After the shooting stops

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Societies throughout the ages have engaged in aggressive or defensive wars. In every society systems and cultures evolved to ensure a sufficient body of citizens or employed mercenaries would be available to protect defend or expand the families, tribes, towns, cities or nations that would otherwise be vulnerable.

In many cultures those who dedicated their lives to battle, warriors who risked their lives for the larger societal good, were, if they survived, greatly honoured. In many societies it was an obligation of citizenship for males to do so. War is never other than brutal but notions of courage, honour and even chivalry gave those engaging in conflict some shield against fear. If they succeeded they often returned as heroes.

Returning warriors might be granted special privileges such as the Romans extended to those who served in its armies. If they failed, many did not return at all. Before modern battlefield medical advances a grave wound was usually mortal. Even relatively minor battle injuries often lead to death. That remained so up to and including the Crimean War where Florence Nightingale made her name by focussing attention upon the dying the wounded and the sick. When we read of the mortality figures of field hospitals of even such recent times it comes as a shock. Until recently medical care was primitive and fundamental advances in sanitation and germ theory had not yet occurred. In the American Civil War from 1861 to 1865 for every man killed in combat, two died of disease during the war.

Of course the picture was not entirely binary. Past systems of warfare left behind their share of shattered bodies, blind soldiers and amputees. But as a proportion of those who lived and died those who returned stricken but alive were relatively few.

Although the evidence was not analysed in those terms, amongst those who returned home many suffered profound psychological disturbances as a result of their exposure to battles,[1] or what often went with war: sacks of cities, rapes

[1] See Barry R Schaller, *Veterans on Trial: The Coming Court Battles over PTSD* (Potomac Books, 2012) at 56-60 where the accounts of post conflict experiences of American Civil War Veterans are re-examined in the light of current understanding of PTSD.

and looting. In those less scientific times those who succumbed to shock, horror or fear were often accounted cowards or malingerers.

World War I forced home to western cultures a different conception of warfare and its costs. World War I required the total mobilisation of the citizens of all of Europe. Millions died in stalemated trench battles. The war dragged on for years.

The term “shell shock” entered our vocabulary. That language revealed a belated recognition that some humans pressed beyond all endurance would suffer mental and not merely physical destruction in war. Tragically it was too late for scores of young men on both sides who frozen with horror failed to respond to commands and, as a result, were summarily executed for cowardice.

In the aftermath of World War I millions of former soldiers returned home a large number suffering from injured lungs from gas (now prohibited as a legitimate weapon of war) or amputations and, in some cases gross psychological disturbance. Systems for reintegrating such a large number of the wounded into post-war society were overwhelmed. In so far as mental injury was concerned the rehabilitative response was completely inadequate. Out-dated notions of the value of stoicism as a soldier’s duty resulted in those consequences being ignored in all but the most florid instances and the injured were left to suffer silently whatever symptoms they had to cope with.

Perhaps World War II represented a return, in some senses, to the more traditional relationship of citizen to warfare. Whilst bloody on an unprecedented scale World War II at least could be conceptualised, on both sides, as a conflict for the survival of their society and the triumph of its values. Thankfully the values of the Axis powers did not prevail. Unlike World War I which ground to a grudging, pointless and indecisive end, World War II had a clear end with victors and vanquished. For the victors there were few moral uncertainties-- even if historians still debate the legitimacy of the bombing of Dresden and the atomic blasts over Hiroshima and Nagasaki. While I am old enough to remember how common it was to find the veterans of World War II reluctant to speak of their war, it is possible to suppose that, for those reasons, the psychological toll on those veterans was less compared with that imposed by World War I.

The nations that were the victors in World War II were also better prepared for its aftermath—at least the physical and economic toll. Australia, for example, recognised responsibility for its wounded and maimed and developed programs such as the soldier resettlement schemes, university entrance programs and low interest housing loans to reward its veterans. However, again, there was faint recognition of those who did return with what we now accept to be post-traumatic stress disorders.

It was only in the aftermath of Australia’s engagement in a series of ‘asymmetrical’ wars, such as the Korean War, the Malayan Emergency, the Vietnam War, the occupation that followed the second Iraq campaign and the war in Afghanistan that Australia’s system of compensation for veterans was forced to grapple more regularly with invisible but incapacitating psychological injuries. Such wars forced young men to engage in conflict zones where

differentiating enemy from friend, combatant from civilian was fraught and problematic. Domestic support for their participation was often limited or contested and ambiguous.

A recent book *Veterans on Trial* examines the legacy of US involvement in those conflicts zones. The author notes:

> The number of Vietnam veterans who suffer from PTSD has increased substantially since that war ended, with estimates ranging from 30% to as high as 70% of veterans experiencing PTSD symptoms. Likewise 30% of Korean War veterans may have suffered from the symptoms of PTSD. The estimates, viewed in light of the historical experience of past wars, suggest that, in the long run, 30 to 40% of Iraq and Afghanistan veterans will suffer from PTSD… Aside from personal medical and mental health problems, social and relationship problems, and economic problems, some studies suggest that increased exposure to combat may increase the likelihood of criminal arrest and conviction. A US Department of Veterans Affairs (VA) study indicated that many veterans of the current wars will experience fates similar to those of Vietnam War veterans.[2]

The Middle East Area of Operations Census Health Study, published by the Department of Defence in August 2013, found that Australians deployed to Iraq and Afghanistan were many times more likely to develop PTSD if they reported numerous traumatic combat-related experiences, and if those traumatic experiences were of different types. Among those who completed the survey two or three years after their most recent deployment, the prevalence of PTSD symptoms was almost 30%. The study appears to leave open the question of delayed expression of PTSD among veterans more than three years after their deployment.[3]

How then are claims by veterans for compensation for such prevalent injuries to be assessed?

Before directly turning to that question, it is useful to quickly sketch the way in which it has been decided that compensation claims for other injuries inflicted through war are to be determined.

The framework for compensation for war caused harms in Australian law is contained in the *Veterans Entitlements Act 1986*. The framework deliberately tilts the balance of proof in favour of the veteran.

Claims in relation to incapacity or death from operational, peacekeeping or hazardous service must be determined by reference to section 120 (1) to (3) of the Act. Under those subsections, it is necessary to decide whether there is a reasonable hypothesis connecting the injury, disease or death with the circumstances of operational, peacekeeping or hazardous service, and if there is, the claim will succeed unless a decision maker is satisfied beyond reasonable doubt that the death or incapacity was not war caused.

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[2] Ibid at p 3

[3] Centre for Military and Veterans' Health, MEAO Census Summary Report, pp 4, 20-21; MEAO Census Report Volume 1, pp 70-73.

Section 120A(3) provides an effect that a hypothesis connecting an injury, disease or death with the circumstances of service is only reasonable if there is in force a Statement of Principles (SoP) that upholds that hypothesis.

The leading case that explains how to apply the act relevant to claims in relation to operational service, peacekeeping service and hazardous service, is, as of course you are all aware, *Repatriation Commission v Deledio* (1998) 83 FCR 82.

In that case the Full Court (Beaumont, Hill and O'Connor JJ) said a decision-maker (the AAT) should proceed in accordance with the following steps:[4]

1. The Tribunal must consider all the material which is before it and determine whether that material points to a hypothesis connecting the injury, disease or death with the circumstances of the particular service rendered by the person. No question of fact finding arises at this stage. If no such hypothesis arises, the application must fail.

2. If the material does raise such a hypothesis, the Tribunal must then ascertain whether there is in force an SoP determined by the authority under s 196B(2) or (11). If no such SoP is in force, the hypothesis will be taken not to be reasonable and, in consequence, the application must fail.

3. If an SoP is in force, the Tribunal must then form the opinion whether the hypothesis raised is a reasonable one. It will do so if the hypothesis fits, that is to say, is consistent with the "template" to be found in the SoP. The hypothesis raised before it must thus contain one or more of the factors which the Authority has determined to be the minimum which must exist, and be related to the person's service… If the hypothesis does contain these factors, it could neither be said to be contrary to proved or known scientific facts, nor otherwise fanciful. If the hypothesis fails to fit within the template, it will be deemed not to be "reasonable" and the claim will fail.

4. The Tribunal must then proceed to consider under s120 (1) whether it is satisfied beyond reasonable doubt that the death was not war caused, or in the case of a claim for incapacity, that the incapacity did not arise from a war-caused injury. If not so satisfied the claim must succeed. If the Tribunal is so satisfied, the claim must fail. It is only at this stage of the process that the Tribunal will be required to find facts from the material before it. In so doing, no question of onus of proof or the application of any presumption will be involved.

While these provisions give rise to their own complex questions they clearly place fact-finding at the final point rather than as a threshold issue. This works straightforwardly enough in most instances because whether or not any particular events occurred as claimed is not indispensable to a diagnosis. The decision maker at the first step is merely obliged to examine the collection of

[4] *Deledio* at 97.

symptoms of which the claimant complains to determine whether, according to the standard of "reasonable satisfaction" they constituted disease for the purpose of entitling the veteran to a pension. Cancer is cancer whether or not it was provoked by smoking taken up in consequence of exposure to cigarettes during a war or by some other unrelated cause. Accordingly the determination of a diagnosis does not involve or require a finding of whether particular events in service did or did not occur; that exercise being confined to the fourth step in *Deledio* and the service person benefits from the reverse criminal onus of proof.

However, what to do where the clinical diagnosis of a condition requires a finding of whether a particular event did or did not occur?

That was the question the confronted the Full Court of the Federal Court of Australia in *Repatriation Commission v Bawden* (2012) 206 FCR 296.

At the time *Bawden* was decided the then current *Diagnostic and Statistical Manual of Mental Disorders DSM-IV* stated the diagnostic criteria for Posttraumatic Stress Disorder required inter-alia that:

> A. The person has been exposed to a traumatic event in which:
> (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and
> (2) the person's response involved intense fear, helplessness or horror.

The Court (per curiam Keane CJ, Jacobson and Bennett JJ) adopted the reasoning of Kiefel J in *Repatriation Commission v Warren* (2007) 95 ALD 606 that diagnosis was anterior to any potential relevance of a SoP.

> The anterior, or threshold, question for the Tribunal is whether the veteran suffers from the disease as claimed. It is a distinct and separate statutory question, in the nature of a precondition to any entitlement to a pension. There is no provision of the VEA which expressly requires the Tribunal to have regard to the SoP criteria in determining this question. The requirement that the tribunal be reasonably satisfied that the veteran suffers from the claimed disease will usually require medical opinion. A clinical diagnosis of a condition classified under DSM -IV would necessarily have regard to that manual and the criteria provided by it.

Thus the actual happening of a traumatic event, the Full Court held, was essential for the diagnosis of PTSD at a medical level. That was not because that requirement was contained in the, then and still, current *Statement of Principles Concerning Posttraumatic Stress Disorder No 5 of 2008* but because a valid medical clinical diagnosis of the condition required that circumstance to exist.

Without a medical diagnosis of PTSD there could be no hypothesis as the starting point for the four stage *Deledio* methodology to be commenced.

Given that a medical diagnosis of PTSD required, as understood under DSM-IV, both exposure to a traumatic event and a response involving intense fear helplessness or horror, if those circumstances were absent the veteran's case failed at the threshold.

That required fact-finding which could not be deferred to the 4th stage of the *Deledio* process. Thus in Mr Bawden's case the Full Court held that the AAT had been correct first to determine whether Mr Bawden had experienced or witnessed an event involving actual or threatened death or serious injury to himself or a threat to his physical integrity, and having found that he had not done so, simply rejected his claim in so far as the cause of his incapacity was asserted to be PTSD.

The practical impact of *Bawden*, at least in so far as medical diagnosis based on DSM IV are concerned, is that veterans who claim PTSD as the cause of their incapacity uniquely are denied the benefit of the reverse criminal onus of proof as to factual matters going to causation.

Given the number of potential claimants and the life changing consequences of PTSD that are now acknowledged as the sequelae of war many veterans may feel this to have resulted in the creation of an unjustifiable exception. *Bawden* has been applied already in a number of Administrative Appeals Tribunal decisions.[5]

However, and here I wish to tread carefully because the issue may come before the Administrative Appeals Tribunal, it may be that some of the sting has already been taken out of the *Bawden* exception.

That is because *Bawden* operates at the point of diagnosis. In mid-2013 the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) was published. In so far as the factual basis required for the establishment of a diagnosis of PTSD is concerned the DSM-5 has significantly modified what was previously provided for in the DSM-IV. DSM-5 requires only:

> A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
>
> 1. Directly experiencing the traumatic event(s).
>
> 2. Witnessing, in person, the event(s) as it occurred to others.
>
> 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

[5] See, eg, *Kaluza and Repatriation Commission* [2013] AATA 424; *Hair and Repatriation Commission* [2013] AATA 190; *Ambler and Repatriation Commission* [2013] AATA 303.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

   Note Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.

It may be readily noted that the diagnostic criteria no longer require direct personal exposure to events (see criterion A3) and that there is no requirement that the person's response involved intense fear, helplessness, or horror.

It seems reasonable to predict that decision-makers may, in the future, be presented with medical diagnoses of PTSD based not on the DSM-IV but on the more recent DSM-5. Assuming that to be so, many more veterans may be able to satisfy a decision-maker that the threshold circumstances objectively required for their medical diagnosis of PTSD have been established.

Once a medical diagnosis has been established, it would appear the logic of *Bawden* would require that the anterior question having been answered in the veteran's favour, and that threshold crossed, that the ordinary 4 step *Deledio* methodology would then apply to the determination of the veteran's claim.

This analysis raises its own set of complex questions regarding the distinction between the primary use of the DSM as a diagnostic tool even in a context where its language has also been adopted as a legal criterion for other purposes.[6] My understanding of *Bawden* suggests that that distinction remains critical. This understanding appears consistent with *Benjamin and Repatriation Commission*[7] and *Repatriation Commission v Warren.*[8] Some controversy remains, however, as to whether the diagnostic criteria set out in the SoP for the disease in question must be satisfied for the SoP to support a reasonable hypothesis at the third stage of the *Deledio* test.[9]

Assuming this analysis to be correct, unless and until there are parallel changes to the SoP 5 of 2008 (which is based on the earlier psychiatric manual DSM-IV) bringing it into line with the more up to date DSM-5, for a veteran to succeed there would still need to be a hypothesis connecting the injury or disease (PTSD) with the veteran's service and that hypothesis would still have to fit the "template" of the current SoP which is expressed in terms that reflect the previous DSM-IV.

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[6] See the discussion in Ian Freckelton and Hugh Selby *Expert Evidence: law, practice, procedure and advocacy* (5th ed, Thomson Reuters Lawbook Co., 2013) at pp 935-937

[7] (2001) 70 ALD 622 at [41].

[8] (2008) 167 FCR 511 at [36]-[38] per Lindgren and Bennett JJ.

[9] See *Repatriation Commission v Warren* (2008) 167 FCR 511 at [24], [38] Lindgren and Bennett JJ stated that the disease as diagnosed must satisfy the relevant SoP; Logan J at [101]-[108] reached the opposite conclusion, as did the trial judge: *Repatriation Commission v Warren* [2007] FCA 866 at [26]-[29] per Kiefel J. See the analysis in *Hunter v Repatriation Commission* (2010) 114 ALD 89 at [36]-[37] per Perram J.

However, the veteran, having crossed the threshold for a medical diagnosis for PTSD, would then have the benefit of the reverse criminal onus of proof at the most critical fact finding stage—step 4 of the *Deledio* methodology. These assumptions may however require testing – see *Simos v Repatriation Commission* where some obligation of fact finding appears to have been required by Tracey J at the point of establishment of the hypothesis.[10]

I express no concluded views as to whether this is how cases may present themselves before the VRB, on review before the AAT or on appeal to the Federal Court or how any such cases might be decided. My remarks, untested by the benefit of argument, are simply observations respecting some of the possible implications that may flow from the updating of DSM-IV to DSM-5. They are necessarily tentative and conditional.

I was greatly honoured by the invitation given to me by your principal member Doug Humphreys who invited me to deliver the keynote address to your conference on case law developments in veterans' law with particular reference to *Bawden.* I am not sure that my gratitude would have been so great had I realised the scale of the task I was taking on.

In the course of preparing this paper I came across a large number of cases which have dealt with the complexities of veterans' law. I was delighted to discover that your principal member has his place in that lexicon not merely as the head of your tribunal but also as the instructing solicitor for the veteran in a case that reached the High Court, *Benjamin v Repatriation Commission*.[11]

Independent merits review gives Australian citizens a right to careful reconsideration of decisions made by government officials and ministers. It is a right that the citizens of few other countries share. We should be proud of our role. All of us who work as members of tribunals should never take the responsibility that that confers upon us lightly. The work of the Veterans Review Board no doubt is often unglamorous and difficult but everything we do is part of the important architecture of independent merits review. I hope your participation in this conference will be applied to the challenging task of undertaking high-quality independent merits review in a manner that is fair, just, economical, informal and quick—the task that the VRB and the AAT share in common.

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[10] [2013] FCA 607.
[11] [2002] HCATrans 302.