Senate Foreign Affairs, Defence and Trade References Committee

SUBMISSION COVER SHEET

Inquiry Title: Effectiveness of Australia's Military Justice System

Submission No: **P16E**

Date Received: 09.07.04

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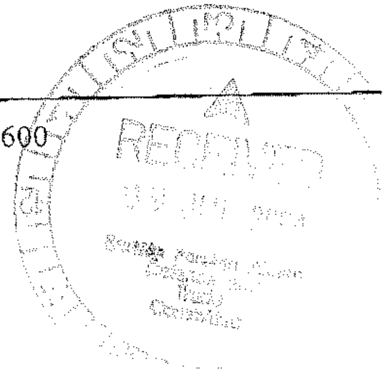
CHIEF OF NAVY



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CN/OUT/2004/409

Senator Steve Hutchins
Chair, Senate Inquiry into the effectiveness of the Military Justice System
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Dear Senator Hutchins,

Thank you for providing a copy of the submission made by Mr Laurence Mahony for Navy's comment. The opportunity to respond is welcomed, particularly as it relates to a primary area of focus in the Senate Inquiry's Terms of Reference.

Mr Mahony's submission deals with issues concerning the fire onboard HMAS WESTRALIA. The disaster and the tragic deaths of four young men and women, have led to major changes that have permeated almost every aspect of Navy life; engineering, risk management, safety management, damage control, training and operations. Every person in a position of any responsibility has been exposed to the lessons of the fire onboard HMAS WESTRALIA with a view to embedding the necessary changes in Navy's culture.

Mr Mahoney's stated aim in providing his report of 18 March 2004, was to provide "*suggestions to the Senate, Foreign Affairs Defence and Trade Committee's Committee on 'Effectiveness of Australia's Military Justice System'*", and he states that his particular interest is in Quality Assurance (QA). Mr Mahony makes many suggestions and allegations across a broad range of areas. Upon examination it is evident that most, if not all his issues, have either been addressed by other actions, or have been subjected to close external examination by the Western Australian Coroner or COMCARE, or else have no foundation.

Notwithstanding the many suggestions in his report, it appears that Mr Mahony has some fundamental misconceptions about the purpose of a Board of Inquiry (BOI). The BOI process is a fact-finding mission. The Court process is essentially a guilt/liability finding mission – the two are not interchangeable and remain separate for specific purposes.

Because of the number of observations and allegations made by Mr Mahony in his lengthy submission, it is not intended to address every issue separately. Mr Mahony's main concerns appear to be in three areas: the fairness and partiality of the BOI; the Navy's QA knowledge and process integrity; and Navy staffing and resources applied to QA functions.

This submission will address the aggregated issues against these issues of concern, particularly the BOI fairness and partiality issues.

Boards of Inquiry – Efficacy, Fairness and Integrity Issues

As an opening observation, it is Navy's view that the efficacy of the HMAS WESTRALIA BOI has already been thoroughly reviewed by the Western Australian Coroner and COMCARE, both of which are independent authorities, unconstrained by the requirements of the Military Justice System. Both authorities have recognised the value of the BOI, its findings and its recommendations for remedial actions.

The BOI was a public and open fact-finding process, particularly in light of the fact that there were two eminent civilian experts on the Board. The Board judged Navy's actions by objective, civilian standards. It identified the problems and recommended reforms in a way that met Navy's immediate needs as well as satisfying the external probity standards of the Western Australian Coroner, who stated at pages 15 and 20 of his report:

> *"The report contained an excellent analysis of safety issues and reached a total of 161 conclusions and made 114 recommendations."*
>
> *"The evidence provided to the Board of Inquiry has been of great assistance to me and its availability has obviated a need for me to further explore many issues which were exhaustively examined before the Board. In addition the Board's Report deals with a wide range of issues in a comprehensive and most helpful way as a result of which it is not necessary for me to re-visit many of these issues."*

Allegations of Unfair Processes.

Mr Mahony's allegation that "the military ought not be a judge in its own case" belies his misconception of the role and purpose of BOIs. Administrative Inquiries including BOIs were described in the first Defence Submission to this Senate Inquiry (Paras 2.61-2.68, pages 24-27). The purpose of a BOI is also clearly set out in ADFP 06.1.4 Chapter 7, which states:

> ***Purpose***
> *7.3 The purpose of a Board of Inquiry is to determine the facts and circumstances surrounding an incident or situation so that an informed decision may be taken about the action required including, where appropriate, action to avoid a recurrence.*
>
> ***Criminal and disciplinary conduct***
> *7.4 A Board of Inquiry is not to conduct a criminal or disciplinary investigation nor conclude that an offence has or has not been committed. Where the facts point to a likelihood that a criminal or disciplinary offence may have been committed, the inquiry into that aspect of the matter is to cease and the matter reported immediately to the Appointing Authority to determine the future course of the inquiry. A Board of Inquiry may find that grounds exist for a matter to be the subject of a Defence Force Discipline Act 1982 or civilian police investigation and to so recommend.*

Regarding Mr Mahoney's allegation that the Department of Defence should not be allowed to conduct BOIs into matters where there is death, serious injury or potential prosecution and litigation, the following points must be borne in mind:

Defence has legal obligations as well as vested interests in conducting a BOI. Navy has a 'duty of care' obligation under the *Occupational Health and Safety (Commonwealth Employees) Act 1991* to find immediate causal issues and rectify them as early as practicable;

A BOI is purely a 'fact finding process'. The purpose of a BOI is to determine the facts and circumstances surrounding an incident or situation so that an informed decision may be taken about the action required including, where appropriate, action to avoid a recurrence;

The court process, for example, in criminal, commercial, civil, and administrative law matters, has an entirely different role and purpose to that of an investigative BOI. The role and purpose of the court process in a civil context is *inter alia* aimed at finding guilt, liability or fault, imposing sanctions, awarding costs, enforcing rights and permitting appeals; and

The conduct of a military BOI has no bearing upon COMCARE's rights to make independent investigations and findings. COMCARE can pursue action against Commonwealth authorities under the terms of the *Occupational Health and Safety (Commonwealth Employees) Act 1991*. In the case of the HMAS WESTRALIA fire, COMCARE did indeed conduct an independent review, and placed Improvement Notices upon the Department of Defence.

Fairness and Partiality

Mr Mahony's "general discussion on fairness and partiality" (pages 36–37) is in places contradictory. The following points should be noted:

The Western Australian Coroner has largely upheld Navy's BOI procedures. COMCARE had also reviewed the facts leading to the fire in WESTRALIA, as well as the adequacy of Navy's responses to BOI recommendations. Their reports support the findings of the BOI.

Mr Mahony alleges that BOI ought to be fair and impartial. He makes numerous statements that this BOI was unfair and partial, yet he states at para 128 that " nobody has levelled complaints against the Board to my knowledge".

Mr Mahony alleges that COMCARE was not represented to ask questions in public and receive answers in public (para 100, page 33) yet, he has conceded that COMCARE did in fact "send a list of questions to the Navy which were answered" (para 119, page 35). Furthermore, COMCARE has conducted its own review of Navy's response to the fire. He further concedes that COMCARE was present at the hearing (para 131, page 36).

He further alleges that COMCARE did not play a sufficiently aggressive role in examining Navy. An important legal distinction is that COMCARE was an interested Party but not a relevant Party for the purposes of the BOI. It was permitted to have a presence at the BOI, to submit a list of questions that were duly answered, and was permitted access to most of the documents and transcripts arising from the BOI.

COMCARE's continuing scrutiny of Navy's safety management and technical regulatory systems and post-fire actions also is at odds with Mr Mahony's claims. COMCARE has reviewed the Coroner's findings and as of June 2004, is now conducting an audit of Navy's processes against two COMCARE Improvement Notices.

Mr Mahony's criticisms of Captain Callaghan and Air Commodore Kirkham in their cross-examination of relevant witnesses are totally without foundation. The cross-examinations by Captain Callaghan and Air Commodore Kirkham were not improper. It was the sort of robust cross-examination expected and demanded of Senior Counsel of the calibre and standing of these men regarding very important issues.

Any allegation Mr Mahony makes regarding the BOI being unfair or biased can also be answered with reference to the following procedural and probity matters:

Witnesses were given statements of their rights and obligations; (Refer to Captain Callaghan's opening address para 81, pages 30-31);

Interested Parties were given the opportunity to be legally represented and did in fact take up that opportunity;

The BOI President, Commodore Lamacraft said, *"during the hearing it became apparent that the Board might make findings adverse to certain persons. Where possible, the substance of that matter involved was put to that person during questioning, or in counsel assistings' final address. This allowed the person to respond. Where, during its deliberations the Board found that they might make an adverse finding which a person may not previously have been given an adequate opportunity to address, that person was given written notice of that possible finding and given the opportunity to make further submissions."* (para 43, page 18). This statement runs counter to Mr Mahony's allegation that witnesses were not treated fairly.

In relation to Mr Mahony's allegation that the BOI was partial (para 4, page 11) to the interests of their sponsor on important issues, it is significant that none of the lawyers representing the interested Parties made an application that there was a "reasonable apprehension of bias" upon of the Board members.

Mr Mahony also does not make valid comparitive judgements by trying to draw parallels or quoting from the 'Longford Royal Commission', which was conducted under an entirely different process and dealt with different issues.

Engineering Expertise Issues

As to Mr Mahony's assertion that somebody with an engineering background should have been a member of the BOI, (para 40, page 17) the following facts should be noted:

The President of the BOI, Commodore Lamacraft was an accomplished, respected and fully qualified Naval Engineer and project manager, with considerable experience in engineering, technical integrity and assurance matters. His operational engineering and project engineering knowledge and experience included engineering quality assurance issues, Mr Mahoney's area of sub-specialisation.

The remaining BOI members were highly qualified and senior officers or civilian personnel, eminently capable of conducting a fair BOI competently, namely, Captain Filor, a leading civilian Marine Accident Investigator, as well as Assistant Chief Officer Cuneo, an extraordinarily experienced civilian Fire Fighter. These civilian board members were assertive in pursuit of issues within their specialist expertise.

It is not uncommon in the civilian court process for Judges who do not possess a technical background to hear and make determinations on cases of a highly technical nature. They are required to assess information and make judgements across a broad range of disciplines affecting a given case, informed by subject matter expert testimony as required.

Quality Assurance

Mr Mahony has in his submission overlooked the fact that of the 114 recommendations made by the BOI, six dealt specifically with QA (recommendations 108-113), all of which Navy has now completed. Many more issues related to QA and engineering integrity issues have been addressed by actions that have flowed from the initial Board recommendations, as well as from Navy's continuous improvement programs.

Mr Mahony's hierarchy of QA policy at the time of the fire (para 158, pages 42-43) is flawed. For example, he incorrectly places the priority of Financial Regulations 42 and 45 before the *Financial Management and Accountability Act, 1997* and the *Occupational Health and Safety (Commonwealth Employment) Act 1991*. His submission does not highlight the more mature system of safety and technical regulation, certification, assurance, test and trials and audit now in place in Defence and Navy.

In 2000, Navy established a new agency, headed by the Director General Navy Certification, Safety and Acceptance (DGNCSA), in recognition of the systemic deficiencies that led to the WESTRALIA fire. He is responsible to Chief of Navy for establishing and managing the Navy's safety management systems, whole of Navy regulation, certification systems in support of regulation, independent acceptance and operational release systems for new capabilities entering service.

The regulatory and certification systems are based upon requirements for competent authorities to provide assurances of the integrity and safety of platforms, systems, personnel and support systems against defined standards. These systems also provide for trials and audit-based approaches to verifying the effectiveness of regulatory and certification processes.

The whole of Navy functions of DGNCSA are most important in light of the many reorganisations that have occurred within Defence, in particular those affecting the Defence Material Organisation (DMO). These changes mean that many Systems Program Offices and Logistics Support organisations that provide direct technical design and maintenance support to Navy, exist outside Navy within DMO. DGNCSA specifies the overall regulatory requirements that must be met by DMO and their supporting contractors, and performs and manages compliance assessment and audit functions. Ship classification societies, such as Lloyds Register, Det Norske Veritas, Germanischer Lloyd, Bureasu Veritas and American Bureau of Shipping, are engaged to provide certification, assurance, risk assessment, design verification and inspection support. These societies assist in providing DGNCSA and Navy with required assurances of safety and integrity.

The Chief Naval Engineer is in turn responsible to DGNCSA for provision of a more robust technical regulatory system that goes beyond technical QA. He has improved technical regulatory processes, instituted authorised engineering organisations and accreditation systems, a new set of DEFAUST standards, and instituted a risk-based approach that drives the levels of assurances required to ensure the integrity of engineering work and products. The Chief Naval Engineer is working with ship classification societies to improve the rule sets against which Navy ships are designed and supported, and against which technical quality assurance is performed.

Again, the current technical regulatory regime requires competent and qualified authorities, preferably within approved engineering organisations and certification authorities, to provide evidence of compliance and assurances of work completion, work quality, technical integrity and safety, against defined standards, cognisant of risk.

Defence and Navy do not take the view that a certified quality management system (QMS) guarantees quality of product. Whilst contractors supporting DMO and Navy are required to be quality accredited, and contracts have been strengthened to ensure duty of care obligations are met, Navy recognises that layers of assurance beyond quality assurance are required. Navy therefore conducts material inspections, safety inspections, certification audits, configuration audits, tests, trials, light-off examinations, operational inspections and technical administration checks. Engineer Competence Certification and Charge Qualification Boards include interviews and assessments of knowledge of these safety and assurance aspects.

These improvements have been independently assessed by COMCARE, as noted in evidence to the WA Coroner. Further scrutiny of RAN progress and processes by COMCARE is now occurring. This is not to say that QA is not applicable to the RAN, rather, that it forms part of a broader regulatory framework.

Defence Efficiency Review and Staff Levels for QA

Mr Mahony (para 3.h. page 10, and paras 363-376, pages 87-89) criticises technical and QA staffing levels and workloads, but at para 375 states *"I can not say whether workload or job design were contributing factors"*. Navy has implemented the BOI Recommendations regarding Quality Assurance. As described above, there have been many reorganisations within Navy and DMO since the Defence Efficiency review, which have changed the organisational boundaries, functions and responsibilities of organisations and individuals involved in the performance of technical work and assurance of its integrity. New organisations such as DGNCSA and increased support from ship classification societies, have changed the resources applied to all assurance and integrity processes, not just QA.

Any implied suggestion that Navy used the Defence Efficiency Review to deny proper engineering oversight and QA resources is not agreed. Navy agrees that there should have been adequate engineering oversight of work done in WESTRALIA, and had reasonable expectations that ADI and its subcontractors should have applied such engineering and QA expertise in performing that work. Navy also acknowledged systemic failures and process deficiencies that led to in-house engineering checks not being performed. These failures were not due to resourcing decisions.

That said, in the post-WESTRALIA fire Navy, there is a broad understanding that the human factors and organisational factors contributing to any safety incident must be investigated. Those factors may include the job design, workload and organisational process issues raised by Mr Mahony. DGNCSA has opened up extensive dialogue with COMCARE, the Australian Transportation Safety Board, Australian Maritime Safety Authority, ship classification societies and safety experts to improve Navy's knowledge of these issues. Future involvement by COMCARE and external experts in future safety-related BOIs is agreed.

Conclusions

Whilst Mr Mahony's contribution to the Senate Inquiry is recognised as being detailed and coupled with a high degree of effort, it is nonetheless, Navy's view that all the significant issues raised have already been addressed, with extensive and ongoing scrutiny of Navy's actions by external authorities. Many more issues related to Quality Assurance have been addressed by actions that have flowed from the initial Board recommendations and from Navy's improvement initiatives.

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28 June 2004