SUBMISSION TO THE SENATE REVIEW OF SCHEDULE 9

Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) Act 2025
Review of Schedule 9 establishing the Defence and Veterans' Services Commission

Executive Summary

This submission responds to the Senate's Review of Schedule 9 of the Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) Act 2025. It is made in the strongest and most urgent terms, urging the Parliament to ensure that the Defence and Veterans' Services Commission (DVSC) is not another symbolic oversight body. Instead, Schedule 9 must embed enforceable statutory powers, codified independence, and binding obligations for transparency, survivor-inclusion, and government accountability.

Drawing directly from the Royal Commission into Defence and Veteran Suicide (RCDVS), this submission highlights systemic failures through lived-case evidence including Jesse Bird, a Navy whistleblower, and Petty Officer David Finney. These tragedies, underscore the need for oversight that is immune to political influence and entrenched bureaucratic resistance.

It recommends specific legislative amendments to Schedule 9, aligned with key RCDVS recommendations (1, 4, 69, 122), and calls for mandatory public reporting, whistleblower protections, and referral powers to integrity bodies.

1. LEGISLATIVE CONTEXT AND PURPOSE

Schedule 9 provides a legislative mechanism to continue systemic inquiry and reform in the wake of the RCDVS. However, unless strengthened, the Commission risks becoming merely symbolic.

The intent of Schedule 9 must align with Recommendation 122 of the Royal Commission into Defence and Veteran Suicide, which states:

"Establish a new statutory entity to oversee system reform across the whole Defence ecosystem."

The Government has agreed to this recommendation. Schedule 9 must therefore embed enforceable statutory powers, not discretionary or symbolic roles.

2. THE DANGERS OF ANOTHER SYMBOLIC COMMISSION

The RCDVS Final Report highlights that:

"Over the past four decades, the Australian Government has accepted many recommendations to improve the support system. However, these changes have too often not been implemented in full or at all."

— Royal Commission into Defence and Veteran Suicide, Final Report, Vol. 1, p. 18

Without clear statutory authority, Schedule 9 risks replicating the same structural weaknesses that have failed to prevent deaths by suicide, including those of Jesse Bird and David Finney.

3. ACCOUNTABILITY, INDEPENDENCE AND RESOURCING

To be effective, the DVSC must be:
- Statutorily independent, reporting directly to Parliament
- Permanently resourced, with its own legal and investigative capacity
- Empowered to initiate systemic inquiries, compel cooperation, and refer matters to external oversight bodies

These conditions align with the intent behind Recommendation 1 of the RCDVS, which calls for changes to strengthen future oversight bodies:

"To enable the efficient operation of future royal commissions: [...] the Australian Government should amend the Royal Commissions Act 1902 (Cth) so there are meaningful consequences for non-compliance with a compulsory notice."

4. PAST FAILURES CANNOT BE ALLOWED TO CONTINUE

The RCDVS documented decades of inaction despite repeated reviews:

- The Clarke Review (2003)
- The Toose Review (1994)
- Senate Inquiry into Veteran Suicide (2017)
- Productivity Commission Report (2019)

To ensure Schedule 9 does not replicate past failings, it must embed enforceable monitoring powers and legislated reporting obligations. This reflects the spirit of Recommendation 4, which addresses systemic disruption and calls for fairness and stability:

"Defence should work to mitigate the adverse impacts of the posting cycle on members and their families [...] prioritise the stability of location for families with school-aged children [...] and ensure that decisions about who should move or not move are transparent and fair."

5. RECOMMENDED AMENDMENTS TO SCHEDULE 9

Schedule 9 must include legislative safeguards to:
- Enshrine DVSC's statutory independence
- Mandate direct reporting to Parliament
- Require transparent government response to DVSC findings
- Protect whistleblowers
- Empower DVSC to escalate systemic failures

These align with Recommendation 69:

"The Australian Defence Force should revise and improve its suicide-prevention training so it: [...] delivers all suicide prevention training in-person by no later than 31 December 2025."

Like that recommendation, Schedule 9 must impose enforceable deadlines and practical accountability.

6. Case Studies of Systemic Harm

The Royal Commission into Defence and Veteran Suicide has documented real-life tragedies that exemplify the systemic failures the DVSC must prevent.

One such case is that of Jesse Bird, an Afghanistan veteran who died by suicide in 2017. Despite lodging multiple claims with the Department of Veterans' Affairs (DVA), he was denied incapacity payments in the final weeks of his life. His mother testified that DVA delays and rejections reflected a culture of 'delay, deny, die'. Jesse's case became a catalyst for the establishment of the Royal Commission.

Another example comes from a former Royal Australian Navy officer who gave evidence to the Royal Commission. After enduring severe workplace bullying and being subjected to an unfair internal inquiry while hospitalised in psychiatric care, the officer was discharged and left without adequate support. Their story illustrates the re-traumatisation that occurs without meaningful systemic protections.

A particularly poignant case is that of Royal Australian Navy Petty Officer David Finney, who served for 20 years. Following a suicide attempt in 2017, he sought mental health support but was told there would be a six-month wait. He died by suicide in 2019. His mother, Julie-Ann Finney, led a national campaign which directly contributed to the establishment of the Royal Commission.

These tragedies reinforce the urgent need for DVSC to be independent, empowered, and permanent.

7. CONCLUSION

This is a critical moment. The creation of the DVSC must not become another token gesture. The Royal Commission made it clear: change must be enforceable, transparent, and survivor-informed. The lives of current and future ADF

members and veterans depend on getting this right.

The Parliament has a choice: enshrine systemic oversight with teeth—or condemn another generation of veterans to bureaucracy, delay, and preventable harm.

Submission to the Review of Schedule 9 – Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) Act 2025Appendix: Alignment with RCDVS Recommendations

RCDVS Recommendation	Recommendation (Exact Wording)	Government Response
Rec 1	To enable the efficient operation of future royal commissions: [...] amend the Royal Commissions Act 1902 (Cth) [...] ensure more independent representation in government [...] apply consistent and transparent arrangements to allow access to material covered by public interest immunity.	Note
Rec 4	Defence should work to mitigate the adverse impacts of the posting cycle on members and their families, particularly children [...] prioritise the stability of location for families with school-aged children.	Agree
Rec 69	The ADF should revise and improve its suicide-prevention training [...] delivers all suicide prevention training in-person by no later than 31 December 2025.	Agree
Rec 122	Establish a new statutory entity to oversee system reform across the whole Defence ecosystem.	Agree