

**REPORT OF THE COMMISSION OF INQUIRY  
INTO THE DEATH OF CORPORAL J.R. GOSS  
MONASH UNIVERSITY REGIMENT  
CLOTHING STORE, WHITON STREET,  
MOUNT WAVERLY, VICTORIA  
ON 31 JULY 2007**

## PREFACE

The President of the Report of the Commission of Inquiry concerning the death of CPL J.R. Goss, Mr P.A Willee, RFD, QC, forwarded the Commission's report to the Appointing Authority, Air Chief Marshall A.G. Houston, AC, AFC, on the 20<sup>th</sup> of February 2009. 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. Some material has not been published because publication would be an unreasonable disclosure of sensitive personal information. These parts are not material to the findings or recommendations in the report. Where there are multiple amendments within a paragraph, the number will follow the paragraph number in parentheses.

**Table of Amendments**

Title		Not published for reasons of unnecessary disclosure of personal information.
Paragraph	1	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	9 (6)	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	10	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	12.e.	Not published for reasons of unnecessary disclosure of personal information.
Group Title		Not published for reasons of unnecessary disclosure of personal information.
Paragraph	13	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	15	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	16	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	18	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	19 (4)	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	24	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	39	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	43. b.	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	46	Not published for reasons of unnecessary disclosure of personal information.

Paragraph	47 (7)	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	48	Not published for reasons of unnecessary disclosure of personal information.
Paragraph	93 (2)	Not published for reasons of unnecessary disclosure of personal information.
Annex		Not published for reasons of unnecessary disclosure of personal information.

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**Appointment of Commission of Inquiry**

1. On 18 October 2008 Air Chief Marshal A.G. Houston AO AFC, Chief of Defence Force (CDF) by instrument of appointment<sup>1</sup> appointed a Commission of Inquiry (COI) constituted by me for the purpose of inquiring into the circumstances surrounding the death of Corporal (CPL) John Richard Goss (the deceased) in accordance with the instrument of appointment and its associated terms of reference (TOR).

**TOR**

2. The TOR<sup>2</sup> require the COI to obtain evidence and provide a report to CDF detailing with reasons the findings of the COI as to:
  - a. the circumstances surrounding the death of the deceased, 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 actions and decisions taken by Defence personnel which were materially relevant to the deceased's death, both prior and subsequent thereto.
  - c. Any weakness or deficiencies (isolated or systemic) in Defence systems, policies, equipment, practices, procedures and training proximately associated with the deceased's death.

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<sup>1</sup> Annexe A Instrument of Appointment

<sup>2</sup> Annexe B TOR

## COI INVESTIGATION

3. The COI sat on 6 days in open session at the Defence Plaza in Melbourne from 12 to 21 January 2009 assisted by Colonel G. Hevey as Counsel Assisting (CA) and with Lieutenant P. Billings RANR appearing as Counsel Representing (CR) on behalf of CPL Goss's representative, Ms Goss.
4. Recorded Evidence<sup>3</sup> (based in the main on witness statements obtained by CA and interviews conducted by the Inquiry Officer (IO)) was received orally from witnesses. In addition 34 documents were tendered through those witnesses or directly by CA as marked exhibits (some in more than one part)<sup>4</sup>. After the hearing was completed a number of supplementary documents (SD) were obtained at the direction of the COI by CA. All SDs were shown by CA to CR as they became available with an indication of their provenance and the way in which reliance was intended to be placed by the COI on such evidence together with an invitation to make any further submissions which CR wished, or indicate further investigation or, if necessary, the re-convening of hearings. In every instance CR's response (after seeking further instructions) was to agree with such evidence being used by the COI in the indicated manner and to express the view that it was unnecessary to reopen the hearings to deal with the matters covered by such evidence.

### Scope of the COI inquiry

5. The scope of the COI into a death, thought at the outset as likely to be from natural causes, was quite limited and seemed to require few inquiries outside the range of personnel identified by the IO. Nonetheless issues were explored with a tighter focus attuned to statements taken by CA from witnesses. Where appropriate these statements incorporated information in the transcript of records of interview (ROI) taken by the IO. Statements (but not the ROI) were read into evidence by CA, adopted by the witness, and both Statement and ROI for each witness were tendered as an exhibit. As it turned out extraneous inquiries became much more frequent both during but particularly after the hearings had been

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<sup>3</sup> Annexe C Transcript of Hearing (TOH)

<sup>4</sup> Exhibits 1-38 to the TOH.

completed. In the main these related to the whereabouts of CPL Goss's unit medical records (UMR) in the period of about six months between his arrival at Monash University Regiment (MonUR) and shortly before his death.

6. Exceptions to this process occurred where factors such as the difficulty of obtaining evidence, convenience, cost, and uncontentiousness of the evidence or its lack of relevant weight, required the COI to discontinue attempts to obtain the evidence or receive it without adhering to strict forms of verification by oral evidence or weakening the basis of any necessary finding. Nevertheless, the civil standard of proof was used throughout and where warranted and appropriate the Briginshaw standard was applied<sup>5</sup>.
7. No steps were taken to liaise with the Coroner because the Coronial Inquiry had been certified as complete by notification to that effect on 5 November 2007. That notice included the autopsy report (Exhibit 2). The finding of the cause of death was clear and apparently unlikely to be controverted. Of course the COI remained open at all times to reconsider that situation if even a scintilla of evidence pointed to a different conclusion. In fact, except for one ancillary matter which did not bear on the ultimate cause of death, the autopsy results and findings were confirmed by the opinion of the COI expert cardiologist Dr. P. Habersberger.

## **Outline of Evidence**

### **Personal History**

8. The relevance of the deceased's early personal history to the circumstances of his death being slight, no evidence was obtained concerning it. His medical records<sup>6</sup> disclosed that he is recorded as having been born on 04 September 1961. He enlisted twice in the Army. First for 6 years and 2 months from June 1980 until August 1986; and second for nearly 5 years from 27 August 2002 until his death in on 31 July 2007.<sup>7</sup> He held the substantive rank of Corporal with seniority to date 23 November 2004. At the time of his death CPL Goss was a little under

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<sup>5</sup> Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 and Anderson v Blashki [1993] 2VR 89 at 96

<sup>6</sup> Exhibit 13 Vol 11. They also recorded 11 and 14 Sep 61 as his DOB because the later records opt for 4 September 1961, a finding that such was his correct birth date was made.

<sup>7</sup> Ibid Vol 11

seven months into his posting from Kapooka to MonUR preparing to attend subject 1 for Sergeant, a course of instruction due to commence in September 2007. In the opinions of his immediate supervisor and of Captain J.R. Eccelston, the unit adjutant, there was no doubt that he would have passed that subject with little difficulty. Captain Eccelston's description of CPL Goss was typical of every witness who was called and knew him at the time. He described him as: "... a solid, hard-working guy. ... My observation of him was that he was a good soldier with a lot of life experience. He was perfectly positioned as a CPL to assist the junior reserve soldiers in developing their understanding of the army and what was expected of them. While CPL Goss was a large guy, I would never have described him as being fat. He was probably overweight, but was of a solid and strong build. I understood he was doing a fair bit of weight work."<sup>8</sup>

9. Ms Goss married the deceased on 27 November 2004 and bore him one child, a daughter on . Ms Goss had known her late husband for 14 years prior to his death and was able to describe his previous marriage to from whom he separated in about 2003, and was divorced in February 2004. CPL Goss also had three children from his first marriage, and the youngest of whom was 16 at the time of CPL Goss's death. A strong interactive relationship was evident between all three older children and Ms Goss.
10. Ms Goss described the features of the CPL Goss's family life as being: His devotion to his daughter the sporting interaction with his sons as well as his own enjoyment of fishing and golf; and really active home husbandry. He made constant and long term friends to whom he was extremely loyal.
11. That these traits combined to make CPL Goss a most popular man both within and without the Army was attested to by the attendance of two to three hundred mourners at his funeral. Flight Lieutenant McPhail the military support officer from DCO said: "*It was probably the largest funeral I've ever been to. It was incredibly well attended by John's family and friends. He was obviously a very popular man. And it was very moving and it was very beautiful.*" In the

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<sup>8</sup> Ibid p 332 ln 22, p 336 ln 4. Captain Stearn described him as: ... a likeable sort of a soldier who seemed to get on well with everyone. He was a respected member of the unit. Transcript p125 line 29

memorial area at MonUR where a large rock bears a commemorative plaque for General Monash and smaller rocks bear plaques commemorating the members of the unit who have died during their time with the unit; a plaque recognising CPL Goss has been added. MonUR also named their military skills shield after CPL Goss. Members of the family were invited to a unit function and to the presentation of the Goss Shield in 2007. Yvette Goss also presented the Goss Shield in 2008.

12. Ms Goss referred to comparatively few incidents relating to the deceased's ill health. These included:
  - a. Complaining of chest pain and shortness of breath one night either shortly before or around the time he was rejoining the Army (August 2002) for which he was admitted overnight to the Northern Hospital at Coopers Road, Epping. A number of tests were conducted including an electrocardiogram and blood tests. CPL Goss was not referred for any form of post-admission treatment after his discharge early the next morning. The episode was ascribed to stress associated with his marriage break-up.
  - b. Complaining of bloat from time to time after drinking too much coke-a-cola.
  - c. Complaining of nausea and being hospitalised at Puckapunyal from 10 to 12 February 2007 while at camp with Monash University Regiment.
  - d. Complaining of a sore throat in May of 2007 for which he received palliative treatment.
  - e. Being aware from the autopsy that John apparently had a heart attack about 10 to 14 days before he died of which she had no knowledge and which she was sure CPL Goss did not know about either. Ms Goss cited two incidents which might have produced excitement and physical activity occurring about that time neither of which produced any symptoms associated with a heart attack having occurred. That was a birthday party of                      at which

she and her father used a jumping castle and an attendance at a passing out parade for his niece<sup>9</sup>.

- f. That he had been in the habit of taking Zantac sometimes daily for heartburn for a few years.
- g. Being aware that John had high cholesterol. For which he was taking Lipitor before he joined the Army; that he had been taken off Lipitor at some time that she could not remember and a vague memory that he was put back on Lipitor while at Kapooka, of being unsure if he was still on Lipitor at the time of his death. Recollecting that after his death she found, some of boxes of Lipitor in the bathroom the contents of which (if any) were not checked before being thrown out.

#### **Immediate Circumstances Accompanying Death (Incident)**

- 13. On the morning of 31 July 2009 some of the full-time staff at MonUR had arranged to attend at a local civilian Gymnasium as was their practice. At about 08:20 (as he then was) called in at his clothing store office at MonUR to change clothing before running to the Gymnasium.
- 14. As he passed the entrance to the clothing store he called a greeting to CPL Goss and continued to his own office. He then heard the thud of someone falling accompanied by the sound of a chair moved by the impact. He immediately entered CPL Goss's office where he found him lying on his stomach about half a metre from his desk with his feet toward the door and the chair pushed back from the desk.
- 15. CPL Goss appeared to be convulsing and was thought by to be suffering an epileptic fit which the warrant officer had seen several times before in other people. After rolling CPL Goss, who was then breathing heavily, into the recovery position and clearing his airway (which took less than two minutes) the

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<sup>9</sup> The lack of symptomatology accords with the expert medical evidence questioning the occurrence of a heart attack 10 to 14 days earlier see transcript p 239 ln. 38 and paragraph 90 infra.

warrant officer in less than 10 seconds ran a short distance to his office to obtain his telephone and Travelex directory. He then ran a short distance into the hallway to shout for assistance upstairs where he thought some Naval Officers might have been at work, before telephoning Victoria Barracks Health Centre (VBHC). He did this to get medical assistance as to what he should do next, believing that all he had to do was to get CPL Goss to the VBHC after he regained consciousness from his fit.

16. Upon being connected and informing the receptionist of what he believed to be the position, he was asked to hold on while a doctor was found to speak to him. After he was left on hold for what seemed to him an eternity but was probably only about 10 seconds, he hung up. Noting that CPL Goss's breathing had become laboured, and that he was unable to detect his pulse immediately commenced first aid and cardiopulmonary and mouth-to-mouth resuscitation (CPR) a procedure in which he was very experienced. After the first breathing iteration of that procedure he pulled the fixed line telephone towards him put it on speaker function and dialled zero for an outside line and then triple zero for emergency services before resuming CPR.
17. He continued this and from time to time shouted at the speaker telephone for assistance for something under ten to fifteen minutes without receiving any apparent response. He then paused to listen to the telephone and hearing a message to dial double five spoke with an emergency operator all the while continuing with CPR until relieved by a fireman who took over that procedure at about 09:00.
18. At no time did CPL Goss show any sign of life. continued to work in his office conscious of the ambulance officers attempting to revive CPL Goss and eventually hearing that it was time to stop some 20 minutes after they commenced attending to him. Thereafter he continued to perform administrative tasks relating to recalling key personnel to attend at the unit and the preparation of NOTICAS. He was in a state of mind he described as working on overdrive,

automatically in accordance with his training. Eventually he was driven home by a colleague at he believed 16:00.

### **Fire and ambulance service officers**

19. Leading Firefighter Paul McIlfatrick one of the Fire Service officers who attended to the deceased with ambulance personnel after their almost simultaneous arrival around 09:00 on the morning of the incident, in response to an emergency call received at about 08:50 or shortly thereafter, gave further evidence confirming account of the latter stages of his administration of CPR. He said that his observations of showed that the application of CPR being used accorded with his training and was appropriate and adequate; although was obviously tiring from the effort required. Accordingly, while the ambulance officers set up their defibrillating equipment he and his colleague took over from performing CPR in two-minute rotations. This involved managing airways, ventilating CPL Goss with a bag valve mask and compressions. During his attendance he observed no sign of life in the deceased. Once the ambulance officers had set up their equipment, they took over management of the airways. The Leader and his colleagues continued chest compressions on two-minute rotations under the instruction of the ambulance officers for about twenty minutes, until instructed to discontinue.
20. William Brookes a qualified mobile intensive care ambulance paramedic told the COI that members of the crew of the first ambulance to arrive were attending to the deceased at the time of his arrival at 09:02. He obtained certain information about him from an unidentified Australian Defence Force (ADF) member present at the incident concerning increased cholesterol, epilepsy and obesity and of the deceased being slumped over his desk still breathing when found. He took that information in good faith but agreed that it is possible that his note of it is not completely accurate.
21. On arrival he observed that CPL Goss was being ventilated with one hundred percent oxygen but had no spontaneous breathing of his own, no palpable pulse and that the basic electrical output of his heart was of a type known as

electromechanical dissociation. That is to say, that although there was some sort of electrical activity, his heart was actually not responding to the electrical activity it was giving out, and not producing any blood flow to the brain. Apart from the CPR treatment CPL Goss was being given, the witness in accordance with standard practice with patients in this particular rhythm administered adrenalin in order to try and improve circulation to the heart.

22. After 17 minutes of monitoring what the witness described as “*Query fine ventricular fibrillation, or Query whether it's just some output from another area of the room,*” appeared on the monitor attached to the patient and the appropriate defibrillation was applied twice without result.
23. At 09:30 after (at least) 30 minutes of resuscitation, the deceased not having responded to treatment and after consultation with all other paramedics present Mr. Brookes pronounced that it was appropriate to cease the resuscitation procedures in accordance with Metropolitan Ambulance Service and Rural Ambulance Victoria clinical practice guideline, version 4, CPG: A05O1<sup>10</sup>. Paragraph 2 of that document outlines the circumstances in which ambulance officers are permitted to desist from continuing resuscitation attempts reads as follows:

*“An adult patient 18 years or older who, after 30 minutes of advanced life support resuscitation, including advanced airway management, defibrillation and/or adrenalin, has no return of spontaneous circulation, is not in VF or VT, has no other signs of life present, such as gasps or pupil reaction and hypothermia or drug overdose are not suspected.”*

24. The COI finds that first aid and CPR administrations to the deceased including his attempts to obtain further assistance were appropriate and performed with the utmost of his skill and ability.

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<sup>10</sup> Circumstances in which Resuscitation Efforts may be ceased, attachment to Exhibit 19A

## Notification of Death and Bereavement Activity

### Legal Requirements

25. The military requirements of notification of death current for the incident are contained in *DI(G) PERS 11-2 of 18 DEC 01*, (Exhibit 10) as amended by *Chief of Defence Force Directive On Notification Responsibilities When A Member Becomes A Casualty 29/2006 of 11 November 2006* (the Directive) which was included in evidence after the closure of the hearings as an SD, GOSSDOC 01. Both documents have now been superseded by *DI(G) PERS 11-2 of 20 May 2008* (Exhibit 34). The provisions of Exhibit 10 (as amended by the Directive) which are relevant to the circumstances of the incident are as follows:

#### **CDF INTENT**

1. **Purpose.** The purpose of this directive is to detail my requirements for the formal notification of Australian Defence Force casualties to the Primary Emergency Contact, Next of Kin and other approved persons whilst Reference A [DI(G) 11-2] is being revised.
2. **Method.** 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. Notification Teams will notify the Primary Emergency Contact, the Next of Kin and other approved persons. ... [and] ... 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.

3. **Endstate.** 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.

#### **DEFINITIONS**

4. For the purpose of these instructions the following definitions apply:

- a. **Casualty** - A casualty is defined as an ADF (including Reserves on duty), member of the Australian Cadets while on an approved activity 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.
- b. **Notification Team** - The composition of the notification team will be situation dependent and will be activated by the Defence Community Organisation Headquarters. The team will consist of appropriately skilled and trained personnel, who will carry out the notification task to the Primary emergency Contact, Next of Kin and other approved persons. The team will usually consist of a Commanding Officer, or delegate of at least MAJ (E) rank, and an ADF Chaplain of the same religious denomination (where possible) as the member. Where appropriate, a representative from the member's unit or workplace should be included with the team. The military officer and the Chaplain will normally be of the same Service as the casualty.

- c. **Primary Emergency Contact**- The person, as identified on PMKeyS, who is to be formally notified first in person by the notification team. ...

## IMPLEMENTATION

### Responsibility

5. Notification is a command responsibility and rests solely with myself and the Service Chiefs. Involvement of other Services or Groups in the notification process is not to occur except at the express direction or request of the relevant Service Headquarters. The Defence Community Organisation has a central role in support of the chain of the command to activate the Notification Team/s and ensure that notification is performed quickly, professionally and in a coordinated manner. ....

8. Advice of Casualty. In the event of casualties occurring , normal NOTICAS procedures are to be followed in accordance with Reference A. ...

### Notification Teams

1. The primary role of the Notification Team is to promptly, compassionately and formally advise, in person, the nominated Primary Emergency Contact and/or Next of Kin of the condition of the member. ...

26. Reference A (of the Directive) is of course the original *DI(G) PERS 11-2*. The sparse words of paragraph 8 of the Directive require some examination in their application to the original *DI(G)*-Exhibit 10 to find out exactly what parts of it are applicable after the amendment and just which NOTICAS procedures survive to be followed or implemented.

27. Paragraph 3. h. of Exhibit 10 defines NOTICAS as being:

3.h **Notification of casualty (NOTICAS)**. NOTICAS procedures are carried out to notify specified authorities and individuals of the illness, injury or death of a member in accordance with this instruction. In all

NOTICAS procedures the two most important elements are accuracy and speed. Accurate and prompt notification reduces the risk of unofficial or false information being obtained.

28. Paragraphs 4. and 24.a. require the CO of the reporting unit to determine the classification of the casualty which in this case is a fatal casualty according to the definition in paragraph 5. a.

5.a. **(FATALCAS)**. The member is reported as a FATALCAS when there is definite evidence of death, ... .

29. In turn, this triggers the reporting requirements of that classification. The reporting requirements not superseded by the Directive appear to be covered in paragraphs 10 to 24 inclusive. In particular, these include the documentary requirements contained in paragraph 23 Annexe C (casualty notification check list) and 24 b. Annexe A (FATALCAS) signal format; the follow up procedures such as the confirmatory report (Paragraph 41) and the letter of condolence paragraph 46.

30. Sergeant Crawford both drafted and sent the FATALCAS in respect of the incident (Exhibit 24) after it was approved by Major Davison who indicated that he had previous experience with NOTICAS but not FATALCAS. He said that he knew where to look to find out what he needed to do. Sergeant Crawford said that she did not experience any difficulties on the morning with her task. They both seemed to agree that it had been accepted by MonUR's superior headquarters as a job well done from the administrative side. Major Davison remembered that Major Mary Rose Mulvaney from RMC complimented the unit on it.

31. It would appear that none of the addressees who received it faulted the document and until CMDR Walters gave evidence (paragraph 63) no-one seems to have noticed that it had a significant defect: One of the information addressee required, the Local Area Health Service for Victoria was wrongly described as JHSA MACLEOD instead of AHS-VIC. Since the FATALCAS was never received at Army Health Services -Victoria (AHS-VIC) it may be assumed Joint Health

Support Agency Macleod (JHSA MACLEOD) either did not receive it or if it did no-one there saw fit to redirect it to its correct address. Commander (CMDR)Walters's evidence pointed to the seriousness of this error in that it deprived the Local Area health service from registering an interest in the autopsy, having access to it and the means of determining if there was any causative factor that Defence could have prevented or needed to address. Further, it prevented the closing off CPL Goss's medical records.

32. The COI finds that there was a significant defect in the FATALCAS signal sent in respect of the incident in that an information addressee: The Local Area Health Service for Victoria was wrongly specified as JHSA MACLEOD instead of AHS-VIC.

#### **Actual Notification to PEC**

33. Ms Goss described the circumstances of the notification to her of her husband's death as happening as she was parking her car at the Ruthven railway station. She received a telephone call on her mobile. A paramedic identified himself and asked if she was the wife of John Goss and told her that he had some bad news that about an hour earlier John had suffered a suspected heart attack and they had been unable to revive him. She asked him to repeat himself, because she was unable to believe it. He did so in a matter-of-fact manner. He asked her to come down to MonUR and if she wanted a taxi arranged.
34. Ms Goss said that although she was shocked, it was better to find out as she did rather than at work. She was only five minutes drive from her sister-in-law's house, able to drive there and receive support from her immediate family.
35. There is no official ambulance service guideline or particular requirement directing Mr. Brookes to notify the next of kin and there would be no sanction if he did not carry out that task. Nevertheless, the practice of the paramedics doing so is generally adopted throughout the ambulance service and the situations in which to do it or not is learned from experience and from other paramedics. In this case he said he felt compelled to offer and to actually inform Ms. Goss of her husband's death to avoid the possibility that Ms Goss might be misinformed about

the situation and to answer any questions she might have. He was also motivated to do it to alleviate some stress on the deceased's work colleagues who he described as clearly distressed and to make sure that Ms Goss was one of the first people notified rather than her being notified some hours later, unaware her husband had passed away. One of the staff at scene produced a mobile phone and a list of contact numbers. He was told that CPL Goss had a wife, and she was at work or home and he made the call to her introduced himself and used words to the effect of: *"I am so sorry to have to inform you that your husband appears to have had a heart attack and, despite our best efforts, we were unable to revive him"*. He had noted on the case sheet that she would get a relative to drive her to MonUR.

36. MonUR's Chief Clerk, Sergeant (SGT) P. Crawford described the notification process not as one where the members were hampered by distress so much as by the ambulance officer's actions evolving so quickly as to prevent the members of the Unit's full-time being given a choice in the matter. That is, while they were attempting to weigh up such considerations as achieving speedy notification to Ms Goss without alerting her to her husband's death before personal contact could be made in accordance with the requirements of the Exhibit 10. This included weighing up such considerations as finding her workplace address, without using either her workplace or mobile telephone numbers or those of the deceased's eldest daughter. As SGT Crawford put it, notification was supposed to be by personal home visit but *"we don't have a definitive list of where everybody's husband and wife works. ... So the DI(A) reads like a home visit, ... you know an Army car pulls up out at the front. The Chaplain, DCO, CO get out. ... but in the Reserves our CO was-may be away ... and how do you get DCO and the Chaplain and the CO all together at the same time within a small time frame?"*
37. As it happened that was exactly the incident situation. MonUR's Commanding Officer Lieutenant-Colonel A. Smith was overseas on business, its second in Command Major S. Davison was at Monash University studying and its adjutant Captain J. Eccelston was skiing at Mount Buller in Victoria, the training Warrant Officer was at an appointment away from MonUR.

38. Major Davison said that he spoke to one of the ambulance officers and learnt that they had already telephoned Ms Goss and advised her of her husband's death. He was in two minds about this. While he knew that notification was supposed to occur through a uniformed officer and a chaplain, he also knew MonUR would have been unlikely to carry out notification in a timely fashion. In any event, it was a fait accompli, and there was nothing he could do then to change the situation.
39.                                was on his own admission the person who supplied the mobile number to Mr. Brookes. He did so in the circumstances outlined in paragraph 32 above and after requesting that they wait until the Chaplain who was on his way arrived and the ambulance officers telling him it was standard procedure, apparently quite oblivious of the mandatory nature of the and in a state of shock.
40. Flight Lieutenant FLTLT McPhail, the military support officer assigned by DCO for immediate family bereavement support, was surprised by the manner of the notification of CPL Goss's death because it was contrary to Defence Instructions familiar to her as a result of training notification teams; and because Ms Goss travelled to MonUR under her own steam. However, she conceded that the relevant DI(G) extant at the time appeared to be conceived in the context of deaths occurring in combat or operational circumstances separated from the emergency contact (EC) by distance, or the absence of rapid and secure communication facilities connecting military communications with those of individual civilians rather than a death from natural causes in a military establishment in a large city. The witness agreed that some expansion and correction to the DI(G) to deal with this type of situation would be appropriate. Her major concern was the inability of the Defence system to adequately meet its policy of timeously notifying the casualty's EC.
41. The COI thinks this is a sensible suggestion and worthy of consideration but makes no recommendation in relation to the matter because of the complex nature of competing circumstances and the unequivocal way in which the policy intent of the directive is expressed. There was ample opportunity to consider this at the

time exhibit 34 was being drafted (although perhaps not in these circumstances) and the policy intent seems to be unchanged.

42. Captain R. Stearn, an officer attached to the unit as an instructor, (a Reservist but formerly a member of the Australian Regular Army of 27 years service overall) was also working at the unit in his civilian employment with DMO as a matter of convenience. He was also concerned by both the method of notification and also initially the attendance of the family at the unit to view the body of the deceased. He revised his view of the latter event when he realised how much benefit the Goss family derived from it. He put the matter in these terms: *"I sort of regard it as being a badge of honour that the Defence Force should look after its member and inform the next of kin themselves. I've got to say that I was preparing myself to do that particular task myself in lieu of or in the absence of any other information. I was quite taken aback when I found the ambulance had rung the next of kin. I was further disturbed by the family's wishes to attend to unit to view the body of the partner, because that's something that just wasn't in the instructions and something you just don't think about. ... However, ... from personal experience, I've realised that it was a good thing for the family to go and do, if that's what their wishes were, and I was quite prepared to accommodate that, and I was not prepared to accommodate the idea of ringing them up and saying, 'Don't come because it's not in accordance with Defence Instructions.' I couldn't do that."*

43. The COI finds that:
- a. The notification breached the Directive in that notification of the PEC, Ms Goss, was carried out by a civilian paramedic when the only agency permitted to perform that task by the directive was a duly constituted ADF notification team.
  - b. In the prevailing circumstances at the time of the breach including whether he knew of the provisions of the directive, his emotional state of shock, the lack of the immediate presence at the scene of the incident of an commissioned member of full-time staff and the compulsion felt by Mr Brookes the occurrence of the breach is understandable.

- c. Despite the breach, most of the primary purposes of the expressed endstate of the Directive were satisfied because the notification to the PEC was timeous, accurate, and more satisfactory to Ms Goss, who preferred being notified while not in her workplace and welcomed the access to the deceased's body in the workplace so soon after his death.

### **Bereavement Process**

44. FLTLT McPhail gave detailed evidence of a satisfactory completion of all the tasks of the bereavement process including the provision of Defence relationship support, counselling, funeral arrangements, and the resolution of matters relating to the Ms Goss's financial entitlements in part due to her intervention.
45. Andrew Pickard was the social worker appointed by DCO together with FLTLT McPhail as Military Support Officer, to provide bereavement support (including funeral and estate assistance) to the Goss family. He described the matters attended to by the notification team and the way in which the team members meshed cooperatively with the family members who so readily expressed their appreciation of their assistance in achieving the objects of the Directive. That appreciation was repeated by CR at the request of Ms Goss (who also expressed it on her own account in evidence)<sup>11</sup> as a preface to his questioning of both these members of the notification team and again at the request of the family. He was at pains to thank them again as well as Chaplain Ted McMillan<sup>12</sup>, and the other members of MonUR for their support and assistance and for the way in which the funeral was arranged and conducted.

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<sup>11</sup> Defence were terrific in helping to pay the funeral costs and the associated expenses such as the cost of the plot. I am extremely grateful for all that they did in this regard. John's financial entitlements from Defence were paid very quickly and this was appreciated. However, the MSBS entitlements seemed to take forever. While it was only a couple of months it caused a lot of frustration in having to deal with the bureaucracy at that difficult time. FLTLT Michelle McPhail was of enormous assistance. I am very thankful for everything that she did to ensure that the payments were made

<sup>12</sup> The whole hearing of the COI was suffused with the esteem in which Chaplain McMillan was held generated by his skilful and effective interventions in the bereavement process.

46. was greatly affected by his involvement in CPL Goss's death<sup>13</sup>. He described his reaction in the following way: *"... it's still quite raw, as you can see, .... With someone less tough maybe it affected them a lot more than it affected me, and I'm affected, don't get me wrong. But, you know, there's been nothing [by way of follow up after the first consultation] from the psychologist or from anybody else ... with me. .... I won't say I was coping poorly with it. I wasn't coping - you obviously think about the situation quite a lot. So - but did I seek? [Additional counselling] No, I didn't seek. Would I seek [it]? No, I wouldn't seek [it]. ... I can't answer if I'd feel better or feel worse [if a psychologist had made a follow up visit] .. I'm talking more for procedures that I would think that should be in place. If you go to deployment you get follow-up and three months later you get a follow-up and then if you need any further, they mark it in your record for another follow-up. Now, for a situation what's occurred, I would feel that there should be a follow-up earmarked in that person's - whether it be me or someone else procedural wise. Would I go? I don't know, but ... it would be nice maybe if they contacted me - would have been nice."*

47. attitude to the lack of follow up counselling (particularly by the psychologist) is understandable but somewhat tempered by the evidence of other members of the full-time staff. SGT Crawford, the Unit Chief Clerk, described the visit by the Chaplain, DCO staff, and psychologist both on the day and later, as an initial group and individual counselling session followed up by the Chaplain about a month later spending more time with than anyone else, and returning yet again to speak with him before he went overseas on long service leave at the request of the adjutant. Captain Eccelston said that situation was the subject of special visits to the unit from time to time by Chaplain McMillan with whom all personnel had a much better affinity than the psychologist. Captain Eccelston actually asked the Chaplain to make those visits to each member of the full-time members as a cloak for the satisfaction of the real need perceived by him that required closer monitoring over a

<sup>13</sup> CAPT Eccelston described him on the late afternoon of 31 JUL 07 as: 'pretty shaken up'. SGT Crawford described him as very affected, feeling that he did not do enough on the day and questioning himself as to whether he had done everything that he could. That he has better days than others and he is very sad.

longer period of time. The Commanding Officer spoke of his previous unit experience where a death had occurred in the unit and drawing on that formed the opinion that it was “care for the living”, those who were closest to the incident, which was the most important consideration. As for the Commanding Officer asked those around what they were seeing of and to assess that he was in a good state of mind and was coping with the incident himself.

48. As put it, the COI could indeed see that the experience had left him still quite raw. It is not possible to determine whether his subsequent successful application of CPR saving a life while he was on holiday in Europe exacerbated or tempered that rawness.<sup>14</sup> Nonetheless he is coping in his own way and knows the sources of assistance available to him. The COI takes the view that that process is best left to play out without further intervention, unless circumstances change.
49. The COI finds that the bereavement processes were handled in a most professional way by both MonUR and DCO personnel, and that without making unfair or unwarranted distinctions, records that the actions of FLTLT Lieutenant McPhail, Mr. Pickard and Chaplain McMillan left those involved with particularly favourable impressions.

#### **CPL Goss's Unit Medical Records**

50. Both CPL Goss's central medical record (CMR) and unit medical record (UMR) were produced from archives to the COI with welcome alacrity (Exhibit 13) and made available to the expert witnesses Dr. P. J. Habersberger and CMDR K. Walters RAN; before they gave evidence. Annexure A is a tabular summary of CPL Goss's CMR produced by CA (Exhibit 32).
51. Medical Records are accountable documents. Both SGT Crawford and subsequently CMDR Walters, described the procedure for the delivery of medical documents either by safe hand or defence post as being their enclosure in an inner sealed envelope and then in an outer envelope also containing an issue and a receipt in counterparts, one for return to the sending establishment and the other

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<sup>14</sup> Briefly referred to at p 85 ln. 9 of the transcript

for retention by the receiving establishment. Such issue and receipts are in the form of a *PM 384-Personal Health Records Transit Notes (Issue and Receipt Voucher)*, or an *AB 872 a Receipt for Regimental Documents* (each generically referred to in this report as a Counterpart Transit Note (CTN)). That evidence accords with the procedure set out in the *Health Manual Volume 1*, Chapter 2.

52. Initially the evidence of SGT Crawford was that at some time and for some reason (both unremembered) a search was instituted for CPL Goss's UMR. She thought that his treatment for a sore throat in May 2007 may have prompted the search. Inquiries made at both Victoria and Simpson Barracks drew a blank. Kapooka, from where CPL Goss had been posted, on checking their journal record for the CTN receipts for the documents informed MonUR that they had been sent to HMAS Cerberus. SGT Crawford first said that the UMRs go missing regularly but then later resiled from this by saying that sometimes they went missing and cited confusion between different abbreviations of the unit name being used, namely MUR instead of MonUR as being one cause
53. Before the hearings were completed CA made enquiries at Kapooka (directed through the legal officer) which revealed the main objective of the march out procedures in place when CPL Goss left Kapooka is to ensure that all relevant authorities and/or sections are notified either electronically or personally by the member who is departing their posted unit on either posting or discharge. The member will then obtain clearance release and a document package for UMRs produced by the process, either for posting or safe hand delivery by the member to the receiving unit (Exhibit 29).
54. Further inquiries produced a facsimiled copy of 1<sup>st</sup> Recruit Training Battalion Kapooka Register for the issue/return of UMRs (Exhibit 30) demonstrating that CPL Goss's were recorded as being sent to MonUR on 5 December 2006, probably by post. That document has a column for recording the return of the CTN for UMRs dispatched from Kapooka. On the exhibit some 18 different members' UMRs are recorded as being dispatched. There is but one recorded entry for the return of such a CTN and it is not for CPL Goss.

55. A thorough and comprehensive check of the medical records system at HMAS Cerberus requested by CA indicated that all records received, even by mistake and held at the unit for but a single day would still be recorded as having been received and dispatched. There is no record of CPL Goss anywhere in their systems.
56. CA instituted further inquiries at Simpson Barracks on the basis that CPL Goss's UMR showed it had been audited on 17 July 2007. A statement was obtained from the practice manager Ms Clare Webb which attached a computer record (GOSSDOC1) which attached a computer record (GOSSDOC 1-1) showing that the UMR arrived on 16 July 2007, was receipted on that date before being dispatched to Victoria Barracks Health Centre (HC) on 07 November 2007 for the attention of CMDR Walters no doubt at his request and foreshadowed in his interview with the IO on 07 November 2007. Further inquiries by Ms Webb as to how and when the documents arrived at Simpson Barracks revealed a CTN (GOSSDOC1-2) which shows that UMRG was received from MonUR by Simpson Barracks after delivery by CPL Goss himself on 16 July 2007.
57. A further search at MonUR was then ordered which revealed a bundle of documents in the Regimental Aid Post (RAP)(GOSSDOC 2-1 to 2-5). Documents in that bundle showed that the UMR had been received at that unit on or before 22 January 2007 and erroneously dispatched to Australian Defence Force Health Records-Army (ADFHR-A) at Victoria Barracks by a Recruit Nelson (instead of to the HC at that establishment) where they were receipted by Ms. C. Leaman on 24 January 2007 (GOSSDOC 2-1).
58. Another CTN in that bundle dated 21 June 2007 directed to ADFHR-A by SGT Ralph of MonUR (GOSSDOC 2-4) seeking the return of the documents from that establishment to MonUR demonstrates that by that date SGT Ralph had discovered the whereabouts of the UMR at the ADFHR-A. The counterpart of that CTN returned the UMR to MonUR on 11 July 2007 and is receipted by SGT Ralph on 13 July 2007 (GOSSDOC 2-5).
59. The bundle is the subject of two further statements obtained from SGT Crawford (GOSSDOC 2) and Ralph (GOSSDOC 3) respectively acknowledging that the

documents in the package disclose the actual movement and whereabouts of CPL Goss's UMR (and documents that should have been placed on that file) during the period from its arrival at MonUR which is different to earlier statements and sworn evidence concerning those matters.

60. The explanation for clearly colour coded UMRs being so received and not immediately returned to MonUR or sent to the HC after inquiry of MonUR to ascertain if this was their intended destination was obtained from Patricia Zerna, the Customer Liaison Officer of ADFHR-A at the relevant time, on 19 February 2007 (GOSSDOC 4). It is that UMRs are normally forwarded for storage when a person is no longer serving with the ADF. On receipt no check is made to demonstrate that such is the case, it is assumed to be so because otherwise the documents should not be forwarded to ADFHR-A. On receipt a member's UMR would normally be placed with their CMR). Nevertheless, there is an audit control in place to provide a safeguard against this type of misplacement of medical records being the CTN returned to MonUR on 24 January 2007 in respect of CPL Goss's UMR. It would appear that in this case the audit control failed because that document was in the bundle in the RAP at MonUR.(GOSSDOC5).
61. CMDR K Walters RAN, a medical administrator of over 36 years experience and the former senior health officer for Victoria, examined the deceased's medical records and gave the following evidence in relation to them: The records were in three parts. First, a standard bound green-coloured CMR held at the central medical records facility in Victoria Barracks in the case of an Army member. Secondly, a similar folder containing the soldier's records of his second engagement. Thirdly, a buff folder with a mauve and brown spine, being the UMR designed to be held in a treating health centre (THC) geographically closest to or at a member's work establishment or the member's where their parent establishment did not have a THC.
62. He went on to describe the CMR as a most complete compendium of a member's medical history the formal record which as the witness put it would be used in a court of law, although the UMR might be the most up-to-date depending on the speed with which duplicate documentation from patient treatment records made

its way onto the CMR. It was his expectation that the UMR would travel with a member by safe hand moving between postings at different establishments or that it would be transmitted by Defence mail to the chief clerk equivalent in the establishment to which the member was being posted or which was to become his THC. In either case a record of the transmission would be kept at the former Unit or Establishment by way of a receipt on the CTN provided with the UMR to the member who received it for safe hand transmission or a record of the date of mail out and in either case a counterpart receipt on the CTN to be returned by the receiving unit or establishment evidencing that the UMR had reached its destination.

63. Following receipt, the chief clerk of a unit without a THC would direct the member delivering the UMR to one of the major health facilities (i.e. with a THC) to submit those records, which could then be audited and any ongoing treatment managed.. Any records of treatment (PM 105) away from the parent medical unit indicating attendance, examination or treatment is made in duplicate and sent to the CMR or recorded in those places where the facilities exist such as at Victoria Barracks, in the Medical Information Management Index (MIMI) a stand-alone database that is populated by a feed from PMKeyS, and the original placed on the UMR.
64. Information entered into MIMI is only accessible from the HC from whence it is entered into the database; it cannot be accessed from a different HC.
65. The object of the witness' examination of these processes was to ensure that outposted personnel like CPL Goss had access to the appropriate levels of health care through the linkages into the Defence Health Organisation as even preventive health monitoring is an matter for which commands are responsible.
66. CMDR Waters identified a number of matters derived from CPL Goss's medical documents which caused him concern. Subsequent evidence removes any necessity to deal with some of them. However his evidence about the Lipitor dispensing history of CPL Goss (Exhibit 14) confirms that the deceased did not resume filling his prescription for Lipitor after his supply would have expired at the end of January 2007. CMDR Walters also said that on the basis that there was

a treatment regime in place, which was apparently discontinued, his suggested implementation of an electronic system would reveal that the member was no longer collecting his Lipitor.

67. The witness conceded that there are times when UMRs do go missing but pointed to the Services' ability to send out message traffic to ask everyone to make a search with a reasonable degree of success and the prompts that PMKeyS sends if a data processor tries to enter fresh medical information in respect of a member whose UMR is not available.
68. Next he described what he regarded as the inability of the ADF to properly manage its health information and health records in the 21st century environment so that they might be accessed timeously wherever the member is located at any time in a military environment. He mentioned the ADF's 20 million dollar plus investment over 15 years in a program known as HealthKeyS, designed to be a distributive electronic health record. So far it has proved cumbersome and unusable and together with MIMI is the subject of a review which tracks the health needs and preventative health aspects of personnel posted under the care of HCs. It has an interface with the Defence personnel program PMKeyS, albeit a manual one, to ensure that all personnel posted to a particular unit are recorded in the database. This does not include the units remote from their parent unit; that are those with no parent medical unit such as MonUR.
69. Based on his extensive use of the US military Composite Health Care System Mach II, CHCS II; his suggested solution is for the Australian Defence Force is to invest in a web based commercial off-the-shelf health information system such as Medical Director with appropriate preventative medicine, specialist medical examination and in-patient modules along with allied health and dental capability; privacy protected by a secure socket layout. That system is currently used by a significant number of civilian primary health care practices in Australia and New Zealand. Such a system would enable an ADF member out posted without parent medical support to be traceable in terms of preventative health measures; including pharmaceutical tracking and the provision of medications from a central dispensing point thereby reducing the cost of providing pharmaceuticals using

commercial outlets. Other linked systems already in use in Defence (*WINIFRED and PILS*) could also be linked with Medical Director which would enable checking if the prescriptions or repeats have been filled, and the monitoring of the completion date of the medication leading to the recall of the member for further treatment evaluation.

70. The singular advantages to be derived from the development of electronic health records include:
- a. Access to the health record of every member for the provision of adequate health care, regardless of their unit's disposition or where they are serving,
  - b. total visibility of treatment regimens, critical data, preventative health measures and the entire medical history of members,
  - c. details of the actual stage at which any particular activity in relation to a person's treatment had reached,
  - d. the means of circumventing the problems created by the transmission of UMRs by safe hand, and other causes of lost or misplaced medical records,
  - e. obviating the necessity for searching a number of treatment facilities likely to be the actual repository of a member's UMR for current medical information about such a member in times of Emergency, and
  - f. the means on discharge of members to transmit their CMRs from the Defence Department to the Department of Veteran's Affairs.
71. His suggestion was that steps be taken to raise and reinforce the level of understanding at the unit level of the importance of the NOTICAS, and FATALCAS reporting system particularly for the timely reporting requirement of injury, illness or death, especially the requirement in those notifications to advise the relevant JHSA State Headquarters.
72. He mentioned, as did some of the MonUR officers, that the provision of primary response and first aid to members in isolated situations and generally across Defence is a concern giving rise to an ongoing training requirement to ensure

skills maintenance similar to the requirement of St John's first aiders and other similar organisations.

73. Finally, he drew attention to the need to supplement a first aider with an automated capability in the form of a defibrillator enabling that person to provide a situational appreciation to the ambulance service which has a potentially beneficial effect for any patient. This observation (also made by some of the MonUR officers) was prescient of its repetition by the expert medical witness whose evidence came later.
74. Consultations with CMDR Walters after the hearing resulting in him making further inquiries at a higher level about the progress of the implementation of HealthkeyS revealed that a review of the system is well advanced and that the review report may be nearly ready. Even if this matter could be said to be within the terms of reference of the COI (which it is not) the COI could only make a finding that supported a recommendation that consideration be given to implementing what is already in place – a review.

### **Repercussions**

75. One actual and some of the relevant potential weaknesses (P) in Defence systems that the evidence contemplates and their possible repercussions (R) are listed as follows:
- a. (P) The failure to correctly address the Local Area Health Service in Victoria in the FATALCAS.
- (R) The death of the deceased could not be recorded at all in ADF medical records and the deceased's file closed off. The Autopsy records could not be accessed for information likely to assist with improving the health of other ADF members.
- b. (P1) The acceptance at ADFHR-A of a UMR and retention of same without inquiry with the result that (P2) it remained at the wrong centre for nearly 6 months because of (P3) the corresponding failure of MonUR to check the whereabouts of the UMR.

(R1) During that time the ongoing health needs of CPL Goss such as the need for him to remain on Lipitor or (R2) otherwise to be monitored in respect of any existing health condition could not be attended to. (R3) In other circumstances this might result in life saving monitoring and attendant treatment not being given to a member or (R4) the application of any of the features of the preventative health care program in ADF health being identifiable as applicable to the member or undertaken. In this deceased's case it included life style counselling, diet, and exercise.

- c. (P) The possible failure in 19 recorded instances at Kapooka to return CTNs or if returned to record the return. This is one of the major training establishments in the ADF with many transiting members.

(R1) There may be UMRs which have not reached their proper destination.

(R2) There is no apparent method for Kapooka HC to accurately inform any inquirer in any particular instance if a UMR arrived at its destination or if not, where it went.

- d. (P) The failure to record the arrival of CPL Goss's UMR at MonUR or to make a proper record of the same or access such a record to enable them to accurately determine where to start to search for such records and possibly failing to return the CTN in respect of the UMR to Kapooka HC or alternatively of staff at the latter HC to record the receipt of the CTN for six months after the arrival of such records in MonUR, and

- e. (P) The depositing of a bundle of significant records relating to the transmission of medical records being kept in the RAP at MonUR either unknown to or ignored by record accounting staff such as the Chief Clerk and the Registry Administration Clerk.

(R1) An inability to remember the facts of the situation, or even recall that the records were stored in an envelope in the RAP.

(R2) The confusion and attendant inconvenience and waste of resources cause by the reliance on a false memory to explain the whereabouts of CPL

Goss's UMR and the persistence in that explanation during the hearings of the COI.

76. The COI finds that the evidence establishes that:
- a. CPL Goss's UMR was never directed to or received by the HC at HMAS Cerberus, but was dispatched to and received at MonUR and erroneously dispatched to ADFHR-A Victoria Barracks on or about 22 January 2007 where it remained neglected and unattended for almost six months until 16 July 2007 when it returned into proper circulation.
  - b. CPL Goss's UMR was for all practical purposes lost and unavailable within the ADF system for virtually 6 months between 22 January and 16 July 2007.
  - c. In this particular instance the lack of the availability of access to CPL Goss's UMR during the time it was misplaced within the system and unavailable had no effect on the quality or completeness of the medical treatment required or received by the deceased during that period and did not bear in anyway on his death or the causes of it.
  - d. However the unavailability of CPL Goss's UMR during the time it was misplaced had the deleterious consequences referred to in paragraphs 75 a. above.
77. The unabridged exposition of these circumstances is provided for two purposes. First, to emphasize what might be both isolated and systemic weaknesses in part of the process relating to the storage and movement of ADF health records in that the auditing measures in place for insuring the safe and efficient transmission of medical records between health centres or from health centre to central medical centres may be being circumvented. Second, to found the possible significance of those matters and their repercussions which might not be so apparent from a brief recitation of the physical situation of the records during the time they remained misplaced at ADFHR-A instead of at a HC.

78. Save for those matters which have been made the subject of a finding, no findings can be made in relation to the remaining apparent weaknesses which have come to notice in this COI, because their tenuous proximate association with the death of the deceased is insufficient to bring them within the TOR of the COI. Moreover, a proper and complete examination of them, sufficient to enable findings to be made, is beyond the boundaries intended to be set by those TOR, and the purposes for the establishment of the COI and its current resources. Further, the ADF has more informed and better suited mechanisms to assess the need for further investigation of these matters and the means of performing them, than this COI as currently constituted could provide.

#### **Recommendation concerning medical records**

79. Because of the potential seriousness of these matters in the opinion of the COI they ought to be the subject of some action. The COI recommends that consideration be given to making an unannounced random sample audit of both CMRs and a selected but small number of Units in widely geographically separated areas; particularly those without onsite HCs. This will allow an assessment to be made of the extent of any problems, the potential risk they pose to the security and fidelity of ADF medical records, preventative and operational health care in the ADF. It may also lead to the more effective transition of existing systems and records to any electronic health records system such as HealthKeys; particularly but not exclusively from the computer auditing and systems engineering perspective.

#### **Cardiologist evidence**

80. Dr. P. G. Habersberger, a specialist cardiologist who is an acknowledged expert in that field, and a Commodore Assistant Surgeon General-Navy until 2006 (Exhibit 17) gave evidence. In his evidence, he took the COI through the basic structure of the human heart and attendant major blood vessels pertinent to the Inquiry. He indicated that the progressive narrowing of the major blood vessels either blocking them off or restricting blood flow to a critical level known as coronary artery disease (CAD) caused heart attacks which were presently responsible for the majority of deaths in our community. Likewise, he described the effect of the

damage caused to the heart muscle by being deprived of an adequate blood supply which if critical causes it to die and the heart to stop with associated rhythm problems.

81. He said the narrowing effect in CAD is caused by the natural depositing of plaque on the artery walls and that plaque is composed of cholesterol, calcium, inflammatory cells, and other tissue. Further, that cardiologists spent a lot of time trying to identify patients who may be at particular risk due to CAD and who are asymptomatic. He added the most important screening test for CAD was exercise testing (ET). This would be followed by an angiogram which was the gold standard, because nothing is better than a direct look at the coronary arteries, The results then allow a decision to be made as to the appropriate treatment, such as angioplasty using a balloon and a stent, or by-pass surgery, or medication.
82. He dealt with the effect on the heart deprived of adequate blood supply to its own muscle developing collateral or alternative blood supply vessels saying they were difficult to see at autopsy; but if seen angiographically, are indicators of a long standing problem. He described the ease with which a completely blocked vessel can be seen, or a clot caused by a rupture of the plaque releasing clotting agents into the blood stream, as well as pressure damage to the artery wall due to high blood pressure.
83. The benefits of the statins drug group such as Lipitor lies not only in their ability to lower bad cholesterol but also in stabilizing plaque thereby reducing the danger of rupture.
84. He said ET is not done as a general rule for all members of the population. As a matter of policy the same situation prevails in the ADF. The witness opined that ideally it would be appropriate for patients presenting with, for example, a family history of heart problems. A suggested age group for ET regardless of people being asymptomatic would be age 50. The witness said that an ECG at rest is a valuable thing to do and often gives the examiner a lot of information. However, if more detailed information is required, an ET is more appropriate; because it provides a lot more information than a resting ECG.

85. Nonetheless he did not criticise the ADF for not doing an ET on CPL Goss before he joined the Army. Even so, he felt that it would have been appropriate or reasonable to do an ET, despite it not being ADF policy when re-enlisting a man at age 41, who has put on 32 kilograms since his first enlistment, and is coming into a physical job.
86. Dr. Habersberger was of the opinion that the ADF has made good attempts to try and identify problems. This included for all members, regardless of age, such measures as regular physical assessments (every six months for Army members), and an annual health assessment, (including a major health assessment every five years) and for members over 40 years of age, the encouragement of the measurement of Lipid levels and blood pressure. He commented on the fact that as a consultant to the ADF he saw many patients for assessment because the ADF doctors are concerned that they may have, or are potentially developing a heart problem, and so the doctors are well aware of the risk factors. He said the ADF addresses the question of coronary risk factor management quite well. Certainly he believed that the ADF does this very much better than most other employers.
87. So far as Dr. Habersberger was concerned, the relevant findings relating CPL Goss's death are that he had significant coronary artery disease with a 60 per cent narrowing of the left main coronary artery, 80 per cent narrowing of the left anterior descending coronary artery, 75 per cent narrowing of the left circumflex coronary artery, and 30 per cent narrowing of a dominant right coronary artery. He agreed with the pathologist's finding that the cause of death was ischemic heart disease due to coronary atherosclerosis. He said that CPL Goss died as a result of the complications of extensive coronary artery disease, proven at autopsy. (Exhibit 18)
88. His opinion was that CPL Goss's coronary artery disease had been present for at least a decade or more, and had been getting progressively worse over this period of time until coronary artery flow was reduced to such a level that ventricular fibrillation occurred. After hearing the evidence of Mr. Brookes (infra paragraph 21 above) he modified that opinion to the heart being in a state of electromechanical dissociation not ventricular fibrillation.



in this report. Quite incidentally, this view coincided with Ms Goss's evidence that at or around 10 days prior to his death, the deceased had engaged in physical activity in a jumping castle at his daughter's birthday party and on another occasion attended his niece's march out of Kapooka, both with no apparent ill-effects.

95. Dr Habersberger reinforced the views of CMDR Walter that the ADF does not have a good recall system to monitor people. Asked if that was something that the ADF should address he replied that it was and that in the interest of ADF patients there was a responsibility to try and get patients to attend on a regular basis.
96. Pressed on the distinction in the context of the ADF between saying ET was not an unreasonable procedure to carry out and saying, that it was not something which he would criticize the ADF for not doing in CPL Goss's case Dr. Habersberger referred to the difference between being a specialist cardiologist and an RMO or Ship's Doctor and his greater exposure to and knowledge about cardiac disease. The point of discrimination, between not criticising the regimental or ship's doctors, is that these things were a matter of course for him because of his specialisation and the Service medical officers cannot be seen in any way to be derelict in their duty for not doing it because it formed no part of their routine and there is nothing to alert them to the fact that they should do it. Nevertheless he thought that it should be considered for inclusion as part of policy for older aged recruits and re-enlistments. Asked if there was a range of sensible indicators to alert Service Medical Officers to the need for ET or not, he adverted to the successful program base on point scoring for particular attributes put in place in respect of Airline Pilots who attained the age of 60. These were aligned with risk factors such as Age, cholesterol level, blood pressure, smoking, and diabetes. He opined that something of that sort would be appropriate for the ADF. Although it would not be perfect and would be of no assistance for the young who were not at risk, a lot of patients who have acute heart attacks are perfectly all right one day, then they rupture a plaque the next. ET at forty years of age for re-enlistment or for recruitment was reasonable and 50 years of age would be an appropriate age for ET as part of a five yearly medical.

**Other Recommendations**

97. In light of the evidence, particularly that of Dr. Habersberger and CMDR Waters the COI also recommends that consideration be given to:
- a. Taking steps to raise and reinforce the level of understanding at the unit level of the importance of the NOTICAS, and FATALCAS reporting system particularly for the timely reporting requirement of injury, illness or death, especially the requirement in those notifications to advise the relevant JHSA State Headquarters
  - b. Whether it is appropriate to outfit Units of the ADF with Automatic Defibrillators particular those Units without a Treating Health Centre on site.
  - c. Whether it is appropriate to implement an ongoing first aid training requirement to ensure skills maintenance similar to the requirement for St John's first aiders and other similar organisations.
  - d. Reviewing current ADF health policies to determine whether it is now appropriate to require the introduction of the exercise testing of members of the ADF and candidates for enlistment or re-enlistment whose age and health risk profile make such testing advisable and appropriate.

### **Commission Findings Related to TOR**

98. 5.a. (i) The deceased died on 31 July 2007 at the Clothing Store Monash University Regiment, Whiton Street, Mount Waverley, Victoria.
- (ii) The deceased died of natural causes to wit ischemic heart disease due to extensive coronary atherosclerosis.
- (iii) At the time of his death the deceased was a serving member of the Australian Regular Army, on duty in the clothing store at Monash University Regiment.
- b. There were three sets of actions or decisions taken by Defence personnel one prior to and two after the death of the CPL Goss which were materially relevant to the deceased's death namely.
- (i) The misplacement of CPL Goss's UMR for a period of almost seven months immediately prior to his death.
- (ii) The error in an information address in the FATALCAS signal sent in relation to CPL Goss.
- (iii) The breach of the Directive by the notification of the death of the deceased by a person not authorised by the Directive to make that notification
- c. There were no deficiencies in Defence Systems, proximately associated with the deceased's death. However, evidence of several other matters raising the possibility of the existence of deficiencies (both isolated and systemic), but in respect of which no completed finding is made, are set out in paragraph 76 of this report.

### **Acknowledgements**

99. 94. The COI wishes to draw to the attention of CDF to the efficient work done by counsel assisting, Colonel Hevey, Counsel Representing, Lieutenant Billings RAN, whose representation of Ms Goss and through her other members of the family was competent and constructive, the administration staff, especially

Ms Leah-Barbara Maguire who doubled her duties with those of the COI Coordination Directorate and also Major Tony White, Captain Doug McGuire and CPL Michael Devrell. The performance of all these members engaged in the task, (particularly Colonel Hevey who applied himself to it assiduously tenaciously and unremittingly), enabled it to be completed in a relatively short time frame during and after a major vacation period. The COI also received most valuable assistance from consultations with Group Captain Andrew Elfverson of the COI Coordination Directorate and Group Captain Hanna, Director Defence Council Services.

*P. A. Willee*

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President  
CPL Goss Commission of Inquiry

20 February 2009

**Annexures:**