Senate Foreign Affairs, Defence and Trade References Committee

SUBMISSION COVER SHEET

Inquiry Title: Effectiveness of Australia's Military Justice System

Submission No: **P14**

Date Received: 08.02.04

Submitter: Ms Sturgess

Organisation:

Address:

Phone:

Fax:

Email:

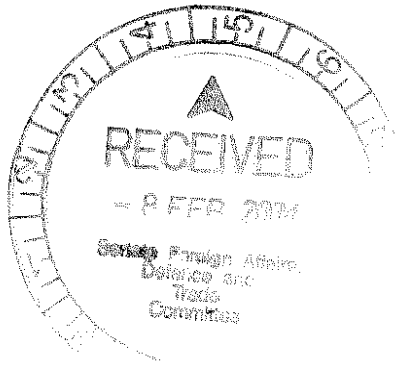
Name/Contact: Ms Yvonne Sturgess

Date Authorised:

Patience, Saxon (SEN)

From: Yvonne Sturgess
Sent: Sunday, 8 February 2004 4:23 PM
To: FADT, Committee (SEN)
Subject: Submission to Senate Foreign Affairs, Defence and Trade References Committee

80204Senateinqui ysubmission....



8th February 2004

Ms Saxon Patience
Acting Secretary
Senate Foreign Affairs, Defence and Trade References Committee Suite S1.57 Parliament House CANBERRA ACT 2600
Email: fadt.sen@aph.gov.au
Phone: (02) 6277 3536
Fax: (02) 6277 5818

Subject: Submission to Senate Inquiry - Effectiveness of Australia's military justice system

Dear Ms Patience

Please accept the following submission to the Senate Committee. My son Corporal Jason B. Sturgess was killed in a vehicle accident whilst returning to his base after completing an exercise just prior to returning to East Timor. As you will see in my submission I do not believe the subsequent Army investigation reached the correct conclusions and I hope the Senate Committee maybe able to address my concerns more independently.

I would like to request that my submission is made public as I hope other families who have suffered similar losses may feel less isolated and encouraged to come forward with their own concerns.

I am forwarding by mail a copy of the Army report into my son's death and a letter and response I wrote and received to the Minister Mr Robert Hill for your information along with the signed original submission.

I would appreciate a return email or phone call to confirm you have received this submission.

Many thanks

Yours sincerely,

Yvonne Sturgess

8th February 2004
Yvonne Sturgess

The Secretary
Senate Foreign Affairs, Defence and Trade References Committee
Suite S1.57
Parliament House
CANBERRA ACT 2600
Email: fadt.sen@aph.gov.au
Phone: (02) 6277 3536
Fax: (02) 6277 5818

Subject: Submission to Senate Inquiry - Effectiveness of Australia's military justice system

To the Secretary, Senate Foreign Affairs, Defence and Trade References Committee

On the 22nd February 2002, my son Jason was crushed to death when the Armoured Personnel Carrier (APC) he was commanding unexpectedly veered off the road and rolled over whilst returning to base after his unit had completed it's final exercise just prior to returning to East Timor. Jason loved his job, was held in high regard by his mates and supervisors. The Army's post accident support for my family and myself exceeded my expectations and I thank them for that.

The Army Board of Inquiry commenced its investigation in Townsville approximately 6 months after my son's death and I was invited to attend (at the Army expense) and if I wished could make a statement to the Board. I accepted this invitation, attended for the whole duration and gave my statement. Whilst I have forwarded to you a copy of the final report, I do not have a copy of the transcripts. I believe it would be helpful to the committee if you could request these from the Army.

Whilst a cursory look at the Army's response and investigation into the accident looks thorough, I and everyone (family and friends) who have been shown the report, cannot believe how the Board of Inquiry could find that the evidence presented was insufficient to determine the primary causes of the accident. Subsequently the process and subsequent report has left me with the feeling that no real lessons have been learned and as a result another mother will unnecessarily lose their son or daughter. I have also raised this issue with the Minister Mr Robert Hill (correspondence forwarded with report in the mail) and received assurances from Mr David Moore (Chief of Staff, Minister Assisting the Minister for Defence) that steps have been taken to address the issues raised in the report. However this did not specifically address my concerns rather just some of the recommendations in the final report and so confirms in my own mind that Government is only receiving the information the Army wants it to see (Can't a Minister investigate further?) and confirms my view that there needs to be a permanent and suitably qualified independent auditor/investigator established to ensure that we can all be confident that the type of accident that killed my son is not repeated.

Whilst this letter is from me it is in fact a collaborative effort between other family members and myself. I have forwarded to you by mail a copy of the ADF accident report titled "Report of the Board of Inquiry into the Death of 1802433 Corporal Jason B. Sturgess on Hervey Range Road Townsville, Queensland on 22nd February 2002." My comments in this submission are based on my notes from the inquiry and the subsequent investigation report. I/we do not pretend to be legal or mechanical experts, but our assessment of the unreliable methods and conclusions of the report is based on our collective life experience and common sense.
As a general comment I believe the report did not set out to misrepresent the circumstances in which the accident occurred however I believe it contains a large number of deficiencies and unsafe conclusions.

Firstly the inquiry into the cause of the APC accident Jason was travelling in when it overturned was unjustifiably narrow in focus. That is, it seems to have used a very limited definition of possible causative factors for the accident, while failing to explain what the definition or standard used was. Factors that contemporary industry and legal norms would consider highly relevant or causal, such as the accident vehicle not having been given maintenance services and being classified as unfit for use *(see F3 on page 4)*, were dismissed by the Board with little or no attempt at justification.

For example page 16. Paragraph 52. states, *"the Board concluded that whilst there were numerous maintenance issues concerning, B Sqn APCs and the maintenance of APC 10B they were not causative to the accident."* The Board did not attempt to justify this rather extraordinary and counter-intuitive conclusion. Nor did it explain how it reached this conclusion, which gives me no confidence in the reasoning process that led to it.

People I/we have spoken to with similar industry experience suggest that the extent of maintenance problems on the APCs at Townsville, should have resulted in a much deeper and broader investigation into Army-wide vehicle maintenance and record deficiencies and safety problems. That is, the severe maintenance deficiencies exposed by Jason's death is clear evidence of deficient procedures and practice, which could very well be duplicated in other or all aspects of the unit(s) operations, and in other units. Further, although the particular maintenance problems found by the Board not to be direct causative factors, the "culture" (or attitude) to non-compliance with regulations and procedures should itself have been considered a possible causative factor.

The following findings (para's 61 and 62); from the report also fills me with great concern:

61. The documentation for the maintenance of APC 1-B was poor. CPL Schonrock also indicated that the maintenance job sheet for the service would have been destroyed at the completion of the service, as this was the practice in B Sqn at the time...Therefore, there is no way of ascertaining who, or even if, the service was conducted on APC 10B. Also, entries into the computer system that tracks and details the maintenance requirements do not align themselves with the physical documentation, i.e. Technical Inspection Report. The print out of the computer records...shows that APC 10B's odometer reading at the time of servicing as 15741 km while the

technical inspection details the odometer reading (at what should be he same point in time) as 17844.

62. Given all of these factors, the maintenance of APC 10B was inadequate. There is also no way of knowing who actually conducted the service (or even if one was conducted) as records were destroyed and the documentation was poor.

It is not unreasonable to conclude from this that the ADF breached its duty of care to drivers of APC10Bs, given that it was found that:

- It is not known whether the accident vehicle was serviced;
- It is not known whether, if the accident vehicle was serviced, whether it was serviced by someone who was qualified to service APB 10Bs;

Given that it was also found that the technical trade qualifications of the soldiers who signed off on a 'Technical Inspection' the two were "inadequate for the tasks given." and not adequately supervised (Para 72), I remain extremely concerned about the integrity of the findings that the Army was not responsible in any way for my son's death.

The evidence heard by the Board and partly presented in the report also would lead a reasonable person to think that the Army Command Structure was already aware of the incompetency of the personnel charged with maintaining and verifying the safety of APC10Bs, and refused to act.

For instance, paragraph 88 states: "The board heard evidence that at the beginning of 2002, B Sqn was experiencing some manpower shortages due to ongoing commitments to East Timor."

It goes on to say that "Correspondence with HQ3 Bde ~ shows the constant requests for APC qualified staff and retention of the civilian staff to assist with the maintenance shortfalls. In this context the situation with the servicing and maintenance issues was exacerbated by these shortfalls."

To my mind this clearly shows that the Command structure was not only aware of critical maintenance problems, but did not act appropriately. Army command not only failed to supply non-qualified personnel to carry out technical inspections and maintenance, but also allowed the APCs to be used meanwhile. . (It must be also remembered that at the time of Jason's death, this unit was about to leave to serve in East Timor.) In non-defence industries companies and managers would incur heavy penalties if it were discovered by the regulatory bodies that such maintenance practices had been allowed to occur there.

Even if the Command could mount a successful argument that it was not aware of the maintenance failures at Townsville, it clearly failed to ensure effective and robust reporting systems were in place to monitor maintenance and competency. It is not unreasonable to conclude that other procedures and systems associated with operations and safety of the M113 in this unit are likely to be inadequate, and therefore should have been investigated by the board in the context of this fatality. Yet the Board neglected all these obvious implications, dismissing evidence of extreme incompetence and systemic failures and yet concluding that it was unable

"to definitively determine the primary causal factors of the accident." In regards to contributory factors, the Board, although acknowledging there to be insufficient evidence to allow any definitive conclusions to be reached, speculates that one or more of the following factors may have contributed to the accident;

a. Speed,
b. Downhill gradient,
c. Driver inattention, and
d. Incorrect driving technique.

In other words, the Board is happy to speculate that environmental factors and driver fault may have caused the accident – with scant or no evidence for this – and yet overlooks in its reckoning the large amount of evidence that the vehicle's maintenance was seriously deficient. The Board also overlooks, most breathtakingly, the fact that the APC10B was regarded by the Army itself as untaskable – that is, not fit for service but this was not considered to be causal to the accident. There is no attempt to explain let alone justify the reasoning that led the Board to this conclusion.

Consider also the fact that in the report the Board states that it regards a witness, Mr Martin, as an expert on the M113 (APC). Mr Martin gave evidence that the view of ADF personnel regarding the APC operating phenomenon of "diff lock" and "brake lock" was "urban myth". The Board rejected this assertion of Mr Martin. It then accepts however Mr Martin's evidence that despite the vehicle being untaskable and having some major defects, including brakes below safety standards, that the M113 (APC) could still be safely operated.

It seems reasonable to me that once the board had discredited Mr Martin's evidence about the diff lock issue, they would be wise to be cautious in accepting Mr Martin's evidence in general. (I am not sure, but I seem to recall that Mr Martin was the Australian Agent for the US Manufacturer of the APC and therefore may have had a conflict of interest in regards to the giving of his evidence) However it relied heavily on Mr Martin's evidence in considering whether maintenance or other technical matters were causative factors, simply because it seems that the technical expertise and reporting within the Unit (as the Board found) was inadequate prior to the accident.

For these and any many other reasons, I do not think it is reasonable for the Board to conclude that the M113 was untaskable but that this was not a causal factor of the accident. Especially given that no actual comparison of the performance and reactions of the vehicle involved in the accident were made to that of a serviceable vehicle under the same operating conditions.

It is my view that a reasonable person would conclude from the evidence and the report's commentary that significant causative factors, dismissed by the Board, may have been:

- Inadequate maintenance and safety reporting
- Non-compliance with procedures or regulation particularly in regards to maintenance and Risk Management Assessment.
- Inadequate funding
- No dedication to quality competency assurance.

- Inadequate or non-existing training.

I have highlighted these particular examples of the Investigation Board's conclusions, as I believe they show that the Army is incapable of objectively investigating itself. This was clearly demonstrated to me when I was approached by a previous Commanding Officer of Jason's unit when I was receiving an "Australia Medal" on Jason's behalf. In his efforts to comfort me he stated, " Soldiers die Yvonne, it's part of the job". When a Commanding Officer accepts death of his charges as an inevitable consequence of military service how can we expect him to objectively investigate a critical incident in his command?

As previously stated, I believe the ADF is currently incapable of objectively investigating itself probably because of an internal 'culture' at odds with ordinary civilian standards and values, and because it has no responsibility to any authority than Parliament itself.

I believe this could be addressed by the ADF having non-combat related deaths investigated by an independent and adequately resourced and funded authority with the powers to allow it unrestricted access to records, facilities and personnel. Also normal operations such as maintenance of equipment and compliance with procedures should be open to regular audits and investigations by a suitably qualified and independent authority or company engaged by and reporting to parliament not the ADF.

In conclusion I do not believe the conclusions reach by the Army inquiry into my son's death are fair or adequate, especially given Jason's dedicated and enthusiastic service to the Army and his country. I was very disappointed with the tokenistic response from the Ministry's CEO of the department which I thought was ultimately responsible for the welfare of my son and his mates. Given that General Cosgrove personally contacted me within hours of Jason's death I was expecting that on such an important and personal matter to me, (the death of my son!) that the Minister could have, at the very least personally signed the response from his department.

I thank the committee for your efforts and hope you can effect changes that will ensure that our ADF service personnel work in as safe an environment as can be reasonable expected and to a standard compatible with what our broader community expects.

Yours sincerely

Yvonne Sturgess