Senate Foreign Affairs, Defence and Trade References Committee

SUBMISSION COVER SHEET

Inquiry Title: Effectiveness of Australia's Military Justice System

Submission No: **P7**

Date Received: 30.01.04

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Summary of Peter Gerrey Submission To Senate Committee re ADF Justice

This submission concerns two major themes namely:

1. To include in Terms of Reference the death/suicide of an Army recruit who died after shooting himself at the range at Puckapunyal in 1995/96. Relevant facts here include:
   - He was marginal on entry
   - His normal hygiene and personal habits were not acceptable,
   - He could not conform to military standards,
   - The range procedures were inappropriate in allowing this recruit to have unsupervised access to a loaded magazine and weapon, and
   - The reporting process at Puckapunyal were not appropriate to this situation.

I am not sure of the exact time or date but there should be ADF and Comcare files that can be retrieved,

2. Having conducted and reviewed many ADF inquiries I am of the opinion that additional expertise needs to be added to ADF inquiries where an accident has occurred in the workplace and there has been a fatality or serious personal injury. Additionally, there is little review of the procedures that may have lead to fatalities or serious injuries in the ADF workplace as the ADF officers accept work practices as satisfactory while they assume the individuals are to be blamed for the incident.

Plus that there is an opportunity for the Committee to consider initiating legislation to remove the "Shield of the Crown" from the OHS (CE) Act 1991 which presently prevents the ADF and the Australian Public Servant from prosecution as a result of failing to provide a safe workplace or not acting in the appropriate manner as prescribed by the OHS Act & Regulations. Presently, there is discussion at State level for there to be a charge, possibly 'workplace manslaughter', for a fatal accident at the workplace.

Submission to Senate Committee

Effectiveness of Australia's military justice system

Objectives:

1. For the 1995/96 death (suicide) of an Army Recruit to be added to the Terms of Reference (TOR) and
2. That the ADF be restrained from using officers untrained in investigative procedures and risk assessment in the conduct of investigations into death, suicides and personal injury at the workplace, and
3. For the "Shield of the Crown" to be removed from the OHS (CE) Act 1991

My submission relates primarily to the Terms of Reference (2) requesting that the death (suicide) of a new entry Army Recruit at Puckapunyal in 1995/6, after five weeks new entry training, be considered under the Terms of Reference.

I also wish to make comments on my experience and knowledge of some ADF enquiries and their outcomes in accordance with the Terms of Reference (1),(b) (i) and (ii). Namely that ADF Inquiries into workplace accidents resulting in fatalities, suicides or serious personal injury should not be conducted by ADF officers to the exclusion of other agencies or authorities such as Comcare.

/ I was employed.

I was employed from 1995 to 2000 by Comcare as an Occupational Health and Safety Advisor and as a workplace investigator under Section 41 of the *Occupational Health and Safety (Commonwealth Employment) Act 1991.* I completed *An Investigation Methods Course* conducted by the University of Canberra as well as courses in *Quality Systems in OH&S Management, Risk Management* plus I hold a *Diploma in OHS Workplace Management.*

Between 1991 and 2000 I conducted workplace inspections in military establishments for both the Navy and Comcare. When required, by Comcare, I conducted or reviewed ADF Inquiries into workplace accidents in NSW that had resulted in fatalities or serious personal injuries. The ADF and Comcare had an agreement whereby the ADF would conduct their internal inquiries and/or investigations following a serious personal injury or a fatality at an ADF workplace. A Comcare investigator would then review these inquiries and/or investigations.

One of these ADF Inquiries was into the death, at Puckapunyal in 1995/6, of a new entry recruit on his fifth week of training. I carried out the review of the ADF inquiry and my report was forwarded to the ADF and Comcare Head Office in Canberra. I do not have a copy of this report and so my comments are general in nature. However, a perusal of the ADF or Comcare files will provide the details, that I am sure the Committee will find to be disturbing. The incident identified in this inquiry caused me considerable anguish, as the circumstances of the death should have alerted the Army trainers to a poor system of reporting and the basic lack of justice to new recruits who did not fit the Puckapunyal parameters.

This particular recruit was identified in his recruiting papers as marginal on entry. This information was not conveyed to his basic trainers. On day two of his recruit training one of his Corporals commented that the recruit should never have been enlisted.

A trail of inappropriate actions by the recruit, his failure to meet Puckapunyal standards and poor personal hygiene, on many occasions caused the recruit to be "punished" or retrained and eventually restricted in his leave. Unfortunately, there was not sufficient reporting of the incidents and circumstances to a higher level of command within the Training Unit or to the unit psychiatrist.

/... The recruit was

The recruit was strongly supported by his immediate trainers and his fellow recruits who helped him whenever possible. Despite his below average performance he remained with his contemporaries when they carried out live weapon firings at the local range. Unfortunately, the appropriate range procedures were not strictly followed and all personnel were issued with ammunition for the firings. After loading the ammunition into the magazines, the magazines were stowed in each recruit's pouches and left together with the firearms until required for the firings.

This recruit was then detailed as part of the 'butts party' and together with other recruits took their weapons and pouches to the butt's area. During a break in the firings the recruit moved to his weapon, loaded it with the magazine and fatally shot himself.

It was perhaps fortunate that this particular recruit showed no animosity to his trainers or fellow recruits otherwise the result could have been disastrous with multiple deaths or injuries. He was simply a non-conformer, unable to comprehend the requirements of the military and society in general.

Another contributing factor to this incident was the culture of forcing people through the recruiting pipeline. A trophy was in existence at the time for the most successful platoon or section, namely that platoon or section that achieved the best throughput of recruits.

To read some eight years later that a suicide had occurred at Singleton, that the practices had changed little and no person or persons had been held accountable has caused me to raise this matter. Additionally, many of the recommendations from the Army Inquiry at Puckapunyal, if fully implemented, may have contributed to another outcome for the Private at Singleton.

Recommendation: The death of this Recruit in 1995/96 is considered under Terms of Reference (2) of this Committee.

/...TOR (1) (b)(1).

TOR (1)(b) (1) – *'quality of investigations, the process for their instigation, and implementation of findings';*

When the ADF investigates accidents, fatalities, including suicides at ADF workplaces, a continuation of the procedures that may have contributed to these unfortunate incidents and deaths may be justified or ignored by the ADF inquiry.

When ADF personnel, who have not been trained in investigative procedures and risk assessment, investigate their own procedures it is natural and appropriate for them to accept some procedures without asking questions as to the origin of that procedure. Additionally, the procedure may be many years old and not appropriate for today's workplace.

It is not sufficient for a specialist in a department or activity to conduct an inquiry into that department's procedures to find the contributory causes of an accident or fatality. Persons with other experiences, training and attitudes need to be included in these inquiries.

Conducting an inquiry requires specialist skills and in the case of injury or fatalities a 'Risk Assessment' should be conducted. Additionally, this risk assessment is required by the *OHS (CE) Act 1991 and Regulations.* My experience is that investigations at military establishments following ADF enquiries have generally failed to find 'Risk Assessments' of procedures possibly contributing to accidents or injuries.

In many cases ADF officers accept that a procedure is satisfactory and assume that the ADF person made a mistake or was negligent. Other instances indicate that persons are allowed to perform duties with specialist skills that they may not have used for many years. This practice has reduced recently with module training but some of the culture remains. This culture needs to change – in an inquiry all procedures must be questioned and substantiated.

In one instance, an ADF inquiry into the loss of a sailor's finger recommended that the sailor be charged with deliberate self-mutilation. There were no facts in the inquiry report or the statements taken that could have led to this conclusion. The facts that the sailor had been removed from his normal activities during the working day and then ordered to carry out the maintenance on a weapon after normal leave times may have contributed to this accident were not mentioned.

/... How are these

How are these facts related to Military Justice?

To my general knowledge the following accidents, fatalities and suicides have caused the ADF to conduct investigations or inquiries.

Deaths:	Two sailors drowned when left topside when a submarine dived outside Sydney Heads
	APC accident at Holsworthy
	Navy helo pilot at Albatross in 1995 – incidents similar to this accident had been recorded since 1987
	Army Recruit suicide at Puckapunyal
	HMAS Westralia
	Black Hawk fatalities
Serious Injury	APC Holsworthy
	Parachute Training by 3RAR – numerous

This is not a complete list but is submitted to indicate that few persons have been disciplined, fined or demoted or practices changed as a result of these incidents. In some cases, the practices have continued for many years and no 'Risk Assessment' conducted or documented.

Another challenge to achieving some justice when accidents or injuries are the result of inadequate management is the 'Shield of the Crown'. The fact that ADF personnel cannot be prosecuted for contravening provisions of the OHS (CE) Act 1991 is contrary to modern thinking with some authorities considering including " workplace manslaughter" in their OHS Acts. The present "Shield of the Crown" protects too many persons and prevents some of these cases being bought to the attention of the Director of Public Prosecutions for possible prosecution.

/...Additionally, the culture

Additionally, the culture remains in some parts of the ADF whereby the first assumption by ADF officers is that the personnel have been negligent or failed to follow the correct procedures. However, on more intense and appropriate investigation it is usually found that the incident was caused by a lack of or the absence of supervision together with inadequate training as contributory factors.

Recommendations:

1. The ADF should not be the sole authority conducting investigations into fatalities and serious personal injuries in the ADF and
2. The removal of the "Shield of the Crown" is considered.