CHIEF OF THE
DEFENCE FORCE

INQUIRY OFFICER INQUIRY
REPORT

INTO THE DEATH OF CHIEF PETTY
OFFICER AVIATION TECHNICIAN
AIRCRAFT KANE VANDENBERG ON
11 OCTOBER 2013

17 JUNE 2014

Report redacted for public release

CDF COMMISSIONS OF INQUIRY
R1-6-A098, RUSSELL OFFICES
CANBERRA ACT 2600
R18575695

CDF (Through: DCDFCOI)

INQUIRY OFFICER INQUIRY REPORT INTO THE DEATH OF CPO K. VANDENBERG on 11 OCT 13

References:
A. Terms of Reference and Instrument of Appointment of 06 Mar 14
B. ADFP 06.1.4 Administrative Inquiries Manual
C. CDF Directive 04/2010 Interim Arrangements – Quick Assessments and Administrative Inquiries
D. Work Health and Safety Act 2011

Introduction

1. By instrument of appointment at Reference A, I was appointed by you to inquire into the circumstances surrounding the death of CPO Kane Vandenberg who died in a mountain bike accident on 11 Oct 13 at the 2013 Australian Defence Cycling (ADCC) Carnival (the Carnival). I was originally directed to provide to you the report by 06 May 14. On 05 May 14, I requested an extension to complete the draft report. DCDFCOI, granted an extension to 06 Jun 14 to submit a draft report.

2. TheTOR require me to gather evidence concerning the following points:
   a. the extent to which the mountain bike race at Mount Stromlo in which CPO Vandenberg was taking part was designed or conducted by the ADF;
   b. whether the ADF conducted any risk assessment for the bike race;
   c. whether CPO Vandenberg was on duty at the time of the incident; and
   d. whether notification procedures following the death of CPO Vandenberg were policy compliant and if not, why not.

Conduct of the Inquiry

3. The inquiry was conducted in accordance with Ref B and C. The following personnel provided statements for the inquiry:
   a. ADF 1, former CO HMAS Harman; and
   b. ADF 2, former President ADCC. ADF 2 was the of the Mountain Bike Activities.
4. ADF3 was interviewed on tape and a transcript produced. ADF3 was the overall coordinator of the Carnival and was OIC of the Road Activities.

5. ADF4, former XO HMAS Harman, was informally interviewed on 28 May 14. However, he was unable to provide a formal statement. The information he provided to the IOI during his informal interview was sufficient to complete the inquiry. A record of conversation was produced.

6. I made no adverse findings against any person during the course of the inquiry.

**Conduct of the Carnival**

7. The ADCC organised and participated in the 2013 Road and Mountain Bike National Cycling Carnival at Mt Stromlo, ACT, from 08 – 15 Oct 13. The ADCC in Oct 13 comprised of ADF and Defence APS members and was properly described as an ADO sporting club. CPO Vandenberg was one of the participants in that Carnival. One of the events in the Carnival was the Super D event.

**Super D Event**

8. The Super D event combines elements of cross country and downhill mountain bike riding. It is designed as an event that can be participated in by a broad range of riders with varying experience levels. There were two parts to the ADCC’s Super D event: a practise run and a timed ‘competitive’ run.

9. The Super D event was ultimately held on 11 Oct 13. The event was originally scheduled to run on 10 Oct 13. However, owing to very high winds on 10 Oct 13, the Carnival organisers decided to reschedule the event for 11 Oct 13. The high winds on 10 Oct 13 presented an unacceptable risk of injury for the Super D event.

10. CPO Vandenberg was a participant in the Super D event. The practise run was conducted in the morning of 11 Oct 13 over the assigned course. The practise ride was completed without incident. The timed run was conducted in the afternoon over the same course.

11. At some stage in the morning of 11 Oct 13, CPO Vandenberg had a minor accident. He sent a text message to his wife, Mrs Vandenberg, informing her of this and that he was alright. That message was not received by Mrs Vandenberg until approximately 1558h, 11 Oct 13.

12. During CPO Vandenberg’s timed run, he lost control of his mountain bike near the finish line, slid along the ground off the track and collided with a large rock. First aid was provided at the scene and CPO Vandenberg was transported by ambulance to Canberra Hospital. CPO Vandenberg was pronounced deceased at Canberra Hospital on 11 Oct 13.
Civilian Inquiries into CPO Vandenberg’s Death

13. ACT Police were present at the scene of the accident. Officers at the scene informed ADF 2 that CPO Vandenberg had died. An investigation was conducted by ACT Police on behalf of the ACT Coroner.

14. An autopsy report was prepared on behalf of the ACT Coroner by Dr Sanjiv Jain of ACT Forensic Medicine Centre, Phillip. The autopsy found that CPO Vandenberg’s death was due to an aortic rupture arising from a traumatic chest injury. A toxicological screen detected no drugs or alcohol in CPO Vandenberg’s body.

15. On 20 Dec 13, Magistrate Boss, a Coroner for the ACT, made an order dispensing with a hearing into the circumstances surrounding CPO Vandenberg’s death. The Coroner relevantly found that no matter of public safety was found to arise in relation to CPO Vandenberg’s death. She also noted that ACT Police had reported that no suspicious circumstances had been disclosed from their enquiries.

Risk Assessment

16. The ADCC produced a Sport Safety Management Plan (SSMP) on 10 Aug 11. This is required by DI(G) PERS 14-2 Australian Defence Force policy on sport. The SSMP states that risk management for competitive events is the responsibility of the organising club. The SSMP provides guidance on conducting a risk assessment of cycling events.

17. A specific risk assessment for the Carnival was produced by the ADCC and provided to the Stromlo Forest Park. This risk assessment was required by Stromlo Forest Park before the ADCC could use the facilities at Mount Stromlo. This risk assessment identified, as a generic mountain bike hazard, loss of control at high speed and assessed it as a MODERATE risk: the likelihood was assessed as conceivable and the consequence as catastrophic. The risk assessment identified the control for the risk was two fold: competitors were to be reminded to ride within their limits; and to remove from the course the more technical sections of the trail. Contingency actions identified in the risk assessment, relevantly for this inquiry, were a rider safety brief before the event and first aid support.

18. The evidence demonstrates that ADCC were conscious of the risks associated with the carnival. A safety brief was provided to all participants at the commencement of the Carnival. The evidence also supports that the ADCC adhered to their own risk assessment for the Carnival: of note, when it was assessed that the wind on 10 Oct 13 posed a risk of injury to riders, the Super D event was postponed to 11 Oct 13.

19. The Administrative Instruction for the activity was signed by ADF 5 on 19 Jul 13. In relation to equipment, the Administrative Instruction stipulated, at paragraph 16, the following:
Equipment. Personnel are to use their own equipment and must comply with [Cycling ACT Technical Regulations] . . . . Helmets must comply with the Australian standard, including time trial helmets for the road time trial. Minimum of full face helmet and knee protection is required for DH and 4X events.

20. No special riding equipment is required or expected of participants in a Super D event, beyond an approved bicycle helmet. CPO Vandenberg was wearing cycling clothes that included some padding, and a normal bicycle helmet.

21. ADCC appropriately identified the risk associated with the Carnival. Appropriate mitigation strategies were identified and enacted as appropriate. The risks associated with the Carnival were therefore mitigated as far could be reasonably practicable.

Duty Status

22. CPO Vandenberg was a member of the RANR. He was on CFTS contract at NPCMA. ADF6, DNPCMA, gave verbal approval for CPO Vandenberg to participate in the Carnival.

23. The Administrative Instruction for the Carnival states, at paragraph 10, that:

As attendance at the event is a place of duty, personnel who will be arriving late or departing early must clearly identify this when nominating. All personnel will be considered on duty for each event, and must be available to support events they are not competing in. Where insufficient volunteers are available to support the conduct of the events, members will be allocated supporting roles. Roll calls will be taken for military personnel.

24. Di(G) PERS 14-2, at paragraph 40, provides that ‘Defence personnel who are authorised to participate in sport within the terms of this Instruction are authorised as “on duty” subject to any applicable exclusions’.

25. The Carnival was an authorised sporting activity and ADF members participating in the event were on duty. CPO Vandenberg was therefore on duty at the time of his death.

Policy on Notification of Deaths to Next of Kin

26. The responsibility for notification to a member’s primary emergency contact (PEC) is the chain of command, supported by the Defence Community Organisation (DCO). Notification to a member’s PEC is to be made in person and include Chaplaincy support. However, the clear policy intent, stipulated in Di(G) PERS 11-2 Notification of Australian Defence Force and non-Australian Defence Force casualties is that ‘In all notification of casualty procedures, the most important elements are accuracy, speed and compassion and that emergency contacts are advised as quickly as possible, and before the information reaches the media’.
27. Where the PEC resides in a different location to the responsible unit, the local unit is to activate a notification team. As Mrs Vandenberg was located at [redacted], the responsible unit for raising the notification team was [redacted].

Notification of Death – Next of Kin

28. [redacted] was one of the participants at the Carnival and was present when CPO Vandenberg fell from his bike. [redacted] called [redacted], then XO HMAS Harman at approximately 1426h, and informed him CPO Vandenberg had had an accident, was injured, and was being attended to by paramedics. [redacted] was not provided with any further detail of the nature of the injuries suffered by CPO Vandenberg.

29. [redacted] discovered that the emergency contact details for CPO Vandenberg on PMKeyS were incorrect as it listed his PEC living in Canberra. CPO Vandenberg had not updated the details when he commenced CFTS. The ADCC did not have immediate access to emergency contact details for participants at Mount Stromlo, despite participants having provided this information during the online registration process. This information was, however, quickly sourced from the ADCC website manager and provided to HMAS Harman. [redacted] was very quickly able to confirm that CPO Vandenberg’s PEC was his wife, Mrs [redacted] Vandenberg.

30. At 1454h, the XO called Mrs Vandenberg and informed her that CPO Vandenberg had had an accident and was injured. [redacted] states that Mrs Vandenberg did not appear concerned but stated that she would drive to Canberra to be with her husband. She further told [redacted] that she would not do so until her son returned home from school.

31. [redacted], the overall Carnival Organiser, was at ADFA at the time of the accident. He was called by personnel at Mount Stromlo and informed of the accident. [redacted] returned immediately to Mount Stromlo to assist.

32. At approximately 1521h, [redacted] informed [redacted] that he heard via the ACT Police radio that CPO Vandenberg had died. CPO Vandenberg’s death was confirmed by [redacted], [redacted], at 1526h and [redacted], who was at Canberra Hospital, at 1557h.

33. Once notification of CPO Vandenberg’s death had been received at HMAS Harman, [redacted] immediately called the Officer of the Day at [redacted] and the DCO Family Helpline to initiate the proper notification in accordance with the requirements of D(I) (G) PERS 11-2.

34. At approximately 1558h, Mrs Vandenberg left a phone message with [redacted] stating that she had just received a text message from CPO Vandenberg stating that he had an accident but was alright. This text message actually referred to an accident that CPO Vandenberg had had earlier in the day.

35. [redacted] and [redacted] had discussed throughout the afternoon whether to inform Mrs Vandenberg of CPO Vandenberg’s death on the phone. [redacted] states that she directed [redacted] to inform Mrs Vandenberg via telephone this for a number of reasons:
a. Mrs Vandenberg is very well connected within the Navy community and was concerned that she would be informed of the death by someone outside the chain of command before the notification team could reach her;

b. ADF 1 wanted to inform Mrs Vandenberg of her husband’s death before she left Canberra. ADF 2 was aware that Mrs Vandenberg was likely to take to Canberra and would therefore would be difficult to contact;

c. Mrs Vandenberg had a support network in Nowra but not Canberra;

d. no timeframe was available for when the notification team would be available – consequently, ADF 1 considered it impossible to ask Mrs Vandenberg to stay in without telling her why; and

e. the final factor that cemented her decision was the text message Mrs Vandenberg received from CPO Vandenberg at approximately 1558h.

36. Notification to Mrs Vandenberg as the PEC was in accordance with DI(G) PERS 11-2. ADF 1’s decision to notify Mrs Vandenberg over the telephone was appropriate and the best course of action in circumstances. To have not informed Mrs Vandenberg at that time was likely to have resulted in Mrs Vandenberg not being informed by the chain of command. Had Mrs Vandenberg not been informed at that time, she would have arrived in Canberra, where she did not have a support network, to be told that her husband had died.

37. Mrs Vandenberg spoke with ADF 1 and ADF 4 in Nov 13. She told ADF 1 that she was extremely grateful for the support that Navy had provided her following her husband’s death. She specifically told ADF 1 that she appreciated the fact that she was told of CPO Vandenberg’s death when she was, and in the way she was.

38. The overall intent of DI(G) PERS 11-2, that notification to a member’s PEC be accurate, speedy and compassionate, was complied with.

Notification of Death – FATALCAS

39. DI(G) PERS 11-2 stipulates that the Reporting Unit (in this case, HMAS Harman) is to raise a FATALCAS when a member is reported deceased.

40. After ADCC were made aware that CPO Vandenberg had died, ADF 3 contacted Duntroon Medical Centre. He was told that Canberra Hospital had called Duntroon Ward and confirmed CPO Vandenberg’s death. ADF 3 was then told that the Duntroon Medical Centre would prepare the FATALCAS. This was incorrect. At some point during the afternoon, ADF 3 spoke with DCN and informed him that the Duntroon Medical Centre was going to draft the FATALCAS.

41. ADF 1 understood that it was the responsibility of HMAS Harman to draft and release the FATALCAS. The FATALCAS was initially drafted as a NOTICAS and was changed to a FATALCAS when confirmation of CPO Vandenberg’s death was received.
42. The notification requirements in DI(G) PERS 11-2 were complied with by HMAS Harman staff.

Notification of Death – Chain of Command

43. ADFl directed the Officer of the Day at HMAS Harman to prepare a Quick Assessment on 11 Oct 13. A subsequent Quick Assessment was conducted by ADFl for Command System Office – Establishments on 22 Oct 13 that dealt with the issues surrounding notification to CPO Vandenberg’s PEC.

44. Notification to the chain of command by HMAS Harman was timely and appropriate and accorded with Defence policy.

Notification of Death – Comcare

45. ADFl called the Comcare hotline and reported the fatality shortly after confirmation of CPO Vandenberg’s death. An investigator from Comcare attended the scene of the accident shortly afterwards.

46. The Comcare Investigator prepared a report in accordance with Ref D. No substantive issues were raised in the report. The only recommendation that stemmed from investigation was that ADCC conduct a formal inspection of each trail prior to use. ADCC have adopted this recommendation and intend to apply it at their next event.

47. Section 38 of the Ref C requires, inter alia, that Defence notify Comcare of the death of a Defence member immediately after becoming aware of the fatality. Notification must be given by telephone or in writing. If the notification is given by telephone, Comcare can also require Defence to provide written notification within 48 hours after the initial advice of the fatality has been made. No distinction is made regarding the activity the deceased is involved in: there is no distinction made for a fatality occurring during a Defence sporting activity.

48. DI(G) PERS 20-6 Death of Australian Defence Force personnel at paragraph 16, stipulates that notification to Comcare of a fatality is not required when the fatality occurs during ‘organised ADF sporting activities (as defined in DI(G) PERS 14-2 – Australian Defence Force policy on sport)’. DI(G) PERS 20-6 was drafted to comply with now repealed Occupational Health and Safety Act 1991. It now is in contravention of Ref C and needs to be amended, as a failure to comply with s 38 of Ref C is punishable by a pecuniary penalty.

Findings

49. In accordance with my terms of reference, I make the following findings:
   a. the mountain bike race at Mount Stromlo was designed and conducted by the ADO;
   b. the ADCC conducted an adequate risk assessment before, and during, the Carnival;
   c. CPO Vandenberg was on duty at the time of his death;
   d. notification procedures following the death of CPO Vandenberg were policy compliant;
(1) notification to Comcare was in accordance with Defence’s legal obligations;

(2) notification via the FATALCAS system was policy compliant; and

(3) notification to Mrs Vandenberg, CPO Vandenberg’s next of kin, accorded with the intent of DI(G) PERS 11-2 that notification be accurate, speedy and compassionate;

e. the notification to Mrs Vandenberg by ADF 4 was entirely appropriate in the circumstances;

f. the confusion regarding who was responsible for production of the FATALCAS stemmed from the conversation between ADF 3 and a member of the Duntroon Medical Centre. It did not ultimately affect the drafting and release of the FATALCAS by HMAS Harman;

g. CPO Vandenberg’s death arose in the course of his Defence service; and

h. a COI into matters connected with CPO Vandenberg’s death is unlikely to obtain any new evidence.

Conclusion

50. CPO Vandenberg’s death was a tragic accident that, apart from not participating in the Carnival at all, was not preventable. Appropriate risk mitigation practices and strategies had been implemented by the ADCC before and during the Carnival.

51. Notification to Mrs Vandenberg of CPO Vandenberg’s death by HMAS Harman appropriate in the circumstances and complied with the overriding intent of Defence policy, particularly DI(G) PERS 11-2.

52. CPO Vandenberg’s death appears to have occurred in the course of his Defence service. However, a COI is very unlikely to uncover any new information beyond this IOI.

Recommendations

53. I recommend the following:

a. that during ADCC events, emergency contact details of participants be available in hard copy form at the event;

b. DI(G) PERS 20-6 Death of Australian Defence Force personnel be amended to properly reflect Defence’s legal obligations for notification of fatalities in accordance with the Work Health and Safety Act 2011;
c. that you advise MINDEF that while CPO Vandenberg’s death appears to have occurred in the course of his Defence service, no COI is required.

Inquiry Officer

17 Jun 14