CITATION: Comcare v Commonwealth of Australia (Department of Defence) [2021] NTLC 023

PARTIES:	COMCARE V COMMONWEALTH OF AUSTRALIA (DEPARTMENT OF DEFENCE)
TITLE OF COURT:	LOCAL COURT
JURISDICTION:	CRIMINAL
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JUDGMENT OF:	JUDGE ELISABETH ARMITAGE

CATCHWORDS:

Failure to comply with a health and safety duty*- Australian Defence Force; live fire exercises; risk of death; failure to take reasonably practicable and available steps; failure to implement an assurance mechanism; failure to comply with doctrine and safety policies; failure to conduct risk assessment; failure to conduct a training needs analysis; failure to mark dangerous spaces; failure to conduct progressive training; failure to conduct adequate briefings; failures causal of death.*

Sentencing*-objective seriousness; extent of departure from duty owed; extent of risk; likelihood and foreseeability of death or serious injury; specific and general deterrence; victim impact; guilty plea; contrition and remorse; reparation; cooperation with authorities; character and antecedents; discount; worst category of offending; maximum penalty.*

Work Health and Safety Act 2011 (Cth) s 32

Crimes Act 1914 (Cth) s16A

Comcare v Commonwealth (2007) 163 FCR 207

Comcare v Post Logistics Australasia Pty Ltd (2012) FCR 178

Comcare v Commonwealth (2007) 163 FCR 207

Comcare v Commonwealth of Australia [2012] FCA 1419

Comcare v Commonwealth of Australia [2015] FCA 810

Comcare v Commonwealth of Australia [2007] FCA 662

DPP v Amcor Packaging Australia Pty Ltd (2005) 11 VR 557

Dotmar Epp Pty Ltd v The Queen [2015] VSCA 241

DPP v Frewstal Pty Ltd (2015) 47 VR 660

R v Commercial and Industrial Constructions Group Pty Ltd [2006] VSCA 181

Singh v The Queen [2018] NSWCCA 60

R v Propsting [2009] VSCA 45

Bulga Underground Operations Pty Ltd v Nash (2016) 93 NSWLR 338

Nash v Silver City Drilling (NSW) Pty Ltd [2017] NSWCCA 96

R v Glen Keith Allen [2005] QCA 073

REPRESENTATION:

Counsel:

Crown:	Jennifer Single SC with Georgina Wright
Defendant:	Fiona McLeod SC with Lindy Barrett

Solicitors:

Crown:	Commonwealth Director of Public Prosecutions
Defendant:	Australian Government Solicitor

Judgment category classification:	A
Judgment ID number:	023
Number of paragraphs:	74

IN THE LOCAL COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 21918421

BETWEEN

COMCARE

Crown

AND

COMMONWEALTH OF AUSTRALIA

(DEPARTMENT OF DEFENCE)

Defendant

REASONS FOR DECISION

(Delivered 1 September 2021)

JUDGE ELISABETH ARMITAGE

1. On 25 May 2021 the Commonwealth of Australia entered a plea of guilty to one count of failing to comply with a health and safety duty thereby exposing a person to a risk of death, injury or illness, contrary to section 32 of the *Work Health and Safety Act 2011 (Cth)*(WHS Act). The maximum penalty for this offence is a fine of $1,500,000.

The Facts

2. Private Jason Walter Challis (Pte Challis) joined the Australian Defence Force (ADF) on 5 July 2016. Pte Challis undertook initial entry training at Kapooka and Singleton before he was posted to Darwin on 24 February 2017. Pte Challis was killed on 10 May 2017 while participating in a live fire training exercise with the ADF at Mount Bundey in the Northern Territory. Pte Challis sustained a fatal gunshot wound to the head when he was struck by live ammunition during the training exercise. He had been in the Australian Army for approximately ten months. He was 25 years old when he died.

3. The plea was entered on agreed facts which I summarise as follows.

4. The Commonwealth of Australia, through its responsible agency the Department of Defence (the Department), operated the ADF which includes the Australian Army.

5. The Department operates a business that includes the work carried out by the ADF. The Department is a “person conducting a business or undertaking” within the meaning of section 5 of the WHS Act. The Department is charged with one offence contrary to section 32 of the

WHS Act, namely, that the Department exposed ADF members, including but not limited to Pte Challis, to a risk of death or serious injury. Members were at risk of being struck by live ammunition during live fire exercises.

6. Pte Challis was a participant in a live fire urban operations training exercise on 10 May 2017 (the urban operations exercise). Participants in the urban operations exercise, including Pte Challis, were members of the ADF and "workers" who were "at work in the business or undertaking" conducted by the Department.

7. The Department owed ADF members (including those participating in the urban operations exercise) duties imposed by the WHS Act that included providing and maintaining, so far as reasonably practicable, safe systems of work.

8. Part of the urban operations exercise involved armed teams entering a mock village to engage pretend enemy targets situated inside simulated buildings. The mock village consisted of a central street with simulated buildings, constructed of plywood and hessian, on either side of the street. It was envisaged that the urban operations exercise would involve members moving down each side of the street, and entering and "clearing" each simulated building. To clear a building members were expected to enter the front of the building and shoot at the pretend enemy targets situated internally and at the rear of the building, before proceeding to the next building. The location of the pretend enemy targets at the rear of each building meant that the sides and rear of each building were dangerous spaces through which bullets could travel. The design of the range was intended to reduce the risk to members by reducing the likelihood of firing across the central street, in recognition of the risk to members who were clearing buildings on the opposite side of the street.

9. The urban operations exercise ought to have been conducted in accordance with the various requirements set out in the ADF's policies and doctrines including its Land Warfare Procedures-General (LWP-G) which are mandatory general orders pursuant to section 3 of the *Defence Force Discipline Act 1982(Cth)*.

10. The Commanding Officer of 5th Battalion, Royal Australian Regiment (5RAR), Lieutenant Colonel Paul Shields, was responsible for the overall control and safe conduct of the urban operations exercise. He was required to apply the policies and doctrines of the ADF. Lieutenant Stephen Cross was the OIC Practice and was responsible for the range design, the administrative preparation and conduct of the urban operations exercise. Sergeant Robert Ashley assisted Lt Cross.

11. On the morning of 10 May 2017, Lt Cross conducted a safety briefing and walk-through of the range with members who were likely to be used as safety supervisors during the urban operations exercise. He then conducted a briefing to members who would fire weapons during the urban operations exercise.

12. The urban operations exercise was being completed by members attached to Bravo Company which consisted of at least four Sections. Each Section was split into two groups, referred to as "Bricks". Each Brick consisted of four firers and two combat engineers (who did not carry live ammunition). Two safety supervisors were responsible for overseeing the firers. A third safety supervisor was responsible for overseeing the combat engineers. Jointly, the safety supervisors were responsible for ensuring the Brick they were supervising completed the

urban operations exercise safely. Lt Cross took a position in the middle of the mock village and had general oversight and responsibility for the conduct and safety of the urban operations exercise.

13. Three Sections of Bravo Company completed the urban operations exercise. It was then the turn for Section 2-2 Charlie, led by Section Commander Corporal Spencer Gregory, to complete the exercise. Pte Challis was one of the four firers in his Brick (Alpha Brick). At about 12 pm Cpl Gregory explained the general mission and manoeuvre to Section 2 -2 Charlie.

14. Instead of approaching the front of the first simulated building from the central street as envisaged in the design of the range, Alpha Brick approached the side and rear of the first building. When they approached the building, two of the four firers separated from the rest of the Brick and moved around the far side of the building out of sight of the rest of their Brick. Cpl Gregory and Lt Cross identified that this was dangerous and Lt Cross stopped the exercise.

15. Before the exercise restarted, ostensibly the Brick regrouped at the front corner of the simulated building. However Pte Challis did not join the others. He remained standing at the rear far corner of the simulated building in a dangerous space.

16. There was a 65 second window of opportunity for members to identify the Pte Challis was missing before the exercise recommenced. Inexplicably and tragically, no one noticed that Pte Challis was missing. Although the Brick was supposed to operate on a buddy system, Pte Challis's buddy did not notice he was missing. His absence was not noticed by any of the three safety supervisors. His absence was not noticed by his Corporal or by his Lieutenant. Nor indeed by the two ADF members who were accompanying and recording the exercise on video and by photograph.

17. The urban operations exercise recommenced without Pte Challis. The pretend enemy target in the first simulated building was situated against the rear plywood wall, directly in front of where Pte Challis was last seen standing. The remaining firers of Alpha Brick entered the first building and fired live ammunition at the pretend enemy target. The members who fired the shots could not see Pte Challis who was behind the plywood wall. Two rounds penetrated the plywood wall and struck Pte Challis. He suffered a non-fatal gunshot wound to his left leg and was killed by a gunshot wound to the head.

18. Approximately one and a half minutes passed between when Pte Challis took up his position concealed behind the target and when he was shot. "Stop" was called about 2 minutes after he was shot, when Pte Challis was found deceased. In total Pte Challis had been missing from the rest of his Brick for about three minutes and fifty two seconds during which time live firing took place.

19. Through its plea of guilty the Department admitted that it failed to take reasonably practicable and available steps to control the risks arising from its business or undertaking. The Department failed to provide and maintain a safe system of work by failing to implement an adequate assurance mechanism (such as a checklist to be completed by the Officer in Charge of Practice or other safety staff) to ensure that its safety policies were complied with.

20. In consequence of not having an adequate assurance mechanism in place to ensure compliance with its safety policies, the Department failed to comply with those policies. While each of these failings is not alleged as a separate breach of the duty, they flow from and exemplify the gravity of the charged breach.

    a. No risk assessment of the urban operations exercise was completed.

        i. LWP-G 7-3-1 mandated that detailed and thorough risk assessments were to be prepared as part of the planning process for specific activities, such as the urban operations exercise, in order to ensure that the OIC Practice had a thorough knowledge of the potential dangers and the actions required to remove or limit the impact of those dangers. The urban operations exercise was one part of a larger activity known as Exercise Tigers Run 17 (Tigers Run). A risk assessment was prepared for Tigers Run which identified the risk of injury or death during the urban operations exercise, including risks to members entering unsafe areas. However, in spite of being aware of the risk of death (via its overarching risk assessment of Tigers Run) the Commanding Officer and OIC Practice failed to comply with LWP-G 7-3-1 and no specific risk assessment was completed for the live fire urban operations exercise.

        ii. There was no mechanism in place to ensure that the risk assessment had been completed.

    b. A training needs analysis (a mechanism to check training currency and individual competency) was not completed.

        i. LWP-G 7-3-1 required that the Commanding Officer ensure members participating in live fire activities were appropriately qualified and trained to participate in the particular exercise. In addition the Commanding Officer was to have an understanding of each member's level of practical proficiency in order to ensure the planned activity was safely achievable. This responsibility included an assessment of the qualifications and proficiency of the proposed safety supervisors. As I understand it, in order to inform themselves of a member's proficiency, the Commanding Officer was, for example, to consider records kept of each member's shooting standards and capabilities (which records were required to be kept pursuant to LWP-G 7-7-8). It is not clear whether or not these records were maintained as required.

        ii. It is admitted that the Commanding Officer, Lt Col Shields, did not properly inform himself as to each participant's level of qualification, training and experience. In particular he failed to inform himself as to the currency of qualifications and the actual experience of Lt Cross, Sgt Ashley and the proposed safety supervisors, in relation to the urban operations exercise.

        iii. If a training needs analysis had been completed it would have identified that while participants possessed necessary qualifications, certain key participants had limited experience in the roles that had been allocated to them. Lt Col Shields's experience was dated, having last been involved in urban operations training in 2008. It was Lt Cross's first time performing the role of OIC Practice for the urban operations exercise. The two safety supervisors for the Alpha Brick

live firers had no previous experience in that role. The Section Commander and leader of Alpha Brick, Cpl Gregory, did not participate in the April 2017 Combat Shooting Week, and so did not have first-hand knowledge as to how the firers (including Pte Challis) performed during their training. The remaining two live fire members of Alpha Brick had only been with the ADF for 10 months and 13 months respectively, and were inexperienced soldiers.

iv. There was no mechanism in place to ensure that the training needs analysis had been completed.

c. Dangerous spaces were not marked on either side of each simulated building either during the construction of the range or at any time during its use.

i. LWP-G 7-3-1 mandated that dangerous spaces be clearly marked. Specifically it required that each simulated building be clearly marked inside and outside showing arcs of fire, penetration markers and dangerous spaces. In addition, LWP-G 7-3-1 mandated that all dangerous spaces be cleared of personnel before firers engaged each target. There was a complete failure to comply with these obligations. None of the simulated buildings were marked as required. Additionally, not one participant in the urban operations exercise identified the lack of markings as a failure to comply with the safety policies, either before or during the exercise.

ii. The failure to mark dangerous spaces directly contributed to Pte Challis death, being in the dangerous location when he suffered the fatal gunshot.

iii. There was no mechanism in place to ensure the areas were marked as required.

d. Alpha Block participants had not engaged in progressive training before the urban operations exercise commenced. The progressive training ought to have included a dry rehearsal without ammunition and a rehearsal with blank ammunition.

i. Defence policies LWP-G 7-3-1 and LWP-G 7-7-8 emphasised that training must be done in a progressive way commensurate with the capacities and experience of the participants. Consistent with the policies, the training progression ought to have included walk-throughs, demonstrations, dry runs (without ammunition), and blank runs (blank firing) before proceeding to live ammunition. Training progression was deemed essential for any approval to conduct urban operations exercises. The OIC Practice was expected to directly observe training progressions to ensure participants and safety supervisors were properly prepared for the exercise and had demonstrated an appropriate performance standard before live firing.

ii. In addition LWP-G 7-3-1 recognized that situational awareness was a “critical tenet of range safety”. Everyone on the range was expected to be situationally aware. Situational awareness was expected to be developed through, inter alia, walk-throughs and rehearsals.

iii. The urban operations exercise proceeded with no planning for a blank ammunition progression and no blank ammunition was available.

iv. Some Sections did complete dry run-throughs prior to their live firing exercise and had access to the range. Those Sections completed the exercise without incident. However Pte Challis and his Section had not completed any walk-throughs or dry runs before their live fire exercise.

v. Had progressive training occurred, the positioning of Pte Challis could have been detected in non-lethal conditions and corrective action taken. The Department concedes that if a dry run or a blank run been conducted by Pte Challis, it would have reduced or eliminated the risk of him standing in a dangerous area directly behind a pretend enemy target during live fire.

vi. There was no mechanism to ensure progressive training requirements were complied with.

e. Before completing the live fire exercise participants and safety supervisors were not adequately briefed concerning hazards, risks and control measures.

i. LWP-G 7-3-1 required that Commanding Officers ensure that a safety brief was provided to all their personnel immediately on entry into a training area.

ii. On 9 May 2017 (the day before the exercise) Lt Cross gave a scenario brief to the Section Commanders which included a rough diagram of the range.

iii. On the morning of 10 May 2017 Lt Cross conducted a safety brief and walk-through of the range with members who were likely to be safety supervisors. This did not include the firers, such as Pte Challis, who were to perform the exercise.

iv. Lt Cross then conducted a brief to firers, including Pte Challis, which did not include a walk-through of the range.

v. Each briefing was inadequate. The briefings did not adequately, or at all, identify the hazards, risks and control measures on the range. Safety supervisors were not reminded of their responsibility to ensure dangerous spaces were cleared and all participants were accounted for before firing commenced.

vi. Had the Commanding Officer and safety supervisors been alert to the dangerous spaces and the need to ensure they were cleared before live firing Pte Challis's death may have been avoided.

vii. There was no system in place to check and ensure that proper briefings had been conducted.

21. In response to the killing of Pte Challis, the Army suspended similar live firing exercises and to date those exercises have not been reinstated.

22. In addition the Department:

a. Reviewed, re-wrote and relaunched the LWP-G 7-3. The new Doctrine contains a checklist which the Department intends will ensure greater compliance with and implementation of the provisions of the Doctrine.

b. Introduced annual recertification and currency training for ADF members with range safety qualifications.

c. Implemented an information management system to record more detailed information about each soldier's weapons and range training and competency.

d. Introduced a formal system of auditing and assurance for its range safety system.

e. Created the positions of "Land Range Safety Regional Advisors" which are accessible to each of Army's main combat brigades.

Sentencing principles

23. Sentencing for Commonwealth offences is governed by Part 1B of the *Crimes Act 1914 (Cth)* (the Crimes Act). The court must impose a sentence that is of a severity appropriate in all the circumstances of the offence: s 16A(1). In addition to any other relevant matters, such as the maximum penalty for the offence, the court must take into account relevant matters listed in s 16A(2) including: the nature and circumstances of the offence; general and specific deterrence; punishment; victim impact; the fact, timing, and benefits of the plea; the degree of contrition by the offender including by taking action to make reparation; the level of cooperation by the offender; and the character and antecedents of the offender.

24. In *Comcare v Commonwealth* (2007) 163 FCR 207 at [120], drawing on various decisions of New South Wales courts concerning criminal sanctions under that state's occupational health and safety legislation, Madgwick J identified the following considerations as relevant to determining penalty:

> *"(i) The penalty must be such as to compel attention to occupational health and safety generally, to ensure that workers whilst at work will not be exposed to risks to their health and safety.*
>
> *(ii) It is a significant aggravating factor that the risk of injury was foreseeable even if the precise cause or circumstances of the exposure to the risk were not foreseeable.*
>
> *(iii) The gravity of the consequences of an accident does not of itself dictate the seriousness of the offence or the amount of penalty. However, the occurrence of death or serious injury may manifest the degree of seriousness of the relevant detriment to safety.*
>
> *(iv) A systemic failure by an employer to appropriately address known or foreseeable risk is likely to be viewed more seriously than a risk to which an employee was exposed because of a combination of inadvertence on the part of an employee and a momentary lapse of supervision.*
>
> *(v) General deterrence and specific deterrence are particularly relevant factors in light of the objects and terms of the (relevant) WHS Act.*
>
> *(vi) Employers are required to take all practicable precautions to ensure safety in the workplace. This implies constant vigilance. Employers must adopt an approach to safety which is proactive and not merely reactive. In view of the scope of those obligations, in most cases it will be necessary to have regard to the need to encourage a sufficient level of diligence by the employer in the future. This is*

particularly so where the employer conducts a large enterprise which involves inherent risks to safety.

(vii) Regard should be had to the levels of maximum penalty set by the legislature as indicative of the seriousness of the breach under consideration.

(viii) The neglect of simple, well-known precautions to deal with an evident and great risk of injury, take a matter towards the worst case category.

(ix) The objective seriousness of the offence, without more, may call for the imposition of a very substantial penalty to vindicate the social and industrial policies of the legislation and its regime of penalties."

25. While His Honour's decision is a civil penalty case and the so-called "Madgwick factors" pre-date the current WHS Act, the "Madgwick factors" provide assistance in determining appropriate penalties under work health and safety legislation because they are consistent with a body of authority and the theoretical principles concerning the role of deterrence: *Comcare v Post Logistics Australasia Pty Ltd* (2012) FCR 178 at [64][68-69].

26. In *Comcare v Commonwealth* (2007) 163 FCR 207 at [121] Madgwick J also reflected on the purpose of penalising the Commonwealth. He said:

"The evident purpose of making the Commonwealth liable to a penalty for a breach of… the OHSA is to mark the seriousness of the conduct and act as a deterrent to the Commonwealth, Commonwealth agencies and other persons who may be subject to the OHSA."

27. In *DPP v Amcor Packaging Australia Pty Ltd* (2005) 11 VR 557 at [35] the Victorian Court of Appeal observed:

"When determining the appropriate penalty in the case of the breach of a statutory duty imposed for the purpose of protecting the lives and well-being those who may be affected by the breach, the foreseeable potential consequences must be taken into account as it is the avoidance of these consequences which, when considering the objective seriousness of the offence, constitutes the raison d'etre for the establishment of the legislated regime in the first place. To a substantial extent the seriousness of the breach must be assessed by reference to those potential consequences and the measure of evidenced disregard concerning the safety of employees in the circumstances."

28. In *Dotmar Epp Pty Ltd v The Queen* [2015] VSCA 241 [22]-[23] Priest JA (with whom Maxwell P and Kaye JA agreed), on the question as to whether the seriousness of the offence should involve consideration as to whether a fatality had occurred, said:

"… With respect, the fallacy inherent in that approach lies in the assumption that the seriousness of an offence under the OHSA is necessarily to be gauged by whether death or injury has been caused (or, for that matter, by whether there is an absence of death or injury). Such an approach equates the gravity of the consequences of a breach – that is, whether the breach resulted in death or injury, or neither death nor injury – with the gravity or seriousness of the breach. The OHSA is concerned generally with risks to health and safety; Part three is

concerned specifically with the duties owed with respect to health and safety. It is the extent of the failure to ensure that employees are not exposed to risk to their health and safety which determines the objective gravity of the offence. The consequences of the failure generally do not. That is not to say that the fact of death or injury occurring is necessarily irrelevant. The occurrence of an accident, resulting in death or injury of a particular kind, may inform an assessment of, first, the existence of the risk, and, secondly, the nature and seriousness of that risk.

Hence, determining the gravity or seriousness of the offence, the sentencing court must assess, first, the extent of the departure from the duty owed; secondly, the extent of the risk to health and safety thereby created; and thirdly, the likelihood of the risk of the particular harm resulting. Put another way, in a case such as the present, the gravity or seriousness of the breach is to be measured by reference to the potential consequences of the breach; the extent of the evidenced disregard for the safety of the employee; and the risk of the potential consequences of the breach materialising."

29. In *DPP v Frewstal Pty Ltd* (2015) 47 VR 660 at [127], considering the effect on penalty if death or serious injury resulted from a breach of work safety legislation, Priest JA and Kaye JA said that sentencing judges should be guided by the following principles:

"First, unlike cases of unlawful homicide, the occurrence of death or serious injury is not an element of the offences charged. An accused is punished according to the gravity of the breach of duty owed under the [Act], not according to the result or consequences of the breach.

Secondly, the gravity of the breach is measured by two factors – the seriousness of the breach itself (that is, the extent to which the defendant has departed from its statutory duty); and, the extent of the risk of death or serious injury which might result from the breach.

Thirdly, an assessment of the extent of the risk itself involves consideration of two factors – the likelihood of the occurrence of an event as a result of the breach (such as the event that occurred in the particular case) endangering the safety of employees or others; and, the potential gravity of the consequences of such an event (in particular, whether there is a risk of death or serious injury).

Fourthly, the fact that the breach in the particular case resulted in death is relevant only in the sense that it might manifest or demonstrate the degree of seriousness of the relevant threat to health or safety resulting from the breach."

30. In *R v Commercial and Industrial Constructions Group Pty Ltd* [2006] VSCA 181 it was observed:

"How and why the failure occurred is, however, relevant to sentencing. In assessing the company's culpability, it will be relevant to know, for example, whether the breach was the result of the failure to adhere to systems put in place by management or, alternatively, was the result of a failure by management to establish adequate safety systems and procedures in the first place."

31. Considering the interrelationship of contrition, remorse and the plea of guilty, in *Singh v The Queen* [2018] NSWCCA 60, Payne JA at [28] (Johnson J agreeing at [50] and Campbell J agreeing at [51] said:

> *"Whilst it is correct that contrition and remorse are factors required to be taken into account separately under s 16A(2)(f)* [of the Crimes Act 2014 (Cth)] *in addition to the plea of guilty under s 16A(2)(g), those factors often overlap. Nothing in Xiao* [[2018] NSWCCA 4] *provided to the contrary. This potential for overlap was lucidly explained by Gleeson CJ in R v Gallagher (1991) 23 NSWLR 220, a case that involved, inter alia, Commonwealth sentencing prior to the introduction of Part 1B of the Crimes Act, at 228 as follows:*
>
> > *"It must often be the case that an offender's conduct in pleading guilty, his expressions of contrition, his willingness to co-operate with the authorities, and the personal risks to which he thereby exposes himself, will form a complex of interrelated considerations, and an attempt to separate out one or more of those considerations will not only be artificial and contrived, but will also be illogical."*
>
> *That passage was specifically approved by the plurality in Wong at [76]* [Wong v R (2001) 207 CLR 584] *as applicable to the correct construction of s 16A where there Honours explained (after setting out the passage above from Gleeson CJ in Gallagher):*
>
> > *"So long as a sentencing judge must, or may, take into account all of the circumstances of the offence and the offender, to single out some of those considerations and attribute specific numerical or proportionate value to some features, distorts the already difficult balancing exercise which the judge must perform."*

32. The imposition of a maximum penalty is reserved for the worst category of cases. However as noted by Vincent JA in *R v Propsting* [2009] VSCA 45 at [15]:

> *"There is a stage at which conduct becomes so egregious that it must be regarded as being of a kind attracting the imposition of a very substantial, if not the maximum, penalty for the commission of the offence involved regardless of whether a more serious example could be imagined."*

33. In *Comcare v Commonwealth of Australia* [2012] FCA 1419 at [99] Griffiths J said:

> *"In my view, the maximum penalty (or an amount close to it) may well be appropriate in a particular case even though there is no conscious or contumelious decision to flout the law. I might add that it is difficult to imagine that the Commonwealth would ever deliberately flout the law. In those circumstances, acceptance of the Commonwealth's proposition that the maximum penalty should never be imposed absent a deliberate flouting of the law, would mean that the Commonwealth would never have to be at a maximum penalty even in an otherwise extreme case. I do not accept that proposition."*

The objective seriousness of the offence

34. In order to determine the gravity or seriousness of the offence the court must assess: the extent of the departure from the duty owed; the extent of the risk to health and safety thereby created; and the likelihood or risk of particular harm resulting.

The extent of the departure from the duty owed

35. By the affidavit dated 25 May 2021 and evidence of Major General Matthew Pearse the Department has acknowledged that the death of Pte Challis was avoidable and that the Department had failed to take reasonably practical steps to provide a safe system of work for Pte Challis and other members of the ADF.

36. The Department had a duty to ensure the safety of members of Bravo Company, and all persons on the range, while they were undertaking the live fire exercise at Mount Bundey. It is not disputed that the Department had in place detailed policies to mitigate the risk posed by live fire training. The very existence of those policies demonstrate the Department's detailed understanding of the extent and seriousness of the risk involved in carrying out live fire exercises. However, the policies could only ever mitigate the risk if they were applied and followed in practice. The failure by the Department to have a compliance assurance mechanism to ensure the policies were understood and implemented by its members resulted in numerous and significant aspects of the safety policies being ignored or overlooked. The departures from the safety policies directly contributed to Pte Challis's death. Indeed, the lack of adherence to safety policies, all of which went undetected, meant that all persons on the range during live fire exercises were exposed to greater risks of death or serious injury than they should have been.

37. Although the Department initially submitted that the offence was at least in part the product of individual inadvertence or momentary lapses of supervision, it did not maintain that position, and accepted there were at least in some aspects systemic failings in respect of adherence to the safety policies. I consider that that concession was appropriate and consistent with the facts. The Department's failure to implement an assurance mechanism to ensure compliance with the safety policies resulted in a multifactorial failure on the part of both senior and more junior members to comply with those requirements: see [20] of this decision. Taken together, the wide range of safety measures that were missed, the fact that no member (senior or junior) identified or sought to rectify the missing safety measures, and the protracted time frame during which those failings persisted (the period of set up and use of the range), point to a systemic failure by the Department to adequately respond to the risks associated with live fire exercises which it well understood. There was a practical and reasonably available mechanism for reducing the risk: an assurance mechanism (such as a check list). That such a mechanism did not exist points to the Department bearing a high degree of culpability for this offence.

38. The Department was acutely aware of the risk of death or serious injury from urban operations type exercises. In 2009 Lance Corporal Mason Edwards received a fatal gunshot to the head and a second soldier was wounded in the arm during a training exercise involving live ammunition.

39. The details of Lance Cpl Edwards's death were considered by Foster J in *Comcare v Commonwealth of Australia* [2015] FCA 810 (*Cultana*). The death of Lance Cpl Edwards and the wounding of his comrade occurred while Special Forces soldiers were conducting a live fire training exercise at *Cultana* in October 2009. During the exercise Lance Cpl Edwards and the other soldier that was wounded were positioned behind a penetrable wall. They took up position behind a target which they could not see. Those firing at the target could not see that they were firing at their comrades positioned behind the penetrable wall. Acknowledging that there were other differences between the circumstances of Lance Cpl Edwards's death and Pte Challis's death, there were also some very disturbing similarities.

40. In *Cultana*, the Department admitted that the systems, procedures and policies that it had in place were not sufficient to protect the health and safety at work of its employees. Tellingly, in addition to other shortcomings in the policy, the Department admitted that the manual for training exercises did not include any adequate procedures or mechanisms to check, monitor, audit or ensure that the Department's policies were being implemented or to ensure that those responsible for carrying out tasks to mitigate the risks of live fire actually completed those tasks.

41. In addition, the Department knew that it could not rely on the mandatory nature of its policies or on disciplinary proceedings to ensure compliance with its safety policies. The Department had previously been warned as to the ineffectiveness of relying on disciplinary proceedings in respect of safety requirements. In June 2016, Comcare issued an improvement notice to the Department after a "near miss" incident during a live fire exercise in March 2015. On that occasion two personnel entered a firing range in a four wheel drive to conduct target maintenance. They were given permission to do so by the OIC Practice, who then failed to tell anyone else.

42. In June 2016, Comcare Inspector Styles reported to the Department in RAS 156:

> *"… The current ADF system relies heavily on the premise that a member has been trained to perform a role, lawfully ordered to perform a role and should therefore undertake the role correctly in accordance with his training. However… there was no functioning system or mechanism present before or during the incidents to ensure compliance by the individual at that time… The lack of adherence is often acknowledged by the ADF and the member by way of a disciplinary process after the event [but this] provides no remedy to the problem."*

43. Having been warned, the Department knew that the safety of its members was at stake if it did not have compliance assurance mechanisms in place before the live fire exercises commenced. In September 2016, in response to the Comcare improvement notice, the Department concluded that the "near miss" incident "resulted from a lack of positive command, control and communications and non-adherence to procedures that lead to insufficient supervision of a trainee. This occurred through individuals with safety-related duties failing to discharge their duty in accordance with policy, procedures and training, or individuals failing to follow policy, procedures and training." The Department said it would, inter alia, **ensure all activities are conducted safely and comply with doctrine and safety publications**: see RCR 01-Army Headquarters Minute, Comcare 231251.

44. The detailed policies and procedures outlined in LWP-G 7-3-1 were developed in response to the known risk of death or serious injury in live fire exercises, which risk had been realised by death and injury to soldiers in *Cultana* and the near miss incident. Tragically, in spite of the policies being amended, some of the shortfalls and failures identified as contributing to those earlier incidents were repeated in this case. In spite of the Department's knowledge as to the level of risk and its expressed understanding of the need to ensure compliance with its policies, no mechanism was in place to ensure compliance, the safety policies were not complied with and Pte Challis was killed.

45. In addition, unlike the *Cultana* soldiers, Pte Challis and his immediate comrades were inexperienced. Indeed, the movement of the entire Brick into the danger zone, led by the Corporal and including the safety officers, ought to have set alarm bells ringing as to their level of preparedness for the exercise. The junior members of the Brick, including Pte Challis, were clearly relying on instruction and direction from their superior officers for their safety. Greater care was required in those circumstances. The duty that is owed the inexperienced soldier who is obliged to participate in inherently dangerous training is particularly acute.

46. The Department submitted that, in assessing objective seriousness, the court should distinguish between cases where policies were in place and not followed, and cases where policy was lacking. In the circumstances if this case, I do not consider much weight can be given to such a distinction. In this case a failure of policy, to have in place an assurance mechanism, resulted in numerous and significant failures to comply with policy. Policy, in and of itself, no matter how thorough, provides no protection unless it is complied with.

47. In light of the severe level of risk involved, discussed below, I consider it a very serious failure by the Department not to have in place an adequate assurance mechanism to ensure compliance with its existing safety policies because those policies could only ever mitigate the risk if they were applied and applied scrupulously. That there was no assurance mechanism to check and confirm that the safety requirements were complied with resulted in significant and protracted failures to comply with the safety policies going undetected, ultimately resulting in the foreseeable catastrophic consequences. In his evidence Colonel Richard Parker agreed with the proposition that in this case the failure by the Army to comply with its work, health and safety duties was a catastrophic failing. In all the circumstances, I consider that the departure from the duty owed was at the very upper end of objective seriousness.

The extent of the risk and likelihood of death or serious injury

48. In *Cultana* the Department admitted that it knew of the very significant risk to the health and safety of its employees posed by live firing exercises. In this case however, while the Department readily acknowledged that live fire exercises are inherently dangerous activities which impute a risk of serious injury or death, it submitted the risk of this eventuating was relatively low given the safety policies in place. In its written submissions the Department identified the "true causal factors relevant to Pte Challis's death" as follows:

> *"a. The primary failure, the failure of Pte Challis's platoon to undertake a "dry" or blank rehearsal. This mechanism was the key obligation designed to minimise the potential for participants to be exposed to the risk associated with live fire more broadly. Had such a rehearsal been undertaken, it is apparent that the participants*

would have known both the location of the target tree and the dangerous space, and thus been cognisant of the need to avoid those areas;

b. The second failure, the failure to mark dangerous areas and arcs of fire on the range. This mechanism effectively captures the risk of non-compliance with the primary obligation to undertake a dry or blank rehearsal (i.e. the obligation essentially to familiarise participants with the range). In the event that participants had not undertaken a dry rehearsal, whether due to a deliberate decision, misunderstanding or inadvertence), the visual markings of dangerous space were designed to, and would serve as, an alert to participants of areas that should be avoided; and

c. The third failure was the failure of all the participants, but particularly the safety supervisors and the OIC Practice, to observe that Pte Challis was not with the fire team upon the recommencement of the activity. Again, this mechanism – the requirement to know where participants were at all times – is essentially the last "failsafe" of the extant system. In essence, it addresses the risk that might arise from the two earlier failures (i.e. a lack of familiarity with the range, coupled with a limited understanding of the dangerous areas). Had Pte Challis been properly accounted for by means of a simple head count for visual identification of all brick members, such that other participants were made aware of Pte Challis's absence, the activity would likely not have proceeded until he was located."

49. The Department submitted that its policies and procedures had appropriate layers and levels of mechanisms, which individually and collectively should have avoided the risk and, because those policies and other planning processes were in place, the real risk of death or serious injury was relatively low.

50. I do not accept that submission. While the Department may have intended that its policies would be complied, given they were mandatory and disciplinary proceedings could follow from non-compliance, as already discussed, the Department was well aware that ex post facto disciplinary proceedings would not mitigate the immediate risk in the event there was a failure to comply with the policies. In addition, the extent of the non-compliance with the policies including by Commanding Officers and the OIC Practice is indicative of systemic failings, not simply failings on the part of individuals. The risk of death or serious injury from live ammunition ought to have been mitigated by compliance with safety doctrines. But the policies that were said to be in place did not operate effectively because there was no mechanism to ensure that they were complied with before live firing commenced.

51. The simulated buildings used in the exercise were made of insubstantial and penetrable plywood and hessian. Those materials provided no protection to members but they obscured vision. Similarly to *Cultana*, in this case neither the firers nor Pte Challis could see each other. The fact that members were blind to each other during the live fire exercise gave rise to what I class to be an extreme risk of death or serious injury. In addition, as discussed earlier, the soldiers involved in the Mount Bundey incident were significantly less experienced than the Special Forces soldiers training at *Cultana*. Accordingly due to the inexperience of the soldiers the risk was greater and more stringent care was called for.

52. Further, as discussed earlier, the entire Brick approached and entered the danger zone, including the Corporal and the safety officers. This suggests that none of them were appropriately alert to the dangerous space, either through training or briefings. In addition, there were no markings to alert them to the danger. If Pte Challis and his comrades had been trained in accordance with the policy that dangerous areas would be marked, they may well have been misled (by the lack of markings) into assuming the area was safe.

53. In order to determine the objective seriousness of the breach, I am required to consider the foreseeable potential consequences of the breach. In this case the history of these types of exercises, together with its complexity, the inexperience of the soldiers, the lack of progressive training, the lack of dangerous zone markings, and the use of live ammunition made the risk of death or serious injury not simply foreseeable but actually known. That Pte Challis died exemplified the extreme nature of the risk.

54. I have no difficulty finding that complex live fire training exercises such as the urban operations exercise carry with them a degree of risk of death or serious injury at the very upper or extreme end of the scale. This extreme level of risk was well understood by the Department. Although policies and procedures had been amended to better address the risk, similarly to the incidents at *Cultana* and the "near miss" incident, the safety policies and procedures were not properly implemented because there was no pre-exercise mechanism in place to ensure or confirm compliance. The risk that was not mitigated because procedures were not followed, crystallised when Pte Challis received a fatal gunshot wound to his head, but many other lives were also put at risk.

Specific and general deterrence

55. The objective of the WHS Act is to protect workers against harm through the elimination or minimisation of risks arising from work. Workers are to be afforded the highest level of protection against harm from hazards and risks at work as is reasonably practicable: s 3 WHS Act.

56. Courts have repeatedly said that general deterrence is a significant sentencing factor when safety obligations are breached: *Bulga Underground Operations Pty Ltd v Nash* (2016) 93 NSWLR 338 at [180] and that general deterrence provides a means of promoting compliance with health and safety requirements at work: *Nash v Silver City Drilling (NSW) Pty Ltd* [2017] NSWCCA 96 per Basten JA at [47].

57. I consider general deterrence is to be afforded significant weight in the sentencing of this matter.

58. In this case significant weight must also be given to specific deterrence due to the history of breaches by the Department in complying with its own safety doctrine, the more so when those breaches have resulted in death, injury, and near misses. Each of those incidents alerted the Department to the potential risks realised in this incident. This offence was not an isolated failure nor an uncharacteristic aberration. The Department was acutely aware of the risks of these exercises, and following other investigations had previously committed to

ensuring compliance with its safety policies. As discussed elsewhere, the extent and breadth of the failure to adhere to the safety systems on this occasion occurred because again there was no adequate assurance mechanism in place to check on and ensure compliance before the exercise commenced.

59. The Department intends to continue to train its members using complex live fire exercises. Accordingly soldier's lives remain at risk. The Department must actually learn from its previous mistakes and in future ensure that its safety requirements are fully implemented in practice. The penalty imposed in this case should compel the attention of those responsible to be vigilant and proactive in ensuring the safety of the members of the ADF.

Victim Impact

60. The court received victim impact statements from Pte Challis's parents and step parents. As one would expect the paternal and maternal families, including siblings, have been devastated emotionally and also financially by his death. One of the victim impact statements referred to the death as causing the family "extreme trauma". Although four years have now passed, the pain of the grieving families has not abated. It persists as both acute and raw, as evidenced by the presentation of their victim impact statements to the court. The delay in finalising these proceedings has contributed to the families' ongoing suffering.

61. In addition it is acknowledged and accepted by the Department that Pte Challis's colleagues, including the serving members in his Platoon and 5RAR, have been deeply affected by his death and the circumstances in which it occurred. The Department submitted that "any death in training or on operations in service to the nation is a tragedy".

Guilty plea, contrition, reparation and cooperation

62. Major General Matthew Pearse formally acknowledged that Pte Challis's death was an avoidable tragedy and expressed profound remorse to his family and the community on behalf of the Department.

63. Acknowledging that no payment can ever make amends, as a demonstration of genuine remorse the Department offered to pay reparation to the families of Pte Challis. In light of that offer, reparation has now been ordered. While I consider that payment of significant reparation calls for a significant discount on the sentence, I also accept the submissions of the Prosecution that any reduction must be balanced against s 16A of the Crimes Act which requires that a sentence be imposed that is of a severity appropriate in all the circumstances of the offence. In *R v Glen Keith Allen* [2005] QCA 073, a fraud case in which full restitution had been made, McMurdo P said:

> *"Whilst courts would never allow wealthy offenders with the capacity to pay compensation to buy their way out of an appropriate custodial sentence, restitution is…a relevant mitigating factor in that it compensates the victim and benefits society and is often, as here, a tangible demonstration of genuine remorse."*

64. The Department cooperated with Comcare's investigation into the death of Pte Challis and in December 2018 offered to enter into an Enforceable Undertaking, which was rejected by Comcare. In about December 2019 the Department sought to resolve this matter by offering

to plead guilty to a new or amended charge similar to the present charge on which the matter finally resolved. Ultimately that plea offer was substantially accepted and the plea of guilty was entered four years after the incident, to a recently amended charge.

65. The delay was attributable to negotiating the exact words of the breach of duty, a task which fell to both parties. However, those negotiations were conducted in the face of a very strong crown case as to the existence of a breach of the duty. The video evidence tendered on the plea was immediately available to the parties following the tragedy. The video clearly depicts the bungled handling of this fatal exercise. The video together with the detailed reviews and investigations of the Department identified failures to follow safety procedures. While the matter was listed for contested hearing, in light of the strength of the crown case I consider that the likelihood of the matter ever proceeding to hearing was remote. Accordingly, the discount for the plea is to be determined in the light of a very strong case.

66. The Department quickly responded to the tragedy. The response included:

    a. The suspension of all urban operations live firing practices using temporary urban training facilities on Category C Ranges. The suspension is to remain in force until the Department is satisfied that its controls are sufficiently robust to ensure a safe system of work while using live fire in this setting. The Army has resumed warfare training without the use of similar live fire exercises. Hence, the Department acknowledges that it is still not satisfied as to its capacity to ensure a safe system of work during such live fire exercises. While the suspension of the exercises points to contrition, it is a double edged sword. The delay and extreme caution taken before reinstituting similar exercises exemplifies the seriousness and complexity of the failings that occurred during this incident.

    b. Members of the ADF were subject to disciplinary proceedings following this incident.

    c. Multiple enquiries and reviews to ascertain the circumstances of the incident and to make recommendations as to improvements that might be made to ADF safety systems, including a complete review of the Land Warfare Procedures – General Doctrine. A comprehensive outline of the changes that have been implemented is contained in the Department's Outline of Sentencing Submissions and in the evidence of Colonel Richard Parker. I accept that the Department took the incident seriously and has reflected on and sought to amend its practices.

67. However, the community would expect nothing less than abject apology, comprehensive review and reflection, and positive change from the Department following such an incident. When asked why promulgated policy was not followed in the lead up to Pte Challis's death, Colonel Richard Parker frankly admitted in his evidence, *"I honestly couldn't tell you"*. Colonel Parker also agreed that the incident *"was a catastrophic failure by Army to comply with its own doctrine"*.

68. It is important to remember that Pte Challis was not the first soldier to die during ADF training in the Northern Territory at Mount Bundey. On 10 November 2004, while participating in a Corporal training course, Trooper Lawrence collapsed, was evacuated to Royal Darwin Hospital and was pronounced deceased from acute heat stroke. The circumstances of his death were considered by Madgwick J in *Comcare v Commonwealth of Australia* [2007] FCA 662. His death resulted from an abject and systemic failure by the Department to comply with health and safety policies articulated in a policy document known as SAFETYMAN. The risks associated with conducting exercises and training in extreme heat conditions were known, and hence, SAFETYMAN was developed to address those risks. Yet repeatedly and systemically SAFETYMAN was ignored or overlooked by the ADF, even in the face of significant numbers of reported cases of heat injuries, including Priority 2 events which meant that "life or limb was in serious jeopardy". Following Trooper Lawrence's death, The ADF conducted further detailed reviews to improve safety including the implementation of the Army Occupational Health and Safety Management System known as ArmySAFE, which was apparently intended to be a comprehensive and modern response to all the demands of occupational health and safety in the Army. Concerning the response by the Department to the death of Trooper Lawrence his Honour noted at [131] that, *"the ADF has sought to enter what is hoped to be a new era of service safety, both as to heat illness and generally"*. At [134] His Honour also reflected on the inadequacy of the then civil regime and its limited penalties to *"engender public confidence that proper legal standards of protection of Commonwealth employees, including our service people, is rigorously required of their superiors"* and, without apology, His Honour advocated for *"consequences that will really bite"*.

69. In response to each serious safety incident the Department has similarly expressed remorse and conducted reviews. The Department's sentiments and responses are now to be assessed against this further lost life.

Character and antecedents of the offender

70. The Department has two previous convictions for offences against the same provisions, although the facts in those cases are very different from the facts in this case: see *Docker v the Commonwealth of Australia* Downing Centre Local Court 9 March 2020; *Williams v The Commonwealth of Australia* Magistrates Court of Queensland 15 March 2021 per Luxton LCM. In addition, under the previously operating occupational health and safety civil penalty regime that applied to the Commonwealth under the *Occupational Health and Safety Act 1991* (Cth), the defendant received five civil penalties for occupational health and safety breaches in proceedings brought in the Federal Court of Australia: see *Comcare v Commonwealth of Australia* [2007] FCA 662; [2009] FCA 700; [2011] FCA 1043; [2012] FCA 1419; and [2015] FCA 810. The maximum penalty available in the civil cases was much lower than the penalty available in this criminal case and accordingly the civil penalties provide limited assistance as comparative sentences.

71. Given the Department's history of breaching work health and safety legislation, the Department is not to be treated with the degree of leniency that might be afforded a first-time offender.

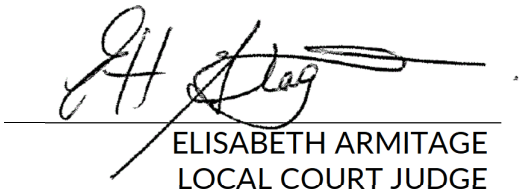
Conclusion

72. The Department admitted that it failed to put in place a simple, well known precaution, an assurance mechanism such as a checklist, to ensure that its safety policies were implemented. The risk was the highest there is, a risk of death. That risk was not only foreseeable it was foreseen. In response to other serious incidents the Department had indicated it would ensure its safety policies were complied with, but it failed to institute a mechanism that had that effect. Without a mechanism or procedure to check that safety standards had been complied with, what followed was: multiple breaches of the safety policies including by senior personnel, which were not detected, and which persisted over an extended period of time. All persons on the range were put at a greater risk of death or serious injury because of the safety failures. That one person died exemplified the extreme nature of that risk. Taking into account all the circumstances, I consider the breach in this case does fall into the worst category for this kind of offending.

73. In light of the objective seriousness, the high degree of culpability and loss of life, I consider that, save for a discount for matters in mitigation, the appropriate starting point for the penalty would be the maximum penalty of $1,500,000. Taking into account the strength of the crown case, I give a discount for the plea, contrition, cooperation and reparation in the order of 33%.

74. The Commonwealth of Australia is convicted and ordered to pay a fine in the sum of one million dollars ($1,000,000).

Dated this 1st day of September 2021



ELISABETH ARMITAGE
LOCAL COURT JUDGE