AUSTRALIAN DEFENCE FORCE

OFFICE OF THE CHIEF OF THE DEFENCE FORCE

REPORT

COMMISSION OF INQUIRY INTO THE DEATH OF CPONPC RUSSELL BRUCE RENNE, [redacted]

HELD CAIRNS QUEENSLAND
BETWEEN 19th OCTOBER 2010 AND 25th OCTOBER 2010

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CAREER OF CHIEF PETTY OFFICER RUSSELL BRUCE RENNE, [redacted]

- Born 1 January 1959 Brisbane Queensland. 50 years of age at time of his death.
- Enlisted in the Royal Australian Navy (RAN) on 12 April 1977 as a Radar Plotter.
- Promoted to Leading Seaman 5 December 1980. Transferred to Naval Police Coxswain (NPC) 8 March 1985.
- Petty Officer 7 September 1990, Chief Petty Officer 30 November 2000.
- Over 30 years service in RAN serving on a number of ships and shore establishments:

o HMAS Cerberus	1977, 1989, 1990 and 1992
o HMAS Watson	1977, 1980, 1982 and 1996
o HMAS Jervis Bay	1977
o HMAS Swan	1978
o HMAS Melbourne	1981
o Naval Support Command	1982, 1985, 1993, 1994, 1995, 1996
o HMAS Lonsdale	1985, 1988, 1989, 1991, 1992
o HMAS Penguin	1994, 1996, 1997
o HMAS Betano	1995
o HMAS Cessnock	1996, 1997, 1999
o Corporate Support	1999
o HMAS Coonawarra	2000
o Naval Training Command	2000
o HMAS Cairns	2007

- 16 June 2006 awarded Australian Defence Medal

CPONPC Russell Bruce Renne completed a long and distinguished career in the Royal Australian Navy.

1. INTRODUCTION

1.1 Appointment of the Commission of Inquiry

The Commission of Inquiry was appointed by the Chief of the Defence Force by instrument of appointment dated 27 May 2010 enacted pursuant to the Defence (Inquiry) Regulations 1985 (The Regulations) as amended to inquire into the circumstances surrounding the death of CHIEF PETTY OFFICER RUSSELL BRUCE RENNE, [redacted]

1.2 The Inquiry Task: (Terms of Reference)

"4. The essential purpose of the Commission is to obtain information to inform military decision-making – principally in a safety context. To this end, the Commission's focus should be on any Defence-related factors materially contributing to CPO Renne's death and any actions that might reasonably be taken by Defence to reduce the chance of a similar recurrence.
5. Subject to paragraph 4 above, the Commission is to obtain evidence and to provide me with a report detailing, with reasons, its findings as to:
a. the circumstances surrounding the death of CPO RENNE. the sufficiency of any actions and decisions taken by Defence personnel or
a Defence Contractor which are materially relevant to CPO Renne's death,
both prior and immediately subsequent thereto.
c. any substantial weaknesses or deficiencies (isolated or systemic) in Defence systems, policies, equipment, practices, procedures and training proximately associated with CPO Renne's death."

1.3 The Terms of Reference dated 20 August 2010 raise two important questions:

Should CPO Renne have been allowed to undertake the Blue Arrow Circuit given his Medical Employment Classification (MEC) and being overweight?
Were there sufficient steps taken by ADF personnel to protect his health and welfare before, during and after the Blue Arrow Circuit exercise, with regard to individual failure or a systemic failure which requires determination?

1.4 Events Surrounding the death of CPONPC Renne

CPO Renne died 8 May 2009 aged 50 years (born 1/1/1959). At the time of his death CPO Renne was engaged with a command approved exercise walk on a public walking track adjacent to the Cairns Botanical Gardens known as the "Blue Arrow Circuit" and he was at the time on duty. The event was a Divisional Meeting of the Executive Department HMAS Cairns. CPO Renne was one of a number of naval and civilian personnel from HMAS Cairns Far North Queensland.

1.5. Anecdotal evidence supported the proposition that he was reducing his weight and increasing his fitness to return to sea duty at a future time and to take his IR test. He was on a fitness regime arranged by CPO J.L. Cunningham who was supervising the Blue Arrow Circuit walk.

1.6 CPO Renne at the time of his death was a Naval Coxswain and was working on a specific investigation task.

1.7 CPO Renne had a significant history of obesity and had been examined and medication provided, over many years by medical practitioners. He also underwent numerous changes in his Medical Employment Classification (MEC). *(Exhibit 40).*

1.8 The full medical history of CPO Renne was meticulously analysed by LTCDR Dr. J.M. Bailey from the Central Unit Medical records which were not in sequence when produced to the COI. Dr. Bailey also outlined the MEC System and the MEC categories of CPO Renne during his career. This again is relevant to the circumstances surrounding the death. The work of LCDR Bailey was greatly appreciated by the President and others in understanding the medical history.

1.9 A post mortem examination by Dr. Paul Botterill on 11 May 2009 found that the cause of CPO Renne's death was due to coronary artery atheroma against a background of obesity.

1.10 <u>Members Participating in the Blue Arrow Circuit Walk</u>

CPOPT J.L. Cunningham
CPONPC J. Lambert
CPONPC R.B. Renne
CPONPC R.K. Rosendale
PONPC S.K. Boak
[redacted]
LS J.R. Little
LSWTR M. B'Brien
ABWTR S. Clubb
Mr. B.T. O'Connor and
Mr. M.J. O'Connor

1.11 Planning/Briefing of the Blue Arrow Circuit Walk

- The participants were briefed by CPOPT J. Cunningham and she had in her possession a First Aid Kit and other items together with a sufficient supply of water.*(T.134-37)*
- The activity commenced at 0700 hrs.
- Following a rest more than 4 km into the walk CPO complained of dizziness and a pain in his arm. *(T.140-40.T.141-16)*
- CPO Renne rested for a short time and when he was feeling recovered he commenced walking with a group of 6 members and after a short distance he fell to the ground.
- CPOPT Cunningham was unable to locate a pulse and commenced CPR and she was joined by the others. An ambulance was summoned; logged at 0921 *(Exhibit 20)*. Paramedics arrived together with Dr. E. Finn of Careflight.
- CPR and other procedures continued until 1005 when life was pronounced extinct.

2. CONDUCT AND PROCEDURES OF THE COMMISSION OF INQUIRY

2.1 Appointment of Commission of Inquiry

By an Instrument of Appointment dated 27 May 2010 and by Terms of Reference dated 20 August 2010 Air Chief Marshal A.G. Houston AC, AFC and Lieutenant General D.J. Hurley AG, DSC (Acting Chief of the Defence Force) appointed Frank Cullen President of the Commission of Inquiry(Annexures "A" and "B" respectively).

2.1 The appointment of the Counsel Assisting Commander Gary Charles Barrow and Lieutenant Colonel Craig John Barker were initially appointed as Inquiry Officers on 27 May 2010.

2.2 Appointment of President and Inquiry Officers

The appointment of the President and Inquiry Officers simultaneously, was extremely beneficial to the preparation of the scoping and obtaining evidence for the Commission of Inquiry.

2.3 I am extremely supportive of the abovementioned practice however there is a difficulty with the distinction made regarding the two processes. In my experience there are two opposing views as to the power of the President during the inquiry phase particularly to the issue of summonses to assist the Inquiry Officers' investigation.

(i) A change to the provisions relate to the "Appointing Officer" specifying that it was an administrative function only with regard to the Inquiry Officer's report. I am of the view such a change would enable an Inquiry President's powers to be utilised.

(ii) The contra view that is expressed above does not accept the issuing of summonses with the legislation in its present form. An Inquiry Officer who is appointed pursuant to Regulation 70A Defence (Inquiry) Regulations 1985 is responsible to the Appointing Officer and not the President of the COI in the Inquiry Officers' phase. There is no provision for a President to have any supervisory role or any direct inclusion at that specific phase. I recommend: The President should have statutory input into the inquiry phase particularly with regard to issuing summonses duces tecum, to produce documents i.e., medical records.

2.4 **Recommendation**

That legal advice is sought regarding the parallel appointment of the Inquiry Officer and the President of a Commission of Inquiry which would enable a President to participate in the inquiry investigation phase:

(i) to enable consultation with the Inquiry Officers regarding the scoping of the investigation and

(ii) to issue summonses to obtain material (evidence) outside of the military system, i.e., bank, telephone, accounts, civilian medical records, pharmacy records and coronial police documents.

With respect I would advance the proposition that any amendments to the legislation should be minimal by amendment to Regulation 118. The amendment would clarify and give certainty to the extent of Inquiry Officers' investigations and the ability of the President to assist. There would also be further benefit of having access to a major part of evidence prior to the commencement of the COI phase. The proposed amendment would facilitate a smooth transition from the ICO phase to the COI phase.

2.5 Potentially Affected Persons

There was only one person who was identified before the commencement of the COI as a Potentially Affected Person (PAP), CPOPT J.L. Cunningham. CPO Cunningham was therefore provided with Counsel, LCDR P. Panayi. In addition the Deceased and the family of the Deceased were represented by CMDR H. Scott-Mackenzie.

2.6 Location and duration of the Hearing

The Commission of Inquiry was held in a conference room at The Sebel Hotel Cairns. The venue was adequate with very good facilities however I do not fully understand why the COI was not held at HMAS Cairns which I understand has the necessary facilities.

The evidence before the COI was taken over a five day period. It had originally been considered that the Hearing would be nine days however hearing time was lessened by the cooperation and good will of the family of CPO Russell Renne.

2.7 Appointments/Scoping

The Terms of Reference dated 27 May 2010 set out the Terms of Reference for the Inquiry Officer phase of the process. The President's appointment at the same time as the Inquiry Officers enabled consultation as to scoping other issues that arose during that phase.

One of the important decisions made at the pre-hearing meetings was to consult with an independent cardiologist. It was agreed that Dr. Peter Habersberger, Consultant Cardiologist Alfred Hospital Melbourne, should be consulted and provided with all relevant documents.

2.8 The Hearing

Sixteen witnesses gave viva voce evidence and the transcribed records of interview of a further nine were tendered with the consent of all counsel. (Annexure C Witness List).

2.9 On 21 October 2010 on the third day of the hearing, Mr. Russell Power Command Occupational Health and Safety Manager HMAS Cairns, was called to give evidence. His evidence was confusing and it appeared that he was confused. There was conflicting evidence and a high degree of misunderstanding between the witness and the Counsel Assisting. In the interest of procedural fairness I adjourned Mr. Power's evidence until the final day of the hearing arranging for him to obtain legal advice and representation. I am grateful to LCDR Adam Johnson a Brisbane barrister who travelled to Cairns over a weekend to prepare Mr. Power. The response by LCDR Johnson was exemplary.

2.10 Submissions to the COI

Counsel Assisting and LCDR P. Panayi Counsel Representing CPO J.L. Cunningham made final submissions at the end of the evidence. CMDR H. Scott-Mackenzie Counsel for the Deceased and the Deceased's family submitted written submissions on 12 November 2010. In addition CMDR Scott-Mackenzie addressed the hearing on behalf of the family which was dedicated to their gratitude to all concerned in the proceedings. The address was supplemented in the written submissions of the CMDR and also outlining recommendations which are dealt with later in the report. Following his recommendations a response was received from CMDR G.C. Barrow stating his view of the recommendations of CMDR Scott-Mackenzie.

2.11 Medical Confidentiality

Breaching medical confidentiality was raised. This topic has been dealt with previously by Commissions of Inquiry and recommendations made. In this specific case it is not appropriate to continue such a vexed question. It is acknowledged there are strong views on both sides of the argument with regard to disclosure of medical evidence within the Australian Defence Force. However there is a recommendation regarding an electronic record at paragraph 6.4 of this report.

3. THE MEDICAL EMPLOYMENT CLASSIFICATION SYSTEM (MEC)

Defence Instruction (General) Personnel 16-15
Australian Defence Force MEC system
Health Directive 263 MEC procedures 21.11.2005
Health Directive 206 extant 06 Feb 02 – Overweight and obesity

3.1 The MEC has numerous classifications as follows:

(a) MEC 1. Members who are medically fit for deployment or seagoing duties (without restriction).

(b) MEC 2. Members who have medical conditions that require access to various levels of medical support or employment restrictions, however they remain medically fit for duties when deployed or seagoing. When MEC 2 is determined with a sub classification access to the required medical support always takes precedence over specified employment restrictions.

(c) MEC 3. Members who have a medical condition making them unfit for duties in a deployed or seagoing environment.
These members should be medical managed with the intention of regaining MEC 1 or MEC 2 within twelve months of allocation of the MEC 3. Within the 12 months following the allocation of MEC the MEC is to be reviewed.
If after that period of time above if the recipient is still medically unfit for military duties in an operational environment, are downgraded to MEC 4 or if appropriate, referred to MEC Review Board (MECRB) for consideration of an extension to remain MEC 3.

(d) MEC 4. Medically unfit for deployment or seagoing service in the long term. When classified as MEC 4 for military duties will be subject to review and confirmation of the classification by the MECRB.

3.2 The system allows for sub classifications to MEC 2, 3 and 4. The purpose is to amplify the classification and identifies the health support or restrictions on duties or deployment. In addition to the basic sub classifications, additional restrictions in regard to specialist employment *(Exhibit 40.para2.p13.)* The sub-classifications are set out in Annexure B to Report of LCDR Bailey. *(Exhibit 40.13-15)* (Annexure "D")

3.3 The MEC must be accurate and be current to allow planning for operational commitments and career management. The MEC system is of assistance to Career Management Agencies (CMA) with regard to deciding issues, for example, postings, promotions and overseas deployment and to engage in seagoing service. The relevance of such provisions is that decisions not only impact on the individual careers but also on the effectiveness of the ADF capability.

3.4 The Health Directive (HD 236) and DI(G) 16-15 must be read in conjunction with the policy. The HD provides implementation instructions for assigning an MEC to a member of the ADF. DI(G) 16-15).

3.5 The MEC is determined according to a member's primary military occupation. In determining the appropriate classification the environment in which the member's occupation may be performed when deployed and any other additional tasks the individual is expected to perform in their general military duties.

3.6 There are a number of other issues as to the MEC system and employment, deployment and performing seagoing duties.

3.7 DI(G) PERS 16-15 deals with the responsibilities of a commanding officer paragraphs 32-37 and 44-45. The DI(G) PERS 16-15 also sets out the importance and relevance of the MEC Review Board. The other provisions in my view do not have any relevance with regard to the circumstances surrounding the death of CPO Renne.

AND FURTHER

The Medical Employment Classification Review Board (MECRB) is a pivotal component of the Medical Employment Classification System

Confidentiality
Dealt with in paragraphs 32 to 36 HD 236 of 21 November 2005 and paragraphs 3 to 5 DI(G) PERS 16-15 of 11 April 2005. Both permit the disclosure of health information to commanding officers for operational purposes.
The HD goes further in a number of respects by allowing health information to be given to supervisors in addition to the commanding officer. The Counsel Assisting in his closing address disclosed a strong view with respect to the release of medical in confidence information. His view was that it should be completely confidential. *(T.410.13-29)*

I disagree as I believe it is of considerable benefit to the individual and the command to be informed of any restrictions which may affect others.

4. CIRCUMSTANCES SURROUNDING THE DEATH OF CPONPC R.B. RENNE

4.1 Divisional meetings of the Executive Department HMAS Cairns were held on a monthly basis. *(Exhibit 42.p6).* The meetings were held in conjunction with an activity followed by a breakfast and the meeting. Organisation for each meeting and activity were rotated between sections of the Base. *(T.131.10-35)*

4.2 <u>Notice, plan and briefing before Blue Arrow Circuit walk</u>

On 7 May 2009 at 1409 an email was distributed to a number of the members and others. The email set out the following:

> *"Tomorrow's Divisional Meeting will kick off at 0700 from the Red Arrow Car Park, to undertake the Blue Arrow (5.2 km).*
> *Members are asked to be at the Red Arrow car park no later than 0655, as we need to commence the walk at 0700 in order to get around in a reasonable timeframe (Approx 1.45 mins).*
> *Dress for the event:*
> *good runners with traction, either shorts or long pants (your choice if you don't want to get mud on you or perhaps bitten by things).*
> *T/Shirt/long sleeve shirt*
> *Aerogard (PT staff will supply)*
> *Water bottle (either camel pack or waist holder)*
> *A ball cap or hat to shady (sic) against any green ants or spiders webs falling.*
> *The distance is achievable and there will be personnel along the way to encourage you along. Who knows you may surprise yourself.*
> *If you eat before the event, then I suggest you don't eat too much, just enough to get you around.*
> *After the event:*
> *After the outing, we will proceed to Dolce Café for breakfast located in Shield Street across from McDonalds on the other side of the road towards Museum Café.*
> *At present we have 13 personnel attending, if you cant make it then you ring me on 04176754375(sic) by 0630 8 May 09"*

The email set out in detail all requirements for the information of participants. *(Exhibit 6).*

4.3 The participants assembled at the Red Arrow car park. They were addressed by CPOPT J. Cunningham. One of the key points addressed was that of hydration and water to be carried.

4.4 The Blue Arrow Circuit walk *(Blue Arrow Circuit Exhibit 13)*

The Blue Arrow Circuit walk described as stairs/hills in intervals (undulating) and requires equipment to be carried i.e., water, towel, watch, first aid kit, mobile 'phone and heart rate monitors. The latter equipment was not on the inventory and appears to be superfluous to the exercise. The Blue Arrow is rated as having a low risk level all of the perceived risks were adequately dealt with. *(Exhibit 3).* (See also 4.10 Risk Assessment).

During the walk the participants had rest stops along the way. There were no incidents or problems until about 800 metres from the finish. CPO Renne who was in the final group complained of being dizzy and had a sore arm. He did not complain of any chest pain. The group stopped in the shade and CPO Renne had a drink of water. He was resting for about 8 or 9 minutes when he stated he was alright to continue. He was joking and in good spirits. He walked forward then appeared to trip, however it was noted that it was not a trip. He fell against banking and was assisted into the recovery position by CPOPT Cunningham. He was not responding to stimulants and CPR was commenced. An ambulance was summoned and paramedics subsequently attended. CPO Renne was given oxygen and drugs to stimulate his recovery however he did not respond. A Careflight doctor attended and pronounced life extinct and his body was conveyed to the Cairns Base Hospital.

4.5 The issues relating to the walk:

(i) The organisation and status of the exercise together with the planning – Was the planning sufficient and satisfactory?

(ii) The origin of the email. *(Exhibit 6)*

(iii) The effect of the lack of knowledge of the email by CPOPT Cunningham.

4.6 The initial organisation and planning was reliant on the email *(Exhibit 6)* supra. CPOPT Cunningham although denying sending the email by stating she did not recall being the author or putting the email out. *(T.130 L.6-25)* However CPOPT Cunningham did accept that the email was sent to her and relayed to the other participants but not from her computer. CPO Cunningham did not recall being the author of the email. I find that she could only have been the author given the detail of the instructions which are contained in the document. Consideration of that situation has led me to conclude there was no benefit deliberately stating she was not the author or the person who circulated the information. The email and its content were regarded as being reasonable and appropriate. I find as stated she was more likely the author than not. In my view the certainty of the origin is of no consequence, it is the content which is of paramount importance. The content of the document regarding the planning of the event was found to be reasonable by LCDR A. Von Senden the Senior Physical Education Instructor at HMAS Cerberus. He stated: *"In my opinion... to*

provide a plan for the Blue Arrow Walk was reasonable and provided the basic information required to undertake the walk. (T.76.2-5).

LCDR Von Senden *(Transcript p.76 L.21)* also acknowledged that all the participants in the walk were adequately dressed however he did comment on the amount of water for each person was sufficient. *(T.77.7-15).* There was no evidence however that water or the lack of it was a factor in the death of CPO Renne, the pathologist did not find any signs of dehydration.

4.7 The participants in the walk agreed that there was a briefing by CPO Cunningham before the commencement of the walk. CPO Cunningham checked clothing, footwear, and water and outlined issues in detail with pre warm-up and post exercise cool down *(T.p.133 L21-45 and p.134)*

4.8 <u>Adverse findings</u>

I was requested by the CA CMDR Barrow, to determine the credit of the CPO by her demeanor and her responses to questions put to her. I was also requested to take into account the evidence of CPO Cunningham and that of LCDR Von Senden. He concluded that the briefing was adequate and therefore there was no evidence to support any adverse findings against her.

I agreed with the submission and at the conclusion of the hearing, with a view to enable the CPO to return to her duties without having the added burden of uncertainty regarding the possible findings by the Commission of Inquiry, I advised her of my views. The decision was based on the evidence and was in my view the correct time to determine the matter. I informed CPOPT J. Cunningham that I would not be making any adverse findings resulting in administrative action being taken.

4.9 <u>Risk Assessment Document</u> *(Exhibit 3).*

This document was not in Mr. Power's possession.
The document is unsigned.
The document is not in the correct format.
There is no evidence to support the origin of the document.
There is uncertainty as to who had the document at the relevant time of the walk.
The document is however of benefit in appreciating the walk and the action of CPOPT Cunningham.

The evidence of Mr. Power Occupational Health and Safety Manager, *(T.p.255 L.38)* was that he did not have the document at the commencement of the walk. His evidence was that he received the document from a member of the PT staff; however he was not certain with regard to that issue *(Transcript.256-L.25 and T p.255-30).*
Mr. Power was certain that he took possession of the document following the event regarding CPO Renne.

- The form of risk assessment procedure is not directed towards the individual participant but to the activity itself.

- The risk assessment did not conflict with the plan for the walk or any of the pre-walk procedures. All of the evidence presented when reviewed, did not show any failure to have regard to the assessment.

- It is clear that there has been a move to ensure that the risk assessment process is controlled as the result of the Fleet Commander's minute dated 02 March 2009 *(Exhibit 47)*.

- The foregoing was a result of a review of Standing Risk Profiles (SRP) and Command Decision Summaries (CDS) in 2008 to develop a process of dealing with Risk Assessment and its control.

The events leading to the death of CPO Renne and the element of risk are of significance. CPOPT Cunningham is a very experienced supervisor in the RAN for 32 years; a PT Instructor nearly 30 years, highly regarded, had extensive experience and had known CPO Renne during their naval careers when both were at HMAS Coonawarra in 1998. She had assessed the ability of CPO Renne and had adequately made an assessment of the Blue Arrow Circuit walk.

When CPOPT Cunningham arrived at HMAS Cairns she spoke to CPO Renne with regard to his fitness and devised a program for him. The exercises were demonstrated to him and his progress would be monitored.*(Exhibit 18)*. CPO Cunningham stated that the whole program was based on self motivation. *(T.120.33-45)*. The process by CPOPT Cunningham was in effect a full assessment of CPO Renne and his program.*(T.121.1-5)* She was aware of his diabetes and high cholesterol but <u>not</u> his hypertension.*(T.121.16-23)*

4.10 <u>Risk Assessment:</u>

Counsel Assisting CMDR G. Barrow requested me not to make any adverse finding with regard to the risk assessment question. On considering this matter I have formed the view that there was no failure with the Risk Assessment of the Blue Arrow Circuit walk. (See also 4.4 The Blue Arrow Circuit walk).

I find there was no evidence to support the proposition that CPO Renne did not have the ability to complete the exercise. The medical conditions which affected him were only known to him and could have occurred at any time.

4.11 **Recommendation**

Counsel Assisting supported a recommendation as follows:

It is open to consider a worthwhile recommendation along the lines that every plan for any activity covered by a risk assessment *must* contain specific reference to the risk assessment in force for that activity at the time. *(T.405.37-40)*
This would ensure that PT supervisors who are not as experienced as CPOPT Cunningham are aware of all available information.

I agree the recommendation may well have beneficial effect on activities such as the Blue Arrow Circuit. I have given consideration also to a requirement regarding the evaluation of the individual participants. The assessment of the activity together with the individual may well be of benefit although in my view would not be achievable. I do however conclude that a recommendation as to the terms of the documents is achievable. The recommendation is as follows:

> Proposed Recommendation:
> Every plan relating to any physical activity either voluntary or compulsory covered by a Risk Assessment *must* contain a specific reference to the risk assessment in force applicable to that activity.

Following consideration of all of the evidence regarding risk involved in the Blue Arrow Circuit walk and the participation of CPO Renne I find there was no failure of any protocol or procedure in the planning or execution of the event. The issue of Risk Assessment has been addressed by the RAN and outlined in the Fleet Command Minute dated 02/03/2009 *(Exhibit 47)*.

In determining the risk assessment of any activity the supervisor should have regard to the health and fitness of participants. The supervisor has responsibility to point out risks although it is not mandatory and clearly in this case, the supervisor, CPOPT Cunningham, had a long history of involvement in physical exercise. CPO Cunningham has very broad experience in her role as a Physical Training Supervisor. She had also made an assessment previously as to CPO Renne's physical capabilities.

4.12 Adequacy of execution of the Blue Arrow Circuit walk

In line with my findings of the planning of the walk and with regard to safety, regard was given to the execution of the Blue Arrow Walk and the screening of participants taking part. As previously stated the supervisor had knowledge of CPO Renne's health and his ability to undertake such an exercise. The Counsel Assisting posed the question of whether or not CPO Renne should have participated.

The Physical Fitness Test

- CPO Renne was not in-date for his physical fitness test. Dr. J. Bailey *(Exhibit 40)*
- DI(G) PERS 31-38 (Fitness Policy Navy)
- DI(G) PERS 16-11 (Policy Physical fitness and fitness testing)

The interpretation of the standard of the physical fitness test was succinctly given by LCDR A. Von Senden (Officer in Charge PT School HMAS Cerberus)

> *"The physical fitness test is a minimal test and the standard decreases with age until you get to 55, in which case it levels out. So the test for a 55 year old is exactly the same for a 65 year old (T.67-40)*

The LCDR went on to state:

> *"the key to it is, if at 56 you cannot pass the fitness test, then you will be better off retiring" (T.68-35)*

CMDR Barrow – philosophy behind fitness testing *(T.406-35)*

> *"If people cannot pass this minimal fitness standard then there is a serious question of their ability to continue service...whether they are physically fit to be retained by the service"*

LCDR Von Senden's view was that he would insist that a member should be in date for the RAN fitness test before he would permit the person to do the Blue Arrow Walk. However he conceded there were other views held in certain circumstances. *(T.95-25)* There is no hard and fast policy with regard to participating in such an exercise. The decision as to who participates is a matter of judgment by the supervisor. LCDR Von Senden conceded in certain circumstances others may have a different view. In the circumstances relating to the Blue Arrow Circuit walk on the 8 May 2009 CPOPT Cunningham did not share the view of LCDR Von Senden. It may well be that in the decision of LCDR Von Senden a measure of hindsight is included. The fitness test as stated is an indicator only and in my view given the circumstances in this case should not be a prerequisite to participating in the Blue Arrow Circuit walk or other event where there is an experienced PT supervisor who has made an assessment of the participants.

4.14 Participation in the Blue Arrow Circuit walk

CPO Renne had demonstrated that he had the physical ability to complete the walk. He had completed a four kilometer walk and had been on a fitness program.*(Exhibits 17 and 18)*. I am satisfied that there were reasonable grounds for CPOPT Cunningham to reach the conclusion that she did. I find that there was no error of judgment in her decision in allowing CPONCP Renne to participate when not in date with his fitness test. He had not been in date with his RFT since 2006.

4.15 Medical Services Cairns

In addition to his primary medical degrees Dr. Shane Brun has fellowships both from the UK and Australia in sport exercise medicine together with a Master's Degree in Sport Medicine and is contracted to provide medical services to HMAS Cairns. In an email to LEUT N. Holmes Annexure to Exhibit 29 dated 8 May 2009 Dr. Brun states:

"At no stage in his medical records is there any mention of episodes of chest pain/discomfort, shortness of breath or palpitations with exercise. Over the last several months he has been exercising daily... Russell's 5 yr CVD risk (fatal and non fatal) ... had fallen from 20% to 2.75% in 2009"

Dr. Brun *(T.330-10)* was shown Exhibit 33 (Clinical Notes Dr. Byrnes) and was asked by Counsel Assisting regarding the walk, the topography of the Blue Arrow Walk and the health problem CPO Renne had. The Doctor responded as follows:

"It's irrelevant the topography the person's exercising on. What's important is how they are exerting themselves and the degree they're exerting themselves... he may in fact exert less energy than jogging along the Esplanade." (T.330.14-19)

There was no evidence from any of the participants on the walk that CPO Renne was over exerting himself before he collapsed. In addition, none of the medical experts called to give evidence at the hearing concluded that the CPO's involvement in the walk was a problem. *(T.308-330.10)*

CPO Renne's medical records (6 March 2009 Exhibit 36) show he told Dr. Byrnes of his exercise regime and that he was doing "push-ups".Regardless of that information a waiver had been provided to CPO Renne regarding taking the fitness test and was continued for another 42 days. At the time of the walk CPOPT Cunningham was aware of CPO Renne's diabetes and also a demonstrated ability to walk for 5 kilometres within the requirements for a fitness test. The five kilometres walked referred to was along the Esplanade in Cairns and was completed in 38 minutes 20 seconds which was within the 46 minutes allowed for his age group. CPO Cunningham accompanied CPO Renne on this walk. *(T.124.24-40).*

The Blue Arrow Circuit walk was completely voluntary and the evidence supports the view that CPO Renne was a very senior sailor who was independent and would not have participated in the walk unless he wanted to do so. *(T.108-20).* I am satisfied on the evidence that CPO Renne took part in the Blue Arrow Circuit walk in order to continue his objective to become fit for sea duty in the future. There was no undue pressure on participants during the walk, it was voluntary and was never a compulsory exercise. I conclude that the event was purely a social outing and I find that participation in the Blue Arrow Circuit walk was a purely voluntary exercise.

4.16 <u>Medical assistance given to CPONPC Renne</u> at location on Blue Arrow Circuit walk at time of collapse.

At approximately 0900 on 8 May 2009 the participants gathered at the final rest station on the Blue Arrow Walk. There were five colleagues with the CPO who was joking and laughing as they walked along the pathway. About one kilometer from the finish CPO Renne complained of feeling dizzy and had a sore arm. He indicated the top of his arm, however he stated that he did not have chest pain. *(T.140.40-45)*. He was moved to a shelter where he was given additional water and told to rest for eight to ten minutes. He then told his companions that he felt better and only had some tingling in his fingers and indicated he would continue. *(T.141.1-11)*.

- At approximately 0915 having stood up he walked forward along the pathway towards the end of the walk. CPO Renne appeared to trip over.

- CPOPT Cunningham assisted CPO Renne down to the ground and LSPT Weston then placed him in the recovery position. There was no sign of life, no pulse and no breathing.

- CPOPT Cunningham commenced CPR and LS Weston rang emergency for an ambulance to attend. CPR was continued until the arrival of paramedics at 0943. *(T.140-40)*.

- CPOPT Cunningham applied CPR to CPO Renne and then transferred the task to Mr. Bernard O'Connor and LS Little. CPO Cunningham then continued the transfer of breath into the CPO. The CPR continued between the three mentioned for between twenty to twenty five minutes. *(T.143.31-36)*

- There was continued contact between LS Weston and the paramedics by mobile phone who were provided with signs and symptoms of CPO Renne during the period of CPR and they were advised regarding the number of compressions to apply to the Chief. The rate was raised on the advice of the paramedics. *(T.143.40-45)*.

A comparison of the timeline *(Exhibit 5)* and the records provided by the Queensland Ambulance Service *(Exhibit 20)* confirm the accuracy of the times and events. There could be no criticism of the procedure carried out in the attempt by CPOPT Cunningham, LSPT Weston, LS Little and Mr. Bernard O'Connor to revive CPO Renne. The endeavours of the four are deserving of some commendation from the Navy.

- On the arrival of the paramedics the CPO was intubated and stimulating drugs, adrenaline on four occasions and atropine, oxygen and a defibrillator were administered to him. However at 1005 he was pronounced dead by Dr. E. Finn of Careflight who attended the scene and CPO Renne's body was then conveyed to the Cairns Base Hospital.

4.17 Actions/Procedures of Command following the death of CPONPC Renne

The following needs to be addressed:
Were the procedures correct and were they effective?

At approximately 1030 it was confirmed that CPONPC Renne had died and the Commanding Officer HMAS Cairns, CDR R. Heffey informed. In addition, pursuant to DI(G) PERS 11-2 and CDF Directive 12 of 2006 the required steps were taken.

- A crisis management team was set up.
  The DCO was informed as was the Chaplain who attended the Commanding Officer's office.
- Debrief of colleagues and participants in the Blue Arrow Circuit walk by Dr. Brun.
- Comcare was notified.
- Quick assessment carried out. *(Exhibit 4).*
- Fatal Cas 680054Z *(Exhibit 7).*

The comprehensive record of the action taken by HMAS Cairns following the death is contained in Exhibit 5, Timeline compiled by LEUT Donaldson. (Appendix "D")

There is no evidence to support the proposition that there had been any flaw with the protocols or procedures required. I find that they were carried out in a professional manner.

4.18 First Aid.

It has been stated that the initial CPR was administered in a proper manner as mentioned by RAN personnel.

The Queensland Ambulance Records indicate that a comprehensive examination, tests and treatment were administered to CPO Renne as previously outlined.

I find that the First Aid by both the Naval personnel and the Paramedics was of a high quality, prompt and everything was done to revive CPO Renne.

4.19 The notification of CPONPC Renne's family

The Commanding Officer CMDR Heffey and Chaplain Renfrey attended the home of CPO Renne to inform Mrs. Renne of the death of her husband. From the evidence this task was emotionally difficult for CMDR Heffey. [redacted] The procedure was completed by Chaplain Renfrey. CMDR Heffey's reaction was a human one and no matter how much training he had undertaken it would remain a difficult task. There is no criticism in this regard. The experience was traumatic for Mrs. Renne due to the sudden event. *(T.26.34-37).*

Given the unexpected situation which arose, the notification procedure was effectively carried out by the Chaplain which in his view affected his further care to the family due to the negativity that attaches to the person who informs of a death. The question arose as to the training relating to the notification procedure. The situation highlighted deficiencies in the notification procedure as to the training given to commanding officers.

Both CMDR Heffey and Chaplain Renfrey suggested that the training procedure regarding notification of families with regard to death should contain a major element of role playing situations.

4.20 Recommendation

I recommend that the training for the notification procedure should contain a high content of "role playing". It was also suggested:

- it is not always necessary for the CO to carry out the task of notification *(T.276-5).*

- in some circumstances i.e., where there was or had been disciplinary proceedings with the deceased member, the CO should not be the person to notify family or next of kin.

- I am satisfied that there is a case to introduce further training for senior officers.
- I would suggest that this training is carried out as an adjunct to other training.
- I am of the view that training is necessary to accomplish the goal of improving the process and to focus the attention of senior officers to what is a very unpleasant duty.
- It may be an advantage to collate the instances of notification and circumstances and reactions in the training.
- I would also suggest that information is requested from all Australian police forces regarding their training of recruits in similar procedures which are a common task for them.

4.21 Command actions following the death of CPO Renne

Issues which are relevant to the question are:

(i) the actions of the command rendering appropriate reports (Fatal Cas and Quick Assessment
(ii) setting up the Critical Management Team (CMT)
(iii) provision of care and assistance to the family (DCO-Chaplain Services
(iv) debrief of participants by medical officer.

The command functions and actions were traversed in the evidence of the Commanding Officer CMDR Heffey, the Executive Officer LCDR Cummins, Dr. Brun, CHAP Renfrey and LEUT Holmes, the latter coordinating the tragic event.*(T.27.8-10, T.55.32-35,. T.192.43, T.193.3, T.322.32-35.)*

Counsel Assisting suggested I conclude that all of the actions taken by the command were effective and in accord with established directions and procedures. *(T.414-40).* There was absolutely nothing in the evidence that supported any adverse comment with regard to a failure by an individual or by any of the procedures.

4.22 Role of Command Occupational Health and Safety Manager

One of the procedures undertaken by Mr. Power was the notification of COMCARE, and that CPO Renne was IR compliant when it was not necessary. I am of the view that instances required to be notified to COMCARE should be made clearer than they are at present. However I am able to conclude that the information, although wrong, was of little or no importance in these circumstances. The notification of COMCARE was not an event requiring the procedure to be carried out.

Therefore the procedures regarding the notification of COMCARE death or injury should be reviewed. I am of the view that this issue is not one which should be the subject of a recommendation. I do not intend to make any adverse comments on the issue which related to the action of Mr. Power. However it is imperative that OH & S members are fully conversant with all of the notification procedures.

4.23 The role of the Defence Community Organisation (DCO)

The role of the DCO is one of care to members and the family of members. It was outlined by CA that the indicator in deciding the question of the sufficiency and adequacy of care is the reaction of the family concerned. In this case I am of the view that it was unnecessary to analyse the performance of policy and procedure of the Organisation. The Renne family had nothing but praise for the Organisation and for individuals within the Organisation. CMDR Scott-Mackenzie in his submission read a statement prepared by Mrs. D. Renne in which she acknowledged the assistance of the DCO *(T.398-20)* thanking the Organisation and giving particular mention to one of the counselors Ms Jodie Claproth for whom she has high praise and whom she now regards as a friend. The comments by Mrs. Renne illustrate and demonstrate the performance of the Organisation. A better insight into the performance of the Organisation in this matter could not be obtained. *(Exhibit 31 and T.399.1-9).*

4.24 Risk factors – medical confidentiality

Would risk factors have been recognised if there had been disclosure of the possible risks applying to CPO Renne's medical problems? There had been some disclosure made by the information contained in the Medical Advice *(Exhibit 22).* The consequence of the lack of full disclosure did not affect the outcome of the Blue

Arrow walk. In these circumstances it is not necessary to analyse the policy regarding medical confidentiality.
The issue of confidentiality was raised in the circumstances surrounding the death of CPONPC Renne. *(T.410.13)*. Disclosure by the medical practitioners or access to his medical records would not have reduced the risks in embarking on the Blue Arrow walk. This topic of confidentiality has been dealt with previously by many Commissions of Inquiry and recommendations have been made. In this specific case it is not appropriate to continue such a vexed question. It is acknowledged there are strong views on both sides of the argument with regard to disclosure of medical evidence within the Australian Defence Force.

4.25 **Cause of death of CPONPC R.B. Renne**

CPO Renne's death raises the following questions:
(i) Should CPO Renne have been on the Blue Arrow Circuit walk?
(ii) Were the organisers or any other person aware of any reason why CPO Renne should not have been on the walk?

The Post Mortem (PM) held by Dr. Paul Botterill, Senior Staff Specialist Forensic Pathologist, Cairns Base Hospital, *(Exhibit 25)* records the cause of death as:

- coronary artery atheroma (with a significant condition contributing to the death but not related to the underlying cause
- obesity. (obesity policy is within HD No.206 Amendment No.4).

Dr. Botterill provided an additional report, 2/9/2010 *(Exhibit 38)* to his PM Report which was provided to the Queensland Coroner. In addition, the Doctor was called to give evidence at the COI. He explained atheroma *(T.291.7-16)*. being the fatty tissue which is atheroma within the left midpoint anterior descending artery causing narrowing and reduced blood flow, found in CPO Renne. There was no thrombosis present in the artery and he explained what he meant by exacerbated by recent exertion. *"I found no evidence to suggest severe exercise induced pathology such as marked dehydration or traumatic bleeding within muscles or in the kidneys. So I cannot* say *with certainty that exercise associated injury has contributed. I am still of the opinion that recent exertion has exacerbated the underlying condition." (T.293-15-20)* Dr. Botterill went on to state the benefits of exercise being good for weight loss and increases the responsiveness and effectiveness of the heart. Other medical practitioners including the cardiologist Dr. Habersberger and Dr. Brun called to the COI agreed with the findings of Dr. Botterill.

The totality of the medical evidence was reviewed by Dr. Peter G. Habersberger *(Exhibit 48)*. The report concluded there was dizziness and pain in arm. That he stated indicates angina pectoris and that he had myocardial schemia collapsed due to ventricular fibrillation. He may have developed spasm on the stenosis in his left anterior descending coronary artery, the spasm could not be detected at post mortem. At no stage did he appear to have any symptoms to suggest underlying coronary artery disease.

4.26 The medical treatment provided to CPONPC Renne

The medical history of CPO Renne discloses a consistent battle with his weight over the 32 years of his service. He was on occasion successful in reducing his weight and his BMI by compliance with his rehabilitation program achieving reasonable control of a multitude of risk factors. *(Exhibit 40.p.5).*

Was the medical attention given to him during his 32 year service adequate and appropriate?

The complete medical history contained in CPO Renne's Central Medical Record has been comprehensively summarised by LCDR J. Bailey *(Exhibit 40).* Dr. Brun also summarised the Record in his report. The report was not tendered as an exhibit however it is attached to this report as Annexure "D". It is of note that Dr. Habersberger saw CPO Renne in 1993 when he diagnosed that CPO Renne was suffering from hypertension, dyslipidemia and obesity. Dr. Habersberger was categorical that he could not find any failure with regard to the medical treatment of CPO Renne during his lengthy career stating that CPO Renne had been the subject of numerous medical examinations and tests during his career with the RAN. *(T.378.21-39)* He had been diagnosed and actively treated for the medical problems.

LCDR Bailey stated that CPO Renne was consistently managed over approximately 32 years in the RAN and she stated the medical treatment was in accordance with civilian guidelines and military policy *(Exhibit 40.5)*. He had not shown any symptoms of heart disease.

4.27 Stress Test

Dr. Habersberger introduced into his evidence the subject of "stress testing", a screening test. The test by the use of a treadmill with an ECG test simultaneously. The object of the test is to identify patients who are at risk. It is of significance that being overweight is not that important however he did highlight the additional medical problems of CPO Renne as being in a high risk category and it would not be unreasonable to take such a test. However the Doctor predicated his recommendation on whether the subject was to engage in a taxing or strenuous walk. In the case of CPO Renne there were no symptoms so there was probably no indication to do the test. But in an asymptomatic 50 year old probably not. However Dr. Habersberger thought that in CPO Renne's case: *(T.380.7-42)*

> *he did have these other issues and I would have thought it was probably not unreasonable,... to undertake an exercise test" (T.381.8-42)*

He went on to state that because he was on quite an active program in an attempt to help him lose weight and this was, to a certain extent, part of that program maybe. But I don't see that there was any indication to do an exercise test.*(T.381.1-7)* See also Recommendation 4, page 27 of this Report.

Having considered the question of stress testing as set out in the evidence of Dr. Habersberger I am not persuaded that such testing would be expensive and would not be either available and certainly would not be achievable within the military environment. Clearly members with symptoms of heart disease would be referred for a stress test when exhibiting symptoms. Dr. Habersberger was surprised that CPO Renne had almost completed the walk before feeling discomfort of an ensuing cardiac arrest.

I find that there is no compelling reason to make a recommendation regarding stress testing. Medical practitioners treating members should be the arbiters of such a decision. *(T.385.5-10).*

5. CLINICAL FINDINGS AND MEDICAL HISTORY

5.1 A healthy weight range for CPO Renne would be to achieve a BMI 20-27 meaning a weight range between 67.7 kg and 91 kg. Health Directive 206 – obesity clearly states that a BMI over 35 has complicated obesity – CPO Renne never had a recorded BMI over 35. However it does state that a BMI from 30-35 has additional uncontrolled cardiovascular risk factors which would require the same management and is considered to be complicated obesity. Current entry medical standards allow individuals with a BMI up to 33 to enter the ADF. A comment by LCDR Bailey was as follows:

"whilst BMI is used as a general guide to risk, it is not a perfect measure of obesity or risk and hence the ability to apply case by case flexibility depending on other risk factors is essential".(Exhibit 40.p.-2-20-22)

5.2 On recruitment in 1977 a medical examination revealed that CPO Renne was 82.5 kg (height 1.84, BMI 24.3). During the following five years his weight increased and by June 1982 his weight was 99.5 (BMI 29.3). He was advised by the medical authorities to lose weight. At that time he was placed on a weight surveillance program and by July 1983 was taken off the program. However by 1987 he had regained weight (he had not presented for a medical examination between December 1984 and April 1987) again being placed on the weight surveillance program. It is again noted in his medical record that by February 1989 he had lost weight and was removed once more from the program. By August 1989 he had again gained weight (103 kg BMI 30.4). The failure to take a fitness test, in this case some three years, is not uncommon within the RAN. *(T.p69-27-45)* LCDR Von Senden believed that there could be as much as 30% of personnel who are out of date with fitness test (RN).

5.3 1996 to 2003:

In June 1996 having undergone a seagoing medical CPO Renne was noted as suffering from impaired glucose tolerance (risk for future development of diabetes). Over this period of time he was consistently receiving weight loss advice. In June 2000 he was diagnosed with diabetes, elevated blood pressure and made unfit for seagoing service. CPO Renne was prescribed medication to control both blood pressure and diabetes. He was referred to a multi-disciplinary team for diabetes (as diabetes educator, dietician, endocrinologist and ophthalmology advice). By December 2000 CPO Renne's weight had risen to 117 kg (BMI 34.5). Notwithstanding the diagnosis of diabetes, it had been well controlled and his endocrinologist recommended continuing diabetes' management. There had been no reduction in weight, his blood pressure had been adequately managed. In February 2002 he was prescribed Xenical to assist with weight loss. Between October 2000 and February 2003 he was unfit for seagoing service. Medication was prescribed over that period to control his risk factors and diabetes.

5.4 2003 to 2009:

By February 2003 CPO Renne's weight had been reduced to 112 kg (BMI 33), risk factors controlled and he was made fit for seagoing service. His health was continually monitored and improvements were noted, remaining fit for seagoing service until March 2007. At that time in 2007, the MECRB determined that CPO Renne's cardiovascular risk factors were too high and he was made unfit for seagoing service. He was referred for rehabilitation under legislative requirements (2004).

Following a medical regimen by July 2008 he was made fit for seagoing service due to improved control of risk factors. In February 2009 he was prescribed weight loss medication. On 6 March 2009 he reported a weight loss of 10 kg over the previous fourteen months. LCDR Bailey's observation was that this was unlikely given his weight at post mortem was 110 kg. CPO Renne also reported on 6 March 2009 that he had completed the PFT without symptoms.

5.5 Dr. Bailey came to the following conclusions from reading the medical records and other documents. *(Exhibit 40.p.5)*

> *"CPO Renne's death from a cardiac event at such a young age is a loss. He was consistently managed over approximately 32 years in the RAN, in accordance with civilian guidelines and military policy. When he was closely managed he also actively participated usually successfully in his own health and achieved reasonable control of a multitude of risk factors. Civilian specialists were comfortable with his management and did not recommend major changes in management. If any recommendations to management were to be recommended, a risk assessment regarding the impact should be conducted (for example if COI was to consider anyone with a BMI over 30 was to be non deployable, how many ships would be affected and what do we do with those entering with a BMI of 33? Any additional health care above that required in the civilian community would have a significant cost impact, without a substantial improvement in morbidity and mortality likely. A further focus on more stringent management of obesity is likely to be misplaced, rather the focus should be on other more important cardiovascular risk factors, whilst continuing the current management of obesity."*

5.5(a) The report of LCDR Dr. J.M. Bailey (Annexure "D")

6. RECOMMENDATIONS

There were a number of recommendations made to the Commission of Inquiry in addition to those contained in the body of the report. They were in the written submissions of CMDR Scott-Mackenzie (Annexure "E"). Issues important to the Renne family. Also at Annexure "F" the response of the Counsel Assisting.

6.1 Recommendation 1.

CMDR Hugh Scott-Mackenzie (Annexure "E" p.24-236)

If available a doctor should be notified of an impending notification and available to attend at short notice should the need arise.

The evidence was that it was known [redacted], however the severity of her reaction was not known nor could it have been foreseen in the circumstances by the notification party.

I have found that the notification which had problems was unfortunate.

In circumstances where it is known that [redacted] notifying a medical practitioner to be on standby would be appropriate. I am satisfied that the evidence did identify a minor weakness and deficiency in the training aspect of the notification procedure. It is recognised that people react in various ways in such situations. Some reactions are severe as in the case of Mrs. Renne or in circumstances where the recipient of the notification has not any medical problems. To have a doctor on notice and available to attend at short notice to provide assistance if required. Occasions where a doctor is required to attend would be uncommon. I suggest that such a requirement is both reasonable and achievable.

6.2 Recommendation 2

It was also suggested in the submission a recommendation as to a fitness test should also apply to Reserve Members. (Annexure "E" p.24-243)

The RANPFT be reviewed having regard to the level of fitness necessary for a member to discharge his or her duties adequately and safety (sic) and with a view to extending the requirement to undertake the test annually to reserve members

There was evidence from CMDR Heffey that the fitness test itself was inadequate:

> *"The test is simply very easy to pass and to ensure that our members stay at a reasonable level of fitness, I believe that the fitness test level should be higher." (T.34.5-8).*

Counsel Assisting CMDR Barrow put forward that such a recommendation has merit. (Annexure "F"). There is a reasoned argument that – Reserve members whether on CFTS or training days serve with permanent members. Therefore Reserve members should be required to undergo a medical fitness test.

It was put that it was incongruous that there were two classes of members with regard to the fitness test. The submission concluded that such a recommendation was both reasonable and achievable.

Having considered the recommendation I am not convinced that it is reasonable or achievable with regard to Reserve members. The situation is worthy of debate and review to determine whether such a radical change is reasonable and achievable or is necessary. In addition the standard of fitness referred to by CMDR Heffey is solely a personal view. On the material before me, I am unable to make any determination as to the level of fitness that is required.

6.3 Recommendation 3

The syllabus for the notification procedure should be reviewed and greater emphasis given to role play?

This recommendation has been specified in paragraph 4.20 of this report.

6.4 Recommendation 4

Joint Health Command (JHC) give consideration to the introduction of exercise stress testing targeted at members at high risk of heart attack.

Dr. Habersberger did not support the introduction of exercise stress testing for all members however he did support introducing the test targeting members at risk of heart attack providing there was a diagnosed problem. *(T.383.10-15).*

However Dr. Habersberger was also sceptical with regard to its application of those exhibiting "at risk" factors. *(T.383.20-27)*

On the evidence, clearly CPO Renne may well have benefited from a stress test although there are occasions when it is not conclusive. In addition CPO Renne being fifty years of age with a number of factors was asymptomatic. The mass testing of members with some or all of the symptoms would not be reasonable nor would it be readily achievable without specific equipment being available. There would also be a significant cost in such an exercise. The present system whereby those exhibiting symptoms of heart disease are tested is sufficient.

Recommendation
Medical Fitness Advice Form PM101 (MFAF PM101):

There was evidence during the hearing with regard to the replacement of the MFAF PM101. The recommended replacement was a computer based system however the subject of such recommendation has currently been implemented on a trial basis. The ability to access such a record would be of immense benefit. No doubt the question of medical-in-confidence is being appraised during the trial. The ability for commanders and others to make an informed decision regarding the member's suitability to participate in a particular activity would be of significant value.

I urge that the electronic system is implemented when the technology (software) is available. I am cognisant that there are problems associated with a complete electronic medical record. I do however understand that the provision of Medical Fitness Advice (PM101) is possible and is reasonable and achievable.

6.5 Gratitude of the Renne Family

The written submission of CMDR Scott-Mackenzie (Annexure "E" p.26/27 para.266-267) presented the sentiments of the family towards the whole of the Commission of Inquiry process. This is a result which is the paramount aim and objective of a Commission of Inquiry.

(i) The family concluded that no blame was attached to the RAN or any individuals.

(ii) The acknowledgement of the high standard of medical care received by CPO Renne over many years.

(iii) The family also acknowledged their recognition that the event could have happened at any time or place.

(v) The recognition that the COI was carried out with a thoroughness which successfully answered their questions. In addition the COI process would be of assistance in achieving closure for the family.

Sentiments of Mrs. Deborah Renne and family.

Statement read into evidence by CMDR Scott-Mackenzie on behalf of Mrs. Deborah Renne: *(T.p.398).*

> *"I would like to express my appreciation to the Defence Force for this Inquiry into Russell's passing. For my family and myself, it has answered questions and given us a bit more insight on what happened on 8 May 2009. It is comforting knowing Russell was happy and joking, and he was with friends and workmates that morning. I know all was possibly done to revive him and I will be grateful to each person who was there to help him. I would also like to express my appreciation to the Navy. They have been absolutely wonderful in looking after myself and family. A very big thank you to CMDR Bob Heffey I know it was very difficult for you to tell me about Russell. I hope you never have to deliver news like that again. I would also like to thank you for your ongoing support of the family. To Chaplain Ed, thank you for your support and help, and the wonderful service you delivered for Russell. I had people coming up to me after the funeral saying it was one of the best ones they had been to. It was done the way Russell wanted it. He wanted people to laugh and I think we achieved that. To CPOPT June Cunningham, you are a great sailor, wonderful person and a terrific friend. Thank you for all you did for Russell and for all that you have done for the family. I know there are many more people who helped him one way or another on 8 May and to them I say thank you. To DCO, I would also like to thank for their help and ongoing support, especially Jodie, who I now consider a friend. Jodie has helped me so much and is very easy to talk to and she is a great listener. I am so grateful that there is a DCO, as they do so much to help families. Keep up the good work. Finally, I would like to say that the Navy is one big family when one of us is in trouble or need of help. There is always someone there to help. There is always someone there to help or a shoulder to cry on. Thank you once again to everyone who has helped and supported us over the last 17 months. I will finish off by letting Russell have the last word. He would love that. Our home has swinging doors and you are welcome to come in for coffee and chat any time."*

AND FURTHER

Submission of CMDR H.A. Scott-Mackenzie, RFD, RANR p.27-267.

> *...The family extend to the President, Mr. Cullen, and counsel assisting, CMDR Barrow and LTCOL Barker, their gratitude for the thoroughness in which the Inquiry has been conducted. Many questions have been answered and the process will assist to bring closure for the family.*

7. CONCLUSION

7.1 Adverse Findings

I have no reservations in finding that based on the evidence before the Inquiry, there was no material that would substantiate any adverse findings being made against CPOPT J.L. Cunningham. The decision is based on all of the evidence with regard to the element of risk. As previously stated CPOPT Cunningham has a plethora of experience. In addition to the health of CPO Renne being known to her, there is the additional factor of flawless planning, even though the email has uncertain origin with regard to its distribution. However I am satisfied that the content of the email was devised by CPOPT Cunningham.

The step taken by me to have the Command Occupational Health and Safety Manager, Mr. Russell Dean Power *(Transcript p.250),* legally represented following his appearance before the Commission of Inquiry was due to the uncertainty and confusion of his original testimony and was justified. The step was taken following consultation with Counsel Assisting and was the appropriate action given that there was a possibility that an adverse finding may be made and was predicated on what appeared to be uncertainty on his behalf. When Mr. Power returned to the Commission hearing to resume his evidence, a statement had been prepared and the anomalies were dispelled. At the conclusion of all of the evidence I concluded there would not be any adverse finding made against him. I am satisfied his initial evidence was affected by a nervous episode and nothing more. I am satisfied that the action was reasonable and unavoidable.

7.2 Evidence was given during the Commission of Inquiry that there was a high percentage of members of the RAN who avoid the fitness test for a number of reasons. Both CMDR Heffey and LCDR Von Senden alluded to the problem. Whereas one of my findings was that CPO Renne had not been in date with the test for approximately four years, I am of the view that to make any recommendation would be outside my TOR. I will suggest a review of the "fitness test" as to the appropriateness of the testing and its difficulty. In addition a review of the number of members in all three services who are not in date for the IR fitness test.

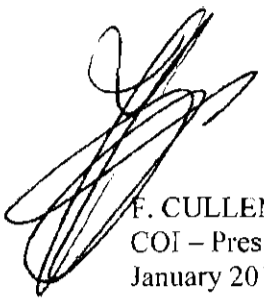
7.3 That CPONPC Russell Bruce Renne be commended for his 32 years of loyal, dedicated and distinguished service to the Royal Australian Navy.

7.4 That CPOPT J.L. Cunningham, LSMT Justin Little, Mr. B. O'Connor and LSPT Weston be commended for their actions in attempting to resuscitate CPONPC Renne for an extended period of time prior to the arrival of the paramedics.

7.5 That SGT [redacted] and Ms. [redacted] be commended for their services to the Commission of Inquiry together with the two members of the RAN POWTR [redacted] and LSWTR [redacted] who gave excellent support.

7.6 That a copy of the Commission of Inquiry report, whether or not made public by the Minister be provided to Mrs. Deborah Renne as next of kin.

7.7 The Commission of Inquiry does not recommend that administrative action be taken against any potentially affected person.



F. CULLEN
COI – President
January 2011