AUSTRALIAN DEFENCE
Human Research Ethics Committee

Annual Report July 2009 – December 2010
Foreword

2009/10 saw a diverse and complex array of Defence human research presented to ADHREC for ethics consideration. Protocols included psychology studies, drug evaluations, systems evaluations and clinical interventions, all of which had ethical implications for researchers and/or participants.

As the duly constituted Human Research Ethics Committee for Defence, ADHREC operates according to the National Health and Medical Research Council Act 1992 (NHMRC Act). The NHMRC Act mandates that the National Health and Medical Research Council (NHMRC) provide guidelines in its National Statement on Ethical Conduct in Human Research (NHMRC, 2007) for committees such as ADHREC to consider in the ethical evaluation of human research. The primary purpose of this Statement of principles and associated guidelines for research involving humans is the protection of the welfare and rights of participants in research.

The ethical and legal responsibilities which researchers have towards participants in research reflect basic ethical values of integrity, respect for persons, beneficence and justice. These responsibilities accord with accepted moral and scientific principles set out in declarations, conventions and guidelines agreed to by the Australian Government, the NHMRC and the Australian Research Council. The guiding value for researchers is integrity, which is expressed in a commitment to the search for knowledge, to recognised principles of research conduct and in the honest and ethical conduct of research and dissemination and communication of results. ADHREC continues to support research that aims to improve the health outcomes of our serving members.

T.L. Smart (Deputy Chair) for

P. V. ALEXANDER
Major General
Chair,
Australian Defence Human Research Ethics Committee

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2 Australian Defence Human Research Ethics Committee
Committee members
Australian Defence Human Research Ethics Committee

Major General (MAJGEN) Paul Alexander was the Commander Joint Health and the Surgeon General of the Australian Defence force (SGADF) to the end of 2011, during which time he had responsibility for the provision of Health Support within Australia and was the Chair of the Australian Defence Human Research Ethics Committee (ADHREC).

MAJGEN Paul Alexander joined the Army in 1976 and completed his medical training at the University of Melbourne in 1978. Following several years of clinical training in Victorian hospitals, he commenced the first of several regimental appointments as the Regimental Medical Officer (RMO) of the 3rd Battalion Royal Australian Regiment. This was followed by several years working as an RMO in Papua New Guinea with the PNG Defence Force. He then served as the RMO for the Special Air Service Regiment for three years and completed SAS selection during his tenure.

In 1988 he undertook a period of postgraduate medical training in the UK in the areas of Sports Medicine and Tropical Medicine as well as undertaking several military attachments with UK medical units. On return to Australia he was promoted to Lieutenant Colonel and appointed as Commanding Officer of 11th Field Ambulance and subsequently as Commanding Officer of 1st Military Hospital Yeronga. Three years were then spent with the US Army as the Australian Army Exchange Officer to the US Army Medical Department where he was employed in the area of Capabilities, Combat and Doctrine Development and was involved in the redevelopment of US Army battlefield hospital systems.

Major General Paul Alexander
Chair, National Statement category (a)

On return to Australia he was promoted to Colonel and posted to Headquarters 1ST Division as the Senior Medical Officer and during this period, deployed with the initial peacekeeping force to Bougainville on Op BEL ISI. He transferred to the Army Reserve in 1998 and subsequently assumed the position of Director Reserve Health Services for Army in Qld. During this period he deployed as the Public Health Officer to the UN Peace Keeping Force in East Timor.

He was promoted to Brigadier in January 2004 and assumed the position of Assistant Surgeon General ADF - Army. He continued to work in clinical practice and was a partner in a large group medical practice in Queensland, undertaking the duties of managing partner. He was active in primary health care policy development as the Chairman of the Redcliffe Division of General Practice.

MAJGEN Alexander has also been actively involved in risk management and legal medicine. He has completed a Masters in Legal Medicine and is a Fellow of the Australian College of Legal Medicine. He was the principal medico-legal adviser in Queensland for Medical Indemnity Protection Society (MIPS), the second largest medical indemnity organisation in Australia. He actively provided medico-legal support to all MIPS doctors throughout Queensland. MAJGEN Alexander was promoted to the rank of Major General on 25th March 2008.
Ms Kaye Hogan AM, PSM

Member, National Statement category (b) at least two lay people, one man and one woman, who have no affiliation with the institution and do not currently engage in medical, scientific, legal or academic work; (NHMRC 2007)

Ms Hogan is an experienced registered nurse and health services executive who has worked in both the public and private health sectors in Australia and overseas. She has considerable remote and rural clinical nursing and health management experience. Ms Hogan is a midwife with degrees in Arts (Sociology, Political Science) and Applied Science (Advanced Nursing). She is a member of the Australian Red Cross Blood Service (ARCBS) Board, Chair of the Australian Red Cross, ACT. She has previously served on the ACT Health Hospitals Board and Board Research Ethics Committee. She is currently a member of the Department of Veterans Affairs' Human Ethics Committee and the ARCBS Ethics Committee.

Ms Hogan’s ACHS surveying and consultancies have enabled a broad perspective of healthcare settings, governance arrangements, roles and achievements throughout Australia and internationally. These roles have included managing change, major redevelopment of health services; policy development and implementation; clinical role delineation and service delivery for health sectors; clinical and non-clinical risk management; service assessments and improvement recommendations and preparation of facilities for accreditation. Her management of major projects includes the transfer of postgraduate specialist nursing education to the tertiary sector and the establishment of enrolled nurse training in the TAFE system.

Ms Hogan is a member of a number of professional organisations including the Royal College of Nursing (RCNA) on which she has served as a previous Board member. She has represented and provided professional advice to RCNA and government on nursing and health related issues and policy.
Mr Murray was the Headmaster of the Canberra Grammar School during his tenure on ADHREC until 2010, when he relocated to Adelaide to take up a position as Headmaster of St Peter’s College. Mr Murray has thirty three years experience in educational institutions of which seventeen have been as Headmaster of co-educational and all-boys schools. His experience includes research into teaching and learning, equity and diversity issues, pastoral care including bullying, privacy concerns and policy development of staff, ethics and values education, boys’ education, accountability to government, parents and community, and media. Mr Murray has been a member of the Association of Heads of Independent Schools of Australia (AHISA) from 1991 to the present. He was a member of the Association of Independent Schools of Western Australia (AISWA) 1991 – 1998. He has been a member of AISACT 1998 to present and AISNSW 2006 to present. He has been a member of the Headmasters Conference (HMC) in the United Kingdom since 1998. He was also a board member of the National Council of Independent Schools Associations now called Independent Schools Council of Australia (ISCA) 1999 – 2004. Mr Murray has also had many church responsibilities as a member of the Bishop in Council, Anglican Diocese of Bunbury and also the Anglican Diocese of Canberra Goulburn, and as a Member of Ministry Executive, Anglican Diocese of Canberra Goulburn 1999 – 2004.

Mr Murray was formally appointed to ADHREC in October 2006 and served until February 2010.

Mr Simon Murray
Member, National Statement category (b) at least two lay people, one man and one woman, who have no affiliation with the institution and do not currently engage in medical, scientific, legal or academic work; (NHMRC 2007)
Mr Lindsay Roe

Member, National Statement category (b) at least two lay people, one man and one woman, who have no affiliation with the institution and do not currently engage in medical, scientific, legal or academic work; (NHMRC 2007)

Lindsay Roe has worked for over thirty years in the Australian Public Service, initially in the field of design and development of administrative computer systems. He was also involved in the introduction of computing to a number of areas within commonwealth departments and the training of staff in computing skills. He subsequently moved on to project management and IT audit and eventually performance audit with the Australian National Audit Office.

Lindsay received a Bachelor of Science degree from the University of Queensland in 1974 and a Master of Arts from the University of Western Sydney in 2004.

He now is a freelance consultant in the areas of Quality Assurance and workplace interactive skills.

He was appointed a member of ADHREC in June 2010.
Professor John H. Pearn, AM, RFD

Member - National Statement category
(c) at least one person with knowledge of, and current experience in, the professional care, counselling or treatment of people; for example, a nurse or allied health professional

Professor Pearn has been a member of the ADHREC since 1990, and its Chair during 1998 until December 2000. During his service career of 35 years, Professor Pearn has served in a number of Medical Officer, command and non-regimental positions in Australia, the United Kingdom and Papua New Guinea.

He served in Papua New Guinea on operational duty during Confrontation (1966), as the physician to the Australian and New Zealand Forces during the Vietnam Campaign (1970) and with UNAMIR II as the Resuscitationist and Intensivist in the Forward Surgical Team in Rwanda (1994-1995).

He served as the Defence Platoon Commander with the Royal Green Jackets (UK); and as RMO with the 4th Battalion Parachute Regiment (UK) in 1972-1974. He commanded 2 Field Hospital (1978-1981), based in Brisbane and in 1997 was appointed the Representative Honorary Colonel of the RAAMC. In the period 1998-2000, as Major General John Pearn, he served as Surgeon General Australian Defence Force.

He has published extensively in the area of military medicine and military history. Professor Pearn is the Professor of Paediatrics and Child Health (University of Queensland) and a former Surgeon General of the Australian Defence Force. He is a Senior Paediatric Consultant at the Royal Children’s and Mater Children’s Hospitals in Brisbane and Honorary Consultant in Paediatrics and Genetics to the Royal Women’s Hospital, also in Brisbane. He is an Honorary Life Member of the Human Genetics Society of Australasia of which he is a Past President. Professor Pearn is also the Preceptor within the School of Medicine at the University of Queensland and is the Honorary Colonel of the Queensland University Regiment.

He is the author of some 500 papers on clinical medicine and medical research in the international refereed literature. He is the author of 24 books and of some 68 chapters in medical textbooks. He has a special interest in medical ethics and for his work in this field was created a Fellow of Green College, the University of Oxford.
Born in Melbourne, Chaplain (Air Commodore) O’Keefe lived the majority of his youth in Sydney attending St Joseph’s College, Hunters Hill NSW for his secondary schooling. In 1964 he felt God’s call to follow a vocation to the priesthood in the Catholic Church and commenced studies at St Columba’s College, Springwood, NSW. After four years of Humanities and Philosophical studies, he proceeded to St Patrick’s College Manly for theological studies. During this period he interrupted his seminary formation to further discern his call to ministry. In 1970 he recommenced his priestly formation at St Paul’s Seminary Kensington, NSW and was ordained Deacon in December 1971 and Priest in March 1972. He commenced ministry in the rural Diocese of Wagga Wagga in January 1972. Between 1972-1982 Chaplain O’Keefe served in a number of parish appointments and in 1978 he was appointed the Director of Youth Ministry within the Diocese. In 1983 he was commissioned as a Chaplain in the Royal Australian Air Force and posted to RAAF Base Wagga Wagga where he was employed as a Chaplain at the RAAF School of Technical Training with character development and training. In 1984 he was posted to an operational position at RAAF Darwin followed by a posting in 1986 to the Royal Malaysian Air Force (RMAF) Base, Butterworth as part of the RAAF Contingent. During this time he saw the major withdrawal of RAAF personnel from the RMAF Base. In 1986, whilst in Butterworth, he transferred out of the Diocese of Wagga Wagga and incardinated into the newly formed Military Ordinariate of Australia within the Catholic Church.

In March 1989 Chaplain O’Keefe returned to Australia with a posting to a Training Command position at RAAF Williams, Laverton, Victoria. During this posting he was involved with the Officers Training School, Point Cook and the character training of the radio mustering apprentices at Laverton, Victoria. In 1993 he returned to Air Command with a posting to RAAF Williamtown, the home of the FA-18 Fighter Aircraft. With his posting to RAAF Richmond, outside Sydney, in 1995 he assumed the position of Coordinating Chaplain at the Strategic Air Lift Group Base and was promoted to Chaplain (Wing Commander). In 1998 Chaplain O’Keefe was posted to Headquarters Air Command, RAAF Glenbrook as Command Chaplain and promoted to Chaplain (Group Captain). In this role, he worked both within Air Force and at a tri-Service level with Headquarters Australian Theatre in the oversight of the provision of chaplaincy services.

Monsignor (Air Commodore) Peter J. O’Keefe

Member - National Statement category (d) at least one person who performs a pastoral care role in a community, for example, an Aboriginal elder, a minister of religion;
Monsignor (Air Commodore) Peter J. O’Keefe continued

services to Defence operations and deployments, in particular East Timor, from September 1999 until October 2001. In October 2001, he was appointed Principal Air Chaplain Roman Catholic and posted back to RAAF Base Richmond. With this advancement and promotion to Chaplain (Air Commodore) he was appointed Vicar-General of the Catholic Military Ordinariate of Australia. In August 2002, he was appointed a Prelate of Honour by His Holiness Pope John Paul II and given the title of Monsignor. In October 2002 he was appointed the Director-General Chaplaincy Services - Air Force and moved to Canberra. In this position he is responsible to the Chief of Air Force for the RAAF Chaplaincy program and the day to day management of the RAAF Chaplain Branch.

In June 2007 Chaplain O’Keefe was honoured with the award of membership in the Order of Australia being appointed as a member of the order (AM) in the Military Division.
Chief Justice Terence John Higgins is a resident Judge of the Supreme Court of the Australian Capital Territory and a Judge of the Federal Court of Australia, being so appointed on 2 July 1990. He was appointed Chief Justice on 31 January 2003. On 9 June 2008 he was appointed an Officer in the General Division of the Order of Australia. He was born in Hobart, Tasmania but was educated at St Augustine's Christian Brothers College in Yarraville, Victoria, and later, at St Edmund's College, Canberra and the Australian National University, Canberra. After completing articles of clerkship with J J O'Neill Solicitors he was admitted as a barrister and solicitor in the ACT in 1967 and served at the bar from 1984 being appointed as Queen’s Counsel (ACT, NSW and Victoria) in 1987. He was Vice President of the ACT Bar Association from 1988 until his judicial appointment in 1990. Justice Higgins began practising law with J J O’Neill, solicitor in 1967 and remained until 1971 when he became partner in the law firm Higgins, Faulks & Martin (formerly Higgins & Faulks). In 1981 that firm became Higgins Solicitors and he remained a partner until 1984 when he went to the ACT Bar.

Justice Higgins is currently the National President of the Royal Life Saving Society of Australia, Chairman of Youth Care Canberra and a member of the Australian Academy of Forensic Sciences ACT Chapter. Present member of University of Canberra Faculty Board since February 2009. Patron of Reserve Forces Day Council since 2008. In the past Justice Higgins has been involved in various committees and associations including National President of the Royal Life Saving Society of Australia (1997-2003; 2009-current), Board Member Open Family Australia (1988-2010), Chair of the ACT Community Law Reform Committee (1994-96), Senior Member of the ACT Gaming and Liquor Authority (1987-90), Chairman of SEC Board 1990-2003 and President, Senior Common Room of John XXIII College ANU (1993-95). Widowed with five children. Remarried to Gayle on 6 June 2010 and residing in the Australian Capital Territory. Justice Higgins was appointed to ADHREC (Australian Defence Forces Human Research Ethics Committee) in 1993 (then called ADMEC (Australian Defence Medical Ethics Committee)) and has served on the committee ever since. On 27 June 2003 he was appointed Honorary Air Commodore of No. 28 (City of Canberra) Squadron RAAF. On 23 April 2004 the Chief Justice was inducted as Honorary Ambassador for the ACT by the Chief Minister, Mr Jon Stanhope MLA.
Dr Ken McAnally received a Bachelor of Science degree with honours in zoology from the University of Queensland in 1985. He received a Doctorate of Philosophy in physiology and pharmacology from the University of Queensland in 1990 examining aspects of the neural basis of hearing. Dr McAnally conducted post-doctoral research on the physiology of cochlear implants at the University of Melbourne, on human auditory perception at the University of Bordeaux under a fellowship from the Centre National de la Recherche Scientifique, and on the biological basis of dyslexia at Oxford University before joining the Defence Science and Technology Organisation (DSTO) in 1996. At DSTO, he works in Air Operations Division on aviation human factors. He has published over 50 papers in the international scientific literature in the fields of sensory physiology and experimental psychology as well as a number of DSTO reports. Dr McAnally also holds an honorary fellowship with the Department of Psychology at Melbourne University.

**Dr Ken McAnally**

*Member - National Statement category (f)*

at least two people with current research experience that is relevant to research proposals to be considered at the meetings they attend. These two members may be selected, according to need, from an established pool of inducted members with relevant expertise.
Dr Keith Horsley has recently retired from the Australian Institute of Health and Welfare, and from the Department of Veterans’ Affairs. A graduate from Queensland University, he holds degrees in medicine and a masters degree in public administration. During the 1990s he was responsible for developing policy in relation to a number of sensitive issues, including Agent Orange and the mustard gas and malaria experiments during World War Two. As a result of his work with Agent Orange, he became interested in the health effects of dioxins and furans, and has been a consultant to a number of different areas of government in this area. He was also part of a team that undertook a major re-engineering of the compensation program of the Department of Veterans’ Affairs, which received several awards for excellence in public administration. He has researched the health of Australia’s veteran community, particularly as it relates to cancer incidence and mortality. He is also interested in military medicine, pandemics (particularly influenza) and the effects of exposure to stress. He is a member of the editorial board for the Journal of Military and Veteran Health, is an honorary Associate Professor at the Centre for Military and Veteran Health, and a tutor in medicine at the Australian National University. In his retirement he is writing a history of the 1918-19 influenza pandemic in Australia.

**Dr Keith Horsley**

*Member, National Statement category (f)*  
*at least two people with current research experience that is relevant to research proposals to be considered at the meetings they attend. These two members may be selected, according to need, from an established pool of inducted members with relevant expertise.*
Mr Tony Cotton, AM

Member, National Statement category (f) at least two people with current research experience that is relevant to research proposals to be considered at the meetings they attend. These two members may be selected, according to need, from an established pool of inducted members with relevant expertise.

Tony Cotton is a psychologist with nearly thirty years experience providing and managing a broad range of psychological services in large and complex workplaces. He completed his undergraduate studies at Queensland University, did his M.Sc. at ANU, and has completed Army Staff College.

He spent over 20 years in the Army working as a psychologist in a wide range of recruiting, staff, and research postings finishing his career as the Director of Psychology for the Australian Defence Force (ADF). He was the inaugural Director of Mental Health for the ADF in which position he was responsible for developing and implementing the ADF Mental Health Strategy for which he was made a Member of the Order of Australia.

After leaving the ADF he spent five years as the senior psychologist in the Australian Federal Police (AFP) managing AFP Wellbeing Services, a multi-disciplinary team of psychologists, social workers and chaplains delivering comprehensive clinical, pastoral and organisational support to a highly complex workplace.

Tony is currently the Director of Human Capital Research and Analysis at the Australian Public Service (APS) Commission where he is responsible for overseeing a broad range of workplace and organisational psychology research to support the development of the APS Human Capital Framework.

He is an external invited member of the NSW Ambulance Service Wellbeing and Resilience Advisory Panel, a member of the beyondblue Expert Reference Group on Workplace Mental Health, and was formerly a member of the board of the Alcohol and other Drugs Council of Australia.
Lieutenant Colonel (Dr) Victoria Ross

Member - Defence specific category: Health Manual volume 23, Chapter 3.12 National Statement category h. two health graduates from Defence (at least one being a medical graduate).

Lieutenant Colonel Ross joined the Army undergraduate scheme while completing her medical training at the University of Melbourne and the Royal Melbourne Hospital. After two years working as a medical resident at the Geelong Hospital, LTCOL Ross came into the full time Army. Lieutenant Colonel Ross has been posted to the 1st Field Hospital, Duntroon Medical Centre (now Canberra Area Medical Unit), Headquarters Logistic Command and the Defence Health Service Branch. LTCOL Ross was awarded Fellowship of the Royal Australian College of General Practitioners in 1997, and completed a Masters of Public Health (MPH) in 2003. In 2006 she was made a Fellow of the Australasian Faculty of Public Health Medicine (FAPPHM).

She was Executive Secretary of ADHREC in July 1998 to June 2000 and was appointed a member of ADHREC in 2002.

Brigadier (Dr) Stephan James Rudzki, AM

Member - Defence specific category: Health Manual volume 23, Chapter 3.12 National Statement category h. two health graduates from Defence (at least one being a medical graduate).

Brigadier Rudzki joined the Army Reserve in 1975 after completing high school. He become an officer cadet in Adelaide University Regiment in 1977 while completing his medical studies, and graduated as a 2nd Lieutenant in the Royal Australian Army Infantry Corps in 1980. He joined the undergraduate scheme in his final year of medicine and on receiving his medical degree from Adelaide University in 1982 he transferred to the Royal Australian Army Medical Corps.

Brigadier Rudzki has served in a variety of junior Medical Officer postings, including the 2nd Military Hospital, Regimental Medical Officer in the 3rd Battalion (Para), 8/12 Medium Regiment (Artillery) and the 1st Recruit Training Battalion. Brigadier Rudzki took a year of leave without pay in 1986 to work with the British Army as a Senior House Officer in Rheumatology and Rehabilitation at the Queen Elizabeth Military Hospital in Woolwich.
Command and staff appointments have included SO2 Medical at Headquarters Second Military District (1988-89), Officer Commanding Medical Company and Medical Support Company 1st Field Hospital (1989-1991), Officer Commanding Albury-Wodonga Medical Centre (1994-95) and Commanding Officer of Canberra Area Medical Unit (1997-1999). Brigadier Rudzki served as an exchange with the United States Army at the US Army Medical Department Centre and School in San Antonio Texas (2000-01). While there he worked in the areas of Telemedicine and electronic health records.

Higher education achievements include a Graduate Diploma in Sport Science (Cumberland College 1986), Master of Public Health (Sydney University 1997), and Doctor of Philosophy (Australian national University 2009). Brigadier Rudzki has had a long standing interest in reducing injury in military recruits, and has published a number of research papers on the subject. He was awarded a Defence Force Fellowship in 1993 to document and compare Injuries in the Australian Army with Allied Forces. He was also responsible for the introduction of the Defence Injury Prevention Program in 2003, and his PhD thesis was titled “The Cost of Injury to the Australian Army”. He was awarded a foundation Fellowship of the Australasian College of Sports Physicians in 1991.

Senior staff appointments have included Director of Preventative Health, Defence Health Services Division (2003-2005), Director of Occupational Health and Safety – Army (2005-2008) and inaugural Director of Army Health (2008-09). As the inaugural Director of Occupational Health and Safety, Brigadier Rudzki was responsible for the introduction and implementation of Army’s Safety Management System and oversaw the introduction of Army’s Risk Appreciation process.

Operational postings have included Indonesia (2 Field Survey Squadron, May-Aug 1983), Western Sahara (MINURSO April-Nov 1992), Bougainville (Officer Commanding Combined Health Element Oct-Dec 1999), East Timor (Chief Medical Officer for the United Nations UNTAET, July 2002 - Jan 2003) and the Middle East (J07 HQJTF633 July-Nov 2009).

Brigadier Rudzki received a Commander Logistics Command Commendation in 1994 and was awarded membership of the Order of Australia in 2005. He later became Director General Strategic Health Coordination in Joint Health Command, and joined ADHREC in May 2010.
Lieutenant Colonel Landy graduated with honors from the Faculty of Dentistry, University of Melbourne in 1978. She joined the Royal Australian Army Dental Corps in 1980 after training for a year at St Vincents Hospital in oral surgery. She has served in fourteen locations throughout Australia in both clinical and Command and Staff roles. She has also served in New Zealand, where she was awarded a Graduate Diploma in Oral Surgery with distinction in 1992. Lieutenant Colonel Landy left the Regular Army in 2002, and is currently a member of the Active Army Reserve. She obtained a post graduate Diploma in Drug Evaluation and Pharmaceutical Sciences from the Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, in 2003. Lieutenant Colonel Landy is married and has two young sons.

LTCOL Landy was worked with ADHREC as Minute Secretary from Jan 2000- March 2001, then as Executive Secretary from March 2001- Oct 2010.

Georgina joined the Department of Defence in 2001 as an Administration Officer for the Directorate of Clinical Policy. In 2003 Georgina was promoted to Research Officer in the Directorate of Clinical Policy. Some of her duties included record management, quality representation, preparing routine correspondence and maintaining the directorate’s financial budget. In May 2006 Georgina joined ADHREC on a contract and was made permanent in October 2006.
Lieutenant Elise Burnside  
Assistant Secretary

Lieutenant Burnside joined the Navy in 1986 and graduated from the Australian Defence Force Academy with a Bachelor of Science in 1989. She spent 9 years with the permanent Navy before transferring to the Reserves in 1996. She has worked in a variety of positions on a part time basis before joining ADHREC in 2009 to assist with the administration of the committee.
Awareness of the importance of respect for ethical codes in research involving human participants was accelerated in response to revelations of unethical practices, particularly during World War II. In June 1964 many countries of the world met in Helsinki, Finland, and created the Declaration of Helsinki to prevent future unethical practices in human research. Over the past 38 years the declaration has been amended six times.

In Australia, the National Health and Medical Research Council (NHMRC) first published the Statement of Human Experimentation in 1966. The statement has recently undergone its third review and the NHMRC National Statement on Ethical Conduct in Human Research 2007 is now available.

The Australian Defence Medical Ethics Committee (ADMEC) was formed to ensure that the Defence Force complied with these guidelines. The Chief of the Defence Force (CDF) and the Secretary for Defence formed ADMEC as a non-statutory body in 1988.

The first meeting of ADMEC was held in November 1989. Meetings were originally held biannually or as needed, but as the amount of research conducted in Defence has grown over the years, the Committee now meets more frequently with some out of session determinations being made as required.

In June 2001 the committee changed its name to the Australian Defence Human Research Ethics Committee (ADHREC). The Committee met eleven times in the period from July 2009 to end December 2010. The 19th Annual Report covers the period from July 2009 to December 2010.
Committee Members

Composition of the Australian Defence Human Research Ethics Committee (ADHREC) is determined according to the National Statement on Ethical Conduct in Human Research (NHMRC 2007), which is:

Composition of HRECs

5.1.29 The minimum membership of an HREC is eight. As far as possible:

(a) there should be equal numbers of men and women; and

(b) at least one third of the members should be from outside the institution for which the HREC is reviewing research.

5.1.30 This minimum membership is:

(a) a chairperson, with suitable experience, whose other responsibilities will not impair the HREC’s capacity to carry out its obligations under this National Statement;

(b) at least two lay people, one man and one woman, who have no affiliation with the institution and do not currently engage in medical, scientific, legal or academic work;

(c) at least one person with knowledge of, and current experience in, the professional care, counselling or treatment of people; for example, a nurse or allied health professional;

(d) at least one person who performs a pastoral care role in a community, for example, an Aboriginal elder, a minister of religion;

(e) at least one lawyer, where possible one who is not engaged to advise the institution; and

(f) at least two people with current research experience that is relevant to research proposals to be considered at the meetings they attend. These two members may be selected, according to need, from an established pool of inducted members with relevant expertise.

Additionally, ADHREC refers to Health Manual Volume 23, Chapter 3, which states that the committee must have:

(h) two health graduates from Defence (at least one being a medical graduate).

The structure of the committee, which meets NHMRC guidelines, is detailed on page 40.

Committee appointment terms are staggered to ensure that continuity is maintained and large losses of corporate knowledge are minimised.

The committee had two changes in the July 2009 –December 2010 period with the appointment of Brigadier Stephan Rudzki and Mr Lindsay Roe.

Attendance at meetings and expenditure details are listed on pages 41-45 respectively.
New Research Projects
Considered During the Period July 2009 - December 2010

The Committee received 45 new protocols during the reporting period. These protocols are detailed on pages 11-13. There are 3 of these protocols that have been completed, 32 are in progress and 6 are considered new protocols that require further action before ethical approval to undertake the research is granted. The status of these protocols as at 31 December 2010 is as follows:

<table>
<thead>
<tr>
<th>Protocol Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Progress (approved)</td>
<td>32</td>
</tr>
<tr>
<td>New Protocol</td>
<td>6</td>
</tr>
<tr>
<td>Completed</td>
<td>3</td>
</tr>
<tr>
<td>Withdrawn by researcher</td>
<td>4</td>
</tr>
<tr>
<td>Not Approved</td>
<td>-</td>
</tr>
<tr>
<td>Resubmitted</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>

Number of New Protocols Considered by ADHREC for the past 10 Years
# New Protocols Received & Considered by ADHREC

## During the Period July 2009 - December 2010

<table>
<thead>
<tr>
<th>Protocol No.</th>
<th>Research title</th>
<th>Protocol status</th>
</tr>
</thead>
<tbody>
<tr>
<td>562-09</td>
<td>Multiple dose pharmacokinetics and ex vivo pharmacodynamics of the fixed dosed combinations of Artequick artemisininpiperaquine) and Coarsucam (artesunate-amodiaquine) in Vietnamese volunteers.</td>
<td>In Progress</td>
</tr>
<tr>
<td>563-09</td>
<td>Occupational Health and Safety: Knowledge and Attitudes amongst RAAF and Non RAAF Personnel.</td>
<td>Completed</td>
</tr>
<tr>
<td>564-09</td>
<td>A case study on the impact of uncertainty in Geographic Information Science (GIS) on dynamic decision making – Australia’s response to the December 2004 Aceh earthquake and tsunami.</td>
<td>In Progress</td>
</tr>
<tr>
<td>565-09</td>
<td>The incidence of ligament injuries seen on ultrasounds examinations of military members and the ultrasonic indicators for Deltoid ligament injuries.</td>
<td>In Progress</td>
</tr>
<tr>
<td>566-09</td>
<td>Service Police Investigative Culture within the ADF. (Ethnographical exploration of Sydney: Establishing and Maintaining A Visionary Tri-Service Investigative Policing Culture Within the ADF Investigative Service (ADFIS).)</td>
<td>In Progress</td>
</tr>
<tr>
<td>567-09</td>
<td>Australian Peacekeepers: The Long Term Effects on Mental Health Status, Health Service Use and Quality Of Life.</td>
<td>In Progress</td>
</tr>
<tr>
<td>568-09</td>
<td>Measurement of Deliberate Self Harm (DSH) Behaviour: Rasch Analysis.</td>
<td>Withdrawn</td>
</tr>
<tr>
<td>569-09</td>
<td>Optimising Risk Management for Soldier Load Carriage.</td>
<td>In Progress</td>
</tr>
<tr>
<td>570-09</td>
<td>Improving Quality Through Clinical Governance In Primary Health Care.</td>
<td>In Progress</td>
</tr>
<tr>
<td>571-09</td>
<td>In the Service of Peace - The Future Commemorations of Peace Operations.</td>
<td>In Progress</td>
</tr>
<tr>
<td>572-09</td>
<td>Tiered Body Armour System (BAS) Mobility Assessments.</td>
<td>In Progress</td>
</tr>
<tr>
<td>Protocol No.</td>
<td>Research title</td>
<td>Protocol status</td>
</tr>
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<td>-------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>574-09</td>
<td>Prevalence of Mental Health problems in the Australian Defence Force - Health and wellbeing study (Component of MilHOP).</td>
<td>In Progress</td>
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<td>Injury in the Australian Defence Organisation and its Cost.</td>
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<td>Physiotherapy Musculoskeletal Screening for Injury Detection and Prevention in Australian Defence Force Cadets.</td>
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<td>Absent Aviators: The Under-Representation of Women in Piloting.</td>
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<td>582-10</td>
<td>Implications of Male Childhood Sexual Abuse for Members of The Australian Defence Force: A Preliminary Investigation.</td>
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<td>Effectiveness of Screening for Chronic Obstructive Pulmonary Disease (COPD) in Australian Defence Force Aircrew.</td>
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<td>Coping Strategies used by Australian Defence Force Personnel on Deployment.</td>
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<td>Evaluating the Effects of Self-Esteem, Gender and Age on Alcohol Abuse among Royal Australian Navy Personnel.</td>
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<td>Land 125 phase 3A. Dismounted Battle Management System - Load Carriage System Development Trial.</td>
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<td>Thermal Imaging of Stress Fractures in the Lower Limbs.</td>
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<td>Measuring the Affect of Military Training on Individual Risk Attitude.</td>
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<td>Cancer and Mortality Study of The Australian Gulf War Veteran Cohort: 2010 follow up.</td>
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<td>Team-based Decision-Making Using a Classical Decision Theory Model in a Naturalistic Environment.</td>
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<td>Vocational Education and Learning In The Military Context.</td>
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<td>Participants Observation of Interactions at the Australian Defence Force Academy.</td>
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<td>Effect of ‘Supervising the Supervisor’ in Enhancing Supervisory Practices.</td>
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<td>Protected Mobility Vehicle Seat and Restraint Human Factors Trial.</td>
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<td>602-10</td>
<td>The Influence Of The Military Posting Cycle on Group Formation and Team Development In The ADF.</td>
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<td>603-10</td>
<td>Thought Suppression As A Means Of Coping: Exploring Ego Depletion And Ironic Rebound As Explanatory Theories.</td>
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<td>604-10</td>
<td>Is a Harm Minimisation Program Suitable As A Method Of Alcohol Intervention in the Australian Defence Force ? (Evaluation of the Keep Your Mates Safe (KYMS) - Alcohol workshop).</td>
<td>New Protocol</td>
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<tr>
<td>606-10</td>
<td>The Legal and Ethical Obligations of the ADF to Detainees and Prisoners of War.</td>
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Validation Of Combined Altitude Depleted Oxygen (Cado) Paradigm As A Tool For Hypoxia Training Of Adf Aircrew

Published as: AVMED report 09/A.

Abstract
Most major Air Forces carry out hypoxia awareness training to familiarise their aircrew with the symptoms of hypoxia in order to prepare them better to identify and respond to such symptoms in the air. Hypoxia training normally involves a controlled exposure to reduced barometric pressures in a hypobaric chamber. Major hazards associated with such training are the risks of decompression illness and barotrauma. This report describes how the Royal Australian Air Force Institute of Aviation Medicine developed an alternative method of imparting hypoxia training which combines exposure to moderate altitude of 10,000 feet in a hypobaric chamber with breathing of a gas mixture containing 10% Oxygen and 90% Nitrogen. The paradigm, called Combined Altitude and Decreased Oxygen (CADO), places the subjects at a physiological altitude of 25,000 feet, and provides demonstration of symptoms of hypoxia and the effects of pressure change in a safe manner by eliminating the risk of DCI, and with greater fidelity of training for military fast jet aircrew. The report also includes a review of the statistics that underpin the imperative of hypoxia training that originally drove the development of CADO, outlines the physiological literature validating the use of Reduced Oxygen Gas Mix (ROGM) methods for hypoxia training, and describes the way in which a hypobaric chamber was modified to allow for a hybrid form of hypoxia training utilising both modest altitude exposure and a reduced oxygen gas mix.
in response to a tactical scenario, respond to a questionnaire and wargame their plan on a computer simulation called TacOps ANZAC, a simulation used in training. The planning and dynamic tasks were carefully designed with the assistance of qualified military tacticians to have high ecological validity, be relevant to tasks normally expected of participants and, doctrinally correct.

A method of identifying experts that was easy to evaluate and administer was developed from the literature and based upon length of experience, domain specific experience and relevant experience. The definition of expertise was demonstrated to be accurate and accounted for 46% of the variance in decision quality in Study 1. Increased amounts of information were detrimental to experts and novices on both the planning and dynamic tasks when time was limited. However, in Study 2 when participants were given as much time as they required to complete the planning task there was no effect of level of information on decision quality. Although, the frame of the problem had no impact upon decision quality it was clear that experts, but not novices, paid attention to and accounted for the frame of the problem when making their decisions.

Pacini and Epstein’s (1999) Rational and Experiential Inventory was adapted to suit a military environment. This scale evaluates a person’s preferences for, and ability in, analytic and intuitive thinking styles. On the planning task high preferences for, and ability in, either analytic or intuitive thinking styles were related to higher decision quality. Contrary to the arguments presented by some schools of thought, neither thinking style was superior to the other.

The definition of expertise was expanded to include experience with the computer simulation for the TacOps ANZAC phase of testing. Expertise was found to be beneficial to tactical decision making on the dynamic task. Further, there was a clear relationship between good plans and good outcomes on the dynamic task. Not only did experts have better plans, but also they varied from those plans less, and when their plan was adapted in a dynamic context, the consequences were neither good nor bad. In contrast, novices varied from their plans to a much larger extent and this was detrimental to the outcome on the dynamic task.

When developing their plans the participants who had considered the broadest range of features relevant to the scenario made the highest quality decisions. The implications of the findings for military decision making and their generalisability to decision making in complex domains are discussed.

352/04

**Body Measurement Using Three-Dimensional Whole Body Scanning**

There were numerous publications arising from the broader ADAPT project, including:


361/04

The Tolerability, Safety And Pharmacokinetics Of Piperaquine In Healthy Vietnamese Volunteers.

Results published as:


365/04

Effectiveness Of Personal Protective Padding During Infantry Operations

Outcomes for internal DSTO use. Not published.

379/05

Pharmacokinetics Of Dihydroartemisinin And Piperaquine After Artekfin Treatment Of Plasmodium Falciparum Un Vietnamese Soldiers.


384/05

Nutritional Requirements Of Soldiers Undergoing Initial Employment Training At The School Of Infantry

The final report is classified.

390/05

Oxygen Requirements, Relative Stress and Performance under Mild Hypoxia (Equivalent 1000, 2000 And 3000 Metres AMSL).

Results published as internal report.

391/05

Ration Packs to the Sunday Roast- An Analysis of the Australian Defence Force Experience with Post Deployment Reintegration

Report not available

410/05

Mortality And Cancer Incidence Monitoring In F-111 Deseal/Reseal Personnel


(Extract)

About this report

This report is the third study into mortality and cancer incidence in 873 male personnel involved in the F-111 aircraft Deseal/Reseal (DSRS) programs at RAAF Base Amberley between 1977 and 1999. The incidence rates for DSRS personnel were compared with those of the Australian male population and two comparison groups from RAAF Base Amberley and RAAF Base Richmond.

The first and second mortality and cancer incidence studies were undertaken in 2003 and 2004 respectively as part of the
larger Study of Health Outcomes in Aircraft Maintenance Personnel (SHOAMP). The SHOAMP followed a Royal Australian Air Force Board of Inquiry (BOI) that was convened in 2000 following concerns that personnel had raised health risks due to exposure to the chemicals used in the spray sealing of F-111 fuel tanks in 1999.

The second mortality and cancer incidence study utilised the National Death Index (NDI) to identify deaths for the period up to 2001, and the National Cancer Statistics Clearing House (NCSCH) to identify cancers for the period up to 2000.

This third study utilises more recent data – the NDI to identify deaths for the period 1980-2004, and the NCSCH to identify cancers for the period 1982-2003. In addition, this study separates 1999-2004 mortality data to reduce the bias associated with non-identification of personnel before 1999.

**Key findings**

Findings from this study are consistent with findings from the previous study.

- Overall cancer incidence in male personnel who were involved in DSRS programs was elevated by 44% when compared with the Australian male population; however the very small number of people involved means that this result was not statistically significant.

- Lip cancer incidence in DSRS personnel was four times as high as in the general Australian male population. This result was statistically significant, but based on only four cases.

- Overall mortality was lower for DSRS personnel when compared with the Australian male population; however, mortality, based on two cases of non-Hodgkin lymphoma, was higher than expected in the 1999-2004 period.

- Cancer incidence in personnel in the two comparison groups (RAAF Base Richmond in New South Wales and RAAF Base Amberley in Queensland) was similar to that of the Australian male population.

- Overall mortality for the two comparison groups was lower than for the Australian male population; these results were statistically significant.

- Comparing the exposed groups (the DSRS personnel) with Amberley personnel showed no significant differences in mortality or cancer incidence.

- Comparing the exposed groups (the DSRS personnel) with Richmond personnel showed increased cancer incidence which was statistically significant. The results for mortality were less clear, with analysis of deaths in the period 1980–2004 showing a statistically significant lower rate, whereas analysis for the period 1999–2004 showed a statistically non-significant higher rate.

Given the number of borderline significant and non-significant findings, the AIHW believes that current data is inconclusive and recommends that this study be repeated in 2011 when more data will be available to provide greater statistical power and to improve certainty about the findings.

**418/05**

**Special Forces Deployed Health & Nutrition Study. See Also Follow-Up Study 514/08.**

The final report is classified.
Herbal and Over-The-Counter Medication Use in Aircrew

Published as AVMED Report 15/2005.

Abstract

Introduction. Despite all aircrew undertaking aviation medicine training and refresher training which both highlights the risk of medication use by aircrew, and emphasises ADF policies on the use of medications by ADF aircrew and the central role of the Aviation Medical Officer (AVMO) in their health care, anecdotes suggest that a proportion of military aircrew use over-the-counter (OTC) medications and health supplements (herbal preparations, nutritional supplements, and alternative medicines) without the knowledge of an AVMO.

Method. A survey exploring the use of OTC medications and health supplements by aircrew, and the reasons for self-medicating rather than seeing an AVMO, was distributed to 177 aircrew attending AVMED for refresher training.

Results. 143 surveys were completed and returned. 77% of respondents reported using OTC medication within the previous twelve months, but only 14% disclosed the use to an AVMO. Similarly, 50% of respondents had used health supplements within the previous 12 months, but only 11% of these disclosed the use to an AVMO. The most common OTC medications used were paracetamol, cold and flu preparations, and non-steroidal anti-inflammatory agents; vitamins were the most common health supplements used by aircrew. 61% of respondents prefer to self-medicate rather than see an AVMO. Many of these (59%) self-medicate because they perceive the requirement to see an AVMO to be too time-consuming and cumbersome, especially for a condition they believe to be trivial and self-limiting (69%). Only 62% of respondents claim to be aware of the potential for OTC medications and health supplements to cause aeromedically-significant side effects, and only 19% of aircrew who use health supplements claim to know the side-effect profile of the supplements they were taking.

Conclusions. It is possible that the OTC medications used most commonly by aircrew could have been taken within the guidelines proscribed by ADF policy; it is also possible that many aircrew using OTC medications and health supplements may not have been flying during the period the agents were being used. However, this report identifies several issues which could compromise aviation safety: the use by aircrew of OTC medications with aeromedically-significant side effects; illegitimate use by aircrew of medications prescribed for someone else; the proportion of aircrew who admit a preference to self medication because they are afraid of being grounded by an AVMO or because they believe access to an AVMO to be too time consuming; and the apparent unawareness of many aircrew that OTC medications and health supplements have the potential to cause aeromedically-significant side effects.

Evaluation of Commercial Repellent Formulations against Mosquitoes in Australia.

Executive Summary

Introduction

The Defence Deployed East Timor Health Study (hereafter referred to as the East Timor Health Study) is part of a series of studies that aim to research the health and wellbeing of Australian Defence Force (ADF) veterans who have deployed on active service overseas. It was conducted by the Centre for Military and Veterans’ Health (CMVH) as part of the Deployment Health Surveillance Program (DHSP).

Study aims

The aim of the East Timor Health Study was to conduct an investigation of the health status of a random sample of Australian Defence Force serving and ex-serving members who deployed to East Timor between June 1999 and May 2005 on Operations FABER, SPITFIRE, WARDEN, TANGER, CITADEL and SPIRE, relative to an appropriate comparison group who were ADF members at the time, but did not deploy on these operations. The key research questions examined were:

a. Do East Timor veterans have different rates of negative mental health outcomes relative to an ADF comparison group who did not deploy to East Timor?

b. Do East Timor veterans have different general health problems from an ADF comparison group who did not deploy to East Timor? For example, were there different rates of tobacco smoking and alcohol consumption?

c. Do East Timor veterans have different health behaviours relative to an ADF comparison group who did not deploy to East Timor? For example, were there different rates of tobacco smoking and alcohol consumption?

d. What deployment issues and hazards were reported by East Timor veterans?

e. Do East Timor veterans have different rates of mortality or cancer from an ADF comparison group who did not deploy to East Timor?

The first four research questions are addressed in the current report. Additionally, deployments to East Timor varied greatly in their overall nature. At the most fundamental level some deployments were considered warlike and others non-warlike. Accordingly, an additional brief examination of the impact of early versus later deployments is included in this report.

The study is of retrospective, cross-sectional design with a comparison group matched across strata of age, gender, Service (Navy, Army and Air Force) and service type (regular or reserve). The CMVH self-report questionnaire data and the Defence Health and psychological screen records were collected throughout 2008.

Defence Deployed Bougainville Health Study

Executive Summary

Introduction
The Defence Deployed Bougainville Health Study (hereafter referred to as the Bougainville Health Study) is part of a series of studies that aim to research the health and wellbeing of Australian Defence Force (ADF) veterans who have deployed on active service overseas. It was conducted by the Centre for Military and Veterans’ Health (CMVH) as part of the Deployment Health Surveillance Program (DHSP).

Study aims
The aim of the Bougainville Health Study was to conduct an investigation of the health status of all ADF personnel who deployed to Bougainville between November 1997 and August 2003 as part of Operations BEL ISI I & II, relative to an appropriate comparison group who were ADF members at the time, but did not deploy on these operations.

The key research questions examined were:
a. Do Bougainville veterans have different rates of negative mental health outcomes relative to an ADF comparison group who did not deploy to Bougainville?
b. Do Bougainville veterans have different general health problems from an ADF comparison group who did not deploy to Bougainville?
c. Do Bougainville veterans have different health behaviours relative to an ADF comparison group who did not deploy to Bougainville? For example, were there different rates of tobacco smoking and alcohol consumption?
d. What deployment issues and hazards were reported by Bougainville veterans?
e. Do Bougainville veterans have different rates of mortality or cancer from an ADF comparison group who did not deploy to Bougainville?

The first four research questions are addressed in the current report. The study is of retrospective, cross-sectional design with a comparison group matched across strata of age, gender, Service (Navy, Army and Air Force) and service type (regular or reserve). The CMVH self-report questionnaire data and the Defence Health and psychological screen records were collected throughout 2008.


Development Of Food Frequency Questionnaire For Land Based Operations - Phase Two - Validation Study

Published as DSTO Report. Summary of findings:

Aims
The aims of this study are to:
• Develop a dietary intake assessment tool suitable for use by the Australian Defence Force under operational/training conditions.
• Further refine the tool developed by Denmen (2005)
• Trial the tool and compare results with those obtained by the current method used within DSTO, that is direct observation via weighed plate wastage.

Method
A 144-item, 3-section food frequency questionnaire (FFQ) was redeveloped using the recommendations from Denmen’s (2005) earlier research where she designed a 156-item, 3-section food frequency questionnaire to assess short
term dietary intake. The reproducibility of the questionnaire was assessed via repeat administration to a sample population from the University of Tasmania. Relative validity of the questionnaire was assessed via comparison with DSTO’s current method that is direct observation (weighed plate wastage). Food records were also used as a second method for comparison to determine relative validity as this was the method used by Denmen (2005).

Participants
Forty-two (42) individuals gave signed consent to participate in the study including seventeen (17) females and twenty-five (25) males. Twenty-five (25) participants did not complete the study.

Results
The initial intention was to compare the results at the basic level of serves of ration pack food items as calculated from each of the FFQs and as recorded in the OC and FR. The results would then be analysed at a higher level where average daily intake of energy and macro nutrients calculated by the three methods would be compared, to assess reproducibility and comparative validity.

The ration pack food items chosen for comparison were taken from those that over half of the respondents reported consuming on the FFQs and for which data could easily be extracted from the OC and FR information collected. The nine (9) food items selected were: main meals, high starchy foods, soup, dairy, fruit, sugar, biscuits, muesli bar and energy bars.

Conclusion
Overall the FFQ showed poor comparative validity and did not suggest it would be a suitable tool for assessing the dietary intake of ADF personnel. As outlined above there are a number of factors that the chief researcher feels led to these results however the information gained from this study can be used to further refine the FFQ or consider other formats to better meet the needs of the ADF.

485-07
Optimising The Utility Of Injury Surveillance Systems Through New Methods Of Analysis

Published as a Report to the Secretary of Defence: “Injury Surveillance within the Australian Defence Force” McKinnon, A.

Executive Summary
An understanding of where, when and how injuries occur and who they occur to is critical for the development of interventions designed to prevent and control injuries (Cusimano, Chipman, Glazier, Rinner, & Marshall, 2007). In recognition of the growing importance of injury and the burden injury places on society and the workforce the ADF has established injury surveillance systems to further their understanding of the issues at hand.

The World Health Organisation (WHO) and the Centers for Disease Control and Prevention (CDC) define health surveillance as “the ongoing, systematic collection, analysis and interpretation of health data essential to the planning, implementation, and evaluation of health practice, closely integrated with the timely dissemination of these data to those who need to know. The final link of the surveillance chain is in the application of these data to prevention and control” (Holder et al., 2001, p.11). Within the context of the current research, injury surveillance systems will be defined by three key components:

1. the ongoing, systematic collection of data;
2. the analysis and interpretation of that data; and
3. the dissemination of information for prevention purposes.
Injury surveillance systems are fundamental to informing evidence based injury prevention activities (World Health Organization, 2007). However, the importance of injury surveillance systems has not been reflected in scientific research, as evidenced by a scarcity of critical research directed at optimising their performance and utility for injury prevention purposes. The limited research examining injury surveillance systems has focused on the technical design and construction of such systems or the subsequent evaluation of these systems. The lack of knowledge surrounding injury surveillance is most significantly evidenced in the analysis and dissemination of injury surveillance data.

Despite the technical guidance available regarding these systems many operational injury surveillance systems continue to function at sub-optimal levels due to a variety of issues. The issues negatively influencing the performance of current injury surveillance systems fall into one of two categories: 1) the impact of human interaction with such systems (Ashby & Clark, 2003; Boergerhoff, Gerberich, Anderson, Kochevar, & Waller, 1999; Doraiswamy, 1999; Marson, McD Taylor, Ashby, & Cassell, 2005); and 2) a lack of knowledge regarding optimal injury surveillance methods (Driscoll, Harrison, & Langley, 2004; C. Finch, 2006; Pocheret et al., 2004). Currently, such issues and their subsequent impact on injury surveillance activities are an accepted by-product of surveillance. The limited research examining the optimisation of these critical information systems represents a serious gap in knowledge surrounding these systems.

Consequently, the current report has adopted a holistic view of the surveillance process, examining the three facets of injury surveillance systems individually and then examining global factors that impact upon these systems. The aim of this review is to identify methods to optimise the utility of injury surveillance systems for injury prevention in the ADF. Recommendations for the optimisation of ADF injury surveillance systems are provided below.

**Injury Data Collection - Key Recommendations**

That the ADF:

1. Rationalise the many systems currently employed to collect and manage data on injury incidents. This could potentially reduce personnel and financial overhead currently associated with such activities. The design of a standardised system should consider the requirements of localised injury prevention and legislative requirements to report all injuries sustained by Defence personnel.

2. Effectively utilise emergency department (ED) equivalents (health centres, RAP etc) of the ADF as a key point of data capture.

3. Make informed and purposeful decisions regarding whether or not dedicated data collection and entry staff should be appointed.

4. Make informed and purposeful decisions regarding which data elements will be captured in ADF injury surveillance systems, for both legislative reporting and injury prevention purposes.

5. Ensure that those responsible for data collection and entry are properly trained for this role, subject to continuing education, and receive regular feedback on the benefits yielded to the ADF from their efforts.

6. Make informed and purposeful decisions regarding the level and types of technology that will or will not be
employed for injury data collection. Designs will need to consider the varying contexts in which the ADF functions and should be regularly revisited as technology advances.

7. Explore and employ data linkage where beneficial.

8. Ensure explicit and tangible senior endorsement and support of the ADF injury surveillance system, at all levels of command.

Analysis and Interpretation of Injury Data - Key Recommendations

That the ADF:

1. Continue a strong emphasis on effective risk management approaches at all levels of command and service, and resource this adequately.

2. Explicitly recognise and reinforce as standard practice the need for local analysis of injury data and secondary data collection and analysis to inform injury risk management at each level of command.

3. Increase local use of simple and effective tools like the Haddon’s matrix, root cause analysis, Haddon’s list of 10 injury countermeasures, risk prioritisation criteria, and countermeasure selection criteria, and provide widespread and regular training and updates on the use of these tools.

4. Make informed decisions regarding appointments of specialist analysis staff, procurement of specialist analysis hardware and software, and establishment of automated analysis systems that identify emerging trends and priority issues, to support commanders at each level of the organisation in their efforts to manage injury risks.

5. Recognise the importance of timely information provision for commanders, and ensure that injury surveillance systems meet this need.

6. Establish, promulgate and regularly review and update injury tolerance levels for the range of ADF contexts, which include attention to criteria (types and levels) against which rates and consequences can be reasonably assessed and benchmarked, based on the best available evidence.

Dissemination of Injury Data – Key Recommendations

That the ADF:

1. Establish an online management information system incorporating real-time access to dynamic injury surveillance datasets and other information that will support local ownership and action for injury prevention in ADF units.

2. Make injury surveillance datasets transparent (accessible) both horizontally and vertically within the ADF chain of command. Consideration should also be given to some public transparency of a low resolution injury surveillance minimum dataset, similar to that provided online by the United States Department of Defense, as a means of driving sound injury prevention practice.

Global Factors Affecting Injury Surveillance Systems - Key Recommendations

That the ADF:

1. Appoint a senior operational commander to represent the CDF and Service Chiefs in consulting with key stakeholders to establish a clear and comprehensive set of objectives and organisational strategy for ADF injury surveillance systems,
and injury prevention more broadly. This will be important in guiding future development and resourcing of these systems and ensure they meet the needs of ADF commanders.

2. Consider situating development and maintenance of injury surveillance system(s) within a central OH&S agency within the Department of Defence. The command and control of these resources should be adopted by the senior levels of ADF operational command (rather than support entities), as a tool in the operational monitoring and control of cohort readiness for deployment. This will elevate the perceived importance of injury surveillance and control across the ADF, improving injury control, and so result in enhanced force preservation through injury prevention.

3. Centralise data processing for analysis of macro level (i.e. Service level, ADF level) injury issues for prevention purposes (i.e. equipment or infrastructure changes). This will also assist in creating accountability for preventive action amongst military commanders if monitored and evaluated by senior military personnel. Moreover, centralisation of macro level data processing and analysis will facilitate the reporting of injury incidents as required by legislative reporting requirements.

4. Strongly promote effective injury risk management as a tool for commanders in managing Force readiness and capacity in challenging contexts, rather than solely to comply with OH&S legislation.

5. Establish and effect a formal communication plan, developed and overseen by a central OH&S agency, which will bring together all injury surveillance system stakeholders routinely, for system review, sustainment and enhancement. It is essential that this has considerable support and representation from Senior ADF commanders.

6. Explicitly acknowledge and systematically implement a two-stage injury surveillance framework across the ADF, drawing on existing risk assessment and injury prevention processes that serve this end.

This review has made several recommendations for injury data collection, the analysis and interpretation of injury data, the dissemination of injury data and global factors impacting upon the optimal operation of ADF injury surveillance systems. These recommendations have been drawn from empirical evidence, where possible, and anecdotal evidence from health surveillance systems internationally. Many options for action have been suggested and represent a starting point for discussion. The recommendations in this document are not mutually exclusive, nor will it be possible to implement them all simultaneously. However, the recommendations do provide a holistic guide for the optimisation of injury surveillance systems within the ADF, with the potential to yield gains in force preservation and operational capability.

497/07

Efficacy And Pharmacokinetics Of Artesunate And Azithromycin For The Treatment Of Plasmodium Falciparum In Vietnamese Subjects.

Comparison Of The Protection Factor Provided To Users From Four Respirators Using A Simulated Battlefield Protocol.

The Final report is Classified.

Occupational Fatigue At Basic Flying Training School (BFTS)


Abstract

Introduction: The Royal Australian Air Force Institute of Aviation Medicine (RAAF AVMED) was tasked to conduct a study of fatigue levels at the Australian Defence Force Basic Flying Training School (ADF BFTS) and to investigate fatigue measuring tools for possible use in managing weekly flying programs.

Methodology: This task was accomplished in three steps: discussion sessions with the Qualified Flying Instructors (QFI) and management at BFTS; administration of a fatigue survey tool (Occupational Fatigue Exhaustion Recovery scale [OFER 15]); and investigation of currently available fatigue tools.

Results: the discussion sessions identified a number of possible contributors to the fatigue levels of BFTS QFIs. The results of the OFER 15 survey identified four specific individuals who were “at risk” of fatigue related problems. The remainder of the survey results were inconclusive, with regard to identifying a cause of fatigue at BFTS. The discussion and survey findings appear to be in conflict, possibly as a result of the change to the QFI manning levels at BFTS, which occurred between the two data collection periods. The Crew Duty & Rest Planner and the Prior Sleep Wake Model (PSWM) were identified as two possible tools for use at BFTS.

Conclusions & Recommendations: BFTS should carefully monitor the QFI population for signs of “at risk” individuals; consider a comparative analysis of ADF BFTS and 2 FTS service conditions; investigate the use of the Crew Duty & Rest Planner (or similar tool) and PSWM for use in its operations; and establish a fatigue monitoring program.

The Use Of Artificial Intelligence In Military Simulation For The Training Of Junior Leaders In Infantry Minor Tactics.


Abstract

Military training has always consisted of endless repetitions of drills aimed at teaching young soldiers self-discipline and an instinctive reaction to orders regardless of the circumstance. This methodology still holds true in our modern day battlefields, however, external pressures such as budgets and operational necessity are weighing heavily upon the time and resources available to achieve this. Therefore, military forces across the world are looking more and more to simulation to provide cost effective training solutions.

During this thesis a series of surveys and experiments were conducted to investigate the use of current state AI to support the delivery of junior leadership training. The AI within a current in-service military simulator was adapted via scripting to act in a pre-designated doctrinal fashion. Also a novel voice interface was developed
to investigate the benefits of more commonly recognisable control mechanisms commanding computer generated forces. The results of a series of section attacks by a combination of modalities were analysed in order to provide a qualitative and quantitative analysis of their performance. After action reviews from these experiments were also presented to a team of judges in a modified ‘Turing Test’ to evaluate the judges perception of how ‘soldier like’ the actions of the modalities were.

The results of this investigation indicate that the use of AI in this role is limited for some very basic reasons. It also indicates that these factors may be overcome to some extent by the use of more reasonable interfaces and adaption of the AI in order to make AI based avatars act and react in a more ‘soldier like’ or doctrinal manner. It is hoped that the outcomes of this thesis will assist in the future development and research into the use of more realistic AI within military simulations.

555/09


Publication outcome- Dissertation: Pendlebury, J.

Introduction (abridged)

State-sponsored militaries exist to represent the nation-state, but they also represent the wider society that forms the basis of their recruitment (Hackett 1983: 61). In order to enjoy continued relevance and capability, it follows that a state’s military must be considered legitimate, particularly since it is one of the few organs given the mandate to perform legalised violence. While the factors that contribute to the legitimisation of many social and political relationships are well defined (such as the election of democratic representatives), there are no clear and obvious ‘legitimators’ strengthening the relationship between the military and society. This dissertation will explore the factors that contribute to legitimise military organisations, and explore the influence of religious diversity as a ‘legitimator’.

Conclusion (abridged)

The ADF is approaching a crossroads given the statistical shift in the demography of Australian society. Two choices are available to policy makers; do nothing, or use this indicative data as the catalyst to evaluate the potential benefits of embracing diversity.

This evidence combines to produce a compelling argument for embracing diversity in the ADF. It has been established that a number of barriers exist that hamper the ability of the ADF to appeal to certain parts of Australian society as an employer of choice. The current levels of representation of minority religious groups are evidence of this barrier, and despite temptation to the contrary, this dissertation argues strongly against the ‘quick fix’ of targeted quota recruitment. A far more sustainable solution can be implemented through robust diversity policy frameworks.

This dissertation has argued that legitimisation is vitally important to any government agency, and the ADF is no exception. Max Weber’s Theory of Social and Economic Organization was used as a conceptual framework to identify key bases affecting the legitimacy of an organisation. The concept of the military as ‘a model to imitate’ (1947: 130) is useful to this discussion, as it underscores the existence of a two-way relationship between society and the military. This link is central to the argument that the amount to which an organisation reflects the composition of society affects the level (and even the
basis) of legitimacy it enjoys. The ADF faces a number of challenges in addressing the two-way relationship with wider Australian society, many of which are inherent to the role of the military and as such, difficult to address. Factors such as the secrecy surrounding much of its operations, and the disconnection from society enforced by security measures such as strict base access controls contribute to this sense of the military being removed from the Australian constituency. While diversity is clearly another factor that indicates a disconnect between society and the ADF, there is much that can be done to address this particular barrier through the implementation of policy that seeks to encourage recruits from the entire cross-section of society. The recruitment of minority faith chaplains and the modification of dress regulations to allow items of religious clothing are examples of policy that could address this challenge.

There is evidence to suggest that the ADF stands to enjoy many benefits by embracing diversity. These benefits are both normative and instrumental, and have the potential to transform the capability, efficiency and morale of the organisation. Addressing the concept of Otherness lies at the heart of tackling the barriers to diversity in the armed forces, since members of a diverse military who are culturally aware, and understand the importance of difference are less likely to be able to dehumanise people they perceive as exhibiting divergent religious and cultural traits. This should result in a military that is more effective not only on active service, but on humanitarian missions where the aim is to provide support and assistance to those in need.

563-09

**Occupational Health and Safety: Knowledge and Attitudes amongst RAAF and Non RAAF Personnel**

Publication outcome: Thesis. Tracy, G.

**Abstract:**

The purpose of this study was to investigate whether the occupational health and safety (OHS) knowledge and attitudes vary between Royal Australian Air Force (RAAF) and non-RAAF groups at Amberley Air Base in south east Queensland. This was achieved by employing a mixture of quantitative and qualitative methods. A questionnaire was distributed to approximately 400 personnel on base, of which 118 valid responses were returned completed. In addition to this, 19 interviews were held with personnel who possessed some degree of responsibility for OHS management. The study was carried out between September and October 2009. The data from the questionnaires illustrated a difference in safety climate score between RAAF and non-RAAF groups, in which the safety climate score of RAAF personnel was found to be significantly lower than the non-RAAF personnel. In particular, in the dimensions of Management Commitment, Work Environment, Supportive Environment and Priority of Safety, the RAAF were shown to have lower attitudes with statistical significance. Also the data from the questionnaires illustrated a significant difference between the age and education levels of the RAAF and non-RAAF groups. The information reported in the interviews identified the themes of training, safety as a secondary role, involuntary nature of many safety positions and poor safety attitudes. These findings provide some valuable insight into the safety attitudes and safety structure of the RAAF and non-RAAF groups on base. The results from this study indicate the RAAF needs to consider the training amongst those with OHS responsibilities,
and the structure of their safety system. This study also suggests the need for further investigation into the role of age and education in the military culture of safety.

532/08

Field Evaluation of a New Mosquito Repellent (BUSHMAN 40% DEET)

Outcomes published as:

535-08

'Pigs Can Fly!': The Impact Of The Introduction Of The F-111 On The RAAF

Publication outcome: Thesis. Lax, M.

Abstract

This thesis is about Australia’s strategic weapon - the F-111 bomber. It presents the case that the F-111 aircraft forced a post-Vietnam RAAF to systematically mature the way it commanded, operated, maintained and developed not only its strike/reconnaissance force but its entire order of battle. The aircraft almost single-handedly changed the RAAF due to its operational capabilities, complexity, cost of ownership, and the politically sensitive nature of its possible use. The F-111 also challenged Australian policy makers to define how, and under what circumstances, the aircraft would be used.

The controversy began in the 1960s and continued into the 1970s, with cost blowouts, a ten year delay to delivery and significant technical problems. All were eventually overcome, but the need to continually upgrade the aircraft to remain relevant to modern air operations during periods of strategic uncertainty also forged considerable debate. Finally, when its withdrawal from service was announced for 2010, public and media pressure was brought to bear to keep the aircraft beyond 2020 because of its range and precision and its deterrent effect.

To determine how the RAAF was changed by the introduction of the F-111, and to what extent, the thesis is presented chronologically. This fifty-year history of the F-111’s service with the RAAF is divided into decades commencing in 1953 by examining the RAAF’s desire to acquire a modern, jet bomber force to replace the Canberra aircraft fleet. The idea that strategic strike was an essential component of any professional post-World War II air force also emerged. The thesis then covers the decades of application of the F-111 as a bomber, sustainment and upgrade of the fleet and finally, offers a commentary of the aircraft’s replacement and the future of the strike role in the RAAF.

This thesis concludes that the F-111 forced the RAAF to become technologically adept and self-reliant, while simultaneously offering Government a broad range of land and maritime strike reconnaissance options. The experience also allowed newer capabilities such as the F/A-18 Hornet to be brought into service much quicker, and established a model for the acquisition of the F-35 Joint Strike Fighter due in several years. Finally, the aircraft offered to Government a full range of independent strike and reconnaissance options, giving the RAAF an enviable reputation as a professional and balanced air force.
RMC Instructional Staff Health and Wellbeing Review

Abstract

Background:
As part of the ongoing Royal Military College (RMC) Physical Conditioning Optimisation Review (PCOR) project, a review into the health and wellbeing of staff posted to RMC was undertaken. The intent of the project was to review the health and wellbeing of staff posted to RMC as well as provide an insight into the impact of an instructional posting on ADF members.

Methods:
RMC staff were invited to complete a voluntary online survey. Basic Fitness Assessment (BFA) data for the year 2009 were obtained and internal policies that relate to staff health and wellbeing collected for review. Injury data recorded on Incident Report Forms (AC563) were collected as were physiotherapy treatment attendance data. Inferential data analysis was conducted utilising the EXCEL Statistical ToolPak software. Ethical clearance was provided by the Australian Defence Human Research Ethical Committee (ADHREC).

Results:
A total of 40 (37%) staff members completed the survey while 120 BFA results, belonging to 86 staff, met the criteria for inclusion. Eight internal defence documents, five AC563 forms and 43 physiotherapy appointments belonging to 17 RMC staff, were also gathered. The results showed that a majority of staff may not be meeting the recommended physical activity guidelines recommended by health and ADF authorities with fitter members in particular considering their fitness at RMC to be decreasing. Staff members who were injured over the review period were proactive in seeking and attending treatments for their injury, however there does appear to be an increasing number of staff who delay seeking treatment immediately following injury. RMC staff, as a population group, portray sleep patterns similar to a deployed Infantry Battalion. There is an identified concern that a number of staff are driving or acting in safety roles in a cognitive state similar to that induced by breaching the blood alcohol content levels recommended for these activities and are therefore at an increased risk of accident related injury to themselves, other staff, and trainees. Over 50% of responders considered their diets to be worse at RMC when considered against their diets in previous units. More than half of the staff responders were considered to be leading an potentially unhealthy lifestyle of missing meals and eating lunch at their desks. When viewed collectively approximately 90% of responding RMC staff failed to meet at least four of the identified healthy lifestyle habits.

Recommendations:
Recommendations to improve staff management (through secondment of additional staff and development of a ‘staff fatigue management plan’), improve staff healthy lifestyle education (recommendations and consequences), and for further study are made.
**Protocol Status as at 30 June 2009**

The status of all ADHREC protocols as at 30 June 2009 is tabulated below. A total of 511 protocols are listed with ADHREC and of these 104 are currently in progress.

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<td><strong>109</strong></td>
<td><strong>540</strong></td>
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**Publication Media for Completed ADHREC Protocols**

Journals in which ADHREC cleared research has been published include, but are not limited to, the following:

- Australian and New Zealand Journal of Surgery
- Aviation, Space and Environmental Medicine Journal
- Journal of Applied Physiology
- Journal of Clinical Infectious Diseases
- Journal of Hand Therapy
- Journal of Medical Entomology
- Medical Journal of Australia
- Military Medicine (USA)

**Activities & Initiatives**

*Human Research in Defence - Instructions for Researchers*

ADHREC monitors aspects of health and human performance research in Defence. The functioning is detailed in the Health Manual, Volume 23 Human Research in Defence—Instructions for Researchers. The procedures contained in this manual are intended to improve the management and governance processes applying to the conduct of human research. A wide range of human research activities have been defined and the procedures allow for organisational oversight in the approval process. The manual retains the extant system of ethical oversight of human research while allowing for improved administrative procedures. New protocol application procedures have been developed and work continues on developing a fully electronic submission format.
Audit of Research

In 1999, the Committee decided to conduct audits of researchers’ files and practices, as an additional means of facilitating and improving ADHREC's monitoring of Defence research. This has become a regular activity of ADHREC.

The use of audits to monitor ADHREC approved research has proven to be most beneficial in clarifying with researchers what is required of them as part of ADHREC approval. ADHREC will continue to conduct audits of approved research as standard monitoring procedure, ensuring the continued compliance of Defence research with the NHMRC guidelines.

Major Researchers in Defence

Major researchers within Defence who have had protocols considered by ADHREC include:

- Army Malaria Institute (AMI)
  Areas of research include prevention and treatment of vector borne disease through pharmacological agents (e.g. medications - both vaccines and oral medicines, and insect repellents) or physical means (e.g. bed nets, protective clothing).

- Royal Australian Air Force Institute of Aviation Medicine (RAAF AVMED)
  Both AVMED and individuals with an interest in Aviation Medicine have studied various effects of hypoxia (diminished availability of oxygen to body tissues) and gravitational forces (+Gz) on aircrew, their physiology and performance.

- Defence Science and Technology Organisation (DSTO)
  Various departments within DSTO have been researching the physiological responses of soldiers under different climatic and work conditions, evaluating equipment for use in the field and investigating options for optimum nutrition of soldiers.

- Directorate of Mental Health (DMH), Psychology Research Technology Group (PRTG) and the Directorate of Strategic Personnel Planning and Research (DSPPR).
  PRTG’s main tasks comprise the assessment of the human factors of Defence, the development of selection techniques, e.g. psychometric or aptitude tests, and the evaluation of the utility and validity of psychological tests. PRTG also acts as a consultant to other areas of Defence on matters of selection, training and retention of staff.
  DSPPR provides Defence with a consolidated personnel research capability to support strategic work force planning and strategic personnel planning. DSPPR also provides advice and assistance in relation to the evaluation of personnel management policies and practices.

- Other
  The majority of other researchers have been individuals completing Masters thesis or Doctoral dissertations, and practicing clinicians or epidemiologists with a special interest in the area researched. All research involving Defence personnel, as either researchers or subjects, that are brought forward for consideration by ADHREC must have some benefit to Defence. The development and management of the Defence Health and Human Performance Master Plan makes this benefit more transparent.
ADHREC’s Approach to Research Protocols

ADHREC’s primary function is to assess all submitted protocols to determine whether that research is ethical. ADHREC applies the Privacy Principles to each protocol. The Committee pays particular attention to the issues of informed consent, quantification of risk, voluntary participation and that there be no detriment to the careers or medical care of volunteers whether they choose to participate or withdraw from the project. There are a number of reasons why a protocol may not be approved.

ADHREC does not grant retrospective ethics approval. The Committee is also reluctant to allow Defence personnel to participate in the collection of safety data for new drugs (pharmaceuticals) or participate in drug trials where there is no clear benefit to the individual or to Defence. The Committee does not approve protocols which have an inadequate study design, would not produce scientifically valid results, or projects that are likely to have adverse outcomes to the volunteers or their military careers. Similarly, where a researcher requests access to records maintained by Defence (eg medical documents), ADHREC pays particular attention to Section 95 of the Privacy Act 1988.

If ADHREC determines that the benefit of the research does not outweigh privacy considerations, then the protocol will not be approved. Australian Defence Force personnel are in a unique position of receiving and following orders and as such they can be considered a ‘captive audience’. ADHREC is very sensitive to the relationship and importance of the functioning of the commanding officer, and the responsibilities associated with both duty and command. ADHREC balances this relationship with its awareness of the Defence population being a potentially ‘captive audience’, and the potential this has for impacting on research in the Defence environment. ADHREC recognises the operational imperative for Defence to conduct health surveillance and assessment of efficacy of health protocols in an operational environment.
Future Activities

- **Number of Meetings**
ADHREC conducted eleven meetings in the period from July 2009 to December 2010 and has planned seven meetings to occur in the period of January 2011 to December 2011.

- **Researcher Audits**
The Committee plans to conduct further audits of approved protocols. Auditing facilitates and improves ADHREC’s monitoring of Defence research, in accordance with NHMRC guidelines.

- **Compliance with the National Statement on Ethical Conduct in Human Research - National Health and Medical Research Council (NHMRC).**
In 1999, the NHMRC issued the ‘National Statement on Ethical Conduct in Research Involving Humans’ (the National Statement) made in accordance with the National Health and Medical Research Council Act 1992. In 2007 NHMRC released an updated document, the ‘National Statement on Ethical Conduct in Human Research’.

The National Statement combined a number of previously separately published documents, outlining comprehensively the membership and operations of HRECs, guidelines on the storage, handling and privacy of information held by HRECs, and on various components of health and medical research. It provides guidelines about maintaining the privacy and confidentiality of personal information or material of research participants.

ADHREC has been formed in accordance with the National Statement, and functions in compliance with the guidelines. ADHREC will continue to maintain its compliance with the National Statement, ensuring that ADHREC undertakes best-practice ethical review. ADHREC has developed mechanisms for receiving complaints or comments regarding both the considerations and conduct of the committee.
### Australian Defence Human Research Ethics Committee

#### Structure of Committee

<table>
<thead>
<tr>
<th>Membership Appointment</th>
<th>Description</th>
<th>Name</th>
<th>Appointment Tenure</th>
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<tr>
<td>The Chair</td>
<td>Surgeon General Australian Defence Force SGADF</td>
<td>MAJGEN P. Alexander</td>
<td>Jan 2009 - end of period as SGADF</td>
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<tr>
<td>Member</td>
<td>A laywoman not associated with the ADF</td>
<td>Mrs K. Hogan, AM PSM</td>
<td>31 May 2008 - 31 May 2013</td>
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<td>Member</td>
<td>A layman not associated with the ADF</td>
<td>Mr L. Roe</td>
<td>31 May 2010 - 31 May 2015</td>
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<td>Member</td>
<td>A layman not associated with the ADF</td>
<td>Mr Simon Murray</td>
<td>9 Oct 2006 - Feb 2010</td>
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<td>Member</td>
<td>A member with knowledge of, and current experience in, the areas of research that are regularly considered by ADHREC</td>
<td>Dr K. McAnally</td>
<td>17 Mar 2008 - 17 Mar 2013</td>
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<tr>
<td>Member</td>
<td>A member with knowledge of, and current experience in, the professional care, counseling or treatment of people</td>
<td>Professor J.H. Pearn AM, RFD</td>
<td>1 Jan 2001 - 9 Jan 2011</td>
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<tr>
<td>Member</td>
<td>A health graduate from Defence (one of two, one of who is to be a medical graduate)</td>
<td>BRIG S. Rudzki AM</td>
<td>31 May 2010 - 31 May 2015</td>
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<tr>
<td>Member</td>
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<td>LTCOL V. Ross</td>
<td>25 Nov 2002 - 25 Nov 2007; 25 Nov 2007 - 25 Nov 2010</td>
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<td>Member</td>
<td>A member with knowledge of, and current experience in, the areas of research that are regularly considered by ADHREC</td>
<td>Dr Keith Horsely</td>
<td>22 June 2009 - 22 June 2014</td>
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<td>Member</td>
<td>A member with knowledge of, and current experience in, the areas of research that are regularly considered by ADHREC (psychology)</td>
<td>Mr Tony Cotton</td>
<td>22 June 2009 - 22 June 2014</td>
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<td>LTCOL Rosemary Landy</td>
<td>2001 - Oct 2010</td>
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<td>Mrs Georgina Gill</td>
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<td>LEUT Elise Burnside</td>
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Attendances July 2009/Dec 2010
Australian Defence Human Research Ethics Committee

Monday 13 July 2009 at 1630 hours

Present:
Major General Paul Alexander
Chair
Lieutenant Colonel Rosemary Landy
Executive Secretary
Mr Tony Cotton
Chief Justice Terence Higgins
Mrs Kaye Hogan
Dr Keith Horsley
Dr Ken McAnally
Mr Simon Murray
Monsignor Peter O’Keefe

Apologies:
Professor John Pearn
Lieutenant Colonel Vicki Ross
Air Commodore Tracy Smart

Monday 24 August 2009 at 1630 hours

Present:
Major General Paul Alexander
Chair
Lieutenant Colonel Rosemary Landy
Executive Secretary
Mrs Kaye Hogan
Dr Keith Horsley
Mr Simon Murray
Monsignor Peter O’Keefe
Professor John Pearn
Lieutenant Colonel Vicki Ross
Air Commodore Tracy Smart

Guest:
Dr Jason Masanov

Apologies:
Mr Tony Cotton
Chief Justice Terence Higgins
Dr Ken McAnally

Monday 12 October 2009 at 1630 hours

Present:
Air Commodore Tracy Smart
Acting Chair
Lieutenant Colonel Rosemary Landy
Executive Secretary
Chief Justice Terence Higgins
Mrs Kaye Hogan
Dr Keith Horsley
Dr Ken McAnally
Mr Simon Murray
Monsignor Peter O’Keefe
Professor John Pearn
Lieutenant Colonel Vicki Ross
Mr Tony Cotton

Apologies:
Major General Paul Alexander

Monday 23 November 2009 at 1530 hours

Present:
Air Commodore Tracy Smart
Acting Chair
Lieutenant Colonel Rosemary Landy
Executive Secretary
Mr Tony Cotton
Chief Justice Terence Higgins
Dr Ken McAnally
Monsignor Peter O’Keefe
Professor John Pearn
Lieutenant Colonel Vicki Ross

Apologies:
Major General Paul Alexander
Mrs Kaye Hogan
Dr Keith Horsley
Mr Simon Murray
Monday 15 February 2010 at 1630 hours

Present:
Major General Paul Alexander
Chair
Lieutenant Colonel Rosemary Landy
Executive Secretary
Chief Justice Terence Higgins
Mrs Kaye Hogan
Professor John Pearn
Lieutenant Colonel Vicki Ross
Air Commodore Tracy Smart

Apologies:
Mr Tony Cotton
Dr Ken McAnally
Mr Simon Murray
Monsignor Peter O’Keefe

Observer:
Brigadier Steve Rudzki

Monday 12 April 2010 at 1630 hours

Present:
Major General Paul Alexander
Chair
Lieutenant Colonel Rosemary Landy
Executive Secretary
Mr Tony Cotton
Chief Justice Terence Higgins
Mrs Kaye Hogan
Lieutenant Colonel Vicki Ross
Dr Ken McAnally
Monsignor Peter O’Keefe

Apologies:
Dr Keith Horsley
Professor John Pearn
Air Commodore Tracy Smart

Observer:
Mr Lindsay Roe
Professor Sandy McFarlane
Mr David Morton

Monday 31 May 2010 at 1630 hours

Present:
Air Commodore Tracy Smart
Acting Chair
Lieutenant Colonel Rosemary Landy
Executive Secretary
Mr Tony Cotton
Chief Justice Terence Higgins
Mrs Kaye Hogan
Dr Keith Horsley
Professor John Pearn
Lieutenant Colonel Vicki Ross
Dr Ken McAnally
Monsignor Peter O’Keefe

Apologies:
Major General Paul Alexander
Mr Lindsay Roe
Brigadier Stephan Rudzki

Monday 12 July 2010 at 1630 hours

Present:
Major General Paul Alexander
Chair
Lieutenant Colonel Rosemary Landy
Executive Secretary
Chief Justice Terence Higgins
Mrs Kaye Hogan
Dr Keith Horsley
Monsignor Peter O’Keefe
Professor John Pearn
Mr Lindsay Roe

Apologies:
Mr Tony Cotton
Dr Ken McAnally
Lieutenant Colonel Vicki Ross
Brigadier Stephan Rudzki
Air Commodore Tracy Smart
Monday 23 August 2010 at 1630 hours

**Present:**
- MAJGEN Paul Alexander
- Chair
- BRIG Stephan Rudzki
- AIRCDRE Tracy Smart
- Mr Tony Cotton
- Chief Justice Terence Higgins
- Mrs Kaye Hogan
- Dr Keith Horsley
- Dr Ken McAnally
- Monsignor Peter O’Keefe
- Mr Lindsay Roe
- LTCOL Rosemary Landy
- Executive Secretary

**Apologies:**
- Professor John Pearn
- LTCOL Vicki Ross

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Monday 18 October 2010 at 1630 hours

**Present:**
- MAJGEN Paul Alexander
- Chair
- BRIG Stephan Rudzki
- AIRCDRE Tracy Smart
- LTCOL Vicki Ross
- Chief Justice Terence Higgins
- Mrs Kaye Hogan
- Dr Keith Horsley
- Dr Ken McAnally
- Monsignor Peter O’Keefe
- Mr Lindsay Roe
- LTCOL Rosemary Landy
- Executive Secretary

**Invited Guest:**
- Mr David Morton

**Apologies:**
- Professor John Pearn
- Monsignor Peter O’Keefe
- Mr Tony Cotton

**Secretary:**
- Miss Lucy Greenacre

**Minute Secretary:**
- LTCOL Vicki Ross

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Monday 22 November 2010 at 1630 hours

**Present:**
- MAJGEN Paul Alexander
- Chair
- BRIG Stephan Rudzki
- AIRCDRE Tracy Smart
- Mr Tony Cotton
- Chief Justice Terence Higgins
- Mrs Kaye Hogan
- Dr Keith Horsley
- Professor John Pearn
- Dr Ken McAnally
- Monsignor Peter O’Keefe
- Mr Lindsay Roe
- LTCOL Vicki Ross
- Secretary
- Miss Lucy Greenacre
- Minute Secretary
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AUSTRALIAN DEFENCE HUMAN RESEARCH ETHICS COMMITTEE (ADHREC)

The Australian Defence Human Research Ethics Committee (ADHREC) was established in 1989. As the Human Research Ethics Committee for Defence, ADHREC is committed to the creation and maintenance of an environment in which research on humans is conducted both professionally and ethically. The Committee generally meets eight times a year and considers all proposed human research projects undertaken on Australian Defence Force (ADF) personnel, by ADF personnel, or on Defence property, as per National Health and Medical Research Council (NHMRC) guidelines.

If you are interested in knowing more about ADHREC, their contact details are below:

Contacts/Information
Australian Defence Human Research Ethics Committee

Contact Details

Contact details for ADHREC are as follows:

Australian Defence Human Research Ethics Committee
Department of Defence
CP2-7-101
PO Box 7911
CANBERRA BC ACT 2600
AUSTRALIA

Ph: +61 2 6266 3837
Fax: +61 2 6266 3072
E-Mail: ADHREC@defence.gov.au

More Information

The ADHREC Intranet web site can be accessed at http://intranet.defence.gov.au/vcdf/sites/Research/ComWeb.asp?page=38869. At this site, the ADHREC Researchers Guidelines, ADHREC’s Guidelines for Volunteers as well as information on all the committee members can be accessed.

DHS has developed an internet site at http://www.defence.gov.au/health/research/adhrec/i-adhrec.htm. This site shows the history of ADHREC, its members and the steps required to fill out and submit an application.