Chapter 5

Investigations into notifiable incidents

Commissions of Inquiry

5.1 In its 2005 report on Australia's military justice system, the committee raised concerns about administrative inquiries into grave and complex matters such as sudden death or serious accidents. It could not stress strongly enough the importance of having investigating authorities 'above any suspicion of partiality'. It recommended that all notifiable incidents including suicide, accidental death or serious injury be referred to its proposed Australian Defence Force Administrative Review Board (ADFARB) for investigation or inquiry. Although the government agreed that there was a need to demonstrate that ADF inquiries into serious incidents were independent and impartial, it rejected the recommendation to establish such a board. Instead, it undertook to establish a Defence Force Commission of Inquiry to meet the objectives of independence and impartiality.[1]

5.2 In keeping with this principle, the government indicated that it would propose amendments to legislation to create the commission. Under the proposal, the CDF would appoint a mandatory commission of inquiry into suicide by ADF members and deaths in service. The commission would consist of one or more persons, with one being a civilian with judicial experience. Where the commission was to consist of more than one person, the civilian with judicial experience would be the president. This form of inquiry would be in addition to the existing arrangements for appointing investigating officers and boards of inquiry.

5.3 On 14 September 2006, the government introduced into parliament the Defence Legislation Amendment Bill that would allow the Governor-General to make regulations in relation to the appointment, procedures and powers of CDF commissions of inquiry. This reference to a CDF commission of inquiry would enable such a commission to be established under the Defence (Inquiry) Regulations 1985. The bill received assent on 11 December 2006.

5.4 The CDF informed the committee that a panel of suitably qualified civilians has been identified and was now available to preside over a CDF commission of inquiry. He explained further:

> The panel consists of six persons and is expected to increase this year. To date, three boards of inquiry have been conducted under interim arrangements with a civilian president from this panel. Other members of a CDF commission of inquiry may be either civilian or military and are

1 Government response to recommendation 34.

> selected on the basis of their expertise relative to the nature of the incident under inquiry.[2]

The role of state coroners

5.5 Both the references committee's 2005 report on Australia's military justice system and the legislation committee's progress report on reforms to the military justice system, referred to the role of the coroner in cases of a sudden death of an ADF member.[3] The government's response to the 2005 report and Defence's first status report stated that State and Territory coroners would continue to review the outcomes of ADF inquiries into deaths of personnel. Furthermore, they indicated that the ADF would work towards completing a Memorandum of Understanding with State and Territory coroners. [4]

5.6 During the committee's 2006 public hearing, Rear Admiral Bonser, leader of the Military Justice Implementation Team, explained that work had been done on a memorandum of understanding with state coroners in the past. He noted, however, that:

> …there was not a unanimous view from all of the state and territory coroners on where that might go, so it could not be finalised. I think there were some concerns that something as formal as it was becoming might have created some perceptions that were perhaps detrimental to their statutorily legislated obligations and responsibilities. We have taken that on board and we are working very closely now with the various jurisdictions for an exchange of letters to establish protocols between the ADF and the state and territory coroners. In the first instance…we are establishing that, working closely with the Victorian coroner and looking at adopting that across all of the jurisdictions once the coroners are happy with the process we have in place.[5]
>
> We would expect to have this finalised around the end of this calendar year. It is really not an issue of agreeing relevant points. It is simply the nature of the protocol we are putting in place. Rather than a more formal memorandum of understanding, there will be letters that set out the protocols that we will use between the ADF and each of the relevant state and territory jurisdictions.[6]

5.7 In its second status report, dated October 2006, Defence informed the committee that it was pursuing the adoption of 'protocols' with all State and Territory

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2 *Committee Hansard*, 26 February 2007, p. 10.

3 Senate Foreign Affairs, Defence and Trade References Committee, *Effectiveness of Australia's military justice system,* June 2005, p. 188–189; and *Reforms to Australia's military justice system: First progress report, August 2006,* paragraph 4.43.

4 Government response to recommendation 34.

5 *Committee Hansard*, 19 June 2006, pp. 26–27.

6 *Committee Hansard*, 19 June 2006, p. 27.

Coroners and that two jurisdictions—Tasmania and Victoria—had signed letters agreeing to the protocols. At the recent February public hearing, the CDF further indicated that South Australia had agreed to establish liaison arrangements.[7]

5.8 The committee has sought additional information on the powers of a coroner to investigate the sudden death of an ADF member and placed a number of questions on notice on this matter (see appendix 4).

Committee view

5.9 The committee notes that it will continue to monitor developments in, and reforms to, Defence administrative inquiries and in particular how they interact with State coroners.

The independence and impartiality of an investigator

5.10 During its inquiry into Australia's military justice system, the references committee identified the potential for conflicts of interest to taint the objectivity of an investigation into sudden deaths. Witnesses to that inquiry saw a need to have independent investigators.[8]

5.11 During the public hearing on 26 February 2007, the committee raised the matter of the independence and impartiality of an investigating officer involved in the inquiry into the death of Trooper Angus Lawrence. Trooper Angus Lawrence died from acute heat stroke while attending a Subject One Course for Corporal. In this case, the coroner noted ADF's responsibility to keep their members safe:

> I acknowledge that soldiers must train in all climatic conditions and be placed under pressure to assess their performance, but I cannot understand why they should be put in life threatening situations during training, particularly when the evidence of experienced soldiers at the Inquest suggested that the defensive scenario practiced on subject one for corporal courses was 'archaic' and not in keeping with current operations being conducted by defence personnel…I remain concerned about the merit of the decision. However, I do not have to and do not make a conclusive finding on the merit or otherwise of the decision, that is a matter for others.[9]

5.12 He did, however, have reservations about an aspect of two comprehensive reports which highlighted a number of shortcomings and systemic failures—a Comcare report and an investigating officer's report by Colonel Michael Charles.[10]

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7 *Committee Hansard*, 26 February 2007, p. 10.

8 Senate Foreign Affairs, Defence and Trade References Committee, *The Effectiveness of Australia's military justice system*, paragraph 9.15.

9 *Inquest into the death of Angus Lawrence [2005] NTMC 069,* paragraph 16.

10 *Inquest into the death of Angus Lawrence [2005] NTMC 069,* paragraph 34.

The coroner was not convinced that systemic weaknesses were the only factors contributing to the death of Trooper Lawrence:

> My only concern about the reports is that both investigators conclude that systemic failures caused or contributed to the death. As I indicated at the Inquest, systems are made up of people who are required to make decisions that can affect others. In particular in the Defence Force, which is a disciplined hierarchical force, those holding senior appointments do make decisions that affect those who are subordinate (in rank) to them.[11]

5.13 The coroner recommended that:

> …the Chief of Army review (once again) the position of some of those responsible for allowing the exercise to occur during which the deceased became ill. I accept the evidence of WO2 Wallace that he specifically warned higher command that exercises at the place, and at the time of year, during which the deceased became ill would lead to death. This warning was echoed to a significant extent by WO1 Lucas. I note that WO2 Wallace gave oral evidence about this warning at the Inquest, as well as in his statement which had been made quite some time before the Inquest. Nothing I heard or read suggests that this explicit warning was not given. I remain unsure that this warning was taken seriously enough or that the response was appropriate enough in the circumstances.[12]

5.14 According to evidence taken at the committee's public hearing on 26 February, as a result of the coroner's statement, the Chief of Army asked Colonel Mike Charles, who was the initial investigating officer, to inquire into the circumstances of the statements made by Warrant Officer Wallace.

5.15 This request goes to the heart of the matter of an investigator's independence. The coroner had already questioned the findings of Colonel Charles that only systemic failures caused or contributed to the death. Yet he was the very officer to review his initial findings.

5.16 The Chief of Army did not agree that this was a case of 'Caesar reviewing Caesar'. He said:

> In the Charles' statement, Warrant Officer Class 2 Wallace was not interviewed by this inquiry officer in either of the two previous defence inquiries, as he had not been identified as a person of interest or anyone who had a direct involvement in the circumstances of Trooper Lawrence's death. So he is not reviewing his own work; he is actually interviewing him for the first time.[13]

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11 *Inquest into the death of Angus Lawrence [2005] NTMC 069*, paragraph 35.

12 *Inquest into the death of Angus Lawrence [2005] NTMC 069,* paragraph 40.

13 *Committee Hansard*, 26 February 2007, p. 25.

5.17 The committee has no reason to doubt that Colonel Charles is a capable and experienced investigating officer. To ensure the independence and impartiality of the investigation, the committee argues strenuously that Colonel Charles should not have been asked to review his own investigations. Notwithstanding the fact that WO2 Wallace had not been interviewed previously, the further inquiries clearly relate to the initial investigation. The committee takes this opportunity to repeat the findings contained in the 2005 report into Australia's military justice system:

> One of the most persistent concerns raised by witnesses involved conflicts of interest and the perceived unfairness of the investigation process. Any perception that an ADF inquiry lacks objectivity and impartiality undermines the integrity of the whole military justice system.[14]

5.18 In the committee's view, the ADF must address this problem of perceived bias undermining the integrity of the administrative inquiry process and do more to eliminate this perception.[15]

5.19 The committee's concern about the independence of an investigator, however, is not the only one in the case of inquiries into Trooper Lawrence's death. The committee has serious misgivings about a number of aspects of the investigations into this death. They relate not only to the independence of the investigator reviewing his own investigations, but to the work done by Army in preparing a report for the coroner, Army's response to the coroner's findings and the manner in which, after its third review, Army informed the coroner of 'new evidence'.

5.20 The committee intends to pursue this matter further. It will be seeking additional information from the Army and will report in greater detail on its findings.

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14 Senate Foreign Affairs, Defence and Trade References Committee, *The effectiveness of Australia's military justice system,* June 2005, paragraphs 8.55 and 8.75.

15 Senate Foreign Affairs, Defence and Trade References Committee, *The effectiveness of Australia's military justice system,* June 2005, paragraphs 8.55 and 8.75.