RE-ESTABLISHING THE RULE OF LAW IN ORDER TO FULFILL AUSTRALIA'S DUTY TO PROTECT ITS INJURED, ILL, DISABLED AND VULNERABLE VETERANS FROM INSTITUTIONALISED CRIMINAL NEGLECT, ABUSE AND RELATED CRIMES

Submission to the Senate Foreign Affairs, Defence and Trade Legislation Committee Inquiry into the National Commissioner for Defence and Veteran Suicide Prevention Bill 2020 and the National Commissioner for Defence and Veteran Suicide Prevention (Consequential Amendments) Bill 2020

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> *"Those veterans and all serving men and women protect our community and our freedoms. It is our duty to do the same for them."*
>
> Prime Minister Scott Morrison, 5 February 2020

Introduction

I thank the Committee for this opportunity to make this submission to the inquiry into the *National Commissioner for Defence and Veteran Suicide Prevention and Consequential Amendment Bills* and look forward appearing as a witness to any forthcoming hearings.

I am a retired Australian Army officer whose 28-year career included six operational deployments (Afghanistan, Iraq, Bougainville, Ethiopia & Eritrea and Sumatra) and a wide range of leadership, training and management roles. I was medically discharged from the Army in 2017 while undergoing rehabilitation for an acquired brain injury (ABI) which I sustained during my service.

In 2015, while still serving in the Australian Defence Force (ADF) and while under the protection of the *Public Interest Disclosure (PID) Act*, I testified to this Committee's inquiry into the Mental Health of Serving ADF Personnel. My testimony focused on the adverse health impacts of the Army Malaria Institute's (AMI) notoriously unethical and unlawful clinical trials of the neurotoxic anti-malarial drugs mefloquine and tafenoquine, brain injury in the ADF, and more broadly on neglect, mismanagement and abuse by senior ADF officers as key factors contributing to the unacceptably high rate of suicides among serving ADF personnel and veterans. During that inquiry I condemned the "culture of denial, deceit and impunity that extends to the most senior officers in the ADF," and called for a Royal Commission of Inquiry into these matters.

Since 2015 I have testified in writing and/or in person to a further four related parliamentary inquiries, including this Committee's 2018 inquiry into the use of quinoline anti-malarial drugs in the ADF. During this period I have also met with a Prime Minister, several Ministers and Shadow Ministers, dozens of MPs and Senators, and hundreds of veterans, family members, health care providers and other carers, in four states, at my own expense, in a voluntary capacity. I have repeatedly witnessed shocking neglect and abuse in various forms, and fruitlessly attempted to have this abuse properly addressed by the relevant officials, departments, agencies and ministers. I have stopped counting the number of lives lost as veterans continued to fall victim to this intractable culture of neglect and abuse.

The Australian public will be shocked and horrified when they become fully aware of this appalling state of affairs, just as they were shocked and horrified at the state of our aged care, disability care

and banking systems when those Royal Commissions began their respective hearings. I believe that the Commonwealth Government's main motivation in stonewalling a veterans Royal Commission is one of avoidance and self-preservation, i.e. they simply want to avoid the inevitable political fallout when the public becomes aware of the shocking realities we face on the ground. These realities cannot be "spun" into a "good news story."

While I do acknowledge the dedication of this Committee and many of its parliamentary colleagues over many years, the sad truth is that the most serious matters raised during previous Senate inquiries have not been satisfactorily addressed by this Committee, the Commonwealth Government, or other relevant agencies, indeed the situation now is in some ways worse. The various recent veterans "mental health" or "suicide prevention" measures launched in response to those inquiries are political band-aids at best. At worst they have perpetuated the neglect, abuse and corruption. The veteran community's repeated calls for a Royal Commission have been deflected, the suicide problem has not been addressed in any substantial way, and the culture of criminality and impunity in the Departments of Defence and Veterans Affairs has been emboldened by political apathy, intransigence and obfuscation at the highest levels of Government.

The Bills under consideration by this inquiry are another manifestation of this dereliction, in that they seek only to solve what is perceived as a short-term political problem by "kicking the can down the road," rather than properly addressing systemic failures causing significant loss of life. Prime Minister Morrison is absolutely right in saying that Australia does have a *duty* to protect the men and women whose lives have been adversely impacted by their service to this country, however his proposed Commission and its genesis reflect nothing but a continued *dereliction* of that duty.

This submission briefly addresses the subject Bills, then explains why a Royal Commission of Inquiry into the neglect and abuse of ADF personnel and veterans must now be initiated *as a matter of urgency* if Australia is to meaningfully address the widespread, systemic failures by multiple agencies which continue to devastate our lives and wellbeing. This submission focuses largely but not exclusively on the impact of the quinoline drug trials, the Commonwealth's refusals to provide appropriate care for those affected, and the unaddressed culture of abuse and criminality which lies at the heart of these problems. These are not the only matters necessitating a Royal Commission but do serve to highlight the severity of the broader set of problems which need to come under the comprehensive scrutiny of a properly empowered and resourced inquiry.

Background

Since 1970, there have been more than 50 "inquiries" into ADF abuse, mental health, suicide and related matters: an average of one "inquiry" per year. These "inquiries" have gone nowhere and amounted to nothing.[1] In recent years there has been a profusion of costly but ineffective "mental health" or "wellness" programs and sundry other PR stunts, all designed to create a perception of progress, all of which have comprehensively failed to arrest the suicide rate. The proposed Commission is only the latest expensive PR stunt in a long line of expensive PR stunts.

The first step to solving any problem is to acknowledge the true nature of the problem. Veteran suicides are the predictable outcome of toxic leadership and catastrophic failures by military and related institutions to uphold their own purported values.[2] Australia is yet to take the *necessary first step* towards arresting the veteran suicide rate by acknowledging institutionalised criminality and toxic leadership at the highest levels of the relevant organisations, including but not only the ADF and the Department of Veterans Affairs (DVA).

The widespread misdiagnosis of quinoline poisoning as post-traumatic stress disorder (PTSD)[3] or other "mental health" disorders among affected veterans, and subsequent mistreatment, medical abuse and denial of appropriate care, within a broader context of high level abuse, criminality and corruption, illustrate the futility of framing veterans suicidality narrowly as a "mental health" problem, or attempting to "fix" the problem by wasting millions of taxpayer dollars on "mental health" or "wellness" initiatives[4] led by opportunistic so-called "innovation consultants" or other self-proclaimed "suicide prevention experts."

The ADF's notorious quinoline anti-malarial drug trials have been the subject of extensive media and parliamentary attention for the past five years. Since the early 1990s, around 5,000 ADF personnel were given the quinoline anti-malarial drugs tafenoquine or mefloquine during their service, including (but not only) in clinical trials conducted by AMI. From 1999 to 2002, 3,742 ADF personnel were "volunteered" to participate in a series of AMI clinical trials in Australia, Bougainville (Papua New Guinea) and East Timor. Attention has largely focused on the 2,855 subjects who were given tafenoquine and/or mefloquine (the remainder were given comparator drugs such as doxycycline or primaquine). Mefloquine was a registered drug which had already been relegated to the ADF's second-line malaria prevention drug (and later third line) specifically due to the risk of adverse neuropsychiatric effects, while tafenoquine was yet to be approved by any drug regulator.

Proponents of the trials from the Department of Defence and other agencies insist that they were necessary to meet a need for new, safe and effective anti-malarial drugs, and that they were conducted ethically because the subjects signed "consent forms." These claims do not withstand the most basic scrutiny. Safer, equally effective drugs were readily available throughout the period of the trials, while atovaquone-proguanil (a drug now considered so safe that it is available over the counter [without prescription] in many countries) had previously been trialled by AMI but not introduced because it was considered too expensive.[5] Mefloquine was acknowledged by the World Health Organisation and the manufacturer (among others) to pose serious neuropsychiatric safety risks *a decade before to the ADF trials took place*,[6] while official drug regulator safety warnings have highlighted the risk of lasting or permanent neurological damage for at least the last seven years.[7] Seven decades of scientific evidence clearly indicates that the quinolines, including but not only the 8-aminoquinolines (tafenoquine is an 8-aminoquinoline, used at similar dosages to the WWII-era 8-aminiquinolines which were discontinued because of their known hepatotoxicity and neurotoxicity)[8] can cause permanent brain damage, chronic ill-health and suicidality in a significant minority of users, including psychiatric symptoms that mimic PTSD.[9]

The ADF tafenoquine subjects were in fact used as a convenient pool of human guinea-pigs *as part of a commercial agreement* between the manufacturer, the U.S. military and the ADF, which the responsible U.S. military officials have since acknowledged was "naïve" and "desperate" on their part.[10] Tafenoquine, an analogue of primaquine, is known to be ineffective against vivax malaria for up to one quarter of the population due to a common and well-known CYP2D6 enzyme deficiency.[11] The link between CYP2D6 deficiency and tafenoquine treatment failure was identified by the Walter Reed Army Institute of Research (the organisation which first developed the drug and co-sponsored the AMI trials two decades ago) *almost seven years ago*,[12] as was the risk of potentially serious adverse drug reactions associated with the same enzyme-dependent metabolic pathway.[13] Not only is tafenoquine more dangerous than the drug it was/is being positioned to replace, it is equally as ineffective as primaquine *for the same scientific reason*. Even before we address the question of ethics, the various official post-facto justifications for the trials and denials of the drugs' harmful effects are all demonstrably false.

On the question of ethics, the ADF's claim that the subjects provided informed consent was best debunked by retired Lieutenant General John Caligari, Commanding Officer (CO) of the 1st Battalion Royal Australian Regiment (1 RAR) during the 2000-2001 tafenoquine-mefloquine malaria prophylaxis trial in East Timor, in his testimony to this Committee's 2018 inquiry:

> *I don't think there is any such thing as informed consent in the military. We do things because we are ordered to do things; we don't have the opportunity to say yes or no to some things; we shouldn't have a say in anything. There are occasions where I have sent soldiers to do things that they didn't want to do, and they didn't get to say whether they consent or not. Informed consent, as I understand it, for this activity in particular was more of an academic requirement than anything else; and it has something to do with the double-blind trial and the academic nature of the trial they were running. As far as I am concerned, we should not have informed consent; we should be told what to do. There should not be—and there is not—informed consent in the ADF.*

The simple facts are that the ADF trial subjects were not properly informed of the known risks, they were coerced to participate in the drug trials in various ways, and they have not been provided proper follow-up care. Many have died by suicide or neurological disorders, or suffered permanent disability, as a result of this negligence. The full extent of this harm is not yet known because of the continued and impenetrable culture of denial, deceit and impunity. Based on a very conservative estimate, I have stated publicly that the drug trials have killed more Australian soldiers than the Taliban.[14]

Despite all this, tafenoquine was granted regulatory approval by the Australian Therapeutic Goods Administration (TGA), *during the period of this Committee's 2018 inquiry*, based largely on the results of the AMI's 1 RAR tafenoquine clinical trial report, *even as this Committee was hearing eye-witness testimony that the published report had been defrauded* (see below).

In the face of these facts, the Departments of Defence and Veterans Affairs (among others) have maintained a cynical strategy of denial, not only refusing to provide urgent medical care appropriate to the actual clinical needs of those affected, but disseminating false misinformation designed to deliberately prevent us from receiving the necessary care and disability support from independent health professionals. Acquired brain injury (ABI) is a type of cognitive disability which requires specific care from appropriately qualified specialists including ABI rehabilitation medicine physicians, occupational therapists, speech therapists, physiotherapists and other allied health professionals. This denial strategy means that the affected veterans continue to be misdiagnosed with "mental health" disorders such as PTSD or schizophrenia, mistreated with inappropriate and dangerous pharmacotherapies or electro-convulsive therapy (ECT), accused of malingering and/or subjected to various other forms of medical abuse in DVA-funded healthcare facilities, while being systematically denied access to life-saving medical care and social support available from *existing* ABI rehabilitation and outreach programs in each state.

Further deaths and abuse have continued to occur even since the 2018 inquiry, as a direct result of this ongoing denial strategy, i.e. *veterans continue to die as the intended outcome of official Commonwealth Government decisions, policies and procedures.* There have been continual, systematic, deliberate breaches of the *Disability Discrimination Act*, presumably for the purpose of the Commonwealth avoiding legal or financial liability for injuries we sustained as a direct result of our ADF service. Further, this denial strategy has facilitated the regulatory approval of a dangerous drug, with substantial financial gain to the manufacturers, based largely on fraudulent ADF clinical trial results, and now poses a significant risk to public safety.

The first part of this submission will address the logical perversion at the heart of the proposed Commission. The remainder of the submission will provide specific examples of the culture of criminality, abuse, neglect, cover-up and corruption which will need to be fully and comprehensively examined by a full Royal Commission of Inquiry, if the Australian community is serious about upholding it's duty of care for veterans who were injured or otherwise disadvantaged as a result of their ADF service.

Perverse Logic, Perverse Outcomes: The Proposed Commission and the "Suicide Prevention" Bills

Australia's *National Suicide Prevention Strategy* is based on a systems approach to suicide prevention, led by primary health networks, in partnership with local organisations, states and territories. The strategy emphasises promotion, prevention and early intervention.[15] Although the strategy focuses largely on mental health and does not address the specific matters raised in this submission, the key point is that suicide *prevention* involves *proactively* identifying vulnerable individuals or groups, *actively intervening* to *prevent* suicide, and providing *comprehensive* care and support. The National Mental Health Commission recognises several key *social determinants* which influence mental health and wellbeing, including housing, education, employment, and *social justice*.[16] Social justice is the concept of "*fair* and *just* relations between the individual and society."

Section 3(1) of the first Bill under consideration by this inquiry states:

> *The main object of this Act is to provide for a Commissioner to examine defence and veteran deaths by suicide, in order to support the prevention of future such deaths.*

Section 11(2) states:

> *To avoid doubt, the following are not functions of the Commissioner: (a) to make findings of civil or criminal wrongdoing; (b) to make findings on the cause of death in relation to a defence and veteran death by suicide.*

Two things are obvious from these sections of the Bill. Firstly, when compared to the title of the Bill, Section 3(1) is a logical perversion: it is not possible to "prevent" a suicide by investigating or inquiring into a suicide *after* the suicide has occurred. Although I do concede that over time it might be *possible* for some of the proposed Commission's findings to "support the prevention" of future deaths in a very limited way, the proposed legislation is *not* a proactive "suicide prevention" measure. Secondly, explicitly disempowering the proposed Commission from making findings on criminal wrongdoing or causes of death would *preclude* the proposed Commission from addressing the key cause of veteran suicides which is the main focus of this submission: *institutionalised, systemic criminality at the highest levels of Commonwealth departments and agencies and the existing culture of impunity which perpetuates and enables that criminality.* Indeed, should the Bill be passed into law it would serve only to *reinforce* this culture of impunity by explicitly precluding criminal prosecution or even civil or administrative findings with respect to causality.

The perverse logic at the heart of this Bill sends two key messages to the institutions and individuals responsible for this criminality, the victims of the criminality, and the Defence and veteran communities more generally:

1) If you need "help" after falling victim to serious abuse or crime, first you must die.

2) If you commit a crime causing a death or deaths, you will be immune from prosecution.

The remainder of this submission provides specific examples of the systemic criminality that the proposed legislation would not only fail to deal with but would likely exacerbate and perpetuate.

Blast from the Past: Fraud and Cover-Ups during the AMI Anti-malarial Drug Trials

Five AMI clinical trials involving tafenoquine and mefloquine were conducted during the 1999-2002 period. The first was a 1999 tafenoquine vs primaquine post-exposure prophylaxis (PEP) trial in Bougainville, involving 584 personnel from the Peace Monitoring Group (374 tafenoquine subjects, 210 primaquine subjects). The second was a 2000 tafenoquine vs primaquine PEP trial in East Timor, involving 928 personnel from 3 RAR, 5/7 RAR and attached units (639 tafenoquine subjects, 289 primaquine subjects). The third was a 2000-2001 tafenoquine vs mefloquine prophylaxis trial in East Timor involving 654 personnel from 1 RAR and attached units (492 tafenoquine subjects, 162 mefloquine subjects). The fourth was a 2001-2002 mefloquine vs doxycycline trial involving 1,545 personnel from 2 RAR and 4 RAR (1.157 mefloquine subjects, 388 doxycycline subjects). The fifth was a tafenoquine vivax malaria relapse prevention trial involving 31 ADF personnel in various healthcare facilities across Australia.

During this Committee's 2018 inquiry, dozens of witnesses provided first-hand testimony of severe and/or chronic adverse health conditions which are consistent with the well-established toxic effects of these drugs. Numerous witnesses also testified that they were actively discouraged from reporting adverse drug reactions (ADRs) by their superior officers and/or medical officers, to the extent they were threatened with disciplinary action, accused of malingering, or bullied for attempting to do so. Numerous accounts of severe adverse neuropsychiatric reactions were provided, including weapon or vehicle accidents. By way of example, one of the more serious incidents of fraud and cover-up occurred at Aidabeleten, near the East/West Timor border, during the 1 RAR tafenoquine-mefloquine trial (aka "Study 033") in December 2000.

1 RAR is a constituent unit of the Townsville-based 3rd Brigade. In 2000-2001, the Commander of 3rd Brigade was Brigadier (now retired Major General) Mark Kelly. The Senior Medical Officer (SMO) of 3rd Brigade was Lieutenant Colonel (now Brigadier) Leonard Brennan, who as part of his duties was directly involved in the preparation, oversight and reporting of medical care for all 3rd Brigade personnel, including 1 RAR, and the tafenoquine-mefloquine trial. Brigadier Brennan is named as one of the co-authors of the published Study 033 trial report. The Commanding Officer (CO) of 1 RAR was Lieutenant Colonel (now retired Lieutenant General) John Caligari. The commander of D Company 1 RAR, based at Aidabeleten, was Major (now Brigadier) Wade Stothart.

Accurate and transparent reporting and recording of ADRs is a basic requirement of any clinical trial. A "severe" ADR is generally defined as any incident requiring admission to a health facility or resulting in long-term or permanent injury or illness. All "adverse events" are required to be recorded and reported, even before any judgements are made about possible drug causation. For Study 033, a "severe" adverse event was defined as an event after which "daily duties could not be completed" by the subject. The published Study 033 trail report states that there were 85 "mild" or "moderate" neuropsychiatric adverse events, but "all were reported as mild or moderate,", i.e. there was not one single severe neuropsychiatric adverse event during the trial.[17]

On the evening of 11 December 2000, Private Christopher Carter and a colleague were posted on sentry duty in a guard tower at the D Company forward operating base (FOB) near Aidabeleten village. Private Carter had previously exhibited behavioural symptoms consistent with quinoline poisoning, but a decision was made for him to continue taking the trial anti-malarial drug. On this occasion, Private Carter became psychotic, took an ADF F1 grenade from his colleague, removed the pin and dropped or threw the grenade. The grenade exploded and Private Carter was injured by the blast.

The 1 RAR chain of command immediately fabricated a cover story for this adverse event and the resulting grenade accident. ADF operational reports, United Nations reports and media reports of the incident state that D Company was attacked by a suspected East Timorese militiaman, who purportedly threw a grenade or explosive device into the D Company FOB.[1819] On 12 December 2000, ADF media spokesperson Major David Munro stated:

> *Suspected militia threw an explosive device. We can't ascertain whether or not it was a hand grenade or a home-made device. In the explosion Private Christopher Carter was wounded or suffered minor shrapnel wounds to the lower left leg and also in the buttock.*

In response to the purported "attack," a helicopter was called in to evacuate Private Carter to Dili for medical treatment. A quick reaction force of helicopters, armoured vehicles and additional troops was called in to conduct a security sweep around the FOB. The following morning, Major Stothart ordered soldiers from D Company to conduct a security clearance of Aidabeleten village, on the false pretext of the purported "attack" the previous night, and to search for the "suspected militia" or related evidence of the "attack." During a subsequent formal ADF "investigation" into the incident, several of the D Company soldiers informed the investigators that the grenade in question was an ADF F1 grenade, not a "militia" grenade or other explosive device. The official version of these events is a complete fabrication, regardless whether it occurred during a clinical drug trial.

The Aidabeleten grenade incident is probably the most spectacular cover-up of an adverse drug reaction in the history of clinical trials, however it is only one of the many severe ADRs which were covered up during Study 033 and the other AMI quinoline drug trials. These incidents are common knowledge among the members of those units. One of the members of D Company 1 RAR in fact described the Aidabeleten grenade incident during the 31 August hearing of this Committee's 2018 inquiry in Townsville:

> *Crazy stuff started happening. We had a guy from my own company who ended up pulling a para flare apart, for no reason. No-one does that stuff. The next minute, we got back to our FOB and he ended up taking one of my mate's grenades. At that time we'd had a change in the grenade—once the pin was pulled out, you couldn't put it back in unless you had a special tool. He ended up throwing that grenade. The grenade went off and he ended up fragging himself. He just wigged out.*

During my research for this submission, an internet search found a media release posted on the Department of Defence "Health Portal" media webpage, dated 4 September 2019, under the heading "Discrepancies in the official reporting of 1 RAR operations in East Timor 2000-2001, the Study 033 tafenoquine trial report, and the grenade incident at Aidabeleten 11-12 December 2000." Curiously, the text of this document omits any reference to a grenade incident at Aidabeleten, but does state in part:

> *The conduct of Defence's anti-malarial studies were the subject of an Inspector-General Australian Defence Force Inquiry (IGADF). The report of the Inquiry found that the studies were conducted ethically and in accordance with both the Australian Defence Medical Ethics Committee (ADMEC) and later Australian Defence Human Research Ethics Committee (ADHREC) approved protocols and National Health and Medical Research Council (NHMRC) National Guidelines*.[20]

The title of this document alone shows that the cover-up of the Aidabeleten grenade incident and the defrauding of the various official reports, including but not only the Study 033 trial report, has

been brought to the attention of senior ADF officials as recently as September 2019, but once again they have failed to take the appropriate action for serious criminal misconduct.

The 1 RAR operational reports of the Aidabeleten grenade incident are fraudulent documents, as is the Study 033 trial report co-authored by Brigadier Brennan. Despite numerous "investigations" and "inquiries," and despite the severity of the fraud and its consequences, nobody has ever been held to account for this fraud, or the systematic fraud which occurred throughout the ADF quinoline drug trials more generally. Major Stothart has been promoted up through the ranks to Brigadier, has received awards for "distinguished command and leadership," and is now the head of Army Personnel. Lieutenant Colonel Brennan was promoted up through the ranks to Brigadier, has received awards including an AM, and is now in a senior role in Joint Health Command (JHC), as well as the Head of the Royal Australian Army Medical Corps (RAAMC). In his JHC role he is responsible in part for the "oversight" of AMI, has been directly involved in official ADF, DVA and government responses to concerns regarding misconduct relating to these trials, and has attended recent meetings of the Open Arms National Advisory Committee (NAC) as an *ex-officio* representative of JHC. He was appointed to the latter role, by the Minister for Defence Personnel and Veterans Affairs, at the same time Open Arms was developing a health response to meet the unmet medical needs of the soldiers who were injured while under his care two decades ago (see below), including incidents that were fraudulently omitted from a clinical trial report he co-authored.

The *Dunn Inquiry* Perversion of Justice: the Cover-up of the Cover-ups

According to their website, the Inspector General of the ADF (IGADF) "provides a means by which failures of military justice may be exposed and examined so that the cause of any injustice may be remedied."

In 2015 I made a written complaint to the IGADF regarding the AMI quinoline drug trials, which included substantiated allegations of serious ethical breaches, cover-ups, corruption, fraud and other crimes by a number of senior ADF officers involved in the drug trials. This resulted in a so-called "independent inquiry" by Assistant IGADF, Brigadier Andrew Dunn (the *Dunn Inquiry*). The report of the *Dunn Inquiry*, published in October 2016,[21] has been widely cited for having exonerated senior ADF officials from any wrongdoing.[22]

As the originator of the complaint, and having been directly involved in the proceedings, I can say that the *Dunn Inquiry* is best described as a *perversion of justice*, for numerous reasons I outline here. Notably, had I made these facts public at the time the inquiry report was published, I would have been subjected to criminal prosecution under the IGADF regulations.

The terms of reference for the *Dunn Inquiry* excluded several of the most serious allegations made in my original complaint to IGADF. The report purportedly "exonerated" ADF officials of serious wrongdoing in part because Brigadier Dunn was not directed to investigate the most serious allegations, including corruption allegations.

The terms of reference directed Brigadier Dunn to review the circumstances of the trial, "in consultation with relevant subject matter experts." During the inquiry I suggested to Brigadier Dunn that he should consult with the National Health and Medical Research Council (NHMRC) and the Therapeutic Goods Administration (TGA) specifically in relation to the ethical standards for clinical drug trials and the relevant aspects of the *Therapeutic Goods Act*. His response to my suggestion was that he did not want to bother external agencies. Instead, the "subject matter experts" relied upon by Brigadier Dunn were members of AMI or senior officers who conducted the drug trials that were the subject of his inquiry, including Colonel (now Brigadier) Brennan, who was the subject of my

most serious allegations. Perversely, the *Dunn Inquiry* concluded that the relevant ethical standards had not been breached because the officers under investigation said so.

Much of the Dunn Inquiry focused on the 1 RAR tafenoquine-mefloquine prophylaxis trial in East Timor from 2000 to 2001 (Study 033). At Brigadier Dunn's request, I provided him with a list of (among others) names and contact details for 35 soldiers who had served in East Timor with 1 RAR during this trial and were prepared to be interviewed. The list included numerous eye-witnesses to cover-ups of severe ADRs and the defrauding of operational reports, such as the Aidabeleten grenade incident described above. Brigadier Dunn decided to interview only six of the witnesses on this list, while also interviewing six of the 1 RAR officers including the Commanding Officer (Lieutenant General [then Lieutenant Colonel] Caligari) and Officer Commanding D Company (Brigadier [then Major]) Stothart. No questions were put to the officers about cases of fraud or cover-up which are common knowledge among members of the battalion, including but not only the Aidabeleten grenade incident. The *Dunn Inquiry* did not investigate blatant fraud and cover-ups, mainly because Brigadier Dunn decided not to interview the relevant witnesses.

The main subject of the inquiry, Brigadier [then Colonel] Leonard Brennan, was promoted to Brigadier during the inquiry, and remained in a position where he was advising senior ADF leaders and other Commonwealth agencies in their official responses to the controversy throughout this period. Brigadier Brennan was also filtering and responding to queries from the families of ADF personnel who had died as a result of their involvement in the drug trials.

The *Dunn Inquiry* was the cover-up of the cover-ups. An "inquiry" process purported to "remedy injustice" served instead to perpetuate and cover-up serious injustice, including (among other things) the most spectacular cover-up of an adverse drug reaction in the history of clinical trials, paving the way for a drug regulatory approval worth up to US$350 million, based on a fraudulent drug trial report.

Criminal Negligence and the Perversion of the Legal and Ethical Standards for Clinical Trials by Unlawfully Applying an Arbitrary Standard of Proof to Circumvent the Relevant Law

The purpose of drug safety studies such as the AMI quinoline trials is to determine the true safety of the given drug/s, by properly reporting and recording all adverse events in the clinical trial reports, including adverse events considered at the time to be either attributable or non-attributable to the drug/s. What should already be clear from this submission and the extensive evidence presented to this Committee's 2018 inquiry is that the results of the AMI quinoline trials did not achieve that purpose, because of the systematic institutional barriers to adverse event reporting, including bullying, threats of disciplinary action, blatant fraud and cover-ups.

The problem has been exacerbated by the Commonwealth's arbitrary application of veterans' entitlement law as a basis for circumventing its legal obligation to provide medical care for the clinical trial subjects. One of the key points I have made in my previous submissions to this Committee is that the guidelines for good clinical practice for clinical trials (which constitute Regulations under the *Therapeutic Goods Act*, i.e. they are Commonwealth law) state that an institution conducting a clinical trial must provide appropriate medical care for subjects who experience "*any* adverse events" (including adverse events not related to the study drug/s) "during *and following* a subject's participation in the trial." The guidelines define an "adverse event" as:

> *Any untoward medical occurrence in a patient or clinical investigation subject administered a pharmaceutical product and which does not necessarily have a causal relationship with this treatment.*[23]

I emphasise the fact that there is *no onus of proof* required on the part of the clinical trial subjects themselves to establish a causal link between the drug/s and the adverse event/s. The institution conducting the trial is required by law to provide the appropriate care regardless of any question of causation.

As part of their denial strategy, Defence and DVA have gone to enormous lengths to highlight the outcomes of a Repatriation Medical Authority (RMA) "investigation" which claims that the quinolines cannot cause permanent brain damage, despite an overwhelming body of evidence proving otherwise. This finding is being unlawfully used by DVA and Defence to deny the trial subjects from access to appropriate medical care. In her testimony to the 2018 Inquiry, DVA Secretary Ms Liz Cosson repeatedly claimed that all necessary care was being provided by DVA under the "non-liability healthcare" (NLHC) program. This is *demonstrably false* because the NLHC only provides care for a specified list of mental health conditions. As a matter of policy, DVA does not and will not provide care for any other conditions unless the claimant proves causation to the standard laid down in respective veterans' entitlement acts. Worse, by providing "free" non-liability medical care only for specified mental health conditions while simultaneously and unlawfully denying claims for other conditions, DVA is exacerbating the risk of further harm, including suicide, by inappropriately channelling affected veterans into "mental health treatment" pathways in the absence of proper diagnosis or care by the relevant health professionals. If you were going to design a system for intentionally killing people by medical abuse, this current system would provide an ideal design template.

The role of the RMA is *not* to make determinations about the causation of adverse events during clinical trials conducted by the ADF or any other institution, nor is it a drug safety regulator. By subjecting the clinical trial subjects' claims to irrelevant veteran entitlement legislation requiring proof of causation, and/or subjecting claims to irrelevant considerations laid out in RMA guidelines as a basis for such determinations, the Commonwealth has arbitrarily and unlawfully reversed the onus of proof as it relates to the *relevant* laws and regulations, i.e. the guidelines for good clinical practice which constitute Commonwealth Law under the *Therapeutic Goods Administration Act*. More correctly, it has unlawfully applied an arbitrary onus of proof in order to the circumvent the relevant law, which explicitly does not require any proof of causation. This is one of the main reasons I have described the trials as *manifestly unethical* and the Commonwealth's ongoing denial strategy as *unlawful*. The entire purpose of the clinical trials has been perverted by an unlawful policy response, which has in turn facilitated the regulatory approval of a dangerous drug. The fact that veterans have died after being denied appropriate medical care as a result of these unlawful determinations shows that the Commonwealth has been criminally negligent.

I have repeatedly explained this problem to Ms Cosson on numerous occasions and recommended achievable courses of action to resolve the problem, to no avail. See for example my presentation to Ms Cosson and Dr Firman on 12 April 2019 at Attachment 1. I have a sound recording of this briefing, including Ms Cosson's evasive responses, which I would be pleased to provide to this Committee if requested. Please also see my 16 August 2019 email to the newly appointed Repatriation Commissioner Mr Don Spinks at Attachment 2, which included this presentation and urged Mr Spinks to follow-up my proposals with Ms Cosson and Dr Firman, *specifically to mitigate the risk of veteran suicides*:

> *We must make every possible effort to prevent the next suicide epidemic and this presentation spells out how to achieve that with clear and achievable recommendations.*

Ms Cosson is criminally negligent for allowing this situation to continue and she is culpable for the deaths that have resulted during her tenure at DVA.

Contempt of Parliament by Government Witnesses who have Repeatedly Lied to Parliamentary Hearings with Impunity

Over the past five years, senior Commonwealth officials have repeatedly lied to and otherwise misled Parliament during Senate inquiries and Senate Estimates hearings regarding the events I have described in this submission. During this Committee's 2018 inquiry, I made several supplementary submissions to highlight false or misleading testimony given by numerous witnesses. Here I highlight two further examples of demonstrably false and misleading testimony, in this case by Professor Dennis Shanks, Director of the ADF Malaria and Infectious Disease Institute (ADFMIDI, formerly AMI). During the 11 October 2018 hearing, Professor Shanks was asked to respond to my allegation that the AMI clinical trials reports had been defrauded. Notably, Professor Shanks was not directly involved in those trials, so it is a simple matter of fact that he *would not know* if fraud had occurred, unlike the eye-witnesses to specific cases of fraud who did provide direct evidence of fraud in their oral and written testimony. Regardless, his testimony with respect to several related *matters of public record,* including a previous mefloquine trial in which he was involved*,* was demonstrably false.

In response to questions from Senator Moore about commercial relationships between the ADF, the U.S. military and drug manufacturers involved in the AMI quinoline trials, Professor Shanks stated:

> *These drugs just make no money, have no commercial interest.*

This is a demonstrably false statement. In my written submissions to the 2018 Inquiry I explained that as the licensee of tafenoquine for malaria prophylaxis, 60 Degrees Pharmaceuticals CEO Dr Geoff Dow had stated publicly that his motivation in seeking FDA approval was to obtain a priority review voucher (PRV). PRVs can be sold to third parties and have been sold for amounts up to US$350 million, hence the regulatory approval itself has a significant commercial value, even before a single tablet is sold on the market. Dr Dow stated in 2015:

> *I think that probably in terms of hot topics in this space the focus and investor interest is really around the priority review voucher. That is basically a voucher granted by the FDA if you succeed in getting regulatory approval for a drug for a tropical disease. Those vouchers can be sold to another company that allows fast track review at the FDA of an unrelated therapeutic. They are freely saleable on the open market. The most recent sale was for three hundred and fifty million by United Therapeutics to Abbvie. Three out of four of our products are eligible for the PRV and it is a financial incentive independent of your actual development program or the therapeutic you are moving forward. Therefore, that definitely has interest for individual investors, but also big pharma who have an interest in molecules that happen to be in your portfolio*.[24]

When asked by the Chair to comment on mefloquine loading doses, Professor Shanks' response included the following statement:

> *In the early 1990s, this was specifically tested in a double-blinded situation in the United States Marine Corp versus chloroquine in a non-deployment situation. I was involved in that trial. The specific question was whether it was tolerable, and it was, and that result was published.*

Professor Shanks was referring to the 1993 Boudreau et al study involving 359 U.S. Marines that compared two groups taking weekly mefloquine prophylaxis, one of which was given an initial loading dose, to a third chloroquine group. There were ten withdrawals in the mefloquine groups, six of which were attributed to insomnia or vivid dreams ("withdrawals" are typically excluded from the "adverse events" data, a practice which in fact contributes to under-reporting). Two mefloquine subjects were withdrawn for depression and suicidal thoughts, neither of which was attributed to the drug.[25] What Professor Shanks omitted from his testimony regarding this trial is that a number of the trial subjects were subsequently awarded disability claims by U.S. Veterans Affairs (VA) medical doctors, who attributed causation of chronic neuropsychiatric illness or permanent disability directly to their use of mefloquine during this trial. The VA in fact has a dedicated diagnostic and treatment pathway for veterans suffering from chronic mefloquine toxicity. One of these cases has been published in a peer reviewed medical case report:

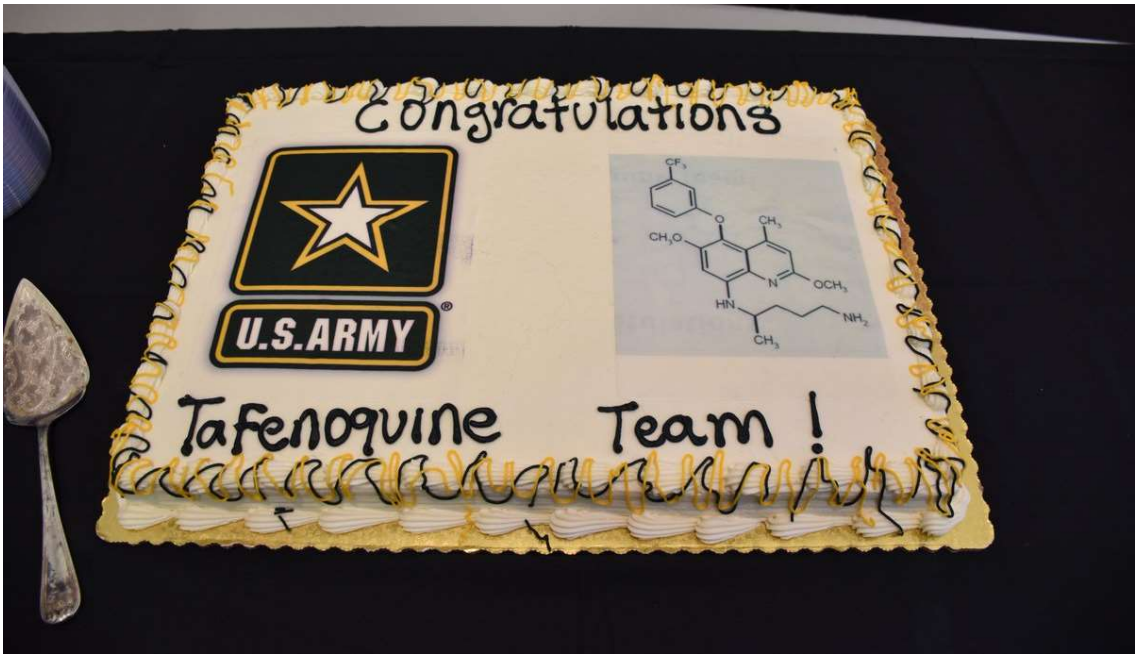
> *During the study he experienced insomnia, abnormal dreams, and nightmares. He also developed symptoms of anxiety, depression, cognitive dysfunction, and changes in personality—including anger and irritability—that were severe enough to be noted by his family members. The patient had not been advised of the significance of these symptoms and therefore did not report them during the clinical trial, nor did he report their intermittent presence after the study's conclusion through his retirement in 1996,* ***fearing adverse career consequences****. Subsequent exacerbations of these chronic symptoms later contributed to the patient's loss of civilian employment in 2010.*
>
> *After becoming aware of the 2013 boxed warning that these chronic symptoms could be due to his earlier exposure to mefloquine, the veteran sought evaluation by a VA clinician. On evaluation, the clinician noted no history of deployment, and no history of posttraumatic stress disorder (PTSD) criteria A stressors, and posited that the veteran's chronic neuropsychiatric symptoms were most likely a consequence of his earlier use of mefloquine. The VA subsequently awarded the veteran 50% disability for an anxiety disorder characterized by chronic sleep impairment and frequent panic attacks,* ***attributing these to his service-connected use of the drug****.*[26]

This example also serves to highlight the false and misleading nature of Professor Shanks' testimony regarding the under-reporting of adverse events during clinical trials and chronic illness resulting from mefloquine prophylaxis. Professor Shanks' opinion that mefloquine does not cause chronic illness contradicts the actual findings and determinations of medical doctors, including U.S. VA medical doctors providing medical care for actual patients: in this case a patient who was permanently injured as a result of a mefloquine trial in which Professor Shanks was personally involved, *and* an adverse event that was not recorded in the original trial report precisely because of the military barriers to reporting that I have been emphasising. His *opinion* is at odds with well-established *facts* already on the public record.

When asked by the Chair to respond to claims of under-reporting of adverse events in clinical trials, Professor Shanks stated:

> *It's not true. You can't do that and get your drug registered. The reporting of adverse events is quite detailed, and you don't know what you're going to get till the end. These clinical research forms are filled out as you go, and you report what you find. What that basically says is that we've been conducting fraudulent trials. We reject that assertion and say that the FDA and the TGA also assert that our trials were valid.*

In this response, Professor Shanks essentially claimed that it is not possible for a drug to be registered if adverse events have been under-reported or defrauded. From the evidence in this submission and other eye-witness testimony to the same inquiry, it should be obvious that the AMI trials were in fact defrauded and that tafenoquine was registered by both the TGA and the FDA despite that fraud. Professor Shanks may wish to continue to ignore or dispute the fact that the AMI trials were systematically defrauded, but what he cannot dispute is that there are many other well-known cases of serious fraud already on the public record, including GlaxoSmithKline (GSK), co-sponsor of the AMI tafenoquine clinical trials.



Congratulatory "Tafenoquine Team" cake at the USAMMDA ceremony attended by Professor Shanks at Fort Detrick, Maryland (two weeks after misleading a Senate inquiry) to celebrate the U.S. FDA regulatory approval of tafenoquine, based on the fraudulent Study 033 trial report, 25 October 2018 (USAMMDA Public Affairs)[27]

GSK is a notoriously corrupt organisation and has been for many years. The company has been repeatedly fined and subjected to criminal sanctions in numerous countries for fraud and related crimes, including the defrauding, withholding or misrepresentation of clinical trials data relating to adverse drug effects such as suicidality, for the specific purpose of facilitating the regulatory approval and/or sales of its pharmaceutical products. For example, in 2012 the company pled guilty and agreed to pay US$3 billion for three counts of criminal information, including the withholding of clinical trial data demonstrating lack of efficacy for the anti-depressant drug Paxil.[28]

Misleading a Senate inquiry is a contempt of Parliament. To my knowledge, no witness to the 2018 inquiry or any of the related inquiries has ever been sanctioned for providing false or misleading testimony. Perhaps unwittingly, this Committee's 2018 Inquiry followed the same pattern as the *Dunn Inquiry* and other "military justice inquiries" but worse, this inquiry did in fact hear direct evidence of fraud but *chose to ignore that evidence* and make findings based on the blatant lies of senior Government officials and/or other so-called "experts" who were not witnesses to the fraud. This Committee has perpetuated the culture of denial, deceit and impunity.

U.S. Attorney Ms Carmen Ortiz announcing US$3 billion in criminal and civil penalties to GlaxoSmithKline for offences including withholding of clinical trials safety data in order to facilitate U.S. FDA drug regulatory approvals, 2 July 2012 (ABC World News)

60 Degrees Pharmaceuticals Director Appointed to NHMRC "Advisory Board" During the 2018 Senate Inquiry

To give this Committee some credit, the 2018 inquiry did attempt to determine the role of the NHMRC and their role in this overall controversy. One of the criticisms I made of the *Dunn Inquiry* is that no independent expert advice was sought from agencies such as the TGA or the NHMRC. During my testimony at the 30 August 2018 hearing in Brisbane, I was asked by Senators O'Sullivan and Moore whether I had approached the NHMRC to raise my concerns about the Dunn Inquiry. When I stated that I had not, I was asked to explain why. The first part of my explanation was that the NHMRC is not responsible for the oversight of the ADF or IGADF.

During the 11 October hearing in Canberra, Dr Willis from the NHMRC stated in his opening address that "NHMRC is not a regulator. We are a funding agency." When the Chair asked Dr Willis whether he "had a view" regarding the findings of the *Dunn Inquiry* he answered:

> *We haven't been asked and we don't have a view. I think it's important to understand that NHMRC isn't responsible for the work of individual research ethics committees, and that I understand was the focus of the inspector-general's considerations. Because of that, we can't provide advice around decisions that individual ethics committees make or assessment of their work. … We don't do that. We don't have the authority or the scope to do it. … It's not our business. It's beyond our scope and authority.*

The second part of my explanation was that it would have been pointless to do so anyway. What I did not state explicitly at that time is that the NHMRC is another corrupt institution. Three weeks after the 11 October 2018 hearing, Ms Jennifer Herz was appointed for a three-year term as a member of the NHMRC "Health Innovation Advisory Committee" (HIAC).[29] Ms Herz is a director of 60 Degrees Pharmaceuticals and a co-owner of Biocelect, the Australian distributor of Kodatef (tafenoquine for malaria prophylaxis). 60 Degrees Pharmaceuticals is the licensee and manufacturer

of Kodatef. Kodatef had been granted TGA and U.S. FDA approval (the U.S. trade name is Arakoda), based largely on the fraudulent results of the Study 033 trial report.

The HIAC is one of the four principal NHMRC committees established under the *NHMRC Act*. The role of the HIAC is to provide advice on "current and emerging issues related to the development, commercialisation and uptake of innovative technologies and practices arising from health and medical research."[30] Section 42 of the *NHMRC Act* states that members of the principal committees must be appointed in writing by the Minister for Health.

Ms Herz is also a member of the Australian Partnership for Preparedness Research on Infectious Disease Emergencies (APPRISE CRE) "Expert Reference Group."[31] APPRISE CRE is an NHMRC-funded "network of leading experts, institutions and research networks involved in clinical, laboratory, public health and ethics research." Notably, the establishment of APPRISE CRE has been attributed largely to the efforts of Dr Firman, during her tenure at the Department of Health, prior to her commencing her current role as the DVA Chief Health Officer in early 2019, soon after this Committee's 2018 Inquiry.[32]

In sum: Ms Herz is a board member of the licensee and manufacturer Kodatef, a drug granted regulatory approval in the U.S. and Australia for significant commercial gain based on the fraudulent results of Study 033 (after clear evidence of that fraud was repeatedly ignored or actively covered-up by numerous government agencies over an extended period) during the period of the 2018 Inquiry; she is the co-owner of the Australian distributor of Kodatef; she is the member of an NHMRC-funded organisation established for the specific purpose of influencing government infectious disease policy including NHMRC funding decisions, with the direct involvement of the current DVA Chief Health Officer; and she was appointed to a principal NHMRC advisory board, by the Minister for Health, three weeks after the NHMRC's testimony to the 2018 Inquiry.

Where is the probity and accountability?

The Purported "Independence" of Open Arms and the Senate Inquiry Recommendations that Go Nowhere While Veterans Continue to Die

As I have previously explained to this Committee, ABI is a condition that requires specialist care and rehabilitation which differs substantially to the care of individuals with "mental health" disorders. Notably, the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* defines ABI as a cognitive disability, with a dedicated line of inquiry into the barriers to care faced by those of us with ABI and related cognitive disabilities.[33] Regardless of causation, treating ABI affected patients for "mental health" disorders such as PTSD without correct diagnosis, and integrated care under the overall lead of a specialist ABI rehabilitation physician, is dangerous and life threatening. For example, standard mental health pharmacotherapies pose a risk of severe adverse drug reactions including suicide, while electro-convulsive therapy (ECT) can cause further permanent brain damage, severe neurological disorders and/or other physical disability. These risks exist even for patients with correctly diagnosed mental health conditions (see for example Dr Niall McLaren's testimony to this Committee's 2015-16 inquiry into ADF mental health, and other published work).[34]

Shortly before the 2018 Inquiry, Professor Jane Quinn and I were invited to "co-design" a new Neurocognitive Health Program (NHP), initiated by Open Arms (formerly the Veterans and Veterans Families Counselling Service) in direct response to the health concerns of quinoline veterans and brain injured veterans more generally. The avenue for this "co-design" process was a "steering committee" comprising health experts, academics and veteran representatives with the relevant

expertise, chaired by Open Arms National Manager Dr Stephanie Hodson. The NHP was eventually re-named Brain Injury Rehabilitation Program, at the suggestion of the CEO of Brain Injury Australia, who was also a member of the steering committee. I spoke positively and constructively about the initial work of the NHP in my testimony to the 2018 Inquiry.

Over time, it became clear that there was no intention whatsoever for "co-design." At best, the "steering committee" could be described as an "advisory board." Crucial aspects of the advice, including serious safety concerns were disregarded – even a formal complaint of psychological abuse by an Open Arms psychologist against a disabled veteran – while the actual decision making was done outside the committee's purview. The committee was being used as a "rubber stamp." I repeatedly raised concerns about patient safety, the lack of coordination with DVA, and blatant conflicts of interest. My concerns were typically ignored and excluded from meeting minutes. I raised specific concerns about Brigadier Brennan's involvement in Open Arms on numerous occasions. I resigned from the steering committee on 19 January 2020 and my resignation email is at Attachment 3.

Open Arms claims to be independent of DVA and Defence. The Open Arms National Manager is Dr (retired Colonel) Stephanie Hodson, a former head of the Australian Army Psychology Corps. Open Arms is governed by a National Advisory Committee (NAC) chaired by Professor Jane Burns, a BUPA Australia "innovation consultant." The role of the NAC is to "provide the Minister for Defence Personnel and Veterans Affairs with independent advice on the needs of the veteran community and how these can be addressed through Open Arms." There are seven members representing veterans' organisations and relevant health professions, and eight *ex-officio* members. The *ex-officio* appointments include the Repatriation Commissioner (from 2010 to 2019 the Repatriation Commissioner was Major General Mark Kelly, Commander 3rd Brigade during the AMI quinoline trials), the DVA Commissioner, and four recently established, uniformed *ex-officio* representatives of ADF organisations: Navy, Army, Airforce and JHC.

The minutes of the 29-30 November 2018 NAC meeting state that "The Chair and the NAC revisited the membership of the committee recommending that the Minister be approached to have tri-service representation on the NAC and a representative from Joint Health Command." Dr Hodson stated that this Committee's 2018 inquiry report would soon be released and that regardless of the inquiry's findings, affected veterans would soon be able to seek support from the Open Arms NHP.

The minutes of the 28-29 March 2019 meeting state that the Minister had approved the addition of the four uniformed *ex-officio* members listed above, on the recommendation from the NAC's previous meeting. Dr Hodson stated that Open Arms had circulated the 2018 Senate Inquiry report, that extensive work was underway in terms of the development and implementation of the NHP, and the NAC "discussed the importance of having JHC involved in the program."

The 13-14 June 2019 NAC meeting was the first to be attended by the newly appointed *ex-officio* members listed above, which had been approved by the Minister on the recommendation of Professor Burns and the NAC around the same time that the 2018 Senate Inquiry was finalising its report. The inaugural JHC *ex-officio* member was Brigadier Brennan, co-author of the fraudulent 1 RAR tafenoquine Study 033 trial report and Major General Kelly's Senior Medical Officer during the period of the trials. Brigadier Brennan also attended the next NAC meeting on 26-27 November 2019 as the *ex-officio* representative of JHC. Although NAC meetings are held three times per year, none of the minutes of subsequent meetings are currently available on the Open Arms website.

Repatriation Commissioner Major General Mark Kelly (front row, seated), inaugural ex-officio Joint Health Command representative Brigadier Leonard Brennan (back row, fourth from right) and Professor Jane Burns (back row, fifth from right) at the Open Arms National Advisory Committee Meeting in Darwin, 13-14 June 2019 (Jane Burns/Instagram)

Cronyism, Corruption and the $2.1 Million "Appeasement" Contract Awarded to BUPA Australia Under the Pretext of a DVA "Veterans Health" Initiative

On 15 March 2019, Minister for Defence Personnel and Veterans Affairs Mr Darren Chester announced that the government had committed $2.1 million for a national program of "comprehensive health assessments" for veterans adversely affected by mefloquine or tafenoquine, in response to the findings of the 2018 Senate inquiry.[35] Around that time, Dr Hodson had stated during NHP steering committee meetings that she was close to receiving the funding required for the NHP. My initial assumption was that the $2.1 million announced by Mr Chester was for the NHP, however at the next steering committee meeting, Dr Hodson and the other Open Arms staff said that they were surprised by the Minister's announcement and that the $2.1 million was not for the NHP. Dr Hodson stated that the funding had been allocated to DVA for "comprehensive health assessments" to be undertaken by GPs. The committee agreed that we needed to know more about this program, so that it could be coordinated with the NHP. Dr Hodson also stated that she would invite representatives from the relevant DVA section to attend the next NHP steering committee meeting.

The next steering committee meeting was attended by two DVA staff from the DVA section developing the "comprehensive health assessments" program. The two staff stated that they were equally surprised by the announcement and they were in the early stages of "reading into the problem" so to speak. When I asked about the genesis of the program, they stated that they were uncertain, but presumed it had originated in the Minister's office. Professor Jane Quinn and I both

offered to assist them with the development of the program, to ensure that it met the needs of the affected veterans. The two staff seemed reluctant to take up this offer, stating that they were receiving advice from DVA medical advisors. When I stated that Professor Quinn was one of the world's leading experts on the subject, they became defensive. At every subsequent NHP steering committee meeting, I stated that there was a great deal of confusion among the affected veterans and reinforced the need for the "comprehensive health assessments" program to be coordinated with the NHP, but this never eventuated for the rest of my tenure on the steering committee.

On 20 December 2019 I received an email invitation from DVA to attend a "co-design workshop" for the program, to occur at the BUPA Australia offices in Brisbane on 24 January 2020. The invitation stated that BUPA Australia had been awarded the $2.1 million contract, and that documents describing the purpose of the program would be provided to attendees closer to the date. The email also stated:

> *Separately, BUPA will be conducting a workshop with a small group of clinicians to develop the health assessment tool and supporting clinical guidance.*

This occurred approximately nine months after DVA staff had declined our offer to assist them with the development of the program.

On 9 January 2019, I emailed DVA Assistant Secretary Client Coordination and Support Ms Leonie Nowland to raise my concerns about this program. I had managed to obtain the draft documents for the "small group of clinicians." My email to Ms Nowland (Attachment 4) stated that there were serious errors and misrepresentations in these documents, including *a gross misrepresentation of the 2018 Senate inquiry report*, and requested that these errors be immediately corrected. Ms Nowland did not reply to my email or subsequent phone messages. Having received no reply from Ms Nowland, I emailed Ms Cosson on 12 January 2019 (also at Attachment 4) to reinforce the same concerns, as well number of concerns about the serious problems arising from misinformation and lack of coordination. I received no reply from Ms Cosson.

Around this time, I became aware that Brigadier Brennan had been directly involved in this process, under the auspices of his membership of the Open Arms NAC, then submitted FOI requests to Defence, DVA and the Minister's office seeking documents relating to the genesis of the program, the awarding of the $2.1 million contract to BUPA Australia and communications between the various parties. I was already aware that Professor Burns was employed by BUPA Australia as an "innovation consultant," and I had raised my concerns about her involvement in the NHP due to her various conflicts of interest six months previously, to no avail. I had also raised my concerns to Dr Hodson about the involvement of Brigadier Brennan. DVA rejected my FOI request partly on the justification that some of the documents were Cabinet-in-Confidence, however some of the documents I received from Defence (Attachment 5) not only shed light on the genesis of the program, but show at least one medical professional in the Department of Defence had raised similar concerns to my own.

On 4 March 2019, Ms Veronica Hancock (DVA Assistant Secretary, Health Policy Branch), wrote to Air Vice Marshal Tracy Smart (then ADF Surgeon General):

> *Dylan [Kurtz] called from the Minister's office this afternoon to advise that following discussions with Minister and PMO [Prime Minister's Office], Minister is intending to make an early announcement of the mefloquine Budget measure, at the same time as tabling the*

> *Government response to the Senate mefloquine inquiry. The Budget measure is a $2.1 million commitment ...*

Air Vice Marshal Smart replied:

> *Thanks Veronica - appreciate the heads up. We sensed that **the PMO was looking for more ways to appease the concerns**.*

A 30 August 2019 email from Dr Victoria Ross (Department of Defence Senior Medical Advisor, Military Population Health) to DVA provides the most concise explanation as to why this appeasement exercise will be a waste of $2.1 million in taxpayer's dollars while vulnerable veterans continue to die (which seems to be the intended purpose of the overall Defence/DVA denial strategy in the first place):

> *How does continuity of care factor in? If this assessment is done by a BUPA provider, will they continue on as the veteran's GP? The primary issue is that these veterans are not engaged with or don't trust the system. There is a risk that **their care may become even more fragmented**.*

Despite numerous FOI requests, I have not been able to ascertain exactly what discussions took place between Professor Burns, Mr Chester or the Prime Minister's Office prior to the awarding of the $2.1 million appeasement contract to Professor Burns' employer BUPA Australia, however some further clues can be gleaned from Professor Burns' Instagram account and contemporaneous emails between erudite members of the various "Colleges of Medicine" and the National Commissioner for Mental Health.

Professor Jane Burns (back row, centre) et al meeting with Federal Treasurer Josh Frydenberg (front row, third from right) MP and Prime Minister Scott Morrison MP (out of picture) in Melbourne to lobby against the proposed Royal Commission and Commonwealth funding for proposed "veteran health" initiatives, 12 December 2019 (Jane Burns/Instagram)

On 12 December 2019 several representatives of the "Colleges of Medicine," RSL Victoria and other parties met Federal Treasurer Josh Frydenberg and Prime Minister Morrison in Melbourne to lobby for funding for initiatives to "improve mental healthcare and reduce suicides in veterans and first responders." The meeting was organised by Dr Peter Wirth, who had previously been suspended

from his appointment at a regional hospital amid allegations of bullying.[36] Other attendees included Dr Judith Silberberg,[37] who was serving a suspension for professional misconduct, and Professor Jane Burns, as an official representative of Open Arms. Dr Wirth's email debrief from the meeting (Attachment 6) describes Mr Morrison's participation as follows:

> *During the meeting he was very engaged, asked questions, and wrote copious notes. One subject which he raised was the proposed Royal Commission, and what our group's' views were.* ***Every person at the table gave clear reasons against the Commission.***

Professor Burns is certainly to be admired for her expertise in "innovation" and "appeasement" but at this juncture surely we must ask this question: at what point does the "innovation" of a $2.1 million "appeasement" contract dressed up as a "veterans' health" initiative cross the threshold of "corruption"? If it walks like corruption, quacks like corruption, and involves lobbying a Federal Treasurer or a Prime Minister for "innovative contracts" on the eve of a federal budget *quid-pro-quo* "independent expert advice" undermining calls for a Royal Commission into Veteran Suicides – it's corruption.

Cabinet Ministers Turning a Blind Eye to Fraud and Corruption

The first and foremost responsibility of any Minister is to uphold the law, particularly those laws relevant to their specific portfolio. This section of my submission outlines two documented cases of Commonwealth Ministers abrogating their responsibility to uphold the law by investigating substantiated allegations of serious criminal offences under relevant Acts, involving Commonwealth officials including very senior ADF officers.

In May 2017 I made a written complaint to the Australian Federal Police which included allegations and evidence of serious criminal misconduct by senior ADF officials, including officials involved in the IGADF inquiry, with sufficient evidence to warrant a criminal investigation. The allegations and evidence are reflected in much of this submission. The AFP decided to take no action. When I raised this matter with the then Minister for Justice Mr Michael Keenan via Ms Amanda Rishworth (then Minister for Veterans Affairs) in September 2017, Mr Keenan referred the matter to the AFP. According to Mr Keenan's reply to Ms Rishworth of 17 October 2017 (Attachment 7), the Fraud and Anti Corruption Centre "reviewed the details of the information provided," but did not conduct an investigation. Perversely, the AFP recommended that I re-direct my complaint to IGADF, i.e. the organisation that was the subject of some of my criminal allegations. In other words, the Minister for Justice was fully aware of serious crimes including fraud and corruption involving senior ADF and IGADF officers (crimes which had resulted in deaths), but was satisfied that the AFP turned a blind eye to those crimes.

Also in 2017, I became aware that the TGA had removed tafenoquine adverse event reports, including suicides, from the Database of Adverse Event Notifications (DAEN). This was a serious concern at the time because the TGA was considering the regulatory approval of tafenoquine, based on the fraudulent Study 033 trial report. When this was brought to the attention of the Minister for Health, the response from his chief of staff, the response was to explain it away as an "administrative error" and take no further action (Attachment 8).

Prime Ministers Turning a Blind Eye to Fraud and Corruption

Prime Ministers Malcolm Turnbull and Scott Morrison are both fully aware of the fraud, corruption and abuse outlined in this submission. Both have met with affected veterans, have been informed in

person and in writing, have been requested to intervene, have offered their support, then failed to follow-up.

On the morning of 7 June 2018, myself and several other affected veterans met with Prime Minister Turnbull at a forum held in the Sandstone Point Hotel (Bribie Island) in Queensland. During this meeting I gave Mr Turnbull a written brief including documentary evidence of fraud and corruption, and requested him to initiate a Royal Commission of Inquiry. Mr Turnbull took the brief, wrote down my phone number, and said "I'll get back to you." Video and audio of our meeting, including subtitles, was broadcast nationally on Sky News later that day,[38] including this exchange:

> *McCarthy: "The Senate Inquiry is fine, but the brief that I've compiled provides two decades of evidence of criminal misconduct on the part of senior ADF officials, including pretty strong evidence of corruption, so we need a Royal Commission."*
>
> *Turnbull: "I'll follow that up and I'll get back to you."*

Over the next several days I made numerous calls to the Prime Minister's Office, to check what follow-up action was being taken. I received no response whatsoever from Mr Turnbull or any of his staff.

Meeting with Prime Minister Malcolm Turnbull at the Sandstone Point Hotel near Bribie Island, requesting a Royal Commission to investigate two decades of criminal misconduct by senior ADF officials, 7 June 2018 (Sky News Australia)

On the morning of 7 February 2020, several veterans who were involved in the 1 RAR tafenoquine trial (Study 033) met Prime Minister Morrison at the Australian Warfighter Cafe in Townsville.[39] These included two members of D Company 1 RAR, witnesses to the Aidabeleten grenade incident in December 2000. Member for Herbert Mr Phil Thompson was also present at the meeting. As a former member of 1 RAR (although he joined the battalion after the East Timor deployment), Mr Thompson was also fully aware of the cover up of the grenade accident, given it was common knowledge in the battalion and the attendees of this meeting had previously discussed it with him.

For around 15 minutes, the 1 RAR veterans outlined many of the issues included in the written brief, including the Aidabeleten grenade incident and other examples of fraud and corruption, then handed Mr Morrison an updated version of the written brief I gave to Mr Turnbull in 2018. They requested Mr Morrison to initiate a judicial inquiry into the drug trials, which he agreed to on the

spot. Mr Morrison was particularly alarmed about the 60 Degrees Pharmaceuticals/Linear Clinical tafenoquine safety study currently under way in Perth, given that this involves the same tafenoquine dosage regimen used in Study 033.

Over the next several days I made numerous calls to the Prime Minister's Office, to check what follow-up action was being taken. I received no response whatsoever from Mr Morrison or any of his staff. The meeting attendees have also requested Mr Thompson to follow the matter up with the Prime Minister, but he has refused to do so. Mr Thompson also has a copy of the written brief that was given to the Prime Minister, as well as correspondence with the Prime Minister's Office and other Commonwealth officials discussing how the Government should respond to the alleged criminal misconduct.

Prime Minister Scott Morrison meeting with 1 RAR tafenoquine Study 033 veterans in Townsville, 7 February 2020

Mr Turnbull and Mr Morrison have both been derelict in their duty. Both were informed, in person and in writing, that serious crimes were committed by very senior ADF officials, resulting in deaths. Both failed to take any action, turning a blind eye to fraud and corruption which facilitated the regulatory approval of a dangerous drug, for the financial gain of the pharmaceutical industry.

Failure to Protect Witnesses to the Brereton Inquiry, Resulting in Death and Risk of Further Deaths

Many of the soldiers who were subjected to the AMI tafenoquine and mefloquine trials in Bougainville and East Timor continued their careers in special forces units including the Special Air Service Regiment and 2 Commando Regiment, including subsequent deployments to Afghanistan, Iraq and other operations. A number of these soldiers or their family members, including some who are still serving in the ADF, have informed me that they continue to suffer neuropsychiatric symptoms of chronic quinoline poisoning and have been unable to access the appropriate medical care. Among the multiple cases of suicide in this group in recent years, two were *still serving in ADF special forces units at the time of their deaths*. One of the deaths was subjected to an IGADF inquiry, while the other was subjected to a coronial inquest in NSW. The outcomes of these inquiries are unknown to me (including whether their involvement in the AMI quinoline trials was considered as part of the inquiries) but would be discoverable under the powers of a Royal Commission of Inquiry.

A significant number of the special forces soldiers who were involved in the trials have also been directly involved in the *Brereton Inquiry* into allegations of laws of armed conflict (LOAC) violations by ADF personnel in Afghanistan, either as witnesses or accused. Among these was Mr Kevin Frost, who was given mefloquine during the 4 RAR mefloquine-doxycycline trial in East Timor in 2001. Mr Frost was a witness to the *Brereton Inquiry* and had also made public allegations of serious misconduct by ADF personnel in Afghanistan.[40]

In December 2019 Mr Frost went missing near his home in Western Australia and was later found dead, possibly as the result of suicide. His family stated publicly that he had suffered from the chronic effects of mefloquine poisoning.[41] In the days following Mr Frost's death, concerns were raised in the media regarding the apparent lack of care for witnesses to the *Brereton Inquiry*.[42] The official response to these concerns from an anonymous Defence spokesperson was:

> *Defence provides comprehensive healthcare including routine and targeted screening for physical and mental health conditions for all ADF members.*

Mr Frost died three years after the Government failed to implement this Committee's recommendation that Defence and DVA contact all ADF members and veterans during their service to advise them of possible side effects and give them access to appropriate medical care,[43] and 18 months after the Open Arms NHP "steering committee" meetings began. His death, among other deaths, was the result of criminal negligence on the part of Defence and DVA, exemplifying the human cost of the culture of denial, deceit and impunity. A good man who served his country in war then had the integrity to stand up and do the right thing regardless of the personal consequences was left to die, and the best response the ADF had to offer was a few misleading, bureaucratese weasel-words formulated by an anonymous PR officer.

Although Justice Brereton has publicly acknowledged that the results of his inquiry will likely cause "distress" to some of those involved,[44] it is a simple matter of fact that those suffering from chronic quinoline poisoning are not being provided the appropriate specialist care, and cannot access the appropriate care, as a direct result of the ADF/DVA denial strategy. Lives remain at risk because of the ongoing criminal negligence of those organisations.

Continued Medical Abuse in DVA-funded Healthcare Facilities

On numerous occasions since the 2018 Inquiry, I have raised substantiated concerns regarding widespread medical abuse of veteran inpatients and outpatients at DVA-funded healthcare facilities at various locations throughout Australia, including but not only inappropriate and dangerous mistreatment of brain injured patients with psychiatric medications and/or electro-convulsive therapy (ECT), in writing, by telephone or in person, with senior DVA officials including but not only Ms Cosson and Dr Firman. My email of 7 April 2019 to Ms Cosson, Dr Firman, Dr Hodson and the Minister at Attachment 9 outlines systematic breaches of the *Disability Discrimination Act* and the *United Nations Convention on the Rights of Persons with Disabilities* (UNCRPD). In January 2019 I met with the Minister and Ms Cosson at a face-to-face meeting in Canberra and raised a number of concerns, including widespread medical abuse. On numerous occasions I have also requested urgent intervention by Ms Cosson, Dr Hodson and Dr Firman to assist veterans who had experienced medical abuse in DVA-funded healthcare facilities. These concerns have repeatedly been ignored and there are numerous veterans who remain at risk of suicide because of this negligence.

Vulnerable Australian Civilians Subjected to Unethical Tafenoquine Drug Trials funded by the U.S. Army

During the U.S. FDA regulatory approval process for tafenoquine, the FDA mandated that 60 Degrees Pharmaceuticals conduct a Phase 4 clinical long-term safety study, as a condition for the drug's approval. The clinical trial required to meet this condition was initiated in two centres in the U.S., and in Perth, funded by the U.S. Army. Around 200 vulnerable civilian subjects were enrolled into this trial by Linear Clinical in Perth. This trial is inherently unethical because there is no risk of malaria in Perth, and the trial subjects were not informed of serious risks to their safety.[45]

Continued "Volunteering" of ADF Personnel for Unethical Quinoline Drug Trials

During and since this Committee's 2018 inquiry, the Department of Defence has claimed that it has introduced new measures to address concerns that were raised about its previous systematic failures to uphold accepted standards for human research ethics, specifically in the oversight and conduct of clinical drug trials involving ADF personnel. This claim was debunked less than 18 months after the inquiry concluded.

In March this year I became aware that ADF medical personnel mobilising for the ADF's response to the Covid-19 pandemic were being recruited for a proposed ADFIMI clinical trial for chloroquine prophylaxis for Covid-19. When my concerns about this were brought to the attention of SGADF Rear Admiral Sarah Sharkey, her bizarre justification was that "international organisations such as the World Health Organisation and the Gates Foundation are coordinating worldwide efforts to test these compounds to determine their efficacy." Official public statements from the WHO contradicted her assertion. Rear Admiral Sharkey was also blissfully ignorant of the known toxic effects of chloroquine (Attachment 10). I also learned that the Departments of Defence and Veterans Affairs Human Research Ethics Committee (DDVA HREC) had not yet approved the trial. Large scale clinical trials of chloroquine and hydroxychloroquine for Covid-19 treatment and prophylaxis since that time have found that the drugs provide no clinical benefit. Healthy ADF medics being deployed as frontline healthcare workers during a pandemic were being recruited into a high-risk prophylaxis trial, for no clinical benefit, without DDVA HREC approval. Clearly the ADF has taken no heed whatsoever of the concerns raised during the 2018 Senate inquiry, despite official assurances to the contrary.

Australian Defence Force "Values"

According to a glossy brochure posted on the Department of Defence website, the ADF purports to uphold the following values: professionalism, loyalty, integrity, courage, innovation and teamwork. How can this organisation have any claim to these values when the harsh reality of the last two decades is that senior officials have not only committed serious crimes against their own subordinates, resulting in numerous deaths and permanent disabilities, but have been actively protected, promoted and rewarded for doing so, while veterans have continued to die and our elected representatives (including two Prime Ministers, several Cabinet Ministers, many MPs and Senators) have *turned a blind eye to the blatant abuse, fraud and corruption which have caused these deaths*?

As I stated in the introduction, veteran suicides are the *predictable outcome of toxic leadership and catastrophic failures by military and related institutions to uphold their own purported values*. How could the institutions responsible for the events I describe in this submission credibly claim to be upholding the values of professionalism, loyalty, integrity, courage, innovation and teamwork? How could any reasonable person honestly wonder why so many current or former members of these

institutions are ending their own lives in utter despair? How could any reasonable person honestly believe that establishing a "commission" to "investigate" individual suicides, after they have occurred, is an adequate or credible "suicide prevention" measure? The situation can only be improved by once and for all dealing with the culture of criminality in the senior ranks of the ADF and related institutions, and political apathy on the part of our elected government.

Anything Less than a Full Royal Commission of Inquiry Would be a Dereliction of Duty

In my previous written and oral testimony to this Committee, I have not only emphasised the need for a full Royal Commission, I have also explained why the powers and resources of a Royal Commission are required, as opposed to a parliamentary or other inquiry. A Royal Commission has the power to summons witnesses and compel them to testify under oath, including prosecutions for perjury if needed. A Royal Commission has the power to seize documentary and other evidence. A Royal Commission has the resources to properly gather evidence, to expertly analyse that evidence and fully investigate the chain of evidence until proper findings and conclusions are reached. A Royal Commission can be given the power to initiate criminal prosecutions. Importantly, a Royal Commission also has the resources to properly protect witnesses and provide them with the appropriate care and support. From this brief summary, it should be self-evident why a Royal Commission is the most appropriate avenue to properly deal with the institutionalised criminality and corruption I have outlined in this submission, where other forms of inquiry have not, cannot and will not.

As I have highlighted on several occasions in this submission, one element of the Defence/DVA denial strategy has been a reliance on unattributed "media statements" in response substantiated allegations of serious or even criminal wrongdoing. This serves only to perpetuate the existing culture of denial, deceit and impunity. To properly address the matters I have raised in this submission, justice must not only be done, it must also be *seen* to be done. Only the transparency of a full Royal Commission can ensure individuals are properly held to account and expunge a toxic leadership culture which flourishes in an environment of anonymity.

What also needs to be acknowledged is that senior ADF and other Commonwealth officials responsible for criminal wrongdoing currently hold positions of authority or influence over perverse Government policies or dysfunctional executive decision-making structures that are contributing directly to the veterans suicide problem, indeed they are probably impeding more appropriate responses deliberately to cover-up their previous wrongdoings. Not only have crimes previously been committed, there is clear evidence that crimes *continue* to be committed and/or covered-up by some of these individuals. A Royal Commission needs to be initiated urgently, to prevent and deter continued criminal misconduct, including the potential destruction of evidence required to ensure effective investigation or prosecution. A necessary first step to prevent the destruction of evidence or other possible interference in any investigations into the specific matters raised in this submission would be to suspend Brigadier Brennan, Brigadier Stothart, Ms Cosson, Professor Burns, Dr Hodson and Dr Firman from their current ADF and DVA appointments, pending the establishment of the Royal Commission.

Prime Minister Morrison and others have claimed that the proposed Veterans Suicide Prevention Commission will somehow be "bigger and better" than a full Royal Commission. This claim is demonstrably false. The proposed Commission is empowered only to investigate individual suicides, after those suicides have occurred, and the Bill explicitly precludes appropriate prosecutions for criminal wrongdoing. Put bluntly, the proposed Commission would be a glorified body-counting

exercise which would not only fail to address systematic criminality, it would also fail to deter or prevent ongoing criminality or corruption.

Given the severity and the extent of the criminality and institutional failures outlined above, coupled with the continued human toll on the victims of these crimes, it should be clear to the Committee that it would be negligent for the Commonwealth not to initiate a full Royal Commission as a matter of urgency.

Conclusion

One of the key foundations of Australian democracy is the *rule of law*, including the principle of *equality before the law*. This submission has highlighted only a few examples of serious, systemic criminal misconduct by Commonwealth officials and other parties, including very senior ADF officers, some of whom are directly involved in advising the Commonwealth Government in its official responses to the concerns raised in previous parliamentary inquiries. Even these few examples illustrate a deeply entrenched culture of criminal abuse, denial, cover-up, corruption and impunity which extends all the way to the most senior ranks of the ADF and DVA, among other organisations, and possibly into Ministerial offices. There has been, and continues to be, a *breakdown in the rule of law*. "Investigating" individual suicides cannot and will not resolve a *systemic* breakdown in the rule of law. This *systemic* problem is the *core problem* which is preventing real progress in addressing the failure in Australia's duty of care towards the very people who literally put their lives on the line to protect this democracy.

The proposed Commission and the Bills under consideration by this Committee are *perversions* that will not address the *core problem*. They will fail because they are *designed to fail*. They are part of a perverse, cynical strategy of cowardly political avoidance, and if enacted will only perpetuate the core problem by creating a false perception of progress, to "kick the can down the road." The Bills represent a *dereliction* of Australia's duty to its injured veterans.

The cost of this criminal, neglectful, abusive culture continues to be borne by those of us who were injured in our service to this country, and our families. The unacceptably high rate of veteran suicide is only one manifestation of this problem. High rates of family breakdown, homelessness, financial distress, substance abuse, incarceration and other social problems are also well documented.

To borrow from Prime Minister Morrison's quote above, *it is now this Committee's duty to protect us by restoring the rule of law to these failing institutions. As our elected representatives in Parliament, I urge you to uphold your unfilled duty to us. I urge you not to derelict your duty to us by succumbing to continued political expedience. I urge you to reflect upon the countless lives already lost or destroyed as casualties to political expedience. I urge you to do the right thing instead of the easy thing. I urge you to do the right thing now, today.*

I strongly urge the Committee to reject these Bills in their totality. Once again, I strongly urge this Committee to recommend that the Commonwealth Government implement a full Royal Commission of Inquiry into the neglect and abuse of ADF personnel and veterans. Finally, I put this question to you: should you fail to fulfill your duty to us today by recommending a full Royal Commission, *how many more lives must needlessly be lost before you do?*

Attachments

1. Stuart McCarthy, *Presentation to the Department of Veterans Affairs: Chronic Quinoline Encephalopathy: How to Prevent Mefloquine 2.0*, 12 April 2019

2. Stuart McCarthy, *Follow up with Liz Cosson and Jenny Firman on 12 April meeting re mefloquine and tafenoquine*, email to Repatriation Commissioner Mr Don Spinks, 16 August 2019

3. Stuart McCarthy, *Resignation from Open Arms Neurocognitive Health Program Steering Committee*, email to Open Arms National Manager Dr Stephanie Hodson, 19 January 2020

4. Stuart McCarthy, *Serious concerns regarding the DVA $2.1 million "comprehensive health assessment" program for ADF veterans adversely affected by tafenoquine or mefloquine*, email to DVA Secretary Ms Liz Cosson, 13 January 2020

5. FOI documents from the Departments of Defence and Veterans Affairs regarding the $2.1 million appeasement aka “comprehensive health assessments” program for mefloquine and tafenoquine veterans

6. Dr Peter Wirth, *De-brief and update*, email to National Mental Health Commissioner Christine Morgan et al, 14 December 2019

7. Michael Keenan (then Minister for Justice), Letter to Amanda Rishworth (then Shadow Minister for Veterans Affairs) regarding Australian Federal Police “review” of fraud and corruption complaint against senior ADF officials, 17 October 2017

8. Wendy Black (Chief of Staff to Minister for Health Greg Hunt), Letter to Amanda Rishworth (then Shadow Minister for Veterans Affairs) regarding the removal of tafenoquine adverse events from the DGA DAEN database, 19 October 2017

9. Stuart McCarthy, *Neglect and Abuse of Veterans with Quinoline Encephalopathy by the Department of Veterans Affairs*, email to DVA Secretary Ms Liz Cosson et al, 7 April 2019

10. Stuart McCarthy, Concerns over proposed chloroquine prophylaxis trial for ADF personnel, email to Rear Admiral Sharkey, 1 April 2020

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