these serious issues had not begun because she was waiting for the results of my interview with the VRB to arrive before sending both results to your office.

On three occasions I had to explain to that the results of the VRB were not contingent upon her beginning the investigation into the above issues. I had to insist that she begin the investigation because the crimes committed 36 years ago have nothing to do with the illegal and criminal actions by the DVA in recent years.

Her reasoning was that she felt that instead of sending the information singularly she could send both together to your office, but did comment that the investigation could have started and the results sent through earlier.

Sir, I suffer from Post Traumatic Stress Disorder and am being treated at the Repatriation Hospital in Adelaide for eight weeks.

I am certain that you would understand that the continued immoral, illegal and criminal behaviour towards me by DVA is reprehensible and is continuing to exacerbate my condition.

An inquiry into the above events should have begun 11 years ago when I again brought to the attention of the authorities (the VRB) the criminal assault against myself and the rape of

These crimes were ignored by the VRB back then and also the DVA ever since.
The DVA has gone to extreme measures to try to ignore these issues. This includes the excuse by of only needing to send one email instead of two. It would appear that the decisions of a minor public servant outweigh the directions given by the Minister for Veteran Affairs

In my last email to you I stated that I had contacted the South Australian Police concerning these issues. I now intend to take these matters to the SA Police Fraud Squad.

Yours faithfully,

John Lawler

Senator the Hon. Michael Ronaldson
Minister for Veterans' Affairs
Minister Assisting the Prime Minister for the Centenary of ANZAC
Special Minister of State

Ref: M13/2314

Mr John Lawler

Dear Mr Lawler,

I refer to your correspondence of 2 October 2013 and the acknowledgment letter of 23 October 2013 from Assistant Secretary from the Department of Veterans' Affairs (DVA).

The matters you have raised are currently being investigated by DVA.

A response will be provided once this investigation has been completed.

Yours sincerely,

SENATOR THE HON. MICHAEL RONALDSON

2 3 DEC 2013

Parliament House, Canberra ACT 2600 Tel: (02) 6277 7820 Fax: (02) 6273 4140

Senator the Hon. Michael Ronaldson
Minister for Veterans' Affairs
Minister Assisting the Prime Minister for the Centenary of ANZAC
Special Minister of State

Ref: M13/2314

Mr John Lawler

Dear Mr Lawler,

Thank you for your letter of 2 October 2013 concerning your dealings with my Department and your service records. Your letter of 3 October 2013 to the Prime Minister, the Hon Tony Abbott MP, has also been passed to me for response, as the issues you raise fall within my portfolio responsibilities. I apologise for the delay in responding.

I was concerned to read your letter and asked my Department to investigate. I now understand that the psychiatric evidence in your case is complex, as there are different opinions concerning the diagnosis of your condition. Upon receipt of the report of 8 October 2013 from consultant psychiatrist it was accepted that the weight of evidence favoured a diagnosis of post traumatic stress disorder (PTSD), and this condition was accepted for the purposes of treatment only. It is important to note that this does not imply any finding in relation to the causation of your PTSD, or the relationship of that condition to your defence service.

As you are aware your claims for the following conditions; PTSD, generalised anxiety disorder and alcohol dependence (in remission) are currently being reviewed by the Veterans' Review Board (VRB). On 25 November 2013 the VRB adjourned your review and requested my Department provide a historical report on the circumstances surrounding the event. Your review will be re-listed as soon as this report is received. If your appeal to the VRB is successful, you will be considered for disability pension at the Special Rate or Intermediate Rate. However, if it is not successful and you are not happy with any aspect of the VRB decision, you may appeal to the Administrative Appeals Tribunal (AAT).

The AAT is an independent authority and is well placed to review cases outside of my Department. Importantly, the AAT is not bound by the rules of evidence and can inform itself in any manner it considers appropriate. It is required by law to conduct its proceedings with as little formality and technicality, and as quickly as possible, while giving due consideration to the matter before it. During AAT proceedings, applicants also have the opportunity to air any grievances they have had with the claims process.

Please be advised that even if the Defence Abuse Response Taskforce (DART) accepts claims as 'plausible' and compensation is issued under that scheme, the eligibility criteria and the standard of proof under the DART are different to that of the *Veterans Entitlements Act 1986* (VEA). The assessment of 'plausibility' is well below the standard of proof required to establish liability under the VEA, which must be on the balance of probabilities/reasonable hypothesis.

With regards to your request for reimbursement of costs, I have attached a claim form for you to complete and forward to my Department together with any invoice/s, if you wish. However, I must reiterate that for your claim/s to be successful, it would be necessary for you to have sleep apnoea accepted by my Department as being caused by your defence service.

I am further advised that the other issues you have raised have previously been addressed and as such, there is nothing more that I can add to the advice already provided. Additionally, the Ombudsman has also addressed the issues you raised and advised my Department that it has not acted unreasonably and no further investigation is warranted. Therefore, I hope you can appreciate that I will only respond to any new issues, together with supporting evidence, that you may raise in the future.

The issue you raised in relation to alterations to your medical documents comes under the portfolio responsibilities of the Assistant Minister for Defence, the Hon. Stuart Robert MP, and your correspondence has been passed to him for consideration.

I hope that you find your further dealings with DVA to be more satisfactory.

Yours sincerely,

SENATOR THE HON. MICHAEL RONALDSON

ENCL

cc. The Hon. Stuart Robert MP, Assistant Minister for Defence.

13 JAN 2014

Annexure 2 - Correspondence with Minister for Defence John Lawler

Date: Tue, 12 Apr 2011 15:09:59 +1000
From:
To:
Subject: Sexual assault

Dear Minister,

Approximately thirty years ago I was a sapper in the Royal Australian Engineers working in the Chief Engineers Office Victoria Barracks Sydney as an Architectural Draftsman.
I was bashed and left unconcious by a group of four or five serving soldiers while attempting to stop the sexual assault (rape) of a female soldier at Randwick Barracks.
I reported the assault at the time to superior officers to no avail.
Approximately eight years ago I appllied for a disability pension for my ongoing injuries attributed to serving in the Defence Force through Veteran Affairs. My application was unsuccessfull.
I currently recieve a disability pension from Centrelink and have suffered for a number of years from depression.
I attribute my ongoing medical problems with my six years in the Defence Force.
I wish to ask for your assistance in appealing the decision by Veteran Affairs.
Please advise me that you have recieve this email.

yours Sincerely,
John Lawler

Ph:

Annexure 2 - Correspondence with Minister for Defence John Lawler

Date: Mon, 6 Jun 2011 14:58:38 +1000
From:
To:
Subject: RE: Sexual assault [SEC=UNCLASSIFIED]

UNCLASSIFIED

Dear Mr Lawler

I am writing in response to your recent email to Stephen Smith, Minister for Defence, concerning your experience as a member of the Australian Defence Force.

To bring you up to date : the Minister for Defence, Stephen Smith MP, announced on 11 April 2011 an external legal review of the large number of allegations of sexual or other forms of abuse that have been raised since the recent Australian Defence Force Academy incident.

As outlined by the Minister, all these allegations are of concern and will be assessed methodically and externally from Defence.

The external legal review is being conducted by the law firm DLA Piper (formerly DLA Phillips Fox). The Review team is led by DLA Piper Special Counsel, Dr Gary Rumble, assisted by former Commonwealth Ombudsman and DLA Piper Special Counsel, Professor Dennis Pearce AO, and by partner Melanie McKean.

In accordance with this process, your email has been forwarded to the external legal team for their assessment. If you would like to contact the review team directly, contact DLA Piper on 1800 424 991 Monday to Friday between 2 pm and 9 pm (AEST) or email

It is important that persons wishing to provide information on a confidential basis contact the review team before they submit the information to discuss options for doing so.

Defence has established support arrangements for people who are experiencing distress or otherwise feel that they require emotional support. Support is available to current and former Australian Defence Force and Australian Public Service personnel and their immediate families who raise or have raised allegations with the external review team. Details of the relevant support arrangements are available from the DLA Piper team and through internal Defence channels.

This process will be ongoing until all matters raised have been assessed.

Please let us assure you that we are treating your concerns with due seriousness.

Best wishes

Office of Hon Stephen Smith MP
Minister for Defence

Annexure 2 - Correspondence with Minister for Defence John Lawler

-----Original Message-----
From:
Sent: Tuesday, 12 April 2011 15:10
To: Smith, Stephen (MP)
Subject: Sexual assault

Dear Minister,

Approximately thirty years ago I was a sapper in the Royal Australian Engineers working in the Chief Engineers Office Victoria Barracks Sydney as an Architectural Draftsman.
I was bashed and left unconcious by a group of four or five serving soldiers while attempting to stop the sexual assault (rape) of a female soldier at Randwick Barracks.
I reported the assault at the time to superior officers to no avail.
Approximately eight years ago I appllied for a disability pension for my ongoing injuries attributed to serving in the Defence Force through Veteran Affairs. My application was unsuccessfull.
I currently recieve a disability pension from Centrelink and have suffered for a number of years from depression.
I attribute my ongoing medical problems with my six years in the Defence Force.
I wish to ask for your assistance in appealing the decision by Veteran Affairs.
Please advise me that you have recieve this email.

yours Sincerely,
John Lawler

Annexure 2 - Correspondence with Minister for Defence John Lawler

The Hon Stuart Robert MP
Assistant Minister for Defence

MC14-000223

Mr John Lawler

- 5 MAR 2014

Dear Mr Lawler

On 20 January 2014 the Minister of Veterans' Affairs, Senator the Hon Michael Ronaldson responded to your letter of 2 October 2013. In his letter Senator Ronaldson commented that your Army medical documentation matter falls within my portfolio responsibilities. This has now been referred to me for response.

I am advised that an explanation regarding the amendment of your Medical Examination Record was provided by the Department of Defence and included in correspondence to you dated 26 July 2013.

Defence advised that your Central Medical Record contains a letter from Health Records, dated 18 May 1981, stating that boxes 49 to 51 were not originally completed, and indicating that the documents were returned to the Medical Centre for completion of this section. This implies that this section was completed at a later date. There is no evidence to explain why these sections were not completed at the time of the original final medical board.

Defence has advised that returning your final medical board documentation to the medical centre for completion was appropriate and consistent with the policy of the time. In addition, the completion appears to have been undertaken by the same medical officer undertaking the final medical board, and within a timeframe to make this completion accurate and appropriate.

In your correspondence you questioned the existence of the letter from Central Medical Records, which directed completion of boxes 49 to 51 of your final Medical Board Examination Record. This letter does exist and I have been assured that it was sourced directly from the hardcopy of your central medical record by Defence. Defence policy does not allow the release of original documents. However, I have attached a copy for your reference.

If you still have concerns regarding the authenticity of the attached document Defence is willing to send your original medical files to a local Defence health facility in Adelaide to allow you to view the original documents. Should you wish to accept this offer your point of contact is Lieutenant Colonel who is the Commanding Officer of the Joint Health Unit South Australia. Lieutenant Colonel is based at Royal Australian Air Force Base Edinburgh and can be contacted on telephone: r via email:

In summary there appears to be no evidence that fraudulent alteration of your medical **documentation has occurred** and I trust you will accept the offer from Defence to review your **original** file.

I would like to thank you for your service in Defence and wish you well in the future.

Yours sincerely

Stuart Robert
Encl

Annexure 2 - Correspondence with Minister for Defence John Lawler

MEDICAL IN CONFIDENCE

Telephone:

HEALTH RECORDS
DAHS (M)
GPO BOX 1932R
MELBOURNE VIC 3001

18 MAY 81

Quote in reply:
A309-5-23/81/297/9

4 Military District

CENTRAL MEDICAL RECORDS CHECK OF MEDICAL BOARD PROCEEDINGS FOR

Service Number	Rank	Name and Initials	Unit
	LCPL	LAWLER JO	A W BRANCH

Reference: A. Manual of Personnel Administration Vol 1, Chap 14.

1. Routine review of the enclosed Medical Board Proceedings completed on 30 APR 81 for the above member shows:

(a) BOXES 49 to 51 INCL. ON PAGE 1 REQUIRE COMPLETION.

2. It is requested that the enclosures be reviewed, the necessary action be taken and the proceedings returned to Health Records by 9 JUN 81.

3. Please return a copy of this request with the Board proceedings to the above address.

COL
for DGAHS

Enclosures:

F Med 1 & 64
~~F Med 1A~~
~~F Med 2~~
F Med 2A
Other (State)

MEDICAL-IN-CONFIDENCE

~~SA. POLICE~~

Annexure 3 - Correspondence with Commonwealth Ombudsman

[Review use: DLA Piper Review reference 213504]

DLA PIPER

DELIVERED TO ADELAIDE OFFICE CWLTH OMBUDSMAN 17/5/13.

PART 2 - PERSONAL DETAILS AND BACKGROUND

Section 2A - Personal Details

1. Your current title	☒ Mr	☐ Mrs	☐ Ms	☐ Miss	☐ Dr	→ or Rank	**2. Your Rank or APS level** (Current or at separation from Defence)	L/cpl		
3. Your name (and any previous names)	John Osborne Lawler My DLA Piper no. is:									
4. Your PM Keys, Regimental or AGS Number							**5. Your date of birth**	6/10/1948		
6. Your gender	☒ Male	☐ Female	**7(a). Are you currently with Defence**				☐ Yes	☒ No	**7(b) If No, when did you leave Defence?**	2/6/1981
8. Your Unit, Ship or Area in Defence (Current or at separation from Defence)	Chief Engineers Office Keswick Barracks 4MD						**9. Your contact No and the best time to call:**			
10. Your Postal Address							**11. Your email:**			
							Dated: 19 / August / 2011			
Suburb			**Postcode**				**12. Your signature (above)**			

Section 2B - Background in Defence

13. Please give a general description your history with Defence i.e. when you first joined **and** what your role in Defence is/has been. [add more sheets or an employment history if that is convenient)

Date of enlistment 3/June/1975 I was corps enlisted into the Army as a qualified Architectural Draftsman.

Following Basic and Corps training my first posting was to the Chief Engineers Office Victoria Barracks Sydney on 3 1 1976 as an Architectural Draftsman.

My second and final posting was to the Chief Engineers Office Keswick Barracks Adelaideon the 15/ 12/ 1976 to 2/6/1981 as an Architectural Draftsman until my honourable discharge.

DLA PIPER

Section 3F - Description of the incident/conduct

28. Please describe the incident or conduct (add extra sheets marked 'Answer to Q28' or copy this sheet if necessary. If you already have a written statement of the incident/conduct please attach a copy.) Please see Part 3A above explaining what kind of information and detail we are asking for.

While posted to the Chief Engineers's Office, Victoria Barracks in Sydney, in mid 1976, I was assaulted by a group of male soldiers. I was beaten about the head and body and rendered unconscious while attempting to prevent what I believed was the imminent sexual assault (rape) of a female soldier.

The events that led to the assault are as follows:
- I was returning to my accommodation block at Randwick Barracks in the evening, I believe that I had been on guard duty, and was passing through the car park at the rear of the O.R.'s mess, which had closed for the night.
- I noticed a female soldier that I worked with at the C.E.'s office. She was with a group of male soldiers (approximately 6 who all appeared sober). One of the male soldiers was a corporal.
- I said hello as I was passing and noticed th as intoxicated. While I was talking to the corporal said that his car was next to us and that I could "go first".
- I believed that may have been at risk of assault or possibly rape, so I sat in the car and talked to her for about twenty minutes in an attempt to allow her to sober up.
- While I was sitting in the car with her, the car door opened and I was pulled out of the car onto the ground by the corporal who was infuriated and who, with at least one of the other soldiers, began to beat me to unconsciousness about the head and body with their fists while I was on the ground.
- I woke up twenty minutes later and found the car, and the soldiers gone.
- I was extremely concerned about welfare and immediately went to the officer's married quarters at the barracks and raised the alarm to a male officer.
- I was advised to return to my accommodation block by the officer.
- The next day I attended work with abrasions and black eyes. I was interviewed that day by a sergeant in the military police. He stated to me that I must have had an involvement with to be so concerned. I replied to him that I was in a committed relationship with a woman in Adelaide and was about to be married. The sergeant discontinued the conversation. I heard nothing of the incident following the interview.
- arrived at work two days later and thanked me for my help that evening.
- She told me that the Military Police had asked her to change corps to the Military Police, and that she could be transferred to Recruiting, and that maybe there was a promotion in the offering.

I have recently contacted two former soldiers in the C.E.'s Office. One of the soldiers stated that he remembers the incident where I "defended ". The other said that finished her service in the Army with the Military Police in Recruiting as a Warrant Officer. I have the contact details for these two witnesses. is witness to the assault. Currently I am receiving treatment from a Councellor, a Doctor, a Mental Nurse and a Psychiatrist.

DLA PIPER

Section 3C - Details of the person(s) who carried out the incident/conduct (the perpetrator(s))

If there are more than two perpetrators, please add sheets providing the same information for each perpetrator marked 'Perpetrator 3', 'Perpetrator 4' etc.

Perpetrator 1 name	?	**PMKeys/Service /AGS No.**	?			
Rank or APS Position at time	corporal	**Age at time (Approx)**	?	**Gender**	☒ Male	☐ Female
Current rank/APS position	?	**Current posting/APS area of Department**	?			

Perpetrator 2 name	?	**PMKeys/Service /AGS No.**	?			
Rank or APS Position at time	?	**Age at time (Approx)**	?	**Gender**	☒ Male	☐ Female
Current rank/APS position	?	**Current posting/APS area of Department**	?			

Section 3D - Details of the person(s) who witnessed the incident/conduct (the witness(es))

If there are more than two witnesses please add sheets providing the same information for each witness marked Witness 3', Witness 4' etc.

Witness 1 name		**PMKeys/Service /AGS No.**	?			
Rank or APS Position at time	Private	**Age at time (Approx)**	20	**Gender**	☐ Male	☒ Female
Current rank/APS position	?	**Current posting/APS area of Department**	?			

Witness 2 name		**PMKeys/Service /AGS No.**	?			
Rank or APS Position at time	Corporal	**Age at time (Approx)**	25	**Gender**	☒ Male	☐ Female
Current rank/APS position	None	**Current posting/APS area of Department**	None			

Section 3E - General information about the incident/conduct

25. Where did the incident occur?	Randwick Barracks Sydney							
26. What was the subject's status at the time?	☐ APS	☒ Normal ADF duty	☐ Under training	☐ Deployed	☐ School Cadet	☐ Other specify →		
27. How was the perpetrator related to the subject? (If there is more than one perpetrator, please explain relationships in the description below.)	☐ CO/ OIC	☐ Supervisor	☐ Subordinate	☐ Teacher Trainer	☐ Senior Co-worker	☐ Co-worker	☒ Other specify →	Did not know any of the perpetrators

DLA PIPER

[Review use: DLA Piper Review reference 213504]

Please complete a copy of this Statement Form for each incident/conduct

Section 3B - Details of the person who suffered the abuse (the 'subject')

14. What was the date(s) or period of the incident/conduct?	Mid 1976		**15. Are you the subject of the incident/conduct?**	☒ Yes	☐ No	
				If yes - go to question 20		
16. How did you find out about the incident or conduct? (eg the subject told me about it a week after it happened.)	Attach a sheet marked 'Answer to Q 16' with statement if necessary					
17. What is the name of the subject? (If the subject's name was different at the time, please include the subject's name at the time?)						
18. Does the subject know that you are informing the Review about this incident or conduct?	☐ **Yes**	☐ **No**	If No, explain why not (Attach a sheet marked 'Answer to Q 18' if necessary.)			
19. If you answered 'Yes' to Q 18, has the subject agreed to you giving information to the Review?	☐ **Yes**	☐ **No**	If No, explain why not (Attach a sheet marked 'Answer to Q 19' if necessary			
20. What was the Rank or APS position of subject at the time?	Sapper in the Royal Australian Engineers		**21. What was the subject's age at the time?**	27 yrs	**22. What was the subject's gender?**	☒ Male ☐ Female
23. Was the subject in Defence at the time?	☒ **Yes**	☐ **No**	If no- how was the subject connected with Defence (Attach a sheet marked 'Answer to Q23' if necessary.)			
24. If yes to Q 23 - what part of Defence was the subject in at the time?	☐ Navy	☒ Army	☐ Airforce	☐ ADFA		
	☐ School Cadets	☐ Dept	☐ Unknown	☐ Other (specify) →		

Annexure 3 - Correspondence with Commonwealth Ombudsman

John Lawler

2 May 2013

Stephen Smith, MP
Warren Snowdon, MP
Ann McEwen, Senator
David Johnston, Senator
Michael Ronaldson, Senator

Dear Ministers and Senators,

I am a veteran of the Australian Army and suffer from PTSD and other medical conditions relating to an assault upon myself where I was bashed unconscious by five Australian soldiers when I attempted to stop them from raping a female soldier at Randwick Barracks in Sydney in 1976.

On the 18/6/2011 I applied for a Disability Pension for "depression, anxiety and stress" which the DVA acknowledged. I was then refused my application for "anxiety disorder and alcohol dependence". DVA had changed my claim without advising or consulting with me and my claim was forwarded to The Veterans Review Board.

On two occasions the Department of Veteran's Affairs had told me to spend my money to be tested for sleep apnoea and to have an inspection of my teeth by a dentist. I hold a DVA white card.

The DVA said that they would refund the money that I had spent and then would follow up with further treatment. When DVA were asked to pay for the consultations and further treatment, DVA refused.

As you are probably aware under Promissory Estoppel it is illegal for the Government to tell a person to spend money and then advise them the Government has changed its mind about a refund and further treatment.

I am currently seeing a psychiatrist and psychologist, both of which are being paid for by DVA under my white card. My wife is also seeing a psychologist because of my illness. I first saw my psychiatrist in January 2011, following a referral from my GP. It was my psychiatrist who advised me I was eligible to apply for a DVA White Card which would help

pay for my treatment. He assisted me with making an application for a white card on the basis of his diagnosis of PTSD. I was subsequently issued a white card for Anxiety.

In 2002 I was seen by a DVA psychiatrist who diagnosed me with a Generalised Anxiety Disorder. In his report he noted that if I did not receive treatment my condition would become permanent. I was not advised by DVA that I would have been eligible for treatment under a white card. I did not receive any treatment until 2006 when, on my own initiative, I sought help from my GP who prescribed anti-depressant medication.

My mental illness has left me unfit for general employment and I receive a Centrelink disability pension.

I have undertaken academic research in Aboriginal Housing as a PhD candidate in architecture at QUT as a Research Scholar with the Australian Housing and Urban Research Institute and in the past have been a Research Fellow with the Aboriginal Research Institute (UniSA) in Aboriginal housing and health. The solitary nature of research meant I was able to research at my own pace when I felt well enough, and it meant I did not feel completely useless and was able to make an important contribution to society. Except for scholarships my research has been unfunded.

The recent SKYPE affair has seriously reactivated the memories of the assault against me in 1976. Over the past two years I have been overwhelmed and unable to continue with my PhD because of the increase of my PTSD.

Six weeks ago, my professor contacted me and offered to send a post-graduate researcher from QUT (Brisbane) to the Barossa Valley to assist me to complete my thesis. I said that although I wished to finish my PhD, my current mental and emotional state prevents me from doing so.

Since the SKYPE affair two years ago I have been on sick leave from my PhD research. Four weeks ago I sent an email to my professor advising him that I was unable to complete because of my mental/emotional illness and that I was withdrawing from my PhD candidature.

Evidence has shown that the Government Authorities have:

- Fraudulently altered my official documents;
- Behaved illegally and criminally towards me;
- Hidden serious criminal assault and rape on three occasions over a thirty six year period;
- Miserably failed in their duty of care both legally and morally towards me.

The reason the ADF, DVA, Repatriation Commission and successive Federal Governments' have hidden this abuse is because if the abuse became public it would reflect badly on the ADF. It would cost the ADF money and reputation and would damage their recruiting efforts.

If the assault upon myself whilst attempting to prevent the rape had been put in the public domain, I most likely would have received an award like the Cross of Valour for "an act of conspicuous courage in circumstances of extreme peril", but the ADF could not afford to let that happen, the ADF's reputation was at stake.

It is the appalling behaviour of the ADF in the past that has caused the mental illnesses of veterans like myself, and it is the current appalling behaviour of the DVA that is continuing and exacerbating the abuse under the umbrella of the Australian Governments. The stonewalling and delaying tactics the DVA engages in deny and delay our claims until we give up, die of old age or commit suicide.

Yours sincerely,

John Lawler

In 2003 I informed The Veteran's Review Board the criminal assaults had taken place as indicated.

VETERANS' REVIEW BOARD

Mr Lawler described to the Board an incident in 1975 (sic), when he was assaulted at Randwick Barracks and severely beaten. He said that he believed that his back was injured in the assault and the later march aggravated his spinal injuries. The Board was unable to find any record of medical treatment following the assault in 1975. (sic)

The Repatriation Commission. The DVA and the ADF did not further investigate the criminal assault upon myself or the rape of the female soldier that I was attempting to protect. The assault and rape were reported at the time to the authorities in 1976, in 2002 and in 2011 with no result.

VETERANS' REVIEW BOARD

Decisions under review:

The Repatriation Commission decisions of 3 May 2002, which refused claims for thoracic spondylosis, cervical spondylosis and anxiety disorder.

Decisions of the Board:

On 29 January 2003 the Veterans' Review Board decided to:

- **AFFIRM** the decisions under review in relation to thoracic spondylosis, cervical spondylosis and anxiety disorder. This means that the Repatriation Commission's decisions are unchanged in relation to those matters.

This is part of a report from to the DVA in 2002. is the DVA psychiatrist.

Given that Mr. Lawler has yet to receive the benefit of psychiatric treatment I would take a conservative approach and rate his current mental state as *"temporary"*. Should there be no change with eight to ten months of psychiatric treatment I would consider his psychiatric state to be *"permanent"*.

Although DVAs' psychiatrist has stated that my psychiatric condition was service related and will become permanent without treatment, the DVA did not offer me any treatment and refused my claim. My psychiatric impairment has now become permanent.

Commonwealth Department of
Veterans' Affairs

Telephone: 133 254
Country Calls: 1800 555 254
Facsimile: (08) 8290 0498

3 May 2002

Dear Mr Lawler,

This letter is to advise you of my decision on the disability pension claim you lodged on 20 August 2001.

DECISION

I have decided that thoracic spondylosis, cervical spondylosis and anxiety disorder are not related to service.

Annexure 3 - Correspondence with Commonwealth Ombudsman

Australian Government
Department of Veterans' Affairs

On two occasions the Department of Veterans' Affairs told me to spend my money to be tested for sleep apnoea and to have an inspection of my teeth by a dentist. I hold a DVA White Card. The DVA said they would refund the money I had spent and then follow up with further treatment. When asked to pay for the consultations and further treatment. DVA refused.
Under Promissory Estoppel it is illegal for the Government to tell a person to spend money and then advise them the Government has changed its mind about a refund and further treatment.

Dear ,

I write with regard to your request for DVA to fund dental treatment for Mr Lawlor.

Unfortunately, Mr Lawlor is not currently covered under his White Card for dental treatment.

Dear Mr Lawler,

I am writing to you in response to a request received in this office on the 14th May 2012, from your Psychiatrist for the supply of a CPAP machine and consumables.

In examining the request it is noted you are a white card holder and you do not have an accepted disability (sleep apnoea) that relates to a clinical need for the supply of a CPAP machine. Based on this information it has been determined that you currently do not meet the Department's criteria for the supply of CPAP equipment and I therefore must advise that the request for the supply of CPAP equipment has been declined. An advice letter has been forwarded to

Australian Government
The Repatriation Commission

On 31 August 2011, Mr Lawler, the veteran, lodged a claim for 'depression; anxiety and stress'.

I am satisfied that the appropriate medical diagnoses for the claim are:

- Anxiety Disorder; and
- alcohol dependence.

The Repatriation Commission had changed my claim without my knowledge or authority.

Australian Government
Department of Veterans' Affairs

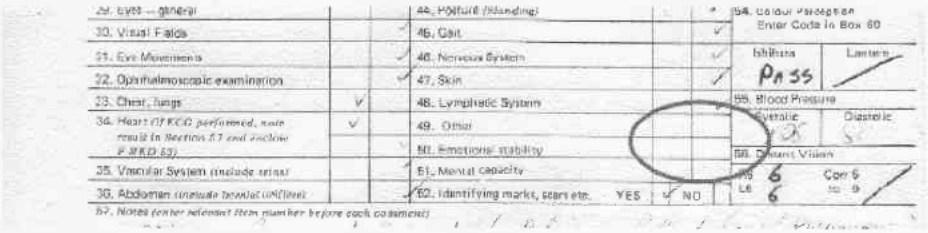
Dear Mr Lawler,

This letter is to advise you of my decision on the disability pension claim you lodged on 31 August 2011.

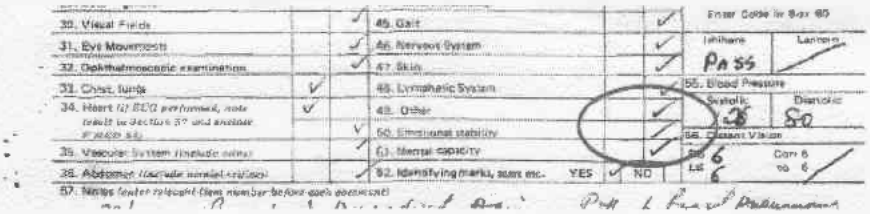
DECISION

I have decided that Anxiety Disorder and alcohol dependence are not related to service.

Veterans' Affairs had made a decision against me on a claim that the Department had concocted.



An image of the carbon copy of my Army medical discharge certificate.



An image of my Army medical discharge certificate that the Government has fraudulently altered to prevent me from receiving a disability pension for PTSD and other injuries.

Annexure 3 - Correspondence with Commonwealth Ombudsman

Commonwealth OMBUDSMAN

Level 5, 14 Childers Street, Canberra
GPO Box 442, Canberra ACT 2601
Phone 1300 362 072 ■ Fax 02 6276 0123
ombudsman@ombudsman.gov.au
www.ombudsman.gov.au

Our ref: 2013-501229

20 May 2013

Mr John Lawler

Dear Mr Lawler

Thank you for your complaint of 17 May 2013 about the Department of Veterans' Affairs (DVA).

As I advised in our telephone conversation on 20 May 2013, our office has decided to investigate your complaint and I will contact you when I have had an opportunity to consider the response from DVA.

As we also discussed, you may wish to contact the Office of the Australian Information Commissioner (OAIC) about your claim that the Department of Defence altered documents relating to your discharge. The OAIC has responsibility for investigating complaints about the use and / or release of personal information by Commonwealth agencies. You can contact the OAIC on 1300 363 992 to discuss your complaint. Information about the OAIC can be found at http://www.oaic.gov.au/about/contact.html .

If you need to contact me, please use the contact details at the top of this letter.

I enclose a copy of our brochure *Making a complaint to the Ombudsman,* which explains the Commonwealth Ombudsman's role in more detail. This information is also available on our website at www.ombudsman.gov.au.

Yours sincerely

Senior Investigation Officer

Annexure 3 - ~~Correspondence with Commonwealth~~ Ombudsman

TRANSMISSION VERIFICATION REPORT

TIME : 22/07/2013 15:00
NAME : BAROSSA LIBRARY
FAX : 0885623230
TEL : 0885621107
SER.# : 000M6J492715

DATE,TIME	22/07 14:56
FAX NO./NAME	0870880699
DURATION	00:03:10
PAGE(S)	10
RESULT	OK
MODE	STANDARD ECM

Annexure 3 - Correspondence with Commonwealth Ombudsman

COMMONWEALTH OMBUDSMAN ADELAIDE

ATTN.

FAX

22/7/13

22 July 2013

The Hon Kevin Rudd MP
Prime Minister
Parliament House
CANBERRA ACT 2600

Dear Prime Minister,

On 2 May I wrote to both the Minister for Veterans' Affairs, Warren Snowden, and the Defence Minister, Stephen Smith outlining the following issues.

- Fraudulent alteration of my official documents;
- Illegal and criminal behaviour towards me;
- Hiding of serious criminal assault and rape on three occasions over a thirty six year period;
- Miserably failing in their duty of care both legally and morally towards me.

To date I have received no reply, nor even an acknowledgement of my letter, from either Minister.

On 17 May I also sought assistance in this regard from the Commonwealth Ombudsman and provided them with a copy of the letters I had sent to the ministers, together with a copy of the statement I had submitted to DLA Piper Review. I have attached copies of these documents.

On 20 May I received a telephone call acknowledging my complaint from Senior Investigation Officer with the Commonwealth Ombudsman, and I subsequently received a letter of confirmation of the same date.

On or about 13 June I contacted by telephone to enquire about progress with my matter. She advised that she had given the Department of Veterans' Affairs additional time of three weeks to respond to her enquiries because they were also in the process of dealing with a "Ministerial" in relation to my file.

I again contacted on or about 4 July to ascertain whether she had received a response from the Department of Veterans' Affairs. She advised no reply had been received. She told

me she would follow up on her request and advise me of the outcome when she returned from a weeks' leave on 15 July.

I telephoned the Ombudsman's Office on 17 July and was advised that was away on sick leave. I asked to speak to the staff member who was dealing with her work in her absence but was told no-one was doing so. I asked to speak to an immediate or superior supervisor and was eventually told that someone would call me back.

On 19 July, I received a telephone call from who advised that if r was still absent this week she would telephone me this morning.

Having heard nothing by midday I telephoned the Ombudsman's Office and eventually spoke to She advised me was still absent on holiday leave and after I again asked to speak with a senior supervisor she said that she would speak to someone.

I pointed out that my matter had been with the Ombudsman's Office for almost 10 weeks and that my ongoing claim with the Department of Veterans' Affairs was potentially being prejudiced by these delays.

I again asked to speak to a manager, and this afternoon I have been contacted by Acting Senior Assisting Ombudsman. He told me that the Ombudsman's office had been in contact with the Department of Veteran's Affairs and had been advised that a response had been sent by the Department to email account a week ago. However, the Ombudsman's Office was not sure if another staff member would be able to access account in her absence. If this was the case, the Ombudsman's Office would contact the Department and have the response resent. He also promised to follow up on my case with the relevant staff when he is in Canberra this coming Thursday.

I understand that public servants need to take leave and that winter is a bad time for people being sick. What I fail to understand is why there are no contingencies in place for work to continue in their absence.

After thirty six years of Army, DVA and Australian Government Departmental incompetence I have had enough.

I look forward to receiving your response.

Yours sincerely,

John Lawler

Annexure 3 - Correspondence with Commonwealth Ombudsman

2 May 2013

Stephen Smith, MP
Warren Snowdon, MP
Ann McEwen, Senator
David Johnston, Senator
Michael Ronaldson, Senator

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The reason the ADF, DVA, Repatriation Commission and successive Federal Governments' have hidden this abuse is because if the abuse became public it would reflect badly on the ADF. It would cost the ADF money and reputation and would damage their recruiting efforts.

If the assault upon myself whilst attempting to prevent the rape had been put in the public domain, I most likely would have received an award like the Cross of Valour for "an act of conspicuous courage in circumstances of extreme peril", but the ADF could not afford to let that happen, the ADF's reputation was at stake.

It is the appalling behaviour of the ADF in the past that has caused the mental illnesses of veterans like myself, and it is the current appalling behaviour of the DVA that is continuing and exacerbating the abuse under the umbrella of the Australian Governments. The stonewalling and delaying tactics the DVA engages in deny and delay our claims until we give up, die of old age or commit suicide.

Yours sincerely,

John Lawler

In 2003 I informed The Veteran's Review Board the criminal assaults had taken place as indicated.

VETERANS' REVIEW BOARD

Mr Lawler described to the Board an incident in 1975 (sic), when he was assaulted at Randwick Barracks and severely beaten. He said that he believed that his back was injured in the assault and the later march aggravated his spinal injuries. The Board was unable to find any record of medical treatment following the assault in 1975. (sic)

The Repatriation Commission. The DVA and the ADF did not further investigate the criminal assault upon myself or the rape of the female soldier that I was attempting to protect. The assault and rape were reported at the time to the authorities in 1976, in 2002 and in 2011 with no result.

VETERANS' REVIEW BOARD

Decisions under review:

The Repatriation Commission decisions of 3 May 2002, which refused claims for thoracic spondylosis, cervical spondylosis and anxiety disorder.

Decisions of the Board:

On 29 January 2003 the Veterans' Review Board decided to:

- **AFFIRM** the decisions under review in relation to thoracic spondylosis, cervical spondylosis and anxiety disorder. This means that the Repatriation Commission's decisions are unchanged in relation to those matters.

This is part of a report from to the DVA in 2002. is the DVA psychiatrist.

Given that Mr. Lawler has yet to receive the benefit of psychiatric treatment I would take a conservative approach and rate his current mental state as *"temporary"*. Should there be no change with eight to ten months of psychiatric treatment I would consider his psychiatric state to be *"permanent"*.

Although DVAs' psychiatrist has stated that my psychiatric condition was service related and will become permanent without treatment, the DVA did not offer me any treatment and refused my claim. My psychiatric impairment has now become permanent.

Commonwealth Department of
Veterans' Affairs

3 May 2002

Telephone: 133 254
Country Calls: 1800 555 254
Facsimile: (08) 8290 0498

Dear Mr Lawler,

This letter is to advise you of my decision on the disability pension claim you lodged on 20 August 2001.

DECISION

I have decided that thoracic spondylosis, cervical spondylosis and anxiety disorder are not related to service.

Annexure 3 - Correspondence with Commonwealth Ombudsman

Australian Government
Department of Veterans' Affairs

On two occasions the Department of Veterans' Affairs told me to spend my money to be tested for sleep apnoea and to have an inspection of my teeth by a dentist. I hold a DVA White Card. The DVA said they would refund the money I had spent and then follow up with further treatment. When asked to pay for the consultations and further treatment, DVA refused. Under Promissory Estoppel it is illegal for the Government to tell a person to spend money and then advise them the Government has changed its mind about a refund and further treatment.

Dear [redacted],

I write with regard to your request for DVA to fund dental treatment for Mr Lawlor.

Unfortunately, Mr Lawlor is not currently covered under his White Card for dental treatment.

Dear Mr Lawler,

I am writing to you in response to a request received in this office on the 14th May 2012, from your Psychiatrist [redacted] for the supply of a CPAP machine and consumables.

In examining the request it is noted you are a white card holder and you do not have an accepted disability (sleep apnoea) that relates to a clinical need for the supply of a CPAP machine. Based on this information it has been determined that you currently do not meet the Department's criteria for the supply of CPAP equipment and I therefore must advise that the request for the supply of CPAP equipment has been declined. An advice letter has been forwarded to [redacted]

Australian Government
The Repatriation Commission

On 31 August 2011, Mr Lawler, the veteran, lodged a claim for 'depression; anxiety and stress'.

I am satisfied that the appropriate medical diagnoses for the claim are:

- Anxiety Disorder; and
- alcohol dependence.

The Repatriation Commission had changed my claim without my knowledge or authority.

Australian Government
Department of Veterans' Affairs

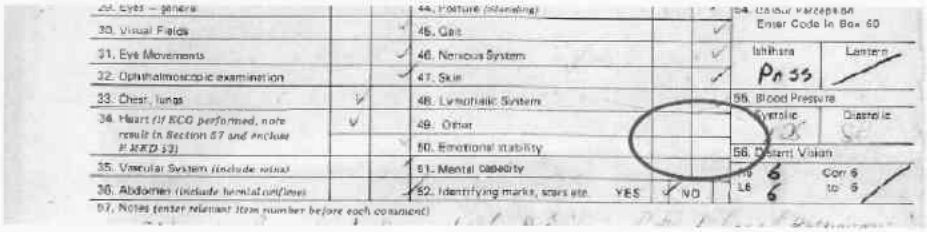
Dear Mr Lawler,

This letter is to advise you of my decision on the disability pension claim you lodged on 31 August 2011.

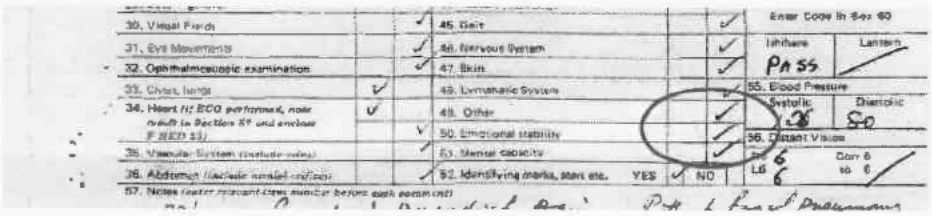
DECISION

I have decided that Anxiety Disorder and alcohol dependence are not related to service.

Veterans' Affairs had made a decision against me on a claim that the Department had concocted.



An image of the carbon copy of my Army medical discharge certificate.



An image of my Army medical discharge certificate that the Government has fraudulently altered to prevent me from receiving a disability pension for PTSD and other injuries.

Annexure 3 - Correspondence with Commonwealth Ombudsman

DLA PIPER

PART 2 - PERSONAL DETAILS AND BACKGROUND

Section 2A - Personal Details

1. Your current title	☒ Mr	☐ Mrs	☐ Ms	☐ Miss	☐ Dr	→ or Rank	**2. Your Rank or APS level** (Current or at separation from Defence)	L/cpl		
3. Your name (and any previous names)	John Osborne Lawler									
4. Your PM Keys, Regimental or AGS Number							**5. Your date of birth**	6/10/1948		
6. Your gender	☒ Male	☐ Female	**7(a). Are you currently with Defence**				☐ Yes	☒ No	**7(b) If No, when did you leave Defence?**	2/6/1981
8. Your Unit, Ship or Area in Defence (Current or at separation from Defence)	Chief Engineers Office Keswick Barracks 4MD						**9. Your contact No and the best time to call:**			
10. Your Postal Address							**11. Your email:**			
							Dated: 19 / August / 2011			
Suburb			**Postcode**				**12. Your signature (above)**			

Section 2B - Background in Defence

13. Please give a general description your history with Defence i.e. when you first joined **and** what your role in Defence is/has been. [add more sheets or an employment history if that is convenient)

Date of enlistment 3/June/1975 I was corps enlisted into the Army as a qualified Architectural Draftsman.
Following Basic and Corps training my first posting was to the Chief Engineers Office Victoria Barracks Sydney on 3 1 1976 as an Architectural Draftsman.
My second and final posting was to the Chief Engineers Office Keswick Barracks Adelaideon the 15/ 12/ 1976 to 2/6/1981 as an Architectural Draftsman until my honourable discharge.

DLA PIPER

Please complete a copy of this Statement Form for each incident/conduct

Section 3B - Details of the person who suffered the abuse (the 'subject')

14. What was the date(s) or period of the incident/conduct?	Mid 1976		**15. Are you the subject of the incident/conduct?**	☒ Yes	☐ No		
				If yes - go to question 20			
16. How did you find out about the incident or conduct? (eg the subject told me about it a week after it happened.)	Attach a sheet marked 'Answer to Q 16' with statement if necessary						
17. What is the name of the subject? (If the subject's name was different at the time, please include the subject's name at the time?)							
18. Does the subject know that you are informing the Review about this incident or conduct?	☐ **Yes**	☐ **No**	If No, explain why not (Attach a sheet marked 'Answer to Q 18' if necessary.)				
19. If you answered 'Yes' to Q 18, has the subject agreed to you giving information to the Review?	☐ **Yes**	☐ **No**	If No, explain why not (Attach a sheet marked 'Answer to Q 19' if necessary				
20. What was the Rank or APS position of subject at the time?	Sapper in the Royal Australian Engineers		**21. What was the subject's age at the time?**	27 yrs	**22. What was the subject's gender?**	☒ Male	☐ Female
23. Was the subject in Defence at the time?	☒ **Yes**	☐ **No**	If no- how was the subject connected with Defence (Attach a sheet marked 'Answer to Q23' if necessary.)				
24. If yes to Q 23 - what part of Defence was the subject in at the time?	☐ Navy	☒ Army	☐ Airforce	☐ ADFA			
	☐ School Cadets	☐ Dept	☐ Unknown	☐ Other (specify) →			

DLA PIPER

Section 3C - Details of the person(s) who carried out the incident/conduct (the perpetrator(s))

If there are more than two perpetrators, please add sheets providing the same information for each perpetrator marked 'Perpetrator 3', 'Perpetrator 4' etc.

Perpetrator 1 name	?	**PMKeys/Service /AGS No.**	?			
Rank or APS Position at time	corporal	**Age at time (Approx)**	?	**Gender**	☒ Male	☐ Female
Current rank/APS position .	?	**Current posting/APS area of Department**	?			

Perpetrator 2 name	?	**PMKeys/Service /AGS No.**	?			
Rank or APS Position at time	?	**Age at time (Approx)**	?	**Gender**	☒ Male	☐ Female
Current rank/APS position	?	**Current posting/APS area of Department**	?			

Section 3D - Details of the person(s) who witnessed the incident/conduct (the witness(es))

If there are more than two witnesses please add sheets providing the same information for each witness marked Witness 3', Witness 4' etc.

Witness 1 name		**PMKeys/Service /AGS No.**	?			
Rank or APS Position at time	Private	**Age at time (Approx)**	20	**Gender**	☐ Male	☒ Female
Current rank/APS position	?	**Current posting/APS area of Department**	?			

Witness 2 name		**PMKeys/Service /AGS No.**	?			
Rank or APS Position at time	Corporal	**Age at time (Approx)**	25	**Gender**	☒ Male	☐ Female
Current rank/APS position	None	**Current posting/APS area of Department**	None			

Section 3E - General information about the incident/conduct

25. Where did the incident occur?	Randwick Barracks Sydney						
26. What was the subject's status at the time?	☐ APS	☒ Normal ADF duty	☐ Under training	☐ Deployed	☐ School Cadet	☐ Other specify →	
27. How was the perpetrator related to the subject? (If there is more than one perpetrator, please explain relationships in the description below.)	☐ CO/ OIC	☐ Supervisor	☐ Subordinate	☐ Teacher Trainer	☐ Senior Co-worker	☐ Co-worker	☒ Other specify →	Did not know any of the perpetrators

Annexure 3 - Correspondence with Commonwealth Ombudsman

DLA PIPER

Section 3F - Description of the incident/conduct

28. Please describe the incident or conduct (add extra sheets marked 'Answer to Q28' or copy this sheet if necessary. If you already have a written statement of the incident/conduct please attach a copy.) Please see Part 3A above explaining what kind of information and detail we are asking for.

While posted to the Chief Engineers's Office, Victoria Barracks in Sydney, in mid 1976, I was assaulted by a group of male soldiers. I was beaten about the head and body and rendered unconscious while attempting to prevent what I believed was the imminent sexual assault (rape) of a female soldier.

The events that led to the assault are as follows:
- I was returning to my accommodation block at Randwick Barracks in the evening, I believe that I had been on guard duty, and was passing through the car park at the rear of the O.R.'s mess, which had closed for the night.
- I noticed a female soldier that I worked with at the C.E.'s office. She was with a group of male soldiers (approximately 6 who all appeared sober). One of the male soldiers was a corporal.
- I said hello as I was passing and noticed that was intoxicated. While I was talking to the corporal said that his car was next to us and that I could "go first".
- I believed that may have been at risk of assault or possibly rape, so I sat in the car and talked to her for about twenty minutes in an attempt to allow her to sober up.
- While I was sitting in the car with her, the car door opened and I was pulled out of the car onto the ground by the corporal who was infuriated and who, with at least one of the other soldiers, began to beat me to unconsciousness about the head and body with their fists while I was on the ground.
- I woke up twenty minutes later and found , the car, and the soldiers gone.
- I was extremely concerned about welfare and immediately went to the officer's married quarters at the barracks and raised the alarm to a male officer.
- I was advised to return to my accommodation block by the officer.
- The next day I attended work with abrasions and black eyes. I was interviewed that day by a sergeant in the military police. He stated to me that I must have had an involvement with to be so concerned. I replied to him that I was in a committed relationship with a woman in Adelaide and was about to be married. The sergeant discontinued the conversation. I heard nothing of the incident following the interview.
- arrived at work two days later and thanked me for my help that evening.
- She told me that the Military Police had asked her to change corps to the Military Police, and that she could be transferred to Recruiting, and that maybe there was a promotion in the offering.

I have recently contacted two former soldiers in the C.E.'s Office. One of the soldiers stated that he remembers the incident where I "defended The other said that finished her service in the Army with the Military Police in Recruiting as a Warrant Officer. I have the contact details for these two witnesses. is witness to the assault. Currently I am receiving treatment from a Councellor, a Doctor, a Mental Nurse and a Psychiatrist.

Annexure 3 - Correspondence with Commonwealth Ombudsman

Commonwealth OMBUDSMAN

Level 5, 14 Childers Street, Canberra
GPO Box 442, Canberra ACT 2601
Phone 1300 362 072 ▪ Fax 02 6276 0123
ombudsman@ombudsman.gov.au
www.ombudsman.gov.au

Our ref: 2013-501229

13 August 2013

Mr John Lawler

Dear Mr Lawler

I am writing to let you know I have finished investigating your complaint about the Department of Veterans' Affairs (DVA). I have decided that, in the circumstances, no further investigation is warranted. My reasons are provided below.

As discussed in our telephone conversation of this morning, in coming to my decision I have considered what you have said to us and I have also examined the relevant legislation and documents as well as the answers to questions I have asked of DVA.

You advised us that, whilst serving in the Australian Army, you were seriously assaulted in an incident at the Randwick Barracks in 1976 when you went to the assistance of a female soldier who was being sexually assaulted. As a result of this incident, you state you have suffered a number of medical conditions. You advised that DVA has declined your claims for a disability pension for these conditions.

DVA has advised me that it has considered your claims. Although DVA has raised concerns regarding the availability of evidence to support your claim regarding the alleged incident in 1976, an issue which you are currently addressing, DVA advised that the reason your claim was declined was because the medical conditions arose from an incident that was not service related.

Having examined the relevant sections of the *Veterans Entitlements Act 1986* (VEA) I note that, for the purposes of the VEA, an injury is only deemed to have been Defence caused, or service related, if it resulted from an incident that occurred during war-like or peacekeeping service, whilst performing hazardous duties (as defined under the VEA) or as a result of travelling to or from duty. The incident you reported as happening at the Randwick Barracks in 1976 does not conform to any of these conditions. Therefore, DVA's decision that you conditions are not as a result of your service was reasonably open to it to make.

However, as discussed, while DVA's decision with regard to your eligibility under the VEA is consistent with the legislation in question, it is open to you to seek redress through alternative means. This may include a claim under workplace safety laws. If you wish to pursue alternative remedies, I recommend you seek independent legal advice to discuss the appropriate avenues.

However, notwithstanding the above, I am also advised that your appeal to the Veterans' Review Board (VRB) with regard to the decisions relating to your anxiety disorder and alcohol dependence, lodged on 19 March 2012, has not been finalised. DVA has advised me that you have not lodged a Certificate of Readiness to proceed with a VRB hearing.

I have also examined the issues regarding your claim, in relation to your dental treatment and tests for sleep apnoea, that DVA advised you to seek treatment at your own expense before seeking reimbursement from DVA. You advised that DVA declined to reimburse you, after you had already incurred the expenses. You advised that DVA had misled you into believing that DVA would pay these costs.

DVA acknowledges that it does provide general advice to veterans, seeking treatment for conditions that have not yet been accepted by DVA, that it is open to the veteran to obtain the relevant treatment at the veteran's own expense and then seek reimbursement from DVA. However, payment by DVA is dependent upon a successful claim being lodged with DVA in relation to the condition in question. DVA has advised that, to date, you do not have accepted service-related conditions relating to sleep apnoea or the need for dental treatment. Nor have you lodged appropriate claims seeking acceptance of such conditions.

I have examined DVA's publically available information relating to this advice. DVA's Factsheet HSV64 clearly advises that reimbursement of medical expenses can be made where you have submitted a claim to DVA for the related condition, and only once that claim has been accepted.

I also note that you currently hold a White Card from DVA. As you are no doubt aware, the use of a White Card is limited to the payment of treatment related to the specific medical conditions accepted by DVA and for which your White Card has been issued.

Based on the information available, DVA's decision is not unreasonable. However, it is open to you to lodge appropriate claims if you believe that the medical conditions, requiring treatment for sleep apnoea or the need for dental treatment, are service related.

Given the above, I propose to finalise my investigation of your complaint at this point. I understand that this may not be the outcome you wanted, but I do not think further investigation would achieve a different result.

As discussed, I will now finalise your complaint and close your record.

Thank you for bringing your concern to the attention of the Ombudsman's office.

Yours sincerely

Investigation Officer

Annexure 3 - Correspondence with Commonwealth Ombudsman

John Lawler

2 September 2013

Commonwealth Ombudsman
GPO Box 442
CANBERRA ACT 2601

Dear Ombudsman,

I refer to your letter of 13 August 2013.

I am writing to you to bring to your attention that in your letter you failed to deal with **all** of the items noted in the letters that were delivered, faxed and emailed to The Commonwealth Ombudsman, dated the 17/05 2013, 22/07/2013 (attention), and 3/08/2013 (attention:), respectively.

You failed to deal with entirely the 'Fraudulent alteration of my official documents', even though you were presented with the evidence.

Even though you were presented with the evidence concerning the sleep apnoea and dental treatment issues, you failed to recognise that both of the treatments were being claimed as necessary for my anxiety treatment which is allowed under my white card.

It is apparent that the evidence presented to your office by myself has been ignored, and incorrect information received from DVA has been regurgitated as being fact. This brings the Commonwealth Ombudsman's impartiality into question. I have not outlined section by section my evidence which repudiates your comments but will ask your office to read the evidence as presented in the three letters which you hold.

I look forward to hearing from you regarding these matters in the near future.

Yours sincerely,

John Lawler

John Lawler

3 August 2013

The Hon Warren Snowden, MP
Minister for Veterans' Affairs
Parliament House
CANBERRA ACT 2600

Dear Minister,

I refer to a letter from your Chief of Staff, , dated 26 July 2013, responding to my letter to you dated 2 May 2013.

My responses to letter are set out below. To make it clear which element of his letter I am referring to, I have also incorporated the text of his letter herein, and make my comments below the pertinent sections.

> Thank you for your email of 2 May 2013 to the Minister for Veterans' Affairs and other addressees, concerning your dealings with the Department of Veterans' Affairs (DVA). This matter falls within the portfolio responsibilities of Minister Snowdon, who has asked me to respond on his behalf. I apologise for the delay in replying.

I note the apology regarding the delay in replying, but would like to bring to your attention, that until I received letter, I had not received any acknowledgement from your office that my correspondence had been received.

> For compensation to be payable under the *Veterans' Entitlements Act* 1986 (VEA) there must be an injury or disease as defined under the Act. Only when it has been established that an injury or disease is present can the relationship of the claimed signs and symptoms to service be considered.
>
> Whether or not an injury or disease is present in a particular case and, if it is, the appropriate diagnosis of that injury or disease, is a matter for medical opinion. As it was the opinion of consultant psychiatrist that the conditions you claimed in 2011 as "depression, stress and anxiety" were generalised anxiety disorder and alcohol dependence, they were from that point onwards referred to in that way by DVA.

As I claimed previously in the letter forwarded to you and others dated 2nd May 2013. "On the 18/6/2011 I applied for a Disability Pension for "depression, anxiety and stress" which the DVA acknowledged. I was then refused my application for "anxiety disorder and alcohol dependence". DVA had changed my claim without advising or consulting with me and (their) claim was forwarded to The Veterans Review Board.

The diagnosis in the report dated 14/10/2011 by (DVA psychiatrist) stated:

"17. DIAGNOSIS
Given the history Mr. Lawler gave to me on this occasion was quite different to what he gave me last time and given there appears to be quite a considerable amount of information which would assist me I would like to see the following information before offering an opinion on diagnosis and causation.

- The details and dates of his drink/driving offences.
- His military charge sheets and records of any disciplinary issues in the military (particularly related to alcohol).
- Mr. Lawler showed me a document which indicates a chronology of events and I would like to see this.
- His medical records from the army (he said he presented to the RAP in relation to symptoms which he attributed to the assault).
- His drug and alcohol questionnaire (from this claim and the last claim).
- report from 1983.
- Reports, notes or letters from
- Any information from
- Mr. Lawler's various claim forms.
- The determination from the Veterans' Review Board in relation to Mr. Lawler's various claims."

The Claims Officer dealing with my case, never asked me for the information held by me that requested.

After I had lodged my application for appeal to the VRB, I had several confusing and distressing phone calls with Claims Office , asking when DVA/VRB would request the additional information I held. My distress reached such a point that my wife had to eventually speak to a supervisor, , who advised her it was appropriate for me to submit whatever additional evidence I held to support my claim, at this stage of the process. He also acknowledged that the Application for Review form was misleading and confusing in that it did not provide information to this effect. apologised for the manner in which I had been treated.

Further, at no time did DVA request that I complete an Alcohol Questionnaire, although I have since been told this should be standard procedure. It was not until my 2011 claim was appealed to the Veteran's Review Board that I was asked to complete this document. At no time have I been asked to complete a Smoking Questionnaire.

A following letter on the 23/11/2011 from claims:

"7. DIAGNOSIS

I preface my response by noting that you have forwarded some of the information to me that I requested to see but not all of the information and in particular I have not seen the following:

- The details and dates of his drink/driving offences.
- His military charge sheets and records of any disciplinary issues in the military (particularly related to alcohol).
- Mr. Lawler showed me a document which indicated a chronology of events and I would like to see this.

- His drug and alcohol questionnaire (from this claim and last claim).
- report from 1983.
- Reports, notes or letters from .
- Any information from

Further, on page 6. states:

> "When taking into account the factors I have just discussed, it is my clinical opinion, based upon a reasonable degree of medical probability that Mr. Lawler is suffering from a **Generalized Anxiety Disorder.** His **Alcohol Dependence** is in remission.
>
> 9. DISABILITY
>
> Given that the facts are currently unclear which means that issues of causation are far from clear I will defer a disability rating until the decision-maker advises me what are the facts in this case."

Clearly felt he was unable to make a clear diagnosis because critical information that he had requested from DVA was not forthcoming. The information that requested from DVA contained important information concerning the criminal assault upon me, the rape of , the subsequent effects on my mental health and the eventual diagnosis of my PTSD by . Despite advising that his diagnosis was offered in the absence of this information, she chose to determine my claim on the basis of an incomplete assessment.

> I understand that you hold a White Repatriation Health Card for Specific Conditions -also known simply as a White Card -that entitles you to treatment for your anxiety disorder only. I have been advised that you have no eligibility for dental treatment and that DVA has no record of you seeking such treatment at DVA's expense at any time.

The claim that DVA holds no record of me seeking assistance with dental treatment is not true. My enquiries about assistance with dental treatment started on a date I did not record, and with a member of DVA staff who did not offer her name, and whose name I did not request. I was told that DVA would contribute an amount, which I recall as being $61, toward the cost of a dental examination. I was also told that if that examination revealed damaged to my teeth arising from my mental health condition, for example damage caused by tooth grinding, DVA would cover the cost of the treatment. On the basis of this advice I attended , who completed an examination. then wrote to DVA on 6 June 2012 seeking approval of the cost of his proposed treatment. DVA denied this request in a letter dated 21 June 2012 from , Medical and Allied Health Services, to . Following this I personally paid account for the examination. Copies of these letters and account are attached.

The White Card was not forthcoming until my psychiatrist submitted a claim for treatment on my behalf on 3 February 2012 on the basis of his diagnosis for PTSD. Prior to the application by I was not advised by DVA and did not know about the DVA White Card. told me that it had taken him five phone calls to DVA to ascertain whereabouts on the DVA website he could access the application form.

A letter I received from DVA dated 16 March 2012 states that "Approval has been given for you to receive treatment for anxiety disorder at the expense of the Department with effect

from 20 May 2001," and that a White Card would be forthcoming. The Department ignored the PTSD diagnosed by , even though, as stated in afore mentioned letter, "Whether or not an injury or disease is present in a particular case and, if it is, the appropriate diagnosis of that injury or disease, is a matter for medical opinion".

It is interesting that DVA continue to privilege the diagnosis of , made on the basis of one consultation, and, on his own admission, offered in the absence of significant and crucial information, over that of who has had numerous consultations with me since I started seeing him in February 2012. Further, despite the outstanding information requested by subsequently being submitted by me, DVA has not sought to have him revisit his diagnosis.

> In May 2012, DVA received a request on your behalf from your treating psychiatrist, , for a CPAP machine for treatment of sleep apnoea. This request was not approved because you do not have eligibility for treatment of sleep apnoea and because a psychiatrist is not an eligible prescriber of CPAP machines. I understand that both you and (sic) were advised in writing of this at the time.
>
> It does happen from time to time that a veteran will seek treatment at DVA expense for a condition that has not been accepted as service-related. In such circumstances, the only way to extend eligibility is to lodge a claim for disability pension and medical treatment under the VEA in respect of that condition. Should the veteran not wish to delay treatment pending the successful outcome of such a claim, he or she will have no choice but to incur the expense and seek reimbursement from DVA at a later date.

With regard to the matter of the CPAP machine, DVA seems intent on, once again, deliberately missing the point of the request. The request was made on my behalf by on the basis that it was **part of my treatment for my mental health condition** because sleeping well is a crucial aspect of improving mental health. In fact, a number of brochures published by DVA attest to this fact.

When I contacted DVA (Adelaide office) to follow up on request, they denied all knowledge of having received his letter, which had been sent by facsimile transmission to , RAP Division. I contacted office and they obliged by sending the letter again. I waited in the DVA office until they confirmed it had been received. In the meantime, the staff member at the reception desk had given me a Claim for Disability Pension form and told me to complete that as part of my request. I tried at length to explain to him that I did not want to claim sleep apnoea as a service related injury and had no intention of wasting everybody's time by doing so. Rather, I wanted to be able to claim treatment for sleep apnoea as part of my mental health treatment, for the reasons stated above.

The situation became increasingly distressing and frustrating and I eventually had to leave the office, leaving my wife to deal with the matter. She asked to speak to a supervisor and was eventually seen by (a manager) and . She had a lengthy conversation with and , explaining my situation and reiterating the point that the request was being made on the basis that it was part of the treatment for my accepted condition and **not** as a claim for a service related condition. and acknowledged this point of view, but said it was highly probable that any request in this regard would be denied because the staff involved would not be able to see the correlation. gave my wife a form for completion by my sleep physician and made the offer that if I were to bring the completed form into her, she would forward it to the relevant division with DVA, with a supportive comment as to why it should be approved.

In the meantime, letter of 3 May 2012 appears to have been forwarded to RAP Queensland. , Client Services, replied most promptly on 16 May 2012 declining the request. Her letter did not advise that was not an approved prescriber for CPAP machines. She did, however, cite the National Schedule of Equipment as specifying "which prescribers are eligible to prescribe the items listed". If DVA believes this constitutes advising and I that he is not considered eligible to prescribe CPAP as a treatment then they are sadly mistaken. I was not given a copy of that Schedule, nor was I told where I might be able to access a copy. I was also, once again, given what now appears to be the stock standard response that I should lodge a claim to have sleep apnoea recognised as service related. As I have said previously, this would have been a futile exercise, because it is not service related. Copies of these letters are attached.

Given the state of my mental health and the increased distress this specific matter was causing me, both my wife and I decided this particular battle should be deferred and pursued at a later date. Several months latter, called and spoke to my wife. She told my wife she was leaving her current position within DVA, and was following up on outstanding matters prior to her departure. She asked if I had taken the matter further, and my wife said no. advised that if I wanted to proceed it would be best to contact either , National Manager of RAP, in Melbourne, or , the Assistant Director of R & C. Having no faith in any assistance DVA purports to offer, I have chosen not to do so thus far.

> It was indeed open to DVA in 2002 and again in 2011 to have extended eligibility to you for treatment of your anxiety disorder, and it is regrettable that this was not done. This was noted in March 2012 when determining your formal application for this treatment, and it was in view of this that your eligibility was backdated to 20 May 2001, three months prior to your original claim.

The statement that "it is regrettable" DVA failed to advise me of my eligibility for treatment of my condition under the White Card facility is trite and offensive. In my view it is has been extremely detrimental to my physical and mental health and in this regard DVA have been exceptionally negligent.

In 2002 advised DVA that:

> "I would recommend that Mr. Lawler attend a Psychiatrist for psychotherapy and psychotropic medication. … He would also benefit from seeing a Psychologist or attending the Vietnam Veteran's Counselling Service."

And

> "Given that Mr. Lawler has yet to receive the benefit of psychiatric treatment I would take a conservative approach and rate his current mental state a "temporary". Should there be no change with eight to ten months of psychiatric treatment I would consider his psychiatric state to be "permanent".

If DVA had advised me that they could assist with treatment, I would have taken it. However, they did not, and my mental health has deteriorated further and my quality of life is accordingly reduced and my disability is now permanent.

When I received the letter from DVA regarding the grant of the White Card I took the date of 20 May 2001 noted therein to be a typographical error, as it made no sense otherwise. Even though letter confirms that this date is indeed correct, it remains unclear as to what effect the back dating of my eligibility for a White Card is intended to have, as it is clearly not

possible for me to retrospectively seek treatment and, as I have not been able to afford to seek treatment in the past, I had no expenses to claim.

discusses in his report of 23/11/2011 the criminal assault that took place upon me in 1976, and the consequences of the assault, and comments that the Veterans' Review Board knew of the assault in 2003. At no point has DVA mentioned, discussed or investigated the report of criminal assault and rape. did not raise the issue of the assault or rape in his interview, I did.

Following the letter from your Office and this response to it, the Government of Australia has now been notified on five separate occasions of the criminal assault against myself and the rape of (nee) in 1976, with no result for 36 years.

> I understand that it was found on 12 December 2011 that your anxiety disorder and alcohol dependence were not service-related. I have been advised that an appeal to the Veterans' Review Board (VRB) was lodged on 19 March 2012 and that the VRB is awaiting your lodgement of a Certificate of Readiness before proceeding to a hearing.
>
> The Minister has no power to influence decisions made by independent authorities such as the Repatriation Commission and its delegates, nor does he have any discretion to review or intervene in any individual case. The VRB is now the appropriate forum within which to resolve the matter of the relationship of your anxiety disorder and alcohol dependence to service.

As you are no doubt aware, part of the appeals process under the Veterans' Entitlements Act is that DVA has the opportunity to review all claims, prior to referral to the VRB. My file indicates that DVA did not take the opportunity this part of the process afforded them to take further evidence or to conduct further investigation. Instead they abdicated their responsibility in this regard by choosing not to review my case and referring it to the VRB. I am fully aware that, following DVA's decision not to review my case, a determination of my claim by the VRB is the next step in the claims process specified by the Act.

My previous experience with the VRB in 2003 has shown that the hearings granted to veterans are predicated on a significant imbalance of power. Firstly, the members of the VRB are serving or former high ranking officers, which is in itself intimidating, particularly for veterans like myself who suffer from mental illness. Secondly, the VRB also enjoys the benefit of legal counsel, as one member of the board is usually a legal practitioner, but veterans are denied similar equity in legal representation, by only being allowed to engage the services of volunteer, DVA trained, advocates.

My records show that I told the VRB about the assault and possible rape in 2003. However, what is not shown in my records is that my testimony was summarily dismissed by one member of the VRB with a flippant comment to the effect of: "I suppose you want to claim for **that** now". No further evidence concerning the assault was taken.

As Minister, perhaps you may be able to offer some assurances that, when and if I appear before the VRB in relation to my current claim, the VRB will consider all the evidence necessary to determine the matter fairly this time. You may also wish to consider how the considerable inequity in the power relationships present in the current process can be redressed.

Finally, the most important point I want you to understand, is that DVA seem intent on ignoring the fact that the assault I suffered, and the possible rape of are beyond the scope of the VEA legislation, and that at least one, and quite likely two crimes occurred. In this regards, the Army, the VRB, DVA and now your office, have failed to act on the reporting of a crime and failed to act on their duty of care.

> In your letter you also refer to the alteration of your medical records, highlighting in particular variations in boxes 49 to 51 on copies of the final medical board form completed at the time of your discharge from the Australian Army. The Department of Defence was asked to investigate your concerns.
>
> I have been advised that your Central Medical Record (CMR) has been reviewed. Boxes 49 to 51 have been completed on the copy of the final medical board form filed on your CMR, and the ticks appear to be similar in nature to the others on that form.
>
> Defence has advised, however, that your CMR contains a letter from Health Records, dated 18 May 1981, stating that boxes 49 to 51 were not originally completed, and indicating that the documents were returned to the medical centre for completion of this section. This implies that this section was completed at a later date. There is no evidence to explain why these sections were not completed at the time of the original final medical board.
>
> Defence has advised that returning your final medical board documentation to the medical centre for completion was appropriate and consistent with the policy of the time. In addition, the completion appears to have been undertaken by the same medical officer undertaking the final medical board, and within a timeframe to make this completion accurate and appropriate.
>
> In view of this, it appears likely that the original copy you received as part of your discharge process was a true copy of the final medical board, before the board paperwork was returned in order to complete boxes 49 to 51.

I did not receive any copies of my medical records as part of my discharge process.

The copies of my medical and dentals records which I now hold were forwarded to me on 9 November 2001 by *Australian Defence Force Health Records – Army*. The covering letter described these documents as:

> "your Unit Medical Record (UMR) which is a duplicate copy of your Central Medical Record (CMR)."

These documents do not contain a letter dated 18 May 1981 concerning boxes 49 to 51. The ticks that have been placed in those boxes are noticeably different from all of the others on the sheet of paper.

If the claim that my final medical board documents were returned to the medical officer concerned shortly after my final examination is true, then I question why all copies of the documents were not returned for completion (the carbon copies). The original signature on the carbon copies I hold indicate these copies were to be considered as original copies also, therefore, if what Defence is claiming is correct, these copies should also have been completed.

It is my belief that the letter dated 18 May 1981 does not exist, and if a letter has been

produced it will be a forgery. I ask for the original letter of 18 May 1981 to be produced so that it can be forensically examined.

An analogy to what has happened to me since the assault in 1976 is that I had attempted to save another Australian soldier's life by running onto the battlefield under fire. Myself and the other soldier were seriously wounded. I lay in the battlefield for 36 years wounded. When I called out for help I was fired at with no hope of repatriation.

The incredible truth here is that the enemy who seriously wounded myself and the other soldier were other Australian soldiers, who bashed and raped their fellow soldiers.

The absolutely incredible truth here is that when I called out for help and was then fired upon, it was by my own country.

So much for the mythology of the Australian digger, who looks out for his mates, used so often by Australian Governments for their own benefit.

My grandfather, who fought at Hill 60 with The First Australian Tunnelling Company RAE against the Germans in WW1, and my father, who defended Australia's airfields against the Japanese in WW2 in the 43 Battalion AIF, would be dumbfounded, and if they were alive today would be appalled to find Australian Governments that did not care about the welfare of its service men and women, only about its own "hip pocket" and reputation. Australian Governments' have lost their moral compasses.

This response from your Office continues the work of DVA in that it is geared toward maintaining the practice of providing false information, delays, denials and obfuscation. DVA and your Ministry appear determined to deny even the possibility that the assault of myself and the rape of actually occurred. In particular, they continue to focus on reports of me citing different years 1975/1976 for when the assault and rape occurred in an attempt to discredit my testimony, and, on the basis of these reports, seek to deny that the event took place.

This seems particularly officious and overly pedantic considering the effects that anxiety and stress can have on detailed memory. I admit I do not have a good memory for exact dates, however, I have always been able to locate the event within the chronology of my life. That is, it occurred shortly before I married my first wife, which was on 20 August 1976.

Also, there are elements of report which are inaccurate, but which have been relied on by DVA in determining my claim. For example, , Review Officer, stated that

> "medical service documents don't confirm a visit to medical officer for treatment after your assault."

Although claims in his report of 23/11/11 that I told him I sought medical treatment immediately after the assault, this is not true. At no stage have I ever said I sought treatment immediately after the assault. To the contrary I have always acknowledged that I **did not** seek treatment for my injuries immediately after the assault, nor was I ordered to do so. The attendance upon a medical officer that I told about was some months after the event, and this was told to during our interview.

The assault I suffered in 1976 at the hands of serving Australian soldiers constitutes a Category 1a stressor. My mental health has deteriorated since then.

The government's ongoing practices of obfuscation and denial have severely impacted on and

added to the deterioration of my mental health and as I have said before, these practices perpetuate the abuse I have already suffered. The abuse has now been institutionalised.

The following artwork has been my attempt at trying to keep myself sane in the face of the continuous DVA and Australian Government onslaught against my claim of criminal assault and rape within the ADF since 1976.

My challenge to the Australian Government and its delegates is to fund this artwork in exhibitions throughout Australia. The Governments' involvement in this would go some way towards showing other ADF abuse victims and the rest of the people of Australia that the Australian Government is serious in its attempting to right the wrongs of the past.

If the Australian Government shows it genuinely cares about the well-being of veterans, by being involved in helping soldiers with PTSD to get back on track by expressing themselves through art, then it will perhaps find its' moral compass.

It is imperative that this matter is dealt with before 6 October 2013, the date of my 65th birthday. It is my understanding that after this date my ability to claim compensation is prejudiced.

I look forward to your response.
Without prejudice

John Lawler

cc: The Hon Kevin Rudd, MP
Prime Minister
Parliament House
Canberra ACT 26000

The Commonwealth Ombudsman
GPO Box 442
Canberra ACT 2601

Attachments:
1. Statutory Declaration/Witness Statement by – 11 June 2013
2. Report of – 6 May 2013
3. Letter from to , DVA – 3 May 2012
4. Letter from , DVA to John Lawler – 16 May 2012
5. Letter from to , DVA – 7 June 2012
6. Letter from to DVA – 6 June 2012
7. Letter from , DVA, to – 21 June 2012
8. Account from to John Lawler – 26 June 2012
9. Receipt from to John Lawler – 2 July 2012

10. Letter from ADF Health Records-Army to John Lawler – 9 November 2001

Annexure 3 - Correspondence with Commonwealth Ombudsman

Commonwealth OMBUDSMAN

Request for review of our decision

To ask us to review a decision we have made about your finalised complaint, you can complete this form and send it to us by post, fax or email. Requests should be submitted within three months of the date we advise you of our decision. If you would like assistance completing this form, please contact us on **1300 362 072**. **If more space is needed, attach an extra sheet to this form.**

Title	**Mr** ☒ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Other**
Family name	LAWLER **First name** JOHN
Address	
	Postcode
Contact Number(s)	( )
Email	
Name of the Australian Government agency you complained about	COMMONWEALTH OMBUDSMAN D.V.A, A.D.F (ARMY)
Ombudsman reference number (if known)	2013-501229
What is the decision you disagree with?	ALL
When were you told about this decision?	13/8/2013
Why do you think the decision we made is wrong?	**Advice given** ☒ **Behaviour of staff** ☐ **Decision/Action** ☒ **Our procedures** ☐ **Time taken** ☐ **Other** ☒
Give details	EVIDENCE NOT LOOKED AT. REFER TO LETTER, DATED 2/9/2013.
Signature	**Date** 3/9/2013

This form can be filled out and mailed to Commonwealth Ombudsman, GPO Box 442, Canberra ACT 2601
faxed to 02 6276 0123 or you can download it and email as an attachment to ombudsman@ombudsman.gov.au. More information on your review rights is available on our website www.ombudsman.gov.au.

Annexure 3 - Correspondence with Commonwealth Ombudsman

Commonwealth OMBUDSMAN

Level 17, 53 Albert Street, Brisbane QLD 4000
Phone 1300 362 072 ▪ Fax 02 6276 0123
ombudsman@ombudsman.gov.au
www.ombudsman.gov.au

Our ref: 2013-501229-R

18 September 2013

Mr John Lawler

Dear Mr Lawler

I refer to your request for a review of decision about your complaint about the Department of Veterans' Affairs.

I have decided that will review this decision. is a senior, experienced officer who has not been involved in the original decision.

will consider the process used by the investigation officer, whether it was thorough and whether the conclusions reached were reasonable and clearly explained to you. There are three possible outcomes from this review:

- a decision that the original conclusion was wrong, and that a new conclusion can be reached without further investigation
- a decision that the complaint file should be reopened and all or part of the complaint should be investigated
- a decision that the original decision was right and that the complaint does not warrant further attention from our office.

I would like to point out that it is our policy that we will review a decision only once.

Yours sincerely

Senior Assistant Ombudsman

Annexure 3 - Correspondence with Commonwealth Ombudsman

John Lawler

2 October 2013

Commonwealth Ombudsman
GPO Box 442
CANBERRA ACT 2601

Attention:

Dear

I refer to previous correspondence.

Please find attached copies of letters I have sent to the Minister for Veterans' Affairs (dated 3 August 2013 and 1 October 2013), and a letter I received from Department of Veterans' Affairs dated 10 September 2013.

It is with great distress that I wish to point out that DVA:

- Continues to ignore my diagnosis of PTSD
- Continues to claim that was able to make an accurate diagnosis, even though, on his own admission, a large amount of significant information had not been made available to him from DVA to make a complete diagnosis. DVA did not ask me for the information.
- Has now changed its position with regards to my request for a CPAP machine – shifting from insisting that the condition requiring CPAP needed to be service related, to now claiming they realised the CPAP was for treatment of my mental health condition, but that I needed to have the need for the CPAP confirmed by a sleep specialist which I have since, obtained but which I have omitted to submit because DVA continued to insist that it needed to be service related.
- Has now adopted the same argument previously put forward about the CPAP machine with respect to my request for dental treatment.
- Continues to adopt a purely legal standpoint and deny any moral or ethical obligation to refer or offer advice to me, as a veteran, with regards to the reporting of the criminal assault I suffered at the hands of serving Army personnel.

Likewise, I point out that the VRB:

- Continues a similar legalistic approach as that of DVA with regards to any action on the criminal assault I suffered.
- Does not provide Information to veterans that all female or all male panels can be arranged to hear sensitive case. Nor is it sufficient to rely solely on the assumption that volunteer advocates will provide that information to veterans as not all veterans use the services of an advocate.

- Is party to a hearing predicated on a significant power imbalance in that the Senior Member presiding over hearings is a lawyer, and it is quite possible at least one, if not both of the other members of the panel may also be lawyers. Therefore, the panel of Members conducting a hearing enjoy the benefits of legal counsel during a hearing, even though it is not acknowledged, but veterans and their advocates do not

Finally, I would like to draw your attention to an annotation which has been made on the cover sheet to my DVA file. The reasons for this notation are unstated. My belief is that the notation of "fraud" by a Government Department has recognised the fact that the altering of my Army medical records by a Government Department is indeed fraud and is a criminal offence.

My application to the Commonwealth Ombudsman has been to investigate three occurrences.

1. The fraudulent alteration of my official documents – that is, alteration of my Army medical records by a Government Department, possibly with the deliberate intent to disadvantage my application for a Disability Pension.

2. The illegal information provided to me by DVA concerning my sleep apnoea and dental treatment under promissory estoppel.

3. The hiding of serious criminal assault and rape, on three occasions over a thirty six year period, which started when my report of the assault to an officer on base was not included in my records.

4. The failure to act on a duty of care, both morally and legally, with regards to the three separate reports of the incident of serious criminal assault and rape.

I look forward to hearing from you regarding these matters in the near future.

Yours sincerely,

John Lawler

Attachments:
1. Letter to Minister for Veterans' Affairs – 3/08/13
2. Letter from Department of Veterans' Affairs – 10/09/13
3. Letter to Minister for Veterans' Affairs – 2/10/13

Annexure 3 - Correspondence with Commonwealth Ombudsman

Commonwealth OMBUDSMAN

Level 5, 14 Childers Street, Canberra
GPO Box 442, Canberra ACT 2601
Phone 1300 362 072 ▪ Fax 02 6276 0123
ombudsman@ombudsman.gov.au
www.ombudsman.gov.au

Our ref: 2013-501229-R

11 December 2013

Mr John Lawler

Dear Mr Lawler

I have reviewed the decision dated 13 August 2013 to finish investigating your complaint about the Department of Veterans' Affairs (DVA). You disagree with the decision because you say that it does not deal with all the matters you raised in your complaint. In your request for a review you ask that I examine two issues namely, the alteration of your medical records, and the manner in which DVA has handled your claim for treatment for sleep apnoea and dental work.

In making my decision I have considered all the documents on our paper and electronic file relating to your complaint, including documents you provided to our office and letter to you of 13 August 2013. I have also considered the information you provided with your review request on 3 September 2013 as well as the information provided with your letter dated 2 October 2013 and delivered to our Adelaide office on 4 October 2013, and your email of 28 November 2013.

After consideration of this information, I have concluded that decision to finalise your investigation was not unreasonable. However regarding the aspect of you complaint that relates to the explanation given by DVA for the sleep apnoea and dental treatment, I have asked to give further consideration to the basis for DVA's decision. I have done so having regard to the fact that the anxiety condition was accepted by DVA on a 'non-liability' basis i.e. not Defence caused, or service related, but it appears that the explanation for the decision in relation to the sleep apnoea (and CPAP machine), and dental treatment has focussed on need to have these conditions accepted as Defence caused or service related. I also note that you say in your letter of 2 October 2013 that DVA has now changed its position in respect of the CPAP machine, and may be considering it as part of your treatment for the accepted anxiety condition. DVA has asked that you obtain evidence from a sleep specialist, but you have not passed this evidence on to DVA because of their original position requiring the sleep apnoea to be a Defence or service related condition. It may be that these matters can be resolved quickly upon further examined by

In relation to the alteration of your medical records you say that the copies you obtained in November 2001 from the 'Army Defence Force Health Records – Army' were described in the covering letter as 'your Unit Medical Record (UMR) which is a duplicate copy of your Central Medical Record (CMR)'. However, you say that your UMR obtained in 2001 are

different to your CMR that you obtained from Defence recently. You do not accept Defence's explanation that correspondence dated 18 May 1981 shows that the documents were returned to the medical officer shortly after your final examination and were altered at that time to complete two previously unchecked boxes. You query why all, including carbon copies, of the documents were not returned at the time for completion, and you are sceptical regarding the existence/creation of the 18 May 1981 letter.

I am not convinced that you have offered any evidence that suggests that the explanation for the variance in the records offered by Defence is unreasonable. Therefore I do not propose to refer this issue for further investigation. You should perhaps seek to obtain a copy of the 18 May 1981 letter which may assist you in understanding the explanation given by Defence. If, once you have requested it, you have any difficulty obtaining a copy of this document, you can contact us again in relation to this issue.

In summary, apart from the one issue referred to above, I affirm the conclusions reached by : on all the issues you raised in your complaint. I believe his assessment of your complaint was thorough, took account of all the relevant information, that the conclusions he reached were not unreasonable and that they were clearly explained to you.

: will be in touch with you in the new year to discuss the progress of you claim in respect of the sleep apnoea and dental treatment.

You may be disappointed with this outcome. Nevertheless, I hope you will see that I have given careful consideration to the concerns you have raised.

Consistent with our policy that we will review a decision only once, we will file but will not necessarily respond to any further correspondence we receive from you about the aspects of this matter that have now been finalised. We will be happy to assist you with any new and substantive issues that are within our jurisdiction and that are unrelated to these matters.

Yours sincerely

Senior legal Officer

Annexure 3 - Correspondence with Commonwealth Ombudsman

Commonwealth OMBUDSMAN

Level 5, 14 Childers Street, Canberra
GPO Box 442, Canberra ACT 2601
Phone 1300 362 072 ▪ Fax 02 6276 0123
ombudsman@ombudsman.gov.au
www.ombudsman.gov.au

Our ref: 2014-101178

1 April 2014

Mr John Lawler

Dear Mr Lawler

I am writing to let you know I have finished investigating your complaint about the Department of Veterans' Affairs (DVA).

As I advised in my telephone conversation on 6 March 2014, as a result of the review by our office, I was seeking further information from DVA as to why medical treatment for your anxiety disorder and post traumatic stress disorder (PTSD) were being covered by DVA, and why your sleep apnoea and dental treatment were not covered by DVA.

DVA has advised that, under section 85(2) of the *Veterans' Entitlements Act 1986* (VEA) veterans with eligible service who have malignant neoplasms (cancers), pulmonary tuberculosis, Post Traumatic Stress Disorder (PTSD), anxiety disorder or depression are eligible for treatment of those disabilities, regardless of whether or not they have been accepted as service related.

In your case, your PTSD and anxiety disorder are covered under the above legislative provision. However, these conditions are deemed as treatment only and there is no acceptance of liability in relation to these conditions for the purposes of compensation or pension payments.

Unfortunately, while you believe there is a link between your PTSD, anxiety and your sleep apnoea and dental problems, there are no provisions to treat the sleep apnoea and dental issues under the same legislative provisions. In order for you to have these medical treatments provided by DVA, you would need to establish that these conditions were linked to your service and for DVA to accept the causal link.

I understand you currently have a claim before the Veterans' Review Board (VRB). Once this matter has been finalised, and if the claim is rejected by the VRB, you may seek a further review through the Administrative Appeals Tribunal (AAT).

I propose to finalise my investigation of your complaint at this point. I understand that this may not be the outcome you wanted, but I do not think further investigation would achieve a different result.

If you think I have overlooked something or there is further information I should consider before finalising my investigation, please contact me using the details at the top of this letter. If I do not hear from you by 29 April 2014, I will finalise your complaint and close your record.

Thank you for bringing your concern to the attention of the Ombudsman's office.

Yours sincerely

Senior Investigation Officer

Annexure 4 - Correspondence with Prime Minister
John Lawler

John Lawler

22 July 2013

The Hon Kevin Rudd MP
Prime Minister
Parliament House
CANBERRA ACT 2600

Dear Prime Minister,

On 2 May I wrote to both the Minister for Veterans' Affairs, Warren Snowden, and the Defence Minister, Stephen Smith outlining the following issues.

- Fraudulent alteration of my official documents;
- Illegal and criminal behaviour towards me;
- Hiding of serious criminal assault and rape on three occasions over a thirty six year period;
- Miserably failing in their duty of care both legally and morally towards me.

To date I have received no reply, nor even an acknowledgement of my letter, from either Minister.

On 17 May I also sought assistance in this regard from the Commonwealth Ombudsman and provided them with a copy of the letters I had sent to the ministers, together with a copy of the statement I had submitted to DLA Piper Review. I have attached copies of these documents.

On 20 May I received a telephone call acknowledging my complaint from Senior Investigation Officer with the Commonwealth Ombudsman, and I subsequently received a letter of confirmation of the same date.

On or about 13 June I contacted by telephone to enquire about progress with my matter. She advised that she had given the Department of Veterans' Affairs additional time of three weeks to respond to her enquiries because they were also in the process of dealing with a "Ministerial" in relation to my file.

I again contacted on or about 4 July to ascertain whether she had received a response from the Department of Veterans' Affairs. She advised no reply had been received. She told

me she would follow up on her request and advise me of the outcome when she returned from a weeks' leave on 15 July.

I telephoned the Ombudsman's Office on 17 July and was advised that was away on sick leave. I asked to speak to the staff member who was dealing with her work in her absence but was told no-one was doing so. I asked to speak to an immediate or superior supervisor and was eventually told that someone would call me back.

On 19 July, I received a telephone call from , who advised that if was still absent this week she would telephone me this morning.

Having heard nothing by midday I telephoned the Ombudsman's Office and eventually spoke to . She advised me was still absent on holiday leave and after I again asked to speak with a senior supervisor she said that she would speak to someone.

I pointed out that my matter had been with the Ombudsman's Office for almost 10 weeks and that my ongoing claim with the Department of Veterans' Affairs was potentially being prejudiced by these delays.

I again asked to speak to a manager, and this afternoon I have been contacted by Acting Senior Assisting Ombudsman. He told me that the Ombudsman's office had been in contact with the Department of Veteran's Affairs and had been advised that a response had been sent by the Department to email account a week ago. However, the Ombudsman's Office was not sure if another staff member would be able to access account in her absence. If this was the case, the Ombudsman's Office would contact the Department and have the response resent. He also promised to follow up on my case with the relevant staff when he is in Canberra this coming Thursday.

I understand that public servants need to take leave and that winter is a bad time for people being sick. What I fail to understand is why there are no contingencies in place for work to continue in their absence.

After thirty six years of Army, DVA and Australian Government Departmental incompetence I have had enough.

I look forward to receiving your response.

Yours sincerely,

John Lawler

6 August 2013

The Hon Kevin Rudd MP
Prime Minister
Parliament House
CANBERRA ACT 2600

Dear Prime Minister,

On the 22nd of July I posted to you a letter claiming serious misconduct within Australian Government Departments. I have not yet received any response from your Office.

This letter confirms the information sent to you previously by myself, and evidence outlining the corrupt behaviour in response to Minister Snowdon's reply.

On 2 May I wrote to both the Minister for Veterans' Affairs, Warren Snowden, and the Defence Minister, Stephen Smith outlining the following issues.

- Fraudulent alteration of my official documents;
- Illegal and criminal behaviour towards me;
- Hiding of serious criminal assault and rape on three occasions over a thirty six year period;
- Miserably failing in their duty of care both legally and morally towards me.

On 17 May I also sought assistance in this regard from the Commonwealth Ombudsman and provided them with a copy of the letters I had sent to the ministers, together with a copy of the statement I had submitted to DLA Piper Review. I had attached copies of these documents to the letter that I forwarded to you on the 22nd of July.

On the 29th of July after nine weeks I received an email from Minister Snowdon's office replying to the above issues. My response to Minister Snowden's office is attached to this letter.

It is imperative that this matter be dealt with before 6 October 2013, the date of my 65th birthday. It is my understanding that after this date my ability to claim compensation is prejudiced.

I look forward to receiving your response.

Yours sincerely,

John Lawler

Annexure 5 - Correspondence with Minister for Mental Health and Ageing John Lawler

John Lawler

4 April 2013

Mark Butler, MP
15 Semaphore Rd
SEMAPHORE SA 5015

Dear Minister,

It is now six weeks since I spoke to Christine at your office at Semaphore. Christine emailed me on the 27th of Feb showing that you had sent a letter to the Attorney-General on my behalf, and stated that you would forward any response received. I have not received any correspondence from your office or the Attorney General and sent you an email on the 20th of March which indicated so. I am again asking if you have received any response from the Attorney-General on my behalf. I explained to Christine at your office that I am a veteran of the Australian Army and suffer from PTSD and other medical conditions relating to an assault upon myself by five Australian soldiers when I attempted to stop them from raping a female soldier at Randwick Barracks in Sydney in 1976.

On the 18/6/2011 I applied for a Disability Pension for "depression, anxiety and stress" which the DVA acknowledged. I was then refused my application for "anxiety disorder and alcohol dependence". DVA had changed my claim without advising or consulting with me and my claim was forwarded to The Veterans Review Board.

I also told Christine that on two occasions the Department of Veteran's Affairs had told me to spend my money to be tested for sleep apnoea and to have an inspection of my teeth by a dentist. I hold a DVA white card.

The DVA said that they would refund the money that I had spent and then would follow up with further treatment. When DVA were asked to pay for the consultations and further treatment, DVA refused.

As you are probably aware under Promissory Estoppel it is illegal for the Government to tell a person to spend money and then advise them the Government has changed its mind about a refund and further treatment.

I am currently seeing a psychiatrist and psychologist, both of which are being paid for by DVA under my white card. My wife is also seeing a psychologist because of my illness. I first saw my psychiatrist in January 2011, following a referral from my GP. It was my psychiatrist who advised me I was eligible to apply for a DVA White Card which would help pay for my treatment. He assisted me with making an application for a white card on the basis of his diagnosis of PTSD. I was subsequently issued a white card for Anxiety.

In 2002 I was seen by a DVA psychiatrist who diagnosed me with a Generalised Anxiety Disorder. In his report he noted that if I did not receive treatment my condition would become permanent. I was not advised by DVA that I would have been eligible for treatment under a white card. I did not receive any treatment until 2006 when, on my own initiative, I sought help from my GP who prescribed anti-depressant medication.

My mental illness has left me unfit for general employment and I receive a Centrelink disability pension.

I have undertaken academic research in Aboriginal Housing as a PhD candidate in architecture at QUT and as a Research Scholar with the Australian Housing and Urban Research Institute. The solitary nature of research meant I was able to research at my own pace when I felt well enough, and it meant I did not feel completely useless and was able to make an important contribution to society. Except for scholarships my research has been unfunded.

The recent SKYPE affair has seriously reactivated the memories of the assault against me in 1976. Over the past two years I have been overwhelmed and unable to continue with my PhD because of the increase of my PTSD.
Last week, my professor contacted me and offered to send a post-graduate researcher from QUT (Brisbane) to the Barossa Valley to assist me to complete my thesis. I said that although I wished to finish my PhD, my current mental and emotional state prevents me from doing so. Since the SKYPE affair two years ago I have been on sick leave from my PhD research. Yesterday I sent an email to my professor advising him that I was unable to complete because of my mental/emotional illness and that I was withdrawing from my PhD candidature.

My mental capacity is becoming worse.

It is the appalling behaviour of the ADF in the past that has caused the mental illnesses of veterans like myself, and it is the current appalling behaviour of the DVA that is continuing and exacerbating the abuse under the umbrella of the Australian Governments. The stonewalling and delaying tactics the DVA engages in deny and delay our claims until we give up, die of old age or commit suicide.

Please advise any assistance you may be able to offer.

Yours sincerely

John Lawler

Annexure 5 - Correspondence with Minister for Mental Health and Ageing, John Lawler

Mark Butler MP

FEDERAL MEMBER FOR PORT ADELAIDE

224/2013

Mr John Lawler

Dear Mr Lawler

I write in response to your letter dated 4th April 2013.

In respect to the DLA Piper Review the Attorney-General, the Hon Mark Dreyfus QC MP has recommended that you contact:

Defence Abuse Response Taskforce
Attorney-General's Department
3-5 National Circuit
BARTON ACT 2600
DART@ag.gov.au

Unfortunately, matters relating to Defence Force Personnel and PTSD do not fall within my portfolio responsibilities, but with the Hon Warren Snowdon MP as Minister for Veterans Affairs. He can be contacted via email at warren.snowdon.MP@aph.gov.au.

Should you need any further assistance in this area from a Government MP, I would encourage you to make contact with the Office of Anne McEwen, as constituent matters that fall within the electorate of Barker are managed by our Federal Senators. The Senators contact details are Senator.Mcewen@aph.gov.au.

Yours faithfully

MARK BUTLER

15 Semaphore Road, Semaphore SA 5019 PO Box 2038, Port Adelaide SA 5015
(08) 8242 0733 (08) 8242 0744 Mark.Butler.MP@aph.gov.au www.markbutler.net.au

Attorney-General
Minister For Emergency Management

MC13/03020

The Hon Mark Butler MP
Member for Port Adelaide
PO Box 2083
PORT ADELAIDE SA 5015

Mark

Dear ~~Minister~~

Thank you for your letter of 23 February 2013, on behalf of your constituent Mr John Lawler.

As you are aware, the Defence Abuse Response Taskforce has been established by the Government to assess individual complaints of abuse and wider systematic issues in Defence.

The Independent Taskforce forms part of the Government's response to the DLA Piper *Report of the Review of allegations of sexual and other forms of abuse in Defence* ("the Review").

The Taskforce is administratively housed in the Attorney-General's Department, but is independent of both the Attorney-General's Department and Defence, therefore any questions about individual matters should be directed to the Taskforce. Further information on the Taskforce is available at www.ag.gov.au.

Mr Lawler may contact the Taskforce directly by emailing DART@ag.gov.au or writing to:

Defence Abuse Response Taskforce
Attorney-General's Department
3-5 National Circuit
BARTON ACT 2600

Information about the Government's response to the Review can be found at http://www.defence.gov.au/pathwaytochange/docs/DLAPiper/govresponse.htm.

Mr Lawler may also wish to call the information Hotline on 1800 424 991.

Yours sincerely

MARK DREYFUS QC MP
19/3/13

Annexure 6 - Article by Prof. Alexander McFarlane
John Lawler

SPECIAL ARTICLE

The long-term costs of traumatic stress: intertwined physical and psychological consequences

ALEXANDER C. MCFARLANE

Centre for Military and Veterans' Health, University of Adelaide, Level 2/122 Frome Street, Adelaide, South Australia, 5000 Australia

The gradual emergence of symptoms following exposure to traumatic events has presented a major conceptual challenge to psychiatry. The mechanism that causes the progressive escalation of symptoms with the passage of time leading to delayed onset post-traumatic stress disorder (PTSD) involves the process of sensitization and kindling. The development of traumatic memories at the time of stress exposure represents a major vulnerability through repeated environmental triggering of the increasing dysregulation of an individual's neurobiology. An increasing body of evidence demonstrates how the increased allostatic load associated with PTSD is associated with a significant body of physical morbidity in the form of chronic musculoskeletal pain, hypertension, hyperlipidaemia, obesity and cardiovascular disease. This increasing body of literature suggests that the effects of traumatic stress need to be considered as a major environmental challenge that places individual's physical and psychological health equally at risk. This broader perspective has important implications for developing treatments that address the underlying dysregulation of cortical arousal and neurohormonal abnormalities following exposure to traumatic stress.

Key words: Post-traumatic stress disorder, allostasis, kindling, hypertension, heart disease

(World Psychiatry 2010;9:3-10)

One of the greatest challenges to the field of traumatic stress has been the observation that many individuals who coped at the time of their traumatic exposure became unwell at a later date.

This observation was particularly challenging in the context of World War I and World War II because the prevailing psychopathological theories at the time did not have a clear rationale for this phenomenon and led to considerable stigmatization of disabled veterans (1). The later emergence of disability in veterans was attributed to compensation neurosis, pre-existing personality disorder, and suggestibility (2). Furthermore, with the blossoming of the general life events stress literature, this pattern of morbidity was not consistent with the prevailing views about high levels of acute distress that progressively ameliorated with time (3, 4). The life events literature which reached its zenith in the 1960s and 1970s focused on notions such as brought-forward time, and emphasized that there was generally a window of approximately six months following which a life event stress could lead to the onset of disorder (5). Delayed onset post-traumatic stress disorder (PTSD) was seen as inconsistent with this conclusion about the window of effect of stressful life events (6).

A primary question has been about how a model of psychopathology could account for this lingering and delayed impact of extreme adversity. Prevailing psychoanalytic constructs and later learning theory did not readily provide an answer to this question. Many significant observations in the context of the depression literature have not been readily adapted by the field of traumatic stress until recent links through the research concerning the relevance of child abuse to depression (7).

This paper explores the evidence about the delayed effects of traumatic stress and their cumulative burden on psychological and physical health. An underlying psychopathological model is summarized and its potential implications for treatment are discussed.

THE RELATIONSHIP BETWEEN ACUTE STRESS DISORDER AND PTSD

The relation between acute post-traumatic symptoms and the emergence of PTSD is an issue of considerable theoretical and clinical importance. There is now a significant body of research documenting that the majority of people who develop PTSD do not initially meet the diagnostic criteria for an acute stress disorder (8). In contrast, the majority of those who have an acute stress disorder are likely to display subsequent PTSD.

A number of longitudinal studies of accident victims have demonstrated that it is only with the passage of time that the level of symptoms crosses a threshold sufficient to warrant a clinical diagnosis (9-13). A similar phenomenon was found in a study of severely injured US troops who were assessed at one month, 4 months and 7 months. This study demonstrated that 78.8% who had a disorder at 7 months did not attract a diagnosis at one month (14). Further support for the delayed emergence is the finding from the screening of military populations that symptoms increase in the first six months following deployment (15,16). Additional adversity, conflict or stress plays a role in the later emergence of psychopathology (17). Hence, in a significant number of individuals, PTSD is a disorder that is not initially manifest in the aftermath of the trauma. Rather, there is a progressive escalation of distress or a later emergence of symptoms, particularly in military and emergency service personnel. A related construct is delayed onset PTSD.

DELAYED ONSET PTSD

Delayed/late onset PTSD is defined in the DSM-IV (18) as a disorder meeting the diagnostic criteria for PTSD which is present after a post-trauma adjustment period of at least 6

months during which diagnostic criteria were absent or subthreshold (19). From a theoretical point of view, these are likely to be individuals who have managed to contain their individual distress by adaptive means, but subsequent stresses and/or the natural progression of neurobiology have led to the manifestation of the symptoms. A recent review emphasized the confusion which has arisen from different definitions of delayed onset PTSD (20). For example, different interpretations of the concept include an individual who has had sub-syndromal symptoms that have subsequently crossed a threshold of clinical severity as well as an individual who has been asymptomatic and then at some later point developed the disorder.

The existence of this delayed form of PTSD emphasizes how a traumatic experience can apparently lie relatively dormant with an individual only to become manifest at some future point. Many unanswered questions remain about when and how this sub-clinical state is triggered into a full-blown syndrome of PTSD. However, increasingly the evidence would suggest that sub-clinical symptoms leave the individual at risk of progressive activation with further environmental stress or trauma exposure.

A related construct in the depression literature is how individuals who have had partial remission following treatment for an episode of a major depressive disorder are at significantly greater risk of a further recurrence (21). This vulnerability relates to the sensitivity of individuals with residual depressive symptoms to environmental triggers. The underlying neural structures that are sensitive to activation are the same that have been identified as being relevant to the aetiology of PTSD. For example, Ramel et al (22) highlighted that amygdala reactivity is an important issue in people with a history of depression in contrast to those without such a history. These results indicated that the amygdala plays an essential role in modulating mood congruent memory, particularly during the induction of sad states of mind in individuals who are vulnerable to depression.

In such individuals, the cognitive and neural processing of emotional information potentially contributes to the vulnerability for negative emotions and the onset of depressive episodes (23). Hence, there is a significant body of literature documenting that individuals who are primed in emotionally labile and sensitive states are at risk for the progressive intensification of further symptoms, particularly when these resonate with the environment. Hence, the presentation of delayed onset of PTSD is not a unique construct in mental health.

Furthermore, Hedtke et al (24) demonstrated that there is a cumulative effect of exposure to interpersonal violence in terms of PTSD, depression and substance abuse problems. The cumulative risk model highlights the ongoing interaction between prior stress exposure and subsequent life events. The severity of stresses that are experienced prior to and following a traumatic exposure have a significant impact on the incidence and severity of the condition (25). Hence, delayed onset PTSD is intimately involved with the fact that individuals live in a dynamic environment in which traumatic events and other life stresses interact, with the progressive accumulation of risk.

A related question is whether a longer duration of repeated exposures to trauma in defined time periods carries a greater risk of PTSD, a question relevant to the military and police. The recent UK study of Rona et al (26) provides the first reliable data from the military addressing this question and suggests that the risk of PTSD is greater in those units that have had longer durations of deployment with less time to recuperate between deployments. This study highlights that PTSD is an emerging disorder where multiple traumatic events progressively increase the risk of occurrence.

THE ENDURING IMPACT OF TRAUMATIC MEMORY

The repeated recollection of traumatic memories is a central component of the phenomenological response to traumatic events. Freud highlighted the importance of traumatic memories in his first lecture with Breuer, suggesting that these were the "agent still at work" playing a central role in symptom onset and maintenance (27). Subsequently, modelling in epidemiological samples has highlighted how traumatic memories account for the relationship between exposure to traumatic events and the symptoms of hyperarousal and avoidance (28).

The triggering of these memories is also a consequence of fear conditioning mechanisms (29), and these serve to sustain and kindle the increased arousal that is central to the symptoms of PTSD (30). The disorder arises because some individuals are unable to progressively shut off the acute stress response, which is ubiquitous at times of exposure to such events. From a learning theory perspective, this process is seen as a failure of extinction or new learning in the aftermath of the fear conditioning. Rather, there is a progressive augmentation of the amplitude of the response to reminders.

TRIGGERING AND SENSITIZATION

A primary component of the symptomatology of PTSD is the re-experiencing or reliving of the traumatic memory, that has both elements of psychophysiological reactivation and psychological distress. A unique part of this condition is the repeated reactivation of the traumatic memory and the associated stress response with the attendant risk of the progressive augmentation of the reactivity of the individual (31). In fact, the suggestion has been made that in PTSD there is a failure of the retention and extinction of conditioned fear and that this is an acquired deficit in the condition (32).

On reviewing the available evidence, Rauch et al (33) have suggested that in PTSD there is an exaggerated amygdala response which underpins the excessive acquisition of fear associations and the expression of fear responses. A corresponding deficit of frontal cortical functioning plays a cen-

tral role in mediating extinction. There is also a deficit in the appreciation of the context of safety, which is related to hippocampal function.

The central mechanism is the process of sensitization to the subtle reminders of traumatic memories as well as exposure to prior and future traumatic events. This process of reactivity to minor cues, which very frequently goes unrecognized, serves to progressively increase and exacerbate the reactivity of the dysfunctional individual (34). This leads to an interaction between the individual's distress, psychophysiological reactivity, and the neurohormonal response at the time of the traumatic event. In discussing this question, it is important to recognize that some traumas in combat and policing are not the equivalent of a single traumatic event such as being in a motor vehicle accident. Combat and emergency service work involves repeated activations of the fear and stress systems that are then prone to present as future dysregulation over time.

Individuals who develop PTSD have been found to have a progressive evolution of dysfunction as described above (30). Progressively, they react to the presence of potential threat with greater amplitude or intensity and ultimately develop a generalized overreactivity to a range of stimuli in their civilian and military environments that remind them of the traumatic event. This cycle of increasing reactivity to a widening range of cues in their environment serves to further reinforce the distress response. This pattern is not unique to PTSD and has been highlighted in depression as having a critical role in early episodes (35).

Elzinga and Bremner (36) have further characterized the role of the noradrenergic system in the enhanced encoding of the emotional memories and fear-conditioning in individuals who develop PTSD. The failure of the normal neurotransmitter inhibitory mechanisms that quell the stress response appears to be important in the progression of the individual's distress into a full blown post-event or post-traumatic stress disorder. According to Miller (37), childhood trauma increases the risk of adult psychopathology because of the same process of sensitization (7). Shalev (38) has highlighted that this process is also intimately integrated into the person's social and cultural setting. He states that traumatic events are followed by "a critical period of increased brain plasticity, during which irreversible neuronal changes may occur in those who develop PTSD". He also emphasizes the importance of group cohesion, marital discord, and leadership skills as mediating factors.

Fear conditioning, kindling, and sensitization contribute to the manner in which repeated activation of the fear memories, in PTSD, leads to the emergence of spontaneous intrusive memories (39). In depression, a similar process predisposes an individual to negative affective appraisal and increasingly depressed mood. There is an emerging medical scientific literature indicating that pharmacological agents may be able to modify these responses (40).

The measurement of the startle response can objectively characterize the sensitization that occurs in the fear and alarm response in PTSD. Increased heart rate in response to sudden loud tones is an abnormality that emerges following traumatic exposure (41,42). This increased reactivity suggests the role of fear conditioning and the impact of the environment following the event. The acquisition of an increased startle response was not related to the severity of the event or the initial intensity of the symptoms. These observations are consistent with the model of progressive neuronal sensitization and increasing heart rate reactivity over the subsequent six months to trauma exposure. This pattern of increased reactivity is also observed in relation to innocuous and aversive stimuli in a conditioning experiment where increased autonomic reactivity was demonstrated to both types of stimuli (43). Once conditioned, those with PTSD had reduced extinction to conditioned responses.

PTSD is only one of the outcomes that have been associated with trauma exposure. The emergence of multiple physical symptoms also has a strong association, and the consensus opinion is that these syndromes are indicative of a general reflection of distress. The underlying mechanisms of these disorders have been related to similar mechanisms of sensitization noted in those with PTSD (44). In parallel, multiple traumas have an accumulative effect on physical health which appears to be independent of the development of PTSD (45).

PHYSICAL MORBIDITY ASSOCIATED WITH TRAUMATIC STRESS

There is longstanding interest in the effects of stress on health, due to the strain that it places on the adaptive capacity of individuals, which thereby leads to an increased risk of disease.

The effects of stress on the hypothalamic pituitary adrenal axis (HPA) and the autonomic nervous system have long been studied and the regulation of these systems has been referred to as "allostatic load". This refers to the wear and tear on the body in response to repeated cycles of stress. This phenomenon has the potential to be manifest in various ways, influenced by the interaction with other personal and environmental risk factors for disease. Hence, the physiological dysregulation that underpins allostasis represents a final common pathway to disease that can be manifest in various ways.

Particularly in the context of post-deployment syndromes, the link to musculoskeletal symptoms has become a focus of increasing interest. Equally, the role of allostatic load has come to be seen as an important risk for coronary arterial disease and its antecedent risk factors. However, the intermediary role of PTSD has not been the focus of particular interest in explaining these relationships until recently. The emerging body of evidence, which coincides with the real prevalence of PTSD in studies such as the National Comorbidity Survey Replication (46), suggests that physiological dysregulation associated with PTSD may play a central mediating role in a range of conditions.

PTSD AND PSYCHOSOMATIC SYNDROMES

Andreski et al (47) reported that, of all the psychiatric disorders, PTSD is the one with the strongest relationship with somatization and particularly medically unexplained pain. Although there is substantial literature relating somatization to PTSD, this body of knowledge is seldom referred to in the broader literature about somatization, which has largely focused on the role of depression and anxiety (48-52). Particularly in the light of more recent epidemiological studies which suggest the previous underestimation of the prevalence of traumatic events and PTSD in many settings, there is a greater need to focus on the possible role of trauma in populations with medically unexplained symptoms (53).

There has been an increasing recognition of a shared pattern of symptoms and aetiology between whiplash, fibromyalgia, irritable bowel, chronic fatigue and PTSD. In particular, disorders of the HPA axis have been identified in all these disorders (54,55), where the shared dysfunction appears to be an enhanced negative feedback of the axis. Such stress-induced changes have been associated with major impacts on neurogenesis and brain functioning (56,57). A recent prospective study has suggested that this dysfunction of the HPA axis plays an important role in the onset of chronic widespread musculoskeletal pain in a general population sample (58). McEwen's model of allostasis has focused on the temporal lobe and the changes induced by cortisol at the times of stress exposure (56). Whilst focusing on the importance of this process in PTSD, persistent pain has also been associated with stress-like induced alterations of hippocampal neurogenesis and gene expression (59).

Sensitization is a critical process in the onset of pain syndromes and also in PTSD, as outlined above. The exposure to environmental triggers to the traumatic memory structure plays a critical role in the emergence and progressive escalation of an individual's distress across time, which includes somatic dimensions. This complex biological process emerges in the weeks and months following the event, involving the interaction between the individual's distress and the neurohormonal response at the time of the traumatic event (34).

The central role of the amygdala in the kindling in PTSD has much in common with the phenomena of windup of C fibre evoked pain (60). The centrality of this process has been suggested in both fibromyalgia and chronic fatigue (61,62).

Similar patterns of sensitization and modified pain sensitivity have been characterized in irritable bowel syndrome (63,64). The shared neurobiological abnormalities in these conditions are a further argument in favour of a generalized stress response syndrome underpinning multiple complaints. Furthermore, this has been associated with a modified autonomic function, that is also thought to play an important role in the pain response in fibromyalgia patients, individuals with neck and shoulder pain, and irritable bowel disorder (65), and has been found to be present also in individuals absent from work with a stress related illness (66).

THE RELATIONSHIP BETWEEN HYPERTENSION AND PTSD

A number of studies have suggested that PTSD has a direct relationship with the risk of developing hypertension. A study of a probability sample from the US National Comorbidity Survey examined the interaction between PTSD and major depression as determinants of hypertension. It concluded that PTSD was related to hypertension, independent of depression, and that this finding could possibly explain the elevated rates of cardiovascular disease associated with PTSD (67). This specific relationship explains the high prevalence rate of hypertension identified amongst refugee psychiatric patients (68).

O'Toole and Catts (69) examined an epidemiological sample of Australian Vietnam veterans, aiming to explore the relationship between the physical health consequences of combat trauma exposure and PTSD. Hypertension was one of the conditions that was found to be associated with PTSD, both before and after controlling for potential confounds. In PTSD, it has been recognized that exposure to traumatic triggers leads to increased blood pressure, heart rate, and sympathetic activation of sweating in the hands (70). This abnormality has a significant degree of specificity for PTSD (71). This is consistent with the observation that in PTSD there is increased activity of the sympathetic nervous system, and in particular hyperfunction of the central noradrenergic system (72).

A US population study of hypertensive individuals looked at the impact of the September 11, 2001 attacks. Whilst these patients did not have a particularly high level of exposure, in the two months following the terroristic attacks they had an increase between 1.7 and 3.3 mm of mercury of systolic blood pressure compared with a similar period in 2000. Hence, at a population level, individuals who are suffering from hypertension are at risk of increases in blood pressure as a consequence of exposure to stressful events (73).

This body of evidence indicates that there is a link between PTSD and the risk of hypertension. This is an important development, as it indicates that the failure to specifically look at the relationship between PTSD and hypertension in earlier studies has led to confusion about the link between stress and coronary heart disease. For example, the Australian National Heart Foundation in 2003 suggested that there was no strong or consistent evidence for a causal association between chronic life events, work stress, patterns of hostility/anxiety disorders or panic disorder and coronary heart disease. The intermediary role of PTSD in this relationship is an important link (74).

HYPERLIPIDAEMIA

Lipid metabolism is an area of importance to the risk of vascular disease. A study of Brazilian police officers demonstrated that officers with PTSD had significantly higher lev-

els of total cholesterol and triglycerides (75). A study from Croatia compared patients with combat related PTSD and a control group consisting of patients with major depressive disorder (76). In this study, lipid profiles consisting of cholesterol, LBL, HDL, and triglycerides were assessed. The groups were matched for age and body mass index (BMI). The individuals with PTSD had higher mean levels of cholesterol, LBL-C, and triglycerides and lower HDL-C than the control group. The arteriosclerotic index was higher in the PTSD than the control group. These results were taken to conclude that patients with combat related PTSD had a higher risk of arteriosclerosis (76-78). It is probable these findings will generalize to other populations.

THE RELATIONSHIP BETWEEN OBESITY AND PTSD

Obesity is associated with an increased risk for several diseases, including cardiovascular disease. Vieweg et al (79), using a national database, documented a significantly increased BMI in individuals with PTSD, not affected by the decade of life. It was concluded that PTSD may be a risk factor for being overweight. This relationship has also been found in clinical samples (80).

A population study of young adults in Germany (81) examined the relationship between a PTSD diagnosis and having a BMI greater than 30. In the 10-year follow-up of this sample from childhood, obesity was predicted by an antecedent subthreshold or full blown PTSD, with an odds ratio of 3, amongst men but not women. This relationship has not been universally identified, and a series of complexities influencing it should be acknowledged. However, a further population sample in New Zealand did find an association between PTSD and obesity (odds ratio 2.64) (82).

In a study of police officers, the relationship between PTSD symptoms and metabolic syndrome was examined. Metabolic syndrome was deemed to be present if an individual had 3 or more components among obesity, elevated blood pressure, reduced high density lipoprotein (HDL cholesterol), elevated triglycerides and abnormal glucose. The officers with severe PTSD had 3 times the rate of metabolic syndrome of the lowest PTSD severity category (83).

THE RELATIONSHIP BETWEEN PTSD SYMPTOMS AND CORONARY HEART DISEASE

The US Department of Veterans' Affairs has conducted a normative aging study (84). The sample, including men who had completed two scales for PTSD, was recruited in 1990. The men were followed up and the incidence of coronary heart disease occurring up to May 2001 was assessed. For each standard deviation increase in the level of post-traumatic symptoms, the men had an attributed relative risk of 1.26 for non-fatal myocardial infarction and fatal coronary heart disease combined and 1.21 for all coronary heart disease outcomes. The importance of this study is that it indicated that the level of post-traumatic symptoms, rather than the PTSD diagnosis itself, is associated with an increased risk of coronary heart disease. These results were maintained after controlling for depressive symptoms.

While hypertension, hyperlipidaemia and obesity are risk factor associations that could link PTSD to heart disease, this could also relate to the exaggerated catecholamine response to trauma related triggers. It has been demonstrated in a variety of settings that catecholamines may lead to injury of the lining intimal endothelium of the coronary arteries, leading to the development of atherosclerosis (85,86). Kubzansky et al (84) concluded that "exposure to trauma and prolonged stress not only may increase the risk of serious mental health problems but are also cardiotoxic".

Boscarino (87) studied a national random sample of 4,328 Vietnam veterans who did not have heart disease at baseline in 1985. The mortality due to heart disease from having PTSD had a hazard ratio of 2.25. When the effects of depression were controlled for, the degree of combat exposure made little difference to the results. The author concluded that "early age heart disease may be an outcome after military service among PTSD positive veterans". Again, this study emphasized that there is a specific risk for heart disease mortality associated with PTSD, but there is also a risk simply associated with an increased level of post-traumatic symptoms in individuals who do not reach the diagnostic threshold.

Another study carried out in former World War II prisoners of war found that prisoners with PTSD had a significantly increased risk of cardiovascular diseases, including hypertension and chronic ischemic heart disease, compared with individuals who had been prisoners of war but had not developed PTSD as well as non-prisoners (88).

In summary, the evidence from prospective studies is suggestive of a link between heart disease and PTSD.

CLINICAL IMPLICATIONS

The association between PTSD and a number of physical conditions emphasizes that the effects of traumatic stress are far reaching. There is the potential for a pervasive disruption of an individual's neurobiology and psychophysiology following exposure, and PTSD is only one end point. The association with cardiovascular risk factors and inflammatory markers indicates that exposure to traumatic stress leads to a general disruption of an individual's underlying homeostasis (89,90).

In essence, the internal physiological environment of an individual adapts to external demands. This dynamic regulatory process involves a continuous adaptation of physiology in response to environmental demand. When the body is repeatedly stressed, the consequent allostatic state has the capacity to disrupt an individual's health (91). For example, Karlamangla et al (92) looked at the longitudinal impact of allostatic load in the MacArthur studies of successful aging,

and found that those individuals whose allostatic load dropped over a 5 year period had a significantly lower risk of mortality.

Hence, the underlying acclimatization of an individual to an environment and the costs that this exerts on the body is critical to the maintenance of health from a psychological and physical perspective (93). Traumatic stress leads to a disruption of the glucocorticoid system, in concert with a range of other neuropeptides such as corticotrophin-releasing factor (CRF), beta endorphin, neuropeptide Y and the catecholamines. The impact of glucocorticoids on the amygdala and hippocampus as part of contextual fear conditioning is an essential component of allostatic adaptation (94).

TREATMENT IMPLICATIONS

At the present time, the treatment of PTSD focuses on cognitive behavioural therapy and the use of selective serotonin reuptake inhibitors (95). However, recommended treatments do not take into account the need to address the underlying instability of psychophysiology, particularly in the earlier periods following exposure. In this light, it is interesting that prazosin, an alpha-adrenergic antagonist, has been found to have a beneficial role in the treatment of PTSD (96), and that cortisol has been found in intensive care populations to have a protective effect against PTSD (97).

One treatment that may be of particular significance and requires systematic investigation is neurofeedback (98,99). There is now an established literature about abnormalities of quantitative EEG which suggest a significant disruption of cortical arousal in PTSD (100). Neurofeedback has been used in other disorders where there are demonstrated abnormalities of cortical activity. Particularly in populations at a significant risk for PTSD, such as military and emergency service groups, the use of this technique may be beneficial. Equally, the development of methods to modify the progressive augmentation of startle could help individuals to re-establish their psychophysiology to its baseline state. Recalibration may be easier prior to the development of a full-blown clinical disorder.

CONCLUSION

The progressive emergence of symptoms following traumatic stress exposure is a challenging concept and delayed onset PTSD has long been a controversial notion. However, there is an increasing body of literature demonstrating that a significant proportion of trauma victims do not have their maximal stressor response in the immediate aftermath of the event, but rather this progressively increases with time. In some individuals, the apparent adverse consequences of the stress exposure lie dormant for a long period of time before some intercurrent adversity leads to its manifestation.

Thus, it would appear that trauma exposure initiates a process of disruption of an individual's internal psychophysiology that is then progressively sensitized and kindled with the repeated exposures to triggers. This pattern of increasing sensitivity to environmental load can also become manifest as hypertension, hyperlipidaemia, and obesity. There is now an established association between cardiovascular disease and PTSD.

Ultimately, major treatment advances in PTSD may arise from considering the broader disruption of these neurobiological systems by their repeated activation. This emphasizes that PTSD is not simply a psychosocial disorder, but one underpinned by a major neurobiological disruption.

Acknowledgement

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References

1. Shephard B. A war of nerves: soldiers and psychiatrists in the twentieth century. Cambridge: Harvard University Press, 2001.
2. Glass AJ. Mental health programs in the armed forces. In: Arieti S (ed). American handbook of psychiatry. New York: Basic Books, 1974:800-9.
3. Brown GW, Harris TO, Peto J. Life events and psychiatric disorders. 2. Nature of causal link. Psychol Med 1973;3:159-76.
4. Paykel ES. Contribution of life events to causation of psychiatric illness. Psychol Med 1978;8:245-53.
5. McFarlane AC. The effects of stressful life events and disasters: research and theoretical issues. Aust N Z J Psychiatry 1985;19:409-21.
6. Solomon Z. The impact of posttraumatic stress disorder in military situations. J Clin Psychiatry 2001;62(Suppl. 17):11-5.
7. Heim C, Nemeroff CB. The role of childhood trauma in the neurobiology of mood and anxiety disorders: preclinical and clinical studies. Biol Psychiatry 2001;49:1023-39.
8. Bryant RA, Creamer M, O'Donnell ML et al. A multisite study of the capacity of acute stress disorder diagnosis to predict posttraumatic stress disorder. J Clin Psychiatry 2008;69:923-9.
9. McFarlane AC, Atchison M, Yehuda R. The acute stress response following motor vehicle accidents and its relation to PTSD. Ann N Y Acad Sci 1997;821:437-41.
10. Carty J, O'Donnell ML, Creamer M. Delayed-onset PTSD: a prospective study of injury survivors. J Affect Disord 2006;90:257-61.
11. Orcutt HK, Erickson DJ, Wolfe J. The course of PTSD symptoms among Gulf War veterans: a growth mixture modeling approach. J Trauma Stress 2004;17:195-202.
12. Solomon Z, Mikulincer M. Trajectories of PTSD: a 20-year longitudinal study. Am J Psychiatry 2006;163:659-66.
13. Southwick SM, Morgan CA, Darnell A et al. Trauma-related symptoms in veterans of Operation Desert Storm: a 2-year follow-up. Am J Psychiatry 1995;152:1150-5.
14. Grieger TA, Cozza SJ, Ursano RJ et al. Posttraumatic stress disorder and depression in battle-injured soldiers. Am J Psychiatry 2006; 163:1777-83.

15. Bliese P, White K, Adler A et al. Post-Deployment Psychological Screening: Interpreting and Scoring DD Form 2900. Research Report 2005-003. Heidelberg: US Army Medical Research Unit - Europe, 2005.
16. Milliken CS, Auchterlonie JL, Hoge CW. Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. JAMA 2007;298:2141-8.
17. Benyamini Y, Solomon Z. Combat stress reactions, posttraumatic stress disorder, cumulative life stress, and physical health among Israeli veterans twenty years after exposure to combat. Soc Sci Med 2005;61:1267-77.
18. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th ed. Washington: American Psychiatric Association, 1994.
19. Buckley TC, Blanchard EB, Hickling EJ. A prospective examination of delayed onset PTSD secondary to motor vehicle accidents. J Abnorm Psychol 1996;105:617-25.
20. Andrews B, Brewin CR, Philpott R et al. Delayed-onset posttraumatic stress disorder: a systematic review of the evidence. Am J Psychiatry 2007;164:1319-26.
21. Pintor L, Gasto C, Navarro V et al. Relapse of major depression after complete and partial remission during a 2-year follow-up. J Affect Disord 2003;73:237-44.
22. Ramel W, Goldin PR, Eyler LT et al. Amygdala reactivity and mood-congruent memory in individuals at risk for depressive relapse. Biol Psychiatry 2007;61:231-9.
23. Leppanen JM. Emotional information processing in mood disorders: a review of behavioral and neuroimaging findings. Curr Opin Psychiatry 2006;19:34-9.
24. Hedtke KA, Ruggiero KJ, Fitzgerald MM et al. A longitudinal investigation of interpersonal violence in relation to mental health and substance use. J Consult Clin Psychol 2008;76:633-47.
25. Maes M, Mylle J, Delmeire L et al. Pre- and post-disaster negative life events in relation to the incidence and severity of post-traumatic stress disorder. Psychiatry Res 2001;105:1-12.
26. Rona RJ, Fear NT, Hull L et al. Mental health consequences of overstretch in the UK armed forces: first phase of a cohort study. BMJ 2007;335:603.
27. Freud S. The aetiology of hysteria. In: Strachey J (ed). The standard edition of the complete psychological works of Sigmund Freud, Vol. 3. London: Vintage, 1962.
28. McFarlane AC. Avoidance and intrusion in posttraumatic stress disorder. J Nerv Ment Dis 1992;180:439-45.
29. Wessa M, Flor H. Failure of extinction of fear responses in posttraumatic stress disorder: evidence from second-order conditioning. Am J Psychiatry 2007;164:1684-92.
30. Post RM, Weiss SR, Smith M et al. Kindling versus quenching. Implications for the evolution and treatment of posttraumatic stress disorder. Ann N Y Acad Sci 1997;821:285-95.
31. McFarlane AC, Yehuda R, Clark CR. Biologic models of traumatic memories and post-traumatic stress disorder. The role of neural networks. Psychiatr Clin North Am 2002;25:253-70.
32. Milad MR, Orr SP, Lasko NB et al. Presence and acquired origin of reduced recall for fear extinction in PTSD: results of a twin study. J Psychiatr Res 2008;42:515-20.
33. Rauch SL, Shin LM, Phelps EA. Neurocircuitry models of posttraumatic stress disorder and extinction: human neuroimaging research - past, present, and future. Biol Psychiatry 2006;60:376-82.
34. Marshall RD, Garakani A. Psychobiology of the acute stress response and its relationship to the psychobiology of post-traumatic stress disorder. Psychiatr Clin North Am 2002;25:385-95.
35. Kendler KS, Thornton LM, Gardner CO. Stressful life events and previous episodes in the etiology of major depression in women: an evaluation of the "kindling" hypothesis. Am J Psychiatry 2000; 157:1243-51.
36. Elzinga BM, Bremner JD. Are the neural substrates of memory the final common pathway in posttraumatic stress disorder (PTSD)? J Affect Disord 2002;70:1-17.
37. Miller L. Neurosensitization: a model for persistent disability in chronic pain, depression, and posttraumatic stress disorder following injury. NeuroRehabilitation 2000;14:25-32.
38. Shalev AY. Biological responses to disasters. Psychiatr Q 2000; 71:277-88.
39. Grillon C, Southwick SM, Charney DS. The psychobiological basis of posttraumatic stress disorder. Mol Psychiatry 1996;1:278-97.
40. Bonne O, Grillon C, Vythilingam M et al. Adaptive and maladaptive psychobiological responses to severe psychological stress: implications for the discovery of novel pharmacotherapy. Neurosci Biobehav Rev 2004;28:65-94.
41. Morgan CA, III, Grillon C, Southwick SM et al. Exaggerated acoustic startle reflex in Gulf War veterans with posttraumatic stress disorder. Am J Psychiatry 1996;153:64-8.
42. Shalev AY, Peri T, Brandes D et al. Auditory startle response in trauma survivors with posttraumatic stress disorder: a prospective study. Am J Psychiatry 2000;157:255-61.
43. Peri T, Ben-Shakhar G, Orr SP et al. Psychophysiologic assessment of aversive conditioning in posttraumatic stress disorder. Biol Psychiatry 2000;47:512-9.
44. McFarlane AC. Stress-related musculoskeletal pain. Best Pract Res Clin Rheumatol 2007;21:549-65.
45. Sledjeski EM, Speisman B, Dierker LC. Does number of lifetime traumas explain the relationship between PTSD and chronic medical conditions? Answers from the National Comorbidity Survey-Replication (NCS-R). J Behav Med 2008;31:341-9.
46. Kessler RC, Berglund P, Demler O et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005;62:593-602.
47. Andreski P, Chilcoat H, Breslau N. Post-traumatic stress disorder and somatization symptoms: a prospective study. Psychiatry Res 1998;79:131-8.
48. O'Malley PG, Jackson JL, Kroenke K et al. The value of screening for psychiatric disorders in rheumatology referrals. Arch Intern Med 1998;158:2357-62.
49. Patten SB, Williams JV, Wang J. Mental disorders in a population sample with musculoskeletal disorders. BMC Musculoskelet Disord 2006;7:37.
50. Simon GE, VonKorff M. Somatization and psychiatric disorder in the NIMH Epidemiologic Catchment Area study. Am J Psychiatry 1991;148:1494-500.
51. Stang PE, Brandenburg NA, Lane MC et al. Mental and physical comorbid conditions and days in role among persons with arthritis. Psychosom Med 2006;68:152-8.
52. Von Korff M, Crane P, Lane M et al. Chronic spinal pain and physical-mental comorbidity in the United States: results from the National Comorbidity Survey Replication. Pain 2005;113:331-9.
53. Zautra AJ, Smith BW. Depression and reactivity to stress in older women with rheumatoid arthritis and osteoarthritis. Psychosom Med 2001;63:687-96.
54. Pillemer SR, Bradley LA, Crofford LJ et al. The neuroscience and endocrinology of fibromyalgia. Arthritis Rheum 1997;40:1928-39.
55. Yehuda R. Post-traumatic stress disorder. N Engl J Med 2002; 346:108-14.
56. McEwen BS. The neurobiology of stress: from serendipity to clinical relevance. Brain Res 2000;886:172-89.
57. Korte SM, Koolhaas JM, Wingfield JC et al. The Darwinian concept of stress: benefits of allostasis and costs of allostatic load and the trade-offs in health and disease. Neurosci Biobehav Rev 2005;29: 3-38.
58. McBeth J, Silman AJ, Gupta A et al. Moderation of psychosocial risk factors through dysfunction of the hypothalamic-pituitary-adrenal stress axis in the onset of chronic widespread musculoskeletal pain: findings of a population-based prospective cohort study. Arthritis Rheum 2007;56:360-71.
59. Duric V, McCarson KE. Persistent pain produces stress-like altera-

tions in hippocampal neurogenesis and gene expression. J Pain 2006;7:544-55.
60. Staud R, Craggs JG, Robinson ME et al. Brain activity related to temporal summation of C-fiber evoked pain. Pain 2007;129:130-42.
61. Meeus M, Nijs J. Central sensitization: a biopsychosocial explanation for chronic widespread pain in patients with fibromyalgia and chronic fatigue syndrome. Clin Rheumatol 2007;26:465-73.
62. McLean SA, Clauw DJ, Abelson JL et al. The development of persistent pain and psychological morbidity after motor vehicle collision: integrating the potential role of stress response systems into a biopsychosocial model. Psychosom Med 2005;67:783-90.
63. Talley NJ, Spiller R. Irritable bowel syndrome: a little understood organic bowel disease? Lancet 2002;360:555-64.
64. Verne GN, Himes NC, Robinson ME et al. Central representation of visceral and cutaneous hypersensitivity in the irritable bowel syndrome. Pain 2003;103:99-110.
65. Nilsen KB, Sand T, Westgaard RH et al. Autonomic activation and pain in response to low-grade mental stress in fibromyalgia and shoulder/neck pain patients. Eur J Pain 2007;11:743-55.
66. Heiden M, Barnekow-Bergkvist M, Nakata M et al. Autonomic activity, pain, and perceived health in patients on sick leave due to stress-related illnesses. Integr Physiol Behav Sci 2005;40:3-16.
67. Kibler JL, Joshi K, Ma M. Hypertension in relation to posttraumatic stress disorder and depression in the US National Comorbidity Survey. Behav Med 2009;34:125-32.
68. Kinzie JD, Riley C, McFarland B et al. High prevalence rates of diabetes and hypertension among refugee psychiatric patients. J Nerv Ment Dis 2008;196:108-12.
69. O'Toole BI, Catts SV. Trauma, PTSD, and physical health: an epidemiological study of Australian Vietnam veterans. J Psychosom Res 2008;64:33-40.
70. Orr SP, Metzger LJ, Pitman RK. Psychophysiology of post-traumatic stress disorder. Psychiatr Clin North Am 2002;25:271-93.
71. Keane TM, Kolb LC, Kaloupek DG et al. Utility of psychophysiological measurement in the diagnosis of posttraumatic stress disorder: results from a Department of Veterans Affairs Cooperative Study. J Consult Clin Psychol 1998;66:914-23.
72. Bedi US, Arora R. Cardiovascular manifestations of posttraumatic stress disorder. J Natl Med Assoc 2007;99:642-9.
73. Gerin W, Chaplin W, Schwartz JE et al. Sustained blood pressure increase after an acute stressor: the effects of the 11 September 2001 attack on the New York City World Trade Center. J Hypertens 2005;23:279-84.
74. Bunker SJ, Colquhoun DM, Esler MD et al. "Stress" and coronary heart disease: psychosocial risk factors. Med J Aust 2003;178: 272-6.
75. Maia DB, Marmar CR, Mendlowicz MV et al. Abnormal serum lipid profile in Brazilian police officers with post-traumatic stress disorder. J Affect Disord 2008;107:259-63.
76. Karlovic D, Buljan D, Martinac M et al. Serum lipid concentrations in Croatian veterans with post-traumatic stress disorder, post-traumatic stress disorder comorbid with major depressive disorder, or major depressive disorder. J Korean Med Sci 2004;19:431-6.
77. Solter V, Thaller V, Karlovic D et al. Elevated serum lipids in veterans with combat-related chronic posttraumatic stress disorder. Croat Med J 2002;43:685-9.
78. Kagan BL, Leskin G, Haas B et al. Elevated lipid levels in Vietnam veterans with chronic posttraumatic stress disorder. Biol Psychiatry 1999;45:374-7.
79. Vieweg WV, Julius DA, Bates J et al. Posttraumatic stress disorder as a risk factor for obesity among male military veterans. Acta Psychiatr Scand 2007;116:483-7.
80. David D, Woodward C, Esquenazi J et al. Comparison of comorbid physical illnesses among veterans with PTSD and veterans with alcohol dependence. Psychiatr Serv 2004;55:82-5.
81. Perkonigg A, Owashi T, Stein MB et al. Posttraumatic stress disorder and obesity: evidence for a risk association. Am J Prev Med 2009;36:1-8.
82. Scott KM, McGee MA, Wells JE et al. Obesity and mental disorders in the adult general population. J Psychosom Res 2008;64:97-105.
83. Violanti JM, Fekedulegn D, Hartley TA et al. Police trauma and cardiovascular disease: association between PTSD symptoms and metabolic syndrome. Int J Emerg Ment Health 2006;8:227-37.
84. Kubzansky LD, Koenen KC, Spiro A, III et al. Prospective study of posttraumatic stress disorder symptoms and coronary heart disease in the Normative Aging Study. Arch Gen Psychiatry 2007;64:109-16.
85. Schneiderman N. Psychophysiologic factors in atherogenesis and coronary artery disease. Circulation 1987;76:141-7.
86. Vanitallie TB. Stress: a risk factor for serious illness. Metabolism 2002;51:40-5.
87. Boscarino JA. A prospective study of PTSD and early-age heart disease mortality among Vietnam veterans: implications for surveillance and prevention. Psychosom Med 2008;70:668-76.
88. Kang HK, Bullman TA, Taylor JW. Risk of selected cardiovascular diseases and posttraumatic stress disorder among former World War II prisoners of war. Ann Epidemiol 2006;16:381-6.
89. von Kanel R, Hepp U, Kraemer B et al. Evidence for low-grade systemic proinflammatory activity in patients with posttraumatic stress disorder. J Psychiatr Res 2007;41:744-52.
90. von Kanel R, Hepp U, Traber R et al. Measures of endothelial dysfunction in plasma of patients with posttraumatic stress disorder. Psychiatry Res 2008;158:363-73.
91. McEwen BS, Stellar E. Stress and the individual. Mechanisms leading to disease. Arch Intern Med 1993;153:2093-101.
92. Karlamangla AS, Singer BH, Seeman TE. Reduction in allostatic load in older adults is associated with lower all-cause mortality risk: MacArthur studies of successful aging. Psychosom Med 2006;68: 500-7.
93. McEwen BS, Wingfield JC. The concept of allostasis in biology and biomedicine. Horm Behav 2003;43:2-15.
94. McEwen BS. Mood disorders and allostatic load. Biol Psychiatry 2003;54:200-7.
95. Australian Centre for Posttraumatic Mental Health. Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder. Melbourne: Australian Centre for Posttraumatic Mental Health, 2007.
96. Raskind MA, Peskind ER, Kanter ED et al. Reduction of nightmares and other PTSD symptoms in combat veterans by prazosin: a placebo-controlled study. Am J Psychiatry 2003;160:371-3.
97. de Quervain DJ, Margraf J. Glucocorticoids for the treatment of post-traumatic stress disorder and phobias: a novel therapeutic approach. Eur J Pharmacol 2008;583:365-71.
98. Arns M, de Ridder S, Strehl U et al. Efficacy of neurofeedback treatment in ADHD: the effects on inattention, impulsivity and hyperactivity: a meta-analysis. Clin EEG Neurosci 2009;40:180-9.
99. Linden DE. Brain imaging and psychotherapy: methodological considerations and practical implications. Eur Arch Psychiatry Clin Neurosci 2008; 258 (Suppl. 5):71-5.
100. Clark CR, Galletly CA, Ash DJ et al. Evidence-based medicine evaluation of electrophysiological studies of the anxiety disorders. Clin EEG Neurosci 2009;40:84-112.