REPORT OF THE COMMISSION OF INQUIRY INTO THE DEATH OF MAJOR THOMAS MCKERRON, ARA.

4 JUNE 2008
VOLUME 1

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PREFACE

The President of the Major Thomas McKerron Commission of Inquiry, Magistrate James Gordon, forwarded the report to the Appointing Authority, Air Chief Marshall A.G. Houston, AC, AFC, on 4 June 2008. The version here includes a number of deletions. Changes are listed in the Table of Amendments.

Material not published

As identified in the Table of Amendments, there are elements of the report which have not been published. This material has not been published because publication would be an unreasonable disclosure of sensitive personal information. These elements are not material to the findings or recommendations of the report. Where there are multiple amendments within a paragraph, the number will follow the paragraph number in parentheses.

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CHAPTER 1– THE COMMISSION OF INQUIRY

1.1. On the afternoon of Friday 11 May 2007, MAJ Thomas McKerron collapsed and died whilst participating in a Basic Fitness Assessment (BFA).

1.2. MAJ McKerron died in the vicinity of the Joint Logistics Unit – South Queensland (JLU-SQ), Bulimba Barracks, Brisbane. He was the Executive Officer (XO) of that unit, having marched-in on 15 January 2007.

1.3. On the day of his death, MAJ McKerron was the Acting Commanding Officer (CO) of JLU–SQ; the CO, LTCOL Glenn Taylor, then being in Sydney on official business. Some four hours prior to his death, MAJ McKerron had received two vaccinations at 2 Health Services Battalion (2 HSB), Gallipoli Barracks Health Centre (GBHC), Enoggera, Queensland.


1.5. The purposes of the COI are to inquire into the circumstances surrounding the death of MAJ McKerron and to make recommendations arising out of the inquiry’s findings. Copies of the Instrument of Appointment and the Terms of Reference (TOR) for the COI are located at Annexure 1 of this Report.

1.6. Pursuant to regulation 112 of the Defence (Inquiry) Regulations 1985, the CDF has appointed me, Magistrate James Gordon, to constitute the COI as the President and sole member.

1.7. As a civilian with judicial experience, including coronial experience, I bring that experience and independence to the appointment. Being a civilian, I am external to and independent of the Australian Defence Force (ADF) chain of command. As President of the COI, I am answerable only to the CDF who, as the Appointing Authority, has approved the TOR for the COI. It remains for me to be impartial, dispassionate, fearless and fair in the performance of my duties.

1.8. To assist me, the CDF has appointed LTCOL Evan Carlin, a legal practitioner, as Counsel Assisting the COI and LCDR Adam Johnson RANR, a legal practitioner, as Junior Counsel Assisting. Chapter 7 of Australian Defence Force Publication (ADF) 06.1.4, the Administrative Inquiries Manual, articulates the role of Counsel Assisting in paragraphs 7.43 to 7.45 inclusive.

1.9. The task of the COI specified in the TOR, is to obtain evidence and provide the CDF with a report detailing, with reasons, the findings of the COI as to the following matters:

(a) the circumstances proximately associated with the death of MAJ McKerron including, without restricting the generality thereof:

(i) the manner and cause of the death; and

(ii) any facts and circumstances establishing that the death arose out of, or in the course of, his service in the army;

(b) the sufficiency of any Defence actions and decisions materially relevant to MAJ McKerron’s death, both prior and subsequent thereto; and

(c) any weaknesses or deficiencies (isolated or systemic) in the Defence systems, policies, equipment, practices, procedures and training perceived in the context of MAJ McKerron’s death.

(d) Pursuant to regulation 110 of the Defence (Inquiry) Regulations 1985, the COI is empowered to make recommendations arising from its findings.
1.10. Paragraph 8 of the TOR provides that any such recommendations should be clear, reasoned, succinct, reasonable and achievable. The COI is authorised and encouraged to consult widely regarding recommendations that it proposes to make in its Report.

1.11. Recommendations need to be explicitly linked to findings made in the COI's Report. For clarity and convenience, recommendations are published in a table format containing, in relation to each recommendation:

(a) the finding to which it relates;

(b) the paragraph and page reference in the Report at which the finding is found.

1.12. Pursuant to regulations 117 (2)(a) and 119 (2) of the Defence (Inquiry) Regulations 1985 the CDF, as the Appointing Authority directed the COI to conduct its inquiry in public in respect of the taking of evidence and the making of submissions (subject to some limited exceptions which are not relevant here), and for all oral evidence given to the COI to be given on oath or affirmation. Those directions have been complied with.

1.13. The COI is purely an administrative inquiry under the Defence (Inquiry) Regulations 1985 (Commonwealth). As stated in the TOR, the COI is not concerned with the attribution of blame, or the identification of conduct that is either criminal in nature or susceptible to disciplinary measures. Whilst the COI is bound by its TOR, it is not bound by the strict rules of evidence or legal formalities. It is not a court of law. Its process is inquisitorial not adversarial.

1.14. Whilst the COI is not bound by legal formalities, fairness and relevance to the issues will guide its procedures. The rules of natural justice, or procedural fairness, apply to the COI.

1.15. Regulation 121 of the Defence (Inquiry) Regulations 1985, provides that the President of the COI may determine that a person might be affected by the inquiry, and if so, arrangements for the representation of that person, as a person affected, are able to be made, by, through and with, the assistance of the Director of Defence Counsel Services (DDCS).

1.16. Save for the deceased officer and his next-of-kin, at no time before the commencement of the COI or during its conduct, did I identify any person who was likely to be adversely affected by the findings of the COI.

1.17. Good sense and common sense, if not a degree of compassion, need to be applied in determining whether a deceased member of the ADF and his or her family, may be or become "affected persons" for the purposes of regulation 121 of the Defence (Inquiry) Regulations 1985. Pursuant to that regulation and in accordance with paragraph 15 of the TOR, I determined that the record or reputation of MAJ McKerron could be affected by the COI. Accordingly, arrangements were made by the DDCS for the appointment of a single legal representative to act on behalf of the deceased officer and his next-of-kin.

1.18. In that regard, I granted leave for CMDR Hugh Scott-Mackenzie RANR, a legal practitioner, to appear on behalf of MAJ McKerron and his next-of-kin, Ms Lynette Morgan, the partner of the deceased officer.

1.19. At the outset, I wish to place on record my appreciation of the professionalism, assistance and support displayed by both Counsel Assisting, LTCOL Carlin and LCDR Johnson, together with Counsel Representing, CMDR Scott-Mackenzie.

1.20. Counsel have provided extensive submissions and summaries of evidence, for which I thank them. This Report draws upon those submissions and summaries.

1.21. Copies of the submissions of Counsel Assisting are Annexures 2 and 3 to this Report. Copies of the submissions from Counsel Representing are Annexures 4 and 5. Further, Counsel
Representing prepared a useful Schedule to his closing address, and a copy of that document is Annexure 6.

1.22. Apart from conducting a view of the relevant areas, the COI conducted its proceedings at Victoria Barracks, Brisbane. It was ably assisted by its Secretary, MAJ Anthony White, a former ARA officer now an army reservist from Adelaide and its Manager, WO1 Allan Flood, a Brisbane based Army Reservist. PTE Nathan Short also provided assistance in the initial crucial stages of busy and sustained preparation. That contribution is also appreciated.

1.23. The COI commenced proceedings on 5 November 2007, at which time a number of documents were tendered. The COI then travelled to Bulimba Barracks, Queensland and undertook a view of relevant places inside and outside the Barracks. The COI reconvened on 6 to 9 November 2007, 14 November 2007, 13 to 15 February 2008, 17 to 19 March 2008, and 2 May 2008. Those 13 hearing days represent only a fraction of the time and effort involved. Many days, indeed weeks, were spent on associated matters before, during and after the hearings.

1.24. Generally speaking, a COI is conducted as quickly as possible. This COI has taken longer than usual, not only because further inquiries had to be made, but also because of a pre-arranged overseas trip and, upon my return, ongoing commitments with a lengthy trial in North Queensland and further part-heard matters in Brisbane. While the situation was not ideal, I thank all concerned for their patience, especially Ms Lynette Morgan, the partner of the deceased officer. In the circumstances, the CDF extended the date for the completion of this Report until 31 May 2008. Unfortunately, the COI has been unable to meet that timeline and the Report will be completed on 4 June 2008.

1.25. Altogether, 38 witnesses gave evidence on oath or affirmation. Three of those witnesses, PTE Carmel Barratt, SGT Christopher Keyes and ABET Amy Morgan, were subsequently recalled to clarify issues arising from other evidence. A summary of the evidence of each witness appears at Annexure 7 and Pages 8-50 of Annexure 4.

1.26. The Witness List is Enclosure A to this Report.

1.27. The COI received 86 exhibits into evidence. The Exhibit List is Enclosure B to this Report.

1.28. The transcript of evidence and submissions consists of more than a 1000 pages. References to the transcript in the Report are indicated by, for example, T100.20, for example, transcript page 100, line 20. Although the exhibits and the transcript are not annexed to the Report, they form part of it and are housed at the COI Coordination Cell in the Office of the CDF.

1.29. Prior to their giving evidence to the COI, Counsel Assisting provided each witness with a copy of the RIGHTS AND OBLIGATIONS OF WITNESSES AT BOARDS OF INQUIRY. That document is located at Annex F to Chapter 7 of ADFP 06.1.4, Administrative Inquiries Manual, 2nd Edition.

1.30. In assessing the evidence and in reaching its findings, the COI applied the civil standard of proof. In doing so, the COI is mindful of and has directed itself in accordance with the principles given by the High Court of Australia in Briginshaw v Briginshaw (1938) 60 CLR 336, per Dixon J at 361-363. The more serious an issue or allegation, the higher the degree of probability required.

1.31. All 38 witnesses, both civilian and military, were co-operative and gave their evidence in an open and straightforward manner. Each appeared to be doing his or her best to tell the truth. In assessing their evidence, the COI is mindful that human evidence suffers from the frailties of those who give it. It is subject to many cross-currents such as partisanship, self-interest, and above all, imagination and inaccuracy. Reasonable minds may reasonably differ as to a view, recollection or opinion. Honesty and reliability are not necessarily the same characteristics in a witness. An honest witness may be unreliable because he or she is mistaken, e.g. because of faulty recollection or faulty reconstruction. During this COI, all witnesses appeared to be honest, if not reliable. Accordingly, it would be unfair in the extreme, to make any adverse finding as to credit, simply because a witness’s recollection may not be perfect.
1.32. Because MAJ McKerron's death occurred in Queensland, it fell within the jurisdiction of the Queensland State Coroner (QSC), pursuant to the Coroner's Act 2003. The conduct of this COI is not usurping the role or function of the QSC.

1.33. In mid 2007, the CDF and the QSC effected a protocol between the ADF and the QSC, concerning the investigating of deaths of ADF members in this State. Amongst other things, that protocol recognises that Defence may commence an inquiry such as this to determine the facts and circumstances surrounding the death of an ADF member in Queensland.

1.34. Such an inquiry is undertaken so that informed decisions may be made by Defence about action required including, where appropriate, action to avoid a recurrence. A copy of the protocol between the CDF and the QSC (exhibit 74) is Annexure 8 to this Report.

1.35. The COI acknowledges and thanks the QSC, Mr Michael Barnes and the Queensland Deputy State Coroner, Ms Christine Clements, for their cooperation and assistance.

1.36. At the time of his death, MAJ McKerron was posted as the XO of JLU-SQ and was acting in the position of CO. That Unit is a Joint Logistics Unit of the Joint Logistics Command (JLC). At the relevant time, JLC was titled the Joint Logistic Group and the Commander of the Joint Logistics Group was MAJGEN G.D. Cavenagh.

1.37. On 31 May 07, MAJGEN Cavenagh sent a Minute to the CDF recommending that a Board of Inquiry be convened to inquire into the death of MAJ McKerron. That Minute forms part of exhibit 66. It reads as follows:

"On the afternoon of 11 May 07, MAJ T. McKerron died whilst conducting a Basic Fitness Assessment in the vicinity of Joint Logistics Unit (South Queensland). A Quick Assessment has been conducted and the findings at the enclosure suggest no suspicious circumstances surround his death. The findings indicate, however, that a contributing factor may have been a number of inoculations administered by 2nd Health Support Battalion on the morning of his death.

In order to ensure transparency, and to dispel or prove any link between the inoculations and MAJ McKerron's death during the Basic Fitness Assessment, it is recommended that your convene a Board of Inquiry to determine if a connection exists."

1.38. Accordingly, one of the tasks of this COI has been to determine if there was any link between the sudden death of MAJ McKerron mid afternoon on Friday 11 May 2007 and the Menecevax and Flu vaccinations administered to him at 2 HSB at 1010 hrs that day.

1.39. The COI found no link between those events.
CHAPTER 2 – SYNOPSIS OF MAJ McKERRON’s MILITARY CAREER AND ASSOCIATED VACCINATION, HEALTH, FITNESS AND LIFESTYLE ISSUES.

2.1. Thomas McKerron (Tom) was born in Scotland on 27 April 1962. He arrived in Australia when four years of age.

2.2. Tom enlisted in the Australia Regular Army (ARA) on 8 August 1978, aged 17 years. At 1RTB Kapooka, he was assessed as "an average soldier".

2.3. However, Tom had a natural aptitude for soldiering and was steadily promoted as an NCO in the Royal Australian Ordinance Corps. On 17 July 1992, he was promoted to the rank of Warrant Officer Second Class.

2.4. WO2 McKerron transferred to the General Reserve (GRES) on 8 August 1998.

2.5. On 10 March 1999, WO2 McKerron was awarded a clasp to the Defence Force Service Medal.

2.6. By October 2000, WO2 McKerron was performing full time service as the Quartermaster of 4 Training Group. Although he retained his WO rank, the duties he performed in that role were those of a Captain.

2.7. In late 2000, an Army Reserve AICS Selection Board noted that Tom had a strong military background and was a candidate who impressed as a person of great integrity, loyalty and commitment to the army. The Selection Board for PSO recommended that WO2 McKerron be appointed to the rank of CAPT in the Army Reserve, Central Region, as a Specialist Service Officer (SSO) in the Royal Australian Ordinance Corps. That appointment was made, with effect from 1 January 2001.

2.8. On 2 July 2001, CAPT McKerron transferred back to the ARA, having accepted a Short Service Commission of 6 years with a probationary period of 18 months. Tom was transferred back into the ARA as an SSO, subject to his attaining:

"A PES of Med Class 1 or 2 in the six months prior to the transfer date".

2.9. In January 2005, whilst attached to the 10th Force Support Battalion (10FSB) in Townsville, Tom deployed to Indonesia as a member of OPERATION SUMATRA ASSIST. He was so deployed for some 10 weeks.

2.10. Later in 2005, CAPT McKerron applied to transfer back to the GRES, with effect from 15 January 2006. A business opportunity in the Townsville area had arisen which Tom perceived as giving him the stability he required in the local area.

2.11. CAPT McKerron’s transfer back to the Army Reserve did not take place. He withdrew that application in October 2005 because his performance within 10FSB opened another career door. In short, that performance indicated that Tom was suitable to transfer from the Specialist Service Officer to the General Service Officer category. The maximum rank for an SSO is CAPTAIN or in certain circumstances MAJOR. As a GSO, an officer is identified for deployment in a wide range of postings and assessed as an officer whose career prospects are very much enhanced as promotion beyond MAJOR is possible.

2.12. In February 2006, CAPT McKerron deployed to Pakistan as part of OPERATION PAKISTAN ASSIST. He was so deployed for approximately 8 weeks. His reporting officer on that deployment, SQNLDR R.J. Spinivasan, JLCO, described CAPT McKerron as “a human dynamo”.
2.13. Throughout his service career, Tom received outstanding performance appraisal reports. The following comments are extracted from some of those reports:

- "A consummate professional in all aspects of his service"
- "Committed and dedicated"
- A "can do and attitude" approach
- An "exceptionally knowledgeable soldier (who) is highly valued"
- A "high degree of involvement and enthusiasm for his work"
- "Acts without direction needing no supervision"
- "A human dynamo always willing to help"
- "An excellent operator who has been a great ambassador for the unit"
- "A confident and respected leader who needs no supervision. Will go out of his way to assist this unit and other local units."
- A "very professional officer who knew his job well" and was "a very trustworthy type of person"
- "His dedication fully justifies his transfer to being a GSO. He will be a great asset."

2.14. In short, Tom McKerron was an excellent soldier and officer.

2.15. After completing an eight week course at the Land Warfare Centre at Canungra in mid 2006, CAPT McKerron was informed that he would be posted to JLU-SQ Bulimba Barracks, as the XO.

2.16. In October 2006, Tom was promoted to the rank of MAJ and he marched into JLU-SQ on 15 January 2007, the same day that the Unit's Commanding Officer, LTCOL Glenn Taylor assumed command.

2.17. At JLU-SQ, MAJ McKerron was regarded as a very hard working and efficient officer. He enjoyed being XO of the Unit, and told his partner Ms Lynette Morgan, that he had "the best job in the Army."

2.18. MAJ McKerron was very conscientious and good at prioritizing tasks appropriately. He imposed a very high and exacting standard on himself and expected the same standard of persons working for him. As his partner stated "Tom placed his dedication to his work and the requirements of the position above his own health."

2.19. Although MAJ McKerron had a very cheery disposition and a great sense of humour, he was regarded at JLU-SQ as a "no nonsense" officer. Ms Jean Ward, the Personal Assistant to the CO at JLU-SQ, said that until people got to know Tom and his manner, he could "rub people up the wrong way as he was very direct". However, Tom was not bombastic or dictatorial. He was "incredibly busy and very conscientious" and very much focused on getting the job done quickly and efficiently. Over time, staff at JLU-SQ saw what MAJ McKerron was really like and came to admire and respect him.

2.20. Prior to assuming command of JLU-SQ on 15 January 2007, LTCOL Taylor had not met or served with MAJ McKerron. It did not take the CO very long to appreciate the professionalism and capabilities of his XO. The CO found MAJ McKerron "professional, knowledgeable and courteous" and developed "great confidence" in him. LTCOL Taylor soon regarded MAJ McKerron as his "right hand man" in a diverse organisation.
2.21.  JLU-SQ is a military unit consisting of approximately 165-170 members, 40 of whom are military members and the remaining 125 members being Australia Defence Organisation Public Servants. In addition, there are approximately 200-250 contracted staff. The Unit has multiple sites in South East Queensland with varied dependencies, namely Navy, Army, Air Force, Cadets and both uniformed and non-uniformed other elements.

2.22.  For the first four months of LTCOL Taylor’s command, the CO estimated that he was away 40% of the time. In the CO’s absence, MAJ McKerron assumed relevant command responsibilities.

2.23.  As XO, MAJ McKerron was responsible for the general unit housekeeping and staff coordination, essentially picking up any task the CO was unable to do. As mentioned, the efficient and competent XO acted in the position as CO when LTCOL Taylor was absent. It is noted that at march-in on 15 January 2007, all of the senior ADF HQ staff at JLU-SQ, with the exception of WO2 Vince Dougherty, were newly posted to the Unit.

2.24.  LTCOL Taylor quickly assessed Tom’s potential and prospects for career promotion. Tom was already part way through an undergraduate degree through the University of New England. LTCOL Taylor discussed with him a more appropriate degree such as one being offered through Monash University, a Masters in Business Logistics. The CO supported Tom and he successfully applied for entry into the Monash Masters Course. Tom was very pleased at that outcome.

2.25.  LTCOL Taylor’s initial observation of MAJ McKerron was that his XO was “older than expected” by appearance alone, and slightly less fit than other officers. MAJ McKerron had a pronounced waist and abdomen. Beyond that, his appearance was unremarkable, being of solid build. WO2 Dougherty described MAJ McKerron as a “tall guy over 6’ in height” who was, in all respects, “a big bloke”.

2.26.  Early in 2007, the issue of individual readiness of members of JLU-SQ arose and, in an informal discussion, LTCOL Taylor asked MAJ McKerron whether he was able to achieve readiness. The CO was aware of MAJ McKerron’s smoking habit and was also aware, at least on an informal basis, of certain health issues concerning his XO.

2.27.  In that context, LTCOL Taylor discussed with MAJ McKerron the maintenance of his Army Individual Readiness Notice (AIRN) and addressed his smoking habit and related dental issues. The CO indicated that he preferred that his XO did not smoke, and actively encouraged him to seek all opportunities to assist him to quit the habit. The CO allowed ample and appropriate time for his XO’s medical and dental appointments.

2.28.  As regards maintaining his AIRN, the CO informed MAJ McKerron that as a GSO, he was expected to do everything that other GSO’s would do, which included maintenance of his AIRN and other individual readiness requirements. It was in the context of a later informal discussion about his AIRN, that the CO indicated to Tom that he (the CO) was prepared to recommend Tom for an operational deployment overseas which would greatly enhance his career prospects.

2.29.  JLU-SQ is part of the Joint Logistics Command (JLC). JLC is the sponsor of a number of operational deployment positions known as JLC Liaison Officers, which rotate every 6 months in Iraq and Afghanistan. There is keen competition for these postings.

2.30.  The issue of deployment was raised by LTCOL Taylor in or about early February 2007, when a position was identified. LTCOL Taylor went into bat for his XO and marketed him as “the man for the job” notwithstanding that such a deployment would be a loss to JLU-SQ, and the CO would lose his “right hand man” during his first year at that Unit.

2.31.  On the issues of possible deployment to the Middle East Area of Operations (MEAO) and his AIRN status, MAJ McKerron told his CO that to date, he had always been able to achieve and maintain AIRN readiness despite being of a robust build. In that regard, MAJ McKerron’s Personnel File (exhibit 2) contains the following comment in an assessment of job performance dated 30 Nov 05
"From an AIRN and physical fitness perspective, CAPT McKerron has maintained a good standard within his medical restrictions, but does not participate in Company PT due to his program. He has made a concerted effort to maintain his AIRN compliance at all times during the reporting period and he is currently AIRN compliant."

2.32. MAJ McKerron fully understood his responsibility to ensure that there were no readiness obstacles in his path if he was to be deployed to the MEAO.

2.33. In late March or early April 2007, it became known to MAJ McKerron that he had been successful in securing the deployment position to the MEAO. It was anticipated that MAJ McKerron would be deployed to the MEAO in or about September/October 2007 to participate in OPERATION SLIPPER in Afghanistan.

2.34. MAJ McKerron was very enthusiastic about, and was looking forward to, his pending deployment to Afghanistan. He was committed to getting himself fit for that deployment.

2.35. The proposed deployment required that MAJ McKerron attend to all pre-deployment issues and, in that regard, he received full encouragement and support from LTCOL Taylor. Those issues included the annual medical examination (Medical Board), appropriate vaccinations and AIRN compliance. As part of the latter, MAJ McKerron needed to pass the six monthly BFA.

2.36. MAJ McKerron’s last BFA was conducted on 21 November 2006. To maintain AIRN compliance and to be eligible for deployment later in the year, MAJ McKerron had to pass his next BFA by no later 21 May 2007. Time was running out.

Physical fitness and Medical Employment Classification (MEC)

2.37. As regards MAJ McKerron’s physical fitness, the following observations can be made after perusing his Medical File (exhibits 3 and 3A) and other relevant documents:

- The Medical Board examination record for 3 July 1990 referred to Tom’s recurring low back strain (since 1986). No physical training test had been conducted during the past 3 years: exercise consisted of regular swimming.

- On 2 April 1992, Tom failed a Basic Fitness Test (BFT).

- Because of orthopaedic problems, medical restrictions applied to Tom’s BFAs for the next 3 years.

- In February 1997, it was observed that Tom “coped with limited running and generally passes BFAs”.

- At Tom’s Medical Board examination on 3 March 1998, it was noted that he was:
  
  "coping with regular normal PT and passes BFAs and passed a CFA. A Grade pass on BFA yesterday".

- At the Medical Board examination on 9 June 1998, it was noted that notwithstanding intermittent orthopaedic problems, Tom was doing "normal PT three (3) times per week and usually passes BFAs, the last one about one (1) month ago".

- A confidential report in exhibit 2, dated 13 September 2000, referred to Tom’s most recent BFA, passed on 10 August 2000. It noted that he “achieves a fitness level well above the required level”.

- In April, 2002, Tom was briefly downgraded to MEC 301 because of low back pain – an
intermittent problem since 1984.

- In June 2002, Tom's medical employment classification was upgraded to MEC 201, with restrictions from prolonged standing and load carrying. That classification, and those restrictions, remained for the balance of his service career.

- In April 2004, at his five yearly Comprehensive Preventative Health Examination (CPHE), Tom indicated that he exercised four days per week and that it was "individual" and "unsupervised" exercise. In October of that year, his PT consisted of running at his own pace. In March 2005, it was reported that Tom had no problems with his physical fitness.

- Exhibit 13 is a PMKeys printout showing MAJ McKerron's history of physical assessments. The six monthly BFAs are recorded therein, and it is clear that from the time he received his commission in the ARA, Tom passed his BFAs and was assessed as "ready".

2.38. It is also clear from the records that MAJ McKerron did not have a history of participating in Unit PT. Because of his restrictions from prolonged standing and load carrying, he participated in individual and unsupervised PT.

2.39. At JLU-SQ, Unit PT sessions are held for military members on Mondays, Wednesdays and Fridays. MAJ Richard Priestly, the Operations Officer at JLU-SQ, also marched into the Unit on 15 Jan 2007. He never saw Tom attend a Unit PT session. He once asked Tom about attendance or his non-attendance at the Unit PT, and Tom replied that it was easier for him to exercise at home before he came to work. MAJ Priestly did not know what exercise was involved and never asked.

Smoking Habit

2.40. As regards consumption of alcohol and dietary habits, MAJ McKerron was a moderate drinker and maintained a healthy diet. However, smoking was a real problem.

2.41. In his autopsy reports (exhibits 5 and 5A), the pathologist, Professor Ansford, relevantly stated that Tom's lungs:

"...showed evidence of heavy cigarette smoking..."

2.42. In January 2007, MAJ McKerron told Dr. Andrea Hersam-Tynan at 2 HSB, that he had been smoking for 35 years and except for one period of 18 months. In a smoking cessation questionnaire, MAJ McKerron said he smoked 30 cigarettes per day (sometimes more) and had attempted to quit on "10 or more occasions".

2.43. MAJ McKerron's Service Medical File (exhibit 3) and the chronology of his medical records (exhibit 3A), evidence his long term smoking habit, and the fact that on numerous occasions, he was "advised" or "strongly urged" to stop smoking. Those documents also evidence MAJ McKerron 's willingness to quit smoking, but for its addiction.

2.44. It is an acknowledged medical fact that people who regularly smoke tobacco products become addicted to nicotine.

2.45. The Fagerstrom Questionnaire is a nationally recognised measure of nicotine addiction or tolerance. When MAJ McKerron filled out this Questionnaire for the Quit Smoking Counsellor at 2 HSB, Ms Lynette Baucia, a qualified pharmacist, assessed Tom as scoring 9 out of 9. That maximum score evidenced the fact that Tom was "highly dependent" on nicotine. Interestingly, the Quit Smoking Counsellor described that MAJ McKerron looked more like a man in his mid-fifties rather than his true age of 46 years.

2.46. The medical records indicate that MAJ McKerron had tried Nicorette patches three times unsuccessfully and that he had also tried a Quit Program and had gone "cold turkey" with varying success. In May 2005, at his request, a course of Zyban tablets was prescribed to assist him in
smoking cessation. That drug was provided at Commonwealth expense and it was reported that the drug enabled Tom to reduce his smoking by 10 cigarettes per day.

2.47. On 25 January 2007, MAJ McKerron indicated that he wished to have another attempt to quit smoking. The reason for that attempt was that he had been diagnosed with gum disease as a result of his smoking habit (exhibit 4, folios 27-28). As a result, Dr. Hersam-Tynan at 2 HSB GBHC referred MAJ McKerron to Ms Lynette Baucia, the Smoking Cessation Consultant at Gallipoli Barracks Health Centre. In a nutshell, that referral was successful because MAJ McKerron then stopped smoking, with the exception of two days in April 2007, namely after the death of his father and on Anzac Day. Tom's father was in his 70's when he died from a stroke and stomach cancer.

Weight and Body Mass Index

2.48. BMI is the Body Mass Index. It is calculated in accordance with Director-General Defence Health Service Health Directive No 206, 6 February 2002 (exhibit 82). That Health Directive deals with Overweight and Obesity.

2.49. The BMI describes relative weight to height, and is significantly co-related with total body fat content. It is recommended as a practical approach for the clinical setting as it provides an acceptable approximation for the assessment of total body fat for the majority of patients. It is calculated by a person's body weight in kilograms divided by the square of their height in metres. The figure is rounded to one decimal place.

2.50. As Health Directive No 206 points out, the BMI should be used to assess overweight and obesity and to monitor changes in body weight. As the document points out, overweight and obesity lead to increased morbidity and mortality. The document was published in 2002 and noted that there had been significant increases in the proportions of overweight and obese Australians since 1987, with greater than 60 percent of all adults either overweight or obese.

2.51. A BMI of between 18.5 and 25 indicates a normal or healthy weight range. A BMI of over 25 up to 30 is considered overweight, over 30 is regarded as obese, and 40 and over as extreme obesity.

2.52. In an individual, other data must be used to determine if a high BMI is associated with an increased risk of disease and death for that person. BMI alone is not diagnostic.

2.53. As Health Directive No 206 mandates, ADF members with a BMI of 30.0 to 34.9 are to be assessed by a Medical Officer and are to be classified as either "complicated" or "uncomplicated" obesity.

2.54. Essentially, "complicated" obesity is defined as BMI of 35 or higher or a BMI between 30 and 35 where the member has a demonstrable medical condition that is associated with, aggravated by or is a consequence of their obesity. Such members are to be downgraded to MEC 3 or MEC 4.

2.55. At no stage was MAJ McKerron classified as having "complicated" obesity. He had no overt medical problems associated with his obesity, which was properly classified as "uncomplicated". Accordingly, his physical fitness was to be assessed by the Army's Operational Readiness requirements.

2.56. As and from 2000 until the date of his death, MAJ McKerron had a BMI of 30 to almost 34. Accordingly paragraph 39a of Health Directive No 206 was applicable.

2.57. Given that during the period 2000 to 2006, Tom was regularly examined or reviewed by medical personnel and counselled by them to stop smoking and to lose some weight, it may be fairly stated that he was "managed" to an acceptable degree. However, self-management is also relevant as regards lifestyle issues. Further, at no time during that period did any medical officer think it necessary, given the circumstances, to exercise their discretion to place Tom into a weight reduction program, nor did Tom seek any such management.
2.58. The medical records indicate that apart from a short period in 2002, there was simply no real risk in Tom’s attempting his physical fitness tests, subject to the restrictions from long standing and load carrying. Further, because of Tom’s "uncomplicated" obesity classification, no restriction applied to his Service responsibilities in relation to his individual readiness.

2.59. Whilst Tom was known to be obese and classified as “uncomplicated”, he presented to ADF medical officers with no other significant risk factors other than his long history of heavy smoking. The coronary disease that caused his sudden death was simply unknown to anyone until the autopsy was performed. Simply stated, he was asymptomatic; MAJ McKerron had no symptoms of cardiovascular disease.

2.60. As regards blood pressure, it may be noted that Tom’s blood pressure was on the upper limit of normal but within the normal range.

2.61. Dr. Dale Thomas, Manager of Medical Services at 2 HSB, was asked by Counsel Assisting what was the purpose of having a BMI. The doctor replied: (T412.31)

"well it helps to stratify somebody's risk for heart disease. It's not a particularly sensitive marker for heart disease, but Defence uses it as an indicator."

2.62. Dr. Thomas also mentioned the relatively recent relaxation in entry standards for recruits, in that they are now allowed to enter the ADF with a higher BMI than previously. (T448.35)

2.63. In his telephone evidence on 2 May 2008, Air Vice Marshal Tony Austin, the Head Defence Health Services also gave evidence about the significance of the BMI and certain aspects of Health Directive 206. AVM Austin explained that in terms of preventative medicine, a public health model is employed and strategies are used that work for the majority of people, but do not necessary work for the individual. In that context, the BMI was developed as a "screening tool" in the population providing an index of body fat percentage which is linked to certain medical conditions such as diabetes and cardio-vascular disease etc. AVM Austin agreed that the BMI is "a crude indicator". He also stated (T110:11):

"Interestingly, in Defence, we have recently changed the BMI standards for recruitment, which previously had been a BMI of not to exceed 30, and, following the proposal from our then Minister for Defence, Brendan Nelson, Defence revised that recruitment standard and in fact now allows people in the range of BMI 30 to 33, regardless of their body fat percentage, to be in fact recruited to the ADF without restriction. So, it’s a shifting field, if you like, so there are no absolute limits."

2.64. Unlike the Army, both Navy and Air Force prohibit a member from undergoing a physical fitness test if the member has a BMI of 30 or above, and does not have a medical clearance. In that context, AVM Austin stated: (T1012.5)

"......to be honest with you, I am not a strong supporter of the issue of having to get a medical officer clearance for a BMI of over 30. And I would suggest to you that the recent change in Defence recruiting policy where we're now allowing people up to BMI of 33 be recruited and to undergo the full physical rigours of recruit training, suggests that there isn’t good scientific evidence to show the benefit of medical officer screening in that population."

2.65. Dr Dale Thomas was a contracted medical practitioner and manager of Medical Services at 2 HSB when he gave evidence in November 2007. He was/is also a Navy Reserve doctor having been in the Permanent Navy for eleven and a half years, transferring to the Reserves in 2003. At the conclusion of his evidence, he was asked if he had any practical and achievable recommendation to make. Looking at the “big picture” of relevant events, the doctor replied: (T444.39)

"......if I could make one suggestion that might – might have made a difference, then I think, you know, we have to pay – pay greater attention to addressing cardiac risk factors – for our members than we have. You know, the simple fact is we have a lot of overweight members who- who smoke, who are at risk of heart disease and there’s – there is not
a lot of emphasis given to addressing those risk factors. I mean, on the contrary, the – Defence has just relaxed the entry standards for weight of members joining the ADF, so people can now join faster than what they used to be able to and, you know, the other issue that may well have come up from Lyn Baucia’s testimony is that our – our Quit Smoking Clinic is about to be cancelled……as a cost cutting measure, so I think that is just ridiculous and very much false economy.” (emphasis added by President)

2.66. Dr Thomas was a strong advocate for the unique Quit Smoking Program conducted at 2 HSB by Ms Baucia. He had argued very strongly to keep the Quit Program Manager’s position, and had been unsuccessful. The program was to end in December 2007.

2.67. Counsel Representing put this question to Dr. Thomas (T446.12):

"Indeed, other than abandon the program, it would be either obviously beneficial to members of the ADF and perhaps for the ADF itself if the program were ramped up rather than brought to an end?"

To which the doctor replied:

"Yes, that’s right……there is …nominally a program run by the Directorate of Mental Health which is referred to ATODS, which is supposed to be alcohol, tobacco and other drugs, but they really spend no effort on tobacco whatsoever. It is all focused on alcohol and illegal drugs, and tobacco is the poor cousin."

2.68. Dr. Thomas agreed that it is common knowledge that increasing weight and obesity in the community at large is becoming a problem. He also agreed that it was becoming an increasing problem within the ADF, although he didn’t have any hard figures to back up that observation. Anecdotally, Dr. Thomas observed "we probably do have more overweight members than we used to" (T446.30).

Vaccination and Awareness of Post - Vaccination Restrictions

2.69. At the time of his death, MAJ McKerron had more than a quarter of a century of service in the ARA. His medical records disclose during that time, and prior to the date of his death, Tom had received more than thirty vaccinations at ADF facilities, on more than 20 separate occasions. Those earlier vaccinations included Vaxigrip for flu, and Mencevax for meningitis.

2.70. Vaxigrip and Mencevax were the two vaccinations administered to MAJ McKerron by PTE Barratt at the 2 HSB RAP at 1010 hrs on 11 May 2007. Although MAJ McKerron needed those vaccinations prior to his deployment to Afghanistan, he did not expect to receive those vaccinations at 2 HSB that morning. He had anticipated receiving the vaccinations at a vaccination parade at the 2 HSB GBHC RAP that Friday afternoon. MAJ McKerron drove from JLU-SQ to the Gallipoli Barracks Health Centre that morning because he had an appointment at the Enoggera Dental Centre at 0845 hrs, and a medical consultation with Dr. Hersam-Tynan at 2 HSB at 0940 hrs. The dental appointment was for periodontal services for his gum condition caused by his smoking habit. The medical consultation with Dr. Andrea Hersam-Tynan was a follow-up on the Quit Smoking consultation of January 2007 and also related to pre-deployment issues.

2.71. It is a normal circumstance of deployment for members to make an appointment for their Annual Health Assessment by the Medical Board. The doctor observed that MAJ McKerron’s last annual assessment was on 19 July 2006, and suggested that the relevant appointments be made whilst MAJ McKerron was attending GBHC that day. MAJ McKerron did in fact make appointments that day for his Medical Board examinations later in the month.

2.72. Dr. Hersam-Tynan also examined MAJ McKerron’s vaccination book to ascertain what vaccinations were required prior to his deployment. Fluvax is required for all deployments, and the doctor identified that MAJ McKerron required a Mencevax vaccination. His last Mencevax vaccination was on 28 Oct 03 and such a vaccination requires a booster every three years.
2.73. Dr. Hersam-Tynan proceeded with MAJ McKerron to the Nurses Station at 2 HSB and told the staff what vaccinations were required. The doctor told the nursing staff to check MAJ McKerron's vaccination and other relevant documents before MAJ McKerron was vaccinated. The doctor also told MAJ McKerron that he would have to sit in the waiting room for 20 minutes post vaccination, before he could leave 2 HSB. The doctor had no further involvement with the vaccination process but observed that all members receiving vaccinations at 2 HSB are provided with post vaccination behaviour information.

2.74. At all relevant times, Ms Wendy Keating was the Nurse Unit Manager of the 2 HSB GBHC RAP. She said that the Unit is akin to both an Accident and Emergency section of a hospital, and akin to a General Practice Medical Centre. Vaccinations are given at the Unit. In that regard, Ms Keating said that the attending nurse or medic usually engages the patient in talk to ascertain what the patient is likely to be doing in the immediate future, and then provides post vaccination warning "tailored accordingly". Ms Keating said it is a matter of experience as to what warning is given. Warnings include no strenuous exercise for 24 hours, no driving or driving of heavy machinery within the hour; no diving within the next 24 hours, no weapons handling within the hour; no PT, drill or parades for 24 hours (exhibit 53 paragraph 17).

2.75. Since the death of MAJ McKerron, the 2 HSB GBHC RAP has resurrected a former practice of issuing a "chit" which provides the essential post vaccination warnings. The document that is now issued is a Form PM101, headed "Medical or Dental Fitness Advice". (exhibit 31)

2.76. Post vaccination warnings are unique to the ADF and are not replicated in civilian medical practice.

2.77. Exhibit 8, ADFP 1.2.2.1 - Immunisation Procedures, Second Ed., September 2004, applies to all members of the ADF. It was issued under the hand of the then CDF. Chapter 3 of that document deals with Standard Vaccination Procedures. One of the headings in that chapter is "Restrictions after Vaccination" followed by paragraphs 3.21 to 3.24 inclusive.

2.78. Paragraph 3.21 states:

"Members are to remain in the vicinity of the place of vaccination at least 15 minutes after vaccination so that any immediate adverse event can be observed and treated. Most life-threatening adverse events begin within 10 minutes of vaccination."

2.79. Paragraph 3.22 states:

"The following restrictions apply to all ADF members after any vaccination is given:

(a) Driving, operating machinery, weapons handling or swimming should be avoided for one hour post vaccination

(b) Members should not undertake any stressful or demanding training such as parachuting, combat survival, or similar course for 24 hours following vaccination.

(c) Members are not to perform excessive physical activity such as physical training, parade or drill for 24 hours following vaccination"

2.80. Paragraph 3.23 of the above document deals with restrictions applying to air crew and divers.

2.81. At 2 HSB GBHC RAP on 11 May 2007, it was medic PTE Carmel Barratt (then Smith) who retrieved MAJ McKerron's file, ascertained what vaccinations were to be administered and administered those vaccinations at 1010 hrs. PTE Rebecca Morgan (then Hutchison) was the nominated checking/second medic. The process to administer a vaccine is a two person process.
2.82. At 2HSB GBHC RAP, vaccination parades are held on Monday, Wednesday and Friday between 1300 and 1330 hrs. Exceptions are made for special circumstances, e.g. deployment, although that was unknown to MAJ McKerron when he first attended that morning. He anticipated the identification of necessary vaccinations in the morning, and returning in the afternoon for the actual injections. Indeed, he had commented about the inefficiency of such procedure to Ms J. Ward, the Personal Assistant to the CO of JLU-SQ.

2.83. It seems clear that MAJ McKerron intended to undertake the BFA on the Friday morning, before having to return to 2 HSB GBHC RAP for the actual vaccinations that afternoon. When he unexpectedly received the vaccinations in the morning, that plan changed.

2.84. As regard post-vaccination warnings given to MAJ McKerron, there is no doubt whatsoever that he was given an oral warning by medic PTE Barratt. However, and unfortunately, the precise content of that warning is not particularly clear or able to be distilled with ease.

2.85. Exhibit 25 is a copy of PTE Barratt's statement, dated 6 Nov 07. The statement was obtained by Counsel Assisting the COI, at the earliest opportunity available to the COI and its Counsel Assisting. That statement was taken almost six months after the date of MAJ McKerron's death. It is most unfortunate that such a statement had not been obtained as soon as practicable after MAJ McKerron's death. Commonsense and the common law acknowledge that a contemporaneous statement is more likely to be accurate than one taken six months after the event.

2.86. During the week following MAJ McKerron's death, SGT Christopher Keyes, an investigator with the Australian Defence Force Investigative Service (ADFIS), endeavoured to obtain such a statement from PTE Barratt. He was frustrated in his endeavours to obtain such a statement, but not because of any sinister "command interference", as originally suggested by SGT Keyes. This this important issue will be visited later in the Report. For present purposes, suffice to say that had such a statement then been obtained, the COI would have a much clearer idea of what warning was actually given by PTE Barratt to MAJ McKerron.

2.87. Prior to administering the vaccine, PTE Barratt recorded the necessary details, including the vaccine batch and vial numbers in the 2 HSB GBHC RAP Vaccination Register (exhibit 26). Further, in the 2 HSB GBHC Outpatients Clinic Record, (exhibit 27), PTE Barratt wrote how each vaccination was given and the dosages. She also noted:

"Nil complaints, mbr advised of post vax procedures."

2.88. PTE Barratt, then using her married name of Smith, then immediately ruled off the entry as was her custom. In her statement some six months after the event (exhibit 25), PTE Barratt said in paragraph 11:

"I then told MAJ McKerron words to the effect 'Sir, no PT, no drill, and no battle PT for 24 hours. Sit in the waiting room for 20 minutes as that would be the most likely time that most allergic reactions would occur. If he felt anything out of the ordinary, he was to seek medical attention.'"

2.89. Whilst the warning given was only oral, it is documented that post vaccination procedures/precautions were given. PTE Barratt could not remember whether MAJ McKerron stayed in the waiting room for 20 minutes or not.

2.90. SQNLDR Stephen Currie, the officer in charge of JLU-SQ, Amberley Detachment, was the officer tasked by LTCOL Taylor to complete a Quick Assessment (QA) into the death of MAJ McKerron. The QA is part of exhibit 66.

2.91. On Tuesday 15th May 2007, in the course of preparing the QA, SQNLDR Currie telephoned 2 HSB and explained his function. The telephone call was transferred to the RAP, the area responsible for the administration of vaccines. He was seeking information about the Army practice in relation to
providing advice to members following a vaccination. As fate would have it, PTE Barratt took that call.

2.92. SQNLDR Currie explained his role to PTE Barratt, and told her he was trying to ascertain what guidance had been provided to MAJ McKerron. He couched the question in general terms, with the view of ascertaining whether there was an ADF wide practice, or whether there was something different for Army. In paragraph 15 of his statement (exhibit 78), SQNLDR Currie had this to say:

"As it happened she replied to my question by referring to the specifics in this particular case. She told me she had advised MAJ McKerron only to proceed with physical activity if he felt well enough to do so. I cannot recall whether she told me that she had recited the advice not to undertake strenuous physical activity within 24 hours. My RAAF experience was that members were advised to undertake nil physical activity within 24 hours after the vaccination. I cannot recall whether PTE Smith (Barratt) told me whether the Army practice was different."

2.93. In his evidence on 17 March 2008, SQLDR Currie said that when he spoke to PTE Barratt in that telephone conversation:

"...she indicated that she remembered MAJ McKerron and I asked her about the 24 hour moratorium that Air Force normally have for the administering of inoculations."

Counsel Assisting then asked:

"What did she say? Did she go to the specifics?"

To which the SQLDR replied:

"Well, she said that generally they provide similar advice, but in this case, she advised the member that – because MAJ McKerron asked whether he was okay to conduct the BFA, to the best of my recollection she indicated that she said "only if he felt well.""

2.94. When PTE Barratt gave evidence on 7 November 2007, she remembered speaking to a male person on the phone in the week after MAJ McKerron’s death. That person had asked her what had happened but did not indicate that he wished to see her personally. She could not remember if she reported that telephone conversation to anyone. It is probable that the person she spoke to was, in fact, SQLDR Currie.

2.95. PTE Barratt was recalled to give evidence on 19 March 2008. When asked specifically about what SQLDR Currie thought she had said concerning MAJ McKerron seeking advice on whether he could do the BFA, and that she allegedly replied along the lines of "only if he was feeling well", PTE Barratt replied: (T964.44)

"I do remember him stating he was preparing to go overseas and he was there to get his vaccinations – but that’s – I don’t recall him saying that he was – if asked if he was right to do his BFA..."

2.96. Other evidence from PTE Barratt, upon her recall, included the following: (T965)

"I don’t recall saying that if he felt fine, if he felt well, he could participate in physical activity, Sir.” and

"I don’t recall whether or not he said, ‘am I right to do a BFA’ because what I give is medical advice, and so if they choose to do a BFA it is up to their own – its own means, if that makes sense. But I would have said no PT, no upper body PT, no battle PT for 24 hours post that vaccination."

2.97. The COI is of the view that PTE Barratt was honest in her evidence and was doing the best to tell the truth as she recalled events many months later. However, as previously mentioned, honesty and reliability are not necessarily the same qualities in a witness. That it is in no way a criticism of
PTE Barratt.

2.98. It is clear that an oral post vaccination warning was given by PTE Barratt to MAJ McKerron. However, the precise content of that warning is not clear or able to be distilled with confidence. It is worth repeating that had a contemporaneous statement been taken, that difficulty would not exist.

2.99. It is not known for how long, if at all, MAJ McKerron remained in the waiting room at the 2 HSB GBHC RAP. In any event, it seems that he drove himself back to JLU-SQ within the hour.

2.100. Regardless of exactly what MAJ McKerron was told by way of oral post vaccination warning, he must have been well aware of the general restrictions within 24 hours of vaccination. Given his lengthy ARA service and his history of ADF vaccinations over the years, it is beyond belief that MAJ McKerron was not aware of those restrictions.

2.101. The COI finds, on the balance of probabilities, that at all material times, MAJ McKerron knew he should not participate in a BFA so soon after being vaccinated.

2.102. It is clear, that MAJ McKerron anticipated completing his BFA before returning to 2 HSB to be vaccinated. Unexpectedly, he was vaccinated before the BFA could be undertaken. It seems he decided to “soldier on” with the pre-arranged BFA without disclosing, until the third phase of the BFA exercises, that he had received a “flu shot” earlier that day.

2.103. As a matter of fairness, MAJ McKerron should have mentioned to the BFA supervisors, WO2 Dougherty and PO Cook, before he commenced the BFA, that he had been vaccinated some four hours before. However, given MAJ McKerron’s very busy schedule, personality and “can do” attitude, the COI is confident that even if that occurred, the Acting CO of JLU-SQ would have insisted upon undertaking the BFA.

2.104. As WO2 Dougherty said if a senior officer tells him or asks him to conduct a BFA, and that officer, when questioned about vaccinations etc, insists that he is “fine” and it is “okay” to continue, one must believe the senior officer and conduct the BFA. (T143.16). Also, WO2 Dougherty observed that if he felt that MAJ McKerron was not in a fit state to participate in a BFA, it would not have commenced.

2.105. From a practical point of view, the issue of rank does present a problem, be it actual or apparent. As a matter of fairness, the position of a BFA supervisor or PTI, regardless of rank, needs to be strengthened. If such a person becomes aware, during a BFA or its equivalent, that a participant has been vaccinated within 24 hours, that supervisor or instructor, as a matter of commonsense, must be empowered to direct the member to cease the BFA immediately. In conducting a BFA, the supervisor is not unlike the pilot of an aircraft or the captain of ship. He or she is in total control, and it matters not, for example, that the CDF is the participant.

2.106. The death of MAJ McKerron during the BFA has taken its toll on both supervisors. Amongst other things, it has extracted an emotional cost on them. WO2 Dougherty is of the strong view that a BFA supervisor, especially a PTI, should have a discretion, if not a power, to terminate a BFA if a participant tells the supervising instructor that he or she has been inoculated during the past 24 hours. (T145)

2.107. The COI is of the view that it is not a matter of discretion at all.

2.108. All members of the ADF, regardless of rank, need to understand and comply with post vaccination restrictions. More will be said on this important issue in this report and the COI makes certain recommendations in that regard.
CHAPTER 3 – PHYSICAL FITNESS, THE BFA AND OTHER EVENTS OF 11 MAY 2007, INCLUDING SUBSEQUENT NOTIFICATIONS.

3.1. Defence Instruction (General) PERS 36-2, dated 4 April 2005 (exhibit 83), deals with the ADF policy on individual readiness. Paragraph 8 f. of that document states:

"Physical fitness. The ADF requires physical fitness of its members in order that they are able to undertake operational duties. Compliance standards are set by individual Services.

3.2. One of the requirements for Army Individual Readiness Notice (AIRN) compliance is a mandatory Basic Fitness Assessment (BFA). Army members are required to be prepared to undertake a BFA at any time in accordance with Defence Instruction (Army) PERS 148-2, 8 August 2006 (exhibit 10).

3.3. It is the responsibility of each member of the ADF to attain a lifestyle that supports the maintenance of individual readiness.

3.4. AIRN requires a BFA to be taken every six months as a minimum. It is the Army baseline conditioning assessment protocol. It is not intended that this assessment be of maximal output, but best efforts are encouraged. Essentially, the BFA is based on the minimum physical ability to perform as a trained soldier.

3.5. The BFA consists of two strength activities (push ups and sit ups) and a mandatory core assessment of aerobic capacity (a 2.4 km run or 5 km walk within specified times). Dress for the BFA is PT attire suitable for the local weather conditions.

3.6. The six monthly BFA is mandatory for all Army personnel respective of their duty status. The conduct and recording of the BFA provides an indication of general fitness levels and ensures AIRN compliance.

3.7. PMKeys incorporates a feature that automatically indicates if a member does not have a current BFA pass.

3.8. MAJ McKerron’s last BFA was conducted on 21 November 2006.

3.9. To maintain AIRN compliance and to be eligible for deployment later in the year, MAJ McKerron had to pass his BFA by no later than 21 May 2007. MAJ McKerron was extremely busy at JLU-SQ and was very excited about his deployment to Afghanistan. On 10 May 2007, he only had eleven days remaining to do his BFA.

3.10. On 10 May 2007, MAJ McKerron phoned WO2 Dougherty to arrange a BFA for himself. At the time, MAJ McKerron was acting CO of JLU-SQ and he was to be the sole participant in the BFA. He informed WO2 Dougherty that he would contact him again to arrange a time. No further contact was made that day.

3.11. On Friday 11 May 2007, at approximately 0730 hrs, WO2 Dougherty telephoned MAJ McKerron to arrange a time for the BFA. MAJ McKerron informed him that he had a number of appointments but would come to see him at approximately 1100 hrs. MAJ McKerron did not mention the nature of the appointments.

3.12. Sometime after that phone call, MAJ McKerron drove from JLU-SQ to 2 HSB at Enoggera for dental and medical appointments. It is clear that when he attended at 2 HSB that morning MAJ McKerron anticipated returning to 2 HSB that afternoon to receive his inoculations.

3.13. At JLU-SQ, MAJ McKerron’s office was next to Ms Jean Ward, the Personal Assistant to the
CO. In her statement (exhibit 19), Ms Ward mentioned that MAJ McKerron had a lot of dental and medical appointments at 2 HSB, and the fact that he had to attend at set times and not necessarily times of his own choosing, could be inconvenient. Ms Ward stated at paragraph 15:

"On the day of the BFA he was not expecting to have the injections on that morning. He had told me that he was going to have to attend the inoculation parade to list his Afghanistan injections in the morning and then go back to Enoggera that afternoon for the actual inoculations. We had discussed in the days – or at least on the day prior, that was not a very efficient system.

I would not be surprised if Tom said to the medical people something like “why don’t you do it while I am here”, but I don’t know. I was surprised when he came into work that morning and said that he didn’t have to go back that afternoon because they had already given them (inoculations) to him."

3.14. MAJ McKerron told Ms Ward that he had to do the BFA. He had to remain compliant and was running out of time. Ms Ward knew that the BFA had been arranged with WO2 Dougherty and that MAJ McKerron must have changed the time when he was not required to go back to Enoggera for the injections.

3.15. Ms Ward said that MAJ McKerron was not overly excited about doing his BFA but accepted that it had to be done. He was convinced that it was going to be easy and wouldn’t take too long. He was of the view that it was so easy even Ms Ward could do it and invited her to do it with him. She declined saying she was wearing high heels. MAJ McKerron laughed and said that she could still do the BFA in high heels.

3.16. At age 46, MAJ McKerron was required to complete 10 push ups and 20 sit ups during the first phase of his BFA. The aerobic capacity, or second phase of the BFA, consisted of timed running over a 2.4 km course or timed walking of a 5 km course. The 2.4 km run component is optional for members who are 41 years or older. MAJ McKerron elected to be timed walking the 5 km course, during which running is not permitted. The specified time for his age was 45 minutes.

3.17. Not having heard from MAJ McKerron by 1100 hrs on 11 May 2007, WO2 Dougherty telephoned MAJ McKerron. He informed WO2 Dougherty that he was showing some people around the Unit and would be up to see him shortly.

3.18. At about 1150 hrs, WO2 Dougherty went outside the QPS area and saw MAJ McKerron approaching with a number of people. MAJ McKerron said that he was showing those people around the Unit and asked if the BFA could be done “after lunch”. Lunch is between 1200-1230 hrs and WO2 Dougherty saw no problem with that.

3.19. The BFA that day was the first time that WO2 Dougherty had any involvement with MAJ McKerron as regards physical training, and PO Cook had only commenced part-time duty at JLU-SQ the day before.

3.20. MAJ McKerron was known to be a positive and assertive officer who achieved his goals. As PO Cook stated, his first impression of MAJ McKerron was of a man not to be annoyed or upset.

3.21. WO2 Dougherty and PO Cook commenced setting up the equipment for the BFA at approximately 1245 hrs. MAJ McKerron arrived at approximately 1345 hrs and changed into his PT kit. WO2 Dougherty obtained details from PMKeys to place on the BFA form (exhibit 23). Upon being asked by WO2 Dougherty if he knew what the BFA involved, the Acting CO replied that he knew what was expected of him. He further said there were no restrictions, and that he was fit to do the BFA.

3.22. A warm up was conducted and after that MAJ McKerron did 20 push ups (10 more than required), had a short rest and a drink of water and then 30 sit ups (10 more than required).

3.23. As previously mentioned, MAJ McKerron elected to perform the 5 km walk rather than the
2.4 km run. After doing some stretches, he obtained a water bottle and went to the start point for the walk circuit, namely the back gate to Bulimba Barracks. Earlier, WO2 Dougherty had explained the location of the circuit including the turn point.

3.24. The distance from the back gate to the turn point outside the Barracks is 1.2 km out, 2.4 km back, 4.8 km for 2 circuits. An additional 200 metres was required and MAJ McKerron elected to do that distance inside the gate, that is, within the Bulimba Barracks area.

3.25. MAJ McKerron commenced the timed 5 km walk at 1400 hrs.

3.26. Just prior to the commencement of the 5 km walk, as MAJ McKerron and the two assessors walked over to the start point, WO2 Dougherty asked MAJ McKerron how he was going. MAJ McKerron stated he was "fine" and that he had had a "flu shot" that morning at 2 HSB. At no time, did MAJ McKerron inform the assessors that he had received two vaccinations that day.

3.27. When told about the vaccination that morning, WO2 Dougherty said to MAJ McKerron something to the effect that he (MAJ McKerron) should not be participating in a BFA on the same day as he received inoculations. WO2 Dougherty knew from his own experience that every time that he had received a vaccination, he was told by the medical staff not to engage in physical activities for 24 hours.

3.28. MAJ McKerron disregarded that observation or advice from WO2 Dougherty, the supervisor of the BFA. The Acting CO told the supervisor that he was "fine", that it was "only a flu shot", and that in any event, he was "only doing the walk".

3.29. MAJ McKerron told the supervisor that he would continue with the BFA and WO2 Dougherty said that "if you have any problems just stop", to which MAJ McKerron replied "fine".

3.30. After completing the first 200 metres inside the Barracks, MAJ McKerron picked up a water bottle at the back gate and commenced the first leg in a "power walking" fashion, leaning forward and really powering along in his walk. His strong start suggested that the 5 km walk would be completed in time (45 minutes).

3.31. Annex B to Dl(A) PERS 148-2, Army physical conditioning assessment system, 8 August 2006, states in paragraph 4 that "where possible, members performing a BFA should be observed by the supervisor for the duration of the 5 km walk".

3.32. Given that a "dog leg" circuit was in use at JLU-SQ at that time, and that the only participant in the BFA was Acting CO of the Unit, MAJ McKerron was not under observation at all times by the two supervisors.

3.33. Due to the route used and the dog leg in the road, the supervisors could see down the road for only about 400 metres. After that MAJ McKerron was out of sight for some time. As WO2 Dougherty observed in his statement (exhibit 21) at paragraph 20:

"(MAJ McKerron) went out to the 1.2 km turnaround and back. He was out of sight for sometime and he is a senior officer and it is a matter of trust as to completing the whole walk to the turnaround point without falling short".

3.34. As MAJ McKerron approached the back gate, after completing the first leg (2.4 km out of the Barracks), WO2 Dougherty observed that MAJ McKerron was still walking strongly and appeared to be okay. He did not have his water bottle with him at that time. MAJ McKerron about–turned at the back gate and headed back down the road on the second leg.

3.35. The supervisor asked MAJ McKerron how he was coping. MAJ McKerron replied to the affect that he was feeling a bit "queasy" or "sick" in the stomach and that it was probably from the needle. WO2 Dougherty asked MAJ McKerron whether he should continue or stop. The Acting CO replied that he was "fine" and the supervisor then told him "to stop if you need to stop", to which MAJ
Mckerron replied "No. It's fine" and that he was "right to go".

3.36. PO Cook also recalled that MAJ McKerron said something about a flu injection but could not remember what was said. He also said that MAJ McKerron made a comment to this effect:

"I'm going to finish this. I'm not coming back a second time – I'm fine"

3.37. PO Cook said that outbound on the second leg of the walk, MAJ McKerron walk was more of a normal walk than a power walk, and his gait gave the impression that he was favouring one leg. Indeed, the medical file indicates that one leg is shorter than the other by 6mm.

3.38. WO2 Dougherty's recollection was that MAJ McKerron commenced the second leg in a power walking action. PO Cook thought it was then more of a normal walk. In any event, both assessors agreed that there was a noticeable change after about 400 metres when MAJ McKerron stopped leaning forward, straightened up and slowed down. He put his hands on the top of his head, and disappeared around the corner of the dog leg.

3.39. WO2 Dougherty told PO Cook to "get the car and go down and check on him". PO Cook obtained the keys of the car from the OPS cell and drove the car out the main gate, up Apollo Road, and down Byron Street and turned into the dog leg. He found MAJ McKerron sitting on the grass against a fence in the dog leg area between Byron and Harrison Streets, Bullimba.

3.40. There was a conversation and MAJ McKerron spoke normally. He told PO Cook that he was "resting" and that he would complete the walk. He indicated that he was on his "way back", having reached and returned from the other turnaround point, 1.2 km from the back gate. PO Cook noticed MAJ McKerron had his water bottle with him, and that his t-shirt looked as though a bottle of water had been poured over his head.

3.41. As mentioned, MAJ McKerron indicated that he had reached and returned from the other turnaround point, that being a distance of 1.2 km from the back gate where WO2 Dougherty was positioned. The distance travelled and the time taken didn't seem to add up. MAJ McKerron looked tired and had indicated he was on his way back to the Barracks, having only about 800 metres to complete.

3.42. Although he was concerned about what he had been told, PO Cook was not about to question the XO who was then the Acting CO. As PO Cook stated in his evidence:

"I was concerned for him and I am not going to question the XO -- when the XO -- when a MAJ at that -- a man of his rank, I'm not going to say, "Sir, no, you are not going to complete the test, get in the car."

He's a MAJ, I'm not going to question a MAJ. I was concerned, that's why I went back to WO2 Dougherty and told him what -- what I saw."

3.43. PO Cook told WO2 Dougherty what he had observed and what he had been told by MAJ McKerron. WO2 Dougherty formed the view that it was simply impossible for MAJ McKerron to have covered the distance in the time since the turnaround at the back gate. WO2 Dougherty had been timing the walk with a stop watch. In his evidence he stated:

"Looking at the time that it took (MAJ McKerron) to get around the corner and the time for PO Cook to get there, (it) would've been almost physically impossible for a person, even running, to have gone down to the turnaround point and come back."

3.44. WO2 Dougherty told PO Cook that when MAJ McKerron returned, he (WO2 Dougherty) would speak to him. He would not question MAJ McKerron's truthfulness, but tell the MAJ he was observed having stopped around the corner at the dog leg, and that in the time concerned, the completion of the walk was not feasible.
3.45. Both supervisors waited some minutes at the back gate as MAJ McKerron had indicated that he was returning to the Barracks, having almost completed the walk. They expected to see him turn the corner and walk down Byron Street to the start/finish point at the back gate.

3.46. MAJ McKerron did not return as expected. Consequently, WO2 Dougherty directed PO Cook to return in the car to check on him. When asked if he considered going in the car as well at that time, WO2 Dougherty replied that he never considered it at that time:

"I thought that two of us going back down there and questioning MAJ McKerron in that sort of position would probably be unprofessional".

3.47. PO Cook returned in the car. The Acting CO had not moved, he was still propped against the fence. MAJ McKerron said to PO Cook words to the effect:

"I am not going to finish the test" and that the "flu injection was giving him the shits".

3.48. PO Cook understood the latter comment to mean that the injection was simply "annoying" MAJ McKerron.

3.49. MAJ McKerron then asked if the air-conditioning in the vehicle was working and PO Cook went to check. Upon doing so, he turned around and saw MAJ McKerron move from a sitting position to a crawling position. MAJ McKerron crawled about half a metre and then collapsed face down.

3.50. PO Cook moved MAJ McKerron into the recovery position which he had learnt at CPR training in order to check his breathing and pulse. The officer was breathing but no pulse could be located. PO Cook shook MAJ McKerron but there was no response. He appeared to be snoring and unconscious.

3.51. PO Cook looked around to see if anyone in the vicinity could assist. There were houses about, but no people. He went to the car and sounded the horn, hoping that WO2 Dougherty would hear. He could not see the other supervisor because of the dog leg. When PO Cook returned to MAJ McKerron was still in the recovery position. He was still breathing and snoring.

3.52. PO Cook needed assistance. He jumped in the car and raced to the back gate sounding the car’s horn and flashing its lights hoping the gain the attention of WO2 Dougherty.

3.53. As the car approached, WO2 Dougherty realised that something was wrong and jumped into the car. As they returned, PO Cook told WO2 Dougherty what had been said and what had happened.

3.54. When the assessors arrived, MAJ McKerron was still lying in the recovery position. WO2 Dougherty tried to get MAJ McKerron to respond to his talk, pinches and slap. There was no response. MAJ McKerron was still breathing. There was a pulse but it was very erratic.

3.55. WO2 Dougherty phoned Triple 0 on his mobile phone. That call was made at 1436 hrs. At that time, MAJ McKerron started to change colour, turning blue. PO Cook again checked his airway, ensuring he had not swallowed his tongue. He tilted MAJ McKerron’s head back and commenced CPR whilst WO2 Dougherty relayed instructions from the emergency operator.

3.56. WO2 Dougherty said that PO Cook was "professional but scared" in administering CPR. He was scared "in the sense that he was wondering whether he was doing the right or wrong thing". WO2 Dougherty said in his evidence:

"He was doing the right thing, by the book, Sir, without problem"

3.57. The first unit from the Queensland Ambulance Service (QAS) arrived at the scene from the Balmoral station within 3 to 4 minutes of WO2 Dougherty’s call. (exhibit 33)
3.58. PO Cook had maintained CPR whilst awaiting the arrival of the ambulance and continued to administer CPR as the QAS set up their equipment. The QAS officers then took over and PO Cook assisted them. A female civilian nurse appeared and asked if she could be of assistance. She was familiar with intravenous cannulation equipment and assisted the QAS officers prepare that equipment.

3.59. One of the two QAS officers in the first response unit, Mr Jamie Smith, was an experienced Advanced Care Paramedic. Shortly after their arrival, another two QAS units responded. Both were intensive care paramedic units, and were in the area at the time. Altogether five QAS paramedics did all they could to assist and resuscitate MAJ McKerron. For 44 minutes they continued with CPR, administered oxygen and adrenalin and used a cardiac defibrillator. During that time, a basic medical history was relayed by phone to the QAS officers from 2 HSB. The QAS officers were informed that MAJ McKerron received vaccinations earlier that day.

3.60. Alas, the prompt, professional and prolonged efforts of the QAS officers were to no avail. MAJ McKerron could not be resuscitated. At 1524 hrs the QAS terminated resuscitation attempts after 44 minutes of intense activity. Under the QAS protocols for discontinuation, the QAS went above and beyond what was required.

3.61. After the QAS officers took over the performing of CPR from PO Cook, he continued to assist them throughout. When the QAS officers took over, WO2 Dougherty then had time to phone the Duty Officer at JLU-SQ. The Duty Officer at the time was a civilian, Mr Ray Girdleston. WO2 Dougherty asked him to contact the senior most officer at JLU-SQ at the time, MAJ Richard Priestly, the OPS officer at the Unit. As earlier stated, the CO, LTCOL Taylor was interstate on ADF business.

3.62. Shortly after 1441 hrs, MAJ Priestly spoke to WO2 Dougherty by phone. At the site, MAJ Priestly tried to contact the CO of JLU-SQ on his mobile. LTCOL Taylor was not available and a message was left to contact MAJ Priestly. At that stage, MAJ McKerron was not deceased.

3.63. It was through MAJ Priestly that QAS officers were given information from 2 HSB. Upon the QAS asking MAJ Priestly about MAJ McKerron’s medical history, he contacted 2 HSB and explained there was an emergency and that he needed access to Tom’s medical records. Those records were located and a doctor was required to interpret them. In due course, MAJ Priestly was advised that the medical records gave no indication of any heart problem, and that the 46 year old officer was slightly overweight. He had also been vaccinated for flu and meningitis at approximately 1000 hrs that day. MAJ Priestly passed on the medical information to QAS within one minute of receiving it. There was nothing specific in the medical records to assist the QAS, but they did note that MAJ McKerron’s age (46) was younger than at first assumed by the QAS officers.

3.64. Amongst other things, MAJ Priestly tasked WO2 Dougherty to contact the Duty Chaplain or Padre at Gallipoli Barracks. Through no fault of the Chaplain, WO2 Dougherty had great difficulty in contacting him.

3.65. Officers from the Queensland Police Service (QPS) also attended the scene. As mentioned, the QAS officers ceased resuscitation at 1524 hrs. MAJ Priestly then made arrangements for Tom’s body to be removed from the site to the Riverside Conference Room (RCR) at Bulimba Barracks, pending removal of the body to the John Tong Forensic Centre.

3.66. The QAS transferred MAJ McKerron’s body to the RCR and they treated his body with respect and dignity.

3.67. At 1555 hrs, MAJ Priestly spoke to Chaplain (MAJ) Phillip Wyllie, the Area Support Chaplain in the Gallipoli Barracks Area and the rostered Duty Chaplain that day. The purpose of the call was to put in place the notification of the next-of-kin. At that time, MAJ Priestly still had not been able to contact the CO.

3.68. At 1630 hrs, MAJ Priestly received a call from the CO. LTCOL Taylor advised MAJ Priestly that Tom’s defacto wife, Lynette, was in Adelaide and that children in their late teens were at home on
their own. MAJ Priestly was concerned about notifying the children when their mother was not present.

3.69. At 1640 hrs MAJ Priestly obtained a full print out of MAJ McKerron's PMKeys record. The record showed that there were two dependent daughters at home, but PMKeys had no record of their names. MAJ Priestly knew that Tom's was a "blended family" and that there were six children, although only two of them at home. He was unsure whose children the two at home were.

3.70. The QPS was aware of the military process for notifying the next-of-kin. It was arranged for a QPS officer to attend the family with Chaplain Wylie and the Duty Notification Officer.

3.71. The QPS advised that a member of the family would be required to formally identify the deceased, unless a military member who had known Tom for the requisite period of time could do the identification. WO2 Dougherty and MAJ (then CAPT) McKerron had worked together during their deployment on OPERATION SUMATRA ASSIST. Accordingly, WO2 Dougherty formally identified Tom's body for QPS purposes.

3.72. MAJ Priestly was concerned to ensure that the appropriate notification process was used. Notwithstanding the best efforts of work colleagues at JLU-SQ and himself, together with Chaplain Wylie, they were still not able to identify all the children's names. Finally, MAJ Lindsay Bancroft from the Defence Community Organisation (DCO) obtained the names from the National Welfare Co-ordination Centre. That organisation held the names because MAJ McKerron was preparing to deploy overseas. As MAJ Priestly said, it was a "stroke of good luck" to get that information.

3.73. It had been MAJ McKerron's responsibility to update details on PMKeys. The COI is confident that that oversight would have been addressed prior to his deployment in any event. Although it is no excuse, it reflects how extremely busy he was. As MAJ McKerron's partner, Ms Lyn Morgan correctly stated, "Tom put his dedication to his work and the requirements of his posting above his own interests".

3.74. Chaplain Phillip Wylie was/is the Area Support Chaplain at Gallipoli Barracks. Amongst other things, he looks after all other chaplains in the area. Due to other chaplains being deployed on operations, Chaplain Wylie was/is frequently the "on-call" chaplain at Gallipoli Barracks and was acting in that capacity on the day of MAJ McKerron's death.

3.75. The Chaplain returned WO2 Dougherty's mobile phone call just before 1600 hrs that day. He then contacted MAJ Priestly who said he would get back to the chaplain when he had more information. No further information was readily available and the chaplain decided that something needed to be done urgently. Chaplain Wylie became proactive. He contacted the QPS and stood them down from any notification role. He took that action because it was more appropriate an ADF Notification Officer and himself to go to the house and break the sad news. The reason given by the chaplain was that the Army (T289.31)

"takes responsibility for these sorts of things as a first recourse all of the time".

3.76. The chaplain then phoned the Duty Officer who gave him the name and contact number of the Duty Notification Officer, MAJ Dobbs. When contacted, MAJ Dobbs asked what information the chaplain had to enable him (MAJ Dobbs) to do the notification supported by the chaplain. Chaplain Wylie replied that at that time there was no information, but there "might be a couple of teenage girls at the house". It was a very difficult situation because time was marching on.

3.77. Whilst it was known that MAJ McKerron and his partner had a "blended" family, at that stage there was no definite information about what members of the family might be at home or their ages. Whilst it was thought that two teenage girls might be at the home, it was not known if MAJ McKerron's partner, Ms Lynette Morgan was at home or in Adelaide attending her sick mother.

3.78. A sense of urgency related to the welfare of those who were at home. The chaplain was concerned that if there were teenage girls at home, they would be distressed and anxious because it
was already 6 p.m. and Tom had not returned from work.

3.79. The notification occurred around about 1900 hrs. Chaplain Wyllie and MAJ Dobbs broke the tragic news to MAJ McKerron’s daughter and his step-daughter. Present as a matter of luck with the girls at that time was a friend of MAJ McKerron, CAPT Cam Willett, who was waiting for MAJ McKerron to go on a fishing trip with him that night or during the weekend. The notification was performed by MAJ Dobbs, and Chaplain Wyllie provided moral support to him and those present in the house.

3.80. Chaplain Wyllie and MAJ Dobbs found out that MAJ McKerron’s partner, Lynette Morgan, was in transit from Adelaide and would be home around 2230hrs. In consultation with all those present at the home, it was decided that the best time to inform her of her partner’s death was when she arrived home. When the Chaplain was asked what was going through his mind, he replied: (T293.20)

“Well, I am a religious man and I was praying she would not find out by any other means prior to arriving home. I was trusting and hoping that she would arrive home, and that she would be informed in an appropriate way, rather than finding out over a telephone.”

3.81. LTCOL Taylor, the CO of JLU-SQ, arrived back at the Unit from Sydney about 2000hrs and was back-briefed by MAJ Priestly on the day’s events. From the house, Chaplain Wyllie phoned LTCOL Taylor at the Unit. The CO decided that he should be the one to inform Lynette of the death of her partner. At around 2200hrs, LTCOL Taylor arrived at the McKerron home. He received a hand over/take over from MAJ Dobbs, and a short brief on what was appropriate language to inform someone of a death in the family.

3.82. When MAJ Dobbs was asked how he felt about the CO breaking the news to Tom’s partner, the Duty Notification Officer replied that not only was it the right of the CO, but that he

“couldn’t think of a more appropriate person to do it because he already had a link with Lyn and that she would recognize him”.

3.83. Ms Lynette Morgan arrived home just before midnight. LTCOL Taylor broke the sad news to her, and Chaplain Wyllie was present and aided Lynette in her deep distress and grief. The chaplain noted that she was a strong person, and in due course, Lynette was able to get her thoughts together and make decisions about notifying other relatives. Both LTCOL Taylor and Chaplain Wyllie left the McKerron home around 0200hrs on Saturday morning.

3.84. In his evidence, Chaplain Wyllie emphasised that in such a situation, one needs to be calm, thoughtful and creative in one’s responses. He and MAJ Dobbs did the best they could with what little information they had. They did not know what to expect when the front door opened.

3.85. As Chaplain Wyllie stated, one needs to be flexible because “you cannot script” (T307.41). The chaplain said that one needs to be ready and available to respond to what occurs because relationships may have changed, the primary contact may not be at home, the address could be inaccurate:

“You don’t know any of those things, irrespective of PMKeys. And so you need to be ready and available to respond to whatever occurs.” (T306.42)

3.86. With the benefit of hindsight, given all that happened, Chaplain Wyllie expressed the view that he “probably would not have done anything differently”: (T309.7)

3.87. CAPT Willett agreed that MAJ Dobbs and Chaplain Wyllie:

“handled the notification sensitively and appropriately.”(T399.5)

3.88. At the conclusion of Chaplain Wyllie’s evidence on 8 November 2007, as President of the
COI, I commended the chaplain for his sensitivity, commonsense and compassion and that all of those qualities were evident "in great abundance" as regards the chaplain's involvement at the time.

3.89. In her statement, exhibit 14, at paragraph 59, Lynette said:

"The manner in which Defence notified me about Tom's passing was appropriate and sensitive."

3.90. There can be no doubt that the notification to ... and at the McKerron home was correct in the circumstance, and it was undertaken in a proper and sensitive way.

DCO Support.

3.91. The statement of Defence Social Worker (DSW) Modini (exhibit 56) and the evidence of MAJ Bancroft, indicate the support and tasks undertaken by Defence Community Organisation (DCO). Ms Lynette Morgan indicated that she found the initial briefing by DCO "unhelpful". (exhibit 14 at paragraph 60).

3.92. MAJ Lindsay Bancroft, Military Support Officer – DCO Brisbane, outlined his understanding of some areas where Ms Morgan had expressed dissatisfaction with aspects of DCO support. One such matter centred around the arrangements being made for MAJ McKerron's family to attend the funeral and the obtaining of the necessary approval from a Defence administration point of view where WO2 Bakker was required to interface with some of MAJ McKerron's close friends who were officers substantially higher in rank to him, (largely Captains and Majors), who, while assisting Ms Morgan, provided their own input. This caused strained communication. The dynamics of communication during what was a very difficult time became strained, and perhaps clouded, by not having a single point of contact with the bereaved family as a focal point of arrangements.

3.93. It is acknowledged that some tensions manifested themselves in the early stages. Those tensions were resolved with a change of personalities. As and from 28 May 2007, MAJ Bancroft has been the single DCO focus point and has provided ongoing support to Ms Lynette Morgan and her family. That support is readily acknowledged and appreciated by Ms Morgan.

3.94. The fact that there were some initial tensions does not evidence a failure of the system, but rather a personality clash or issue at a time when people were highly stressed.

3.95. In his concluding remarks, Counsel Representing referred to a number of people who had been "particularly supportive" to the families of Ms Morgan and MAJ McKerron. MAJ Lindsay Bancroft of DCO was one of the persons to whom Ms Morgan extended her heartfelt thanks for their "friendship, compassion and understanding" during her difficult time.

3.96. The COI acknowledges the great assistance and support given to Ms Morgan and others by DCO, particularly that given by MAJ Lindsay Bancroft.

Notification of other members of the “blended” family

3.97. As and from 22 August 2002, Lynette Morgan and Tom McKerron lived together in a recognised de facto relationship. Both had been previously married and divorced. Subsequent to his passing, Lynette learnt that Tom was planning their marriage in Italy during Christmas leave 2007. At the time of Tom's death, there were two children in the "blended family" living with Tom and Lynette:

3.98. Lynette Morgan has two other children, both of whom are permanent members of the ADF. Amy Morgan is aged and is a member of the RAN with the rank of Able Seaman. Deane Morgan is aged and is a member of the ARA with the rank of Private.

3.99. At the time of Tom's death, PTE Deane Morgan was serving with Rifle Company Butterworth, Malaysia. The OC of that company at the time was MAJ B. Robertson. His statement is
exhibit 69, and MAJ Robertson gave evidence to the COI.

3.100. After MAJ McKerron's death, MAJ Robertson received a telephone call from the ADC to the
Land Commander, Australia, who informed him that PTE Morgan's step-father had died. Brief
particulars were given, and the OC was advised to notify PTE Morgan.

3.101. MAJ Robertson had never performed such a task before.

3.102. The RAAF Padre, Butterworth, was absent on leave at the time. Before notifying PTE
Morgan, MAJ Robertson contacted a number of ADF personnel to provide emotional support after
notification had occurred, and to begin the process for PTE Morgan's return to Australia. MAJ
Robertson duly notified PTE Morgan, with an NCO present to support the soldier. MAJ Robertson
provided PTE Morgan the use of his office to speak privately with his mother by phone. The OC
encouraged PTE Morgan to begin the process for returning to Australia and not to worry about the
time aspect. Before he left for Australia, MAJ Robertson ensures that NCOs checked on PTE Morgan
periodically. (T658.22)

3.103. When asked to express his views about the notification process, MAJ Robertson
emphasised that it was an individual task or responsibility that should never been taken away from the
chain of command. However, better training, or at least access to appropriate resources would assist.
(T664.40) The evidence is that the binder given to the Duty Officer at Rifle Company Butterworth does
not contain any guidance on notification procedures. (T667.6)

3.104. The evidence clearly establishes that the notification of PTE Morgan was satisfactory in
every regard, and the COI so finds.

3.105. At the time of her step-father's death, AB Amy Morgan was a crew member of HMAS
FARNCOMB. On 11 May 2007, the submarine had berthed in Singapore. It was there on an official
visit for Navy Week. After cleaning the submarine, the crew including AB Morgan, were
accommodated in hotels according to mess.

3.106. On the morning of 12 May 2007, then LEUT, now LCDR Coles was the Officer of the Day
(OOD) on HMAS FARNCOMB. Just after 0900hrs, he received a message to telephone the Flag
Lieutenant to Chief of Navy, LEUT Brooke Olds. Upon doing so, he was informed of MAJ McKerron's
death and the pressing need for AB Morgan to contact her mother in Brisbane.

3.107. The OOD then contacted the COB, the XO and CO.... “just to give them a heads up, this
was what was going on”.

3.108. The OOD attempted to telephone AB Morgan without success. (T789.7). After about an
hour, the OOD spoke to the hotel reception and asked that a note be written and placed under the
door to AB Morgan's room.

3.109. The OOD had not had personal experience notifying a person of a death in the family.
Whilst waiting for AB Morgan to contact him, LCDR Coles referred to the OOD Pack (exhibit 68) for
assistance. Therein he found paragraph 35 of Di(G) PERS 11-2.

3.110. Paragraph 35 is headed “Notification to a Serving Member” and states:

"When a ship, unit or establishment has been notified of an illness, injury, or death of
the emergency contact or close relative of a serving member, the member is to be
notified where possible by a Service chaplain. If a chaplain is not available, the
Divisional Unit Welfare Officer or another Officer nominated by the CO is to notify the
member. The Divisional Unit Welfare Officer must be informed when the notification
has been completed so as further can be taken as necessary".

3.111. Apart from paragraph 35 of exhibit 40, there was nothing else in the OOD Pack to assist
LCDR Coles.
3.112. DCO in Australia did not provide LCDR Coles with any guidance other than confirming the CO's authority to return a member to Australia, given that AB Morgan's family wanted her to return. (T794.34 and T795.9)

3.113. Upon receiving the message at the hotel, AB Morgan telephoned the OOD. He moved into the Wardroom to take the call and then spoke to her:

"...I informed her I was sorry to be the one to inform her, but your mother's partner has passed away, and they are after you to contact Australia. I don't have any further details at the moment. She sounded a bit confused at the time, I think she wanted to know if it was her grandfather had died, because apparently they were - he was in a pretty bad way as she found out in the last port in Thailand. So, she sounded pretty confused."

The OOD replied:

"I'm sorry, I don't have a lot of information, can you contact home. I am going to send the duty driver out to you and bring you back to the boat". (T796.9)

3.114. AB Morgan arrived back on board the submarine between 1430–1500hrs. (T797.20) She said she had not been able to speak to her mother, but had spoken to a sister or cousin. LCDR Coles suggested she try again using the Wardroom telephone, which she did and made contact with her mother. The OOD then discussed with her "the mechanical aspects" of returning to Australia. (T798.41)

3.115. SMN Kellaway was AB Morgan's allocated room mate at the hotel. However, SMN Kellaway was on duty aboard the submarine on 12 May 2007. (T704.22) The OOD gave evidence that nothing in the demeanour of AB Morgan suggested that she needed assistance. After she gathered all her belongings together, the OOD asked AB Morgan if she wanted her roommate to go with her. (T798.44) He did not insist that SMN Kellaway accompany AB Morgan. When asked why, the OOD replied: (T799.35)

"From my point of view, that would be a bit of an intrusion...I mean if I told someone I wanted to be alone for a bit, it means I want to be alone. I don't want a minder or anything like that.

3.116. AB Morgan returned to the submarine on Sunday 13 May 2007 at about 0830hrs. She returned to the hotel on the duty bus with her now off duty room mate. During the previous day, the OOD tried without success to contact AB Morgan's Divisional Officer and "Sea Daddy". It did not occur to the OOD that he should arrange for someone to visit AB Morgan's hotel room periodically to see if she was okay. From the point of view of the OOD:

"...that would have been an intrusion and a pretty unwelcome one" (T835.1).

3.117. The OOD had the ability and certainly the personnel to provide assistance to AB Morgan. LCDR Coles was surprised to find out that AB Morgan travelled to the airport by taxi and not by a vehicle arranged by the submarine. (T835.31)

3.118. The COI spent a lot of time hearing evidence from LCDR Coles, AB Morgan, SMN Kellaway, CPO Rule, and LCDR Doolin. Apart from the limited evidence extracted above, the COI finds it unnecessary to refer to that evidence. Essentially, the evidence was given in the context of the criticism made by Lynette Morgan in paragraph 61 of her statement, exhibit 14, namely:

"Amy has said to me that she was told about Tom's passing by phone and then left by herself without support. The manner in which she was notified, in my opinion, was inappropriate and lacked sensitivity. Very clearly, she should not have been left without support or notified in this manner."
3.119. With the advantage of hindsight, it is clear that more could have been done to support AB Morgan, especially when contrasted with the support shown to her brother, PTE Morgan, not all that far away.

3.120. CMDR Christine Clarke, RAN Fleet Human Resources Manager, agreed it may have been desirable to provide AB Morgan with support. (T939.30) She also agreed that the preferred option to notify a member of a death in the family in person. (T938.23 and T942.18) However, in the view of the COI, LCDR cannot be fairly criticised for informing Amy of the death over the telephone in the first instance. She was “part of the submarine family, and the trip from hotel to the submarine, by duty vehicle approximated one hour”. In that context, LCDR Coles was asked by Counsel Assisting:

“.......when you spoke with AB Morgan on the phone, did you consider simply telling her that you were sending a vehicle. She is to report back to the boat instead of telling her on the phone about the death?”

To which LCDR Coles replied: (T796.20)

“I may have very briefly. I probably discarded it as an option. I know from my point of view if I get told, you know, we’re sending a driver for you, report back to the boat, I’m either wondering, you know, something’s blow up, or I’ve done something wrong, you know, my leave’s been cancelled. So, I’d rather know up front from my point of view, so I pretty much said to her, that’s the reason I told her, gave her the heads up there, especially with the limited information I had, just to give her then the chance to contact home and see if she could get more details.”

3.121. In all of the circumstances, the COI is of the view that the manner of AB Morgan’s notification was not inappropriate. In regards the lack of support, noting the qualification in the next sentence, the COI observes that more could have been done. However, that being said, AB Morgan is an adult, and she did not seek any such support. That is in no way a criticism of her. It is however, a relevant observation.

Chaplain Communication Difficulties

3.122. Before concluding this chapter, it is useful to briefly consider an issue that frustrated WO2 Dougherty on the afternoon of MAJ McKerron’s death. He had been tasked by MAJ Priestly to contact the Duty Chaplain and had great difficulty in doing so. That was no fault of the chaplain.

3.123. WO2 Dougherty concluded in his statement (exhibit 21) as follows:

“*The system that did not work well was the initial attempt to contact the Padre.*”

3.124. When WO2 Dougherty phoned the number for the Gallipoli Barracks on-call duty chaplain, he was put onto an “on-call” number. The person answering that call, who was probably Asian, had language difficulties and WO2 Dougherty had to continually repeat himself and spell out his rank. Given the urgency, WO2 Dougherty became very irate and frustrated.

3.125. WO2 Dougherty then tried to contact the Garrison Duty Officer but he was on another call. WO2 Dougherty then returned to Bulimba Barracks to get the chaplain’s number from the duty log book. Upon phoning that number, WO2 reached the chaplain’s answering service. The answering service gave an emergency number, and WO2 Dougherty finally contacted the Chaplain on that emergency number.

3.126. Chaplain Wyllie became concerned and pro-active after learning about the difficulties in contacting the on-call chaplain. He made inquiries and discovered that the difficulty was associated with the “on-call” pager system operating at the time. That “pager” system had been in use for some years at Gallipoli Barracks.
3.127. Upon making his inquiries, Chaplain Wyllie was informed that the telephone company that provided the on-call service for chaplains had sub-contracted it to another organisation that had two call centres in Australia and a third in Jakarta in Indonesia. Chaplain Wyllie assumed it was a person in the Jakarta in the Indonesian call centre who caused WO2 Dougherty's frustrations.

3.128. Chaplain Wyllie became rightly concerned. He called an extraordinary meeting of the Chaplain's Consultative Committee and, as a result, chaplains have now changed to an "on-call" telephone system. That change has occurred Australia wide.

3.129. Chaplain Wyllie also alerted the contractor that provided the service. Clearly, it is inappropriate for any part of the ADF to be working through a call centre in Indonesia.

3.130. Throughout Australia, ADF chaplains have now "retired and returned their pagers." They now use on-call mobile telephones. Anyone who has access to the number can phone the chaplain directly, or they call the duty officer at any base in Australia and be connected through that base to the on-call telephone number.

3.131. The Duty Officer of every Unit in Australia has access to the relevant number as well as the area chaplains for the various states, such as Chaplain Wyllie. Further, at the suggestions of Counsel Representing, Chaplain Wyllie has effected yet another improvement. The Gallipoli Barracks on-call chaplain's telephone now has a message on it that if the duty chaplain does not return the call within 15 minutes, the person seeking the chaplain, is to call the area chaplain (Chaplain Wyllie) on.

3.132. On 29 February 2008, when the President of the COI telephoned the area chaplain, Chaplain Wyllie indicated that, at that time, he had received only one follow-up phone call as area chaplain.

3.133. The COI commends Chaplain Wyllie for his prompt and professional resolution of this problem and, indeed, setting in train an even more efficient system.
CHAPTER 4 – THE INVESTIGATION OF MAJ MCKERRON’S DEATH.

The Coroner

4.1. Traditionally, it is the function of a Coroner to determine the cause of a sudden death and the circumstances surrounding that death.

4.2. The ADF does not have its own Coroner.

4.3. As the sudden death of MAJ McKerron occurred in Queensland, the Coroner’s Act 2003 applied. That Act created the Office of the Queensland State Coroner (QSC) and gave the QSC jurisdiction and responsibility to investigate the cause and circumstances of such a death.

4.4. In 2007, the CDF and the QSC effected a protocol between the ADF and the office of the QSC concerning the investigation and deaths of ADF members in Queensland. That protocol post-dated this death.

4.5. The QSC had the primary jurisdiction and responsibility with respect to determining the cause of MAJ McKerron’s sudden and unexpected death.

4.6. Whenever a sudden death occurs in Queensland, the Queensland Police Service (QPS) is duty bound to attend the scene and investigate the matter. In such circumstances, the essential functions of the QPS are to establish if any suspicious circumstances exist with respect to the death, and to prepare a report for the Coroner.

4.7. No fewer than seven members of the QPS attended the scene near Bulimba Barracks that day. The first response unit consisted of Acting Senior Sergeant Philip Von der Heyde and Constable Theresa Thiele from the Morningside Police Station. Other police officers who attended were members of the Morningside Criminal Investigation Branch (CIB), including Detective Sergeant Christopher Fenelon, an officer from the Scenes of Crime Unit, the QPS South Brisbane District Officer and the QPS Metro South Region Duty Officer.

4.8. The QPS officers were informed by MAJ Richard Priestly that MAJ McKerron had received a vaccine injection for flu and meningococcal virus some time that morning, and that he had been participating in a BFA when he collapsed. MAJ McKerron failed to respond to resuscitation notwithstanding the best endeavours of PO Cook and five very experienced QAS officers.

4.9. The CIB determined that no suspicious circumstances existed with respect to the death. It appeared to Detective Sergeant Fenelon that the death resulted from a heart attack and that it was unnecessary to make any further inquiries.

4.10. As regards the issue whether or not the vaccinations may have caused or contributed to the heart attack, Detective Sergeant Fenelon was of the view that any inquiry in that regard would be initiated by the Coroner, if the Coroner regarded that as an issue of importance. If so, the Coroner would direct the QPS to obtain relevant statements.

4.11. The Coroner’s Act 2003 introduced a very significant change of procedure for the QPS, in the event that the CIB was satisfied that a sudden death was without suspicious circumstances. Under the previous coronial legislation, the investigating police officer was required to obtain a statement from all relevant persons associated with the deceased. In due course, those statements were forwarded to the Coroner.

4.12. With the introduction of the Coroner’s Act 2003, in the event that the CIB assessed a death as ‘not suspicious’, the only further function of the QPS, is to prepare a Report for the Coroner.
such as exhibit 6. In such a case, the QPS does not obtain a single statement unless or until the Coroner so directs.

4.13. The QPS Report to the Coroner (exhibit 6) was prepared on the evening of MAJ McKerron’s death. That report informed the Coroner that on the morning of his death, MAJ McKerron had received a vaccine injection for flu and meningococcal virus.

4.14. The QPS was unaware of the ADF policy or practice of warning members not to engage in physical activities for 24 hrs post vaccination. No reference was made to that practice or policy in the Summary Part of the QPS Report to the Coroner. Consequently, the Coroner was unaware of that policy or practice.

4.15. On the day after the death of MAJ McKerron, the Coroner gave a verbal order for an autopsy involving internal and external examination. The autopsy was conducted by Professor Anthony Ansford on Saturday 12 May 2007. Routine samples were taken for histological examination and blood analysis, if required. Based on his examination and taking into account the circumstances surrounding the death, Professor Ansford formed the view that death was due to coronary atherosclerosis, and issued a certificate to that effect. That certificate was available to the Coroner on Monday 14 May 2007.

4.16. By letter dated 15 May 2007, Dr. Dale Thomas, Acting Director of Clinical Services at 2 HSB GBHC wrote to the Office of the State Coroner. He invited the State Coroner to contact him if the Coroner required access to MAJ McKerron’s Army medical records or if the Coroner required any other assistance.

4.17. The Deputy State Coroner, Ms Christine Clements, was the Coroner who overviewed the death of MAJ McKerron.

4.18. The only statements that the Coroner requested the QPS to provide were a statement from PO Cook and the reporting police officer, Constable Thiele.

4.19. The Deputy State Coroner was aware that the post-mortem had found evidence of very significant coronary artery disease, and she was aware that MAJ McKerron had received vaccinations some hours before his sudden death. It may be inferred that the Deputy State Coroner did not consider there was any link between the two events. Indeed, no toxicology report was requested at that stage. In all of the circumstances, the Deputy State Coroner did not think it necessary to conduct an inquest.

4.20. On 19 October 2007, the Deputy State Coroner issued the Record of Coroner’s Findings and Comments and Notice of Completion of Coronial Investigation (exhibit 7).

4.21. At the time that document was issued, it was known to the QSC that a CDF COI was going to be conducted into the death of MAJ McKerron.

4.22. In determining the cause and circumstances surrounding the death of MAJ McKerron, in response to the TOR, this COI is not usurping the role or function of the QSC. Had this COI not been established, and had further information been given to the Deputy State Coroner, it is probable that a Coroner’s Inquest into the death would have resulted.

4.23. The QSC, Mr Michael Barnes, and his Deputy Ms Christine Clements, have provided open-ended assistance to the COI and those assisting it. That assistance is acknowledged and appreciated.

4.24. In December 2007, at the request of the President of the COI, Counsel Assisting sought the assistance of the Deputy State Coroner in obtaining toxicology testing of MAJ McKerron’s blood samples. A toxicology report was ordered by the Coroner on 13 December 2007, requesting “full testing” of the retained blood samples. The Toxicology Report, dated 7 Feb 2008 forms part of Professor Ansford’s amended Autopsy Report (exhibit 5A).
4.25. No drugs of any description, or alcohol, were detected in the toxicology testing and it is clear from the totality of evidence given to the COI that the drugs involved in the two vaccinations given to MAJ McKerron, in no way caused or contributed to the coronary atherosclerosis which caused his death.

The Involvement of ADFIS

4.26. As MAJ McKerron was on duty at the time of his death, the Australian Defence Force Investigative Service (ADFIS) also became involved.

4.27. SGT Chris Keyes has been an investigator with ADFIS since 2004.

4.28. On 11 May 2007, SGT Keyes was the ‘on call’ duty investigator at Gallipoli Barracks. At about 1630 hrs he received a phone call from the Military Police Duty NCO to the effect that the QPS had advised that a member of the ADF, MAJ McKerron, had passed away during a BFA in the vicinity of Bulimba Barracks. SGT Keyes phoned the QPS and was given further information.

4.29. At 1800 hrs that day, SGT Keyes attended Bulimba Barracks and observed MAJ McKerron’s body. He spoke to Detective Sergeant Fenelon of the QPS and various members of the ADF, namely MAJ Priestley, WO2 Dougherty, and PO Cook. SGT Keyes departed Bulimba Barracks at 2100hrs.

4.30. Because SGT Keyes was busy with other matters, his next involvement with the death of MAJ McKerron was not until five days later on Wednesday 16 May 2007. On that day SGT Keyes made inquiries about the medic who had administered the inoculations at 2 HSB GBHC RAP. The medic was a female, PTE Barratt. SGT Keyes made those inquiries by contacting her chain of command. He did not speak to the medic herself, but said that he would need to obtain a statement from her and that 2 HSB would need to provide relevant medical documents. SGT Keyes envisaged that a statement from the relevant would include information into her responsibilities and training, and any briefing she may have given MAJ McKerron after the vaccinations.

4.31. SGT Keyes said that he was “well known” at 2 HSB GBHC and the general response of the medical staff at 2 HSB GBHC, when requests for documents were made, was “negative” because they believed that such documents were “medical-in-confidence”.

4.32. SGT Keyes let it be known that he would be attending 2 HSB to obtain a statement from the medic and obtain or secure relevant documentation. Later that morning, SGT Keyes was told by his Team Leader, WO2 Kirsty James, that a statement from the medic would not be required. She had spoken to then CAPT now MAJ Smith who advised that unless the QPS required ADFIS to conduct inquiries on their behalf, ADFIS investigative action was to cease, and that in due course, the CDF would appoint a Board of Inquiry into the death. When the BOI was convened, it would direct what statements were required and ADFIS would then become involved.

4.33. SGT Keyes protested and was told that the decision had been made by the ADFIS Regional Commander then CAPT Shannon Smith. SGT Keyes informed WO2 James that he wished to speak to CAPT Smith about that decision so that he (SGT Keyes) could voice his concerns. Later that morning, SGT Keyes went to see CAPT Smith in his office. WO2 Andrew Johnson visiting from Darwin, was also in the office. A conversation, variously described as “reasonably robust” and “very stern” then took place between SGT Keyes and CAPT Smith. WO2 Johnson was a silent party and did not participate in that conversation.

4.34. SGT Keyes could not recall the exact conversation. However, he said that he expressed to CAPT Smith his grave concerns about not being able to obtain a statement from the medic. Such a statement should be taken as soon as possible to ensure an accurate recall. It is well known that memory fades with time.
4.35. SGT Keyes said that CAPT Smith shrugged it off and said that no statement from the medic was required at that time, and if a Board of Inquiry was convened, this statement would be gathered at that time. SGT Keyes protested and said he was told it was the end of the matter, other than his preparing and submitting a final Report.

4.36. SGT Keyes said that CAPT Smith told him that there would be a Board of Inquiry because every death on duty results in a Board of Inquiry.

4.37. In relation to his final report, SGT Keyes said that after it was submitted it was vetted by WO2 James "and what I believe to be vital information removed". (Exhibit 44, paragraph 16)

4.38. The "vital information" allegedly removed related to:

1. The fact that vaccinations were administered to MAJ McKerron on the morning of his death and there was no statement from the medic who had administered those vaccinations; and

2. The fact that no wet globe test was available (at that time) at Bulimba Barracks. Such a test determines the level of activity that soldiers can participate in during the day. It is a test of weather conditions. Gallipoli Barracks has such a testing device and it is consulted on a daily basis.

4.39. As regards the vetting of any report, SGT Keyes agreed that the usual process was for such a report to go through some hands for editing or vetting purposes, to ensure that the final report is correct. Information may be added or removed for that purpose.

4.40. In order to make this COI as complete and comprehensive as possible, SGT Keyes was stood down on 7 November 2007, to enable the complete electronic ADFIS file to be obtained by Counsel Assisting so that all concerned could inspect it. SGT Keyes was also requested to produce his service police notebook in due course (Exhibit 91). While SGT Keyes had made contemporaneous notes in his notebook on 11 May 2007, he made no notes on 16 May 2007 or thereafter.

4.41. Upon being shown the ADFIS file (Exhibit 45) obtained by Counsel Assisting, SGT Keyes conceded that "vital information was alluded to" in the final report but not as strongly as he recalled. (T246.16)

4.42. SGT Keyes said that he could not recall any conversation between himself and CAPT Smith about "jurisdiction", but that the conversation had been "very stern". When asked about the "jurisdictional issue", SGT Keyes replied: (T89.15)

"As far as jurisdiction was concerned, I believe that the circumstances surrounding the death were well within the jurisdiction of the DFDA. Regardless of the fact, there were mitigating circumstances such as the medical treatment prior to the unfortunate death. Had they had any bearing on the death of MAJ McKerron, that vital evidence would have been lost in memory recall had it have been brought up during a commission of inquiry, which does take some time."

4.43. The basis upon which SGT Keyes wished to proceed was to establish if the medic had fulfilled her responsibilities to inform the patient of certain matters at the completion of the treatment. If there had been such a failure:

"Then it may well have been a negligent performance duty issue, well within the terms of the DFDA." (T89.37)

4.44. On Wednesday 16 May 2007, SGT Keyes phoned Detective Sergeant Fenelon who told him that the preliminary autopsy report established that the cause of death was a heart attack. Detective Sergeant Fenelon informed SGT Keyes that the QPS regarded the death as being from
natural causes, that there were no suspicious circumstances, and that no further inquiries would be made by the QPS unless directed by the Coroner.

4.45. In his evidence SGT Keyes said that Detective Sergeant Fenelon expressed support for the decision SGT Keyes for to obtain a statement from the medic. In his evidence, Detective Sergeant Fenelon could not specifically recall such a conversation, but said that if he had been approached in that regard, he would not have seen such a statement "as a bad thing, and certainly would not have discouraged the taking of such a statement".

4.46. On Wednesday 16 May 2007, SGT Keyes also telephoned SQNLDR Currie, the officer appointed by the CO of JLU-SQ to conduct the Quick Assessment (QA). The QA Officer had left a message for the ADFIS team leader, WO2 James, on 15 May 2007 and she returned his call that day. SQNLDR Currie explained to WO2 James that he had been appointed as the investigating officer by his CO to conduct a QA, and that he had been in contact with 2 HSB. Indeed, he had spoken to the medic who administered the vaccinations, and she told him certain things. WO2 James told SQNLDR Currie that the lead investigator, namely SGT Keyes would contact him during the next two days.

4.47. When SGT Keyes phoned SQNLDR Currie on 16 May 2007, he told the QA Officer that he should not speak to certain people such as the medic who administered the vaccines, and that JLU-SQ should await investigative action from the office of ADFIS. The ADFIS file contains a note from SGT Keyes concerning this conversation.

"I explained to SQNLDR Currie that he should cease any investigative action in relation to this matter, as this may hinder any investigative action by ADFIS".

4.48. SGT Keyes said that SQNLDR Currie was quite happy to co-operate in that regard. The QA Officer said that he had completed a draft QA and had spoken to a number of people in relation to the matter. He said that he would send an information copy to ADFIS, and was happy to cease any action in relation to the matter. The QA Officer asked SGT Keyes to notify his CO, LTCOL Taylor. SGT Keyes said that he passed that information to CAPT Smith and left it up to him.

4.49. SGT Keyes believed that he was "told to back down and cease all inquiries" because CAPT Smith and the CO of 2 HSB GBHC had had a conversation and that something had happened between those two officers. (T85.22) In that regard, SGT Keyes was completely mistaken. The evidence is that no such conversation took place. However, there was a conversation between CAPT Smith and LTCOL Taylor. (exhibits 84 and 85) Suffice to say that the QA Officer continued with his task and that SGT Keyes had no further involvement other than preparing a final report. In effect, that report was to state that the matter was with the QPS awaiting the outcome of the coroner's report. (T673.23)

4.50. It is clear that there were personality and other issues between SGT Keyes and the then CAPT Smith. SGT Keyes has stated: (T243.4)

"I have butted heads with CAPT Smith on several occasions before in relation to command interference that is displayed by him on many occasions. That is a motivating factor also in my support for leaving the ADF, Sir. I don't believe that he gives the investigator the opportunity to fully investigate things to fullest extent, Sir."

4.51. CAPT Smith is now MAJ Smith and is based in Canberra as the Director Operations of ADFIS. He described SGT Keyes as:

"very headstrong"... "on numerous occasions I had to speak to him on matters that he was very - very argumentative, with not just WO James, but previous JIO Commanders that he actually worked with. Now, at the end of the day, as I say, that's not a bad thing with investigators sometimes, but, some investigators, they just don't get it -and - on these occasions, SGT Keyes just didn't get it sometimes." (T851.44)

4.52. MAJ Smith described SGT Keyes as a newly appointed SGT who had little experience
and was just an average investigator. He described him as being a fairly headstrong type of person who sometimes became over enthusiastic in his investigations, not that one wants to curb enthusiasm in an investigator. MAJ Smith was aware of changes in SGT Keyes final report and acknowledged that some further information was added to that report by WO James. As he said (T586.5):

“We had some issues with SGT Keyes in relation to his report writing and everything else.”

4.53. WO2 James said that SGT Keyes did not like taking directions. When he believed he was correct, he did not like swaying from his decision. When asked about his “heated” conversation with CAPT Smith, WO2 James replied that most conversations with SGT Keyes were heated.

4.54. When WO2 James was asked about the allegation of SGT Keyes concerning “command interference” in his role as an investigator, WO2 James replied:(T677.28)

“He says that about every direction he receives.”

4.55. WO2 James said she knew that SGT Keyes and CAPT Smith didn’t like each other.

4.56. During her career as an ADF investigator, WO2 James has been involved with a number of sudden deaths as the lead investigator. In that regard, she has liaised closely with relevant state policing agencies and, when requested, has made certain inquiries on their behalf. Simply stated, she said that in a sudden death situation, jurisdiction doesn’t lie with the ADF. The jurisdiction lies with the state policing agency. ADFIS will assist, and gladly assist, but only if its assistance is requested. Without that request it lacks jurisdiction.

4.57. WO2 James said that the only reason she stopped SGT Keyes from obtaining a statement from the medic was the issue of jurisdiction. There had been no request in that regard from the QPS, on behalf of the Coroner.

4.58. ADFIS was established on 2 April 2007. It is the joint investigative service for the ADF and is under the command of the Provost Marshal Australian Defence Force (PM ADF).

4.59. Upon the establishment of ADFIS, CAPT Smith’s position and title was renamed and he became Regional Commander, Northern Region. His role was to command and control all ADFIS investigations in Queensland.

4.60. ADFIS has five offices in Queensland, namely at Brisbane, Amberley, Oakey, Townsville and Cairns, and conducts 350 to 400 investigations in Queensland each year. Amongst other things, the Regional Commander, Northern Region, on behalf of the PM ADF, is to approve and release all service police reports and briefs of evidence and to case-manage all investigations in the Northern Region.

4.61. In his evidence, (now) MAJ Smith pointed out that all sudden deaths of ADF personnel in Australia — whether they are on duty or not — fall within the state or territory jurisdiction of where the death occurred, and the matter is one for the state or territory Coroner (exhibit 64, page 1). In such matters, ADFIS only has a “shadow brief” to facilitate support to the relevant police service on behalf of the Coroner, if requested, and compile a report for the ADF.

4.62. The core function of ADFIS is the investigation of alleged offences against the DFDA. Ninety five percent (95%) of its work relates to criminal or disciplinary investigations. (T589.6)

4.63. MAJ Smith agreed that the QPS has a different agenda and perhaps a more narrowly focused agenda than the ADF might have in relation to the sudden death of a member. However, he emphasised that the primacy for the investigation into MAJ McKerron’s death, lay with the QPS on behalf of the Coroner. If any requests for assistance were received, ADFIS would facilitate those requests.
4.64. MAJ Smith said that the inoculation issue was a matter of concern, and he told WO2 James and SGT Keyes to ensure that the QPS was aware of that information. (T591.29) In fact, the QPS became aware of that information on the afternoon of MAJ McKerron's death and it was included in the report to the Coroner dated that day.

4.65. When MAJ Smith gave evidence, he was surprised to hear, for the first time, that the QPS had not spoken to or received a statement from the medic. He said that at no time was he informed about that. (T592.7) MAJ Smith said that if he had been informed that the QPS had not conducted such inquiries:

"My advice and direction would have been completely different." (T593.24)

4.66. Lack of communication, if not understanding, about who was doing what, by MAJ Smith, did not assist in the proper investigation of that aspect of the matter.

4.67. Given that ADFIS "facilitates" support to the QPS in ADF sudden death investigations, and that SGT Keyes was the point of contact or the support link between the QPS and the ADF, one can well understand and appreciate his frustration. On the other hand, given the jurisdictional issue, ADFIS priorities and limited resources, one can also understand the direction given by CAPT Smith to SGT Keyes. It remains the prerogative of the chain of command within ADFIS to determine the priorities of work and the allocation or use of its scarce resources.

4.68. Whilst SGT Keyes believes he was "barred" from making inquiries, that is not the case. As MAJ Smith was at pains to point out, SGT Keyes would not have been precluded from obtaining a statement from the medic who administered the vaccines, if he (then CAPT Smith) was aware the QPS had asked SGT Keyes, on behalf of the Coroner, to obtain such a statement. No such request was ever made.

4.69. MAJ Smith conceded that an "investigation gap" did result and that it is desirable to fill that gap. (T602.33) Essentially, MAJ Smith agreed that it was desirable that all relevant persons, to the extent they can be identified, should be interviewed as soon as possible after the event, in situations where a COI is likely. (T603.19)

4.70. The fact that no statement was taken from the medic as soon as practicable illustrates a defect that needs to be addressed. The COI is of the strong view that there should exist a capacity within the ADF to quickly obtain statements from key personnel and to procure/secure essential evidence in such matters.

4.71. In reality, that was what SGT Keyes was trying to achieve. Whilst he might have gone about it in a less than optimal way, one cannot fault the perception of SGT Keyes in this matter.

The Quick Assessment

4.72. On the afternoon of Saturday 12 May 2007, the CO of JLU-SQ sent an email to the officer in charge of the Amberley detachment of that unit, SQNLDR Stephen Currie. That email appointed SQNLDR Currie as the investigating officer to conduct a Quick Assessment (QA) into the death of MAJ McKerron.

4.73. Amongst other things, the QA Officer was to give particular attention to the "obtaining of statements from key parties", and was to focus on Unit actions in the period immediately prior to, during and immediately post MAJ McKerron's death. The email further advised the QA Officer:

"Your investigation is to be conducted in accord with extant ADF reference, and is to be completed by COB THU 17 May 07."

4.74. Understandably, the CO of JLU-SQ wanted the QA to be as comprehensive and complete as possible. That explains the expanded time frame given.
4.75. A QA is not an investigation and the QA Officer is not an Investigating Officer (IO). The QA is an internal command process, the purpose of which is to collect sufficient relevant information to enable a commander to make a decision of what other action should be taken.

4.76. The fact that at that time, the requirements for a QA were then located in Chapter 2 of the Administrative Inquiries Manual, may have caused some confusion.

4.77. As from 7 August 2007, the requirements for a QA have been removed from that Manual and are now found in DI(G) ADMIN 67-2. (exhibit 65A)

4.78. Speed is essential in the conduct of a QA. The now repealed Chapter 2 of the Administrative Inquiries Manual stated that:

"Both the QA and the report to the officer initiating the QA should be completed in the same day."

4.79. DI(G) ADMIN 67-2 relevantly states in paragraph 11:

"The QA must be delivered to commander/supervisor who initiated the QA within 24 hours of directing the QAO."

4.80. Given the circumstances, SQNLDR Currie commenced the QA on Monday 14 May 2007 and completed it on Wednesday 16 May.

4.81. As previously stated, the QA is not an investigation. It is simply an assessment procedure. It is an internal command procedure that is autonomous. A QA can be conducted while investigations are being made by, for example, ADFIS, state or federal police authorities and state or territory Coroners. The QA Officer will need to ensure that his or her assessment procedure does not interfere with any external investigative process underway, and to that end, may need to liaise with officers with such investigative bodies.

4.82. Clearly, it may be necessary for the QA Officer to speak to key personnel. However, it is not a function of the QA Officer to obtain formal statements from witnesses.

4.83. DI(G) ADMIN 67-2, at annex B, gives an example of a QA brief. As regards parties to be interviewed by the QAO, it mentions that the QAO should include brief details of what was said by the parties, if any. Specifically, it is now stated:

"It is not envisaged that there would be more than two or three interviewees for a QA and, in fact, there may be none. The interviewees can be contacted by telephone, email or in a face to face discussion."

4.84. Clearly, it was appropriate and indeed essential that SQNLDR Currie, as the QA Officer, speak to the medic who administered the inoculations at 2 HSB GBHC RAP, namely, PTE Barratt. That he did in a telephone conversation with her. It was never his intention, nor was it intended by LTCOL Taylor, that the QA Officer obtain a formal statement from the medic or any other key witness.

4.85. SQNLDR Currie did a commendable job in preparing the QA (exhibit 66).

Investigations at 2 HSB

4.86. The 2nd Health Support Battalion (2 HSB) at Enoggera is a Land Command High Readiness Deployable Health Unit. It consists of two parts, one military and the other civilian. The civilian part being a hospital and an RAP, is fixed. The military part is deployable. In the evidence, the civilian part is sometimes referred to as the "upstairs" or the "white" part of 2 HSB. The military part is sometimes referred to as the "downstairs" or "green" part.
4.87. In the civilian part of 2 HSB, all patients are military and virtually all staff are contracted civilians. The deployable component of 2 HSB, the "green" or "downstairs" section, is staffed entirely by military personnel.

4.88. The hospital part of 2 HSB is now called the Gallipoli Barracks Health Centre, (GBHC).

4.89. At all relevant times, the CO of 2 HSB was LTCOL Ian Spiers, a qualified pharmacist. LTCOL Spiers was the first CO of that Unit who was not a medical officer. In addition to being CO of 2 HSB at the time, LTCOL Spiers was also the Senior Health Officer of Area Health Service South Queensland.

4.90. As part of his command mandate, LTCOL Spiers considered himself the CO of GBHC, even though he did not have much control over its resources and had very limited authority - if any - over its civilian contractors. Nevertheless, as CO, he was responsible and accountable for what happens at GBHC. In such an arrangement, it is recognised that there is an issue or "mis-match" between three critical areas, namely resources, responsibility and accountability.

4.91. At all relevant times, the person who had effective management and control of 2 HSB, was a civilian, Dr. Lindsay McDowell. He was the Director of Clinical Services at 2 HSB. At the time of MAJ McKerron’s death, Dr. McDowell was absent on leave and the Acting Director of Clinical Services was Dr. Dale Thomas, the Manager of Medical Services at 2 HSB. Ms Wendy Keating, another civilian, was then the Nurse Unit Manager at GBHC. In effect, she was the senior most member of the nursing staff. She is now the Quality Manager for GBHC and RAAF Amberley Health Services.

4.92. After MAJ McKerron’s death, no formal investigation was conducted by 2 HSB, nor was any such investigation requested. However, 2 HSB did conduct a “quality review” of its vaccination procedures.

4.93. After the death of MAJ McKerron, Dr. Thomas was aware that two “investigations” were underway, one by the QA Officer and the other by the Coroner.

4.94. Upon being notified of MAJ McKerron’s death on Friday afternoon, Dr. Thomas, then and there, “secured” MAJ McKerron’s Unit medical records, consisting of two volumes (exhibit 3) and retained those records in his office. On Tuesday 15 May 2007, Dr. Thomas invited the Coroner to contact him if access to the medical records was required, or any other assistance could be given.

4.95. On Wednesday 16 May 2007, Dr. Thomas completed an overview of MAJ McKerron’s medical records, as had earlier been requested by AVM Austin, Head Defence Health Services. Essentially, that overview disclosed that MAJ McKerron was known to be obese, but with the exception of his heavy smoking habit, had no other significant risk factors that the ADF was aware of at the time of his sudden death.

4.96. As regards the delivery of immunisations at GBHC, the evidence disclosed that the standards employed exceeded the standards mandated by International Standards Organisation No 9001 Quality System. However, as a result of the quality review of the vaccination procedure, some further control measures were added to further tighten the system.

4.97. As and from 21 May 2007, 2 HSB GBHC RAP has implemented a procedure whereby ADF members requiring vaccinations complete a written pre-vaccination check list which is provided to the attending medical officer who then prescribes (or not as the case may be) the administration of certain vaccines for the purpose identified by the intended recipient. Further and significantly, 2 HSB GBHC RAP, as from 21 May 2007, provides a written medical “chit” which articulates and repeats some of the warnings/ restrictions given in ADFP 1.2.2.1 (exhibit 8).

4.98. The purpose of the chit is to remove the prospects of ambiguity in relation to the content of warning provided to those persons who have received vaccinations. A copy of the 2 HSB GBHC RAP chit is Annexure 9 to this Report.
4.99. The COI commends the practice of 2 HSB GBHC RAP in now providing such a written
chit, but is of the view that such a document can be improved upon to make it even clearer and to
enhance the prospect of recipients reading the same. Further comments and recommendations are
made in Chapter 5 of this Report.

Exhibit 58

4.100. Exhibit 58 is the copy of an email sent by Ms Kristen Scott, the executive support officer
at GBHC to all APS and civilian staff at GBHC. It is dated 10 September 2007 and states as follows:

"Good Afternoon All,

LTCOL Spiers (CO) has advised that if any staff member from GBHC is approached to give
interviews regarding Board of Enquiries, he is to be notified in the first instance.

No GBHC staff member is to provide comment without the CO's prior knowledge/approval.

Many Thanks

Kristen"

4.101. The COI spent considerable time investigating the circumstances of that email. At face
value, it represents an attempt to interfere with, or fetter, a BOI or COI investigation.

4.102. The email implies that civilian staff at GBHC are not to make any comment to
investigators or those assisting a BOI/COI, unless the CO has prior knowledge and given his approval.

4.103. The following points may be gleaned from the evidence:

- LTCOL Spiers did not authorise the email. Indeed, he had not seen it until it was
  shown to him during his evidence on 14 November 2007

- Ms Scott is, in effect, the personal assistant of Dr. Lindsay McDowell, the Director of
  Clinical Services at GBHC and "the boss of GBHC who runs it on a day to day basis".
  LTCOL Spiers had very little to do with her and they had no direct working
  relationship.

- The email was dictated to Ms Scott by Dr. McDowell after "two gentlemen" attended 2
  HSB on 10 September 2007, asking questions.

- Dr. McDowell directed Ms Scott to mention "the CO" in the email he dictated to her.
  She understood the purpose of the email was to ensure that the Director of Clinical
  Services was aware of what was happening at the hospital.

- As far as Ms Scott could remember, that was the only time that Dr. McDowell directed
  her to send an email on behalf of the CO of 2 HSB.

- Dr. McDowell directed that a copy of the email be sent to CAPT Corcoran, the
  Adjacent at 2 HSB to let someone on the "green side know what was going on."

4.104. LTCOL Spiers was a most impressive witness. As previously stated, he had not seen
the email until the day he gave evidence. The COI accepts that. LTCOL Spiers was shocked at the
perception created by the email, but not surprised that Ms Scott would send such an email because in
one sense, it reflected his desire to know what was going on at GBHC. (T488.40)

4.105. The CO of 2 HSB agreed that there was some degree of tension between investigators
wanting direct access to members of his Unit, and his wanting to know, as CO, what was happening in the Unit. (T478.1)

4.106. Some weeks prior to the date of the email, both Counsel Assisting the COI, LTCOL Carlin and LCDR Johnson, made a courtesy visit to the CO of 2 HSB. Counsel Assisting indicated that a COI into the death of MAJ McKerron was underway and that they would be making inquiries. In that regard, they would be speaking to members of 2 HSB staff in due course.

4.107. LTCOL Spiers had had no prior experience of a COI and thought it unusual that legal officers were making investigations.

4.108. On 10 September 2007, both Counsel Assisting attended at GBHC for COI purposes. Upon being told that “two males” were in the building making inquiries that day, Dr. McDowell phoned LTCOL Spiers to find out what was going on. Unfortunately, LTCOL Spiers had not told him about the earlier courtesy visit from Counsel Assisting the COI, and that visit was not mentioned during the phone call. No connection was made between the earlier visit and the two gentlemen now making inquiries.

4.109. Both Counsel had “signed in” to GBHC on 10 September 2007, but it seems that no one told Dr. McDowell who they were. The doctor said it was not his role to find out the identity of visitors. He said that as a matter of “courtesy and politeness”, they should have come to his office to introduce themselves and to explain what they were doing. With the advantage of hindsight, that of course is correct. However, Counsel Assisting had assumed – incorrectly - that the CO of 2 HSB had mentioned to Senior Personnel at 2 HSB the purpose of their earlier visit and their need to return.

4.110. Dr. McDowell said that it was up to visitors to check with the CO or tell him who they were. He said that the visitors reported in the building could have been from the press. Dr. McDowell said he had 169 contractors working for him and because of a number of issues relating to overseas deployments with respects to patients who return with certain illnesses and injuries, “there is a lot of stuff that is classified”. (T848.26).

4.111. Dr. McDowell agreed that the email was very specific about Boards of Inquiry. He directed it to be sent after being told that two visitors were making inquiries about a Board of Inquiry.

4.112. The Director of Clinical Services at GBHC said that in 2007, people phoned 2 HSB for information about members “going on” or “returning from deployment”. 2 HSB does not respond to such inquiries because of security concerns.

4.113. Dr. McDowell agreed that there had been an earlier BOI into the death of a service member that caused a lot of anxiety or angst to 2 HSB, but said that the email was not sent in that context. He said it was all about “spacial” and “situational” awareness of who was in the hospital, and what was going on. As Dr. McDowell said:

“I think that the implication in this email was that if there were other Boards of Inquiries, the CO just wanted to know when people were coming asking about certain things”.

To which Counsel Representing asked:

“And he wanted to know so that he could control the dissemination of information?”

To which the Dr. McDowell replied: (T852.22)

“Well, no, I don’t think so. No, no. No, no. He just wanted to be aware. The CO is responsible for everyone who is inside the unit, he just wants to know who’s there and what their legitimate business is”.

4.114. Dr. McDowell did find out subsequently that the two male visitors at GBHC on 10
September 2007 were involved with this COI.

4.115. Dr. McDowell agreed that the email contained the “unfortunate nuance” that the CO would want to know what somebody would want to say at an inquiry before he allowed that person to speak to an investigator. The Director of Clinical Services at GBHC said that “would not be true” of LTCOL Spiers.

4.116. If sending such an email today, Dr. McDowell would not craft it in the same manner.

4.117. Exhibit 58 resulted from an unfortunate lack of communication or breakdown in communications.

4.118. Notwithstanding what is stated in the email, the evidence is and the COI finds, that at no time did the then CO of 2 HSB, LTCOL Spiers, or the then Director of Clinical Services at GBHC, Dr. McDowell, intend in any way to muzzle or felter staff who may be called as witnesses in a COI.

4.119. After he concluded his evidence, the COI left it to the discretion of LTCOL Spiers to correct any false perception created by exhibit 58.

The Vaccines

4.120. There is no suggestion, let alone evidence, of any link between the vaccinations received by MAJ McKerron at 1010 hrs of 11 May 2007, whilst at 2 HSB GBHC RAP, and his sudden death approximately four and a half hours later.

4.121. The injections received were .5ml of Vaxigrip influenza vaccine and .5ml of Mencevax meningitis vaccine.

4.122. A total of 36 immunizations are recorded in MAJ McKerron’s International Certificate of Vaccination (part of exhibit 3). MAJ McKerron had received both Vaxigrip and Mencevax vaccinations prior to 11 May 2007. The last influenza vaccine was administered on 23 May 2006 and the last meningitis vaccine on 20 October 2003. The former vaccine is compulsory before deployment, and the latter vaccine requires a booster within 3 years.

4.123. Vaxigrip vaccine is manufactured in France and Mencevax vaccine is manufactured in Belgium.

4.124. Before such vaccines can be used in Australia, they must receive approval from the Australian Government, Department of Health and Ageing, Therapeutic Goods Administration (TGA), Woden, ACT.

4.125. Mencevax vaccine for use in Australia received TGA approval on 2 October 1998, and Vaxigrip vaccine for use in Australia received TGA approval on 30 August 2006. Such vaccines are subject to batch or lot release procedures by the TGA. As part of its regulatory functions, the TGA is responsible for authorizing the release into the community of all batches of vaccines. The process involves a combination of laboratory testing and checking manufacturers’ records to ensure correct procedures have been followed in the production and transporting of the vaccine.

4.126. The batch numbers of the vaccines administered by 2 HSB GBHC RAP to MAJ McKerron on 11 May 2007, were:

- Mencevax - A 73CA142C
- and
- Vaxigrip - A 6356-1

4.127. The Mencevax batch was released for general marketing in Australia on 22 November

4.128. Dr. Larry Kelly, Director of the Laboratories Branch of the TGA provided valuable assistance to the COI in his report (exhibit 73A) and in his telephone evidence.

4.129. The batch numbers of the vaccines administered to MAJ McKerron were provided to Dr. Kelly to enable him to check TGA records to confirm that the vaccines met an acceptable quality standard prior to their release by the manufacturer. Samples had been submitted by the manufacturers and those samples were inspected and tested by the TGA.

4.130. The vaccines were found to comply with all specifications and the TGA had no concerns with the quality of the vaccine batches at the time they were released for use in Australia.

4.131. Dr. Kelly also checked with the TGA Adverse Drug Reactions Unit to determine if that Unit had received any unusual report in relation to either of the vaccines. That inquiry indicated that no report of any adverse affect, associated with the batches, had been received.

4.132. The safety profiles of both vaccines appear to be consistent with their Product Information (exhibit 73B).

4.133. In her Review Report (exhibit 72) Dr. Amanda Dines, a very experienced ADF GPCAPT medical officer and Deputy Executive Director of Medical Services at the Royal Brisbane Hospital reviewed the medical literature to determine if either vaccine had been found to produce a detectable increase in the risk of vascular events such as myocardial infarction. The influenza vaccine had not been found to produce any detectable increase in the risk of such events, and there are no reports of any possible association between the Mencevax vaccine and acute coronary events.

4.134. The COI finds that there is no link between the Mencevax and Vaxigrip vaccines administered to MAJ McKerron at 1010hrs on Friday 11 May 2007 at 2 HSB GBHC RAP and his sudden death approximately four and a half hours later.
CHAPTER 5 – FINDINGS OF THE COMMISSION OF INQUIRY IN RELATION TO THE TERMS OF REFERENCE

The Terms of Reference (TOR)

5.1 The TOR require the COI to investigate and report upon:

(a) the circumstances proximately associated with the death of MAJ McKerron including, without restricting the generality thereof:

(i) the date and place of the death;

(ii) the manner and cause of the death; and

(iii) any facts and circumstances establishing that the death arose out of, or in the course of, his service in the Army;

(b) the sufficiency of any Defence actions and decisions materially relevant to MAJ McKerron's death, both prior and subsequent thereto; and

(c) any weaknesses or deficiencies (isolated or systemic) in Defence systems, policies, equipment practices, procedures and training perceived in the context of MAJ McKerron's death.

5.2 Having regard to all of the evidence and information available to it, the COI now addresses those issues.

TOR(a) – THE CIRCUMSTANCES PROXIMATELY ASSOCIATED WITH THE DEATH OF MAJ McKERRON

(i) The Date and Place of Death.

5.3 The COI finds that MAJ McKerron collapsed and died in the mid-afternoon of 11 May 2007, near the intersection of Harrison and Byron Streets, Bulimba, in the State of Queensland, in proximity to or in the vicinity but outside the delimited area of Bulimba Barracks.

5.4 It is impossible to determine the precise time of MAJ McKerron’s death. WO2 Dougherty made an emergency call to QAS at 1436 hrs, while PO Cook was performing CPR on MAJ McKerron. The first QAS unit arrived within four minutes of that phone call and an advanced care paramedic took over the resuscitation attempts. Altogether, three QAS units responded to the emergency call, two of which were intensive care paramedic units.

5.5 Amongst other things, the QAS intensive care paramedics administered oxygen and adrenaline and used a cardiac defibrillator in their urgent endeavours to resuscitate MAJ McKerron.

5.6 The QAS terminated their resuscitation attempts at 1524 hrs, 44 minutes after the arrival of the first response unit.

5.7 The QAS response was prompt, prolonged and professional. The same can be said for the CPR endeavours by PO Cook and his subsequent assistance to the five QAS officers. The COI commends the QAS officers and PO Cook for their outstanding efforts.
(ii) The Manner and Cause of Death

5.8 The evidence establishes that MAJ McKerron died whilst participating in a Basic Fitness Assessment (BFA), as required by, and in accordance with, Defence Instruction (Army) PERS 148-2 "Army physical conditioning assessment system" (exhibit 10), in preparation for his deployment to Afghanistan later in the year.

5.9 The BFA is a component of Army Individual Readiness Notice (AIRN), and is required to be taken every six months as a minimum. As at 11 May 2007, MAJ McKerron had ten days remaining within which to undertake a BFA to maintain his AIRN status.

5.10 Professor Anthony Ansford, a Forensic Pathologist with more than 30 years experience, performed the autopsy on Saturday 12 May 2007. Whilst the autopsy disclosed some damage to MAJ McKerron’s lungs in the form of emphysema, a condition associated with heavy cigarette smoking, the essential finding was that MAJ McKerron suffered a cardiac arrest (heart attack) caused by severe heart disease.

5.11 MAJ McKerron’s heart was enlarged for his body weight and his heart disclosed severe three-vessel coronary artery disease. The coronary arteries which supply blood to the heart showed severe focal areas of narrowing due to Coronary Atherosclerosis, what lay people call “hardening of the arteries”. MAJ McKerron’s coronary disease was very severe, with one artery blocked 99% by fatty deposits and the two other arteries, including the main artery, blocked or narrowed up to 80%.

5.12 Professor Ansford opined that because MAJ McKerron had been exercising at the time he collapsed, the most likely scenario was that not enough blood was getting through to his heart because of the severely narrowed coronary arteries. Blood is needed to produce oxygen. It is likely that the lack of oxygen triggered a “rhythm disturbance”, which, given MAJ McKerron heart disease, proved to be fatal. As Professor Ansford stated (T562.28):

“…..with that sort of coronary disease, you are at risk of sudden death, no matter what you do. I mean, that’s a very severe coronary artery disease.”

5.13 The medical evidence is that with such a severe condition, sudden death could occur anywhere at anytime, but vigorous exercise could exacerbate an adverse outcome.

5.14 Although MAJ McKerron was overweight, Professor Ansford did not regard that as a significant risk factor, unlike the fact that MAJ McKerron had been a heavy smoker for many years. The smoking habit (30 years), and severe coronary disease were the significant factors, and the latter caused MAJ McKerron’s sudden death.

5.15 As regards the two vaccinations received by MAJ McKerron at 2 HSB some four hours before his death, there is no suggestion, let alone evidence, of any link between the vaccinations and his sudden death.

5.16 Although no toxicology report accompanied the autopsy (exhibit 5) on 13 December 2007, as a result of a request from Counsel Assisting the COI, the Deputy-State Coroner requested a “full testing” of the three specimens of MAJ McKerron’s blood retained by the Queensland Forensic Toxicology Laboratory.

5.17 The toxicology certificate (part of exhibit 5A) dated 7 February 2008, indicates that no alcohol or drugs were detected in those blood samples.

5.18 On Saturday 12 May 2007, AVM Tony Austin, Head Defence Health Services, directed that a review of MAJ McKerron’s medical record be undertaken to ensure that his medical management had been appropriate. That review was conducted by Dr. Dale Thomas, the then Acting Director of Clinical Services at 2 HSB. In a nutshell, Dr. Thomas found that the medical file disclosed no evidence of any pre-existing heart condition, only negative lifestyle factors, such as his long history of smoking and, more recently, being overweight.
5.19 AVM Austin was satisfied with that review. As he stated in his evidence (T1014.16):

"So basically we had a gentleman here who was known to be obese, but basically with exception of his heavy smoking, had no other significant risk factors that we were aware of at the time."

5.20 In the circumstances, AVM Austin was satisfied that the medical management of MAJ McKerron had indeed been appropriate.

5.21 GPCAPT Dr. Amanda Dines, a very experienced ADF medical officer and Deputy Executive Director, Medical Services at the Royal Brisbane Hospital, undertook a Review Report on MAJ McKerron's medical history at the request of the COI (exhibit 72). Amongst other things, Dr. Dines reviewed the relevant medical literature. The literature disclosed that the influenza vaccine administered to MAJ McKerron on the morning of his death has not been found to produce a detectable increase in the risk of vascular events. The literature also disclosed no reports of a possible association between the Mencevax inoculation and acute coronary events.

5.22 Although MAJ McKerron had been using nicotine replacement treatment for three and a half months before his death, the reviewed literature did not establish that any such use is associated with any increase of the risk of heart disease/stroke/or sudden death. Professor Ansford was also confident that nicotine replacement treatment in no way contributed to MAJ McKerron's death.

5.23 Dr. Larry Kelly, Director of the Laboratories Branch of the Therapeutic Goods Administration (TGA), Woden, ACT, has provided valuable assistance to the COI in his report (exhibit 73A) and in his telephone evidence.

5.24 The batch numbers of the vaccines administered to MAJ McKerron were provided to Dr. Kelly to enable him to check TGA records to confirm that the vaccines met an acceptable quality standard prior to their release by the manufacturer. Samples had been submitted by the manufacturers and those samples were inspected and tested by the TGA. The vaccines were found to comply with all specifications and the TGA had no concerns with the quality of the vaccine batches at the time they were released for use in Australia.

5.25 Dr. Kelly also checked with the TGA Adverse Drug Reactions Unit to determine if that unit had received any unusual report in relation to the two vaccines. That inquiry indicated that no report of any adverse affect, associated with the batches, had been received. The safety profiles of both vaccines appear to be consistent with their Product Information (exhibit 73B).

5.26 The COI finds that:

- The cause of death was coronary atherosclerosis (hardening and narrowing of the coronary arteries): (exhibits 5 and 5A). Neither MAJ McKerron nor the ADF was aware of that heart condition.

- There can be no doubt that the BFA in which MAJ McKerron was participating in on 11 May 2007, commencing 1345 hrs, was the precipitating event which resulted in his sudden death. However, the direct cause of death was MAJ McKerron's severe coronary disease. Of that, there can be no doubt:

- The two vaccinations ("Vagigrrip" and "Mencevax") administered to MAJ McKerron at the RAP 2 HSB on 11 May 2007 at 1010 hours did not cause or contribute, in any way, to the death of MAJ McKerron. There is no link between those events.
(iii) The facts and circumstances establishing that MAJ McKerron’s death arose out of, or in the course of, his service in the Army.

5.27 MAJ McKerron was the Executive Officer (XO) of JLU-SQ. At the relevant time, the Unit comprised the CO, two majors, one warrant officer, two sergeants, and a petty officer reservist on a part-time basis. The latter was a PTI.

5.28 On the day of his death, MAJ McKerron was the acting CO of the Unit.

5.29 WO2 Vince Dougherty was the OPSWO for JLU-SQ. Amongst other things, he was responsible for conducting Unit PT, BFAs, TOETs and AIRNs. As the OPSWO, he took the bookings for BFAs. On 10 May 2007, WO2 Dougherty received a phone call from MAJ McKerron asking if the WO could conduct his BFA the next day. WO2 Dougherty told MAJ McKerron that BFAs were usually done in the morning, to which MAJ McKerron replied that he had some appointments in the morning and he would contact the WO later about the time for the BFA. WO2 Dougherty received no further call from MAJ McKerron that day.

5.30 On 11 May 2007, WO2 Dougherty phoned MAJ McKerron at 0730 hrs and asked him for a suitable time to undertake the BFA. MAJ McKerron replied that he was about to go to the appointments and would come to see WO2 Dougherty around 1100 hrs. Whilst MAJ McKerron did not tell the WO what his appointments were, it is clear that they were the dental appointment at the Enoggera Dental Centre and the medical appointment at 2 HSB.

5.31 It is clear from the evidence of Ms J. Ward, personal assistant to the CO at JLU-SQ, that MAJ McKerron anticipated two separate trips to 2 HSB that day for the purpose of his vaccinations. The first was his attendance early that morning to obtain authorisation for the vaccinations. The second attendance was to be later in the day during the vaccination parade between 1300 and 1330 hrs.

5.32 It seems clear that MAJ McKerron intended to undertake his BFA prior to his attendance at the vaccination parade. While attending 2 HSB that morning, MAJ McKerron was unexpectedly vaccinated then and there, because of his pending deployment. When he returned to JLU-SQ, Ms Ward observed that MAJ McKerron was delighted that he didn't have to return to 2 HSB that day.

5.33 Not having heard from MAJ McKerron by 1100 hrs, WO2 Dougherty phoned him again. He told the WO that he was showing some civilians around the Unit but would be to see him shortly. At about 1150 hrs, WO2 Dougherty stepped outside his office and saw MAJ McKerron approaching with a few people. The Acting CO said he was busy with those people and asked if the BFA could be done after lunch. WO2 Dougherty saw no problem with that. The day was overcast and it was quite cool, there being a bit of a breeze.

5.34 MAJ McKerron arrived for his BFA at approximately 1345 hrs. He changed into PT gear, did warm up exercises and completed the push up phase of the BFA. After a short break, further warm up exercises were undertaken, instructions given and MAJ McKerron had some water before doing the sit ups.

5.35 Both the push up and sit up phases were completed by MAJ McKerron performing over and above the number of exercises. MAJ McKerron then elected to do the 5km walk rather than the 2.4km run. He did some further stretches, obtained a water bottle and commenced the 5km walk at approximately 1400 hrs.

5.36 It was whilst he was participating in that 5km walk, as part of the BFA, that MAJ McKerron collapsed and died.

5.37 The BFA was supervised by WO2 Dougherty and PO Cook.

5.38 The COI finds that in all respects, the BFA was conducted in accordance with the requirements of exhibit 10, being the Army policy guidance on the conduct of BFAs.
5.39 There is no mandated requirement in exhibit 10 which required the BFA to be terminated when MAJ McKerron told WO2 Dougherty, within earshot of PO Cook, that he had had "a flu shot" that morning.

5.40 MAJ McKerron's medical record (exhibit 3), evidences that his gait was affected by one leg being shorter than the other, consistent with the keen and accurate observations of PO Cook whilst MAJ McKerron was undertaking the 5km walk.

5.41 Nothing that WO2 Dougherty and PO Cook did indicates any lack of concern as to the welfare or otherwise of MAJ McKerron. Indeed, the evidence is in the other direction. Like MAJ McKerron, they were unaware of his condition and were not to know that his myocardial infarction was something that could strike at anytime, as pointed about by Professor Ansford.

5.42 Relevantly, CDF Directive No 12/2006, dated 30 May 2006, applies to all ADF deaths in service. The term "Death in Service" is defined in paragraph 6 of that Directive:

(a) Death in Service includes the death of an ADF member arising out of or in connection with their service in the ADF. (Service nexus).

(b) Factors taken into account to determine whether a Service nexus exists may include:

(1) the member was on duty or in uniform;

(2) the death occurred at a Defence establishment or involved Defence property and/or:

(3) the incident had its making in a defence activity.

5.43 At the time of his death, MAJ McKerron was the acting CO of JLU-SQ, and was on duty. At the material time, MAJ McKerron was participating in a BFA to maintain his AIRN status for the purpose of his deployment to Afghanistan later in the year. Clearly, his death was a Death in Service as defined.

5.44 The COI finds MAJ McKerron's death arose out of, or in the course of, his service in the Army. It was a Death in Service.

TOR (b) – THE SUFFICIENCY OF ANY DEFENCE ACTIONS AND DECISIONS MATERIALLY RELEVANT TO MAJ McKERRON'S DEATH BOTH PRIOR AND SUBSEQUENT THERETO

5.45 Essentially, the only Defence action and decision materially relevant to the death of MAJ McKerron was the conduct of the BFA on the early afternoon of Friday 11 May 2007, and its subsequent continuation when the assessors became aware that the only participant of the BFA had received "a flu shot" some hours earlier.

5.46 The BFA was a precipitating event which resulted in the death of MAJ McKerron. However, as Professor Ansford determined and the Queensland Deputy State Coroner found, the single cause of MAJ McKerron's death was coronary atherosclerosis, namely, his severe but unknown heart disease. Indeed, the Deputy State Coroner observed:

"Coronary atherosclerosis of such severity is well known to cause a sudden and unexpected death. Exercise would no doubt add some added pressure on the heart, but even without physical stress, death can occur at any time" (exhibit 7 p 2).

5.47 In the context of MAJ McKerron's unknown and severe coronary condition, his sudden death was inevitable. In a sense, his heart was like a ticking time bomb.
5.48 Whilst the inoculations at 2 HSB at 1010 hrs that day did not, in any way, cause or contribute to the death of MAJ McKerron, his decision to participate in a BFA within hours of receiving those inoculations was incorrect. That comment can be made with the clear advantage of hindsight. However, that decision must be assessed in the light of the post vaccination warning and advice given to MAJ McKerron by PTE Barratt.

5.49 If it was the case that MAJ McKerron asked PTE Barratt if he was able to participate in the BFA later that day – the COI is unable to make a finding in that regard, given the conflicting evidence and the absence of a contemporaneous written statement from the medic - that decision must be viewed in the context of what MAJ McKerron may have been told by the medic, i.e. only proceed with physical activity if he felt well enough to do so.

5.50 From his past ADF vaccination experience – more than 30 vaccinations on more than 20 separate vaccination days in twenty seven and a half years service in the ADF - MAJ McKerron would have been well aware of the general post vaccination warnings or advice given at ADF medical facilities, and COI so finds.

5.51 A cross referencing of actual vaccination dates and the dates of MAJ McKerron’s BFAs or BFTs during his service, indicates that 11 May 2007 was the only occasion on which MAJ McKerron participated in a BFA within 24 hours of being vaccinated.

5.52 MAJ McKerron did not disclose to WO2 Dougherty or PO Cook prior to the commencement of the BFA that he had received two vaccinations at 2 HSB earlier that day. He should have done so, not that the outcome would have been different, given the circumstances. When MAJ McKerron later disclosed that he had been vaccinated, he simply said, in passing, that he had received a “flu shot” and that was said to WO2 Dougherty as MAJ McKerron commenced the third phase of the BFA, the 5 km walk. Both at that time and at the turnaround after the completion of the first leg of walk, WO2 Dougherty expressed his concern about MAJ McKerron continuing with the BFA, only to be told by MAJ McKerron that he was feeling “fine” or “okay”, and that he was going to finish the BFA because he had no intention of “coming back a second time”. (T70.23).

5.53 Counsel Representing asked WO2 Dougherty why he did not terminate the BFA upon his being told that MAJ McKerron had received a flu vaccination earlier in the day and the supervisor’s belief, based on his own vaccination experience, that the BFA should not be conducted in those circumstances. WO2 Dougherty replied: (T143.16) and (T143.26)

“Sir, if a senior officer tells me that, or asks me to do a BFA, I conduct a BFA” and

“if I felt MAJ McKerron was in no fit state to participate in a BFA, it would not have commenced.

5.54 When MAJ McKerron turned around after the first leg and said he felt a little sick and it could have been the flu needle, WO2 Dougherty asked if he wanted to stop, to which MAJ McKerron replied: (T146.3)

“No, no, no. I’m fine”

and then continued with the power walk.

5.55 One can well understand WO2 Dougherty’s position. As he stated : (T146.45)

“Sir, I don’t question an officer. If an officer turns around, or a senior person turns around and says that they’re fine and they are continuing on, they’re continuing on. For me to go then and question the officer shows disrespect, in my view, and I felt that MAJ McKerron was doing fine.”

5.56 WO2 Dougherty is not a qualified PTI. However, as part of his duties as OPSWO, on direction
from the CO, he conducted or carried out PT at JLU-SQ and organised any BFAs that had to be undertaken. PO Cook had served in the Navy for 15 years and was a qualified PTI. He commenced his part time reservist duties at JLU-SQ on Thursday 10 May 2007. On 11 May 2007, PO Cook was observing WO2 Dougherty conduct the BFA. In a sense, he was assessing the supervisor. PO Cook had no criticism of how WO2 Dougherty conducted the BFA:

"WO2 Dougherty conducted the BFA like any PTI would. But, no, the way he conducted it was fine. It would have been nice in the morning, but unfortunately the XO was pressed for time too, so we had to conduct it within his timeframe." (T79.21).

5.57 Usually BFAs are taken by a group. This was the first time that either PO Cook or WO2 Dougherty had been involved with a fitness test for an individual. At the time, that individual was the Acting CO of JLU-SQ.

5.58 The qualified PTI, PO Cook, was not aware of any instruction or guideline about participating in a BFA after an inoculation. (T82.44) So far as he was aware, unless a member had a "medical chit", there was nothing to stop him or her from participating in a BFA. (T83.8)

5.59 WO2 Dougherty is now of the clear view that the PTI or supervisor conducting a BFA should be empowered to terminate the activity if he or she is told by a participant that they have received an inoculation within the past 24 hours. This COI strongly concurs with that view. Regardless of rank, the supervisor of a BFA or any like activity should be akin to the captain of a ship or the pilot of an aircraft whose word is final, even if the participant or passenger is the CDF himself. Commonsense and good sense need to come to the fore in that regard.

5.60 The best way of achieving that specific objective is to make it crystal clear to all members of the ADF that specific physical activities, such as BFAs, are prohibited within 24 hours of vaccination. That issue will be addressed TOR(c).

5.61 The COI finds that the actions of WO2 Dougherty and PO Cook in relation to the requirements of exhibit 10, concerning the conduct of the BFA, were sufficient. Likewise, it finds that the first aid response by PO Cook and WO2 Dougherty, based upon their training histories, was also sufficient.

TOR(c) - ANY WEAKNESSES OR DEFICIENCIES (ISOLATED OR SYSTEMIC) IN DEFENCE SYSTEMS, POLICIES, EQUIPMENT, PRACTICES, PROCEDURES AND TRAINING PERCEIVED IN THE CONTEXT OF MAJ McKERRON'S DEATH.

5.62 The evidence and information available to the COI has identified a number of weaknesses or deficiencies in terms of TOR(c).

Post Vaccination Warnings

5.63 Paragraph 3.22 of ADFP1.2.2.1 (exhibit 8) contains a number of restrictions which apply to ADF members after a vaccination has been administered. Sub-paragraph c. states:

"Members are not to perform excessive physical activity such as physical training, parade or drill for 24 hours following vaccination."

5.64 The COI finds that the wording of paragraph 3.22 c. of exhibit 8 is less than precise. What is "excessive" for one person might not be for another. The paragraph is subject to interpretation and different meaning and is, in many respects, ambiguous.

5.65 To put the matter beyond doubt, the COI recommends that the paragraph be amended by the removal of the subjective adjective "excessive", to remove scope for variation and/or avoidance of the intent of the restriction. The amendment should include readily understood black and white prohibitions.
5.66 Without seeking to bind or impose the publication sponsor, a form of words to consider might be “members are not to undertake any BFA/PFT assessments, parades, drill or other non-sedentary physical activity”.

5.67 In any event, the paragraph should specifically include “a physical fitness test or basic fitness assessment”.

5.68 **Recommendation 1.** Paragraph 3.22.c of ADFP1.2.2.1 should be amended to exclude the word “excessive” and, in any event, extend the restrictions to physical fitness tests such as PFTs or BFAs.

5.69 Currently, the mandated restrictions in paragraph 3.22 of ADFP 1.2.2.1 are not reproduced and incorporated into exhibits 9, 10 and 11, being the single Service Instructions for the conduct of BFAs or PFTs. Exhibit 9 is the Instruction for the RAN, exhibit 10 the Instruction for the Army, and exhibit 11, the Instruction for the RAAF.

5.70 The COI finds that there is a disconnect between the above single Service Instructions for the running of BFAs or PFTs and paragraph 3.2.2.c. of exhibit 8.

5.71 **Recommendation 2.** The relevant Defence Instructions dealing with the conduct of BFAs or PFTs, (exhibits 9, 10 and 11) should be amended to ensure consistency and parity with ADFP 1.2.2.1 (exhibit 8) in order to provide that BFAs or PFTs are not to be conducted in 24 hours of receipt of vaccinations.

5.72 There is no doubt that PTE Barratt gave an oral warning to MAJ McKerron about some aspects of post-vaccination restrictions. Unfortunately, the COI is unable to determine the precise nature of the oral warning given.

5.73 Such warnings must be given to a member following vaccination. That is mandated in ADFP1.2.2.1, paragraphs 3.21 to 3.24 inclusive.

5.74 As regards the warning or notification of post-vaccination restrictions, the COI has heard evidence of wide and varied practices ranging from not receiving the warning at all, to perfunctory warnings being provided orally, through to an ad hoc procedure, depending on rank and other factors, as to whether a member would or would not receive a medical “chit” which encapsulated the intent of the restrictions in ADFP1.2.2.1. For example, warnings given to LTCOL Taylor following vaccination have varied significantly. They range from…… “Stay here, do nothing for the next 24 hours”; “stay here”; “if you feel okay, do what you want” and “see you later”, “if you feel sick, come on back”. (T10846)

5.75 Whilst ADF nurses or medics receive appropriate training about the post-vaccination restrictions during their basic medical training, the nurse or medic administering a vaccination should not be required to rely on his or her recollection of training received sometime earlier, perhaps years earlier.

5.76 To eliminate variation as to post-vaccination warning procedures, the COI is of the view that following a vaccination at any Defence facility, a member should be given appropriate warnings in terms of ADFP1.2.2.1, both orally and in writing. The member should be instructed to read the written warnings whilst he or she remains in the vicinity of the place of vaccination for at least 15 minutes after the vaccination.

5.77 Following MAJ McKerron’s death, 2 HSB GBHC RAP reviewed its post vaccination procedures. As and from 21 May 2007, that medical facility has provided a PM101 medical “chit” to each recipient of a vaccination. That document contains the restrictions given in paragraph 3.22 of ADFP1.2.2.1. and a duplicate is placed on the member’s UMR.

5.78 In providing such a medical “chit”, 2 HSB GBHC RAP has resurrected an earlier but discontinued practice. Whilst some written warning is better than none, the COI is of the clear view
that a separate or stand-alone warning/restriction is warranted. Using a PM101 form for that purpose is inadequate.

5.79 The primary purpose of a Form PM101 is not to warn the member about post vaccination restrictions, but to notify the member’s Unit that the member is on restricted duties for a period of time.

5.80 Because post vaccination warnings are mandatory in the ADF, the restrictions are important enough to be given appropriate prominence in a separate document. That document should be given to the member following vaccination, with instructions, to read it whilst waiting in the vicinity of the place of vaccination for at least 15 minutes after the vaccination.

5.81 Upon giving such a document to a vaccinated member, the nurse or medic who administered the vaccination should then record that fact by a brief notation in the medical facility’s Outpatient Clinical Record (exhibit 27) or other suitable record. The notation could be as short as “written warnings supplied” (WWS), followed by the nurse or medic’s initials.

5.82 The Head Defence Health Services would be the appropriate person to oversee the wording a separate or stand alone warning. The COI recognises that such a document will constitute yet another piece of paper in a system perhaps already over-burdened with paper. As one medical witness stated “Defence loves paper”. Given that the warnings are mandatory, they are important enough to be clearly spelt out on paper.

5.83 **Recommendation 3(a).** The warnings/restrictions in terms of paragraphs 3.21, 3.22 and 3.23 of ADFP 1.2.2.1 should be incorporated into a separate document, appropriately headed, together with an explanation for the warning and the importance of compliance, and a copy of the document be given to every member of the ADF following vaccination with instructions to read the document while waiting at the place of vaccination for the requisite time after vaccination.

5.84 **Recommendation 3(b).** Upon giving that document to the vaccinated member, the nurse or medic who administered the vaccination should make a brief note in the medical facility’s Outpatient Clinical Record (or other suitable record), that the written warning has been given “e.g. written warning supplied” followed by the nurse or medic’s initials.

**Smoking and an ADF – Specific Quit Program**

5.85 It is an acknowledged medical fact that people who regularly smoke tobacco products become addicted to nicotine.

5.86 Tobacco smoking is the largest single preventative cause of death and disease in Australia today. It is also recognised that cigarette smoking is a major risk factor for cardiopulmonary disease.

5.87 Members of the ADF are part of the community at large, but they also belong to a special community subject to risks and stresses not found in the general community.

5.88 It is recognised that Quit Smoking programs are available in the general community. Quitline is a Federal/State and Territory anti-smoking health initiative, which has a raft of information on smoking cessation and offers a multitude of free resources to assist those wishing to quit smoking. For example, the 24 hour Quitline telephone number in Queensland, “13 quit” is 137848. Regardless of the facilities available, no anti-smoking program works without the smoker having a strong motivation to quit.

5.89 Further, the COI has heard evidence that with constant and personal monitoring and encouragement, high success rates can be achieved, notwithstanding high levels of addiction. Each smoker who is motivated to quit must be treated at a personal level if he or she is to succeed in breaking the habit. Given those conditions, an anti-smoking program can enjoy considerable success. The unique program conducted by Ms Buncia at 2 HSB had a success rate of 72% of patients seen over two years stopping smoking for at least 12 months. Notwithstanding the success of that program,
it was to cease at the end of 2007. (T331.31).

5.90 The Australian Defence Force Alcohol, Tobacco and Other Drugs Services Program (ATODS) was introduced in May 2002 as part of a Defence Mental Health Strategy. The COI has heard some evidence that tobacco is the "poor cousin" in that program.

5.91 It is recognised that support is provided to ADF members via counselling from Unit medical officers, psychologists and smoking cessation counsellors. The use of nicotine replacement therapy, including nicotine gum, patches and lozenges also enhances a smoker's ability to quit smoking, and can be prescribed to ADF members at no cost to themselves. MAJ McKerron participated in the use of nicotine replacement therapy paid for by the Commonwealth.

5.92 The Quit Smoking Program conducted by Ms Baucia at 2 HSB was a trial program and a great success. Seemingly, it ended in December 2007 because of a lack of continuing funds. Notwithstanding its success and the keen support given to it by Dr. Thomas, the program was not put to tender or budgeted for in the last financial arrangements.

5.93 Ms Baucia is a pharmacist of 30 years experience who has a passionate interest in smoking cessation. It is very important that smoking be taken seriously in the ADF and Ms Baucia was very disappointed that the unique program at 2 HSB was to cease. Her experience indicates that "intensive counselling for severely addicted patients is the way to go", indeed the only way to go, and she was disappointed that "Defence can't see the big picture".

5.94 Having smokers, especially seriously dependant patients, quit smoking, is something Ms Baucia is "extremely passionate about" and something she will probably devote the balance of her career to, given that passion. (T341.14)

5.95 Because intensive counselling is essential to success, simply having Unit medical officers counsel or assist patients to quit, will not be successful. Simply stated, such professionals don't have the time. Ms Baucia did have the time and interest. She is aware that other pharmacists who work for the ADF are very keen to assist in such a program.

5.96 The evidence is that there has been a heavy demand by members of the ADF for participation in the 2 HSB smoking cessation counselling program. Gallipoli Barracks was the only Defence Health Centre in Australia to have a dedicated Quit Smoking counsellor.

5.97 Whilst health and fitness are important within the community at large, they are even more important within the ADF. Whilst Ms Baucia has no statistics, her observation is that the incidence of smoking within the ADF is "much higher" than in the general community. (T330.33). Amongst other things, Ms Baucia has observed that deployments have caused a noticeable increase of smokers who have quit but returned to Australia smoking again, and that smokers who are deployed come home smoking more.

5.98 Part of exhibit 52 mentions an estimate from the NSW Cancer Council that cumulatively, lost time through smoking associated illness adds up to about a half day every week per smoker. Over a year, that equates to four weeks or the same as the annual leave entitlement. Australia's largest employer, Coles, with close to 170,000 employees was given as an example. Coles could expect 83 workers to die through smoking related illnesses in the year of the publication. It could anticipate 28 medical retirements and the cost to shareholders was estimated to be $34.5 million that year. Given that the ADF employs approximately 100,000 personnel, the losses to the ADF due to smoking would be proportional to Coles:

- Deaths – 49
- Medical retirements – 16
- Costs of sick leave – $23.3 million
5.99 If results such as those achieved by the program at 2 HSB can be achieved across the whole of the ADF, there can be no doubt that the program would be of considerable benefit to the ADF. Accordingly, the COI considers that such a program should be implemented and made available to the whole of the ADF. Whilst such a program will need to be appropriately funded and promoted, on a cost/benefit analysis, the benefits of ceasing smoking, both for the individual member and the ADF in general, are likely to far outweigh the cost of the program.

5.100 **Recommendation 4:** A Quit Smoking program, focused on the intensive counselling and support model which formerly existed at Gallipoli Barracks Health Centre in late 2007, should be reintroduced at that Health Centre and replicated at other Defence medical establishments throughout Australia. It is further recommended that the ADF appropriately fund and promote such a program.

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**Investigation of a Death in Service: First Response Evidence Collator**

5.101 SGT Keyes of ADFIS quite properly and promptly identified the medic who administered the vaccinations, PTE Barratt, as a key witness in any inquiry into MAJ McKerron’s sudden death.

5.102 Commonsense and good sense dictate that a statement be taken from such a person as soon as practicable after the event, and that relevant documents be secured at the same time. In this matter, SGT Keyes was able to do neither. For that reason, he considered that his investigation had been "interfered with by command".

5.103 The supervisors of SGT Keyes, WO2 Kirsty James and MAJ (then CAPT) Smith told the COI that SGT Keyes was directed to take no further inquiries or take a statement unless requested to do so by the Queensland Police Service for or on behalf of the Queensland Coroner. The reasons for that direction relate to issues of jurisdiction and a command decision concerning the utilization of resources. SGT Keyes was told that in all likelihood, the CDF would convene a COI in relation to the death, and if statements were required for that purpose, they would then be obtained. In the meantime, the role of ADFIS was to facilitate any QPS request on behalf of the Coroner. No such request was ever made.

5.104 The COI understands the perception of SGT Keyes and agrees with the proposition that it would have been useful to obtain a written statement or version of events from key personnel at a time roughly contemporaneous with the events of 11 May 2007.

5.105 Likewise, the COI can well understand and accept the decisions of SGT Keyes’ supervisors as to allocation of resources and work effort, matters of jurisdiction and acting as a facilitating agency for the QPS. No criticism can be made of all of the observations and all positions, as all propositions, though in conflict with one another, have merit.

5.106 It is commonly the case in a COI such as this, that the COI can be convened and persons appointed to it at some appreciable time after the events in question. It is sometimes a simple matter of time lag in administration issues, appointments and the ability of those appointed to commence the task according to their current commitments and diary conflicts.

5.107 Such a time lag presents a real problem in that statements are not taken from key witnesses until much later.

5.108 The reasons for interviewing key witnesses, and potential key witnesses, as soon as possible, and securing the documents and other evidence are self-evident. In this case, there were a number of conflicts between the evidence of witnesses, including important witnesses, which are explicable on the basis of deemed recollections, consequent upon the passage of time.

5.109 That problem is not unique to this COI. It will present an ongoing problem unless remedial action is taken.
5.110 There is a need for an appropriately skilled person to collate and/or secure evidence in an expeditious and contemporaneous fashion following an event resulting in a Death in Service. That task or tasks need to be separate to the Quick Assessment (QA) process, but prior to the convening of a more formalized investigative process or inquiry under the Administrative Inquiry Manual ADFP 6.1.4.

5.111 The QA is not an investigation and QA officer is not an investigating officer. The QA is furnished to a Unit CO within 24 hours of the incident. The QA is an aid to Command to assist in the decision-making process as to what is to happen next or to follow. If the incident was a matter which involved potential Defence Force Discipline Act 1985, (DFDA) action, it would simply be referred to ADFIS or other investigative authorities. If the matter or incident did not bear the hallmarks of a DFDA matter, the QA and other documents would be appropriately staffed through the chain of command and a decision made as to whether an inquiry would be convened at all, and if so, what mode or vehicle of inquiry be convened or employed to deal with the particular issue or event.

5.112 Although a QA officer may need to speak to key personnel, it is not the function of such an officer to obtain written statements from those personnel.

5.113 In the instant case, it would have been useful to have obtained a contemporaneous written version of events from the medic who administered the vaccines to MAJ McKerron, namely, PTE Barratt.

5.114 On or about the time of the incident, PTE Barratt was a person of putative relevance to any inquiry as, at first blush, there may have been a connection between the vaccinations and MAJ McKerron’s sudden death. After thorough investigation and receipt of expert evidence from the pathologist and others, it is clear that the vaccinations had no relevance to the facts in issue. That, of course, is a matter for assessment made in hindsight or after receipt of the full facts.

5.115 Further, it would have also been useful to have documents and/or items of real evidence (such as sample vials of the vaccinations) secured for testing and/or possible admission into evidence. It is important that the integrity of evidence and potential evidence be preserved at an early point in time.

5.116 What is required is the appointment of a "First Response Evidence Collator" who has appropriate skills. It is essential that key statements be promptly and properly taken and that other essential evidence be identified and secured.

5.117 ADFIS, undoubtedly, has members skilled at taking and preparing statements and securing relevant documents and other evidence. However, 95% of the work of ADFIS relates to disciplinary matters where a different standard of proof applies. The inference from the relevant evidence of MAJ Smith is that given resource issues and other problems, ADFIS would not welcome any such additional role. (T603.5)

5.118 However, even if ADFIS was appropriately resourced etc, the COI is of the strong view, that the First Response Evidence Collator should generally be an ADF legal officer, permanent or reserve.

5.119 The QA processes should be undertaken and completed in the manner as contemplated by DI(G) ADMIN 67-2 and normally furnished to the CO within 24 hours after the particular incident.

5.120 Recommendation 5(a). In order to remedy the identified time lag issue or problem, the COI recommends as follows:

1. Upon receipt of the QA, if the CO decides it is matter that is likely to be the subject of an inquiry, the CO should then immediately refer the matter to the Local Area Command Legal Officer to enable the Local Area Command Legal Officer to appoint a suitably qualified legal officer, (permanent or reserve) to be the First Response Evidence Collator.
2. The task of the First Response Evidence Collator should be to act as a temporary investigating officer with the powers and protections afforded by the Defence Inquiry (Regulations) 1985 to:

- Take statements and obtain evidence from key personnel identified in QA or considered in the opinion of the legal officer concerned to be of both relevance and/or putative relevance to the incident.

- To secure documents, items, samples or other items or things that are of relevance or putative relevance to the particular incident, which might be admitted as evidence before a particular mode of inquiry.

5.121 The First Response Evidence Collator would be required to act expeditiously and complete his/her task as soon as practicable, but in any event, generally no longer than seven days after the incident. The First Response Evidence Collator would be guided by or assisted by the content of the QA, but not necessarily bound by the strictures of the content of the QA. As previously noted, the QA serves a completely separate function, and the QA Officer is not an investigating officer.

5.122 First Response Evidence Collators could be on a roster to be available or on call as or when required.

5.123 A First Response Evidence Collator must have a framework to form the basis of that person's powers, responsibilities and immunities when undertaking his/her duties. A sufficient framework already exists within the Defence (Inquiry) Regulations 1985, such that the First Response Evidence Collator, so termed or called, would be appointed as a (temporary) investigating officer pursuant to the authority of Part 6 of the Defence (Inquiry) Regulations 1985.

5.124 The role of a First Response Evidence Collator would be of a temporary appointment with basic terms of reference, mandated by a chapter in ADFP 06.1.4 dealing with the roles and responsibilities of a First Response Evidence Collator. Chapter 2 of ADFP 06.1.4 which is currently vacant, could be used and adopted.

5.125 **Recommendation 5(b).** The COI recommends that in all instances, the terms of reference for a First Response Evidence Collator should be as follows:

- To obtain evidence and/or statements from persons of relevance or putative relevance to the incident; and

- To acquire, collate and secure documents, samples, things or other items of relevance or putative relevance to the incident.

- The First Response Evidence Collator shall complete his/her task by not later than...(insert date).

- The First Response Evidence Collating Officer is appointed pursuant to Chapter 6 of the Defence (Inquiry) Regulations 1985 and acts with the authority, powers, rights, responsibilities and immunities given therein.

- The appointment of the First Response Evidence Collator terminates on the date he/she is required to furnish the material obtained by him/her pursuant to the terms of reference.

- All material obtained by the First Response Evidence Collator is to be forwarded to the CDF COI Coordination Cell or to another place as directed, in writing, by the CDF COI Coordination Cell.
Quick Assessment Issues

5.126 In the case of the sudden death of an ADF Member, a QA is mandatory. It is not an investigation, but simply an internal process to help the CO of the deceased’s Unit determine what course of action should follow. It matters not if an external investigation is being made by ADFIS, State or Federal Police Authorities, or a Coroner. However, in such a case, the QA Officer will need to ensure that his or her assessment does not interfere with any aspect of any such external investigation. To that end, the QA Officer may need to liaise with officers from the external investigative body.

5.127 In an endeavour to make the QA into MAJ McKerron’s death as comprehensive as possible, LTCOL Taylor gave SQNLDR Currie a number of days to carry out the QA. The normal requirement is that the QA should be completed and delivered to the commander or supervisor who initiated the QA within 24 hours of the direction being given.

5.128 SQNLDR Currie was advised that the QA was to focus on Unit actions in the period prior to, during and immediately post MAJ McKerron’s death, with particular attention on, amongst other things, the obtaining of statements from key parties.

5.129 It is not a function of the QA Officer to take formal statements from witnesses, and indeed, that was never envisaged here. What LTCOL Taylor intended here was that SQNLDR Currie identify and speak to key personnel.

5.130 SQNLDR Currie was directed to conduct the QA “in accordance with the extant ADF reference”. At that time, the applicable ADF publication was ADFP 06.1.4. Administrative Inquiries Manual, Annex C2, chapter 2.

5.131 On 7 August 2007, chapter 2 was removed from the Administrative Inquiries Manual, and a stand alone document on Quick Assessments was issued. That document is Defence Instructions (General) ADMIN 67-2 (exhibit 65A). That is the ADF publication now applicable to QA Officers. Such Officers are under a very real time constraint, and it is only fair that all relevant information should be contained in the one document. Unfortunately, that is not the case.

5.132 CDF Directive No 12/2006 was issued on 30 May 2006. That Directive related to INTERIM ARRANGEMENTS FOR CHIEF OF DEFENCE FORCE COMMISSIONS OF INQUIRY INTO ADF SUICIDES AND DEATHS IN SERVICE.

5.133 It is recognised that CDF Directives have limited distribution. Indeed, CDF Directive No 12/2006 was distributed to only 10 addressees.

5.134 In paragraph 12 of CDF Directive No 12/2006, the CDF gave certain time lines for certain activities which are to occur for all ADF suicides and deaths of permanent ADF personnel and on duty reserve ADF personnel. The CDF stated that the specified time frames or time lines are “indicative only” and that he may direct that they may be compressed or extended, as determined by the circumstances.

5.135 Paragraph 12c of the Directive requires the relevant Service Headquarters/Joint Operations Command “to send a copy of the quick assessment (QA)” to the CDF within a time frame of 12-24 hrs. (emphasis added by the President). Further, the sub-paragraph states:

“[In addition to any current policy requirements, the QA is to contain, based on the information available:

(1) action taken by Service and/or civilian police;
(2) dealings with State or Territory Police and Coroners, Federal Police, Comcare and other government and civilian agencies, foreign governments and civilian agencies, foreign armed forces, the media;
(3) recommendation as to whether the matter should be the subject of a CDF-BOI, single Service BOI, Inquiry Officer, and why;

(4) initial information and assessment about the circumstances and possible cause of the death, noting that the actual circumstances and cause of death will be determined by Service and/or civilian police or Coronal investigations;

(5) action taken by the unit and/or DCO in respect of the counselling and support of other ADF members, NOK and friends of the deceased; and

(6) what courses of action are being taken or should be taken in respect of other matters arising out of the incident."

5.136 It is clear that the QA referred to in paragraph 12c of CDF Directive 12/2006 is "the" QA prepared by the QA Officer. However, there is no reference in Di(G) ADMIN 67-2 (7 August 2007), to CDF Directive 12/2006 (30 May 2006) and importantly, to the requirements of paragraph 12c of the earlier publication. Clearly there is a disconnect between the two documents and, as a matter of fairness to any QA Officer, that disconnect needs to be remedied as soon as possible.

5.137 Recommendation 6. Di(G) ADMIN 67-2 (7 August 2007), the extant ADF publication on Quick Assessments should be amended as soon as possible to incorporate the requirements of Chapter 12c of CDF Directive No. 12/2006.

BFA Issues

5.138 There is no doubt that the BFA in which MAJ McKerron was participating on 11 May 2007 was the precipitating event which resulted in his death. However, the cause of his death was his very severe, but unknown, coronary condition. Because of that condition, MAJ McKerron's death could have occurred at anytime. The COI is satisfied that there is no evidence of a pre-existing medical condition, other than negative lifestyle factors, which led to the death of MAJ McKerron.

5.139 The BFA in question had some unusual features. It was conducted in the afternoon, MAJ McKerron was the sole participant, and MAJ McKerron did not disclose the vaccinations earlier that day until he was setting off on the 5km walk component. Even then, all he disclosed was that he had had a "flu shot". When WO2 Dougherty questioned him then, and later, about continuing, MAJ McKerron - who was then acting CO of JLU-SQ - said that he was "fine" or "okay" and was "not going to repeat the BFA".

5.140 The reality is that MAJ McKerron should not have participated in a BFA under the circumstances. That being said, the COI is not aware of any other death of an ADF member during a BFA or PFT in all the years that those assessments or tests have been conducted by the ADF.

5.141 It must be remembered that a BFA is a measure of baseline fitness for serving army personnel. The assessment is based on the minimum physical ability to perform as a trained soldier.

5.142 Members of the ADF are adults who are required to maintain their fitness.

5.143 BFAs are supervised by experienced and mature personnel including PTLs if they are available. Such personnel apply their commonsense and good judgment in the performance of their duties. Without in any way diminishing the tragedy of MAJ McKerron's death, his collapse and death during the BFA were in no way related to the manner in which the BFA was performed, or any lack of care by the supervisor or other assessor.

5.144 The COI needs to be careful that, in these circumstances, it does not overreact – by way of recommendations – by placing unnecessary demands or restrictions on such activities.

5.145 Although the BFA was conducted in the afternoon and MAJ Priestly thought it was "a bugger
of a time to be doing a BFA” (T213.32), the weather at the time was suitable. Counsel Representing has stated that conducting a BFA when the ambient temperature is high, may result in dehydration, heat exhaustion and other medical complications. Counsel Representing has submitted that an appropriate maximum temperature might be established in consultation with medical and physical training experts. He has further submitted that measuring the ambient temperature prior to commencing a BFA would be a simple matter for the assessors conducting the BFA. With respect, the COI does not think that is necessary. The commonsense and experience of BFA assessors will continue to guide the conduct of BFAs. If weather conditions are unsuitable or extreme, the assessors would not conduct the exercise.

5.146 Counsel Assisting submit that prior to the conduct of the BFA, a risk assessment should be undertaken in relation to aspects of the conduct of the BFA, including consideration as to location, lines of sight, proximity of medical facilities or assistance, availability of assistance and communication and other control measures in order to lessen and/or control the risk. Counsel Assisting further submit that sufficient re-hydration facilities be considered and provided as part of the preparation for the BFA.

5.147 Counsel Assisting submit that all BFAs/PFTs ought to be conducted in such a manner as to allow the supervising PTIs to maintain at all times a visual watch of each of the participants, in order to reduce the risk profile and enable the immediate welfare needs of any of the participants to be met in a timely fashion. Finally, as a corollary, to guarantee fidelity and/or confidence that the BFA was, in fact, completed to the full extent.

5.148 The walk element of the BFA of which MAJ McKerron participated, was conducted outside Bulimba Barracks, the nature of the course meant that the assessors (WO2 Dougherty and PO Cook) lost sight of MAJ McKerron for a period of time. The run and walk elements are now wholly within the Barracks, and a line of sight between the assessors and participants is maintained. (T99.43)

5.149 Clearly, where possible, members participating in a BFA should be observed for the duration of the activity by the supervisor. Indeed, that is stated in paragraph 4 of Appendix 2 to Annexe B to DI(A) PERS 148-2, Army physical conditioning assessment system (exhibit 10). WO2 Dougherty did not think it desirable or necessary that line-of-sight be maintained between assessors and participants between the run and walk element of a BFA. As he said:

"With BFAs conducted at Enoggera, it travels up and around two blocks, so you are virtually out of sight for virtually the whole lot of the BFA. It's only the last – the first 150 to the last 150 metres that you are actually in the sight of the PTI conducting the BFA.” (T148.37)

5.150 WO2 Dougherty is a very experienced member of the ARA. He was not keen about conducting a BFA within a circuit such as a football oval, simply to maintain line-of-sight:

"In my own experience over 21 years, Sir, walking around an oval 12 times – it's so boring. Its good when you can get out go down to a point, turn around and come back. (T148.37)

5.151 Bulimba Barracks is without medical facilities on base. Nevertheless, the QAS responded to the emergency telephone call made by WO2 Dougherty within four minutes (T203.36). As the supervisor, WO2 Dougherty carried a mobile phone. The other assessor, PO Cook did not have a phone. As WO2 Dougherty said: (T148.6)

"Sir, if there was something I could change on the day, yes, I would have liked PO Cook to have a phone on him at that time".

5.152 Notwithstanding all of the submissions that have been made about the way BFAs are or should be conducted, the only recommendation that this COI thinks appropriate, in the circumstances, relates to the desirability of all BFA/PFT supervisors having sufficient communications between themselves and outside emergency facilities.
5.153 **Recommendation 7.** That all BFA/PFT supervisors carry a mobile telephone to enable them to contact each other, a base medical facility or outside emergency responders, if necessary.

**Notification of the Death of a Member**

5.154 Perhaps there is no more difficult task in the ADF than the notification of next of kin or family members of a Death in Service.

5.155 Whilst notification is a Command responsibility, those who have been called upon to act as notification officers are, generally speaking, not anxious to repeat that sad duty.

5.156 Notification is a stressful and difficult experience for all involved. A notification officer needs to be professional, sensitive, flexible, apply commonsense and above all, exhibit compassion.

5.157 CMDR Christine Clarke is the RAN Fleet Human Resources Manager. She has been in the RAN for 24 years, and has acted as a notification officer on a number of occasions. Each occasion was difficult and each was different. (T941.5)

5.158 It is important to recognise that every notification circumstance will be different. As CMDR Clarke emphasized, "guidelines" are required rather than "instructions". (T941.44 and T942.13).

5.159 Currently, "the extent of the current guidance" (T927.33) is DI(G) PERS 11-2, entitled "Notification of Service and Non-Australia Defence Force casualties". (exhibit 40)

5.160 DI(G) PERS 11-2 was issued on 18 December 2001. It is currently being rewritten. (T927.6) When Commander Clarke was asked about the progress of the rewrite, she replied:

"It is being—it has been in process for some time, at least six months that I am aware of, and there is an unknown time frame. There—it’s sometimes difficult to align the three services on how they wish to go about the notification process and who is to manage that process, and I believe that is the sticking point. At the same time, there is also a document being raised on assisting bereaved families, so those two documents are proceeding together. I can’t give you an actual time frame on when I expect that document to be re-released."

5.161 The aim of DI(G) PERS 11-2 is spelt out in paragraph 2. It is, "to detail the policy on, and the procedures to be followed for the notification of casualties and dangerous occurrences within the Defence Organisation."

5.162 CMDR Hugh Scott-Mackenzie, Counsel Representing Ms Lynette Morgan, the partner of MAJ McKerron, has provided very helpful submissions on her behalf, concerning exhibit 40 and other aspects about notification of the death of a member. Those submissions are reproduced in this Report:

5.163 **Casualty** is defined in paragraph 3 of exhibit 40. It means

"A member who is killed, wounded, missing, injured, ill or captured."

5.164 Consistent with its name, and the aim, the instruction focuses on the procedure for notifying an emergency contact, next-of-kin or other approved person of a casualty involving a member or non-ADF personnel. Arguably, however, the instruction does not operate in the case of a member who dies in Service but is not "killed."

5.165 Notwithstanding the limited circumstances in which it is intended to operate, the instruction provides guidance on the procedure for notifying a member of a death in the family, albeit scant guidance. The guidance is to be found in paragraph 35, which provides:
“When a ship, unit or establishment has been notified of the illness, injury or death of the emergency contact or close relative of a serving member, the member is to be notified where possible by a Service chaplain. If a chaplain is not available, the Divisional/Unit Welfare Officer or another officer nominated by the CO is to notify the member. The Divisional/Unit Welfare Officer must be informed when the notification has been completed so that further action can be taken as necessary”.

5.166 CMDR Clarke’s attention was directed to paragraph 35 above. She agreed that it is the provision most relevant to notifying a member of a death in family. (T927.16) She was then asked whether she agreed it is scant information and said: (T927.23)

It is scant advice. The reality of that is that it is a command responsibility to inform the serving member, and that is the limit of the information contained within the paragraph. It doesn’t give any particular guidance on how to or when to, it simply gives very minimal detail on how to go about it.”

5.167 The rewrite of DI(G) PERS11-2, which will expand considerably on the notification process (T929.18), is proceeding at the same time as the preparation of a document to assist bereaved families.

5.168 On 11 November 2006, the CDF issued CDF Directive 29/2006 – Chief of the Defence Force Directive on Notification Responsibilities when a Member becomes a casualty. (exhibit 41) The purpose of the directive is to detail CDF’s requirements “…for the formal notification of Australian Defence Force casualties to the Primary Emergency Contact, Next of Kin and other approved persons whilst (DI(G) PER 11-2) is being revised”. (See paragraph 1 of CDF Directive 29/2006 and also T929.1).

5.169 The method by which the purpose is to be achieved is spelt out in paragraph 2. It provides:

“Service Chiefs will, with the support of the Defence Community Organisation raise, train and maintain sufficient Notification Teams to provide coverage for all ADF units and other Defence elements in which ADF personnel are employed. Notification Teams are to be available for short notice tasking. Upon becoming aware of a casualty or fatality, the Service headquarters will advise the Defence Community Organisation Headquarters. The Defence Community Organisation Headquarters, acting in support of the relevant Service Chief’s, will task and coordinate the actions of the Notification Team(s). Notification Teams will notify the Primary Emergency Contact, the Next of Kin and other approved persons. Notification Teams will inform the Defence Community Organisation and Service Headquarters of progress and further support requirements. Notification will continue until the Defence Community Organisation, in consultation with the relevant Service Headquarters, directs that the notification process is complete. Defence Community Organisation Headquarters will ensure the Service HQ and the casualty’s Commanding Officer are kept informed on the progress of the notification task, and advise all concerned when the notification task is complete.”

5.170 The end state, found in paragraph 3, is that the primary emergency contact, next of kin and other approved persons are notified of the casualty in an accurate, timely and compassionate manner and are provided with appropriate follow-on support. Defence reporting and engagement with stakeholders, including Government and the media, achieves confidence in the ADF response to the incident.

5.171 The specifics of implementation, albeit couched in general terms, are found in paragraph 5 and following of the Directive. The formation and training of Notification Teams is provided for in paragraph 6. Service Chiefs, assisted by DCO and ADF chaplains, are required to ensure that sufficient Notification Teams are formed and trained to provide coverage for all ADF units and other Defence elements in which ADF personnel are employed. CDF acknowledges that each Service may adopt a different methodology in this respect and is comfortable for this to take place insofar as each
method meets his intent and his required end state. Notification training is to be coordinated by the DCO. The training is to be conducted with sufficient regularity to ensure currency in skills.

5.172 DCO is available 24 hours to support the Service Headquarters and other relevant stakeholders during an incident: see paragraph 8 of CDF Directive 29/2006. The contact telephone numbers are to be found in the Directive.

5.173 The role of the Notification Team is provided for in paragraph 10 of the Directive. It is "...to properly, compassionately and formally advise, in person, the nominated Primary Emergency Contact and/or Next of Kin of the condition of the member." DCO is tasked with providing guidance in the conduct of additional notifications.

5.174 The tasks of key stakeholders are spelt out in paragraph 14. They include:

(a) ensuring that all personnel regularly review Primary Emergency Contact Details in PMKeyS;

(b) ensuring that personnel are aware of the casualty notification process and that they have made appropriate arrangements for notification in the event that they become a casualty;

(c) ensuring that Notification Teams receive appropriate initial and refreshing training.

5.175 The Directive concludes:

"Receiving notification that a family member is a casualty is a stressful and difficult experience. It is essential that all personnel involved in the notification process understand and are trained to perform their duties professionally and compassionately. All Commanders are to ensure that my intent is met."

5.176 The Directive, in paragraph 18, again observes that DI(G) PERS 11-2 is being revised. If there is any inconsistency between the Instruction and the Directive, Commanders area required to be guided by the Directive.

5.177 The Directive, it is to be observed, is silent on the procedure for notifying a member of a death in the family. Again, on its face, it is only intended to operate in the case of a "casualty". Casualty, however, is given an extended meaning. It is defined as an ADF member (including Reserves on duty), members of the Australian Cadets while on an approved activity or a Defence Civilian deployed in accordance with DI(G) OPS 05-3 – Civilians in Support of Australian Defence Force Operations who is classified as missing, seriously or very seriously ill, or deceased.

5.178 The Service Chiefs have each issued directions for the implementation of CDF Directive 29/2006: CN Directive 2006/1069162 – Chief of the Defence Force Directive on Notification Responsibilities when a Member becomes a Casualty (exhibit 49); CA Directive 18/06 – Casualty Notification Responsibilities (exhibit 42) and CAF Directive 01/07 – Casualty Notification Responsibilities (exhibit 50).

5.179 CN Directive 2006/10691962 (exhibit 49) is said to have been provided "...as interim guidance on the formal notification of the Primary Contact, Next of Kin and other approved persons while (DI(G) PERS 11-2 ) is being revised."

5.180 The regular reviewing of the currency and accuracy of the PMKeys data is provided for in paragraph 2a. It provides:

"Commanders are to ensure that those with Command responsibilities have in place systems which regularly review the currency and accuracy of the PMKeys data for all their personnel in relation to emergency contacts – primary, secondary and next of kin."

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5.182 As mentioned, the revision of DI(G) PERS 11-2 is continuing. (T929.1) Unfortunately, the Commission is without evidence as to the content of the revised Instruction.

5.183 Clearly, MAJ McKerron was a casualty within the meaning of the term in CDF Directive 29/2006 and Defence was correct to implement the procedure it did. Arguably, AB Morgan, as a next-of-kin of MAJ McKerron, was entitled to be notified in the same manner as her mother. If she was not a next-of-kin of MAJ McKerron, then the likelihood is she was not a close relative of MAJ McKerron within the meaning of paragraph 35 of DI(G) PERS 11-2 with the consequence paragraph 35 did not operate in the circumstances here.

5.184 It is not clear whether LCDR Coles was aware of CDF Directive 29/2006 or CN Directive 2006/1069162 at the time of notifying AB Morgan of the death of MAJ McKerron. Certainly, the OOD Pack did not contain copies of the Directives. Of course, even if he had been aware, because, arguably, they did not operate in the circumstances here, he may not have been influenced by them when notifying AB Morgan of the death of MAJ McKerron.

5.185 As is said by CDF in CDF Directive 29/2006, receiving notification that a family member is a casualty, "...is a stressful and difficult experience." Whether the deceased is a member or a close relative of a member, the notification process should be implemented professionally and compassionately.

5.186 As stated in Chapter 3 of the Report, the COI is satisfied as to the sufficiency of the notification decisions made after the death of MAJ McKerron. However, it may be stated that, relevantly, DI(G) PERS 11-2 is deficient in two respects.

5.187 Firstly, DI(G) PERS 11-2 should spell out, in greater detail, the procedure to be adopted for notifying a member of a death in the family. The procedure should be the same as, or similar to, the procedure for notifying the primary emergency contact, next-of-kin or other approved person that a member is a casualty. The death of a person is no less traumatic merely because the deceased is not a member and there can be no justification for adopting a high standard for notifying the primary emergency contact, next-of-kin and other approved persons and a lower standard for notifying a member of a death in the family.

5.188 Secondly, DI(G) PERS 11-2 focuses on the procedure to be implemented in the case of land based Commands. The reviewed DI(G) should be extended to include the procedure to be adopted in the case of ships (including submarines) at sea and in foreign ports.

5.189 **Recommendation 8.** DI(G) PERS 11-2 should be amended to provide a procedure for notifying a member of a death in the family the same as, or similar to, the procedure for notifying the primary emergency contact, next-of-kin or other approved person that a member is a casualty, and to provide a procedure for notifying a member on board a ship (including a submarine) at sea or in a foreign port of a death in the family, consistent with CDF Directive 29/2006.

5.190 The only written guidance on the process for notifying a member of a death in the family in the OOD Pack on board the submarine HMAS FARNCOMB, was a copy of DI(G) PERS 11-2. (T794-34) Otherwise, LCDR Coles was reliant on his recollection of training received some 13 years earlier. (T825.23).

5.191 There is conflicting evidence on what happened on 12 and 13 May 2007 in relation to notifying AB Morgan of the death of MAJ McKerron and the events immediately following and whether the procedure adopted by LCDR Coles complied with the DI(G) PERS 11-2 and was adequate. It is unnecessary to resolve that conflict.

5.192 Whatever be the content of the revised Instruction, clearly an OOD would be assisted by a
summary, or guide, on the requirements of the Instruction for inclusion in the OOD Pack. Indeed, all Commanders, whether land based (in Australia or overseas), at sea or in a foreign port might be assisted by the summary, or guide.

5.193 **Recommendation 9.** DCO should prepare a summary, or guide, on the requirements of the revised DI(G) for notifying a member of a death in the family and distribute the summary, or guide, to all ADF units and Defence establishments in which ADF personnel are employed.

5.194 An OOD on board a ship or submarine in a foreign port, indeed Commanders anywhere, might be further assisted if DCO provided a 24 hour “helpline” for giving guidance on the procedure for notifying a member of a death in the family such as that provided for in paragraph 10 of CDF Directive 29/2006. DCO contact telephone numbers should be included in the summary or guide, as they are in paragraph 8 of CDF Directive 29/2006.

5.195 **Recommendation 10.** DCO should provide a “HELPLINE” for giving guidance on the procedure for notifying a member of a death in the family. The “HELPLINE” should be available 24 hours a day and the contact telephone numbers should be distributed to all ADF units and other Defence elements in which ADF personnel are employed.

**Body Mass Index (BMI), Physical Fitness Tests (PFTs and BFAs) and Medical Clearances**

5.196 In paragraphs 2.48 to 2.68 of this Report, reference is made to ADF Health Directive No 206 (exhibit 82). That document deals with “OVERWEIGHT AND OBESITY”.

5.197 One of the screening tools used to assess if a member is overweight and obese is the BMI. It approximates a member’s body fat percentage. It is calculated as weight in kilograms divided by height in metres squared. (kg/m²).

5.198 A BMI between 18.5 and 25 indicates a normal or healthy weight range. A BMI of over 25 up to 30 is considered overweight, over 30 is regarded as obese and 40 and over is extreme obesity.

5.199 The BMI is simply one of indices for looking at someone's cardiovascular risk profile. Whilst used by Defence to help assess that risk profile, the BMI is not precise and is certainly not able and end all indicator. In some cases, the BMI of an individual is "highly accurate", and in other cases it is "extremely inaccurate", depending on a range of variables. (T1010.8)

5.200 Members of the ADF are assessed according to the BMI standards outlined in paragraph 28 of exhibit 82. Among other things, members with a BMI of 30.0 to 34.9 are to be assessed by a MO and are to be classified as either "complicated" or "uncomplicated" obesity. Members with a BMI of 30 or above are to be classified as having "complicated" obesity.

5.201 ADF members classified as having "uncomplicated" obesity - such as MAJ McKerron - had no restrictions applying to their Service responsibilities in relation to their individual readiness.

5.202 The individual Service Defence Instructions with respect to physical fitness/conditioning and the assessment thereof, are as follows:

<table>
<thead>
<tr>
<th>Navy</th>
<th>DI(N) PERS 31-38, 15 Jun 05</th>
<th>Exhibit 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army:</td>
<td>DI(A) PERS 148-2, 08 Aug 06</td>
<td>Exhibit 10</td>
</tr>
<tr>
<td>Air Force:</td>
<td>DI(AF) PERS 33-4, 20 Dec 04</td>
<td>Exhibit 11</td>
</tr>
</tbody>
</table>
5.203 Paragraph 28 of exhibit 82 is headed "Physical fitness test and body mass index", and states:

"If a member has undertaken an Annual Health Assessment within the preceding year, there is no requirement for the BMI to be repeated prior to the PFT."

5.204 Further, the evidence of PTI qualified PO Cook (T67.34) and the Head of Defence Health Services, AVM Austin (T1011.31-39), indicates that if a Navy or Air Force member, upon being measured prior to the equivalent of a BFA, has a BMI of 30 or above, the member must then obtain a member’s clearance before they can be authorised to undertake the equivalent of a BFA.

5.205 Unlike Navy and Air Force, Army does not measure BMI as a prerequisite for undertaking a BFA.

5.206 Amongst other things, Counsel Assisting submit that the Army Instruction (exhibit 10) should be reviewed to standardize its contents with the Navy Instruction (exhibit 9) and the Air Force (exhibit 11).

5.207 Counsel Assisting submit that such a review would ensure that BMI assessments are undertaken as a preliminary matter prior to the conduct of any ADF physical fitness test, PTF or BFA, and that that would be consistent with the regime required by Health Directive 206.

5.208 The logic of having a uniform standard across the ADF, as regards physical fitness requirements and assessments is obvious. However, the ADF is a tri-service organisation and Army needs and requirements are not the same as those of Navy or Air Force.

5.209 Paragraph 15 of Annexe B to D(A) PERS 148-2 (exhibit 10) commences as follows:

"AIRN requires a BFA to be taken every six months as a minimum."

5.210 Paragraph 36 of the same document concludes as follows:

"Commanders, PTI and BFA supervising officers are to be mindful of age and lifestyle factors when conducting fitness assessments."

5.211 As regards Lifestyle, paragraph 37 states:

"At risk individuals are those that are over 40 years of age, and have a poor exercise history, smoke, have pre-existing injuries or are overweight. A Commander may direct or a PTI, CFL or supervising officer may advise that members observe as at are to undertake a medical assessment prior to participating in a BFA. Based on medical advice, a member may need to be managed as being TMR."

5.212 Having regard to the above lifestyle factors, MAJ McKerron was aged 46, was overweight and had been classified as having "uncomplicated obesity" as and from 2000, had a long history of smoking but had essentially quite three and a half months prior to his death. Whilst he did not participate in Unit PT at JLU-SQ, he performed individual exercise and there was nothing in the medical records to indicate that he had a poor exercise history. As AVM Austin stated, even if MAJ McKerron had been requested to obtain a clearance from a medical officer prior to his participating in the BFA, the evidence clearly suggests that such clearance would have been given:

"...for the simple reason that he had no obvious complications from his obesity. He would have been cleared to undertake the BFA." (T1017.5)

5.213 The reality is that MAJ McKerron had very bad coronary arteries and that the cause of his death was not the classified condition of "uncomplicated" obesity, but his then unknown and very severe coronary artery disease.
5.214 Other factors to be taken into account, in assessing the submission from Counsel Assisting, include the Army's minimum requirement of a BFA every six months, the size of the Army and relevant evidence from the Head Defence Health Services AVM Austin.

5.215 ADF numbers, as at 1 May 2008, are shown below in table form. The numbers have been rounded to the nearest hundred.

<table>
<thead>
<tr>
<th>Service</th>
<th>Permanent Members</th>
<th>Reserve Members (including 1700 on full-time service)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navy</td>
<td>12,700</td>
<td>8,400</td>
<td>21,100</td>
</tr>
<tr>
<td>Air Force</td>
<td>13,700</td>
<td>8,400</td>
<td>22,100</td>
</tr>
<tr>
<td>Army</td>
<td>26,100</td>
<td>29,300</td>
<td>55,400</td>
</tr>
<tr>
<td>Total</td>
<td>52,500</td>
<td>46,100</td>
<td>98,600</td>
</tr>
</tbody>
</table>

5.216 Altogether, Army represents just over 56% of the ADF population.

5.217 AVM Austin is not a strong supporter of having to obtain medical officer clearance for a BMI over 30 when an ADF member undertakes a BFA or PFT: (T1012.5). Further, as the Head Defence Health Services also pointed out, the recent change in ADF recruiting policy, where persons with a BMI up to 33 are being recruited to undergo the full physical rigours of recruit training:

"...suggests that there isn't good scientific evidence to show the benefit of medical officer screening in that population." (T1012.9)

5.218 When ANM Austin was asked by Counsel Assisting about the "management" of a member considered to be overweight or obese, the Head Defence Health Services said that such management was bane of most medical officer's lives: (T1012.44 - T1013.24)

"...insofar as we are aware that cardiovascular disease is one of the main causes of mortality and morbidity in the Australian population, we are aware that lifestyle factors can play a significant part in the development of that disease, particularly cigarette smoking. But we're also mindful of the fact that there are no magic bullets........we're dealing here with so many variables that at the end of the day are in the absolute control of the individual, but all we can do as health providers is provide that education, until such point as we believe that they do in fact have a significant medical impairment and then we roll in the medical employment classification review process, which may ultimately result in them being discharged from Defence."

5.219 As regards weight control, AVM Austin opined that it is extremely difficult for people to achieve enduring weight loss: (T1013.12)

"For every success story there's probably 20 who fail to achieve an enduring weight loss."

5.220 Taking everything into account, the COI is not persuaded that the Army Instruction, should be reviewed to determine whether the RAN and RAAF requirements for BMI in exhibits 9 and 11 should
be duplicated in exhibit 10.

5.221 As AVM Austin pointed out, if a member’s BMI is elevated, the appropriate time to determine the risk factors is during the Annual Health Assessment (AHA) or the five yearly Comprehensive Preventative Health Examination (CPHE).

5.222 Given that the AHA and CPHE are undertaken, AVM Austin regards the measuring of the BMI prior to undertaking a PFT/BFA surplus to requirements. However, the Head Defence Health Services predicated that view on the basis that regular AHAs and CPHEs were undertaken.

5.223 The evidence is there is a large population of ADF members who do not routinely do an AHA. (T1025.27) As AVM Austin stated: (T1025.28)

“Air force, in fact, as a short-term measure, has approved a standing waiver for air force personnel not to undergo an AHA. It’s being done in response to a shortage of medical officers and a very high operational tempo, where many people now are being medically screened as part of the deployment process, so they’re risk-managing, not doing AHA’s. So, if a BMI was required before undergoing a BFA or a PFT, that may well reveal an issue in someone that in a more timely manner than would otherwise be picked up, so I am certainly not averse to that recommendation”

5.224 Essentially, the Head Defence Health Services was not adverse to a recommendation that a BMI measurement be applied prior to the undertaking of a BFA if no AHAs or CPHEs were available with a view to ascertaining a risk profile of a particular member.

5.225 The COI respects the views of AVM Austin. It does not possess his experience and expertise in Defence health matters and the COI does not want to make any recommendation that will be more of a hindrance than a help. However, some matters of concern arise from the evidence:

- The ADF has within it “a large population” of personnel who are not routinely undertaking their AHAs.
- There seems to be growing number of personnel within the ADF who are obese and who smoke.
- The ADF is currently accepting recruits with a higher BMI than before. As AVM Austin stated, Defence

  “… now allows people in the range of BMI 30 to 33 regardless of their body fat percentage, to be in fact recruited into the ADF without restriction.” (T1011.15)

- That being said, it is acknowledged that a BMI “is a very crude tool”. (T1025.16)

5.226 The Head Defence Health Services is “not adverse” to the COI making a limited recommendation with respect to the BMI issue. That issue relates to those members who do not have a current AHA and/or a CPHE.

5.227 Such lack of AHA or CPHE currency would be evident on the member’s HealthKeys, a sub-set of PMKeys.

5.228 Currently, PMKeys contains a data subset dealing with BFA currencies and results. Such information is accessible to supervisors of BFAs. In contrast, there is no visibility of AHA/CPHE information available to supervisors of BFAs as they cannot access a member’s HealthKeys record. Any restrictions or prohibitions identified in an AHA or CPHE needs to be made available to supervisors of BFAs in order to properly manage the risks in relation to a particular member. The PMKeys data subset should be expanded to include a “BFA authorisation/restriction field” detailing whether the member has any restrictions or inability to undertake a BFA after the assessment
undertaken during the AHA/CPHE, which field should default to a restriction/prohibition.

5.229 In the case of a member who does not have a current AHA or CPHE, the PMKeys information should indicate a default prohibition as regards a BFA/PFT. That prohibition could be reversed if an AHA/CPHE was undertaken. In any event, in the absence of a current AHA or CPHE, a BMI assessment ought to be undertaken with respect to any such member with a BMI over 30, prior to his or her being cleared to undertake a BFA/PFT. That would act as an early indicator or means of referral to the Defence medical health system, if necessary.

5.230 Recommendation 11(a). The data subset of PMKeys dealing with BFA currencies and results should be expanded to include “BFA authorisation/restriction field”, detailing whether the member has any restrictions or inability to undertake a BFA after the assessment undertaken during the AHA or CPHE.

5.231 Recommendation 11(b). If a member does not have a current AHA or CPHE, the above “BFA authorisation/restriction field” should default to a prohibition or blanket restriction (which could be reversed upon an AHA/CPHE or other medical examination being completed). In such circumstances the supervising PTI or CFL ought to be required to administer BMI assessment of the relevant Defence member. If that BMI assessment is found to be over 30, the PTI/CFL is to refer the member to the Medical Section for the purpose of procuring a Medical Chit issued by a Medical Officer authorising the undertaking of a BFA/PFT.

5.232 If Recommendations 11(a) and 11(b) are adopted, exhibit 10 will need to be amended accordingly. Such amendments should be addressed by the sponsor of exhibit 10 in consultation with the Head Defence Health Services.

Is it time to amend relevant forms?

5.233 As previously stated, BMI alone is not diagnostic of cardiovascular disease. Other data such as waist circumference should also be used.

5.234 Paragraph 14 of exhibit ADF Health Directive 206 states:

"Although waist circumstance and BMI are interrelated, waist circumstance provides an independent prediction of risk over and above that of BMI."

5.235 The Health Directive defines men with a waist circumference greater than 102 centimetres and women greater than 88 centimetres as being "High Risk" (exhibit 82, paragraph 13).

5.236 Surprisingly, neither the AHA Form (Form AD146) nor the CPHE Form (Form AD147) contains a dedicated field (box) to record a member's weight circumstance measurement ascertained during the yearly assessment or the five yearly examination.

5.237 The absence of a requirement to measure a member's waist circumstance during a medical assessment or examination and to record the measurement on the relevant form is significant omission in terms of the requirements of the Health Directive No 206.

5.238 A further significant omission is the absence of a requirement to assess and record the relative risk category according to BMI and wait circumstance as defined in table 2 to the Directive, risk factors in terms of paragraph 24 and 25 of the Directive and, if the member is obese within the meaning of the Directive, whether the obesity is "uncomplicated" or "complicated". The forms are defective in those regards.

5.239 Additionally, the forms do not provide for recording the action taken in the case of an obese member (for example, counselling, referral to a weight reduction program, etc).

5.240 As regards waist circumstance, the COI recognises the evidence of AVM Austin that such a
measurement "is not a particularly good index, although with some people it can be useful". (T1016.18). The Head Defence Health thought that most people would not regard waist circumference as particularly useful, and in his experience, the most useful index is the "visual assessment of the individual", what he called "eyeball mark 1". (T1016.27)

5.241 Once again, the COI respects the evidence of AVM Austin. Nevertheless, given that ADF Health Directive No 206 remains current, the COI is of the view that the time has come to revisit and improve the format of Forms AD146 (AHA) and AD147(CPHE).

5.242 In paragraph 2.65 of this report, Dr. Thomas expressed the view that the ADF needs to pay greater attention to addressing cardiac risk facts than it has in the past:

"You know, the simple fact is, we have a lot of overweight member who smoke, who are at risk of heart disease and there's - there is not a lot of emphasis given to addressing those risk factors."

5.243 It is to be hoped that the amendment of the relevant Forms will provide a greater focus in addressing those risk factors and achieve greater compliance with Health Directive No 206.

5.244 Recommendation 12. That Forms AD146 and AD147 be amended:

(a) to provide for recording a member's waist circumference;

(b) to provide for recording the risk categories according to BMI and waist circumference as defined in table 2 of Health Directive No 206;

(c) to provide for recording any risk factors such as those identified in paragraphs 24 and 25 of Health Directive No 206;

(d) in the case of a member with a BMI of 30.0 or above, to provide for recording whether the obesity is "uncomplicated" or "complicated";

(e) in the case of a member with a BMI of between 25.0 and 29.9 (overweight) and 30.0 or above (obese), or provide for recording the action taken (for example, counselling, referral to a weight reduction program etc).

5.245 Finally, there is a further issue of importance which should be mentioned in this chapter, even though the COI does not make a recommendation regarding the issue.

Keeping PMKeys Data Current

5.246 Members of the ADF need to be constantly reminded about the importance of keeping their PMKeys data up to date.

5.247 The fact that MAJ McKerron had not updated his data to provide the names and ages of the "blended" family members living with him and Ms Lynette Morgan, presented unnecessary and unfortunate difficulties and stress for all concerned with the notification at the residence. Notwithstanding that oversight, the COI is confident that had MAJ McKerron survived, he would addressed that issue prior to his deployment to Afghanistan.

5.248 The COI understands that members of the ADF can update their PMKeys data by logging on to the DRN.

5.249 It must be remembered that the ADF is not a kindergarten. Members are responsible adults and at the end of the day, even though there is a shared unit and member responsibility to ensure PMKeys data is up to date, the primary responsibility must lie on the shoulders of the individual member, regardless of his or her rank.
5.250 The COI has heard evidence from a very experienced and professional DCO officer, MAJ Lindsay Bancroft. MAJ Bancroft noted that in his experience, PMKeys currency of information falls out of date at, unfortunately, the worst times. As he stated (T281.21):

"I'm afraid that I've had the circumstance on many occasions that I've had to deal with circumstances where senior officers' details have been out of date, and indeed on one occasion completely blank: no contact information at all."

5.251 Legislating to ensure that the primary responsibility holder, namely the member, does what he or she is required in that regard or suffer disciplinary consequences is not what is required.

5.252 What is required is that the ADF become inculcated with an attitude that recognizes and responds to the absolute importance of members keeping their PMKeys data up to date. In that regard, both command and the individual members have a shared responsibility. Vigilance and regular reinforcement of their obligations is imperative.

5.253 How best that attitude can be fostered is, with respect, a matter for the CDF to consider. Accordingly, the COI does not think it appropriate to make a recommendation concerning such a fundamental issue.
## CHAPTER 6 – RECOMMENDATIONS OF THE COMMISSION OF INQUIRY (IN A TABLE FORMAT)

<table>
<thead>
<tr>
<th>NO</th>
<th>RECOMMENDATION</th>
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<th>REPORT REFERENCE</th>
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<tr>
<td>1.</td>
<td>Paragraph 3.2.2.c of ADFP 1.2.2.1 should be amended to exclude the word “excessive” and, in any event, extend the restrictions to physical fitness tests such as PFTs or BFAs.</td>
<td>The wording of the paragraph is less than precise. What is “excessive” for one person might not be for another. The paragraph is subject to interpretation and different meaning and is, in many respects, ambiguous.</td>
<td>Chapter 5 Para 5.64 Page 49</td>
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<td>2.</td>
<td>The relevant Defence Instructions dealing with the conduct of BFAs or PFTs, (exhibits 9, 10 and 11) should be amended to ensure consistency and parity with ADFP 1.2.2.1 (exhibit 8) in order to provide that BFAs or PFTs are not to be conducted in 24 hours of receipt of vaccinations.</td>
<td>Currently, the mandated restrictions in paragraph 3.22 of ADFP 1.2.2.1 are not reproduced and incorporated into exhibits 9, 10 and 11, being the single Service Instructions for the conduct of BFAs or PFTs. Exhibit 9 is the Instruction for the RAN, exhibit 10 the Instruction for the Army, and exhibit 11, the Instruction for the RAAF. There is a disconnect between the above single Service Instructions for the running of BFAs or PFTs and paragraph 3.2.2.c of exhibit 8.</td>
<td>Chapter 5 Paras 5.69-5.70 Page 50</td>
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<td>3(a)</td>
<td>The warnings/restrictions in terms of paragraphs 3.21, 3.22 and 3.23 of ADFP 1.2.2.1 be incorporated into a separate document, appropriately headed, together with an explanation for the warning and the importance of compliance, and a copy of the document be given to every member of the ADF following vaccination with instructions to read the document while waiting at the place of vaccination for the requisite time after vaccination.</td>
<td>The post-vaccination restrictions are mandated. Evidence has been given of wide and varied practices as to what warnings/restrictions are given at ADF Health facilities. To eliminate variation, all members being vaccinated should be given appropriate warnings in terms of ADFP 1.2.2.1 both orally and in writing.</td>
<td>Chapter 5 Paras 5.72-5.82 Pages 50-51</td>
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<td>3(b).</td>
<td>Upon giving that document to the vaccinated member, the nurse or medic who administered the vaccination is to make a brief not in the medical facility’s Outpatient Clinical Record (or other suitable record) that the written warning has been given “e.g. written warning supplied” followed by the nurse or medic’s initials.</td>
<td>After vaccination, members should be instructed to read the written warnings/restrictions whilst they remain in the place of vaccination for at least 15 minutes after being vaccinated. The COI has heard evidence that with constant and personal monitoring and encouragement, high success rates can be achieved, notwithstanding high...</td>
<td>Chapter 5 Paras 5.72-5.82 Pages 50-51</td>
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| 4. | A Quit Smoking program, focused on the intensive counselling and support model which formerly existed at Gallipoli Barracks Health Centre in late 2007, should be reintroduced at that Health Centre and replicated at other Defence medical establishments throughout Australia. It is further recommended that the ADF appropriately fund and promote such a program. | Tobacco smoking is the largest single preventative cause of death and disease in Australia today. It is also recognised that cigarette smoking is a major risk factor for cardiopulmonary disease.

The COI has heard evidence that with constant and personal monitoring and encouragement, high success rates can be achieved, notwithstanding high levels of addiction. Each smoker who is motivated to quit must be treated at a personal level if he or she is to succeed in breaking the habit. Given those conditions, an anti-smoking program can enjoy considerable success.

The unique trial program conducted by Ms Baucia at 2 HSB had a success rate of 72% of patients seen over two years stopping smoking for at least 12 months. Notwithstanding the success of that program, it was to cease at the end of 2007.

Such a program should be available to all ADF members. Its benefits are likely to far outweigh the costs of the program. | Chapter 5
Paras 5.72-5.82
Pages 50-51 |
|---|---|---|---|
| 5(a). | Upon receipt of the QA, if the CO decides it is matter that is likely to be the subject of an inquiry, the CO should then immediately refer the matter to the Local Area Command Legal Officer to enable the Local Area Command Legal Officer to appoint a suitably qualified legal | With the passage of time, memory fades and reliability suffers.

After an event that is likely to result in a COI, key witnesses need to be identified and essential evidence secured as soon as practicable. | Chapter 5
Paras 5.101-5.119
Pages 53-54 |
officer, (permanent or reserve) to be the First Response Evidence Collator.

The task of the First Response Evidence Collator should be to act as a temporary investigating officer with the powers and protections afforded by the Defence Inquiry (Regulations) 1985 to:

- Take statements and obtain evidence from key personnel identified in QA or considered in the opinion of the legal officer concerned to be of both relevance and/or putative relevance to the incident.
- To secure documents, items, samples or other items or things that are of relevance or putative relevance to the particular incident, which might be admitted as evidence before a particular mode of inquiry.

**5(b).** The COI recommends that in all instances, the terms of reference for a First Response Evidence Collator should be as follows:

- To obtain evidence and/or statements from persons of relevance or putative relevance to the incident; and
- To acquire, collate and secure documents, samples, things or other items of relevance or putative relevance to the incident.
- The First Response Evidence Collator shall complete his/her task by not later than (insert date).
- The First Response Evidence Collating Officer is appointed pursuant to Chapter 6 of the Defence (Inquiry) Regulations 1985 and acts with the authority, powers, rights, responsibilities and immunities given therein.

Statements need to be taken, by an experienced person as soon as practicable.

The fact that no statement was taken from medic, Pte Barratt, until six months after the event, well illustrates the problem experienced by the COI.

That type of problem will be ongoing for future COIs unless it is addressed immediately.

**Chapter 5**
Paras 5.101-5.119
Pages 53-54

**As above**

Chapter 5
Paras 5.101-5.119
Pages 53-54
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<td>The appointment of the First Response Evidence Collator terminates on the date he/she is required to furnish the material obtained by him/her pursuant to the terms of reference.</td>
<td>As above</td>
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<td>All material obtained by the First Response Evidence Collator is to be forwarded to the CDF COI Coordination Cell or to another place as directed, in writing, by the CDF COI Coordination Cell.</td>
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<td>6.</td>
<td>DI(G) ADMIN 67-2 (7 August 2007), the extant ADF publication on Quick Assessments should be amended as soon as possible to incorporate the requirements of Chapter 12c of CDF Directive No. 12/2006.</td>
<td>As regards the contents of QAs, there is a disconnect between DI(G) ADMIN 67-2 and CDF Directive No 12/2006. QA Officers are under a very real time constraint and, as a matter of fairness and efficiency, all relevant information as to what is required in the QA should be contained in the one document.</td>
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<td>7.</td>
<td>That all BFA/PFT supervisors carry a mobile telephone to enable them to contact each other, a base medical facility or outside emergency responders, if necessary.</td>
<td>Commonsense and the evidence of the BFA supervisor, WO2 Dougherty, indicate that each supervisor or assessor involved with a BFA should carry a mobile phone during such activities.</td>
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<td>8.</td>
<td>DI(G) PERS 11-2 should be amended to provide a procedure for notifying a member of a death in the family the same as, or similar to, the procedure for notifying the primary emergency contact, next-of-kin or other approved person that a member is a casualty, and to provide a procedure for notifying a member on board a ship (including a submarine) at sea or in a foreign port of a death in the family, consistent with CDF Directive 29/2006.</td>
<td>DI(G) PERS 11-2 is being rewritten. For the reasons given in 5.153 to 5.187, the rewrite should include those matters addressed in this recommendation.</td>
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<td>9.</td>
<td>DCO should prepare a summary, or guide, on the requirements of the revised D(G) for notifying a member of a death in the family and distribute the summary, or guide, to all ADF units and Defence establishments in which ADF personnel are employed.</td>
<td>Notification of a death is a difficult and stressful experience. Those tasked with this sad duty need as much assistance as possible and, in terms of the evidence, need &quot;guidance&quot; more than &quot;instructions&quot;. DCO is well placed to provide that assistance and guidance.</td>
<td>Chapter 5  Paras 5.190-5.192  Pages 62-63</td>
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<td>10.</td>
<td>DCO should provide a &quot;HELPLINE&quot; for giving guidance on the procedure for notifying a member of a death in the family. The &quot;HELPLINE&quot; should be available 24 hours a day and the contact telephone numbers should be distributed to all ADF units and other Defence elements in which ADF personnel are employed.</td>
<td>A 24 hr DCO &quot;HELPLINE&quot; would be of assistance in giving guidance on the procedure for notifying a member of a death in the family.</td>
<td>Chapter 5  Para 5.194  Page 63</td>
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<td>11(a)</td>
<td>Recommendation 11(a). The data subset of PMKeys dealing with BFA currencies and results should be expanded to include &quot;BFA authorisation/restriction field&quot;, detailing whether the member has any restrictions or inability to undertake a BFA after the assessment undertaken during the AHA or CPHE.</td>
<td>Currently, PMKeys contains a data subset dealing with BFA currencies and results. Such information is accessible to supervisors of BFAs. In contrast, there is no visibility of AHA/CPHE information available to supervisors of BFAs as they cannot access a member's HealthKeys record. Any restrictions or prohibitions identified in an AHA or CPHE needs to be made available to supervisors of BFAs in order to properly manage the risks in relation to a particular member. The PMKeys data subset should be expanded to include a &quot;BFA authorisation/restriction field&quot; detailing whether the member has any restrictions or inability to undertake a BFA after the assessment undertaken during the AHA/CPHE, which field should default to a restriction/prohibition.</td>
<td>Chapter 5  Paras 5.220-5.228  Pages 65-67</td>
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<td>11(b)</td>
<td>Recommendation 11(b). If a member does not have a current AHA or CPHE, the above &quot;BFA authorisation/restriction field&quot; should default to a prohibition or blanket restriction (which could be reversed upon an AHA/CPHE or other medical examination being completed). In such circumstances the supervising PTI or CFL ought to</td>
<td>In the case of a member who does not have a current AHA or CPHE, the PMKeys information should indicate a default prohibition as regards a BFA/PFT. That prohibition could be reversed if an AHA/CPHE was undertaken. In any event, in the absence of a current AHA or CPHE, a BMI assessment ought to be undertaken with respect to any such</td>
<td>Chapter 5  Para 5.229  Page 67</td>
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be required to administer BMI assessment of the relevant Defence member. If that BMI assessment is found to be over 30, the PTI/CFL is to refer the member to the Medical Section for the purpose of procuring a Medical Chit issued by a Medical Officer authorising the undertaking of a BFA/PFT.

If Recommendations 11(a) and 11(b) are adopted, exhibit 10 will need to be amended accordingly. Such amendments should be addressed by the sponsor of exhibit 10 in consultation with the Head Defence Health Services member with a BMI over 30, prior to his or her being cleared to undertake a BFA/PFT. That would act as an early indicator or means of referral to the Defence medical health system, if necessary.

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<th>Chapter 5</th>
<th>Para 5.229</th>
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<th>12.</th>
<th>That Forms AD146 and AD147 be amended:</th>
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<tr>
<td>(a)</td>
<td>to provide for recording a member’s waist circumference;</td>
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<tr>
<td>(b)</td>
<td>to provide for recording the risk categories according to BMI and waist circumference as defined in table 2 of Health Directive No 206;</td>
</tr>
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<td>(c)</td>
<td>to provide for recording any risk factors such as those identified in paragraphs 24 ad 25 of Health Directive No 206;</td>
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| (d) | in the case of a member with a BMI of 30.0 or above, to provide for recording whether the obesity is “uncomplicated” or “complicated”;
| (e) | in the case of a member with a BMI of between 25.0 and 29.9 (overweight) and 30.0 or above (obese), or provide for recording the action taken (for example, counselling, referral to a weight reduction program etc. |

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<th>Chapter 5</th>
<th>Paras 5.233-5.243</th>
<th>Pages 67-68</th>
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The COI is of the view that the time has come to revisit and improve the format of the Forms used for AHAs and CPHEs.

Given that the ADF population contains “a lot of overweight members who smoke” it is hoped that the amendments will provide a greater focus for medical officers in addressing coronary risk factors and achieve greater compliance with Health Directive No. 206.
CHAPTER 7 – SUMMARY OF ESSENTIAL FINDINGS, CONCLUSIONS AND AUTHORISATION.

7.1 The essential findings of the COI are given below.

7.2 Shortly prior to 1436 hrs on Friday 11 May 2007, MAJ McKerron collapsed outside Bulimba Barracks, near the intersection of Byron Street and Hamilton Street, Bulimba. Immediate CPR was performed by PO Cook and the first of three QAS Special Units arrived at the scene at 1440 hrs. The QAS terminated the resuscitation attempts at 1524 hrs. The efforts of PO Cook and the five QAS officers were prompt, professional and prolonged and the COI commends their endeavours.

7.3 At the time of his death, MAJ McKerron was the Acting CO of JLU-SQ, the CO, LTCOL Taylor, then being interstate on ADF business.

7.4 MAJ McKerron collapsed and died while participating in a BFA. He was the only participant in the BFA which was supervised by WO2 Dougherty and PO Cook.

7.5 The BFA was conducted in accordance with DI(G) PERS 142-8, in preparation for MAJ McKerron’s deployment to Afghanistan in September/October 2007. MAJ McKerron had 10 days remaining to maintain six monthly AIRN status.

7.6 Clearly, at the time of his death, MAJ McKerron was on duty. Accordingly, his death arose out of, or in the course of, MAJ McKerron’s service in the Army. His was a Death in Service, as defined.

7.7 Some four hours before commencing the BFA, MAJ McKerron had received two vaccinations (Vaxigrip and Mencevax) at 2 HSB GBHC RAP.

7.8 The medic who administered those vaccinations, PTE Carmel Barratt, gave MAJ McKerron an oral warning about post vaccination restrictions, but in the circumstances, the COI is unable to determine the precise nature of the warning given. In any event, during his 27½ years service in the Army, MAJ McKerron had received more than 30 vaccinations on more than 20 separate vaccination days.

7.9 Regardless of what MAJ McKerron may or may not have been told by PTE Barratt, the COI has no doubt MAJ McKerron was aware of the standard ADF post vaccination warnings, including no excessive exercise or PT within 24 hours of vaccination.

7.10 When MAJ McKerron arrived for his BFA at about 1345 hrs, neither WO2 Dougherty nor PO Cook knew that he had received vaccinations earlier that day. The Acting CO did not disclose that fact until he was about to start the third phase of the BFA, the 5 km timed walk. Even then, all that he said was that he had received a “flu shot” earlier that day. When WO2 Dougherty questioned MAJ McKerron about continuing in those circumstances, the Acting CO told his supervisor that he was “fine” to continue. Even when, after the completion of the first leg of the walk, MAJ McKerron reported that he was feeling “sick” or “queasy” from the “flu shot”, he insisted on completing the walk.

7.11 In the circumstances, neither WO2 Dougherty nor PO Cook should be criticised for allowing MAJ McKerron, known as a “no nonsense” and a “very determined” officer, to continue with the BFA. He wanted to complete his BFA and, at the time, was the Acting CO. As MAJ McKerron pointed out it was only “a walk”.

7.12 Clearly, the BFA was the precipitating event which resulted in MAJ McKerron’s death.
However, the cause of his death was coronary atherosclerosis. The very severe but unknown coronary artery disease probably resulted from MAJ McKerron having been a heavy smoker since 1978 and perhaps being overweight.

7.13 So severe was MAJ McKerron's coronary artery disease that the medical evidence indicates that he could have collapsed and died at any time. In that sense, his blocked coronary arteries could be likened to a ticking time bomb.

7.14 Neither MAJ McKerron nor the ADF was aware of his very severe coronary disease. Whilst MAJ McKerron was known to be obese and his obesity was classified as "uncomplicated" in terms of paragraph 28 d. of ADF Health Directive No 206, with the exception of MAJ McKerron's long and heavy smoking history, he presented with no other significant risk factors of which the ADF was, or should have been, aware of at that time.

7.15 On the day after MAJ McKerron's death, AVM Austin, Head Defence Health Services, requested a review of MAJ McKerron's medical records to ascertain if his medical management had been appropriate. Dr. Dale Thomas, then Acting Director of Clinical Services at 2 HSB GBHC, obtained and secured MAJ McKerron's medical records in his office and provided a summary report. AVM Austin reviewed that summary and was more than satisfied with the quality of MAJ McKerron's medical management.

7.16 At the request of the COI, Dr. Amanda Dines, Deputy Executive Director, Medical Services, Royal Brisbane Hospital and a GPCAPT of the Royal Australian Air Force Specialist Reserve (RAAFSR) conducted an independent review of MAJ McKerron's Unit Medical Records and associated documentation. Dr. Dines' Review Report (exhibit 72) provided great assistance to the COI.

7.17 In the circumstances, given what was then known about MAJ McKerron's health, the COI is satisfied that his ADF medical management had at all times been appropriate.

7.18 The lack of relevant PMKeys data at the time, caused difficulties and further stress for members of JLU-SQ, Chaplain Wyllie and the Gallipoli Barracks Dutv Notification Officer, MAJ Dobbs. In all of the circumstances, the notification of the children and at the McKerron household and in the absence of Ms Lynette Morgan, was the correct course of action and was undertaken properly, professionally, and with compassion. The COI commends the actions of Chaplain Wyllie and MAJ Dobbs.

7.19 The notification of Ms Lynette Morgan, at the McKerron household late that night after her return from Adelaide, was based upon sound reasoning and undertaken in a proper and professional way. The COI commends LTCOL Taylor and, once again, Chaplain Wyllie in that regard.

7.20 The notification made to PTE Deane Morgan, then stationed at Butterworth, Malaysia, was undertaken in a proper and professional manner. The COI commends PTE Morgan's OC, MAJ Bradley Robertson, in that regard.

7.21 The notification to ABET Amy Morgan at Singapore on Saturday 12 May 2007, was sufficiently performed in compliance with exhibits 40, 41 and 49.

7.22 Although CMDR. Christine Clarke, Fleet Human Resources Manager, Fleet Headquarters, agreed that the preferred option is to notify a member of a death in the family "in person", the then OOD on board the berthed submarine, HMAS FARNCOMB, at Changi Naval Base, Singapore, LCDR Jonathan Coles, cannot be fairly criticised for his decision to notify ABET Amy Morgan of the death of her step-father, not in person but over the telephone.

7.23 With the advantage of hindsight, perhaps more could have been done to ensure personal support was given to ABET Amy Morgan. Some support was offered to her and even though it was not accepted, perhaps more could have been done, though it is difficult to second guess or countermand the expressed wishes of AB Morgan. Reasonable minds may reasonably differ on this
point such that it is only possible to make a finding akin to an open finding on this issue.

7.24 Apart from some initial problems, the quality of DCO support provided to Ms Lynette Morgan, has been outstanding. In general, the initial problems related to a number of officer friends of MAJ McKerron wishing to assist Ms Morgan as well as some personality issues. In any event, those problems or issues disappeared once MAJ Lindsay Bancroft was appointed the DCO officer to Ms Morgan and her family. Since May 2007, MAJ Bancroft has provided ongoing professional and compassionate support on behalf of DCO. That support and Ms Morgan's appreciation have been acknowledged by Counsel Representing in his final submissions on 2 May 2008. The COI commends MAJ Bancroft for his professionalism, compassion and care.

7.25 At the request of LTCOL Taylor, a QA was conducted by SQLDR Currie. In the circumstances, the QA was given an extended time frame.

7.26 In the course of conducting the QA, SQLDR Currie spoke by telephone to the medic, PTE Barratt, at 2 HSB GBHC RAP. It was never his intention to take a formal statement from her as part of the QA, and that indeed is not a function of a QA officer.

7.27 Whilst conducting the QA, SQLDR Currie needed to liaise with ADFIS. In a sense, a blurring of responsibilities initially occurred between the QA officer and the ADFIS lead investigator SGT Keyes. After intervention by higher authority, SQLDR Currie continued with and completed his QA. The COI commends him on his efforts.

7.28 SGT Keyes of ADFIS also needs to be commended. He was perceptive enough to realize the importance of obtaining a formal statement from the medic, PTE Barratt, as soon as practicable after MAJ McKerron's death. The reason is self evident. Memory fades with time. However, SGT Keyes was directed by his OC, then CAPT Smith not to obtain any such statement or attempt to secure other evidence. That direction was given by CAPT Smith because of jurisdictional and resource issues.

7.29 As regards the issue of jurisdiction, CAPT Smith informed SGT Keyes that the Queensland State Coroner had jurisdiction and if any inquiry was to be made, it would be made by the Coroner through the QPS. If so, ADFIS would facilitate any request from the QPS in that regard. Further, CAPT Smith informed SGT Keyes that, in effect, the CDF would appoint a Board of Inquiry to investigate the death, and ADFIS would provide assistance, in the form of obtaining statements, when directed by the Board of Inquiry.

7.30 The essential complaint of SGT Keyes was that his investigation into the cause and circumstances of MAJ McKerron's death was presented by "command interference". He also complained that when he submitted his final report, the report was vetted and what he believed to be "vital information" removed.

7.31 The COI expended considerable time and effort investigating those allegations and found them to be without merit. However, SGT Keyes was correct in his perception of the importance of obtaining a statement from the medic who administered the vaccinations as soon as possible after the event. Had such a timely statement been obtained, the task of the COI would have been much easier.

7.32 It is clear that there were personality and other issues between SGT Keyes and his chain-of-command in ADFIS. Nevertheless, his perception is to be commended. SGT Keyes is about to leave the ADF if he has not already done so. The COI wishes him well for the future.

7.33 Although the COI is not able to determine the precise warning given by the medic, PTE Barratt, to MAJ McKerron at 2 HSB GBHC RAP on the morning of 11 May 2007, the COI is satisfied that there was sufficient compliance with the requirements ADFP 1.2.2.1 - Immunisation procedures (exhibit 8). After MAJ McKerron's death, 2 HSB GBHC reviewed its procedures and further strengthened them. As from 21 May 2007, every member who receives a vaccination at 2 HSB GBHC RAP receives a Form PM101 with post vaccination restrictions stated thereon (exhibit 31). Whilst that initiative is commendable, the COI has recommended an improvement in that regard.
7.34  Another matter that the COI spent considerable investigating was exhibit 58, the email from the Executive Support Officer to civilian staff at 2 HSB GBHC on 10 September 2007. The email informed staff that the CO of 2 HSB, LTCOL Spiers had advised that he was to be notified before any staff member from GBHC was interviewed regarding any Board of Inquiry and that no staff member was to provide comment without the CO’s prior knowledge/approval.

7.35  At first blush, exhibit 58 appeared to be an attempt to fetter inquiries made by the COI. Exhibit 58 resulted from an unfortunate lack of communication or breakdown in communications within 2 HSB. Notwithstanding what is stated in the email, the evidence is, and the COI finds, that at no time did the then CO of 2 HSB, LTCOL Spiers or the then Director of Clinical Services at GBHC, Dr. McDowell intend to muzzle or fetter staff who may be called as witnesses in a COI. The email was dictated by Dr. McDowell and LTCOL Spiers was not aware of its contents until the day he gave evidence at the COI.

7.36  What Dr. McDowell wished to convey in the email was both he and the CO needed to be aware of what was going on within 2 HSB GBHC. It was all about "situational" or "spacial" awareness. In that regard, the email was poorly crafted and misleading. On the day the email was sent, both Counsel Assisting the COI had returned to 2 HSB GBHC to interview witnesses. Some weeks prior they had paid a courtesy visit to LTCOL Spiers to explain their function and to let him know they would be interviewing witnesses in due course. With his busy workload, LTCOL Spiers simply forgot to mention that to Dr. McDowell. Consequently, exhibit 58 resulted from that unfortunate lack of communication.

7.37  As regards the actual vaccinations received by MAJ McKerron at 2 HSB GBHC RAP some hours before his death, there is no evidence that either vaccination was in any way faulty. Dr. Kelly, Director of the Laboratories Branch of the TGA, provided valuable assistance to the COI in his report (exhibit 73A) and in his telephone evidence. The COI found no link between the vaccinations and MAJ McKerron's sudden death.

7.38  Upon assessing all of the evidence, and information available to it, the COI is satisfied that the ADF could not have prevented the sudden death of MAJ McKerron. However, the COI has identified a number of weaknesses and deficiencies in terms of TOR (c) and has 12 recommendations in that regard.

7.39  Whether the recommendations are adopted and implemented is, of course, a matter for the CDF.

7.40  The recommendations have not been numbered by the COI in terms of their importance. Views will differ as to the "importance" ranking. However, the COI regards following as the four most significant recommendations:

- The appointment of a First Response Evidence Collator. Recommendation 5(a) and (b)
- The Quit Smoking Program. Recommendation 4
- The issuing of written post-vaccination warnings/restrictions to every member upon his or her vaccination. Recommendations 3 (a) and (b)
- That every BFA/PFT supervisor carry a mobile phone while supervising such activities. Recommendation 7
CONCLUSION

7.41 Of necessity, the COI has been selective in the evidence and information referred to in this Report. However, all material has been carefully considered. The COI has endeavoured to make its inquiry comprehensive and thorough. In that regard, it has been successful as acknowledged by Counsel Representing on behalf of Ms Lynette Morgan. (T1041.37) It is an unfortunate fact that the COI has taken longer than desired. Any criticism in that regard should be directed to me and only to me, as President. The patience and support of all concerned is appreciated.

7.42 In particular, I place on record the outstanding assistance received from both Counsel Assisting, LTCOL Evan Carlin and LCDR Adam Johnson RANR. The COI Secretary, MAJ Tony White and Manager, WO1 Allan Flood, are also thanked for their assistance and support. Counsel Representing, CMDR Hugh Scott-Mackenzie RANR has also provided outstanding service and I thank him for his valuable contribution. Ms Lynette Morgan also very much appreciated the assistance provided by her Counsel and that is acknowledged in the transcript. (T1043.22) It is proper that I place on record my appreciation of the outstanding work done by my wife, Elizabeth, in typing this Report.

7.43 The sudden death of MAJ Tom McKerron was a sad event that deprived Lynette Morgan of her partner, his children of a father and deprived the ADF of an outstanding soldier and officer. After his death, it became known that Tom intended to marry Lynette in Italy whilst on leave at the end of 2007.

7.44 The fact that MAJ Tom McKerron was an outstanding officer is perhaps best evidenced by the almost continual attendance of his CO, LTCOL Glenn Taylor, during the COI. Notwithstanding his busy schedule, LTCOL Taylor attended nearly every day. He sat at the back of the hearing room listening to the evidence whilst working quietly on his laptop.

7.45 At the conclusion of LTCOL Taylor’s evidence, I expressed the view that Army is very fortunate to have officers and commanding officers of his ilk and professionalism. (T112.41) Now that the COI has concluded, that view is even stronger. The reason LTCOL Taylor attended the COI so regularly was because he was Tom’s CO and felt it his duty to attend as often as possible. Such attendance was also a mark of respect for his deceased XO, whom he regarded as his “right hand man”.

7.46 The COI can think of no better way to conclude its Report than by quoting LTCOL Taylor, when he was invited by Counsel Assisting (T57.7) to speak about MAJ McKerron.

“In the short time that I had the pleasure to know Tom McKerron he struck me as a professional, capable, enthusiastic officer. Probably one of the most capable officers I’ve had the opportunity to come across. The fact that he had come up through the ranks did not discriminate in any way what he was going to be capable of in his current job, or in fact, discriminate for what he was going to be capable of for the future. In fact, his career development to that point of time would have boded well for future progress through the military ranks and I saw him not only attending well in Afghanistan as the JLC Liaison Officer, but also attendance at – as the Sub-Unit Commander and then attendance at Staff College. Once those three milestones had been completed, I would have seen him – competing strongly for promotion to Lieutenant Colonel. On those observations alone, Tom was, and will be remembered fondly for as long as I live – 11 May is also a date that will resonate strongly with me for many years to come and I just want to offer to the family, and to those friends who know him and love him my condolences and my concern and thoughts for him.”
I, Magistrate James Gordon RFD, confirm the findings and recommendations presented in this Report into the death of MAJOR THOMAS McKERRON, ARA.

James Gordon RFD
Magistrate
President of the Commission of Inquiry
4 June 2008