REPORT OF BOARD OF INQUIRY
INTO THE DEATH OF
CAPT PAUL LAWTON
DECEMBER 2007

CAPT Paul Lawton alongside MV Talisman, Baltimore Maryland, USA, mid August 2006.
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1. INTRODUCTION

1.1 This Board of Inquiry was appointed by the Chief of the Defence Force, by instrument dated 28 March 2007 enacted pursuant to the Defence Act 1903, as amended, to inquire into the circumstances surrounding the death of CAPT Paul Lawton.

1.2 CAPT Lawton died on 31 August 2006. He was 36 years of age. At the time of his death, he was on board a Norwegian ship, MV Talisman. The ship was sailing between the Panama Canal and Papeete.

1.3 CAPT Lawton was leading a three man security detachment to escort 23 Abrams tanks on the ship from Baltimore to Melbourne. The other members of the detachment were Troopers Diprose and Hansen.

1.4 The detachment was part of a tank replacement project, known as the "Land 907 Project", of the Defence Materiel Organisation (DMO) in Melbourne.

1.5 CAPT Lawton was posted to the DMO in March 2004 as the Maintenance Plans Officer - Land 907. He participated in the planning of the shipment, and made a significant contribution. Eventually he was assigned to command the escort party as the "International Security Escort Detachment Commander".

1.6 The cause of CAPT Lawton's death was pneumonitis complicating dilated cardiomyopathy. Pneumonitis is an infection of the lungs. Cardiomyopathy is a disease of the heart muscle impairing ventricular function. Cardiomyopathy may cause sudden and unexpected death, and is usually treated by medication, but if the condition is untreated the risk is increased.

1.7 CAPT Lawton's funeral was held in Melbourne on 12 September 2006 with full military honours.

1.8 CAPT Lawton's heart condition was first diagnosed in December 2003. From that time until his departure from Melbourne on 1 August 2006, he was examined periodically by a number of medical practitioners, and his condition was made the subject of classifications under the ADF Medical Employment Classification System. On 30 January 2004 he was downgraded from MEC 1 to MEC 303, and on 7 July 2005 he was further downgraded to MEC 401.

1.9 The Terms of Reference raise two principal questions. Should CAPT Lawton have been allowed to undertake the escort, given his medical employment classification? And were sufficient steps taken by ADF personnel to protect his health and welfare after his arrival in Baltimore and whilst he was on the ship? With respect to these and other questions, issues of both systemic and individual failure arise for determination.

1.10 Pursuant to regulation 33(1) of the Defence (Inquiry) Regulations, the President determined that the following persons may be affected by the Inquiry:

a. Dr John Gall;
b. Dr Vickie Grove;
c. MAJ Craig Byrne;
d. Mr (formerly MAJ) Christopher Holland;
e. MAJ Mark Keynes;
f. LTCOL Andrew Libby; and
g. Mrs Denise Lawton

1.11 Pursuant to regulation 33(2) of those Regulations, the President authorised Ms Catriona Campbell to appear before the Board as next of kin.

1.12 All of these persons were provided with legal counsel to represent them at the Inquiry.

1.13 CAPT Lawton's family include his mother Mrs Lawton, his daughter Chia by his former marriage, and his partner Ms Campbell. Mrs Lawton was authorised by CAPT Lawton's former wife to represent his daughter's interests at the Inquiry. Ms Campbell was recognized by the ADF as having the status of CAPT Lawton's spouse. As already mentioned, Ms Campbell was authorized to appear as CAPT Lawton's next of kin.

1.14 This is the second Inquiry into CAPT Lawton's death. The first Inquiry completed the taking of evidence and submissions, but was then dissolved before delivery of any report. The evidence before the first Inquiry, both oral and documentary, was tendered before this Inquiry, and has been taken into account.

1.15 CAPT Lawton's family were required to endure, on top of the dissolution of the first Inquiry, delays in the sittings of the second Inquiry. Although they were due to the other commitments of some of the participants, the delays are regrettable, because doubtless they added to the family's distress.

1.16 In this report, words importing gender refer to both male and female, unless specifically stated otherwise.

1.17 For a full understanding of events prior to CAPT Lawton's departure from Melbourne, it will be necessary first to describe the Medical Employment Classification System and the PULHEEMS System of the ADF.

2. THE MEDICAL EMPLOYMENT CLASSIFICATION SYSTEM

2.1 A convenient explanation of the Medical Employment Classification System can be found in the introductory paragraphs of Health Directive 236 (HD 236) of 21 November 2005:

a. The MEC system is the mechanism by which the Defence Health Service (DHS) provides information to the single Service Personnel Managers on the health status of all members of the ADF and is
governed by DI(G) PERS 16-15 (Australian Defence Force Medical Employment Classification System). The MEC must be accurate and current to allow planning for operational commitments and career management. The MEC assists Career Management Agencies (CMA) to make informed decisions about issues such as postings, promotions, and overseas deployments, which have significant impact not only on individual careers but also on the effectiveness of the ADF capability. Failure to deal in a timely manner with personnel identified as requiring MEC Review (MECR) may have significant consequences for the member and the ADF.

b. The HD 236 amplifies the DI(G) 16-15 and must be read in conjunction with that policy. The aim of the health directive is to provide implementation instructions for assigning a MEC to a member of the ADF in accordance with the DI(G) PERS 16-15.

c. The MEC is to be determined according to each member’s primary military occupation. This assessment should be cognizant of the environment in which that occupation may be performed when deployed, and of the additional tasks which an individual could be expected to perform as part of their general military duties.

d. In the case of Army personnel, members must be PULHEEMS Employment Standard Class 1 or 2 to be medically fit for deployment. Army standards are detailed in Defence Instruction (Army) PERS 159-1, PULHEEMS Employment Standards.

e. If the MO has any doubt about the application of an MEC in relation to employment or deployment of a member, the MO may consult with the member’s commanding officer (CO), or request the provision of specific information on the functional requirements of the member’s occupation. The MO is only to discuss the impact of the medical condition on the member’s employment or deployment unless there is written consent of the member. If the CO is consulted the member is to be informed of the nature of the consultation.

f. The four classes of the MEC do not by themselves give sufficient information for personnel managers to deploy and post personnel appropriately. Therefore a MEC may incorporate employment restrictions and / or a review date. Employment restrictions including occupational and deployment restrictions and physical fitness limitations will be recorded as amplifying comments to the MEC. Restrictions must be standard, specific and easily understood and implemented by units. A list of standard employment restrictions is in annex G to the HD 236.

2.2 DI(G) PERS 16-15 issued on 11 April 2005 deals with the responsibilities of a commanding officer in paragraphs 32 to 37 and 44 to 45. COs are to actively manage the employment of personnel in terms of their MEC, especially during the transition from MEC 4 to separation from the ADF (paragraph 32). When informed of the confirmation of the MEC, the CO must ensure that the member is employed in
accordance with the specified employment restrictions (paragraph 33 c). COs are to
be proactive in the MEC management of their members (paragraph 35). The CO must
address the member's employability and deployability within the unit and the
functional effect of any disability on the workplace and deployment given their
current MEC and/or medical restrictions (paragraph 36). A new or re-confirmed
MEC and employment restrictions are to be promulgated to the member, his CO and
supervisor and personnel / career management agency (paragraph 37). Should the CO
determine that the employment or deployment of an individual contrary to a MEC or
employment restriction is appropriate, the CO is to sign a written statement of the
reasons for his decision (paragraph 44). For members who have been classified MEC
3, active medical management and rehabilitation are to have priority over other
employment. Where exceptional circumstances exist and a member is being
considered for a non-operational posting outside of Australia, medical advice is to be
sought from Joint Health Support Agency (JHSA) for a risk management assessment
(paragraph 45).

2.3 The Medical Employment Classification Review Board (MECRB) is a pivotal
component of the Medical Employment Classification System. Paragraph 14d of
Di(G) PERS 16-15 of 11 April 2005 provides that members who are classified as
MEC 4 for their military occupation will be subject to review and recommendation by
a MECR Board. The functions and procedures of the Board are contained in Annexes
B and C.

2.4 Annex B deals with process, and paragraph 14 needs to be quoted in full:

"Should there be any requirement for the determination of a MECRB to be
reviewed, this must, in the first instance, be re-presented to a MECRB. This
does not preclude reconsideration through a representation process, but is for
reconsideration as a result of new information or change in the member's
condition. No Medical Officer, regardless of appointment, has the authority to
overturn the determination of a MECRB. For members determined by the
MECRB as MEC 1 or 2, without waiver, review by MECRB is no longer
required." (paragraph 14)

2.5 Annex C deals with waivers. Two types of waivers can be granted, namely a
medical waiver and a critical skills waiver (CSW).

2.6 According to paragraph 2, members who do not meet defined ADF medical
standards may be granted a medical waiver and upgraded to a deployable MEC; a
medical waiver effectively upgrades a member's MEC from the one that would
normally be allocated and the MECR Board is the only agency authorised to grant a
waiver of a MEC determined by the MECR Board.

2.7 According to paragraph 5, a CSW may be granted to a member who is
permanently non-deployable but who possesses skills critical to the effective
functioning of the ADF; a CSW may only be granted to a member who remains
employable in their critical skills; and a member will be terminated medically at the
completion of their period of service, unless their condition improves and they are
upgraded.
2.8 Issues of confidentiality are dealt with in paragraphs 32 to 36 of HD 236 of 21 November 2005 and paragraphs 3 to 5 of DI(G) PERS 16-15 of 11 April 2005. The HD and the DI(G) both permit the disclosure of health information to commanding officers for the purpose of managing operational “consequences” (in the case of the HD) and “requirements” (in the case of the DI(G)). The HD goes further in a number of respects. The member’s CO and workplace supervisors are to be kept informed of any changes in medical status, and this may be by means of a form PM 532 following confirmation of a MEC (paragraph 32). A member may provide written consent for a MO to release medical information to their CO or personnel managers (paragraph 34). In the case of the Army, if a soldier authorises release of medical information to the CO, “details of the medical condition will be provided to the CO in a letter advising of the outcome of the MECRB” (paragraph 35).

2.9 A number of points critical to the outcome of this Inquiry should be noticed at this stage:

a. Although the primary responsibility for the management of a member's MEC resides with the CO, he has no power to over-ride a determination of the MECRB;

b. No medical officer, regardless of appointment, has the authority to overturn a determination of the MECRB or to grant waivers;

c. A determination of the MECRB cannot be varied except by way of reference back to the Board for a medical waiver or a critical skills waiver; and

d. Earlier we noted that HD 236 is meant to 'amplify' and be read in conjunction with the "policy" of DI(G) PERS 16-15, and the 'aim' of HD 236 is to provide 'implementation instructions' for assigning a MEC in accordance with DI(G) PERS 16-15. CMDR Walters (Senior Health Officer – Vic) told us that the DI(G) provides the strategic overview, whereas the HD is the day-to-day working document. So it appears that the DI(G) is intended to deal with issues of policy and the HD is intended to deal with issues of implementation. Although the asserted conceptual difference between the two documents has a logical basis, both deal with issues of policy, both deal with issues of implementation, and to a substantial degree both cover the same ground. Moreover, the documents are contradictory in at least one respect. The definition of MEC 401 in force after DI(G) PERS 16-15 was amended on 11 April 2005 and before HD 236 was amended on 21 November 2005 was not the same in the two documents. The documents are ambiguous in other respects, and we will deal with the expression "deployment and seagoing service" later in this report. CMDR Walters said that he could see no reason why the DI(G) and the HD should not be condensed into the same document, and we agree.
3. THE PULHERMS SYSTEM

3.1 The PULHEEMS System is exclusive to the Army, and is contained in DI (A) PERS 159-1 of 9 August 2001. Each of the letters in the acronym describes a quality, namely P (physical capacity), U (upper limbs), L (locomotion), H (hearing), EE (eyesight), M (mental capacity) and S (stability). From this it would appear that the PULHEEMS system focuses more on the functional capacity than the medical suitability of a person for military service. Indeed, the Introduction states that the System is designed to “provide a functional assessment of a member’s ability to carry out military duties”.

3.2 The PULHEEMS System overlaps but is separate from the MEC System. DI(G) PERS 16-15 of 11 April 2005 lists DI(A) 159-1 as one of a number of “Related documents”. To the extent that there is an inconsistency, the MEC System prevails (s 9A (4) of the Defence Act 1903, as amended).

3.3 As will appear later, the PULHEEMS figure that was assigned to CAPT Lawton by the MECR Board for physical capacity was P7. According to paragraph 25 of Annex D of DI(G) PERS 159-1, the condition of cardiomypathy should be graded P-7 or P-8 after cardiological opinion.

3.4 The meaning of P7 is found in two tables in DI (A) PERS 159-1. According to the table in clause 9, “Functional Capacity” with respect to a P7 rating is “Markedly diminished”, “Combat Capacity” with respect to a P7 rating is “Severely restricted” and “Environmental Restrictions” with respect to a P7 rating are “Service in Australia only”. According to the table in Annex A, headed “FUNCTIONAL INTERPRETATION OF DEGREES OF EACH QUALITY”, a P7 rating means “Able to perform useful military duties within limits of disabilities. Not likely to break down if suitably employed, which includes time for regular meals and rest. Service outside the Area of Operations only”.

3.5 The evidence before us suggests that the PULHEEMS System is out of date in some respects and of limited use in any event. Dr Gall said (T 1297 16-20):

“...We can talk about this PULHEEMS all afternoon, but the fact of the matter is, this document is out of date. It doesn’t apply to the current medical employment classification system other than to look at the functional capacity of someone...”

COL Van der Rijn said (T 462 9-14):

“...It is an Army-centric system. It is a useful tool for some medical officers in trying to define why a person may be other than MEC 1. But principally doctors think more in general terms I think in these days as to whether somebody is deployable or not deployable, and if they are deployable, whether they’re MEC 2 or MEC 1. So it has a use, but it’s a very limited use...”
4. EVENTS PRIOR TO CAPT LAWTON'S DEPARTURE FROM MELBOURNE

4.1 CAPT Lawton presented to the Canberra Hospital on 19 December 2003 with symptoms of orthopnea (the inability to breathe easily unless sitting up straight or standing erect) and shortness of breath. The diagnosis was dilated cardiomyopathy of unknown aetiology, for which he was prescribed medication.

4.2 CAPT Lawton relocated to Melbourne in January 2004, and was referred by the Canberra Hospital to a cardiologist at the Heart Failure Clinic in Melbourne.

4.3 CAPT Lawton was first seen at that clinic by Dr Peter Bergen, a cardiologist, on 21 January 2004. He gave a history to Dr Bergen of noticing breathlessness when walking up stairs for about two months prior to his initial presentation.

4.4 Dr Bergen agreed that the most likely diagnosis was idiopathic dilated cardiomyopathy. Dr Bergen adjusted CAPT Lawton's medication, and suggested it would be prudent for him to be off work for at least a month pending the results of investigations and clinical progress.

4.5 CAPT Lawton was examined by Dr John Gall for the first time on 30 January 2004. Dr Gall was, and remains, a director of Southern Medical Services Pty Ltd (SMS) and the Senior Medical Officer at Victoria Barracks in Melbourne.

4.6 Dr Gall conducted a medical employment classification review (MEC Review) on 30 January 2004 and downgraded CAPT Lawton to medical category MEC 303. As will appear later in this report, the then meaning of MEC 303 was:

> Medically unfit for deployment or seagoing service in the medium term. Fit for other duties, as defined by a medical officer, in major capital cities (implies access to advanced specialist health care).

4.7 Dr Gall conducted a further review on 5 March 2004.

4.8 CAPT Lawton was further reviewed by Dr Bergen on 4 February 2004. Dr Bergen modified the medication, arranged for an education and exercise rehabilitation program, and reported his findings to Dr Gall.

4.9 CAPT Lawton was posted to the Land 907 Project in the DMO in March 2004. The Project Director was LTCOL Andrew Libby and the Integrated Logistics Support Manager was MAJ Craig Byrne.

4.10 CAPT Lawton was reviewed again by Dr Bergen on 31 March 2004. Dr Bergen's report of that date to Dr Gall (exhibit 41CA) reads:

> "I reviewed Paul today. He has continued to improve and is significantly better than he was in January. He has not yet returned to his premorbid health, however."
He is walking two to four kilometers per day without difficulty and is sleeping comfortably on one pillow. He has returned to work as a Maintenance Planner at Victoria Barracks. This is obviously mostly sedentary work”.

4.11 CAPT Lawton was examined on two occasions by another cardiologist at the Heart Failure Centre, Dr Andrew Taylor. On 30 June 2004, Dr Taylor reported to Dr Gall that CAPT Lawton was working full time at Victoria Barracks, and that his condition was quite stable. On 27 October 2004, Dr Taylor reported to Dr Gall that CAPT Lawton was walking about five km a day, was not limited in his activities of daily living, and again that his condition was quite stable.

4.12 CAPT Lawton’s next review by Dr Gall was on 6 October 2004. Dr Gall noted that a further medical employment classification review (MECR) was required.

4.13 CAPT Lawton was reviewed again by Dr Bergin on 5 April 2005. Dr Bergin reported to Dr Gall that CAPT Lawton looked well, but was in the process of a medical discharge from the Army towards the end of 2006.

4.14 CAPT Lawton saw Dr Gall on 20 May 2005 for the purpose of a MEC Review. Dr Gall signed a Medical Employment Classification Review Record (MECR), known as a PM 518, on that day. As the confirming medical authority, Dr R. J. Vandenberg signed the PM 518 on 30 May 2005. The recommended classification was MEC 401. As will appear later in this report, the then meaning of MEC 401 was:

Medically unfit for deployment or seagoing service in the long term. Employable within current occupation, within restrictions, as defined by an MO.

4.15 The MECR Board met on 7 July 2005, accepted Dr Gall’s recommendation that CAPT Lawton’s classification be downgraded to MEC 401, and offered him a critical skills waiver (CSW) until 31 December 2006. CAPT Lawton accepted the offer of a CSW by letter dated 25 August 2005.

4.16 The Land 907 project contemplated that there would be two shipments of tanks from the USA. Following a visit to Australia of a security expert from the United States in August 2005, MAJ Byrne proposed that CAPT Lawton lead the escort of the first shipment and that he, MAJ Byrne, lead the escort of the second shipment. LTCOL Libby agreed with the proposal. CAPT Lawton was not only willing but also very keen to go. Although his classification at that time (and at all times thereafter) was MEC 401, he was not suffering from any symptoms of his cardiomyopathy.

4.17 Following the issue of DI(G) PERS 16-15 of 11 April 2005 and in anticipation of the issue of HD 236 of 21 November 2005, a training package was developed by Dr J. Bailey and LTCOL V. Ross. Both held positions with the Joint Health Support Agency (JHSA) in Canberra. The package was a power point presentation headed “CMEDR Training Package”. The package was presented by Dr Bailey and LTCOL Ross during a tour of ADF health facilities from June 2005. They visited HMAS Cerberus and RAAF Base Williams on 19 September 2005. The presentation focused on the MEC review process, and no reference was made to the definition of
"deployment" or to any changes in that definition. Dr Bailey told the second Inquiry (T 1930 13-33):

"...The presentation was to try to explain about medical employment classification process so that the information that was provided was what the Medical Employment Classification Review Board needed to make decisions and informed decisions about people, so, yes, part of it was how to fill in the paperwork, but it was also trying to explain the reasons behind that, and why that information was needed, and give examples on what kind of information was needed, because examples are often a very good training tool”.

"...My answer, as stated previously, was that the aim of the package was to try to teach people about the medical employment classification process and not to highlight the changes in policy. It was more to teach them how to apply it to provide the right level of information so that the Medical Employment Classification Review Board could make appropriate decisions based on as much information as possible”.

4.18 Dr Gall and Dr Grove were not invited to, nor were they aware of, any of the presentations. The power point slides were posted on the JHSA website.

4.19 CAPT Lawton saw Dr Gall again on 7 April 2006. Dr Gall’s statement with respect to that visit (Exhibit 49CA) reads as follows:

“24. On 07 April 2006, Captain Lawton came to see me and was referred to his cardiologist with a request also for further blood tests. At this consultation he advised me that he wished to travel to the United States to act as an escort on a ship back to Australia. My understanding of this trip was that he was to fly to the United States and would spend 30 days at sea on a commercial vessel acting purely as the officer attached to a guard for the transportation of Abrams tanks from the United States to Australia. He expressly stated that that he wished to attend on this trip and that his role on the trip was purely supervisory and that it did not require any physical exertion. My understanding was that he was to act effectively as a passenger on the vessel concerned. He was advised at this time that he would need a clearance from his cardiologist.”

4.20 CAPT Lawton saw Dr Bergin again on 18 April 2006. The opening paragraphs of Dr Bergin’s report of that day to Dr Gall (exhibit 41CA) read as follows:

“I was pleased to review Paul today. He continues to be extremely well with no cardiac symptoms at all. He remains NYHA (New York Heart Association) class I.

He told me he is planning a trip to the United States with the Army in August. The trip involves a plane trip there and a trip by ship back. I do not see any reason this could not go ahead.”

4.21 Dr Bergin told the first Inquiry he knew nothing more about the proposed trip than that which he had written in his notes, namely “Planning trip to the US in
August. Plane there, ship back.". Dr Bergen received no request from command to provide a medical clearance for the case. He said (T 721 36-38):

"This was my standard six-monthly review which, in the course of it, he raised, not the Defence, that he was going on a trip".

4.22 Dr Bergin understood the round trip was about a month but did not recall any detail. He did not inquire whether there would be a doctor on board the ship.

4.23 The two soldiers who were to escort the first shipment, namely TPR Diprose and TPR Hansen, were selected in about April 2006.

4.24 Dr Gall’s last consultation with CAPT Lawton was on 12 May 2006. Dr Gall’s statement with respect to that consultation reads as follows (exhibit 49 CA paragraph 25-26):

“My final consultation with the member was on 12 May 2006. I noted in this consultation a letter received from the treating cardiologist, Dr Peter Bergin, dated 18 April 2006 wherein it was noted that Captain Lawton was extremely well with no cardiac symptoms at all. He remains NYHA class I.

He told me he is planning a trip to the United States with the Army in August. This trip involves a plane trip there and a trip by ship back. I do not see any reason why this could not go ahead.

So that the appropriate authorities could be advised and arrangements made for the trip, I informed Captain Lawton that he would be fit to go to sea…”

4.25 MAJ Byrne said in his statement (exhibit 57CA paragraph 21):

“He was given the all clear by both doctors and showed me a letter from his specialist, dated 18 Apr ’06, stating so.”

4.26 CAPT Lawton drafted an "Overseas Visit Authority" which was signed by Mr Colin Sharp on 26 June 2006.

4.27 CAPT Lawton drafted a document headed "Land 907 Tank Replacement Project - International Security Escort Administrative Instruction". The document was cleared by MAJ Byrne, and then signed by LTCOL Libby on 17 July 2006 (exhibit CH1). The document outlined the administrative requirements for the trip, and stated that for all phases CAPT Lawton would be the detachment commander. Amongst the annexures to the documents was Annex B, sometimes referred to in the evidence as the "medical plan", which stipulated the actions to be taken in the event of "Medical emergency in Baltimore" and "Medical emergency on ship". One of the actions under the latter heading was:

"c. seek medical assistance from the ship's medical officer”.

4.28 A point to notice is that “medical officer” means qualified medical practitioner, and the ship did not have, as it turned out, a qualified medical practitioner on board at the relevant time.
4.29 CAPT Lawton and TPRs Diprose and Hansen flew from Melbourne to Baltimore on 1 August 2006.

5. THE MEDICAL EMPLOYMENT CLASSIFICATION SYSTEM AS IT WAS APPLIED TO CAPT LAWTON

5.1 As already mentioned, CAPT Lawton was re-classified twice following the diagnosis of his cardimyopathy in December 2003: to MEC 303 by Dr Gall on 30 January 2004 and to MEC 401 by the MEC Review Board on 7 July 2005.

5.2 The Defence Instruction in force on 30 January 2004 was DI(G) PERS 16-16 of 20 April 2000. The Defence Instruction in force on 7 July 2005 was DI(G) PERS 16-15 of 11 April 2005.

5.3 The relevant definitions were as follows:

a. DI(G) PERS 16-15 of 20 April 2000 (paragraphs 8 and 5):

i. MEC 303. Medically unfit for deployment or seagoing service in the medium-term. Fit for other duties, as defined by a medical officer, in major capital cities (implies access to advanced specialist health care).

ii. MEC 401. Medically unfit for deployment or seagoing service in the long term.


b. DI(G) PERS 16-15 of 11 April 2005 (paragraphs 19 and 8):

i. MEC 303 (now combined in definition of 301). Medically unfit for deployment or seagoing service in the medium-term. Fit for other specific duties and locations as defined by an MO. A review date should be set no later than 12 months from the initial UMECR. Should the member remain non-deployable at the review period the member is to be referred to MECRB. Members must have access to specialist medical care in accordance with their active medical management plan.

ii. MEC 401. Medically unfit for deployment or seagoing service in the long-term. Employable within current occupation, within restrictions, as defined by an MO.

iii. “Deployment”. The full range of occupational and general military tasks performed in any operational / non-operational environment remote from the usual bases of medical support.

Later, in paragraph 9 of Annex B under the heading "Medical Employment Classification Review Board Determinations", and against the word "deployability", the following appears:
MEC is to be assessed in terms of the member’s ability to be employed in their primary occupation when deployed in any operational environment. A member who cannot perform their occupation when deployed is classified as non-deployable.

5.4 Dr Gall’s PM 518 of 20 May 2005 recommended employment restrictions in addition to the down-grade to MEC 401, namely:

1-7, 1-10, 3-2, 3-3, 3-6, 4-1, 4-3.

5.5 For definitions of these codes it is necessary to go to the health directive which was then in force, namely HD 236 of 7 August 2001. The definitions were as follows:

1-7 “physical training at restricted pace; this restriction may be given when members can attempt physical training, but at a slower pace, are able to slow down before symptoms of pain and distress would occur”;

1-10 “exempt combat fitness testing”;

3-2 “no load carrying”;

3-3 “no route marches”;

3-6 “unfit warlike operations but fit peace support operations”;

4-1 “requires access to pharmaceutical resupply”;

4-3 “requires periodic access to specialist care”.

5.6 The MECR Board’s PM 532 of 7 July 2005 shows that Dr Gall’s recommended employment restrictions (other than 3-6) were accepted by the Board, but that the Board added a further restriction for which the code was “5-1 (major city)”. The definition of 5-1 in HD 236 of 7 August 2001 was:

5-1 “Fit for posting only to a specific location (must be defined in additional text)”

5.7 All of the above definitions of MEC 303 and MEC 401 contain the composite expression "deployment or seagoing service". The expression "seagoing service" is not defined in any defence instruction or health directive. It should be observed, however, that the meaning and scope of the definition of “deployment” between 20 April 2000 and 11 April 2005 was widened significantly on and after 11 April 2005. "Military duties" was expanded to "The full range of occupational and general military tasks" and "operational environment" was expanded to "any operational / non-operational environment remote from the usual bases of medical support”.

5.8 These were important changes to the meaning of “deployment”. Before 11 April 2005, the word had an operational connotation, both according to the DI(G) PERS 16-15 of 20 April 2000 definition and, in the view of most witnesses who were asked, according to general usage within the ADF.
5.9 CAPT Lawton's assessment under the PULHEEMS system was noted by Dr Gall in the PM 518 of 20 May 2005 and by the MECR Board in the PM 532 of 7 July 2005. The assessment remained as follows:

P-7, U-2, L-2, H-2, E1/0, E1/0, M-2, S-2.

6. THE MECR BOARD'S DETERMINATION OF 7 JULY 2005

6.1 Pursuant to paragraph 14d of DJ(G) PERS 16-15 of 11 April 2005, Dr Gall's PM 518 of 20 May 2005 triggered the referral to the Medical Employment Classification Review Board (MECRB).

6.2 A number of documents (exhibit 16 CA) were submitted to the MECR Board for the purposes of its determination, namely:

a. A document headed "Workplace Disability Report" signed by LTCOL Libby on 22 February 2005 and marked for the attention of Dr Gall. The document contains the following four paragraphs:

1. CAPT Lawton has been posted to the Tank Program since Mar 04. He has been employed full time as the Maintenance Plans Officer in the integrated Logistics (ILS) Section of the Land 907 Major Capital Equipment Project. A copy of his duty statement is included at Annex A. CAPT Lawton is required to carry out these duties in an office environment seated at a desk for the majority of the time. The work hours are a standard eight hour day with a small amount of travel.

2. CAPT Lawton easily copes with this environment with his medical condition offering no restrictions on his capacity for work or the standard to which this work is completed. CAPT Lawton's condition does not require him to be absent for extended periods from his workplace and he has never been unavailable for a scheduled activity or visit out of the office. CAPT Lawton is always available to his immediate supervisor and his interaction with the rest of the ILS team is fair and equitable with no consideration given to his medical condition during any division of work or responsibilities.

3. In the period directly after his diagnosis CAPT Lawton was understandably upset and depressed. He quickly overcame this emotion and I have seen no sign of anything other than a positive attitude. Specifically, CAPT Lawton continues to seek his attendance on career courses and is actively planning the next few years of his career. In Dec 04 CAPT Lawton successfully completed a Basic Fitness Assessment.

4. I have no hesitation supporting any efforts that may retain CAPT Lawton in the Army. I am certain that he is well suited to his current workplace and capable of offering effective service".
the PM 518 signed by Dr Gall on 20 May 2005 and by Dr Vandenberg on 30 May 2005;

c. a document headed "Notification of Medical Assessment" signed by Dr Vandenberg on 30 May 2005, also known as a PM 64; and

d. a document headed "Member's Health Statement" signed by CAPT Lawton on 24 June 2005. The two concluding paragraphs read as follows:

"...In summary this condition has little effect on my employability within the DMO and limited effect on my wider employability within Defence. My condition is now such that it no major effect on either my work or home life. My health has improved markedly and is still improving and there are no signs that it will deteriorate in the near future. In terms of diet, ability to deal with stress, general fitness, physical and mental health, arguably I am in better condition now than I have ever been.

While my Cardiomyopathy is showing no signs of deteriorating (in fact is still improving) my continued employment in Defence is greatly advantageous to both myself and more importantly Defence. Currently, I am an asset to Defence and it will be some time before I become a liability."

e. a document headed "Medical Employment Classification Review Board Record" signed by COL Wells on 28 June 2005.

6.3 As already mentioned, the MECR Board met on 7 July 2005. Two documents purport to record the MECR Board's determination on that date, namely a set of minutes and a form headed "Medical Employment Classification (MEC) Advice", which was the PM 532. The minutes were signed on 26 July 2005 by MAJ Caldwell as Secretary and by COL (now BRIG) Simpson as Chairman.

6.4 The minutes and the PM 532 both show that Dr Gall's recommendations in the PM 518 were accepted by the Board, with the addition of an offer of a critical skills waiver (CSW) until 31 December 2006. To the restrictions recommended in the PM 518, the PM 532 added a further restriction, namely "5-1(major city)". The principal paragraph in the minutes, which was based upon information in the document signed by COL Wells on 28 June 2005, reads as follows:

"...Medical Advice: CAPT Lawton has developed a serious and potentially life-threatening heart condition. The cause is unknown. It has come under good control with appropriate treatment but he remains on a significant amount of critical medication and requires periodic (regular) specialist review. This type of cardiac condition usually deteriorates over time and there are no specific curative treatment available. Availability of medication is essential and the ability to handle severe physiological stresses is significantly lessened. For CAPT Lawton the likelihood of becoming a medical liability in the deployed environment is high. Prognosis - Guarded (variable outcomes in both the short and longer term). Represents a significant risk in the deployed
environment. Loss of medication may see significant and rapid deterioration. Concurrent illness may exacerbate the condition.

DE Advice: TMS Action Plan submitted. Member's preference is to continue to serve on, although if he were to proceed to discharge, he would seek full time employment using existing skills.

CA Advice: Recommend CSW until Dec 06 if that is medically viable.

Decision by MECRB:

Confirmed MEC 401; P7; 1-7, 1-10, 3-2, 3-3, 4-1, 4-3. CSW until Dec 06. Not reviewable...

6.5 The forms PM 64 and PM 532 are both "staff-in-confidence" documents and both contain a distribution list. The distribution list for the PM 532 reads (under the heading "Army"): 

Original - DOCM-A (Officers) 
- SCMA (Soldiers) 
- APA (Reservists MAJ and below) 
Copy 1 - Unit personnel file 
Copy 2 - Unit Medical Record 
Copy 3 - Member 
Copy 5 - Health records - Army 

6.6 Dr Gall's evidence is that he did not see the PM 532 or the minutes or any other document that emanated from the MECR Board (T 1285-15 and 1286-25).

6.7 In addition to the two documents already mentioned, two other less formal documents also dealt with the determination of the Board. The first was a letter that COL Simpson wrote to CAPT Lawton's superior officer LTCOL Libby. The date is shown as "July 05". We quote the key paragraphs:

"2. The MECRB determined that Captain Lawton should be classified MEC 401 as a result of his condition. In accordance with reference A, this MEC is defined as non-deployable in a military environment and the member will not regain a deployable profile within 12 months.

3. As a result of being non-deployable, in terms of the Army's directive on deployability and physical fitness, regrettably I must inform you that Captain Lawton is medically unfit for further service. However, the Board was willing to provide Captain Lawton with a Critical Skills Waiver (CSW). As such, the MECRB determined that he be offered a CSW until 31 December 2006 and the member will be retired after this date. This CSW is offered on the basis that his condition remains stable."

6.8 The second document was a letter dated 26 July 2005 that COL Simpson wrote to CAPT Lawton. The letter repeated the advice given in the letter to LTCOL Libby that, as a result of being non-deployable, CAPT Lawton was unfit for further service but would be offered a critical skills waiver until 31 December 2006.
6.9 CAPT Lawton accepted the MECR Board’s offer of a CSW by completing and signing the appropriate form, and his letter of 25 August 2005 which accompanied the form reads as follows:

"... I wish to advise DOCM-A that while accepting the CSW, I would still like to be considered for a review at the cessation of the CSW.

I understand the concerns of the MECRB relating to my employment potentially aggravating my condition, however, point out that specialist medical advice is that my condition is improving. Therefore, I believe that you should reserve judgment on my continued employability."

6.10 When the documents that purport to record the MECR Board’s determination of 7 July 2005 are compared, a number of points emerge:

a. The employment restriction “5-1(major city)” in the PM 532 is missing from the minutes;

b. When COL Simpson wrote in his letter to LTCOL Libby that CAPT Lawton’s MEC 401 is defined as ‘non-deployable in a military environment”, he probably had in mind the superseded and restricted definition of “deployment” in DI(G) PERS 16-115 of 20 April 2000;

c. COL Simpson’s letters to LTCOL Libby and CAPT Lawton both omit any reference to the PULHEEMS figures and the employment restrictions fixed by the Board (perhaps he took the view that it was unnecessary to repeat the figures and restrictions already mentioned in the PM 532); and

d. As subsequent events have shown, the risk posed by a “concurrent illness” was important to a proper understanding of CAPT Lawton’s condition, yet only the minutes refer to that risk, and no relevant person had access to those minutes.

6.11 Before leaving this heading, we need to draw attention to the complex nature of the PM 532. The PM 532 is designed to reflect comprehensively and definitively the ultimate view of the MECR Board about the medical employment classification of a member. And, as already appears, the PM 532 has wide distribution within the ADF. Yet the form is in code and inexplicable without reference to three separate defence policy documents. For the meaning of the MEC figure, the reader needs to go to either the current version of DI(G) 16-15 or the current version of HD 236. For the meaning of the restrictions, the reader needs to go to the current version of HD 236. And for the meaning the PULHEEMS figures, the reader needs to go to DI(A) 159-1. A copy of the PM 532 pertaining to CAPT Lawton is one of the annexes to this report.
7. SHOULD CAPT LAWTON HAVE BEEN ALLOWED TO UNDERTAKE THE ESCORT, GIVEN HIS MEDICAL EMPLOYMENT CLASSIFICATION?

7.1 General observations

7.1.1 By the time that CAPT Lawton's medical suitability for the trip became an issue in 2006, the MECR Board had already determined in 2005 that CAPT Lawton was, to quote the first sentence of the MEC 401 classification, "medically unfit for deployment or seagoing service in the long term". Given that CAPT Lawton's trip occurred in August 2006 during the currency of HD 236 of 21 November 2005 and DI(G) PERS 16-15 of 11 April 2005, there can be no doubt that the trip satisfied the expression "deployment or seagoing service". Indeed, the trip was both a "deployment" and "seagoing service". A "deployment", because, in terms of the definition in DI(G) PERS 16-15 of 11 April 2005, the trip fell squarely within "the full range of occupational and general military tasks performed in any operational / non-operational environment remote from the usual bases of medical support". "Seagoing service", because the words are not qualified by definition or context, and so should be construed to mean what they say.

7.1.2 It must follow that the trip was undertaken and permitted in breach of then current ADF instructions and directives. It must also follow that, notwithstanding Dr Gall's advice that "he would need a clearance from his cardiologist" and MAJ Byrne's words "He was given the all clear by both doctors", the trip could not have been lawfully authorized by CAPT Lawton's superiors.

7.1.3 A further point to notice about the classifications and restrictions that applied to CAPT Lawton is the emphasis that they place on the need for access to specialist medical care. Curiously the MEC 303 definitions of April 2000 ("access to advanced specialist health care") and April 2005 ("access to specialist medical care") are stronger in that regard than the MEC 401 definitions that were in force at the time. As for the restrictions, they both require access to medical care ("pharmaceutical resupply" in the case of 4-1 and "periodic access to specialist care" in the case of 4-3). And it will be recalled that, according to the minutes of the MECR Board's determination of 7 July 2005 (exhibit 16CA), CAPT Lawton:

"...remains on a significant amount of critical medication and requires periodic (regular) specialist review."

7.1.4 The MECR Board's determination of 7 July 2005 represented the Board's one and only involvement in the MEC review process for CAPT Lawton. The Board's information at that time was that CAPT Lawton's employment was restricted to duties seated at a desk in an office environment for the majority of the time, and that the work hours were a standard eight hour day with a small amount of travel. Even upon the footing of duties that were essentially sedentary in nature, the Board was still only prepared to offer a critical skills waiver of limited duration to CAPT Lawton.

7.1.5 The decision to select CAPT Lawton to lead the first escort party was made a month or so after the MECR Board's determination of 7 July 2005. Between then and about April 2006, the Board should have been provided with details of the escort duties and asked to revisit the question of waiver. In other words, the Board should
have been given the opportunity to address the nature of the trip and CAPT Lawton’s suitability for it, especially with respect to the availability of regular specialist care.

7.1.6 COL (now BRIG) Simpson was not involved in the decision to allow CAPT Lawton to undertake the trip, but his evidence to the first Inquiry about the meaning of major city is of interest (T 623-45 to T 624-24):

CAPT Hume: “In respect of those parameters, do you consider that this task fell within the restrictions of employment?”

BRIG Simpson: “I would say that it wouldn’t, mainly because the restriction to a major city does relate to where they’re to be posted, but it also relates to where they are going to be spending the majority of their time in terms of their employment as well. As I said before, the Board probably assessed that the member would be doing local travel within Australia. Puckapunyal is not necessarily a major city, but it is reasonably close to major cities, it is an hour away from Canberra - from Melbourne, rather. So, from that point of view, whilst I think that the employment restrictions would have been written with consideration to the employment disability report, and what the Board understand the nature of the person’s duties to be. So they would be read in combination, based on what the Board, the MECRB could foresee the person doing.”

CAPT Hume: “All right, Sir, what I’m asking you is though, that, in your opinion, was his being sent on this trip something that fell outside the restrictions, in other words, it was contrary to the restrictions that were placed on him, in your view?”

BRIG Simpson: “I would say that the restrictions probably in those terms don’t preclude consideration for that type of task being given to the officer. What I would say is that given that it’s outside the employment that has been described to the Board, that a separate assessment should probably have been made as to whether it was appropriate that the person be asked to do that.”

7.1.7 The requirements of DI(G) 16-15 of 11 April 2005 in relation to determinations of the MECR Board should be recalled. LTCOL Libby and MAJ Byrne did not have the authority to over-ride the determination of the MECR Board of 7 July 2005. Dr Gall did not have the authority to grant a “clearance” or, more accurately, a waiver.

7.1.8 The introductory paragraphs of HD 236 of 21 November 2005 should also be recalled. CAPT Lawton’s MEC should have been cognizant of “the additional tasks which (he) could be expected to perform as part of (his) general military duties”.

7.1.9 It is likely that CAPT Lawton stopped taking his medication approximately 6-8 weeks prior to 29 or 30 August 2006. This conclusion is based upon the unused tablets found in his cabin after his death, and upon a statement that he made to Captain Myhre (exhibit 1 CA) in TPR Diprose’s presence (exhibit 36 CA, paragraph 43).
7.1.10 These various points are especially significant when it is remembered that the Board's view on 7 July 2005, as reflected in the minutes, was that CAPT Lawton:

a. should remain on a significant amount of critical medication;
b. that he required periodic (regular) specialist review;
c. that availability of medication was essential;
d. that the likelihood of his becoming a medical liability in the deployed environment was high;
e. that his prognosis was guarded;
f. that loss of medication may see significant and rapid deterioration; and
g. that concurrent illness may exacerbate the condition.

7.1.11 Our final observation under this sub-heading concerns the PULHEEMS System. If the functional restriction "outside the Area of Operations" is read down to accommodate the environmental restriction "Service in Australia only", it must follow that CAPT Lawton's trip was permitted and undertaken in breach of his P7 rating.

7.2 Conduct of persons potentially affected by the Inquiry

7.2.1 Dr Gall

7.2.1.1 Dr Gall is a general medical practitioner and a director of Southern Medical Services Pty Ltd (SMS). SMS is contracted to supply medical services to the ADF. Dr Gall is also a member of the Navy Reserve, but in the provision of medical services through SMS he acted as a civilian.

7.2.1.2 The contract between SMS and the Commonwealth of Australia represented by the Department of Defence for the provision of clinical and administrative services was executed by Dr Gall on 16 March 2005. The question whether SMS through its medical practitioners was bound by the contract to apply ADF health policy was the subject of debate at the hearings. Whatever the answer as a matter of strict law, the drafting of the contract is ambiguous and open to differing interpretations. Paragraph 9.3.1 under the heading "Policy Requirements (Core)" purports to bind SMS and it's representatives to nine separate "Commonwealth policies of general application", but there is no reference at all in the list to ADF defence instructions and health directives. The "Statement of Work" in Attachment A, on the other hand, contains a number of references to ADF health policy. For example "Medical Employment Classification Reviews" are one of the clinical services that the contractor is required to provide (2.2 a(iii)) and "Maintenance of administrative policies" are one of the administration services that the contractor is required to provide (2.3 h).

7.2.1.3 The contract is unsatisfactory in this respect, and future contracts of this kind should make it clear beyond argument that medical contractors are bound to comply with the health policies of the ADF.
7.2.1.4 Although SMS's contract with the Department of Defence, as we have said, was ambiguous on the question whether SMS through Dr Gall was obliged, in the legal sense, to comply with ADF health policy, Dr Gall's evidence was that he did his utmost to comply with defence instructions and health directives, and in this case he did consider CAPT Lawton's MEC 401.

7.2.1.5 Dr Gall's role in relevant events was as CAPT Lawton's general practitioner, but the person who was primarily responsible for CAPT Lawton's cardiomyopathy was the specialist cardiologist, Dr Bergin. Dr Nicholson told the first Inquiry (T 748 35-43):

"So I would think that the general practitioner's role is not really to reproduce what the specialist and their team are doing but to be a bit supportive and encouraging and provide the pills when necessary and perhaps deal with other issues that might crop up, you know, unrelated illnesses et cetera. But I would expect that a GP would largely leave the management of this very complicated problem to this heart failure group that are set up... specifically for the purpose".

7.2.1.6 Dr Bergin said that the medical treatment that CAPT Lawton received from Dr Gall and others before his departure from Melbourne was of the highest possible standard. "Exemplary" was the word that Dr Bergin used.

7.2.1.7 The main criticism that has been advanced against Dr Gall is that he erred in advising CAPT Lawton that he was fit to go on the trip. This criticism brings into prominence a distinction which must be made between medical advice regarding travel, on the one hand, and ADF authorization to travel on the other. Medical advice regarding travel must be judged against the duty of care that a medical practitioner owes to his patient. Albeit informed by medical advice, ADF authorization to travel must be judged against its health policy and its statutory occupational health and safety responsibility to its employees.

7.2.1.8 A distinction should also be drawn between the question whether CAPT Lawton was physically and mentally able to undertake the trip and the question whether prompt (say, within 24 hours) specialised medical treatment would be available to him in the event of a deterioration in his heart condition or the contraction of a concurrent illness. Dr Nicholson was effectively answering the first question when he said (T 739 15-28):

"It's a very difficult question that one, because in hindsight obviously the answer is no. But hindsight is not a very good way of looking at this. You have to make the decision in advance, and by all accounts at the time that decision was made in mid 2006 he was remarkably well. Nobody was to know that he would, apparently, have decided to stop his treatment. That would - I mean, had he said in advance, "I'm going to stop all these medicines", I would hope that would've alerted somebody to the fact that - that he was not in a - a condition to go anywhere. So, I think, in fairness to the - to the people making the decision at that time - and we have to constantly go back to that - the decision that was made in mid 2006 was that at that time he was medically very well; stable; on treatment; with no symptoms of any significant degree;
and he was capable of flying to America and going on a boat cruise. And I understand that in 2005 he did just that. I'm told.”

7.2.1.9 Notwithstanding these distinctions, it is clear from Dr Gall’s evidence that he did not limit his advice to advice that a medical practitioner would give to his patient. Dr Gall considered CAPT Lawton’s medical employment classification of MEC 401 and believed that the DI(G) PERS 16-15 of 20 April 2000 definition of “deployment” still applied. His evidence was (T 1332 15):

“I was unaware of that change of "deployment". If I was aware of the new definition of "deployment", he wouldn’t have gone but, based on the documentation I had, on the Defence Instructions I had, no, there would not have been any change of advice.”

7.2.1.10 So it would seem that Dr Gall saw himself as giving medical advice as a general practitioner, but also as giving effect to ADF health policy as he understood it to be. Although he was mistaken about the meaning of deployment, he was correct in his view that the ultimate responsibility for the application of health policy rested with the CO. It is important to note that Dr Gall was not approached by LTCOL Libby or MAJ Byrne for advice. His only communication was with CAPT Lawton.

7.2.1.11 Dr Gall did not know that the employment restriction 5-1 (major city) had been imposed by the MECR Board. But given the use of the word “posting” in the definition of the restriction, he argued before us that this was a “posting” restriction that was satisfied in the case of CAPT Lawton by his posting to Melbourne. Dr Gall said that knowledge of that restriction would not have altered his view.

7.2.1.12 Dr Gall’s evidence was that he received no formal training concerning defence health policy, and his knowledge of health policy was learned on the job and from the advice of colleagues. He said he was not notified of the change to the meaning of “deployment”.

7.2.1.13 Dr Gall said that the procedures for the receiving, noting and filing of medical information at Victoria Barracks, especially information emanating from the MECR Board, were deficient. Although Dr Gall knew that CAPT Lawton had received a MEC 401 from the MECR Board in July 2005, his evidence to the second Inquiry was that he did not see any of the documents that had been initiated by the Board. By ‘documents’, we mean the minutes, the PM 532, and the letters that COL Simpson wrote to CAPT Lawton and LTCOL Libby.

7.2.1.14 Dr Gall said that it was not his practice to obtain health policy from the DEFWEB (the ADF intranet), rather he used a hard copy. The problem with use of hard copy is that it can become out of date. Of course, the DEFWEB may not always be accessible. Dr Gall’s evidence on this topic should be noted (T 319 17-30):

“...The current policies are haphazard. They are contradictory, both internally and between each other. They come out at irregular times. There’s poor notification of it and poor training and implementation. What is really required, I think, is a single document where you can have it on your desk, so it doesn’t matter whether the computer is working or not or, for instance if
you're on a ship whether you actually have access to it, because I go onboard ships I can't actually access any Defence documentation because, understandably, if you're at sea the CO of the ship wants their computer and access to satellite and other facilities for their running of their ship, rather than issues Defence health documentation. When I have been in other places, and I've been on deployments overseas you can't actually access any Defence documentation at all. But if I had a single volume with all of this material in it adequately indexed and regularly updated, it would help avoid some of these problems."

7.2.1.15 To the extent that Dr Gall purported to give mere medical advice to CAPT Lawton that he could go, we have no quibble with that advice. CAPT Lawton felt well and wanted to go, and his treating cardiologist had said that he could go. Moreover, the advice would have been vindicated by events. If CAPT Lawton had:

a. maintained his medication; and / or
b. sought medical advice on his respiratory symptoms in Baltimore or Panama; and / or
c. accepted the advice of his cardiologist that he should not travel if ill,

doubtless he would still be alive today.

7.2.1.16 To the extent that Dr Gall purported to give effect to ADF health policy, he was in error, because, even on his own concession, this was a deployment in terms of the April 2005 definition of that word. But the overwhelming point is that CAPT Lawton’s trip should not have been permitted by command in breach of his medical employment classification. The only option open to command, namely a reference back to the MECR Board for a waiver, was not an option that was exercised.

7.2.2 Dr Grove

7.2.2.1 Dr Grove had provided medical services to the ADF for 15 years as a member of Southern Medical Services. She had experience of defence instructions, but no training.

7.2.2.2 Dr Grove saw CAPT Lawton on two occasions. The consultation on 27 January 2005 was early in the history, and so nothing more need be said about it.

7.2.2.3 The second consultation was on 20 July 2006. CAPT Lawton wanted tablets for insomnia and sea sickness. He did not consult Dr Grove about his cardiomyopathy or seek advice about whether he was fit to undertake the trip. But Dr Grove did check his file to confirm that he had been cleared by his cardiologist and by Dr Gall. She knew of his MEC 401, and was "a bit surprised" he was going to America. But the decision to allow him to go had already been made, and she had no reason to doubt that due process had occurred.

7.2.2.4 Our conclusion is that, given the timing and limited nature of the consultation, Dr Grove acted appropriately and was not required to make further enquiries about CAPT Lawton’s suitability for the trip.
7.2.3 LTCOL Libby

7.2.3.1 LTCOL Libby was the Project Director for Land 907, and as such CAPT Lawton's senior officer.

7.2.3.2 LTCOL Libby participated with MAJ Byrne in the decision to allow CAPT Lawton to lead the escort party. His evidence to the second Inquiry was (T 1770 12-16):

"...it was more an agreement in principle that what Craig had suggested to me was appropriate, that Paul Lawton was the best person for the task. I agreed that he should start all the planning and go through his preparations then the executive as such has sign off when the travel documents and so on were put into place. It occurred over probably a six to 12 month period”.

7.2.3.3 As mentioned earlier, the “Overseas Visiting Authority” was signed by Mr Colin Sharp on 26 June 2006, and the “Land 907 Tank Replacement Project – International Security Escort Administrative Instruction” was signed by LTCOL Libby on 17 July 2006. LTCOL Libby said that the second of those documents, the administrative instruction, was CAPT Lawton’s authority to travel. He agreed that the administrative instruction did not address CAPT Lawton’s particular medical circumstances, and said that no other document would play that role. He said that a number of risk assessments of the project were done, but none addressed CAPT Lawton’s medical condition.

7.2.3.4 LTCOL Libby told us that CAPT Lawton’s medical employment classification was one of the initial considerations of his suitability for the task, and one of the reasons why “we” (presumably he and MAJ Byrne) "asked him or he was to go and get the clearances through the medical system”.

7.2.3.5 LTCOL Libby was asked (T 1773 5-8):

“And at the time you asked him to go and get the clearances from the medical, was it your understanding that the clearances that could be obtained either from a civilian doctor or simply from a medical officer at Victoria Barracks could over ride the Medical Review Board limitations and restrictions?”

and his reply was:

“My opinion was that the medical officer who was advising us or who was Paul’s GP was the person who could make those decisions. On the primacy of certain documents and certain interpretations of those documents, that wasn’t for me to make that call”.

7.2.3.6 A question arises as to whether LTCOL Libby was CAPT Lawton’s CO for the purposes of paragraphs 32 and 33 of Dj(G) PERS 16-15 of 11 April 2005. The answer is unclear. LTCOL Libby did not have CO status by way of an instrument of appointment from the Chief of Army. He told us he shared the responsibility for CAPT Lawton’s medical welfare with LTCOL McRae (T1768). But it is apparent from LTCOL McRae’s evidence to the first Inquiry that LTCOL McRae had nothing to do with CAPT Lawton. LTCOL Libby, on the other hand, was the most senior
officer in CAPT Lawton’s chain of command, and for all practical purposes seemed to occupy the role of his CO from the point of view of his health and welfare. Moreover, LTCOL Libby prepared the Workplace Disability Report to assist the MECR Board’s determination of 7 July 2005, and he was the recipient of COL Simpson’s letter reporting on the result of the Board’s determination.

7.2.3.7 It was put to us that, within the DMO, the administrative resources for the management of medical employment classifications of uniformed members were less than those that were available to members of Army units within the ADF.

7.2.3.8 By accepting medical advice that CAPT Lawton was cleared to go, and by participating with MAJ Byrne in the decision to allow CAPT Lawton to go, LTCOL Libby effectively over-ruled the MECR Board’s determination of 7 July 2005. LTCOL Libby should have taken an active role in the management of CAPT Lawton’s medical employment classification to ensure that he was only employed in accordance with his MEC 401. He should have referred CAPT Lawton’s critical skills waiver back to the MECR Board for review and a further determination after the decision to allow CAPT Lawton to go had been taken.

7.2.3.9 LTCOL Libby’s errors were unintended, however, and committed in the context of a flawed medical employment classification system. He should have been clearly identified as CAPT Lawton’s CO for the purposes of paragraphs 32 and 33 of DIPERS 16-15 of 11 April 2005. The MECR Board’s PM 532 of 7 July 2005 should have been sent to LTCOL Libby and it should have plainly stated on it’s face, amongst other things, the need for access to regular specialist review and the prohibitive effect of the MEC 401. That would have made it clear that the only option, short of an outright withdrawal of authority to go, was a referral back to the MECR Board for review and a further determination in light of the escort duties proposed.

7.2.4 MAJ Byrne

7.2.4.1 MAJ Byrne was CAPT Lawton’s immediate superior. He took an interest in CAPT Lawton’s career and provided support where he could. In time the two became friends.

7.2.4.2 As for events prior to CAPT Lawton’s departure from Melbourne, MAJ Byrne first learned of CAPT Lawton’s MEC 401 from COL Simpson’s letter to LTCOL Libby. He had not been provided with training in the interpretation of MECs. He did not know of the restrictions imposed by the MECR Board until he saw the Board’s PM 532 when he cleared out CAPT Lawton’s drawer.

7.2.4.3 CAPT Lawton told MAJ Byrne that he had been cleared to go by Victoria Barracks Medical. By accepting that information, and by participating with LTCOL Libby in the decision to allow CAPT Lawton to join the escort party, MAJ Byrne effectively over-ruled the MECR Board’s determination of 7 July 2005. MAJ Byrne’s error, however, was unintended, and it was committed in the context of a flawed medical employment classification system. As stated elsewhere in this report, the MEC system should have addressed the nature of the trip and CAPT Lawton’s suitability for it. The system should then have provided to CAPT Lawton and his
superiors a single document containing a clear and unequivocal prohibition in plain English. The system, and the meaning of words like 'posting' and 'deployment', should not have been open to differing interpretations by command. These deficiencies are overwhelmingly of a systemic rather than an individual nature.

8. EVENTS BETWEEN CAPT LAWTON’S ARRIVAL IN BALTIMORE AND HIS DEATH

8.1 On 1 August 2006, CAPT Lawton and TPRs Diprose and Hansen arrived in Baltimore and remained there for 12 days. Their task during this phase of the project was to supervise the preparation and loading of the tanks.

8.2 CAPT Lawton appeared to MAJ Holland and the two Troopers to have developed flu like symptoms, that is, a bad cough and nasal and chest congestion, during the time he was in Baltimore.

8.3 On 7 August 2006, CAPT Lawton telephoned MAJ Byrne and reported that he had caught the flu and was feeling a bit miserable.

8.4 On 10 August 2006, CAPT Lawton met MAJ Holland who had flown on that day to Baltimore from Detroit. In the chronological sequence of events that accompanied his written statement, MAJ Holland said (exhibit 44CA):

1. Thu 10 Aug 06 – 1540hr I flew into Baltimore from Detroit.

2. Thu 10 Aug 06 – approx 1800hr I met with Paul in my hotel room at the Marriott, Baltimore. Paul said that he was not feeling well enough to go out for dinner or socialise, and said that he had caught a cold because of the long flight, very hot weather in Baltimore, and in and out of air-conditioned facilities. He spoke as if his cold had just developed since arriving in Baltimore. He said he was taking medication bought from a local pharmacy and that he should be alright after a good sleep. Paul did not discuss his heart condition during our conversation.

3. Thu 10 Aug 06 – approx 1930hr Paul left to go to bed, as he was not feeling well and was sniffling and had a blocked nose. We discussed if he needed to visit a doctor and whether we should ask the Mid Atlantic Terminal (MAT) staff the next day, for assistance in locating a local doctor. Paul said that “he would see how he was feeling in the morning” and left my room.

8.5 On 12 August 2006, CAPT Lawton sent e-mails

a. to MAJ Byrne:

“Am finally feeling better. Seriously considered calling 911 the other night, was sure I was going to die and quite concerned that I had made no contingency for an "officer down" in the admin instruction (note that for the PAR) only just today able to determine how to send a letter, so don’t expect a postcard”.

b. to Planet Rock Promotions:
"Have been very ill with the flu and thought at one stage I might be
dying, but didn't so it is all OK".

The detachment boarded MV Talisman on this date, and the ship departed from
Baltimore the following day.

8.6 On 15 August 2006, the ship docked at Savannah and departed the same day.

8.7 On 17 August 2006, the ship's log reported that CAPT Lawton approached the
Chief Officer for medicines for a sore throat and was given Strepsils. The transcript
of the Chief Officer's evidence to the Norwegian Maritime Inquiry reads (exhibit
1CA):

"...The W asked L regularly about his health condition, after 17.08. Every
time he asked L said he was ok".

8.8 On 19 August 2006, which was a Saturday, the ship docked at Manzanillo for
a few hours before anchoring in the canal to await permission to proceed. Both
troopers went ashore at Manzanillo and brought back cold and flu tablets for
CAPT Lawton at his request. CAPT Lawton used his satellite phone to call MAJ
Holland and MAJ Byrne. The call records for the phone (Exhibit 15CA) show that
the duration of the calls to MAJ Holland was 50 seconds and 1.04 minutes
respectively. Paragraph 9 of MAJ Holland's written statement reads (exhibit 44CA):

"...I missed the call as I was mowing the lawn, and Paul left a voice message.
Paul's message said, "Can you give me advice on the medical plan, if I need to
use it." 'I am going to speak with the Captain.' Paul did not request to be
evacuated nor be removed from the vessel for further medical treatment and
did not provide any comment on his medical condition. I was unable to
contact Paul and never spoke with Paul personally, as I could not get through
to the satellite phone. This was the only direct contact that I had with Paul
after we said farewell at the Port."

8.9 On 20 August 2006, which was a Sunday, MAJ Byrne telephoned LTCOL
Libby In paragraph 34 of his written statement, LTCOL Libby states (exhibit 62CA):

"MAJ Byrne contacted me on the morning of Sunday, 20 August and told me
that CAPT Lawton had told him that he was still feeling ill and he may need to
seek treatment in Panama."

8.10 On 21 August 2006, MAJ Holland sent an e-mail to MAJ Keynes with copies
to MAJ Byrne and LTCOL Libby. The relevant paragraphs read (exhibit CA79):

"On Sat afternoon, CAPT Paul Lawton, leader of security escort team, called
me on his satellite phone and reported that his cold/flu had got worse and he
believed he may need to see a doctor. He asked about the medical plan. He
also indicated that he was going to see the Captain about medical treatment.
CAPT Lawton's details are...(details were supplied)

On Sat, 19 Aug 06, the vessel was scheduled to commence sailing thru the
Panama Canal. This is dependent on the amount of traffic waiting. As we
discussed, the decision to evacuate CAPT Lawton will be up to the Captain of
the boat and will be dependent on CAPT Lawton’s medical condition and assessment. If he is provided with medical treatment on-board, then he may be seeking medical support at one of the future Ports of call for the vessel. He will therefore need assistance to locate a suitable medical facility at these ports. Can Australian Embassy inform the various Embassy or High Commission staff about this situation, in case CAPT Lawton does need medical support on arrival at one of the Ports of call or evacuated off the vessel?

CAPT Lawton has a satellite phone No +8816 3143 0771 and a personal Cell No +61 410 021 013. He also has a Defence Travel Card, Diners Club, which he could use to pay for medical treatment if required. We will encourage CAPT Lawton to stay on-board if possible, and seek treatment at the next Port. Can you provide any further advice, and is there any further action that Project Office should take to monitor and ensure that CAPT Lawton’s medical condition does not deteriorate?“.

8.11 On 23 August 2006, Christopher Hawker of Ridgeway International UK and MAJ Holland exchanged e-mails as follows (exhibit 56CA):

a. Christopher Hawker to MAJ Holland:

“...if Talisman has been sitting at anchor, waiting to transit the Canal since Saturday, Paul should have had ample time to go and see a doctor.

I’ve still had no reply to my e-mail to the Captain and have heard nothing from Paul either...have you?”

b. MAJ Holland to Christopher Hawker:

“Thanks for the info. I have forwarded this to Australia. No I have not heard any more from Paul Lawton. I have tried calling a number of times since and cannot get thru. Cheers”.

8.12 On 24 August 2006, after a four day delay at anchor, MV Talisman sailed through the Panama Canal and headed for Papeete. MAJ Byrne sent an e-mail to MAJ Holland (exhibit 57CA):

“I had a call from Paul Lawton this morning 25 Aug and he has informed me that they have finally sailed through the Panama Canal and he is feeling 100% better and will continue with the ship to Melbourne”.

8.13 On 25 August 2006, MAJ Holland sent an email to MAJ Byrne (exhibit 57 CA):

Thanks for the info. I have been ringing Paul a couple of times a day, without success. We also had an email from the Captain yesterday afternoon. He said that Paul was much better and that they were 5 hrs into the Panama Canal. I guess the ‘harden up’ pills are working and all is well. I will advise the Embassy so they can inform the various Embassies and High Commissions to
stand down. I assume that this will throw the party plans at the Dock into turmoil.

On 30 August 2006, the following e-mails were sent (exhibit 57 CA):

a. MAJ Holland to MAJ Keynes:

"1. The condition of CAPT Paul Lawton has now deteriorated. It seems that he has developed a lung infection and is now using oxygen to assist his breathing. He is receiving medical treatment on the vessel and the Captain has received medical advice from the company doctor in Norway. The Captain has also requested medical information on CAPT Lawton from Australia. I have a copy of this info and will send that to you separately. CAPT Lawton will need medical support on arrival in Papeete.

2. The vessel is due into Papeete, Tahiti, on 3 Sep and I have attached a screen copy of the website info as at 30 Aug 06. The vessel has increased speed and is steaming with the intention of arriving earlier, possibly on 2 Sep 06. The Captain is providing daily updates on CAPT Lawton's condition and the vessel schedule. CAPT Lawton is to be removed from the vessel to get this treatment in Papeete, and will return to Australia, when his condition has stabilized and he is released by a doctor. His replacement has been identified and will be waiting in Papeete for the vessel to arrive."

This e-mail goes on to further discuss the provision of medical support for CAPT Lawton in Papeete.

b. Captain Mhyre to MAJ Byrne:

"Ref our telecom this morning (Aus Time)

Captain Lawton has not been feeling well for a few days. He apparently had a cold or a flu (according to himself) on joining the Talisman in Baltimore August 12th. He has taken private medicines for this condition.

After leaving Savannah on the 15th he was feeling a bit "seasick", and had a soar [sic] throat fro a few days but he improved.

After transiting the Panama Canal on the 24th his condition has gotten worse. Have talked to him several times and on Sunday 27th he was given antibiotics for a possible chest infection. To day on the 29th, his condition had worsened again and he had difficulties of breathing normally. He was then given oxygen and after a while improved with regards to normal breathing.

Have been seeking professional help from "Medico Haukeland", a team of doctors and specialists at the university hospital in Bergen Norway. Are still waiting for their response."
Robert / Fridthjof RIC: Have decided to increase to full speed for an earlier ETA Papeete.

Will keep you all updated on the situation...”

c. MAJ Byrne to Captain Myhre:

“Thanks for your update. We are currently organizing a Doctor and Australian Embassy Staff to meet the Talisman when it docks in Papeete. We will take Paul off the ship no matter what condition he is (Hopefully Better) in when you reach Papeete. I will let you know when this is organized. We are also in the process of arranging a replacement to fly to Papeete to meet the ship. His name is Major Gavin Rawlins. I will also send you details when they are finalized. Enclosed are a copy of some of Paul’s Medical Documents that give a summary of his Heart Condition and has his EF (Ejection Fraction) value.

Could you please inform Paul that I have spoken to his Partner Cat and she has been totally informed of what is happening and understands the situation. I will continue to keep her updated and neither of them should worry. Thanks again for your assistance”.

d. MAJ Byrne to Captain Myhre:

“Sorry. This new computer system is driving everyone crazy. Enclosed are Paul’s Med Docs”

8.15 On 31 Aug 2006, MAJ Byrne and Captain Myhre exchanged e-mails as follows (exhibit 57 CA):

a. MAJ Byrne to Captain Myhre:

“Thankyou for the update. It is good to know that Paul is improving. I will pass these details onto his Partner Cat. MAJ Rawlins has the details of your agent in Papeete and will make contact today”.

b. Captain Myhre to MAJ Byrne:

“Regret to inform you all that at 0800 UTC August 31st, Captain Paul Lawton died after a sudden change in his health condition.

Maj. ByrneRIC: Please informe next of kin and others on your side.

Asle RIC: Please inform relevant persons on your side.”

9. THE MEDICAL CAUSE OR CAUSES OF CAPT LAWTON’S DEATH

9.1 The autopsy was conducted by Dr Noel Woodford, pathologist, on 8 September 2006. Dr Woodford gave evidence to the first inquiry on 13 November 2006. He said he found an enlarged heart and signs of rapidly developing cardiac
failure. He also found signs of viral inflammation in the lungs with superimposed bacterial changes. Dr Woodford's autopsy report, dated 17 November 2006, describes the cause of death as:

"pneumonitis complicating dilated cardiomyopathy."

9.2 Dr Bergin gave evidence before the first Inquiry, and some of the points that he made were as follows.

9.3 If a patient with cardiomyopathy develops a chest infection, the infection puts the heart's limited reserve under greater stress.

9.4 CAPT Lawton's heart weighed 632 grams, whereas a normal heart would be 300 to 350 grams. CAPT Lawton's respiratory illness may or may not have been compounded by his heart problem, and it may have been enough on its own to kill him. Severe respiratory illness in the setting of known heart disease carries a high mortality.

9.5 The morphine and oxygen that was administered to CAPT Lawton on ship was appropriate treatment. Lasix was appropriate to get rid of the fluid build-up. The antibiotics Doxycycline and Ciprofloxin covered the likelihood of there being a bacterial component.

9.6 Even had CAPT Lawton been fully medicated, he was still at risk of heart failure. His risk of developing heart failure, without intervention from serious infection, arrhythmia or thyroid disease, was pretty low, provided he adhered to medical advice with respect to the topics of regular exercise, fluid balance, excessive salt and medication. Even if fully medicated, he remained at risk of acquiring a concurrent illness. None of the medications that were prescribed for CAPT Lawton would have produced any cognitive impairment.

9.7 Dr Michael Nicholson also gave evidence before the first Inquiry.

9.8 Dr Nicholson practices as a cardiologist in Tasmania. He is, or was at the time he gave his evidence, Director of the Cardiology Department at the Royal Hobart Hospital and Associate Professor of Medicine at the University of Tasmania.

9.9 Dr Nicholson did not treat CAPT Lawton, but was called to give his expert opinion on relevant material.

9.10 Dr Nicholson explained the inter-relation between CAPT Lawton's pneumonitis and his cardiomyopathy in this way:

(T 734 27-38)

"I think there are two factors which have combined to be the cause of death. The problem is that the cardiomyopathy, which by all accounts had deteriorated, perhaps because of withdrawal of treatment, had been associated with an infection. Each of these two problems makes the other worse; that is, the weakness of the heart with congestion of the lungs that follows makes the chest infection worse and the chest infection makes the heart failure worse. So you can end up in a bit of a downward spiral where
both of these problems are affecting each other and once the process is initiated without effective treatment often of both conditions, then unfortunately survival is uncommon”.

(T 748 1-10):

“It’s a matter of degree. Were he as well as he was reported to be in mid-2006, he would not have been particularly susceptible to lung infection. But he was apparently very unwell in Baltimore. He would be very susceptible to infection then. As I made the point earlier, it’s a bit of a vicious cycle. Once you’ve got your chest infection your heart failure gets worse. Once you’ve got your heart failure, your chest infection gets worse. So you can end up in a downward spiral that is triggered by a chest infection. If his heart failure had been particularly bad at that time – and perhaps it was – then that would explain the whole sequence of events in my mind”.

9.11 Dr Nicholson said that the treatment that CAPT Lawton received before he left on the trip was of the highest possible standard. As for the treatment on the ship, Dr Nicholson had no doubt that CAPT Lawton had become seriously unwell a week or so after the ship’s departure from Baltimore. The drugs supplied were appropriate, but by that stage CAPT Lawton was so unwell that the treatment was unlikely to be successful. Given his symptoms in Baltimore, the process of cardiomyopathy deterioration was already in place at that time, and he almost certainly had a chest infection. Ideally, that was when medical treatment should have been initiated, and had treatment then been similar to treatment provided in Canberra in 2003, there is every chance that his death would have been averted. His chest would have been x-rayed and the likely findings would have led to him remaining in Baltimore. More than a mere resumption of his medication was required. The process of restoration of health would have taken as long as it took in 2003, which was about a couple of months.

9.12 Dr Nicholson agreed with Dr Bergen that the medication prescribed for CAPT Lawton would not have had any significant impact upon his cognitive function.

10. WERE SUFFICIENT STEPS TAKEN BY ADF PERSONNEL TO PROTECT CAPT LAWTON’S HEALTH AND WELFARE AFTER HIS ARRIVAL IN BALTIMORE AND WHILST HE WAS ON THE SHIP?

10.1 General Observations

10.1.1 The conduct of the persons potentially affected by the Inquiry needs to be approached under this heading both objectively and subjectively. Objectively for the purpose of deciding, with the benefit of hindsight, whether errors were made. Subjectively for the purpose of deciding, avoiding hindsight, whether criticism should be levelled. The objective approach will assist the formulation of recommendations on remedies for the future. The subjective approach will assist the formulation of recommendations for or against administrative action.

10.1.2 Many of the persons potentially affected gave oral evidence both before the first Inquiry and before this Inquiry. They also gave written statements prior to and in
anticipation of the first Inquiry. With respect to the credibility of witnesses, we are of the opinion that, with one qualification, the witnesses who gave evidence to the second Inquiry did their best to recount events as they remembered them. The qualification relates to MAJ Byrne and MAJ Holland and their evidence that CAPT Lawton did not want to get off the ship to see a doctor in the Panama region and was not encouraged to remain on board. As will appear shortly, we have concluded that the reverse was the case. We consider that the evidence of MAJ Byrne and MAJ Holland was reconstructed and self-serving in that particular regard. Having said that, we need to keep in mind that we are primarily concerned with the way that witnesses conducted themselves in 2006, rather than with the manner with which they gave evidence to the Inquiry in 2007.

10.1.3 The need to avoid hindsight when considering conduct subjectively for the purpose of deciding whether criticism should be levelled is especially important when considering whether LTCOL Libby, MAJ Byrne, Mr Holland and MAJ Keynes should have done more to protect CAPT Lawton’s health and welfare after his arrival in Baltimore and whilst he was on the ship. They did not know:

a. of the seriousness of CAPT Lawton’s heart condition;

b. of the risk that arises from the failure of a sufferer of the condition to maintain appropriate medication;

c. of the fact that CAPT Lawton had ceased to take his medication approximately 6 to 8 weeks before his death;

d. that a concurrent illness might have serious consequences for a sufferer of the condition;

e. that a cold or flu would fall into the category of “concurrent illness”.

10.1.4 CAPT Lawton was a mature, intelligent and resourceful Army officer, and he must have been aware of the serious nature of his heart condition, of the possible consequences of a concurrent illness, and of the need to maintain his medication. His superiors had no grounds for believing that he might act in a way that was detrimental to his health.

10.1.5 On being asked at the first Inquiry for his reaction to evidence that suggested that some six to eight weeks before he died CAPT Lawton stopped taking his medication completely, Dr Bergen said he would be appalled, and that he spent a lot of time with patients trying to reinforce the need to take prescribed medications. It would be reasonable to stop some medications when there was no longer any need, such as Lasix. Lasix is a diuretic, and can be stopped once the patient is free of fluid retention. But medications which protect the heart, such as Carvedilol and Aldactone, must be maintained.

10.1.6 Dr Bergin told the first Inquiry that if CAPT Lawton reported in Baltimore that he was unwell, he had already contravened rule 1 of Dr Bergen’s advice to every patient with heart disease, which is: don’t travel if you’re not well. Had CAPT Lawton presented to Dr Bergin with a sore throat, sweat and fever, he would have been hospitalised if very sick and if not so sick treated as an outpatient. His blood would
have been tested, his chest x-rayed and a sample of his sputum tested for an infection. If a fever, he would have been given an antibiotic with Amoxil not an unreasonable choice.

10.2 Did CAPT Lawton want to leave the ship, and was he encouraged to remain on board?

10.2.1 The combined and cumulative effect of the following evidence supports in our view a conclusion that, during the four days that the ship was at anchor in the Panama Canal, CAPT Lawton wanted to leave the ship to see a doctor, but was encouraged to remain on board:

a. The voicemail message left by CAPT Lawton for MAJ Holland on 19 August 2006 and the inference to be drawn from the 1 minute 4 second duration of the call that more was said than the words recounted by MAJ Holland;

b. CAPT Lawton made 3 calls to MAJ Byrne on 19 August 2006 (at 1606 h for 3 minutes 32 seconds, at 1611 h for 2 minutes and 1 second, and at 1844 h for 6 minutes and 34 seconds), all on MAJ Byrne’s mobile phone, and 1 call for 5 seconds on his land line;

c. CAPT Lawton made 1 telephone call to Mr Bob Robertson on 19 August 2006 (at 1043 h for 14 seconds) on telephone number 12 027 973 197, presumably in response to paragraph 4c of the medical plan in the administrative instruction (exhibit CH1), namely:

"Contact Overseas Emergency Healthcare representative (Mr Bob Robertson +1 202 797 3197) if medical treatment has been rendered or is required”.

d. CAPT Lawton made 3 calls to MAJ Byrne’s landline and 4 calls to his mobile phone between 20 and 22 August 2006 (with a duration in chronological sequence of 14 seconds, 45 seconds, 1 minute 6 seconds, 7 seconds, 3 minutes 49 seconds, 8 seconds and 40 seconds).

e. The statement of MAJ Keynes (exhibit CA78) regarding the telephone call that he received from MAJ Holland on 19 August 2006 (which is the day the ship docked in Manzanillo and then anchored in the Panama Canal):

“He informed me that he had received a message via satellite phone from Army Captain Paul Lawton that he was not feeling well and said he wanted to see a doctor at the next port of call. I remember asking Major Holland what the next port of call would be and when. I remember him saying that he was looking at the ship's sailing schedule and that it should have left the Panama Canal. He informed me, and my understanding was that the ship was on its way to Papeete”.

f. The evidence of LTCOL Libby that MAJ Byrne telephoned him on the morning of Sunday 20 August 2006 to report that
“CAPT Lawton had told him that he was still feeling ill and he may need to seek treatment in Panama”;

g. The evidence of Ms. Campbell to the first Inquiry that CAPT Lawton telephoned her on 20 August 2006 and said (T 358 12-15):

“...Just that they were stuck in the harbour for four days, but that’s it - and they weren’t allowed to get - he said everyone wasn’t allowed to get off the ship, which I thought was bizarre, but he said it was dangerous, so I was like okay, fair enough, whatever”.

h. The first paragraph of MAJ Holland’s e-mail to MAJ Keynes on 21 August 2006 reporting that CAPT Lawton believed he may need to see a doctor”;

i. MAJ Holland’s e-mail to MAJ Byrne on 25 August 2006 with the observation that:

“I guess the ‘harden up’ pills are working and all is well”.

j. The evidence of Ms. Campbell to the first Inquiry that MAJ Byrne telephoned her on 27 August 2006 and said (T 352 10 and exhibit 39 CA):

“We will be evacuating Paul at Tahiti, because we couldn’t get him off at Panama”.

k. The evidence of TPR Diprose to the first Inquiry that, when the ship was moored at Manzanillo, CAPT Lawton spoke to him (T 123-43 to T 124 14):

“...he said that he had called work, and that he had explained to them that he wasn’t feeling well, and would like to get off the ...he explained that he had asked whether he could get off the ship, and that it had been explained to him that it would be very difficult to do so in Panama because there was - they told him that there wasn’t any consulate or Australian embassy in Panama, and that he would need to make his way to Mexico before he would be able to get back to Australia, and that that would be very difficult”.

l. The evidence of TRP Hansen to the second Inquiry that he went to see CAPT Lawton in his room and (T 1467-23):

“...that’s when he explained to me that he had rang up work and asked them what would happen if someone was to get sick. He basically explained to me in his own words that, “Don’t get sick,” that’s - trying to get off the ship and to get to the hospital and to get to see the consul would be very hard....”.
m. Dr Gall sought information from MAJ Byrne on 1 September 2006 about the circumstances of CAPT Lawton’s death. Dr Gall’s contemporaneous note, with an expansion of his abbreviations, reads:

“The ship okay, but on arrival Panama Canal developed a recurrence. Consideration to remove him from ship to see doctor. Arrangements through embassy in Mexico. For security and health not taken off.”

10.2.2 It is true that some of these items of evidence, if considered in isolation, may be open to other interpretations. But, as we have said, it is the combined and cumulative effect of the evidence overall which is decisive of the point we make under this sub-heading.

10.3 Conduct of persons potentially affected by the Inquiry

10.3.1 LTCOL Libby

10.3.1.1 LTCOL Libby was kept informed by MAJ Byrne from time to time, and was one of the recipients of MAJ Holland’s e-mail of 21 August 2005. With the benefit of hindsight, LTCOL Libby readily conceded before us that he should have acted decisively whilst the ship was in the Panama Canal. But we do not criticize him for failing to act, given his belief on reasonable grounds that CAPT Lawton was suffering from flu-like symptoms and nothing more sinister than that.

10.3.1.2 LTCOL Libby told us (T 1801 – 1802) that there was a strict timetable for the arrival of the tanks in Melbourne, and the four day delay in the Panama Canal was a matter of concern. But he rejected a suggestion that his decision making in relation to CAPT Lawton’s illness was affected by the need to ensure that the ship got to Melbourne on the due date.

10.3.2 MAJ Byrne

10.3.2.1 We have already concluded that, during the few days that the ship was at anchor in the Panama Canal, CAPT Lawton wanted to leave the ship to see a doctor but was encouraged to remain on board. Although we are satisfied that MAJ Byrne knew of CAPT Lawton’s wish to see a doctor and encouraged him to remain on the ship, we are unpersuaded that MAJ Byrne’s conduct in that regard was unreasonable in all the circumstances. We have already made the point that reasoning with hindsight must be avoided. MAJ Byrne’s information at that time was that CAPT Lawton was suffering from a cold or the flu for which he was taking tablets, and that his symptoms were fluctuating. MAJ Byrne had no reason to believe that CAPT Lawton’s situation was any more serious than that.

10.3.2.2 There is no suggestion in the evidence that CAPT Lawton injected any urgency to see a doctor into his discussions with MAJ Byrne. Indeed, had CAPT Lawton thought there was an urgent need to see a doctor in the Panama region, surely he would have communicated his concerns, not only to MAJ Byrne, but to Ms Campbell as well, and also to one or more of TPR Diprose, TPR Hansen, the ship’s captain and the first officer.
10.3.2.3 There is no suggestion in the evidence that MAJ Byrne acted carelessly or uncaringly or in bad faith. Indeed, MAJ Byrne had every reason to do what he could for his friend.

10.3.3 Mr Holland

10.3.3.1 Although Mr Holland took a discharge from the ADF on 24 January 2007, it will be convenient for the purposes of this section of the report to describe him as MAJ Holland.

10.3.3.2 At the time of relevant events, MAJ Holland was stationed in Detroit as the Resident Project Liaison Officer for the Land 907 Project. He had known CAPT Lawton since January 2004, and they had worked together in Melbourne and travelled together to the USA in September 2004. As already appears, they were together again in Baltimore between MAJ Holland’s arrival on 10 August 2006 and CAPT Lawton’s embarkation on 12 August 2006. MAJ Holland was not at that time in CAPT Lawton’s chain of command.

10.3.3.3 Although MAJ Holland was aware that CAPT Lawton suffered from a heart condition, all that he was told in Baltimore was that CAPT Lawton had caught a cold. He had no reason to be concerned about CAPT Lawton’s health at that stage.

10.3.3.4 MAJ Holland’s response to CAPT Lawton’s voicemail message on 19 August 2006, after attempting unsuccessfully to telephone CAPT Lawton, was to leave a message for the Defence Duty Officer at the Australian Embassy in Washington D.C. MAJ Keynes returned the call and MAJ Holland asked him to activate the medical plan and to investigate the availability of medical support. A number of options were discussed, including evacuation from the ship. MAJ Keynes asked MAJ Holland to put his request in writing, hence MAJ Holland’s e-mail to MAJ Keynes of 21 August 2006.

10.3.3.5 By the time MAJ Holland came to compose his e-mail to MAJ Keynes, he had talked to MAJ Byrne about CAPT Lawton’s illness. He did not speak directly with CAPT Lawton.

10.3.3.6 There is a discrepancy between MAJ Holland’s e-mail version of the voice message (“his cold / flu had gotten worse and he believed he may need to see a doctor”) and the version he gave to the Inquiry (“Can you give me advice on the medical plan, if I need to use it?”). We prefer the e-mail version because of its proximity to the message and because it sits more comfortably with the combined effect of other evidence to the effect that CAPT Lawton wanted to get off the ship in the Panama Canal to see a doctor. But the question remains: Did MAJ Holland’s e-mail of 21 August 2006 fall short of what was required?

10.3.3.7 With one qualification, we are of the view that the arrangements discussed in the e-mail, and the circulation of the e-mail to CAPT Lawton’s superiors, LTCOL Libby and MAJ Byrne, with the question “Can you provide any further advice, and is there any further action that the Project Office should take to monitor and ensure that CAPT Lawton’s medical condition does not deteriorate?” represent in all the circumstances an appropriate response by MAJ Holland to the voice message and the information he obtained from MAJ Byrne. We are unpersuaded that it was
inappropriate for MAJ Holland to suggest that CAPT Lawton be encouraged to remain on board if possible and seek treatment at the next port. We refer to our earlier comments about the need to avoid hindsight when considering if and where criticism should be levelled.

10.3.3.8 Our qualification is that the passage “the decision to evacuate CAPT Lawton will be up to the Captain of the boat” could have been better expressed. But we are unpersuaded that MAJ Holland meant to make more than the obvious point that the captain of the ship would need to be involved in any decision to evacuate. It is scarcely likely that he intended to convey that a decision to evacuate CAPT Lawton on medical grounds would be the sole responsibility of the captain without any need to refer to command.

10.3.4 MAJ Keynes

10.3.4.1 MAJ Keynes was a staff officer to the head of the Australian Defence Staff at the Australian Embassy in Washington at the relevant time. His involvement in events after CAPT Lawton’s departure from Baltimore was coincidental. With respect to his telephone call to MAJ Keynes on 19 August 2006, MAJ Holland said “unfortunately I dragged MAJ Keynes into this because it was my decision to activate the medical plan”.

10.3.4.2 MAJ Keynes described MAJ Holland’s call to him in the following paragraphs of his statement (exhibit CA 78):

“5. He informed me that he had received a message via satellite phone from Army Captain Paul Lawton that he was not feeling well and said he wanted to see a doctor at the next port of call. I remember asking Major Holland what the next port of call would be and when. I remember him saying that he was looking at the ships’ sailing schedule and that it should have left the Panama Canal. He informed me, and my understanding was that the ship was on its way to Papeete.

6. I can not remember at the time how long it was before he said the ship was due to arrive but we agreed that I should assist with arranging for Captain Lawton to see a doctor in Papeete when he arrived there if there were still problems. My concern was the member being held up on administrative issues such as cost of treatment once there. Major Holland said he would email what details he had regarding the ships schedule and contact numbers. I told him that since I had taken the call from him I would see the matter through instead of passing it off to another officer”.

10.3.4.3 MAJ Keynes went on to say in his statement that there was no suggestion in his discussion with MAJ Holland that evacuation was requested or warranted at that time. He could not recollect whether there was discussion about CAPT Lawton being encouraged to stay on the ship. He told the second Inquiry (T1480):

“I was under the impression that the ship had already left the Panama Canal and was steaming out into the Pacific on its way to Papeete. So the idea of him leaving the ship... didn’t enter my thoughts... I was focused on arranging medical support at the next port of call which was Papeete”.

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10.3.4.4 MAJ Keynes said in his statement that his response to MAJ Holland’s call was to speak to Embassy Consular staff on the Monday morning to seek advice on medical support for CAPT Lawton (through DFAT) as soon as the ship arrived in Papeete.

10.3.4.5 MAJ Keynes told the second Inquiry that, had he been aware of CAPT Lawton’s MEC 401, he would have contacted people like LTCOL Libby and generally acted with much more concern.

10.3.4.6 Again avoiding hindsight, we are of the view that MAJ Keynes’ response to MAJ Holland’s call was appropriate in the circumstances that he thought them to be at the time. His role was limited to arranging medical support in Papeete. He had no reason at the time to step beyond that role.

11. EVENTS IN THE AFTERMATH OF CAPT LAWTON’S DEATH

11.1 A convenient summary of the steps taken to notify CAPT Lawton’s family is contained in an e-mail which MAJ Byrne sent to various persons including LTCOL Libby on 1 September 2006:

"The following is an update on the current position with regard to CAPT Lawton:

1. A FATALCAS was released at approx 2100hrs 31 Aug 06.

2. His next of Kin (Partner) Miss Cat Campbell was notified by Myself, LTCOL Libby and Padre Lindmeyer at approx 2300hrs 31 Aug 06.

3. His Ex-wife and daughter has not been notified as yet. Padre Clark in Townsville will travel to see them in the morning. 1 Sep 06.

4. His mother in Melbourne has not been notified yet. LTCOL Libby and myself will endeavor to contact his Brother and find the best way to contact his mother. AM 1 Sep 06.

5. His father in New Zealand has not been contacted yet. LTCOL Libby and myself will endeavor to contact his Brother and find the best way to contact his father. AM 1 Sep 06.

6. Cat is aware that you will contact her in the morning (AM 1 Sep 06) and has requested that I accompany on your visit. Please call me to arrange a time.

7. She is with relatives at the moment and her mother and father will fly in from Canberra 1 Sep 06.

11.2 Information about repatriation of the body and arrangements for the funeral were given to the first Inquiry by COL Dodds.

11.3 The repatriation was led by Headquarters Joint Operations Command (HQJOC) and coordinated by HQJOC, Joint Movement Control Office (JMCO) and
DMO. The repatriation team comprised three Military Police (MP), a forensic dentist, a padre, psychologist and use of RAAF assets for repatriation (C-130 Hercules). The chain of custody was maintained by the MP Escort Party, through to the Coroner’s facilities in Victoria.

11.4 DMO was responsible for the reception arrangements from the touchdown of the aircraft at 1830h Wednesday 6 September 2006 and a separate VIP waiting area had been arranged for the family and an escort party to appropriately move CAPT Lawton from the aircraft to a private viewing area and later into the funeral director’s vehicle.

11.5 The arrangements for CAPT Lawton’s funeral on 12 September 2006 were coordinated by COL Dodds’ team.

12. THE TERMS OF REFERENCE AND THE BOARD’S FINDINGS THEREON

Terms of Reference (TOR) paragraph 7a.

The circumstances surrounding the selection of CAPT Lawton to escort the tanks from the United States to Australia (in particular, whether he was medically fit to perform these duties).

12.1 The selection of CAPT Lawton to escort the tanks was made by MAJ Byrne and approved by LTCOL Libby. CAPT Lawton was an ideal person to select from the viewpoint of his skills, training and knowledge of the exercise, and he was keen to go. The selection was recorded in a document headed “Land 907 Tank Replacement Project – International Security Escort Administrative Instruction” (exhibit 14CA).

12.2 CAPT Lawton was medically fit to perform the duties of the escort only in the physical sense. He required prompt (say, within 24 hours) access to specialist medical care, and no such care was available to him during the time that he was at sea. In any event, the selection was in breach of CAPT Lawton’s medical employment classification, because the escort was, in terms of the definition of MEC 401 in DI(G) PERS 16-15 of 11 April 2005, “deployment or seagoing service”.

12.3 CAPT Lawton’s MEC 401 was determined by the MECR Board on 7 July 2005. The selection of CAPT Lawton was made after that date. The Board did not conduct any subsequent review. The Board should have been asked to address the circumstances of the escort for the purpose of granting a waiver. However, it is unlikely that, given CAPT Lawton’s need for prompt access to specialist medical care, a waiver would have been granted.

12.4 The administrative instruction was deficient in that it failed to address CAPT Lawton’s medical suitability for the escort and more especially his medical employment classification.

12.5 The medical plan in Annex B of the administrative instruction was deficient in two main respects:
a. it failed adequately to address CAPT Lawton’s need for prompt access to specialist medical care; and

b. it wrongly assumed that, in the event of a medical emergency on the ship, CAPT Lawton would be able to “seek medical assistance from the ship’s medical officer”. The ship did not have a qualified medical practitioner on board at the relevant time.

12.6 Although there was an erroneous belief in the minds of some at the time of CAPT Lawton’s selection that the only impediment was a medical clearance, the primary responsibility for CAPT Lawton’s participation in the escort must rest, in the final analysis, with a flawed medical employment classification system.

TOR paragraph 7b.

Whether CAPT Lawton was medically fit at the time of embarking on the M/S Talisman in the United States on or about 13 August 2006.

12.7 CAPT Lawton was not medically fit at this time. Quite apart from the matters discussed under TOR paragraph 7a above, he developed flu like symptoms whilst he was in Baltimore. Although neither he nor anybody else was alarmed at the time, the significance of those symptoms is that they were the early manifestation of his respiratory illness. Hindsight shows that a concurrent illness of that kind, when combined with his cardiac condition for which he was not taking medication, represented a serious threat to his health.

TOR paragraph 7c.

The events immediately prior to and after CAPT Lawton’s death; including a chronological account of such events along with a listing of the identity and particulars of persons substantially involved.

12.8 The events medically prior to CAPT Lawton’s death occurred on board MV Talisman. He was taken from his cabin to the ship’s sick bay the night before he died because the oxygen in the cabin was about to run out and there was a stationary oxygen supply in the ship’s sick bay. CAPT Lawton slept through the night and looked much better on the morning of 30 August 2006.

12.9 Captain Pål Myhre, the Master of the MV Talisman, says that he spoke to CAPT Lawton during the 30th, during which he sent his best regards to his colleagues in Melbourne. At 17:30 on 30 August 2006, things got worse for CAPT Lawton. He had eaten some food and soup in the morning which, unlike the day before on 29th, he was vomiting. He had kept everything down on the morning of 30 August. The Chief Officer, Vladimir Tikhonov, had been into see CAPT Lawton at about 15:30 and again at 16:30. TPRs Hansen and Diprose were taking turns sitting with CAPT Lawton. His breathing was very quick and very short, his colour was very grey and he asked for water, saying he was thirsty. His temperature was about 35.5°C, which was low, but it was measured under the armpit.

12.10 Captain Myhre came back to check on him at about 20:00 and CAPT Lawton told him “I’m very scared”. Captain Myhre tried to calm him down and to talk to him
and said that there was nothing to worry about. It was about this time that the doctor in Norway decided that he should be given morphine, which the Chief Officer administered in the amount of 5 mg, which was to be given every two to three hours. The doctor asked for a report after the first hour, which was sent, indicating that the first dose had had a positive effect and that he was calming down and resting and sleeping. CAPT Lawton was also given 40 mg of Lasix, which was his own medicine.

12.11 Through the stethoscope, the Chief Officer detected a "liquid sound" in CAPT Lawton's chest, which sounded like a cracking or bubbling, after which the doctor made a decision to administer the 40 mg of Lasix. CAPT Lawton's heart rate appeared rapid. CAPT Lawton was subsequently given 2 mg of morphine and the Lasix was administered about 23:30. At 23:30 CAPT Lawton told Captain Myhre that he would find CAPT Lawton's heart medicine not on the table in his cabin but on the table under the bookshelf. By this time, Captain Myhre had a copy of an extract of CAPT Lawton's medical records.

12.12 Captain Myhre counted each and every tablet and there were no used tablets. They were all sealed and he then went back to the sick bay, where things had really escalated. Captain Myhre was shown the urine sample in which there was no sugar according to the colour test. CAPT Lawton then asked for water, which was in a can so as to be at room temperature because CAPT Lawton had indicated that he didn't like to drink cold water. A glass was filled and a straw was provided so he could drink from the glass.

12.13 As Captain Myhre gave him the glass, he took a sip, then suddenly everything changed. The Chief Officer was standing at the other side of the bed at this time trying to take CAPT Lawton's blood pressure and the air went out of him, as if out of a car tyre, and his blood pressure went down. CAPT Lawton then went back with the glass of water behind him and he was absolutely limp. The Chief Officer administered CPR to CAPT Lawton with Captain Myhre holding his hand, feeling for a pulse. For a couple of minutes Captain Myhre thought he had a pulse but it could have been because of the hotness. Then there was nothing. Captain Myhre checked both hands for a pulse, and there was absolutely nothing. Captain Myhre gave him CPR for 25 minutes, clearing his throat several times. CAPT Lawton was on his side and he was foaming from the mouth. He was given CPR for 25 minutes without any signs of revival.

12.14 There were continued steps to try to take CAPT Lawton's pulse by the Chief Officer without success. Captain Myhre then contacted the doctor in Norway to ascertain the procedure to be followed. The ship's bosun, the Chief Officer and the two troopers moved his body into the freezer. The freezer was sealed with a master key and master tape.

12.15 The particular persons substantially involved in the events were:

a. Captain Myhre, Master of MV Talisman;

b. Vladimir Tikhonov, Chief Officer;

c. Trooper Hansen,
d. Trooper Diprose; and

c. Dr Alfred Halstensen, Haukeland University Hospital, Bergen, Norway, providing medical advice by telephone.

TOR paragraph 7d.

\textit{When, where and how CAPT Lawton died.}

12.16 CAPT Lawton died at 08:00 UTC on 31 August 2006, on board MV Talisman whilst at sea on its leg from the Panama Canal to Papeete, Tahiti, around position S 09° 20' / W 126° 51'; whilst the vessel was travelling at approximately 20 knots, Lat 09° 20' S Long 126° 51' W. The last port of call was Manzanillo, which was departed from on 19 August 2006 at 17:50. The cause of death was pneumonitis complicating cardiomyopathy.

TOR paragraph 7e.

\textit{The adequacy, in all the circumstances, of medical treatment provided to CAPT Lawton prior to his death.}

12.17 CAPT Lawton did not have his medical file with him when he joined the ship. An extract of the file was provided by MAJ Byrne by e-mail on 30 August 2006. The Chief Officer was qualified to administer first aid, but there was no medical officer on board. Expert medical advice was sought from Dr Alfred Halstensen in Norway. Dr Halstensen is a specialist of internal medicine and infectious diseases, and his advice was given through Medico Norway at Haukeland University Hospital in Bergen. The drugs supplied were appropriate, but medical and hospital facilities were not available on board to address CAPT Lawton’s condition. The owners of the ship were not to blame for the lack of facilities, and the Captain, First Officer and the doctor in Norway did all they reasonably could for CAPT Lawton in the circumstances. Had CAPT Lawton accessed medical and hospital facilities whilst the ship was in the Panama Canal, he would still be alive today.

TOR paragraph 7f.

\textit{Whether CAPT Lawton was on duty and, if so, the specific type of duty being performed at the time of, and immediately prior to, his death.}

12.18 CAPT Lawton was on escort duty at the time of his death. He was leading a three man security detachment to escort 23 Abrams tanks on MV Talisman from Baltimore to Melbourne. Immediately prior to his death, he was not performing any physical activity, because his medical condition had seriously deteriorated and he had been transferred to the sickbay of the ship.

TOR paragraph 7g.

\textit{CAPT Lawton’s medical history and his general state of health prior to his death.}

12.19 We refer to our extensive discussion of these matters earlier in the report. To briefly summarise, CAPT Lawton’s cardiomyopathy was diagnosed in December 2003. After a period of convalescence he became relatively symptom free. He
developed a respiratory infection in Baltimore. Whilst on the ship, his respiratory infection combined with his cardiomyopathy to cause his death.

TOR paragraph 7h.

The adequacy, in all circumstances, of post-death reporting and investigation procedures; including casualty notification, Service Police investigative activities, the conduct of the quick assessment and submission of 'hot issues briefs'.

12.20 The reporting of CAPT Lawton’s death in the immediate aftermath appears to have been appropriate. The Service Police investigations were, in the circumstances, adequate. The captain and the chief officer of the ship refused to be separately interviewed by the Police, but that was a matter beyond their control. The conduct of the quick assessment (exhibit 42 CA) and the submission of the ‘hot issues brief’ (exhibit 5 CA) both appear to have been adequate.

TOR paragraph 7i.

The adequacy, in all circumstances, of ADF repatriation arrangements for CAPT Lawton’s body.

12.21 The ADF repatriation arrangements for CAPT Lawton’s body were, in the circumstances, adequate. CAPT Morley, along with SGT Francis and CPL Bridges, were tasked to meet MV Talisman in Papeete and flew out of Australia whilst the ship was still about halfway to Tahiti. Instructions were given to ensure that the body of CAPT Lawton was to be treated with the respect and dignity of any ADF member and on arrival CAPT Morley made arrangements with the consular officer and addressed issues raised both by the French and Norwegian point of view. Steps were also taken to collect and store evidence and to ensure that CAPT Lawton’s remains were kept at the right temperature, in a secure area, standing piquet with him until he could be repatriated to Australia.

12.22 The process in dealing with the French authorities proceeded smoothly albeit that the French authorities did not wish any investigative procedures to take place on French soil with the exception of dental identification. In relation to which there was a need for a French doctor, from what we would call the Coroner’s Office, to become involved. The French doctor pronounced CAPT Lawton’s life extinct, and certified that he was free from infection so that he could be brought onto French soil.

12.23 CMDR Blenklin, the RAN forensic dentist, also attended to identify CAPT Lawton from his dental records and as the mortuary officer to ensure that the escort party conducted their duties correctly, which is what occurred.

12.24 The Critical Incident Response Team arrived on a C-130 aircraft. There was a minor incident as all team members did not have return tickets. The incident was sorted out and CAPT Lawton’s body was repatriated on the C-130 direct to Melbourne.

TOR paragraph 7j.

Whether action taken by the ADF following the discovery of CAPT Lawton’s death complied with extant guidance, procedures, orders and instructions, and whether
such guidance, procedures, orders and instructions were adequate in all the circumstances.

12.25 The action taken by the ADF following news of CAPT Lawton's death complied with standard guidance, procedures, orders and instructions. The DI(G) PERS 20-6 entitled "Deaths within and outside Australia of Australian Defence Personnel" dated 18 September 2006 addressed the issues concerning identification, investigation and repatriation and was marked Exhibit 2CA. The earlier interim arrangement for the Chief of Defence Force with regard to the inquiries was marked Exhibit 3CA.

12.26 Further action was adequate in all the circumstances, except insofar as it emerged that, in October 2007, more than a year after CAPT Lawton's death, x-rays from a department within the ADF were returned in a letter addressed to CAPT Lawton at the address at which his partner, Ms Carriona Campbell, still resided. There is a need for a coordination by the holder of the primary medical file after the loss of any ADF member to ensure that related department records are all obtained and centrally held to prevent belated correspondence being sent out addressed to the deceased member.

TOR paragraph 7k.

Whether, in all the circumstances, the ADF has provided adequate information, support and assistance (counseling, psychological, legal, financial, other – as applicable and appropriate) to:

i. CAPT Lawton's next of kin and other family; and

ii. ADF personnel affected by CAPT Lawton's death.

12.27 The ADF provided adequate information, support and assistance to CAPT Lawton’s next of kin and other family and to the ADF personnel affected by CAPT Lawton’s death.

TOR paragraph 7l.

The manner in which CAPT Lawton's next of kin and other family were notified of his death, and the appropriateness of such notification.

12.28 CAPT Lawton's next of kin and other family were notified of his death by MAJ Byrne and condolences were sent to the next of kin.

13. BOARD’S RECOMMENDATIONS BASED UPON THE EVIDENCE AND ITS FINDINGS

13.1 That no member of the ADF with a MEC 401 be permitted to travel to perform duties for the ADF outside Australia unless:

a. details of the travel and duties proposed are first submitted to and approved by the MECR Board;
b. the member’s commanding officer or head of service has certified that
details of the travel and duties proposed have been approved by the
MECR Board; and

c. the member takes with him his MECR Board determination.

13.2 That the MECR Board be empowered to impose conditions upon the grant of
approval, including a condition requiring a member to be in possession of the whole
or specified parts of his medical file whilst he is overseas.

13.3 That ADF members posted to DMO receive the command support and
structure that they would receive if posted to an ADF establishment. To that end, the
commanding officer of the member should be identified and provided with the
necessary resources.

13.4 That the Medical Employment Classification System be overhauled, and
attention given to the following features in particular:

a. that defence instructions and health directives be merged, and made
available within the ADF in both hard copy and on line;

b. that standard single forms be used by medical officers (in lieu of the
PM 518) and the MECR Board (in lieu of the PM 532) to
comprehensively record the classification of and restrictions pertaining
to a member;

c. that the forms be in plain English, avoid acronyms and codes, and be
explicable without the need to refer beyond the forms to defence
instructions, health directives or any other health policy of the ADF;

d. that the forms be treated by command and medical officers, and within
the ADF generally, as the official and authoritative source of a member’s
medical employment classification within the ADF;

e. that a determination of the MECR Board not be over-ridden by
command or by the clearance of a medical officer, and only varied by a
medical or critical skills waiver or further determination of the Board;

f. if a member’s duties change during the currency of a medical or
critical skills waiver, that the waiver be referred back to the MECR
Board for review and a further determination;

g. that the overall classification standard for members of the ADF be
uniform and that there not be a unique standard for the Army;

h. if the PULHEEMS system for the Army is to be retained, that it be
expressed in plain English and revised so as not to overlap any other
instruction or directive;

i. if the expression “seagoing service” is still to be used, that the
expression be expanded to clarify whether it applies to all ADF
members performing duties at sea, or whether it is confined to ADF or foreign warships, or to seafarers;

j. that restrictions or limitations attached to the MEC of a member who is to perform duties at sea, whether or not on a warship, be no less onerous than those which are attached to seafarers on general commercial ships;

k. that whenever the expression “medical officer” is used, it be used only in the sense of a legally qualified medical practitioner;

l. that the distribution list for a MECR Board determination of MEC 301 or greater include the member’s commanding officer and the senior medical officer at the location to which the member is posted;

m. if the meaning of a word in an instruction or directive is defined elsewhere in the document, that the word be accompanied by a side or footnote to that effect.

13.5 That a medical plan with respect to a member or members in a risk assessment or administrative instruction be the subject of enquiry and investigation to verify that suitable medical facilities and qualified staff are available and accessible to the member or members, and that thereafter appropriate information including contact details be included in or attached to the medical plan.

13.6 With respect to third party medical reports, that an instruction or order be issued to ensure that:

a. the reports are referred forthwith upon receipt to an appropriate medical officer for the checking of any action required, and

b. proper procedures are in place for the recording and follow up of action required.

13.7 With respect to amendments to any ADF health policy document, that:

a. before promulgation and while the amendments are still in draft form, JHSA seek advice and comment from reserve and contracted medical personnel;

b. the amendments be accompanied by instructions both for the prompt dissemination of those amendments to civilian contractors and other relevant persons and for the prompt training of those contractors and persons;

c. between promulgation and implementation of the amendments, there be a delay, of say 4 to 6 weeks, to allow for such dissemination and training;

d. JHSA be provided with sufficient resources for such dissemination and training; and
e. when incorporated in the policy document, the amendments be highlighted and accompanied by a side or foot note specifying the date from which they take effect.

13.8 That all contracts for the provision of medical services by civilian medical officers contain an obligation to comply with AFD health policy as specified, and a requirement that all subcontracts for the provision of those services contain a similar obligation.

13.9 That medical officers be provided with appropriate administrative time for reviewing information received relating to members and for general medical documentary administration and education.

13.10 That civilian medical officers contracted to provide medical services to the ADF be appropriately remunerated for:

a. reviewing information received relating to members and for general medical documentary administration and education; and

b. attending meetings, courses and seminars relating to ADF medical standards and administration.

13.11 With respect to a document that is missing from a medical or personal file (especially relating to medical employment classifications), that an instruction or order issue to ensure that:

a. the identity of the missing document is noted on or in the file; and

b. proper procedures and timelines are in place for follow up and the return of the document or a copy thereof.

13.12 With respect to the duties of a member with a MEC 301 or greater, that risk management policies and guidelines require that a risk assessment be conducted and reduced to writing, and that consideration be given to whether the assessment should include the specific telephone numbers of medical officers to be contacted in the case of an emergency.

13.13 With respect to a member with a MEC 301 or greater travelling or proposing to travel overseas on duties for the ADF, that an instruction or order be issued to empower his commanding officer to access his medical file for the purpose of determining his suitability or otherwise for those duties.

13.14 That a Defence Regulation be passed to bind any medical officer providing services to an ADF member, if of the opinion that the member's medical condition renders him unfit to perform his duties or poses a threat to himself or others, to disclose to the member's commanding officer such medical information about the member as the medical officer considers appropriate.

13.15 That an instruction or order be issued to bind any medical officer providing services to an ADF member, upon receiving a specific request from the member's commanding officer to advise whether the member's medical condition renders him unfit to perform specified activities or duties or poses a threat to himself or others, to
provide that advice and, if appropriate, advice also on how the situation might be addressed.

13.16 That an instruction or order be issued to require that command seek appropriate medical advice if a medical issue arises in relation to a member with MEC 301 or greater in a location where there is a risk that the member may not be able to access medical advice or treatment within 24 hours.

13.17 That command, when seeking advice on whether a member of the ADF is medically fit for proposed duties, specify details of the proposed duties, the proposed location and the nature of any travel required.

13.18 That a Defence Regulation be passed to provide that:

a. a commanding officer who accesses a member’s medical file pursuant to and for the purposes of paragraph 13.13 above

b. a medical officer who provides advice to a member’s commanding officer pursuant to and for the purposes of paragraph 13.15 above

c. a medical officer who provides medical advice to command pursuant to and for the purposes of paragraph 13.16 above

is deemed to have done so with the member’s consent.

13.19 That CAPT Lawton be commended for his contribution to the Land 907 Project and his dedication to his duty whilst on the ship.

13.20 That an instruction or order issue to ensure that, following the death of an ADF member, the medical unit holding the member’s medical file should recover and store all medical records including x-rays to prevent the inadvertent return of a record addressed to the deceased.

13.21 That expeditious steps be taken to arrange an alternative dispute resolution process in the nature of a structured mediation to redress the civil consequences for the next of kin and family of CAPT Lawton by reason of his tragic death.

13.22 That WO Paul Walsh and CAPT Stuart Pike be commended for their services to this Board of Inquiry.

13.23 That a copy of the Board of Inquiry report, whether or not made public by the Minister, be provided to Mrs Denise Lawton and Ms Catriona Campbell, as next of kin, to Comcare and the Victorian Coroner.
13.24 Whenever a board of inquiry is to be appointed to investigate the death of an ADF member, that:

a. an appropriate period for grieving be allowed to the member’s family before the hearing commences;

b. the commitments of potential board members and legal counsel be checked in advance to ensure that, as far as may be practicable, the hearing proceeds expeditiously once it commences.

13.25 The Board does not recommend that administrative action be taken against any potentially affected person.

C.R. LEE
President

4 Dec 07

N. MASOTTI
LTCOL
Board Member

9 Dec 07