Chapter 9

Administrative inquiries into sudden death

9.1 The procedures for inquiries into serious accidents or sudden deaths in the ADF are no different from inquiries undertaken by an investigating officer considered in the previous chapter. The complexities often involved in such cases and the close involvement of family members and friends, however, present specific challenges for the investigator. This chapter looks at investigations undertaken by investigating officers into accidents and sudden deaths to assess their effectiveness, fairness and whether they meet the needs and respect the rights of all those involved in such investigations.

Communication and provision of information—next of kin

9.2 The report has identified as a major flaw the failure by investigators to keep complainants and those subject to a complaint or allegation adequately informed about the proceedings. The relatives of ADF members who had died suddenly also raised concerns about the difficulties they had in gaining access to information about the matters surrounding the death. Mrs Campbell, whose daughter was under the impression she was to be discharged from the Air Cadets and subsequently took her own life, had to go through the FOI process to obtain material to help her understand the circumstances of her daughter's discharge. She stated:

> I was never at any time given any access to information at a local level without my having to drag it out of them.[1]

9.3 Mrs Palmer, the mother of a soldier who had committed suicide, stated she was naïve in waiting for the report on her son's death. She told the committee she did not realise that she 'had to go chasing it'. She added:

> I went and found things myself. There was nothing forthcoming. I had to write to ministers and do a ministerial and all that sort of thing to get anywhere…I only got one page of an autopsy which just said 'healthy male'. I never got a full report. [2]

9.4 Another parent of a son who had committed suicide confided that, 'If they were not so secretive and silent then maybe we could stop wondering. As it is now we cannot move on with our lives'.[3] This family had many more questions that they believed could be answered by officers and supervisors. Another father, attempting to clear his son's name, maintained that:

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1 *Committee Hansard*, 21 April 2004, pp. 4–6.

2 *Committee Hansard*, 1 March 2004, p. 84.

3 Confidential *Submission C12*, p. 3. Confidential *Submission C16* makes a similar point.

> Never did RAAF contact me with information. All that is now known was initiated by me and on every occasion. RAAF has been evasive and supplied information only under FOI, and many applications were totally refused.[4]

9.5 Furthermore, some family members of suicide victims felt that they were not sufficiently involved in the investigation. Mr Satatas suggested that it should be 'automatic for the Army to have asked our family whether we wanted an Inquiry into John's death'. He also wanted to be fully informed about all aspects of the inquiry including the reasons for the inquiry and its progress. He asserted that, 'The Army did not tell us that an Inquiry would be held and they did not tell us the reason for making the decision to hold an Inquiry.'[5] He argued further:

> For the Inquiry to have any meaning it would have had to be full and comprehensive and certainly should have included consultation with and consideration of matters raised by family members and the circumstances of John's death. We believe that the Army ignored some of our suggestions in regards as to who should be interviewed. We have not been asked our views about what the Inquiry was to include. [6]

9.6 A social worker with the Department of Defence told the committee in camera that 'there is too big a gap between what an organisation thinks it has offered and what the families actually experience'. She said, 'the big problem with resolving traumatic death of any sort is that people need information, and they need that information to be given to them in a timely way and in a credible way…'[7]

9.7 In part, the problem may stem from unrealistic expectations of the purpose of an administrative inquiry. Colonel John Harvey, Special Adviser to the Director General The Defence Legal Service, recommended that the ADF change its policy to ensure that the primary purpose of any inquiry in Australia under the Defence (Inquiry) Regulations is to establish what action needs to be taken to avoid a recurrence of an incident.[8]

9.8 That said, the committee believes that the system at present is not meeting the needs of the close relatives of members who have been seriously injured or have died suddenly while serving in the ADF. It needs to be better attuned to the situation of family members and accept that the interests of the forces do not necessarily coincide with those of family and friends of injured or deceased members. It should take account of their needs.

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4 In camera *Committee Hansard*, 10 June 2004, p. 2.

5 *Submission P9A*, p. 3.

6 *Submission P9A*, p. 2.

7 In camera *Committee Hansard*, 9 June 2004, pp. 4, 7.

8 *Submission P64*, p. 5.

9.9 The provision of information, however, is only one aspect of ensuring that people are kept well-informed about an inquiry. Some people may need assistance to comprehend the material made available to them. Mr Satatas told the committee.

> The Army did not offer us any assistance, such as a lawyer, counsellor or translation help after John's death, or relating to the inquiry. Most public services would provide these as a matter of course and in any event should have been available in relation to any inquiry into the death of our son John given the circumstances of his death.
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> We have been given no information in regards to the finalising of the inquiry.[9]

9.10 The Burchett Report, which identified problems similar to those discussed here, made a number of recommendations. It suggested that the complainant ought to have the benefit of an explanation by a trained expert so as to minimise distress which may be caused by the decision.[10] The committee endorses this recommendation.

9.11 Lieutenant General Leahy told the committee about procedures now followed for the sudden death of a member:

> For many years, Army has had suitable protocols for dealing with the death of its members on operations. However, there was no such single set of protocols dealing with the death of Army personnel who were not on operations. Accordingly, on 19 November last year, I authorised a set of protocols to be followed where members of the Army had either tragically taken their own lives or been killed accidentally while on duty in Australia. There are a number of key tenets: prompt reporting, recording of all decisions, ensuring that relevant agencies are notified, close monitoring of all actions, working directly with bereaved families throughout the process and the continued involvement of the chain of command.[11]

9.12 The committee understands the frustration and sense of alienation that some people may experience when, in their view, they are kept in the dark about the process of an inquiry or are not provided with assistance to help them make sense of the information that is provided. Without doubt, the evidence shows that many people are disappointed and disturbed by this failure to be kept adequately informed and consulted about the proceedings of an administrative inquiry.

9.13 The committee notes that the Defence Inquiries Manual gives particular attention to the ADF's responsibility to the next of kin of members who 'are killed or injured in duty-related accidents particularly in peacetime'. It states:

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9 *Submission P9A*, p. 2.

10 Report into Military Justice in the Australian Defence Force, conducted by Mr J.C.S.Burchett, QC, An Investigating Officer appointed by the Chief of the Defence Force, under the Defence (Inquiry) Regulations 1985, p. 105.

11 *Committee Hansard*, 1 March 2004, pp. 32–3.

> The families of deceased members should be treated with sensitivity and understanding. Where practicable and consistent with security considerations, provision is to be made for the next of kin to attend Boards of Inquiry whether the Boards are open or closed; and a liaison officer is to be appointed to assist them during the period of the inquiry. Next of kin are to be offered counselling services, that are relevant to the accident or incident and to the inquiry itself, if required, at Commonwealth expense.
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> Consistent with security and privacy considerations, next of kin should be advised of the outcomes of Boards of Inquiry and informed of steps taken to implement recommendations. In addition, they are to be warned prior to the release of information to the media regarding the inquiry.[12]

9.14 This advice is given in the context of Boards of Inquiry. The committee suggests that similar advice be included in the section that deals with Investigating Officers Inquiries and would also apply to sudden deaths by suicide of ADF members.

Conflict of interest—the individual and the institution

9.15 The previous chapter identified conflicts of interest inherent in the chain of command structure where command influence is seen to taint the objectivity of an administrative inquiry. This criticism applies equally to investigations into sudden deaths where witnesses saw a need to have an independent investigator.

9.16 The members of Jeremy Williams' family shared this observation with regard to investigations into suicide. They argued strongly for the need to have an independent person outside the ADF participate in inquiries.[13] They submitted:

> If it is common practice within the ADF and it certainly seems to be from our experiences of late and our time in the military, that investigations of a controversial nature, where loss of life has occurred, are conducted by high ranking and/or senior officers. This means that often lower ranked members must give their evidence in an environment that is uncomfortable and does not necessarily encourage the submission of evidence without fear or favour. This is particularly true if the perception is held that the evidence being given is of an adverse nature and could reflect badly on the peers or seniors. The need for impartiality for any such investigation is immediately put into question where senior officers are in most cases investigating similarly ranked officers. The integrity and willingness of an investigating officer to find adversely without fear or favour against his or her peers, superiors and even subordinates is open to suspicion and questions.[14]

9.17 Apart from undue influences arising out of the chain of command structure, the Defence Force as an institution may confront a clash of interests on a broader and

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12 Australian Defence Force, Administrative Series, *Administrative Inquiries Manual,* Australian Defence Force Publication 2002 (ADFP 202), paras 1.45–1.46.

13 *Submission P17*, p. 4.

14 *Submission P17*, p. 9.

more subtle front. The very nature and make-up of the ADF and the way of life of its members makes it difficult for members committed to the forces to admit to failings within their own ranks. Understandably, those who hold strong ties of loyalty to an institution would be reluctant to lay bare its flaws.

9.18 Under such circumstances, the rights of an individual to a fair and proper process may be compromised by the desire of those in the ADF to protect the institution. One example, recognised by Lieutenant General Leahy as a problem, occurred with the investigation into allegations about the mistreatment of the bodies of two individuals in East Timor. In this highly publicised case, discussed above in chapter 3, it seems that the Army wanted to appear to be acting decisively but at an unnecessary cost to the alleged offender. Lieutenant General Leahy acknowledged that there were problems with proceeding with administrative action after failing to obtain a conviction.[15] He told the committee:

> The administrative action taken against the solider, on reflection, might have been best not taken. I have directed action to rectify defects which this case revealed in Army procedures and practices. I am also pleased to report to the committee that the soldier is assisting the Army to take remedial action to ensure that a situation like this does not happen again. The recent establishment of a Director of Military Prosecutions is a further positive development.[16]

9.19 In many cases cited by witnesses, however, it would seem that the ADF sought to minimise any harm to its image by withholding information or by deflecting attention away from critical evidence. Generally, this perception arose in cases that were likely to draw significant public attention.

9.20 The mother of a son killed in an accident was highly critical of the 'in-house' nature of investigations with their narrow and biased focus. She described her experiences of the investigation:

> Often it seemed to us that too much time was spent trying to find ways to blame the accident on the crew and too little on the systemic problems that led to it, thus affording protection to those within squadron hierarchy and abandonment to those killed. We had no wish to see any one person held responsible, but felt strongly that, unless roles and procedures were closely scrutinised and improved where necessary, similar circumstances would recur in the future and more lives would be lost.
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> Without transparency and the involvement of external parties, questions and suspicions will always remain close to the surface. Within a closed environment, too easily incompetence and errors can be hidden and faulty systems covered, making any hope of a clear overview unlikely, change unnecessary and military justice impossible.[17]

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15 *Committee Hansard*, 1 March 2004, pp. 29–30.

16 *Committee Hansard,* 1 March 2004, pp. 29–30. See also *Submission P61*, p. 4.

17 Janice McNess, *Committee Hansard*, 28 April 2004, pp. 62–4.

9.21 She was not alone in expressing her doubts about the impartiality of investigations. Mrs Palmer, whose son committed suicide in late November 1999, believes that the ADF is not genuine in its endeavours to stamp out discrimination and bullying. She asserted that, if the ADF were serious, it 'should have no problem with every case of mistreatment, discrimination and death being thoroughly investigated by an independent body to be made accountable to the public, as would any other employer'. In her words:

> The Defence Force is no longer capable of investigating in-house and can no longer hide from its obligations to its members, members' families and the Australian public.[18]

9.22 The committee believes that the establishment of an independent statutory investigatory body as recommended in Chapter 11, which would now take responsibility for an investigation involving a sudden death or serious incident, will go a long way to address this problem of lack of independence in the investigation. (see recommendation 29, para. 11.67)

Competence of inquiries into sudden or accidental deaths and the need for experts

9.23 The criticism directed at the poor standard of administrative investigations discussed in the previous chapter applies with equal force to the inquiries into sudden death. A number of witnesses asked for improvement in the conduct of investigations into sudden or accidental deaths. They felt that the respective investigations were incomplete: that evidence was overlooked and important questions not asked.[19] These types of inquiries, however, often have additional layers of complexity that place extra demands on the inquiry process.

9.24 The immediate stage involving activities such as securing and examining the scene of the incident was one area of concern in the investigation of a sudden death. A number of relatives of members who had committed suicide were critical of the initial examination, with many believing that it was flawed. This type of examination, reliant on specialist investigative skills, is rightly the province of the civil police in the first instance to determine whether any criminal act is involved.

9.25 The actual investigation undertaken by an investigating officer also attracted criticism. Mrs Palmer told the committee that she would have liked the investigation to be more thorough than it was 'just in case there was anything'.[20]

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18 *Committee Hansard*, 1 March 2004, pp. 72–3.

19 For example see Mrs Palmer, *Committee Hansard*, 1 March 2004, p. 75, who felt that there was 'not much of a military investigation with evidence discarded'. Mrs McNess, *Committee Hansard*, 28 April 2004, pp. 62–4.

20 Mrs Palmer, *Committee Hansard*, 1 March 2004, p. 91.

9.26 The Williams family took the same approach. Even though a Brigadier carried out the investigation into Jeremy's death, the family noted that, to their knowledge, this man 'had no training in investigative procedures, interface with the judiciary or making valid and soundly based investigative judgements' other than his officer training. In their view, the people who conduct investigations in the military are 'not trained to a high enough standard, they have no interface with the judiciary, their methods are unsafe and their conclusions are unsafe and unsound'.[21] They go on to state:

> Given the complexity of the factors involved in an investigation, and the importance of having a person qualified to weigh and balance evidence, and reach sound conclusions, it is necessary that this person have the necessary qualifications to carry it through. We are very concerned about the high risk of unsound conclusions being reached, if Investigating Officers with no legal qualification or without training in how to conduct complex, quasi-judicial investigations can be appointed. This can only be achieved with an independent body suitably trained and qualified.[22]

9.27 Questions were also raised about the need for expertise in those conducting an inquiry into a sudden death. Mr Peter Gerrey, who was employed by Comcare from 1995 to 2000 as an Occupational Health and Safety Officer and a workplace investigator and had conducted workplace inspections in military establishments, argued that:

> 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.[23]

9.28 A number of witnesses, including Mr Gerrey, called for independent experts to be involved in investigations of sudden deaths and accidents. Mr Gerrey asserted:

> 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.[24]

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21 *Committee Hansard*, 28 April 2004, p. 58.

22 *Submission P17*, p. 8.

23 *Submission P7*, p. 5. In full, he told the committee that between 1991 and 2000 he: '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 New South Wales 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 injury or a fatality at an ADF workplace. A Comcare investigator would then review these inquiries and/or investigations'. *Submission 7,* p. 3.

24 *Submission P7*, p. 2.

The role of the coroner

9.29 The degree of complexity involved in an investigation into a sudden death will test the training and experience of an investigating officer. His or her ability will be particularly stretched when dealing with matters such as suicide or accident where expert knowledge may be needed. This raises the question of the role of the coroner in the investigation of sudden deaths. The Inquiry Manual advises:

> In serious incidents involving loss of life there is a need to involve civilian police and the relevant State or Territory coroner from the outset. To facilitate the involvement of the coroner, an ADF liaison officer is to be appointed to assist the coroner. Consideration will need to be given to the impact of the incident on relatives and friends, including ADF members, before an inquiry is actually commenced. However, this does not prevent the announcement of an inquiry promptly after an incident occurs.[25]

9.30 A number of witnesses felt that the State coroner should be automatically involved. Mrs McNess, whose son died in an aircraft accident, was distressed by the decision of the coroner not to conduct an inquest despite the request by both families that one be held. She explained:

> His explanation that any accident that had cost the Air Force so dearly in loss of life and equipment would have attracted a comprehensive investigation and thus negated his need for further examination was unconvincing, especially in light of the Defence Force's well documented history of in-house and closed investigations.[26]

9.31 Speaking more generally, Mr Neil James, Australia Defence Association, suggested:

> We believe that if state coroners were involved as a matter of course then we perhaps would not have some of the angst that has been exhibited by some of the families about some of the circumstances. Also, to an extent, some of the full range of things that contributed to some of the suicides might come out.[27]

9.32 Colonel John Harvey explained that:

> Where an incident in Australia results in death, an inquiry by the ADF does not replace or in any way usurp the role or responsibility of the State or Territory Coroner to conduct an investigation or coronial inquest. The fact that a coroner will often accept the proceedings of a board of inquiry and

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25 Australian Defence Force Publication, Administrative Series, *Administrative Inquiries Manual,* para. 1.15.

26 *Committee Hansard,* 28 April 2004, pp. 62–4.

27 Mr Neil James, *Committee Hansard*, 9 June 2004, p. 31.

> decide not to conduct a further inquest is an indication of the quality of some boards of inquiry.[28]

9.33 He recommended that the ADF change policy to ensure the wide promulgation of the fact that State and Territory Coroners retain the primary responsibility to investigate deaths in Australia.[29] The committee agrees with this recommendation.

9.34 Lieutenant General Leahy explained that some years ago the Army, at times, would be happy for the coroner to report on a suicide and that Army would not investigate it.[30] He indicated that that was not good enough and Army now wanted to go beyond the coroner's process and have a suicide investigated 'through a board of inquiry with terms of reference'.[31] He added:

> What we want to do now is try to determine the reasons behind the suicide. We want to try to figure out whether there are other things that we could be doing, whether there is something in the environment or something that we are doing wrong.[32]

Committee view

9.35 The committee notes this development but is of the view that the ADF does not possess the skills, expertise or degree of independence necessary to inquire effectively and properly into deaths and serious accidents within the Services. It has recommended the establishment of an independent body that will have the responsibility for inquiring into sudden deaths and serious accidents. If, after the initial investigation by the civilian authorities and, if no criminal act is suspected, the ADFARB would take responsibility for the investigation. This means that all notifiable incidents including suicide, accidental death or serious injury would be referred to the proposed Australian Defence Force Administrative Review Board for investigation. The CDF would have the authority to appoint a service member or members to assist any ADFARB investigator or AAT inquiry. (see recommendation 29. para 11. 67). In conferring this responsibility on the ADFARB, the committee in no way suggests that State and Territory coroners would not retain the primary responsibility to investigate deaths in the ADF.

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28 *Submission P64*.

29 *Submission P64*, p. 5.

30 *Committee Hansard*, 5 August 2004, p. 18.

31 *Committee Hansard*, 5 August 2004, pp. 18 and 74.

32 *Committee Hansard*, 5 August 2004, p. 18.

Procedures following investigation

9.36 A number of witnesses noted the failure by the ADF to act in accordance with the recommendations contained in an administrative report.[33] Mr Amos asserted that the SOI had failed to implement the recommendations contained in the report concerning the ill treatment of his son, and that Training Command did not follow-up to ensure compliance with those recommendations. He was of the view that, had those in command at SOI acted as required and implemented the recommendations contained in his son's report, there was a good possibility that Jeremy Williams' suicide could have been prevented.[34] He concluded:

> The allegations made about injured soldier treatment and allegations of verbal abuse arising from this tragedy were almost identical to those we had raised in our ministerial about 2 years earlier and had been assured no longer existed.[35]

9.37 Lieutenant General Leahy acknowledged the mistakes made in failing to ensure that the recommendations from the previous incident had not been fully implemented. He told the committee:

> …our investigation revealed that there had been a failure to act on recommendations from a similar incident—not involving a suicide—at the School of Infantry some years before…It became patently apparent that the Army needed to take action to tighten up and formalise mechanisms for tracking and ensuring that recommendations are acted on and followed[36]

9.38 The committee accepts that the death of Jeremy Williams exposed an urgent need for ADF to have in place an effective means to monitor the outcomes of investigations and any required corrective action. This observation leads to the following discussion on the important role that inquiries have in ensuring that inappropriate behaviour and improper conduct are not only identified but that appropriate action is taken to remedy them.

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33 Confidential *Submission C1*, Attachment—Chronological Order of events, pp. 10 and 13 and Confidential *Submission C61*.

34 *Submission P6*, p. 2. He stated: 'Senior staff at SOI assured us that they had fixed the problem they even went as far as to invite me down to inspect the changes they had made…this was backed up by the investigation report covering letter that claimed that the reports recommendations had been implemented. We accepted their word in the firm belief that Orders and Instructions contained in reports are to be acted upon… however it has since been admitted by the army that the recommendations had not [been] implemented.'

35 *Submission P6*, p. 2.

36 *Committee Hansard*, 1 March 2004, p. 34. See letter to Mr and Mrs Williams reproduced in *Committee Hansard*, 28 April 2004, pp. 56–7.

Committee view

9.39 The committee found that inquiries into accidents and sudden deaths by the ADF at the Investigating Officer level are subject to the same shortcomings as other administrative inquiries. Conflicts of interest, poorly conducted investigations and delays undermine the effectiveness and fairness of such proceedings. Moreover, in some cases inquiries into sudden death, which often deal with complex matters, magnify these deficiencies. The involvement of family members still grieving over the loss of a loved one also place heavy demands and responsibilities on the investigating officer. The committee is of the view that the ADF must give particular attention to the need to keep next of kin well informed about the progress of an inquiry and the need to have expert advice available to the investigating officer. It is also important for the ADF to ensure that the interests of the Defence Forces do not take precedence over the rights of close relatives and friends.

Inquiries as early detection mechanisms

9.40 As noted in the previous chapter, complaints from individuals can point to a problem that may be occurring more widely. They can be valuable indicators of broad trends within the ADF concerning matters such as inappropriate behaviour or lapses in safety standards. It is important that each inquiry contributes to an understanding of the overall conduct of personnel in the Forces that may alert the ADF to any potential problems. The incidents related in this chapter underline the importance of recording and monitoring the findings of inquiries.

9.41 Lieutenant General Leahy acknowledged that Army does make mistakes. He accepted that it had failed to detect trends and patterns and had not learnt enough as an institution from the errors identified. He explained:

> This has been largely due to lack of visibility and senior level management oversight. We are now establishing an Army wide database of administrative inquiries. This database will not only allow the progress of inquiries to be tracked but, more importantly, record the decisions of appointing authorities and allow the implementations of decisions to be closely monitored. We will also work with the Registrar of Military Justice to contribute to ADF wide visibility of discipline investigations and administrative inquiries.[37]

9.42 Mr Earley, IGADF, also argued that greater attention needs to be given to making the results of inquiries more widely known if the ADF is to benefit from their findings. He recognised that steps needed to be taken to break down the compartmentalisation within commands, so that the outcome of a particular inquiry builds on an overall appreciation of the findings and recommendations of administrative inquiries across the ADF. He elaborated on the initiative to improve the visibility of the results of administrative inquiries:

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37 *Committee Hansard*, 1 March 2004, pp. 28–9.

> Under development at the moment—and I think this is a very good initiative—is a reporting system whereby all administrative inquiries above the level of investigating officer are to be centrally reported to my office. I volunteered to be the manager of that. For the first time that will enable a wider oversight, a wider visibility, of exactly what types of inquiries are going on out there. In particular, the implementation of recommendations and outcomes from those inquiries could undergo some scrutiny and some monitoring, which currently is a bit of a difficult area and, as I think most people would agree, needs some attention. I think that is a very positive step. I might also say that that general approach is available currently with the discipline system—the conduct of trials. A system that has been developed quite recently by the Registrar of Military Justice will allow that sort of information to be available.[38]

9.43 The committee welcomes the steps being taken to establish one central register that records the results of administrative inquiries. This database should be sufficiently comprehensive to provide information on the nature of matters being investigated, the timeliness of investigations, the recommendations coming out of them, the appointing authorities' responses to the recommendations and the monitoring of the implementation of recommendations. The committee would be interested in receiving feedback about this register and its operation as soon as it is sufficiently developed. It has recommended that the proposed Australian Defence Force Administrative Review Board take responsibility for the monitoring of administrative inquiries and that it include such information in its annual report (see recommendation 29, para. 11.67).

Conclusion

9.44 This and the previous chapter have focused on the routine and the investigating officer inquiry. Given that the Government has undertaken to implement the recommendations of the Burchett Report, and has responded to the JSCFADT's reports, the committee sees little point in reciting their findings and many recommendations to improve administrative inquiries. It has in some instances endorsed certain recommendations and made additional ones. At this stage, however, the committee is not convinced that the measures taken in response to previous inquiries have been or will be adequate and, in particular, will result in a robust and effective administrative system.

9.45 The committee must rely heavily on monitoring the progress of these initiatives to be satisfied that the reforms are producing the desired results. Thus, it is crucial that the committee has before it information that will enable it to scrutinise effectively the implementation of reforms. To address this matter, the committee has recommended that the ADF submit an annual report to the Parliament outlining inter alia the implementation and effectiveness of reforms to the military justice system,

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38 *Committee Hansard*, 5 August 2004, p. 99.

either in light of the recommendations of this report or by other initiatives. (see recommendation para 13.29).

9.46 One of the most important components in any justice system is the right to have a review or the right to appeal a decision. The following chapter examines the avenues open to a member who is seeking to appeal a decision to take adverse action or who wants the findings of an inquiry reviewed.