IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 3044

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF JESSE STEPHEN BIRD

Findings of:	Coroner Jacqui Hawkins
Delivered On:	7 April 2020
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	2-3 May 2019 and 4 February 2020
Counsel Assisting the Coroner:	Senior Sergeant Jenette Brumby, Police Coronial Services Unit, instructed by Mr James Cameron and Ms Elizabeth Morris of the Coroners Court of Victoria
Representation:	Mr Matt Black of counsel representing the Bird family, instructed by Mr Greg Isolani, of KCI Lawyers Ms Catherine Fitzgerald of counsel representing Australian Defence Force and the

	Department of Veterans' Affairs, instructed by Mr Evan Evagorou and Ms Susannah Madden of the Australian Government Solicitor Ms Felicity Cockram of counsel representing Dr Velakoulis, instructed by Ms Madhavi Ligam of Avant Law
Catchwords	VETERAN SUICIDE, EX-SERVING DEFENCE PERSONNEL, AUSTRALIAN DEFENCE FORCE, DEPARTMENT OF VETERANS' AFFAIRS, POST TRAUMATIC STRESS DISORDER, VETERAN CENTRIC REFORM, COMPENSATION FOR PERMANENT IMPAIRMENT, INCAPACITY PAYMENTS

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SUMMARY

1. On 27 June 2017, Jesse Stephen Bird, a 32-year-old army veteran, was found deceased in his home in St Kilda. He was surrounded by his service medals, military equipment, and documentation relating to his service history, mental health issues, and Department of Veterans' Affairs (**DVA**) claims. It was apparent that Jesse had taken his own life.

2. The coronial investigation identified that Jesse had a history of psychological injuries, including post-traumatic stress disorder (**PTSD**), associated with his service in the army. Jesse's mental health had deteriorated in the years leading up to his death in the setting of financial and emotional stressors that were exacerbated by delays and difficulties he faced in claiming financial support and compensation from DVA for his service-related psychological injuries.

3. This inquest examined Jesse's experiences during his army service, subsequent transition from the army to civilian life, and navigation of the DVA compensation system. It explored how psychological injuries such as PTSD manifest, the treatment options available for veterans, and the supports provided to Department of Defence (**Defence**) personnel both during service and following discharge. It also reviewed the ongoing reforms being implemented by Defence and DVA, and identified further prevention opportunities designed to better identify, support, assist and compensate ex-service personnel at risk of, or suffering from, psychological injuries.

CORONIAL INVESTIGATION

Jurisdiction

4. Jesse's death constituted a *'reportable death'* pursuant to section 4 of the *Coroners Act 2008* (Vic) (**Coroners Act**), as his death occurred in Victoria and was unexpected.

Purpose of the Coronial Jurisdiction

5. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

[1] Section 89(4) *Coroners Act 2008*.

6. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

9. Coroners are empowered to:

   (a) report to the Attorney-General on a death;

   (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

   These powers are the vehicles by which the prevention role may be advanced.

10. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[2] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3]

[2] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[3] *Keown v Khan* (1999) 1 VR 69.

Standard of Proof

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[4] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[5]

12. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[6] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

13. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[7] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[8]

Coronial Inquest

14. Section 52(1) of the Coroners Act provides that a coroner may hold an inquest into any death that the coroner is investigating. This discretion must be exercised in a manner consistent with the preamble and purposes of the Coroners Act.

15. In deciding whether to conduct an inquest a coroner may consider factors including (but not limited to):

    (a) whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process;

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[4] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[5] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J, noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[6] (1938) 60 CLR 336.
[7] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[8] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

(b) whether there is a likelihood that an inquest will uncover important systemic defects or risks not already known about;

(c) whether an inquest is likely to assist in maintaining public confidence in the administration of justice, health services or other public agencies;

(d) whether the family or another person has requested the inquest; and

(e) to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths.[9]

16. On 21 July 2017, Mr and Mrs Bird submitted an application requesting that an inquest into Jesse's death. At that stage, the coronial investigation had only just begun, and therefore I initially deferred my decision pending receipt and review of the Coronial Brief.

17. On 21 February 2019, I conducted a mention hearing to assist me in determining whether there was a need for an inquest. Although the immediate circumstances surrounding Jesse's death were non-controversial, I determined to exercise my discretion to hold an inquest as I considered that there were matters of public health and safety that warranted further exploration through a public hearing. Specifically, it appeared that there had been systemic failings by DVA in the processing of Jesse's claims for compensation in the year prior to his death which had been a contributing factor in Jesse's decision to end his life.

Scope of Inquest

18. The purpose of the inquest was to investigate the following issues:

(a) Jesse's experience navigating DVA claims processes, including observations made by family and others as to the impact this had on Jesse;

(b) systemic issues faced by ex-service personnel like Jesse in navigating DVA processes to obtain support, assistance and compensation post discharge from Defence services;

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[9] State Coroners Guidelines, Queensland, December 2003, 8.3; *Chiotelis v Coate* [2009] VSC 256; *Conway v Jerram* [2010] NSWSC 371; United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (the Luce Report), Cmnd 5831 (2003), 80; *Coroners Bench Book 2007*, New Zealand, 166; United Kingdom, *Report of the Committee on Death Certification and Coroners*, Cmnd 4810 (1971), para 14.19 (the *Brodrick report*).

(c) current progress of reforms undertaken by Defence and DVA following Jesse's death; and

(d) the nature and manifestation of psychological injuries, including PTSD, in veterans following deployment and active service, the treatment options available to ex-service personnel, and the best practices for supporting the mental health and wellbeing of veterans following their discharge from service.

19. As my investigation was focussed upon examining systemic issues and it was not my intention to blame individuals, I determined *not* to call any DVA or Defence personnel directly involved in the management of Jesse's case.

Witnesses

20. The following witnesses were called to give *viva voce* evidence at Inquest:

(a) Mrs Karen Bird;

(b) Mr John McNeill, Volunteer Veteran Advocate;

(c) Major General Natasha Fox, Head People Capability at Department of Defence;

(d) Ms Elizabeth Cosson, Secretary at Department of Veterans' Affairs; and

(e) Dr Arthur Velakoulis, Consultant Psychiatrist.

Inquiries and Investigations

21. At the outset, I should note that shortly after Jesse's death, DVA and Defence conducted a joint inquiry (**Joint Inquiry Report**) into the management of Jesse's case. The Joint Inquiry Report led to an on-the-papers examination by Carolyn Spiers (**Spiers Report**) in which she was tasked to identify areas of potential non-compliance with DVA legislation and policy. Subsequently, in March 2019, Emeritus Professor Robin Creyke (**Creyke Review**) completed a review of the implementation of recommendations from the Joint Inquiry Report. A brief outline of the findings and recommendations resulting from these reports is detailed below.

22. These reports have assisted my investigation in allowing me to identify the key issues requiring further investigation, narrow the scope of the inquest, and obviate the need to call any or all of the individual DVA officers directly involved in Jesse's case to give evidence at inquest. In this regard, I have been mindful of the objectives of the Coroners Act to avoid unnecessary duplication of inquiries or investigations.[10]

23. In addition to these specific inquiries into the management of Jesse's claim, there have also been a significant number of systemwide reviews into DVA and veteran suicides over the past few years, including 13 reviews into DVA alone. These have included:

    (a) Productivity Commission inquiry report on the veterans' compensation and rehabilitation system;

    (b) Senate Foreign Affairs, Defence and Trade References Committee inquiry report into suicide by veterans and ex-service personnel; and

    (c) Australian National Audit Office review report into the efficiency of veterans' service delivery by DVA.

24. Many of these reports are subject to parliamentary privilege[11] and I am unable to make any findings or draw any inference or conclusions in relation to those reports. I note these reports for completeness, as I have been informed that they have assisted in shaping the recent and ongoing implementation of reforms across DVA and Defence.

Sources of Evidence

25. This Finding draws on the totality of the coronial investigation into Jesse's death. That is, the court records maintained during the coronial investigation, the Coronial Brief and further material sought and obtained by the Court, the evidence adduced during the Inquest and oral and written submissions provided by Counsel Assisting and Counsel Representing the Interested Parties.

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[10] Section 7.

[11] Section 16(3) of the *Parliamentary Privileges Act 1987* (Cth) states that in proceedings in any court or tribunal (which extends to the Coroners Court) is not lawful for evidence to be tendered or received, questions asked, or statements, submissions or comments made, concerning proceedings in parliament, by way, or for the purpose of:

(a) questioning or relying on the truth, motive, intention or good faith of anything forming part of those proceedings in Parliament;
(b) otherwise questioning or establishing the credibility, motive, intention or good faith of any person; or
(c) drawing, or inviting the drawing of, inferences or conclusions wholly or partly from anything forming part of those proceedings in Parliament.

26. In writing this Finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence should not lead to the inference that it has not been considered.

IDENTITY OF DECEASED

27. On 27 June 2017, Jesse Stephen Bird was visually identified by his friend Jay Dougrey. Jesse's identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

28. On 28 June 2017, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on the body of Jesse and reviewed the Form 83 Victoria Police Report of Death, and the post mortem computed tomography scan.

29. The external examination revealed a ligature mark in keeping with the overlying ligature.

30. Toxicological analysis of post-mortem blood revealed the presence of duloxetine[12], ketamine[13] and Delta-9-tetrahydrocannabinol[14].

31. Dr Francis provided an opinion that the medical cause of death was *"1(a) neck compression in the circumstances of hanging*". I accept this as the cause of death.

BACKGROUND

Personal History

32. Jesse was born in East Melbourne on 1 November 1984. He was of Torres Strait Islander descent. Jesse was described by his mother to be the *"life of the party*" who was very loyal and had a good heart.

[12] Duloxetine is a medication used to treat major depressive disorder, generalised anxiety disorder, fibromyalgia and neuropathic pain.
[13] Ketamine is a medication mainly used for starting and maintaining anaesthesia. It is also used for sedation in intensive care and in the treatment of pain and depression.
[14] Delta-9-tetrahydrocannabinol is an active ingredient in cannabis.

33. When Jesse was very young, his mother Karen separated from his birth father, Arnold Wallis. Karen later married John Bird and had two more children, Brendan and Kate. When Jesse was about four years old, John formally adopted Jesse so that he could carry the same family name as he and Mrs Bird. Jesse had close relationships with Brendan and Kate, as well as his half-brother David Wallis. It is evident to me that Jesse grew up in a loving family.

34. Jesse's experiences during his army service, subsequent discharge and transition to civilian life, as well as his mental health history, financial and emotional stressors and DVA claims history, form an important part of his narrative. It is necessary to set out these facts as they have informed me in my investigation as to the circumstances of, and contributing factors to, Jesse's death.

Jesse's Army Experience

Enlistment

35. Jesse enlisted in the Australian Army in 2007, undertaking the Army Recruit Course from 10 April to 1 July 2007. He was later trained to be a Rifleman. Jesse was a member of the 1st Battalion, Royal Australian Regiment (**1RAR**) based in Townsville.

36. According to Major General Fox, Jesse's battalion had a strong focus on looking after the welfare of the people in the unit. She said that if an individual was mentally unwell they were encouraged to seek assistance.[15] The commanding officers were attuned to the welfare of each other[16] and they created an environment where it was okay to self-refer for psychological assistance.[17] A commanding officer would be able to make a direct referral for a person to go to a doctor,[18] but the preference was for people to self-refer.[19] Major General Fox stated, "*we create an environment where self-referral is the most appropriate means*."[20]

[15] Transcript of evidence, p145.
[16] Transcript of evidence, p166.
[17] Transcript of evidence, p167.
[18] Transcript of evidence, p172.
[19] Transcript of evidence, p146.
[20] Transcript of evidence, p172.

37. Jesse enjoyed the Army, which eventually led to his half-brother David joining too. Jesse and David developed a strong relationship "*forged on being able to talk about shared military experience"*.[21]

38. Jesse's commanding officers provided an insight into Jesse's contribution to the Defence Force.

39. Brigadier Andrew Hocking stated that Jesse was a capable solider with a strong sense of duty. According to him, Jesse was well liked by his peers and was a trusted and valued friend who could be relied upon even in the most challenging of circumstances. Jesse was also known for his swimming prowess and general athleticism and had been identified as a junior leader.[22]

40. Lieutenant Colonel Benjamin McLennan described Jesse as being a well-rounded soldier, who took his profession seriously and could be relied upon to employ his skill-at-arms with mastery.[23]

41. Major Julian Thirkill stated that "*Jesse thrived in a team environment that was central to our success as an Infantry Company. I could always rely on him to make a positive contribution to the overall team effect and he consistently showed himself to fully understand that teamwork was one of the most important aspects of our profession*."[24]

Deployment

42. In May 2009, Jesse was deployed to Tarin Kot, Afghanistan along with the 1RAR battalion, for nine months as part of Operation Slipper, which was part of the Second Mentoring and Reconstructing Task Force (**MRTF-2 Taskforce**). He was 24 years old at the time.

[21] Exhibit 15 - Coronial Brief, p56.
[22] Exhibit 15 – Coronial Brief, p69.
[23] Exhibit 15 – Coronial Brief, p69.
[24] Exhibit 15 – Coronial Brief, p2217.

43. Jesse's deployment to Afghanistan as a rifleman was part of Australia's military contribution to the International Security Assistance Force and International Coalition against Terrorism.[25] The MRTF-2 Taskforce assisted in providing a secure environment for the Afghan people to hold democratic elections and mentored the Afghan National Army (**ANA**) to develop their capacity and enable them in the short term to conduct counter-insurgency operations, primarily against the Taliban.[26]

44. Jesse's operational duties included undertaking security patrols, providing security for elections and searches of Improvised Explosive Devices (**IEDs**), providing cordons and safety nets and searching persons and vehicles for threats.[27] He was also required, when necessary, to engage the enemy under fire.[28]

45. Jesse was also qualified to provide Combat First Aid, which meant that he could provide initial first aid to other soldiers immediately following an incident until medical personnel were able to take over medical treatment.[29]

46. During his deployment, Jesse also took the initiative to learn Pashto, a national language of Afghanistan. According to Major Thirkill, *"the ability to talk to locals in their own language proved to be a highly useful skill which underscored Jesse's determination to contribute to the overall team effort*".[30]

47. In recognition of his service, Jesse was awarded the *Afghanistan Campaign Medal*, the *Australian Active Service Medal with Clasp ICAT,* the *NATO Non Article 5 Medal with Clasp – ISAF,* and the *Australian Defence Medal*.[31]

Exposure to risks and hazards

48. Jesse's good friend in 1RAR, Aaron Harmer, explained that during their deployment, they were exposed to a number of life-threatening actions or hostile engagements with the enemy. This included *"IEDs, small arms fire, sniper fire, mortar fire and grenades, suicide attacks, vehicle bombing attacks and medical emergencies*".[32]

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[25] Exhibit 15 - Coronial Brief, p101.
[26] Transcript of evidence, p134; Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2121.
[27] Exhibit 15 – Coronial Brief, p102.
[28] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2121.
[29] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2121.
[30] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2217.
[31] Exhibit 15 – Coronial Brief, p357.
[32] Exhibit 15 – Coronial Brief, p102.

49. Brigadier WG Budd, Chief of Staff of the Australian Defence Force Headquarters confirmed that Jesse was involved in one IED incident during his deployment where he was subsequently assessed for concussion. It was also reported that *"it is possible that Jesse was exposed to two other IED incidents, however there is no conclusive evidence of these additional exposures"*.[33]

50. On 18 July 2009, one of Jesse's close friends in 1RAR, Private (**Pvt**) Benjamin Ranaudo was killed by an IED during their deployment. This incident had a lasting impact on Jesse. Pvt Ranaudo was the 11th Australian soldier to die in that war.[34] In early September 2009, with the encouragement of his chain of command, Jesse self-referred for psychological assistance to cope with the death of Pvt Ranaudo.[35]

51. Jesse's exposure to hazards and risks during his deployment in Afghanistan was documented in Occupational Health and Safety incident reports (**OHS Reports**) completed by his commanding officers.[36] The OHS Reports were designed to identify the risks Defence personnel may have experienced and capture and record incidents and potential lessons on Defence's computer system.[37]

52. On 22 December 2009, Major Thirkill documented in an OHS Report that Jesse should receive psychological support post deployment.[38]

53. On 30 January 2010, Major Michael McMillan noted in another OHS Report that Jesse had been exposed to "*possible mental trauma*" and recommended that he "*should receive psychological support post deployment*".[39]

Return to Australia

54. Jesse returned to Australia from deployment in about early February 2010.

55. Jesse's family saw an obvious change in him after his return from Afghanistan. According to Mrs Bird, when Jesse arrived back to Australia after his deployment, she noticed Jesse was distant, moody and intolerant of being asked questions about his time in Afghanistan, but she attributed it to *"a bit of culture shock"*. Jesse appeared to keep

[33] Exhibit 15 – Coronial Brief, p148.
[34] Submissions on behalf of the Bird Family dated 26 July 2019, p6.
[35] Transcript of evidence, p 145; Exhibit 15 – Coronial Brief, p308.
[36] Transcript of evidence, p144.
[37] Transcript of evidence, p170.
[38] Exhibit 15 – Coronial Brief, pp163, 165
[39] Exhibit 15 – Coronial Brief, pp162-3, 165.

his family at arm's length, was reluctant to discuss issues of his deployment, and never spoke about his mental health.[40] Mrs Bird said "*I knew from early on that Jesse returned to us a different man with something inside of him that he didn't want to share; something that kept the Jesse we knew before at a distance*."[41]

56. Defence undertakes deployment related psychological screening to identify and provide early intervention for mental health issues experienced by Defence personnel during active service. This includes psycho-educational briefings and training about homecoming and re-integration, a Return to Australia Psychological Screen (**RtAPS**), a Post Operational Psychological Screen (**POPS**) and provision of follow up support as needed.[42]

57. The RtAPS is undertaken at the end of deployment, and the POPS is undertaken three to six months after the return from service.[43] These screens require personnel to complete a set of standardised mental health screening questionnaires, followed by an interview by a psychologist or an examiner psychologist to explore the outcomes of the screens.[44]

58. According to Major General Fox, the results of the screening tests determine whether the interview is conducted by a psychologist or an examiner psychologist. Examiner psychologists are psychology para-professionals who undertake a range of duties under the supervision of a Defence psychologist. These duties include test administration, records management, screening, psycho-educational presentations, research tasks such as survey administration and data entry, and the management of a psychological practice in the context of a military unit.[45] Where the interview is conducted by an examiner psychologist, a psychologist reviews the screening documentation as well as the interview notes and endorses (or otherwise) the final recommendation.[46]

[40] Exhibit 15 – Coronial Brief, pp56-57.
[41] Exhibit 15 – Coronial Brief, p57.
[42] Exhibit 15 – Coronial Brief, p2333; Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p 2132.
[43] Transcript of evidence, p164.
[44] Transcript of evidence, p164.
[45] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2314.
[46] Transcript of evidence, p164.

59. Jesse undertook the RtAPS on 5 February 2010, at the end of his deployment to Afghanistan. Jesse reported his experience as "*positive*" and no areas of concern were identified in the screening.[47] The interview was conducted by an examiner psychologist who noted that "*overall [Jesse] appears to be coping with his experiences on deployment at this stage, with no discernible signs or indications of distress being displayed*".[48]

60. On 28 April 2010, Jesse presented to a medical officer with insomnia. It was noted that there were "*no signs of PTSD yet*" and he was referred to the Veterans and Veterans Families Counselling Service (**VVCS**).[49]

61. Jesse first saw a counsellor through VVCS on 6 June 2010. The counsellor noted that Jesse had:

> *returned from Afghanistan and has developed a problem with his sleep. Said he will have events from the deployment going around in his head. The thoughts are not particularly frightening and more often he feels 'sad' or 'pissed off' about the death of one of his mates, and thinks about what could have happened to him*.[50]

62. VVCS made no referrals or urgent recommendations to Defence as a result of Jesse's counselling sessions.[51]

63. The POPS is considered to be a *"really critical"* psychological screen as it occurs a number of months after the return from deployment, indicates a soldier's wellbeing and provides an opportunity to identify members currently in need of assistance and to provide early treatment to promote recovery and continued wellbeing.[52]

[47] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2132; Transcript of evidence, p165.
[48] Exhibit 15 - Coronial Brief, p2325.
[49] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2132.
[50] Exhibit 15 - Coronial Brief, p1617.
[51] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2133.
[52] Transcript of evidence, p139-140; Exhibit 15 – Coronial Brief, p2318.

64. Jesse completed the POPS on 15 June 2010, approximately five months after he returned from deployment. Again, Jesse reported that his deployment experience was "*positive*", and no issues were identified in the screening. The interview was again conducted by an examiner psychologist who did not have access to Jesse's OHS Reports.[53]

65. The examiner psychologist recorded that Jesse had:

> *ongoing difficulties in dealing with the death of a close friend who was KIA [killed in action]. [Jesse] reported a great deal of difficulty getting adequate sleep as he continues to ruminate on his deployment experience. PTE Bird reported eating a healthy diet and maintaining adequate fitness. The mbr rated his overall mood as flat*.[54]

66. The examiner psychologist noted that Jesse had been able to implement several adaptive coping strategies which were gradually improving the situation since he had been engaged in counselling.[55] As Jesse was already engaging in counselling with VVCS, he was not referred to a psychologist. The POPS report was later reviewed and signed by a psychologist.[56]

Shoulder Injury

67. In March 2011, Jesse underwent surgery for a right shoulder injury that he had sustained during his deployment to Afghanistan.

68. In October 2011, whilst Jesse was applying for discharge from the army, he lodged a claim with DVA seeking acceptance of liability for his right shoulder injury.[57] Jesse indicated in his claim form that he was also seeking both permanent impairment compensation and incapacity payments if liability was accepted.[58]

69. DVA subsequently accepted liability for Jesse's right shoulder injury on 19 March 2012.[59] However, confirmation of this acceptance was sent to an incorrect address in Queensland.[60] It appears Jesse never received this communication as he subsequently

[53] Transcript of evidence, p146-147.
[54] Exhibit 15 - Coronial Brief, p2184.
[55] Exhibit 15 - Coronial Brief, p2184.
[56] Transcript of evidence, p146-147.
[57] Exhibit 15 – Coronial Brief, p487.
[58] Exhibit 15 – Coronial Brief, p490.
[59] Exhibit 15 – Coronial Brief, p413.
[60] Exhibit 15 – Coronial Brief, p310.

resubmitted a claim for his shoulder injury on 9 November 2012. DVA acknowledged receipt of this resubmitted claim form on 20 November 2012.[61]

70. On 17 April 2013, DVA recorded that Jesse had withdrawn his resubmitted claim form as he "*did not realise that his claim had already been accepted*" and noted that Jesse had not received the letter accepting his condition due to a change of address.[62]

Discharge

71. Jesse applied for discharge from the army in about July 2011, whilst he was undergoing rehabilitation for his shoulder injury.

72. As part of the discharge process, Jesse was required to undergo a Separation Health Examination (**SHE**). All Defence members are required to complete a SHE when they cease permanent service, regardless of their reason for leaving.[63] The SHE process "*provides members the opportunity to make a statement indicating if they have any health issues to report*."[64]

73. The SHE involves a review of the individual's health during service and documents their health status on transition and a handover of any ongoing health care needs to the civilian health sector.[65] The medical officer conducting the examination will provide relevant information for the individual to take to a general practitioner post-transition. The health needs of the individual determine the amount and type of information provided.[66]

74. In preparation for the SHE, Defence members undergo a Medical Employment Classification (**MEC**) review.[67]

[61] Exhibit 15 – Coronial Brief, p310.
[62] Exhibit 15 – Coronial Brief, p310.
[63] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2134.
[64] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2134.
[65] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2134; Exhibit 15 – Coronial Brief, p2403.
[66] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2134.
[67] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2134; Exhibit 15 – Coronial Brief, p2403.

75. On 30 November 2011, Jesse underwent an MEC review in relation to his shoulder problems.[68] He was assessed as having recovered from his shoulder injury and was considered "*fit for full duties*". Accordingly, Jesse did not warrant a medical separation.[69]

76. Jesse did not undertake any psychiatric or psychological screening as part of the discharge process at his own request.[70]

77. On 18 January 2012, Jesse underwent the SHE. He did not disclose any mental health issues but ticked "*yes*" when asked whether he was having trouble sleeping or regularly binge drinking.[71] No fresh psychological screening was undertaken, and the SHE assessor was not aware of the recommendations contained in Jesse's OHS Reports that he receive psychological support post deployment.[72] Jesse was assessed as "*MEC J1I*", that is, fully employable and deployable, which meant that he was fit to remain in service.[73]

78. In accordance with the then standard practice, Defence offered to provide Jesse's details to DVA and VVCS for ongoing support post discharge. According to Major General Fox, Jesse declined this offer.[74] My investigation has been unable to ascertain why Jesse declined to provide his details to DVA. However, I note that as Jesse had previously engaged with VVCS for counselling in 2010 and with DVA in respect of his right shoulder injury claim in October 2011, he may not have considered it necessary for his details to again be provided to either organisation.

79. On 29 January 2012, Jesse's discharge from the army took effect. On discharge he was recorded as having a physical injury to his right shoulder. No psychological injury was documented.

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[68] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2135.
[69] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2136; A 'medical separation' occurs when a military member is separated (or retired) from the military for medical reasons as they have a medical condition (including mental health conditions) that renders them unfit to perform their required duties.
[70] Submissions on behalf of the Bird Family dated 26 July 2019, p9.
[71] Submissions on behalf of the Bird Family dated 26 July 2019, p9.
[72] Submissions on behalf of the Bird Family dated 26 July 2019, p9.
[73] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2136.
[74] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2127.

Transition from Defence to Civilian Life

Return to Civilian Life

80. Jesse moved in with his half-brother David and David's partner Kate whilst he transitioned out of Defence. According to David and Kate, Jesse displayed aggressive and moody behaviour, had poor eating and sleeping habits, and was drinking heavily.[75]

Attempt to Re-Enlist

81. Twelve months after his discharge from Defence, Jesse commenced the process for re-enlisting.[76] On 30 January 2013, Jesse contacted Defence Force Recruiting (**DFR**) and expressed his intention to re-commence service.[77]

82. During February 2013, Jesse was in regular contact with DFR to complete the documentation and he completed an application form and an authority to release his health records.[78] At the time, the recruitment team was unable to access Jesse's health records, so they relied upon a review of the medical history questionnaire on his application form.[79]

83. On 11 March 2013, a recruiting officer wrote to Jesse stating that because he had a history of attention deficit disorder, it would affect his ability to join Defence and he was medically unfit for the role of Clearance Diver.[80]

84. Subsequently, on 20 March 2013, Jesse changed his preference to Commando and completed a physical fitness assessment.[81] He was confirmed suitable to proceed to an initial assessment session where an Entry Level Medical Examination, psychology assessment and a Defence Interview would have been undertaken for his then preference for Commando.[82]

[75] Exhibit 15 – Coronial Brief, p57.
[76] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2127.
[77] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2127.
[78] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2127 & p2198.
[79] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2127.
[80] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2127 and Exhibit 15 – Coronial Brief, p2225.
[81] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2127 and Exhibit 13 – Further Supplementary Statement of Major General Natasha Fox dated 26 July 2019, p2.
[82] Exhibit 13 – Further Supplementary Statement of Major General Natasha Fox dated 26 July 2019, p2.

85. On 4 April 2013, a medical officer confirmed Jesse was *"suitable"* to proceed to an initial assessment session.[83]

86. On 6 May 2013 Defence requested further paperwork from Jesse.[84] Eight days later Defence sent Jesse a letter and advised that his enlistment application was no longer active as a result of him not returning their calls.[85] On 29 May 2013, Defence sent a further letter to Jesse advising him that he had been withdrawn as a candidate.[86] My investigation has been unable to ascertain why Jesse did not pursue his application for re-enlistment. It is possible that he chose not to continue with the application as he was able to secure alternative employment.

Post-Army Employment

87. Whilst Jesse was attempting to re-enlist with the Army in early 2013, Jesse moved to Melbourne and secured employment with a National Broadband Network (**NBN**) contractor. Jesse left NBN in October 2013 and began working for Wilson Security on Nauru Island at the Regional Processing Centre. He worked there until his contract concluded in 2015. Whilst employed with Wilson Security, Jesse applied unsuccessfully for other employment opportunities, including with the Australian Federal Police and the Victorian Metropolitan Fire Brigade.[87]

Relationship with Connie Boglis

88. During this time, Jesse was in a relationship with Connie Boglis. He had first met Ms Boglis in April or May 2014 and they commenced their relationship shortly afterwards. Early in their relationship, Ms Boglis observed that Jesse was experiencing night terrors and mood problems.[88] She thought Jesse was suffering from PTSD and encouraged him to seek help and support from VVCS and a psychiatrist. Ms Boglis assisted Jesse in engaging with DVA and enquiring as to his potential entitlements, and helped him to put support structures in place.[89]

[83] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2128.
[84] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2128.
[85] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2128.
[86] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, p2128; Exhibit 15 – Coronial Brief, p311.
[87] Exhibit 15 – Coronial Brief, p59.
[88] Exhibit 15 – Coronial Brief, p59.
[89] Exhibit 15 – Coronial Brief, p60; Transcript of evidence, p72.

89. Their relationship was positive, but in February 2016 Ms Boglis suffered a miscarriage which saddened both her and Jesse. This placed additional pressure on their relationship and they eventually broke up in July 2016.

Engagement with mental health services

90. By 2015, Jesse's family had noticed a deterioration in his mental health. Mrs Bird commented that she became increasingly aware that her son was developing a deep-seated mental health issue that was directly related to his military service.[90] She said his inability to get help just compounded that disease state.[91]

91. Later that year, Jesse was formally assessed and diagnosed with mental health issues, including PTSD, associated with his service in the Army. His General Practitioner referred Jesse to Consultant Psychiatrist Dr Arthur Velakoulis for treatment of depression, PTSD and anger.[92]

92. Jesse first saw Dr Velakoulis on 29 September 2015. On clinical examination, Dr Velakoulis reported that Jesse was miserable, despondent and had transient suicidal thinking.[93]

93. Jesse subsequently lodged a claim with DVA on 13 October 2015 seeking access to health care for his psychiatric conditions, including ongoing treatment by Dr Velakoulis.[94] The claim was accepted and DVA issued Jesse a White Card entitling him to medical treatment for his accepted psychiatric conditions.

DVA Claims for Permanent Impairment and Incapacity Payments

Initial lodgement of claim

94. Jesse found it difficult to secure and maintain stable employment in the setting of his emotional stressors and mental illness. He last worked in around March 2016. By May 2016, he was experiencing significant financial hardship and was reliant on his parents to provide him with financial assistance.

[90] Transcript of evidence, p72.
[91] Transcript of evidence, p72.
[92] Transcript of evidence, pp265-6.
[93] Transcript of evidence, p275.
[94] Exhibit 15 – Coronial Brief, p311.

95. Jesse eventually sought financial assistance from DVA for his service-related psychiatric conditions and lodged a claim with DVA on 18 May 2016 seeking to have liability accepted for his PTSD, depression and alcohol abuse.

96. According to Jesse's family members, this would have taken great courage and effort for Jesse because he "*eschewed the idea of welfare or a hand-out*" and "*didn't like the thought of having to ask for benefits*".[95] He "*would have loathed admitting he wasn't well*"[96] and would have "*seen it as a sign of weakness*."[97]

97. On 5 August 2016, DVA accepted liability for Jesse's claim. DVA's acceptance letter did not refer to or explain the need for Jesse to complete a needs assessment form.[98]

98. On 19 August 2016, DVA provided a needs assessment form to Jesse and his Volunteer Veteran Advocate, John McNeill for completion.[99]

<u>First claim for permanent impairment and incapacity payments</u>

99. On 27 August 2016, Jesse completed and submitted the needs assessment form to DVA. In the form, Jesse indicated he was claiming for both permanent impairment compensation and incapacity payments (**August 2016 claim**).[100]

100. On 29 August 2016, DVA acknowledged receipt of Jesse's needs assessment form via email. In their email, DVA also provided links for a claim of incapacity payments to be made online via MyAccount.[101] The terminology of the email appeared unclear, both acknowledging receipt of Jesse's claim and requiring him to complete another claim for incapacity payments.[102]

101. Despite their email acknowledgement, DVA did not register Jesse's August 2016 claim. It does not appear that any further action was taken by DVA in relation to Jesse's August 2016 claim.

[95] Exhibit 15 – Coronial Brief, p60; Submissions on behalf of the Bird Family dated 26 July 2019, p9.
[96] Exhibit 15 – Coronial Brief, p76.
[97] Exhibit 15 – Coronial Brief, p76.
[98] Exhibit 15 – Coronial Brief, p312.
[99] Exhibit 15 – Coronial Brief, p312.
[100] Exhibit 15 – Coronial Brief, p312.
[101] Exhibit 15 – Coronial Brief, p312.
[102] Exhibit 15 – Coronial Brief, p764.

PTSD Treatment Program

102. On 14 September 2016, Jesse commenced a PTSD Treatment Program for War Veterans and First Responders (**Treatment Program**) at The Geelong Clinic. He had been referred to the program by Dr Velakoulis.

103. The Treatment Program involved individual and group therapy exploring PTSD education, anxiety and anger management, along with drug and alcohol education. The program ran two days a week for approximately 12 weeks.

104. According to Mrs Bird, Jesse was under the impression that if he completed this course it would assist with his ability to obtain incapacity payments.[103]

105. On 2 December 2016, Jesse completed the Treatment Program at The Geelong Clinic. Clinical Psychologist, Matthew Ryan, completed a discharge summary report on that day, which noted that Jesse struggled to engage in the program.[104] Mr Ryan reported that "*the PTSD program at The Geelong Clinic should be viewed as a preliminary step in Jesse's reintegration*."[105]

106. The key recommendations of The Geelong Clinic were that Jesse continue psychological or psychiatric therapy, including further exploration of his experiences in Afghanistan and utilisation of techniques for resolving residual anxiety and distress, along with reiteration that continued substance abuse was preventing progress. The Geelong Clinic also recommended that Jesse be provided with assistance in completing his studies, starting a career as a teacher, and be encouraged to recommence exercise.[106]

Volunteer Advocate assistance to Jesse

107. Mr McNeill re-engaged with Jesse in October 2016 after not having seen him for a while. He noticed a significant change in Jesse's behaviour.[107] Mr McNeill stated *"he wasn't the same Jesse. […] Jesse was the life of the party and then when I did re-engage with him, you know, that happy spark was gone*."[108] It was apparent Jesse had disengaged with DVA and other support networks.

[103] Transcript of evidence, pp80-81.
[104] Exhibit 15 – Coronial Brief, p902.
[105] Exhibit 15 – Coronial Brief, p903.
[106] Exhibit 15 – Coronial Brief, p903.
[107] Transcript of evidence, p27.
[108] Transcript of evidence, p48.

108. Jesse disclosed to Mr McNeill that he was experiencing multiple issues with his mental health, DVA and financial issues.[109] He felt like a burden to his family and the DVA claims system was a significant stressor. It was clear that Jesse did not like being financially reliant on his family.[110]

109. Consequently, Mr McNeill contacted DVA by telephone and expressed his concern that Jesse may be suicidal.[111] He explained to the DVA call taker that this was due to the financial pressure Jesse was under and his distress at the length of time the claims process was taking.[112]

Second claim for permanent impairment and incapacity payments

110. On 28 October 2016, Jesse lodged a second detailed needs assessment for both permanent impairment compensation and incapacity payments.[113]

111. On 4 November 2016, DVA acknowledged receipt of the second needs assessment.[114]

Processing of permanent impairment compensation claim

112. On 10 November 2016, DVA acknowledged the permanent impairment compensation claim and requested further information from Jesse in relation to his availability to attend appointments with medical examiners to assess his level of impairment.[115] There does not appear to have been any acknowledgement of Jesse's second claim for incapacity payments at this time.

113. On 14 November 2016, DVA arranged for Dr Velakoulis to assess Jesse's claim for permanent impairment in respect of his psychiatric condition.[116] DVA requested a report from Dr Velakoulis, which included specific questions to be answered for the purpose of assessing Jesse's claim for permanent impairment compensation.

[109] Transcript of evidence, p27.
[110] Transcript of evidence, p28.
[111] Transcript of evidence, p31.
[112] Transcript of evidence, p31.
[113] Exhibit 15 – Coronial Brief, p312.
[114] Exhibit 15 – Coronial Brief, p312.
[115] Exhibit 15 – Coronial Brief, p312.
[116] Exhibit 15 – Coronial Brief, p312.

114. Under section 68(1)(b) of the *Military Rehabilitation Compensation Act 2004* (Cth) (**MRCA**), a determination for permanent impairment compensation requires an assessment of whether "*the impairment is likely to continue indefinitely*" and whether "*the person's compensable condition has stabilised*."

115. In evidence, Dr Velakoulis explained that there is often a tension between being the treating psychiatrist and being asked to provide a report to DVA. Dr Velakoulis explained the difficulty with the DVA claims process is that when you are treating a patient, you want to help them and remove their stresses but at the same time, you are being requested to professionally answer a specific set of questions.[117] He said his usual practice in these circumstances is to thoroughly review the patient's current symptoms and past profile, such as PTSD, alcohol and depressive symptoms, as well as provide an assessment of their trauma history and functional capacities. This information serves both a clinical and report based function, whilst continuing to clinically manage the patient including risk assessment and any medication changes.[118]

116. On 15 November 2016, DVA contacted Jesse to confirm that appointments had been arranged with Dr Velakoulis and an orthopaedic surgeon for the purpose of assessing his permanent impairment in respect of his physical and psychiatric conditions.[119]

Independent medical examinations

117. On 22 November 2016, Dr Velakoulis reviewed Jesse's symptoms and asked him to prepare a trauma history.[120] In evidence, Dr Velakoulis explained that it is clinically important to understand the patient's trauma history, but acknowledged that documenting it can be difficult for the patient.[121] Dr Velakoulis arranged a further appointment with Jesse on 13 January 2017.

118. Jesse did not attend his scheduled appointment with Dr Velakoulis on 13 January 2017. A 'fail to attend' text was sent to Jesse that day. However, Jesse did not respond or contact Dr Velakoulis to reschedule the appointment.

[117] Transcript of evidence, p307.
[118] Exhibit 11 – Statement of Dr Velakoulis dated 29 May 2019, p2.
[119] Exhibit 15 – Coronial Brief, p312.
[120] Transcript of evidence, p297.
[121] Transcript of evidence, p302.

119. Dr Velakoulis stated that "*where a DVA report request does specify that a specific appointment for the purpose of [the] report has been made and the patient fails to attend, it is my usual practice to contact the patient regarding the circumstances and offer another time*."[122] However, Dr Velakoulis noted that patients also have a responsibility to rebook missed appointments.

120. On 19 January 2017, after unsuccessfully attempting to telephone Jesse, DVA sent a letter to him outlining that he was required to attend an appointment with an orthopaedic surgeon for the assessment of his permanent impairment claim.[123]

121. On 16 February 2017, Jesse attended an appointment with Orthopaedic Surgeon Dr Timothy Lynskey for the purpose of assessing his physical impairment.[124] DVA received Dr Lynskey's report on 9 March 2017.[125]

122. On 10 March 2017, Dr Velakoulis emailed Jesse requesting that he book another appointment and provide the trauma history previously requested.

Request for update on Jesse's claim for incapacity payments

123. On 31 March 2017, Mr McNeill contacted DVA and requested an update on Jesse's claim, and in particular his claim for incapacity payments. According to Mr McNeill, he was informed that DVA had no record of Jesse's claim for incapacity payments ever having been received. Mr McNeill provided DVA with a payslip and information about Jesse's pay group as an infantry soldier.[126]

Assessment of Jesse's claim for permanent impairment

124. As part of their procedures to assess the permanent impairment claim, DVA followed up on the provision of Dr Velakoulis' psychiatric report for the purpose of his assessment of Jesse's impairment.[127] Dr Velakoulis completed his report on 2 April 2017. It was received by DVA on 6 April 2017.[128]

125. In his report, Dr Velakoulis indicated that Jesse had developed *"emergent stability"*, but that there was also room for improvement. At the time of submitting his report, Dr

[122] Exhibit 11 – Statement of Dr Velakoulis dated 29 May 2019, p4.
[123] Exhibit 15 – Coronial Brief, p312.
[124] Exhibit 15 – Coronial Brief, p312.
[125] Exhibit 15 – Coronial Brief, p312.
[126] Exhibit 15 – Coronial Brief, p312.
[127] Transcript of evidence, p262.
[128] Exhibit 15 – Coronial Brief, p312.

Velakoulis had not seen Jesse for four months, which resulted in a question of doubt as to the stability of Jesse's psychiatric condition.[129]

126. Dr Velakoulis' report did not mention Jesse's attendance at The Geelong Clinic in response to a specific question about whether he had undertaken all reasonable treatment. Dr Velakoulis testified that he never received a copy of The Geelong Clinic discharge report and therefore it did not enter into his consideration when he wrote his report. Dr Velakoulis conceded that Jesse's involvement in the program at The Geelong Clinic was technically reasonable treatment.[130]

127. It appears that Jesse was unable to provide further information to Dr Velakoulis about his exposure to trauma in Afghanistan. Dr Velakoulis acknowledged in his report that his assessment was limited due to a lack of detail about this.[131]

128. On 7 April 2017, a DVA medical advisor determined that Jesse's psychiatric condition was not deemed 'stable' and recommended a review in six months once treatment was completed.[132]

Rejection of claim for permanent impairment compensation

129. On 8 May 2017, DVA determined that Jesse was not eligible for compensation for permanent impairment pursuant to section 68 of the MRCA.[133] The determination was made on the basis that Jesse's level of impairment for his right shoulder injury was six impairment points. As Dr Velakoulis' report indicated Jesse's condition had not stabilised, no impairment points were considered for his psychiatric condition. This meant that the combination of the two assessments provided an overall impairment level below the requisite 10 point threshold required for eligibility for permanent impairment compensation.

130. Jesse was notified via letter from DVA that they had rejected his claim for permanent impairment. He did not receive any telephone contact from a DVA officer to verbally explain the determination or his appeal rights.

[129] Transcript of evidence, p300.
[130] Transcript of evidence, p201.
[131] Transcript of evidence, p298.
[132] Exhibit 15 – Coronial Brief, p313.
[133] Exhibit 15 – Coronial Brief, p313; Exhibit 6 – Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case – Inquiry Report, Coronial Brief p246.

131. According to DVA's MRCA policy manual, DVA delegates have the authority to defer a decision about permanent impairment until a condition has stabilised. Jesse was not issued with a deferral.[134] However, according to the relevant DVA policy and processes of the MRCA and based on the medical assessment, "*Jesse should have been offered an option for deferral of determination*".[135] There is no record that any DVA delegate contacted Jesse to discuss the possibility of a deferred determination.[136]

Jesse's response to rejection of permanent impairment claim

132. The rejection letter from DVA devastated Jesse. According to Mrs Bird who spoke to him on the phone, Jesse was "*very, very distressed and very angry about the rejection letter*."[137] Mrs Bird said that he was upset that DVA would just send a rejection letter and leave him out to dry with no follow up.[138] She said he had been led to believe that the claim would be accepted and he would have some payments coming in and he could get back on with his life.[139] He had plans to study and didn't want to be a burden anymore.[140]

133. Mrs Bird went to Melbourne shortly after he received this letter, but he refused to see her.[141] After the rejection letter, she said "*he isolated himself more and more*".[142] According to the Bird Family, Jesse essentially gave up on receiving any help from DVA by this point.[143]

[134] Exhibit 6 – Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case – Inquiry Report, Coronial Brief p247.
[135] Exhibit 6 – Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case – Inquiry Report, Coronial Brief p248.
[136] Exhibit 6 – Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case – Inquiry Report, Coronial Brief p248.
[137] Transcript of evidence, p76.
[138] Transcript of evidence, p76.
[139] Transcript of evidence, p76.
[140] Transcript of evidence, p77.
[141] Transcript of evidence, p77.
[142] Transcript of evidence, p93.
[143] Submissions on behalf of the Bird Family dated 26 July 2019, p16.

Family contact with Dr Velakoulis

134. Out of concern for Jesse, Mrs Bird contacted Dr Velakoulis by telephone for assistance and advice. Mrs Bird stated that Dr Velakoulis informed her that if she was worried about Jesse, she should contact the police and that it was not his *"department"*.[144] Mrs Bird was unhappy with Dr Velakoulis' response and felt that he was dismissive of her.[145]

135. In evidence, Dr Velakoulis said he could not recall being dismissive of Mrs Bird.[146] He said that he remembered the phone call with her but had not written any notes of their conversation.[147] He recalled that they discussed Jesse's crisis, his level of distress and that Jesse was uncontactable. Dr Velakoulis was fairly certain he suggested to Mrs Bird that she contact the CAT team or the Alfred Hospital, and if it was an emergency to request the police do an immediate welfare check.[148]

136. It is apparent that there is a dispute in evidence between Mrs Bird and Dr Velakoulis about the substance, tone and nature of their telephone conversation and there may be an element of truth to both versions. It is apparent, however, that following their telephone call, Dr Velakoulis initiated telephone contact with Jesse on 16 May 2017 and subsequently saw him three days later.[149] In light of this, and as it does not appear to me that the conversation was either causally connected with Jesse's death or could have changed the end result, I do not propose to make any findings in respect of the conversation between Mrs Bird and Dr Velakoulis.

Subsequent reviews by Dr Velakoulis

137. According to Dr Velakoulis, when he saw Jesse on 19 May 2017, Jesse informed him that he had received a letter from DVA one week prior that stated he did not have enough points. Jesse reportedly described secondary distress and disclosed that he had suicidal ideation with regard to using a rope and hanging himself some five days earlier, which had lasted for two days. Jesse stated he was "*pissed off with DVA*" and was contemplating going into the Department to "*scream and punch someone*".[150]

[144] Transcript of evidence, p76.
[145] Transcript of evidence, p 80.
[146] Exhibit 11 – Statement of Dr Velakoulis dated 29 May 2019, p7.
[147] Transcript of evidence, p278.
[148] Transcript of evidence, p278.
[149] Transcript of evidence, p265 and Exhibit 15 – Coronial Brief, p213.
[150] Exhibit 11 – Statement of Dr Velakoulis dated 29 May 2019, p6.

138. Dr Velakoulis stated that Jesse's:

> *major stressors at the time related to his DVA claim issues, poor finances, an argument with his sister and father, his father's liver cancer and limited prognosis, and a sense that he had 'fallen in a heap' after his partner's departure to the USA.*[151]

139. Dr Velakoulis stated there was no evidence of acute suicidal ideation.[152] He concluded Jesse had suffered transient ideation, distress and anger in relation to his negative DVA feedback, which had recently improved.[153]

140. Dr Velakoulis reviewed Jesse again on 15 June 2017. Jesse reportedly told him that he had attended Geelong RSL for advocacy support, had submitted two job applications, described improved return to work desires and stated he had no recent substance use. Dr Velakoulis considered that Jesse appeared likely to improve to a major degree in relation to his impairments. However, he considered that Jesse's psychiatric condition was not stable, given his clinical destabilisation and suicidal ideation in May 2017.[154]

Processing of incapacity payments claim

141. On 1 June 2017, DVA registered Jesse's claim for incapacity payments.[155] Two weeks later DVA prepared a request to Defence for details regarding Jesse's rank and pay rate at separation from the army via their computer system SAM and Jesse provided DVA with an employment separation certificate. DVA then submitted the request to Defence on 21 June 2017.[156]

CIRCUMSTANCES OF DEATH

Events immediately proximate to death

142. On Thursday 22 June 2017, Jesse called DVA and spoke to a DVA officer about the delays associated with his claim.[157] The details of the conversation were not recorded and are unknown.

[151] Exhibit 11 – Statement of Dr Velakoulis dated 29 May 2019, p6.
[152] Exhibit 11 – Statement of Dr Velakoulis dated 29 May 2019, p6.
[153] Exhibit 11 – Statement of Dr Velakoulis dated 29 May 2019, p6.
[154] Exhibit 11 – Statement of Dr Velakoulis dated 29 May 2019, p3.
[155] Exhibit 15 – Coronial Brief, p313.
[156] Exhibit 15 – Coronial Brief, p313.
[157] Exhibit 15 – Coronial Brief, p313.

143. On Friday 23 June 2017, Jesse lodged a written complaint to DVA via the Complaints and Feedback Management System about the delays associated with his claim. His email stated:

> *I don't understand how two government departments with so much in common cannot communicate [DVA & Defence]. I need real help, I have submitted all required paperwork to receive incapacity payments, yet you fail to be able to speak to each other on my rank and pay grade on leaving the army. The person who has been assigned to my case just doesn't care and cannot wait to get off the phone to me. By the sound of her tone and attitude towards me [she] is someone who clearly finds no joy in her job, quit and let people who care and can help take the job. If I didn't have the support of the RSL and my friends I would and have come close to becoming another suicide statistic. I've done my time and now I need your help, please.*[158]

This was clearly a desperate call for help.

144. Jesse's complaint was forwarded to the Incapacity Payments Team Leader (**Team Leader**) who contacted DVA SAM seeking for Jesse's claim to be upgraded to high priority due to financial hardship.[159] The request was not actioned until Monday 26 June 2017.[160]

145. In internal email correspondence that day, the Team Leader stated that she "*had spoken to [Jesse] to give him more clarity around the process and he is fine with that*."[161]

146. The telephone conversation between the Team Leader and Jesse on 23 June 2017 was posthumously recorded by a DVA officer on 29 June 2017. It was noted that "*phone call made to client*" and "*client has been contacted and issues addressed*".[162]

147. The Team Leader also sent an email to Jesse at a Hotmail account. This was not Jesse's email address and it appears that he never received this correspondence.

[158] Exhibit 15 – Coronial Brief, p518.
[159] Exhibit 15 – Coronial Brief, p313.
[160] Exhibit 15 – Coronial Brief, p313.
[161] Exhibit 15 – Coronial Brief, p300.
[162] Exhibit 15 – Coronial Brief, p518.

148. Details of the actions undertaken by the Team Leader on 23 June 2017 were supplied in a comprehensive file note on 19 July 2017. The Team Leader recorded that:

> *I received an email from Angelo … on Friday 23/06/2017 advising Mr Bird had lodged a complaint about the delay in time taken to process his claim. I reviewed the complaint with Thomas .. and then spoke with Mr Bird the same afternoon. During the call I explained to him the process which we are required to undertake when assessing a Veteran's incapacity claim. Mr Bird was appreciative of the call and explanation of the process. I then followed up by sending him an email on 23/06/2017 with the Incapacity acknowledgment letter (which he stated during the call he had not at that time received), the email also contained my contact details for any further queries. After the phone call, on 23 June 2017 I emailed the SAM Team Leader and requested that the SAM request be upgraded from low to high due to Mr Bird's financial hardship.*[163]

149. It does not appear that any action was taken by DVA in response to the comments made by Jesse regarding suicide in his written complaint.

150. On Saturday 24 June 2017, Jesse caught up with some friends for a drink. At one point during the evening he became emotional and made a comment that "*he felt lucky that he'd had such good friends and that it was ok to go*". According to Jay Dougrey, Jesse had never expressed any previous intention to self-harm to his friends and the comment was not interpreted as a reference to suicidal intent. Mr Dougrey believed that it *"was more like [Jesse] was in a good place and if he had to die tomorrow he'd be happy*".[164]

151. Jesse was last seen at around 3.00am on the morning of Sunday 25 June 2017 when he left the group, at which point he was seen to be laughing and joking.

152. On Monday 26 June 2017, DVA contacted Defence via SAM to upgrade Jesse's request to high priority. DVA was advised that this was not required as the request concerning Jesse was nearly completed.[165]

153. On Tuesday 27 June 2017, Jesse's friends became very concerned for his welfare as they had not heard from him over the previous two days. At about 1.00pm, Jesse's friends attended his flat to check on him. They found the front door locked and there was no response from Jesse. They gained access via an unlocked door on the balcony and discovered Jesse deceased in his bedroom.

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[163] Exhibit 15 – Coronial Brief, p518.
[164] Exhibit 15 – Coronial Brief, p115
[165] Exhibit 15 – Coronial Brief, p313.

154. That same day, DVA received advice from Defence that they would have the requested information regarding Jesse's rank and pay rate within two days.

Posthumous acceptance of incapacity payments claim

155. Tragically, less than two weeks after his death, Jesse's claim for incapacity payments was determined and accepted on 5 July 2017. The first payment was processed and paid into Jesse's bank account on 6 July 2017.

156. Mrs Bird noted "*the trauma we suffered upon being told that it was processed after his death sturdied our resolve to fight for Jesse and reform the military compensation scheme*."[166]

Police investigation

157. Attending police found no suspicious circumstances at the scene in relation to Jesse's death. They observed that Jesse had used his army issued ropes and tackle and was wearing his Spartan 1RAR Platoon jumper, with the motto 'duty first' at the time of his death. He was closely surrounded by his medals, his army hat, military equipment, and documentation relating to his service history, mental health issues and DVA claims. The investigation indicated that Jesse had died sometime between 25 and 27 June 2017.

INQUIRIES INTO THE MANAGEMENT OF JESSE'S CASE

Joint Inquiry Report

158. Following Jesse's death, a joint inquiry team was established by Defence and DVA to investigate the facts surrounding the management of Jesse's case. This comprised of staff from DVA, Defence and VVCS and was headed by Ms Elizabeth Cosson, Secretary of DVA.

159. The Joint Inquiry Report was completed in September 2017. It identified six key areas of concern in the management of Jesse's case:

    (a) Jesse's submission of a needs assessment in August 2016 was not registered as a claim for incapacity payments when it was initially received. This was contrary to DVA policy and legislation.[167]

[166] Exhibit 15 – Coronial Brief, p65.

(b) due to resource constraints and limitations in the DVA's information and communications technology (**ICT**) systems, DVA was not able to successfully follow up with Jesse at several key points during the management of his case including:

i. after approval of the White Card for his shoulder injury DVA did not follow up on Jesse's bank account details when he did not provide them;

ii. when Jesse did not attend his scheduled appointment for his medical assessment in January 2017 and he was unable to be contacted by telephone, there was no process for further follow up in relation to Jesse's wellbeing;

iii. following receipt of Jesse's complaint on 23 June 2017, a DVA Team Leader contacted Jesse by telephone. The process to initiate a face-to-face welfare check was not commenced, as his reported demeanour in the telephone call did not indicate a welfare check was required.

(c) interim permanent impairment payments were not offered to Jesse while his mental health condition stabilised ahead of a final determination, an option that was available at the discretion of a delegate;

(d) Jesse was not offered deferral of the determination of his claim for permanent impairment compensation, and no discussion was held with Jesse about his options which included the ability to challenge the decision through the Veterans' Review Board. This was contrary to DVA policy, but was a practice that had arisen over time due to resourcing pressures;

(e) Jesse should have been clinically managed by VVCS as a complex case that required a more team-oriented approach. If such an approach had been taken, he may have been more likely to remain engaged with DVA; and

(f) there was no holistic approach between DVA and VVCS in managing Jesse's case to ensure his wellbeing.[168]

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[167] Exhibit 6 – Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case – Inquiry Report, Coronial Brief p169.

[168] Exhibit 6 – Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case – Inquiry Report, Coronial Brief p170-171.

160. The Joint Inquiry Report concluded that:

> *the combination of Jesse's personal circumstances and continued frustration with delays and rejection increased his risk factors. As neither VVCS or DVA had full visibility of the increasing risk factors, such as his relationship breakdown and lack of employment, no one person understood the whole picture.*[169]

161. Drawing from the learnings of Jesse's case, the Joint Inquiry Report made 19 recommendations directed to improving the service and experience of veterans. This included the following nine priority actions:

(a) for the Secretary of DVA to examine areas of potential non-compliance with current legislation and policy and to provide the Minister with advice regarding any redress action/s;

(b) to provide a clear statement of the policy and processes when considering an interim payment of compensation for permanent impairment to ensure that interim compensation payments are being provided in all cases where appropriate;

(c) to put in place controls to ensure process of registration of claims is consistently followed when needs assessment is received;

(d) to enhance reporting and risk factor escalation between VVCS and DVA through an 'opt-out' model of information sharing so that all support services are integrated for clients with diagnosed mental health issues;

(e) to put in place controls to ensure that complex case management is initiated for complex or high-risk clients;

(f) to revise Service Level Agreement Key Performance Indicators for information sharing with partner agencies, including timeframes for DVA to request information as soon as possible after claim registration;

(g) to review existing Service Coordination processes that provide coordinated, tailored and empathetic response to families, particularly in the case of the death of a non-serving client;

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[169] Exhibit 6 – Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case – Inquiry Report, Coronial Brief p171.

(h) to educate staff and monitor implementation of the inquiry recommendations; and

(i) to identify indicators for veterans at risk to develop best practice case management models.[170]

Spiers Report

162. In response to the first recommendation of the Joint Inquiry Report, Carolyn Spiers conducted an on-the-papers examination to determine whether the actions and conduct of DVA staff were in accordance with the MRCA, military rehabilitation and compensation policies and departmental procedures. The Spiers Report was completed in October 2017. It investigated issues in relation to incapacity payment processing and the determination of permanent impairment payments.

163. The Spiers Report identified that:

(a) the failure to register Jesse's August 2016 needs assessment as a claim for incapacity payments was inconsistent with the legislation and appeared to be *"a standard practice for the work area to manage the workloads and time taken to process claims"*[171];

(b) the incapacity payments team should have ensured that the request of information that was sent to DVA SAM was a high priority as DVA was aware that Jesse was suffering severe financial hardship and mental health issues;

(c) there was a delay in processing Jesse's claim for permanent impairment compensation;

(d) Jesse was not offered interim permanent impairment payments whilst waiting for his mental health conditions to stabilise ahead of a final determination;

(e) Jesse was not offered a deferral of the determination on permanent impairment payments;

[170] Exhibit 6 – Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case – Inquiry Report, Coronial Brief p185-6.
[171] Exhibit 7 –Bird Inquiry: Recommendation 1: Examination of Areas of potential non-compliance with Legislation and Policy and Recommendations for follow up action by Carolyn Spiers (Spiers Report), Coronial Brief, p2603.

(f) there were issues in relation to the management of Jesse's failure to attend scheduled medical examination appointments, the permanent impairment compensation determination and Jesse's complaint to DVA on 23 June 2017; and

(g) Jesse was not paid a MRCA supplement between 2012-2015.

Creyke Review

164. In late 2018, Emeritus Professor Robin Creyke was appointed to conduct an independent review of the implementation of the 19 recommendations by the Joint Inquiry Report. The Creyke Review was finalised in March 2019.

165. Professor Creyke acknowledged that DVA faced significant hurdles due to its complex legislation, which is comprised of three principal acts.[172] This complexity had a consequential impact on DVA's claims processes, staff capability and client experience.[173]

166. Professor Creyke found that appropriate action had been taken on 14 recommendations, and progress was underway on the remaining five recommendations. He noted that DVA is *"undergoing dynamic and profound changes under its program of Veteran Centric Reform, changes which benefit the community as a whole, including those who are at-risk or vulnerable*."[174] He commented that following Jesse's death there had been a *"'perfect storm' of improvements' […] to the way in which the Department interacts with its veteran community and their families"*, driven by the tireless efforts of Mrs Bird and Ms Boglis to maintain pressure for change and ensure Jesse's death was not in vain.[175]

[172] The *Veterans' Entitlement Act 1986* (Cth), the *Military Rehabilitation and Compensation Act 2004* (Cth) and the *Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988* (Cth).
[173] *Independent Review of the Implementation of the Recommendations of the Joint Inquiry into the Management of Jesse Bird's Case* by Emeritus Professor Robin Creyke – 15 March 2019, p4.
[174] *Independent Review of the Implementation of the Recommendations of the Joint Inquiry into the Management of Jesse Bird's Case* by Emeritus Professor Robin Creyke – 15 March 2019, p1.
[175] *Independent Review of the Implementation of the Recommendations of the Joint Inquiry into the Management of Jesse Bird's Case* by Emeritus Professor Robin Creyke – 15 March 2019, p7.

167. Professor Creyke concluded that:

> *Much has been achieved, but more change is needed. Some of those changes are matters which need routinely to occur. They include evaluation, monitoring and testing changed processes to ensure they meet their desired objectives, and that those who are responsible for their administration understand them and can refine them as necessary. Others, such as systems changes, cultural changes, and foundational principles will take longer to embed.*[176]

CORONIAL INQUEST

Jesse's Experiences Navigating DVA Processes

168. During my investigation and the inquest, it became clear that Jesse had faced significant difficulties and delays whilst navigating the DVA processes.

169. Consistent themes emerged in evidence regarding the complexities of the DVA processes including:

(a) that Jesse felt he was being treated as a number rather than a person;

(b) that his claims paperwork would not be registered, or would be lost or rejected, which resulted in having to recommence the process;

(c) there was a lack of adequate and personalised communication;

(d) there were different legal and medical requirements for each stage of the claims process which were not clearly understood; and

(e) that the claims process was a very complex system, in part as it was based on three separate pieces of legislation.

170. Jesse's negative experiences of DVA processes were compounded by his PTSD symptoms. Dr Velakoulis explained that due to neurocognitive issues associated with PTSD, including anxiety, cognitive issues and motivational issues, navigating DVA processes and paperwork can be extremely overwhelming for sufferers. He noted that *"there have been instances where forms have been filled out incorrectly… [and] to reverse those through the DVA process can take years"*.[177] Dr Velakoulis explained

[176] *Independent Review of the Implementation of the Recommendations of the Joint Inquiry into the Management of Jesse Bird's Case* by Emeritus Professor Robin Creyke – 15 March 2019, p7.
[177] Transcript of evidence, p281.

that he generally recommends veterans obtain assistance from a trained advocate in lodging claims for compensation.[178] I note that Jesse had indeed obtained assistance from Mr Richard Embleton and Mr McNeill, experienced Volunteer Veteran Advocates, in lodging his claims for compensation.

171. Jesse's family and friends provided important insight into the frustrations Jesse experienced navigating the DVA claims processes.

172. According to Mrs Bird, Jesse expressed his "*distress and frustration with dealing with DVA, describing it as a 'continual minefield'*".[179] He was reportedly told to resubmit papers after they were lost by the Department, he never had a case manager and he would get stuck in an *"1800-number loop"* when he contacted DVA. Jesse told her that the people on the other end of the phone were making it harder, not easier.[180]

173. Mrs Bird described the DVA claims process as "s*hambolic"*, "*randomised*" and had "*systemic weaknesses"*. She considered that this was in part as *"the legislative framework has created a complex, inaccessible legal system for veteran support"*.[181]

174. Mrs Bird said Jesse did not have one positive engagement with DVA. There was no care model, no face-to-face communication and no one ever asked him how they could help him.[182] She stated "*no one took time to engage with Jesse Stephen Bird, the human being. He was never more than a number of a file for someone else to look into and put on the back-burner for another day*."[183]

175. Ms Boglis stated that she found the terminology in the DVA paperwork difficult to understand and that Jesse needed an advocate to help him, because the claims process was so complex."[184] She stated that Jesse thought "*the process was so hard that he wanted to give up. He would not receive follow up phone calls. He would just wait an unknown period of time, never knowing when he would get an outcome*."[185] She further commented that: "*Jesse was trying his best to navigate the system, but he never got*

[178] Transcript of evidence, p280.
[179] Exhibit 15 – Coronial Brief, p60.
[180] Exhibit 15 – Coronial Brief, p60.
[181] Transcript of evidence, p114.
[182] Transcript of evidence, pp73-74.
[183] Exhibit 15 – Coronial Brief, p66.
[184] Exhibit 15 – Coronial Brief, p97.
[185] Exhibit 15 – Coronial Brief, p97.

anywhere. I tried to help him, but it was hard enough for me and I wasn't going through PTSD."[186]

176. According to Ms Boglis after some time, whenever Jesse saw letters from DVA he would become so overwhelmed that he would almost have a panic attack at the sight of the letters. She said she would find them unopened in the bin at the fear of another rejection. He told her he wasn't being acknowledged and that DVA were making him more depressed. He went overseas and protected our country and when he came back "*he was made to feel like scum*."[187] She said the "*applications used by DVA set veterans up to fail*."[188]

177. Jesse's friend Jay Dougrey explained DVA issues "*used to really overwhelm [Jesse] and stress him out. I'd help send paperwork to the DVA for him. The DVA paperwork was a huge source of anxiety for him*."[189] Jesse would complain about having to "*jump through hoops*" and re-do forms from scratch, as though they had never received any information from him before. He would have to reintroduce himself and submit fresh paperwork every time. It was "*really frustrating, and it really wore him down*."[190]

178. Mr McNeill explained that Jesse's case was not out of the ordinary and was not particularly complex. Mr McNeill felt that the DVA process was adversarial in the way it dealt with its claims,[191] insofar as DVA would "*behave like an insurance company unwilling to pay out on a claim*."[192] Mr McNeill explained that the main obstacles with Jesse's claims process was the lack of communication from DVA.[193] He also explained that in his opinion, many veterans experience similar difficulties with the DVA claims process.[194]

[186] Exhibit 15 – Coronial Brief, p97.
[187] Exhibit 15 – Coronial Brief, p97.
[188] Exhibit 15 – Coronial Brief, p97.
[189] Exhibit 15 – Coronial Brief, p113.
[190] Exhibit 15 – Coronial Brief, p113.
[191] Exhibit 15 – Coronial Brief, p172.
[192] Exhibit 15 – Coronial Brief, p111.
[193] Exhibit 15 – Coronial Brief, p174.
[194] Transcript of evidence, p28.

Concessions

179. DVA conceded there were deficiencies in the processing and determination of Jesse's claims for financial assistance and in the complaints resolution process that followed Jesse's written complaint on 23 June 2017. The Minister for Veterans' Affairs also made a formal apology on behalf of DVA to Jesse's family and friends for the way in which DVA's processes had failed Jesse.[195]

180. These deficiencies were openly acknowledged by the Secretary of DVA, Ms Cosson in her statement to the Coroners Court:

> *I want to clearly acknowledge that there were failures by DVA surrounding the management of Jesse's case and that there is no doubt in my mind that these failures contributed to Jesse's decision to take his own life. When Jesse needed us the most, DVA was not there. I am determined that DVA continues to change so that the risk of a veteran not being heard and supported in future is reduced to the maximum extent possible.*[196]

181. This was an important concession, which was reiterated by Ms Cosson in her evidence at inquest.

182. In acknowledging these failures, Ms Cosson explained that Jesse's death had been a catalyst for significant change within DVA resulting in a transformation in culture, process, systems and essentially the whole nature of the organisation.[197] Ms Cosson stated that these changes had been made to ensure "*that we are supporting our veteran community and that we are being the best we can be*."[198] She stated that DVA had "*corrected what we were doing as bad practice, to make sure that we are now focussed on the wellbeing of our veterans and families when they come to us in need*".[199] Ms Cosson acknowledged "*there's still a lot to do*"[200] but she is seeking some practical and positive outcomes coming from the implemented changes.[201]

[195] Exhibit 5 – Statement of Elizabeth Cosson dated 16 April 2019, Coronial Brief, p2485.
[196] Exhibit 5 – Statement of Elizabeth Cosson dated 16 April 2019, Coronial Brief, p2484.
[197] Transcript of evidence, pp192, 194.
[198] Transcript of evidence, p192.
[199] Transcript of evidence, p222.
[200] Transcript of evidence, p196.
[201] Transcript of evidence, p196.

Ongoing Reforms

183. It has been evident in my investigation that both DVA and Defence have undertaken considerable reform over the past three years. The reform was designed to better support Defence personnel from enlistment through recruit training, postings, deployment and transition into civilian life, including providing ongoing support and assistance where required by ex-service personnel.

184. Defence have initiated a number of reforms including:

    (a) increased focus on promoting mental health, with the release of their Mental Health Strategy 2018 – 2023 which includes annual training programs around mental health, suicide awareness and 'keep your mates safe';[202] and

    (b) allocating members a Career Transition Coach for up to twelve months after transitioning out of Defence.[203]

185. Defence has also collaborated with DVA to improve information sharing between the organisations with implementation of an Early Engagement Model (**EEM**), whereby contact details of Defence members are provided to DVA and the Commonwealth Superannuation Corporation (**CSC**) on a fortnightly basis in order to:

    (a) facilitate a relationship between the member and DVA as early as possible in their career;

    (b) facilitate Defence members being informed of the supports that may be available to them;

    (c) ensure DVA and CSC are aware of particular points in a member's career where early engagement may be appropriate; and

    (d) assist in expediting consideration of any future claim for compensation by removing unnecessary bureaucratic hurdles, including by allowing EEM registration to automatically satisfy DVA's proof of identity requirements upon transition.[204]

[202] Transcript of evidence, pp128-9.
[203] Transcript of evidence, p131.
[204] Exhibit 3 – Statement of Major General Natasha Fox dated 16 April 2019, Coronial Brief, pp2129, 2141.

186. Crucially, DVA has undergone a significant organisational transformation, shifting from an adversarial claims-based model to veteran centric management, with the focus on considering *"the human rather than the claim"*.[205] This shift has been reflected in recent legislative reform with the *Australian Veterans' Recognition (Putting Veterans and their Families First) Act 2019* (Cth). The Act enshrines the Australian Defence Veterans' Covenant[206] in legislation, acknowledging and recognising the sacrifice made by members of the Australian Defence Force, as well as embedding the Government's commitment to determine claims within 90 days of receipt, or within 90 days of any requested information being provided.

187. DVA's extensive reforms include:

(a) establishing a system for veterans to directly contact Ms Cosson, who will ensure the veteran is connected with the support they need;[207]

(b) having the leadership team undertake a 'deep dive' into DVA processes to ensure they are best practice processes;[208]

(c) conducting regular case conferences to identify systemic issues or unwritten practices;[209]

(d) building a 'no blame culture' which encourages stakeholders to not be afraid to *"come forward and say you've identified something"*;[210]

(e) improving training of DVA personnel, including specialised training of staff dealing with particular types of claims and encouraging staff to undertake mental health courses and the like;[211]

(f) streamlining of DVA's numerous IT systems to enable front line staff to have better visibility of a veteran when they lodge a claim;[212]

[205] Transcript of evidence, p216.
[206] See Appendix A.
[207] Transcript of evidence, p196.
[208] Transcript of evidence, p224.
[209] Transcript of evidence, p 223.
[210] Transcript of evidence, p200.
[211] Transcript of evidence, p198.
[212] Transcript of evidence, pp199, 202.

(g) introduction of an online MyService portal for veterans to apply for free mental health treatment, access support for a service-related condition or injury, upload supporting information, access their digital DVA Veteran Card, view accepted conditions and track the status of claims;[213]

(h) improving formal communications to ensure letters and emails sent by DVA personnel are accurate, easy to understand and timely, and encouraging staff to speak with veterans by telephone prior to sending a letter with a negative determination to explain the reason for the determination and their available options;[214]

(i) establishing a 'triage connect' service whereby veterans with risk indicators are referred to case management, and a DVA officer will contact them and help them to navigate the process;[215]

(j) amending the Annual Client Satisfaction Survey to ask DVA clients about their wellbeing using the Australian Unity Wellbeing Index to inform the Veteran Mental Health and Wellbeing Strategy and Action Plan;[216]

(k) engaging a Chief Medical Officer responsible for assisting with streamlining of processes and engaging with clinicians in relation to legal and medical requirements and to assist them in "*veteran literacy*" and provide clinicians with a better understanding of what it means to have served with Defence in the context of the compensation scheme;[217]

(l) simplifying treatment pathways for medical treatment into a single, rather than dual treatment pathway model, and providing DVA clients with access to health care through the DVA Health Card without the need to pay up-front and later seek reimbursement;[218]

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[213] Transcript of evidence, p202.
[214] Transcript of evidence, pp203-4.
[215] Transcript of evidence, p209.
[216] Department of Veterans' Affairs 2019 Client Satisfaction Survey October 2019, accessed via https://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/dva-css-2019-results-summary.pdf.
[217] Transcript of evidence, pp229-230.
[218] *Military Rehabilitation and Compensation Amendment (Single Treatment Pathway) Act 2019* (Cth).

(m) engaging a Chief Data Officer, to gain meaningful insights from the analytical data available;[219] and

(n) continuing their partnership with the Australian Institute of Health and Welfare to monitor and calculate accurate numbers and rates of suicide deaths among serving and ex-serving Defence members.[220]

188. These reforms have already had a positive impact. Mr McNeill agreed in his evidence that he had observed improvements in the DVA system since early 2019, with a higher level of liaison between DVA delegates and advocates, increases in interim payments being offered to veterans where relevant and improvement in the speed at which permanent impairment processes were taking place.[221] Mr McNeill also reported that he had observed DVA delegates being more willing to engage over the phone to make sure all information had been provided and to finalise veterans' claims in *"one hit"* rather than having to go through the Veteran Review Board.[222]

189. Ms Cosson conceded, however, that the compensation scheme was complex, being governed by three separate pieces of legislation, and that some of today's veterans would have eligibility under some or all of the different governing Acts.[223] Ms Cosson acknowledged that *"until we can actually find a way to simplify, harmonise the legislation, then there will be that added complexity"*[224] and that they needed to *"look at how we can simplify the legislation to make it easier for the veterans"*.[225] I was informed that work is already underway by DVA to simplify legislation to improve the claims process for veterans.[226]

Veterans Falling Through the Cracks

190. Despite the extensive reforms being undertaken by DVA and Defence, it is evident that some veterans are falling through the cracks.[227] Ms Cosson estimated that there are about 500,000 veterans in the Australian community that they do not know about.[228]

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[219] Transcript of evidence, p244.
[220] Transcript of evidence, p244.
[221] Transcript of evidence, p53; Exhibit 1 – Statement of John McNeill dated 4 April 2019, Coronial Brief, p174.
[222] Transcript of evidence, p35.
[223] Transcript of evidence, p 194.
[224] Transcript of evidence, p195.
[225] Transcript of evidence, p242.
[226] Submissions on behalf of the Commonwealth of Australia, as represented by the Department of Defence and the Department of Veterans' Affairs dated 6 September 2019, p48.
[227] Transcript of evidence, p114.

191. This appears in part to be due to a deep-seated sense of mistrust of DVA amongst ex-service personnel, as was reflected in comments made by Jesse's friend Aaron Harmer during the coronial investigation:

> *I have no confidence in the DVA at all. I feel like it's inevitable that more veterans will take their own lives because the DVA just does not help them. They strip guys like Jesse of their dignity and run them into the ground to breaking point and endless bureaucracy.*[229]

192. According to Mr McNeill, many former serving defence members are not registered with DVA, or *"they've started the claims process and been so beleaguered and swamped by it that they're out there somewhere, family struggling, needing encouragement to come back in and have another go"*.[230] He noted that it would take some time to repair that relationship.[231]

193. Ms Cosson acknowledged in her evidence that some veterans may not have had a very good experience with DVA.[232] She agreed that a lack of trust takes away hope and it is not easy to re-build that trust.[233] Ms Cosson explained that DVA wants to *"connect with all the veterans to let them know that they can trust [us]"*. Major General Fox agreed, and noted that she had started to see the leadership in DVA making changes and putting measures in place to improve that trust.[234] Both Defence and DVA have been working hard in their approach to transition veterans, actively encouraging people separating from Defence to be in contact with DVA and other support agencies to get the support they need.[235]

194. However, DVA and Defence simply do not know how to reach out to veterans who are not known to them. In this regard, Major General Fox acknowledged that if former veterans *"don't make contact with DVA and they move, we don't know where to contact them"*, and she conceded that *"we don't know where a lot of veterans are*".[236] Major General Fox explained that it was hard for DVA to find former veterans, in part

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[228] Transcript of evidence, p243.
[229] Exhibit 15, Coronial Brief, p 111.
[230] Transcript of evidence, p85.
[231] Transcript of evidence, p53.
[232] Transcript of evidence, p197.
[233] Transcript of evidence pp196-7.
[234] Transcript of evidence, p127.
[235] Transcript of evidence, p127.
[236] Transcript of evidence, p115.

because any information on veterans prior to 2001 was unable to be extracted as DVA files prior to that time were not digitised.[237]

195. DVA have undertaken a number of initiatives to attempt to engage with former Defence personnel who are not known to DVA. This has included collaborations with:

    (a) Australia Post to trial putting posters in post offices asking *"have you served in the Australian Defence Force"* and providing a computer where veterans could log on and obtain information about how to register with DVA;[238] and

    (b) the Federal Department of Human Services (**DHS**) to ensure DHS staff are trained in veterans' issues and identify potential veterans.[239]

196. Ms Cosson conceded that the Australia Post trial was not as successful as they would have hoped, and that there was more to do in this space.[240]

197. At inquest, Major General Fox explained that consideration had been given to collecting information in the census about service with Defence. According to Major General Fox this would assist in locating veteran cohorts, and directing relevant plans, support mechanisms and programs to support veterans in need.[241] Ms Cosson agreed this would be a positive measure to assist in identifying veterans.[242]

198. I note that in February 2020, the Government passed the *Census and Statistics Amendment (Statistical Information) Regulations 2020* (**Census Regulations Amendment**). The Census Regulations Amendment updated the list of topics on which statistical information would be collected to include information about service in the Australian Defence Force from persons 15 years and older. The Explanatory Statement noted that collection of this information would allow for *"a better understanding of the circumstances of Australia's veteran community, and will facilitate targeted services and support related to this community's health, economic and social wellbeing"*. This information will first be collected in the Census scheduled for 2021.

[237] Transcript of evidence, pp85, 157.
[238] Transcript of evidence, p204.
[239] Transcript of evidence, p205.
[240] Transcript of evidence, p204.
[241] Transcript of evidence, p158.
[242] Transcript of evidence, p206.

199. This is a pleasing development which may have significant practical benefits in assisting to identify and provide support to those veterans who may have previously fallen through the cracks.

Request for a Royal Commission

200. During the inquest, the Bird Family submitted that there was a *"pressing and urgent need for a Royal Commission"* and urged me to make a recommendation to the Prime Minister of Australia to call for a Royal Commission into the handling of compensation claims by the DVA.[243]

201. It was submitted that:

> *[a] Royal Commission is needed to get to the bottom of matters such as how the unlawful practice developed within DVA, how many other veterans were hurt because of the practice, what other unlawful practices have been applied, and what can be done to ensure these practices are prevented in the future.*[244]

202. It was also submitted that *"a Royal Commission is needed to restore veteran and community trust in the administration of the veterans' compensation scheme"*[245], and that a recommendation *"of this nature from this Court would be a powerful impetus for change and a significant contributor to avoiding other veterans experiencing DVA the way Jesse did"*.[246]

203. In response, DVA submitted that a decision to establish a Royal Commission is a matter for Government. Further, it was noted that:

> *there have already been a number of reviews and inquiries relevant to the issues of veteran suicide and mental health, the management of [Jesse's] case and DVA's response, and more broadly the DVA system of compensation and rehabilitation. These have in turn generated a large number of recommendations and actions for DVA to take forward. DVA is in the process of implementing many of these recommendations and the recommendations of the recent inquiry report of the Productivity Commission*.[247]

[243] Submissions on behalf of the Bird Family dated 26 July 2019, p29.
[244] Submissions on behalf of the Bird Family dated 26 July 2019, p30.
[245] Submissions on behalf of the Bird Family dated 26 July 2019, p30.
[246] Submissions on behalf of the Bird Family dated 26 July 2019, p2.
[247] Submissions on behalf of the Commonwealth of Australia, as represented by the Department of Defence and the Department of Veterans' Affairs dated 6 September 2019, p49 and Transcript of evidence p33.

204. On 5 February 2020, the day after oral submissions were heard in this inquest, the Prime Minister of Australia, The Hon Scott Morrison MP announced that the Government would be establishing a National Commissioner for Defence and Veterans Suicide Prevention (**National Commissioner**).[248]

205. According to the Government, the National Commissioner would be empowered:

(a) as an independent and permanent public accountability body, with the same powers of a Royal Commission to compel the production of evidence and summon witnesses, and make findings and recommendations to Government; and

(b) to provide an ongoing investigative function of individual cases of suicide, working with each state and territory coronial office, making recommendations to Government.[249]

206. The National Commissioner would conduct an immediate, independent review of historical veteran suicide cases, focusing on the impact of military service and veterans' post service experience, with an interim report to be delivered within 12 months. The National Commissioner would be empowered with the authorities of a royal commission, including the authority to compel evidence, call witnesses and have remedies available to those who would not cooperate. The National Commissioner would also table an Annual Veteran and Defence Suicide Death Report to Parliament, providing data on suicides within the defence and veteran community and updates on the implementation and evaluation of measures to reduce suicide risk factors.[250]

207. The National Commissioner is slated to sit independently within the Attorney-General's Department.[251] Their work would be supported by the Australian Institute of Health and Welfare, the Australian Commission on Safety and Quality in Health Care (**ACQHC**) and coronial and legal experts. Veterans' families would also be provided

[248] Transcript Press Conference Australian Parliament House, ACT on Wednesday 5 February 2020.
[249] Media Release, 'Powerful new body to tackle ADF and Veteran Suicides' dated Wednesday 5 February 2020.
[250] Media Release, 'Powerful new body to tackle ADF and Veteran Suicides' dated Wednesday 5 February 2020.
[251] Transcript Press Conference Australian Parliament House, ACT on Wednesday 5 February 2020.

with the opportunity to engage in the process and participate and tell their stories openly and safely.[252]

208. Additionally, the Government announced the establishment of a Veteran Family Advocate who would sit within the DVA.[253] The remit of the Veteran Family Advocate would be to directly engage with the families of veterans, and improve the design of all veteran programs and services, including mental health supports and services. Their focus would be on mental health and suicide prevention, contributing to our understanding of the risk factors relating to the wellbeing of veterans and their families, particularly during their transition from Defence.[254]

209. In response to this development, I requested further information from the legal representatives of DVA and Defence on the establishment of the National Commissioner and Veteran Family Advocate.

210. On 21 February 2020, I was informed that:

    (a) the implementation of the National Commissioner is being led by the Department of the Prime Minister and Cabinet and the Attorney-General's Department;

    (b) the Government is considering the appointment of an interim National Commissioner, pending legislation to establish the statutory role; and

    (c) work is also under way to establish the new role of the Veteran Family Advocate.[255]

211. I was informed that the representatives for DVA and Defence would continue to update the Coroners Court as further information is made available regarding the implementation of these measures.[256]

[252] Media Release, 'Powerful new body to tackle ADF and Veteran Suicides' dated Wednesday 5 February 2020.
[253] Transcript Press Conference Australian Parliament House, ACT on Wednesday 5 February 2020.
[254] Media Release, 'Powerful new body to tackle ADF and Veteran Suicides' dated Wednesday 5 February 2020.
[255] Letter from Mr Evan Evagorou, Australian Government Solicitor, legal representative for the Department of Veteran Affairs and the Department of Defence dated 21 February 2020.
[256] Letter from Mr Evan Evagorou, Australian Government Solicitor, legal representative for the Department of Veteran Affairs and the Department of Defence dated 21 February 2020.

212. I was further informed that:

(a) the Government is providing $230 million a year towards veteran mental health. This includes the expansion of Open Arms, which provides professional mental health and wellbeing support to veterans and their families, ensuring all veterans can access free mental health care for life. This support is needs-based, uncapped and available to any veteran who has served a single day in Defence; and

(b) the Veteran Mental Health Strategy and a National Action Plan (**Strategy and Action Plan**) will be released in the first half of 2020. The Strategy and Action plan has been developed in consultation with the National Suicide Prevention Advisor, Ms Christine Morgan, and will guide government action on veteran mental health and wellbeing through to 2023. This followed a Veteran Mental Health Summit held in 2019, with experts in the field of veterans' mental health, wellbeing and suicide prevention.[257]

213. In response to this development, the Bird Family submitted that:

(a) the proposal to establish a National Commissioner and Veteran Family Advocate has yet to be implemented, even on an interim basis;

(b) no legislation or detailed plan is yet available as to the establishment of these new roles;

(c) a Royal Commission would more effectively, and expeditiously, investigate historical veteran suicide cases and allow for a 'root and branch' review of DVA's processes; and

(d) the establishment of an independent oversight body was warranted, but it was necessary that such a body not be confined to reactively investigating veteran suicides but to also have a mandate to proactively review DVA processes, undertake 'spot checks' and investigate veteran complaints.[258]

[257] Letter from Mr Evan Evagorou, Australian Government Solicitor, legal representative for the Department of Veteran Affairs and the Department of Defence dated 21 February 2020.
[258] Submissions of behalf of the Bird Family dated 2 March 2020, p2.

214. It is apparent to me that DVA has undergone a substantial overhaul in its processes and management of claims, such that it seems to me to be almost unrecognisable from the organisation Jesse interacted with in the months prior to his death. DVA appears to now have a strong veteran centric focus, and its leadership have implemented a range of initiatives designed to identify and rectify problematic practices. I acknowledge Ms Cosson's public commitments on behalf of the leadership of DVA to continue to improve the compensation system and ensure that it operates as it is meant to, for the support and benefit of Australian veterans.

215. I also acknowledge the Government's commitment to establishing a National Commissioner to serve as a permanent and ongoing public accountability body with the same powers as a Royal Commission, as well as a Veteran Family Advocate. I trust that this initiative will be implemented expeditiously as the issues associated with the impact of military service and veterans' post service experience is paramount to understanding historical veteran suicide and potential prevention opportunities. Accordingly, after extensive consideration, I do *not* propose to make any comment or recommendation regarding the establishment of a Royal Commission at this stage.

Conclusions

216. In reaching my conclusions and findings, I have carefully considered the submissions of all the interested parties and I do not propose to recount all of them here.

217. I find that Jesse was well supported during his time in the army. It is apparent that Jesse's battalion, including his commanding officers, were committed to looking after the welfare of each other during and post deployment. This was documented in the OHS Reports recommending that Jesse receive psychological support post deployment. Whilst it is apparent Jesse later developed PTSD as a consequence of his experiences in Afghanistan, there is no evidence that Jesse had a diagnosable mental health condition at the time of his discharge. I am satisfied on the evidence available to me that at the time of Jesse's discharge, Defence had appropriate and adequate processes for identifying and addressing the mental health and transition needs of Defence personnel.

218. It is apparent, however, that Jesse struggled to transition back to civilian life, despite the supports of his family and friends. His mental health deteriorated in the context of his financial and emotional stressors and increased alcohol use.

219. I accept that Jesse was having great difficulty navigating the complexities of the DVA compensation system, due to complicated and repetitive paperwork and processes, and a genuine lack of understanding of what he was legally and medically required to do and the reasons why. I accept that Jesse also experienced difficulties navigating these processes due to his mental illness, which tended to overwhelm him and cause additional anxiety. The mountainous paperwork, complex terminology, extensive legal and medical requirements, subsequent delays and financial stressors all appear to have exacerbated his mental illness. It appears his resilience and ability to cope with those pressures were exhausted.

220. The evidence indicates that at the time of Jesse's death, DVA was claim-based rather than veteran focussed, and to Jesse, appeared adversarial rather than beneficial. I find that the lack of adequate and accurate communication from DVA personnel to Jesse was problematic, in the sense that it was not a personalised service focused on Jesse, the individual. Instead, Jesse's perception was that he was treated as burdensome and if paperwork had not been filed accurately, he was financially disadvantaged. There appeared to be a lack of care, attention and proactive support, leaving Jesse with the belief that the only choice he had was to give up. This perception was evident in Jesse's written complaint to DVA on 23 June 2017.

221. I find that DVA failed to lodge Jesse's August 2016 claim, contrary to DVA policy and legislation, in an apparent response to resourcing pressures. It appeared that the unwritten practice had become established due to resourcing constraints. The Bird Family implored me to find that the failure to register Jesse's claims amounted to an *"unlawful, unwritten practice"*.[259] That is clearly suggestive of a determination of legal liability, and I have no jurisdiction to make such a finding. The only proper factual finding that can be made is that it was a practice contrary to DVA policy and legislation, as has been properly conceded by DVA.[260]

[259] Submissions on behalf of the Bird Family dated 26 July 2019, p19.
[260] Submissions on behalf of the Commonwealth of Australia, as represented by the Department of Defence and the Department of Veterans' Affairs dated 6 September 2019, p38-39.

222. I find that the subsequent rejection by DVA of Jesse's claim for permanent impairment devastated Jesse and this was a crucial turning point in his mental health which significantly declined in the setting of his increasing hopelessness. The method of sending the rejection letter via post without any personal interaction with Jesse to inform him of the determination, explain the reason for the rejection or to provide him advice about his options, lacked appropriate compassion and empathy, aggravating his mental state.

223. I further note that I found it alarming that a record was not made of the DVA Team Leader's telephone discussion with Jesse until 29 June 2017, after DVA had been informed of Jesse's death, and a detailed account of the discussion was not recorded until 19 July 2017. This was reflective of deficiencies in DVA's complaints system. However, as I did not call any individual DVA employee to give evidence directly about this issue, and as the delay in this documentation was not causally connected with Jesse's death, I do not propose to make a finding about this anomaly.

FINDINGS

224. Having investigated the death of Jesse Stephen Bird, and having held an inquest in relation to Jesse's death on 2-3 May 2019 and 4 February 2020 at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

(a) that the identity of the deceased was Jesse Stephen Bird, born on 1 November 1984;

(b) that Jesse died at 3/45 Wellington Street, St Kilda, sometime between 25 June 2017 and 27 June 2017 from 1(a) neck compression in the circumstances of hanging;

(c) in the circumstances described above.

225. I find that Jesse experienced difficulty in his transition from Defence to civilian life. I further find that he suffered from mental ill health directly linked to traumatic experiences he was exposed to in Afghanistan. Jesse's mental health issues, including his diagnosis of PTSD, caused him difficulties in maintaining interpersonal relationships and obtaining and maintaining sustainable and meaningful employment, which resulted in significant financial instability. I further find that Jesse's personal difficulties were exacerbated by the frustrations he experienced in interacting with, and navigating, DVA's complex compensation and rehabilitation system.

226. Despite the medical care Jesse received, together with the love and support that was provided by his family, friends and advocates, I find that Jesse intentionally ended his own life in the setting of mental ill health and significant financial and emotional stressors.

227. I acknowledge that DVA conceded that there were failures surrounding the management of Jesse's case and that these failures contributed to Jesse's decision to end his life. My investigation revealed that a practice had been established within DVA that was contrary to law and policy. The scope and nature of my investigation meant that I was unable to delve deeper into an examination of the whole DVA compensation system. However, I am satisfied that subsequent reforms have been implemented to identify and remedy any residual systemic issues in the claims process. I am further satisfied that there seems to be a genuine commitment by DVA to improving their systems and processes.

228. Jesse's death was the catalyst for comprehensive system-wide review and reform of DVA and Defence processes. I was extremely impressed with the evidence of Major General Fox and Ms Cosson who have both served in the Australian military and bring with them essential operational and lived experience. I am encouraged by the commitment both Defence and DVA have made to continually improving their organisations. I am unable to say whether Jesse's death would have been prevented had these reforms been in force at the time of Jesse's claim. However, it is apparent that there have been improvements in veterans' experiences of the DVA claims processes since Jesse's death as a consequence of these reforms.

ACKNOWLEDGEMENTS

229. I wish to express my sincere condolences to Jesse's family. I acknowledge the grief and devastation that you have endured as a result of the loss of your precious son.

230. I would especially like to acknowledge and commend Karen and John Bird and Connie Boglis for their tenacity in seeking justice for Jesse. Their dedication and commitment to searching for the truth and advocating for change to DVA and Defence processes has been a catalyst for significant reform in both organisations. Jesse's legacy has ensured that both Defence and DVA now better identify, support, assist and compensate veterans at risk of, or suffering from, psychological injuries.

231. I also commend Mr McNeill for his selfless advocacy assisting returned servicemen and women on a voluntary basis. Veteran Advocates provide an essential role in assisting returned service men and women, and I wish to acknowledge the efforts Mr McNeill took on behalf of Jesse in an attempt to expedite his claim and provide general support to him.

COMMENTS

232. Pursuant to section 67(3) of the Coroners Act, I make the following comments connected with the death.

Monitoring of Veteran Suicide

233. Between 2001 and 2017, the Australian Institute of Health and Welfare (**AIHW**) documented 419 suicides in serving, reserve and ex-serving Defence personnel. The AIHW found the adjusted rate of suicide in ex-serving men was 18% higher than in the general Australian male population, with the rate particularly elevated in male veterans aged under 30 years.[261]

[261] Australian Institute of Health and Welfare, '*National Suicide Monitoring of Serving and Ex-Serving Australian Defence Personnel: 2019 Update'*.

234. The number of suicides in ex-serving Defence personnel identified by the AIHW was ten times higher than the number of Australian soldiers (41) who died during service in Afghanistan. These figures are alarming and demonstrate the need to *"invest in prevention and early intervention strategies to improve the health and wellbeing outcomes"* for those who have served in Australia's armed forces.[262]

235. Victorian Coroners have long been concerned about the prevalence of suicide among veterans. In 2019, Deputy State Coroner Caitlin English delivered her finding without inquest in the death of Nathan John Shanahan,[263] following an investigation during which coronial data sources were used to attempt to establish how many suicides had occurred among serving and ex-serving Defence personnel in Victoria. Sixty-nine relevant deaths were identified in the period between 2008 and 2017. However, Coroner English noted this was likely to be an under-estimate because coronial data was reliant on evidence gathered in an investigation identifying that a deceased person was a veteran, and that information may not always be available.[264]

236. Coroner English further noted that even when veteran suicides were identified, the evidence in each death did not always include relevant data such as state, service branch, period of service, length of time between discharge and death, history of service overseas, or any other features which could have meaningful implications for identifying vulnerable cohorts.[265] Consequently, Victorian Coroners are unable to accurately monitor how many suicides are occurring among veterans. The identified deaths are likely to be an underestimate of the true extent of the public health crisis among this vulnerable group.

237. Coroner English found that Coroners' identification of and insight into suicides among serving, reserve and ex-serving Defence personnel could be greatly enhanced through access to the data sources the AIHW draws upon for its work. In particular, the AIHW has access to the Defence Personnel Management Key Solution (**PMKeyS**) database, which is an independent source of information on veterans who have died and their service history.[266]

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[262] Australian Institute of Health and Welfare, '*National Suicide Monitoring of serving and Ex-Serving Australian Defence Force Personnel: 2019 Update'*.
[263] COR 2016 6067, Finding into death without inquest of Nathan John Shanahan dated 22 March 2019.
[264] COR 2016 6067, Finding into death without inquest of Nathan John Shanahan dated 22 March 2019, p9.
[265] COR 2016 6067, Finding into death without inquest of Nathan John Shanahan dated 22 March 2019, p9.
[266] COR 2016 6067, Finding into death without inquest of Nathan John Shanahan dated 22 March 2019, p9.

238. Deputy State Coroner English recommended that AIHW engage with the Coroners Court to explore whether there were opportunities to share data on Victorian suicides of current and former serving Defence personnel. Such information could assist the Coroners Court in exercising their prevention role by:

(a) identifying veteran suicides with a greater degree of accuracy;

(b) allowing investigating Coroners to more effectively direct their investigation to build the evidence base for prevention; and

(c) informing the design and implementation of suicide prevention initiatives.

239. Deputy State Coroner English recommended that AIHW engage with the Coroners Court to explore whether there were opportunities to share data on Victorian suicides among current and former serving Defence personnel.

240. In response to this recommendation, the AIHW's Acting Chief Executive Officer Matthew James informed the Coroners Court that Defence are the custodians of the PMKeyS system and that they would need to consider any request to supply the data.

241. I support Deputy State Coroner English's recommendation and agree that provisions of the data held on the PMKeyS system could greatly assist Coroners in exercising their prevention role by providing more accurate insight into the true burden of suicide among our veterans and by allowing coronial investigations to be better directed to generate insights into prevention opportunities. Accordingly, I have made a recommendation in line with this for the Secretary of the Department of Defence to consider how the information in its PMKeyS system could be shared with Victorian Coroners. I also consider that such information would be of great assistance to coroners in other jurisdictions and the proposed National Commissioner in the exercise of their duties.

Rebuilding Trust between Veterans and DVA

242. The initiatives undertaken by DVA to support veterans are necessarily limited to those veterans that it is aware of. It is clear that DVA has undergone a significant transformation in its approach to managing compensation claims and supporting veterans and their families. It is encouraging to see the efforts being made to connect with, and rebuild the trust of, veterans, including the Census Regulations Amendments. However, I agree that more may be done to encourage veterans and their families to come forward and seek help.

243. As suggested by Mrs Bird, a public awareness campaign for veterans would potentially help find those veterans that have fallen through the cracks and reconnect with them.[267] Both Major General Fox and Ms Cosson acknowledged the importance of better communicating the reforms within DVA and were supportive of a campaign to encourage veterans to come forward.[268] I consider that a public awareness campaign directed at informing veterans about the reforms undertaken and encouraging veterans to come forward would assist both in reconnecting with veterans and in building trust and confidence in DVA. Such a campaign ought to be multi-modal, utilising where possible, social media, television, print, and radio formats. Consequently, I have made a recommendation consistent with this.

Harmonisation of Legislation

244. The inquest established that the DVA compensation and rehabilitation system is overly complex and difficult for veterans to navigate, in part because it is governed by three separate pieces of legislation, with differences across the Acts in terms of eligibility and beneficial entitlements.

245. I consider that it is crucial to harmonise and consolidate the DVA legislation to:

(a) ensure that the claims system is 'fit for purpose', reflecting the needs of veterans now and into the future;

(b) reduce complexity in the compensation system by streamlining and simplifying the claims process;

[267] Transcript of evidence, p95.
[268] Transcript of evidence, pp156, 242.

(c) remove inconsistencies between the Acts to ensure fairness and equity in eligibility and benefits; and

(d) ensure the legislative framework reflects veteran centric practices.

246. I note and commend the efforts DVA are already undertaking in this regard. I acknowledge that a wholesale harmonisation of the legislation is a substantial undertaking which would require significant time and resources. Nevertheless, such reform has the potential to greatly improve veterans' experiences of the compensation claims process and assist in better supporting veterans in need. Accordingly, I have made a recommendation to the relevant Minister to take the necessary steps to harmonise the legislation governing the veterans' compensation and rehabilitation scheme.

Independent Oversight Body

247. Despite the Government's commitment to establish a National Commissioner, I consider it is vital that an independent body be established to provide ongoing oversight of DVA and to assist both in monitoring the implementation and evaluation of measures to reduce suicide risk factors and in repairing the broken trust between veterans and DVA. The proposed appointment of the National Commissioner appears to be a positive step towards this goal.

248. I recognise however, that the proposed establishment and appointment of the National Commissioner is at an embryonic stage and that specific details of the remit, functions and powers are yet to be determined. Specifically, it is not yet known how the National Commissioner functions will sit alongside the coronial function of investigating reportable deaths.

249. In this regard, and bearing in mind my prevention role, I consider that it is necessary that such an oversight body not be confined to solely investigating veteran suicides, but rather to have an extended remit to proactively review and audit DVA processes and investigate veteran complaints to assist in ensuring that veterans are appropriately supported, particularly where they may be at risk of suicide. I have made two recommendations consistent with this.

RECOMMENDATIONS

250. Pursuant to section 72(2) of the Coroners Act, I make the following recommendations connected with the death:

Recommendation One:

I recommend that the Secretary of the Department of Defence consider how the information in its PMKeyS system could be shared with the Coroners Court to:

(a) enhance Victorian Coroners' ability to identify veteran suicides with a greater degree of accuracy;

(b) allow investigating Coroners to more effectively direct their investigation to build the evidence base for prevention; and

(c) inform the design and implementation of suicide prevention initiatives.

Recommendation Two:

I recommend that the Secretary of the Department of Veterans' Affairs consider implementing a public awareness campaign directed to informing ex-service personnel about the recent reforms undertaken by DVA and encourage veterans to come forward to assist both in reconnecting with them and in building trust and confidence in DVA. Such a campaign ought to be multi-modal, utilising where possible, social media, television, print, and radio formats.

Recommendation Three:

I recommend that the Minister for Veterans' Affairs and Defence Personnel take the necessary steps to harmonise the legislation governing the veterans' compensation and rehabilitation scheme to:

(a) ensure that the claims system is 'fit for purpose', reflecting the needs of veterans now and into the future;

(b) reduce complexity in the compensation system by streamlining and simplifying the claims process;

(c) remove inconsistencies between the Acts to ensure fairness and equity in eligibility and benefits; and

(d) ensure the legislative framework reflects veteran centric practices.

Recommendation Four:

I recommend that the Secretary of Department of Prime Minister and Cabinet extend the remit of the proposed National Commissioner to include powers to proactively review and audit DVA processes and to investigate veteran complaints.

Recommendation Five:

I recommend that the Secretary of Department of Prime Minister and Cabinet provide an update to the Coroners Court on the status of the implementation of the proposed National Commissioner within six months, including where relevant, pending or current legislation, specifics as to the scope, remit and functions of the National Commissioner, and information detailing how the National Commissioner's investigation of veteran suicide deaths will sit alongside the coronial functions.

251. Pursuant to section 73(1) of the Coroners Act, I order that this finding be published on the internet.

252. I direct that a copy of this finding be provided to the following:

The family of Jesse Stephen Bird

Ms Connie Boglis

Mr John McNeill, Volunteer Veteran Advocate

Dr Arthur Velakoulis, Consultant Psychiatrist

Department of Veterans' Affairs, c/o Ms Elizabeth Cosson AM CSC, Secretary

Department of Defence, c/o Mr Greg Moriarty, Secretary

Department of Prime Minister and Cabinet, c/o Mr Phillip Gaetjens, Secretary

The Hon Darren Chester MP, Minister for Veterans' Affairs and Defence Personnel

The Hon Senator Linda Reynolds CSC, Minister for Defence

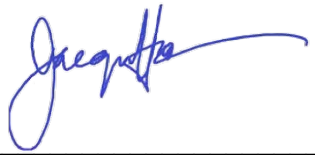
Ms Christine Morgan, National Suicide Prevention Adviser

Veterans and Veterans' Families Counselling Service

Austin Health, c/o Ms Kristen Stanner

Coroner's Investigator

Signature:



JACQUI HAWKINS
Coroner
Date: 7 April 2020

APPENDIX A

Australian Defence Veterans' Covenant

We, the people of Australia, respect and give thanks to all who have served in our defence force and their families.

We acknowledge the unique nature of military service and the sacrifice demanded of all who commit to defend our nation.

We undertake to preserve the memory and deeds of all who have served and promise to welcome, embrace, and support all military veterans as respected and valued members of our community.

APPENDIX B

Suggested Assistance for Veterans in Crisis

If a veteran is suffering from a mental health crisis or needs help or support, please contact:

- **Open Arms -** Veterans & Veterans Families Counselling (24 hr): 1800 011 046
- **ADF All-hours Support Line:** 1800 628 036
- **Operation Life Online:** http://at-ease.dva.gov.au/suicideprevention
- **Lifeline:** 13 11 14
- **Suicide Call Back Service**: 1300 659 467 https://www.suicidecallbackservice.org.au/
- **Beyondblue Support Service:** 1300 224 636 http://www.beyondblue.org.au/
- **Mens Line Australia:** 1300 789 978
- **Austin Health Veterans and Serving Members Unit:** 03 9496 4138
- **Victoria's Mental Health Services:** www.health.vic.gov.au/mentalhealthservices/