

CITATION: *Inquest into the death of Jason Walter Challis*
[2019] NTLC 002

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

FILE NO(s): D0078/2017

DELIVERED ON: 16 January 2019

DELIVERED AT: Darwin

HEARING DATE(s): 20, 21 November 2018

FINDING OF: Judge Greg Cavanagh

CATCHWORDS: **Defence Force urban operations live fire training exercise, safety mitigation procedures not followed, systemic failure, soldier shot in head**

REPRESENTATION:

Counsel Assisting: Kelvin Currie

Counsel for the Australian
Defence Force: Fiona McLeod SC

Judgment category classification: B
Judgement ID number: 002
Number of paragraphs: 114
Number of pages: 24

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

No. D0078/2017

In the matter of an Inquest into the death of
JASON WALTER CHALLIS
ON 10 MAY 2017
AT MOUNT BUNDEY MILITARY
TRAINING AREA

FINDINGS

Judge Greg Cavanagh

Introduction

1. Jason Walter Challis was born in Geelong to Helen and John Challis on 3 February 1992. His parents separated when he was 18 months of age. He had one sibling, Rebecca. When he was five years of age his mother entered another relationship. He acquired two further siblings, Brandon and Kelly. His step-father, Mirko Brandich, was an army reservist.
2. Jason attended Grovedale West Primary School and then College, in Geelong. He joined the Army Cadets at the age of 12. He left school after year 10 to become a qualified joiner. He worked at Pickering Joinery for eight years.
3. He joined the Australian Defence Force on 5 July 2016. He undertook basic training at Kapooka and infantry training at Singleton. He was posted to Darwin on 24 February 2017 as a Rifleman attached to Bravo Company, 5th Battalion Royal Australian Regiment.
4. The live firing exercise in which he was killed was part of *Exercise Tiger's Run*. It was designed to provide experience in a number of areas including Urban Operations. On 8 and 9 May 2017 Bravo Company practiced live fire Rural Section Attacks during the day and the night.
5. On 10 May 2017 the Company undertook the Urban Section Attack. The area for the attack had been set up to resemble a village. There were three mock buildings

on the left hand side of the road and three on the right. The mock “buildings” were made of plywood and hessian.

6. The exercise was to find a person of interest. That was to be achieved by the Section, being divided into two “Bricks” of four soldiers. One Brick was to work their way through the buildings on the right of the roadway and the other, the buildings on the left. The Section was to arrive in armoured vehicles from the west travelling through the village in an easterly direction.
7. Inside the buildings were “drop head” dummies. On the left side of the road the dummies were positioned against the Northern walls, that is, away from the roadway. Behind those walls was a danger zone because the rounds fired at targets would be expected to travel through the dummies and the plywood walls.
8. Each Brick consisted of a Section Commander or 2IC, a Point, a Cover and a machine gunner. Two engineers were also included to detonate explosives. Accompanying each Brick were three Safety Supervisors. One for the engineers and two for the Brick. On the roadway located behind the Section was an armoured vehicle with a machine gunner and traveling behind that was the OIC Practice for the exercise. Behind him was the Acting Commanding Officer of Bravo Company.
9. PTE Challis was the machine gunner in the Brick clearing the buildings on the left or Northern side of the road. His role was to provide fire support to the Point and Cover entering the building.
10. When it came to his Section’s turn to do the live fire run, they alighted from the vehicles to move to the sides of the roadway. The Brick of which PTE Challis was a member walked into the bush on the left hand side of the roadway.
11. On the direction of one of the Safety Supervisors they engaged with an enemy target as they approached the first building. They made their way to the back (North side) of the building. At that point it appears the soldiers did not know the position of the entrance (it was facing the road). PTE Challis took up a position at the back of the building near the northeast corner.
12. It is not known why he took up that position. Perhaps he was told to do so or perhaps, not knowing the position of the entrance, he considered it to be the best vantage point to cover entry into the building. One of the Safety Supervisors told

me he assumed he was told to take that position by the Section Commander, as in his opinion it was a viable position:

“The position that he was standing in provided cover to the North, which is a viable position if we're supposed to be at the back.”¹

13. The Point and Cover walked down the far side (East side) of the building toward the road (and the entrance to the building). In doing so they were dislocated from the rest of the Brick and the Safety Supervisors. They kicked the door open and then realised the rest of the Brick was not with them. Realising that it would be unsafe to fire the Point and Cover raised their weapons and applied safe.
14. The Section Commander walked down the nearside (West side) of the building to the road and noticed the Point and Cover near the doorway. He did not say anything to them but walked to the rear of the building and said, “Be careful, that dude is around the front”.
15. At that point it was assumed by the Safety Supervisors that the Brick would “stack” for entry into the building on the Northern side. However that did not eventuate. The OIC Practice, saw soldiers at the front and rear of the building and yelled, “STOP, STOP, STOP”. Those at the rear of the building immediately turned and walked down the West side of the building toward the OIC Practice on the roadway. That is, except for PTE Challis. He remained facing Northeast, covering the North at the back of the building.
16. The stoppage provided an opportunity for the Brick to reset. However, they did not reset at the same place they had been setting up (back of the building). The OIC Practice instructed that they reset on the South side (road side) of the building.
17. The reset took 53 seconds. However during that time no one noticed that PTE Challis was still in his covering position at the back of the building. No one counted or checked the stack. No one noticed before recommencement that PTE Challis was not at the front of the building.
18. After the restart, the Point entered the building and fired a shot at the drop head dummy on the North Wall. His rifle jammed. He stepped back. His Cover then fired

¹ Transcript p37

a number of shots at the dummy. Behind the plywood wall and in line with the dummy was PTE Challis. Rounds penetrated the dummy and plywood and fragments hit PTE Challis in the head and knee.

19. The Point and Cover moved to the next room in the building and cleared that. Shortly after, the Section Commander noticed that PTE Challis was missing. He sent one of the others to look for him. PTE Challis was found on the ground, wounded behind the building.
20. He was immediately treated at the scene and evacuated by helicopter to Royal Darwin Hospital. However, his wounds were such that there was no possibility of his survival and he was pronounced deceased at 2.59pm that same day.

Investigations

21. The death of PTE Challis sparked a number of inquiries. The first to be completed was undertaken by the Inspector General Australian Defence Force (IGADF). The IGADF inquiry was led by Mr Andrew Kirkham AM RFD QC. During his inquiry he had access to the full Coronial brief and to the Police Officer in charge of the coronial investigation, Detective Acting Senior Sergeant Matthew Allen. Mr Kirkham's Report set out what happened in detail. It was consistent with the information contained in the Coronial investigation. There was therefore no efficacy in reinvestigating the detail of the circumstances of PTE Challis' death at Inquest. I thank Mr Kirkham for his excellent report.
22. Comcare are undertaking an inquiry also in relation to any breaches of the *Work Health and Safety Act*. That inquiry is not yet complete.
23. Just prior to the commencement of the Inquest I was provided with the report of an inquiry said to be into the "Systemic Issues Relevant to the Death of PTE JW Challis" (the Woodroffe Inquiry). That inquiry had recently been completed.

Coronial Investigation

24. The Coronial investigation was undertaken by Detective Allen of the Northern Territory Police Major Crime Unit. The investigation was extensive. The material gathered took up seven large folders. He obtained the "building" and had it re-constructed in Darwin. He obtained a 3D printed computer generated model of the

- building and obtained the services of the NSW Police to provide computer generated crime scene reconstruction. The investigation was impressive in all respects and I thank Detective Allen for his care, thoroughness and lateral thinking.
25. The Coronial jurisdiction is primarily to determine the circumstances and cause of death. Part of the jurisdiction includes identifying systemic issues and recommending any necessary changes so as to prevent similar deaths.
 26. There were clearly a combination of factors at play. There is a natural tendency to look at the persons involved on that day, work out who was in the best position to determine that PTE Challis was not in the correct position and apportion blame.
 27. However that does not advance a systems analysis. There were obviously human errors involved. But to focus on those shifts the focus from those who have the power to bring change to those who do not. The appropriate questions are whether there were systems to ensure that human errors by those involved did not catastrophically compromise safety and if those systems existed, why they failed.
 28. It is unlikely that PTE Challis knew he was in a danger zone, standing behind a concealed target. Whether or not there were others that might have or should have noticed that he was in the danger zone and moved him, PTE Challis was entitled to have sufficient information or direction to know where he should and should not have been. Without it he could not exercise the individual responsibility to take care of his own safety and the safety of those he was tasked to support.
 29. PTE Challis was a young man with 10 months training. It was his first live fire urban operations exercise. He had not been on that range before. He had not been to that building before. The systems of interest are therefore the systems designed to ensure that PTE Challis had sufficient training and awareness to ensure his own safety.

Training and Experience

30. PTE Challis had joined the 5th Battalion of the Royal Australian Regiment (5RAR) on 24 February 2017. I was told by the Acting Company Commander that 5RAR is a “battle ready” Battalion. It had conducted exercises throughout 2016 and 2017 and I was told its members had been trained to the highest standards. Bravo Company was the “rifle” company. It was an ‘online’ or “ready” company. It had just

completed a blank fire exercise in Townsville which included a certification exercise for rapid deployment.² It was suggested that many of the Riflemen had two to five years' experience. I was told the standard was very high.

31. There was however other evidence that provided a slightly different picture. It was not as if PTE Challis was one of just a few new recruits. His Section Commander had more than 10 years' experience. The 2IC had over two years' experience. But after that the rest of the Section had little more experience than PTE Challis. They had all joined the Army between February and July 2016.
32. The Section Commander when asked about the Section said, "Mate they're a brand new Section. They need everything".³
33. The Section 2IC said:

"the entire company was really fresh. But at the same time we still had to proceed with training ... we tried our best to bring them up to speed".⁴
34. The Section Commander had joined the Regiment at the beginning of 2017 but had been on a course and then filling another position until two or three weeks prior to Exercise Tiger's Run.⁵
35. Some of the soldiers had been sent to another engagement days before the Exercise and the Section had two new members from another section. They had no more experience than the others.
36. After joining Bravo Company PTE Challis and his fellow Section members had been to the exercise in Townsville from 19 – 23 March 2017 and to a training exercise at Kangaroo Flats from 3 – 5 April 2017. At Kangaroo Flats there was a "combat shooting range with some urban - basic urban sprawl which [was] used as ... a fire range, or a shooter's lane to familiarise soldiers in urban".⁶

² Transcript p54

³ Interview p14

⁴ Interview p9

⁵ Interview p8

⁶ Transcript p33

Exercise Tigers Run

37. Exercise Tigers Run was a much larger training exercise. It was to run from 5 – 17 May 2017. It was a battle group level exercise where the whole of the Battalion was involved at Mount Bunday Military Training Area. The intention was to qualify to ATL/S 5B.
38. After Exercise Tigers Run they were immediately going into Exercise Southern Jackaroo from 18 - 29 May 2017. That was a joint training exercise with international forces. That was to lead into involvement in Exercise Talisman Sabre in July 2017.
39. The timetable for Exercise Tigers Run envisaged construction of the ranges at Mount Bunday Training Area before deployment on 5 May 2017. That was not possible because the main roads had been rendered impassable by the weather. The buildings themselves were constructed by the Company Engineers after deployment, on 5 and 6 May 2017.
40. The specific 5 RAR Operation Orders signed on 3 May 2017 by the Lieutenant Colonel envisaged that over 5 - 6 May 2017, “All Sub-Unit range prep complete and Sect dry training complete ready for LFX”.
41. On 4 May 2017 there was mention that 5 RAR needed to maintain the “tempo” so as to be ready for Exercise Southern Jackaroo. However by 8 May 2017 the Order was amended. The training outcomes sought from Exercise Tigers Run were scaled back to ATL/S 3B. It was considered that ATL/S 5B would be achieved during Exercise Southern Jackaroo.
42. At that stage (8 May) the weather was reaching 32-40 degrees Celsius by 11.00am and the road base was breaking up. Movements on the roads had to be minimised and training days were cut back to 6.30am to 10.30am with a pause until recommencement at 4.30pm with training going through until 6.30pm.⁷

Doctrine

43. The particular safety mitigation for urban operations live fire training exercises was at that time found at Chapter 15 Annex K (Urban Operation Ranges) of LWP-G 7-

⁷ Although the actual times for training were left to the discretion of the Commanders.

3-1, Australian Defence Force Range Orders (Land) 2015 AL1 (the Orders are collectively referred to by Army as “doctrine”).

44. The particular parts of that Order of interest are:

8.(b) Training must be progressive.

8.(c) Dry practices must be conducted prior to proceeding to blank firing, after which personnel may proceed to ball ammunition.

8.(k) The OIC Practice is to ensure that all practices develop progressively and that the level of training does not exceed (is commensurate with) the individual and/or collective ability of the participants.

*15. **Progression in Training.** All training must be conducted as a progression where the OIC Practice witnesses the training progression in order to ensure that the firers and Safety Supervisors have reached the appropriate standard prior to live firing practice. It is essential that a training progression be included in any approval to conduct Urban Operations on a Category C range. Both dry fire and blank fire practices must be conducted prior to each progression. The dry practice reinforces the safety brief and any mandated walk-throughs.*

45. There is a footnote after the first sentence:

Each step must be practised and revisited as required to ensure that personnel and Safety Supervisors have achieved the required standard prior to progressing to the next level.

17. “... It would also be anticipated that as the training complexity increased walk-throughs would be conducted, followed by dry and blank fire prior to ball live fire at each step ...”

Cultana Report - Walk-throughs, marking of walls and counting stacks

46. The other potential safety mitigation systems were recommended by the Cultana Report after the death of Lance Corporal Mason Edwards on 9 October 2009 at the military training area in Cultana, South Australia. On that occasion there were a group of soldiers going through an urban operations exercise. They had significantly more training than the soldiers in Exercise Tigers Run. They were being assessed for readiness for deployment overseas.

47. It was a night practice. One of the teams took cover behind a plywood building in line with an internal target. Lance Corporal Mason Edwards was fatally shot and another soldier was shot in the arm.
48. The Commander of the Defence Force held an Inquiry. That Inquiry (Cultana Inquiry) was also led by Mr Andrew Kirkham AM RFD QC. He recommended changes to doctrine. Amongst other things, he recommended there be a walk-through of the range for the soldiers prior to the exercise, that danger zones be marked on the exterior walls of the buildings and that the team leader count and check stacks.
49. In the IGADF Report relating to the death of PTE Challis, Mr Kirkham remarked:

“It is apparent that recommendations contained in the Cultana report concerning the death of Mason Edwards on 20 October 2009 in a night live firing exercise that took place in similar circumstances, were not utilised in this particular exercise. These in essence included:

- a. That no-go areas behind concealed targets be marked on the outside of the walls containing such targets;*
- b. ...*
- c. ... that team leaders observe, count and check stacks ... to ensure full awareness of the position and preparedness to move of each team member;*
- d. In live fire exercises, participants be made aware of each area of operations by having a walk-through of such areas prior to the commencement of any exercise.*

... the Inquiry considered that it was reasonable to suppose that if any one or more of these measures had been utilised in the exercise, the likelihood of the incident occurring would have been significantly reduced.

Certificates against self-incrimination

50. The Coroners Act provides that where I believe it is expedient to compel a person to answer questions and where those answers may incriminate them that I provide a Certificate that prevents the answers being used in other proceedings.

51. Five of the witnesses called during the Inquest sought Certificates. The possibility of disciplinary proceedings appeared to be the primary concern. I believed it appropriate to provide Certificates so as to ensure that there was no dissembling due to contemplation of some other process or proceeding.
52. All of the soldiers who gave evidence were impressive individuals who do the Australian Defence Force proud. They gave their evidence in a clear, considered and truthful manner. I thank them for that.

Issues

Doctrine

53. A reading of Annex K by a person unaffected by the traditions and culture of Army indicates that prior to a live fire exercise there should be a dry run rehearsal and a blank fire rehearsal on the range upon which the live fire exercise is to be conducted. Moreover, where the training complexity increased that walk-throughs would precede the rehearsals.
54. That interpretation of Annex K is also held by Army:

“Once that level of training is achieved it is required for rehearsals to be conducted at the specific, urban range site as follows. Briefing and walk-through, dry runs, blank fire then live fire. And that is currently spelt out, clearly spelt out in the current doctrine. It was also included in the doctrine at the time.”⁸

Clash between doctrine and preservation of dynamic setting

55. That interpretation of doctrine is not, however, consistent with a strongly held tenet that live fire exercises are designed to emulate actual combat conditions. They are to be dynamic, to invoke stress and the flow of adrenalin.
56. The Commanding Officer of the 5th Battalion at the time of the death of PTE Challis referred to that view as the “dynamic tactical LFX default mindset”.
57. He said that mindset sought to keep the range “dynamic” for the firers by not letting them see or rehearse on the actual range. It was said to be common practice to use the live fire exercise as a “full dynamic event once progression has been achieved”⁹.

⁸ Fiona McLeod SC Transcript p 115

⁹ Statement of Lieutenant Colonel at paragraph 91

58. He went on to say:

“This default mindset runs counter to the risk mitigation measures outlined in Annex K, which require dry walk throughs followed by blank rehearsals ‘on the buildings’ utilised for the practice. In my view there is still ambiguity as to the scope of Annex K in terms of whether to use the actual live fire range, or similar buildings, for rehearsal.”¹⁰

59. That ambiguity appeared to exhibit in a number of ways. For instance, at the time of PTE Challis’ death neither the Brigade Major nor the Acting Commanding Officer of Bravo Company were aware of Annex K and the requirement for dry fire and blank fire rehearsals before live fire practice.

60. There was also ambiguity in at least one mind as to what “progression of training” referred when used in Annex K:

“I think, at least in my mind, these are two separate things. There’s the requirement for progression of training and there’s a requirement – before going onto an urban range, dry, blank, live, but they’re not one and the same.”¹¹

61. I was surprised that the Acting Commanding Officer of the Company had undertaken the appropriate courses at a time when training progression (dry, blank, live) was not a requirement but was still qualified to supervise the live fire exercise.

The following answers were given in evidence:

Q. Were you aware that blank ammunition was required before there was a live-firing exercise?

A. Yes, so in hindsight now I am. Not 18 months ago.

Coroner: So did you know that was mandated the day that you were supervising this exercise when Challis died Sir?

A. No, your Honour, I wasn’t.

Coroner: But are you telling me that you had been qualified to supervise such manoeuvres?

¹⁰ Ibid paragraph 92

¹¹ OIC Practice, Transcript p92

A. Yes, your Honour. My qualifications from when I completed those courses were still extant.¹²

62. Where the requirement for progression through dry fire, blank to live fire was understood, there was certainly no belief that the progression was mandatory. It was regarded as optional. The Major in charge of Bravo Company, in talking of blank ammunition, is alleged to have said:

“Well, there’s no allocation and we don’t have enough time for it.”

63. Of that conversation it was said:

“...he then began to speak about how it’s also going to dilute the training value if the soldiers already conduct a blank run-through with the full mission profile”.¹³

64. The Acting Commanding Officer of Bravo Company said:

“...the particular activity was not scheduled to have a blank firing component to it. It was all live and you’re probably well aware there were some time constraints on these particular activities.”¹⁴

65. A Platoon Sergeant whose Sections did undertake dry fire rehearsals on the range said:

“So I knew there had to be a dry, blank and live ... unfortunately there was no blank rounds available for that activity at the time ... [the] OIC decided that we’d have to adapt and overcome and conduct dry fire and have to skip the blanks.”¹⁵

66. The view that the training progression was optional was also held by the Section Commander. He stated to investigating officers,

“You don’t want them to know what they’re going into because then you can’t get the reaction”.

¹² Transcript pp 52, 53

¹³ Transcript p 90

¹⁴ Transcript p 51

¹⁵ Transcript p 35

67. That view was expressed in circumstances where it appeared that 5th Platoon had other activities to undertake during the time when others were undertaking dry fire rehearsals. The OIC Practice stated:

I have every faith that [5th Platoon] ... would have conducted those rehearsals given the opportunity. However ... to the best of my knowledge, [they] were digging holes on the other side of the range because they were establishing the platoon rural range that was to be conducted after my range.¹⁶

68. In the event, the Sections of 5th Platoon (the platoon of which PTE Challis was a member) did not undertake a walk-through or rehearsals. There was also evidence that it was the most complex range the company had encountered.

Extent of adoption of the recommendations of Cultana Inquiry

69. The terms of reference of the Woodroffe Inquiry included determining the extent of the adoption of recommendations of the Cultana Inquiry.

70. According to the Woodroffe Inquiry Report, at the date of the death of PTE Challis the recommendation for all participants to have a walk-through of the range had not been adopted.¹⁷ Nor had the recommendation to mark ‘no-go areas’.¹⁸ It would also appear that the recommendation to count and check stacks was not within doctrine at that date.¹⁹

71. During the course of the Inquest I was told by Colonel Parker that the doctrine now (since the death of PTE Challis) makes it mandatory for all participants to have a walk-through of the range unless there is specific exemption not to do so by the formation commander.

72. He told me that doctrine at the time of PTE Challis’ death required the marking of “no-go” zones on the outside of the buildings but that the doctrine was not followed. However, given the finding of the Woodroffe Inquiry that it was not in the doctrine there may be some confusion on that point.

¹⁶ Transcript p 91

¹⁷ Page 137

¹⁸ Page 139

¹⁹ That recommendation may now be seen at Chapter 6 Annex J 8(t) of LWP-G 7-3-1 see paragraph 89 below.

73. If it is current doctrine it might be checked to ensure it is sufficiently explicit. If it has not yet made it into doctrine I would suggest that be undertaken as soon as possible.

What happened?

74. In accordance with doctrine, the Safety Supervisors were provided a walk-through of the completed range along with a safety briefing. However, the participants, the “firers”, were not provided with a walk-through.

75. The OIC Practice offered the range for the conduct of dry fire rehearsals. The members of two Platoons (4 and 6) took up that offer. The 5th Platoon did not.²⁰

76. The offer to conduct dry fire training on the range was not a scheduled event. It had to be conducted around other scheduled activities. The other activities on the days preceding 10 May 2017 were live fire training activities on the Rural Section Attack range. All Sections undertook that during 8 and 9 May 2017. No Sections undertook blank fire rehearsals.

77. When PTE Challis commenced the urban operations live fire training exercise on 10 May 2017 it was the first time he had been to the Urban Operations range.

78. Three Sections undertook the exercise before his Section. They had a dry fire rehearsal the evening before (albeit without the mission profile). They impressed the OIC Practice. He was impressed also with their preparation. He noted that the Section Commander, “had drilled his guys through ... a dozen times”.²¹

79. The Section of which PTE Challis was a member was the fourth Section to undertake the exercise. Their lack of preparation showed immediately:

- a. The engineers (without any ammunition) were initially leading;
- b. The Brick failed to observe a target until they were almost upon it. It had to be pointed out by a Safety Supervisor;
- c. They stopped behind the structure in the danger zone;
- d. There was no separation between the Engineers and the Brick;

²⁰ Transcript p 35

²¹ Transcript of Audio Statement p44

- e. The two leading members of the Brick dislocated from the rest and continued to the South side, causing the OIC Practice to call an emergency STOP and then a restart of the exercise and reset of the stack prior to entering the building.
 - f. Upon the restart there was a failure to note that PTE Challis was not stacked with the rest of the Brick;
 - g. After the restart the firers went under a window through which they were expected to have targeted a drop head dummy.
80. It was shortly after that the Point and Cover went through the door and PTE Challis, still on the other side of the building was shot.

Army Response

81. The institutional response was provided by Colonel Richard Parker, the Commandant of the Combined Arms Training Centre (CATC). It was sent by the Army lawyers at 4.52pm on Friday 16 November 2018. The Inquest was to commence the following Tuesday.
82. Attached to Colonel Parker's 24 page Affidavit were 836 pages of annexures. Given that the Army was provided the brief of evidence on 30 July 2018 that was an extremely late provision of the institutional response. It was not conducive to allowing an early determination as to issues likely to be in dispute or witnesses that needed to be called. The length and complexity of the material with only one day to absorb it was unhelpful.
83. Colonel Parker wrote at paragraphs 21 - 23:

“I am informed that Defence has undertaken a detailed examination of the IGADF Report and there is ongoing consideration of the Woodroffe Report. I am also informed that the overall assessment that Army has made with respect to the incident that led to PTE Challis' death is that while our policy framework may have been adequate at the time, there were vulnerabilities in our systems that hindered the ability of commanders to be confident in their

assessment as to the competency, currency and experience of individuals in the manner they conducted their duties.”

By this I mean that while individuals may have successfully completed Army’s training requirements, so that they are considered qualified, it does not necessarily follow that they immediately possess sufficient experience to effectively carry out more demanding tasks in roles to which they are appointed. Army recognises that experience comes with practice and our ‘crawl, walk, run’ approach to training should allow us to develop the experience of our personnel in a safe and effective manner. Experience is also linked to currency. While there is an expectation that all Army members will keep themselves up to date with procedures and methods of operating, there is also an onus on Army’s commanders to ensure this is occurring. When any element of the three components of competency, currency and experience is compromised, our people are exposed to risk.

Army has recognised this vulnerability and has been introducing progressive changes to our systems to address it.”

84. It was not however clear who it was suggested was not competent, current or lacking in experience. There was then listed in the Affidavit a range of changes and initiatives. It was not clear that they were responsive to any system failures identified as being present in the circumstances of the death of PTE Challis.
85. When Colonel Parker gave evidence he made the following statement:

Your Honour, I know some of these statements have already been made, but I think it’s important that I get to make these statements on behalf of the Army. The Australian Army is incredibly saddened by the tragic loss of PTE Challis and we offer our deepest condolences to the family, friends and colleagues. We are continuing to support PTE Challis’ family during this incredibly difficult time. A number of our personnel were also directly involved in the incident and this has caused them considerable distress. Our people are our Army. They are our competitive advantage and our most valued asset. A death in training or on operations in service to the nation is a tragedy. The death of PTE Challis was a preventable one.

Army must strive to preserve and protect our people, but unfortunately, we do not always get this right. We must do better. Defence has conducted investigations into the incident and surrounding circumstances to PTE Challis' death to establish what occurred and identify how defence could improve its safety framework and prevent future incidents. The reports to these investigations have been provided to the NT Coroner to assist with the inquest. We will, of course, take into account any recommendations of the Coroner to further improve our processes and our practices.

Those reports have identified vulnerabilities within Army systems that hindered the ability of commanders to be confident in their assessment as to currency, competency and experience of individuals in the manner that they can be – that they conducted their duties. The absence of any one of those competencies exposes our people to risk. The safety of our people is paramount. The Army remains dedicated to ensuring the safety of its people in training and on operations.

Army has made important changes to our safety framework, policy and practices, and this includes: annual re-certification training to ensure currency of training; the trialling of a currency management system to ensure that commanders assessing the skill and experience of personnel is both appropriate and within capabilities; and the introduction of full-time regional range safety advisors dedicated to enhancing prevention methods and providing expert advice to Army personnel on all aspects of land range safety.”

86. The following evidence was then given:

Q. So what were the vulnerabilities that you mention there?

A. The vulnerabilities are in regard to the ability of commanders to assess the competency of personnel to undertake range safety appointments.

Q. But you are not sure whether that had an effect or not in this case.

A. No I am not sure.

Q. Okay, so when the detailed examination was had, it indicated that there were vulnerabilities, but you're not sure whether those were vulnerabilities that led to PTE Challis' death?

A. No

87. Since the death of PTE Challis, doctrine has been changed. "Urban Operations ranges" is now Chapter 6 Annex J of LWP-G 7-3-1. On the first page there is a warning between red lines:

WARNING

It is mandatory for all personnel participating in a live fire (ball, CTR) urban operations range to conduct a walk-through prior to the conduct of the practice. This mandatory requirement can only be exempted by the formation commander when they are satisfied that the team conducting the activity have progressed through appropriate Army training levels within the force generation cycle. Failure to comply with this directive may result in casualties occurring.

88. Paragraph 8(s) now states:

"... Safe entry, the engagement of targets and the placement of all participants is to be reinforced during participant walkthroughs and rehearsals with adjustments (if required) made by the OIC Practice in consultation with the SSs to ensure that the practice remains safe".

89. Paragraph 8(t) now states:

"When in a stack prior to moving, the team leader is to report to safety staff following an oral, visual or physical check of their team. Safety staff are then to verify the team leader's report and inform the OIC Practice that all members are correctly positioned, accounted for and ready to proceed prior to entering the building."

Woodroffe Report

90. Attached to the affidavit of Colonel Parker was the Woodroffe Inquiry Report. It was indicated that the Woodroffe Inquiry had been requested by Major General Ellwood to determine "whether any systemic issues were relevant to the incident". The inquiry was said to have been carried out by an "independent Inquiry Officer".

91. The Inquiry report was 144 pages long and it covered many areas. The Inquiry method was to interview key Army personnel and conduct focus groups. There were some observations of interest that came from the focus groups:

“The PTES acknowledged that the walk-throughs do not impact on the realism and in fact build muscle memory and ‘knock out bad habits’. One member (PTE) who had just moved into a new company, appreciated the rehearsals and the opportunity to know where people should be.”²²

“The SQLD SRI/OIC group ... agreed that the progression balance seems to be right – starting small with pairs entering the room and simple targets and building up to a team using dry and then blank with SS assessing as they go through. If someone is not safe then they redo or do not do the live.”²³

92. During one of the interviews, a Major from the Land Range Safety Assurance Team, indicated that when he asked whether a walk-through had happened he was told it had not, “because if they did, it would not be a test and that when they go to war they do not do that”.²⁴ He said that he has had to stress that they were still at a training point.²⁵
93. There was then a discussion of “Training versus Testing”. Wherever the boundary lies, it is very clear that on any reasonable analysis PTE Challis and the other members of his Section were very much in the training phase.
94. What was a little disappointing was that there seemed to be a lack of appreciation of the role of systems in the Woodroffe Report. There are inevitably multiple systems designed to mitigate dangers. Generally if a tragic event occurs it is because of many systems failing at the same time. The Swiss cheese model of accident causation provided a visual representation of that proposition. Systems were described as slices of cheese. Accidents happen when the holes in the cheese line up.²⁶

²² Paragraph 141(a)

²³ Paragraph 141(g)

²⁴ Paragraph 372

²⁵ The interviews indicated that personnel have a very broad spectrum of views on the topic.

²⁶ Originally proposed by James Reason

95. However, in the Woodroffe Report there seemed to be an odd logic that if people could be demonstrated to have failed in their function that there was no need for system reform or strengthening. For instance, it was said that Army implementation of the Cultana Inquiry recommendations had been “sufficient” prior to the death of PTE Challis, (i.e. there was no need to have implemented the recommendation for a walk-through) because the lack of situational awareness of those involved was not due to an insufficiency of doctrine.²⁷ The conclusion included the following: “the inescapable fact is ... that it does not matter what policies, guidelines, doctrine and safety measures are put in place, the human factor is always present”.
96. There is no doubt about that. That is the very reason multiple systems are so important to ensure that when human factors intervene tragedy is not the inevitable outcome. But in this case it was not simply “human factors” that intervened. There was catastrophic systemic failure.
97. The Woodroffe Report made 18 recommendations. The majority of those recommended further review or reinforcement. There was a recommendation against further doctrinal change. On the final day of the Inquest Senior Counsel for the Army tendered a Decision Document indicating acceptance of the majority of those recommendations.

Comment

98. It is difficult to get past the fact that in a live fire training exercise, at the very first building, there was a dislocation in the movement of the Brick that ultimately led to three members being on one side of the building and the fourth member on the other side.
99. PTE Challis was inexperienced. He had not had the benefit of being trained on a complex urban operations range before. He was not provided the progression of training on the range anticipated by doctrine (i.e. rehearsals). If he had been given a walk-through, a dry fire rehearsal or a blank fire rehearsal it is unimaginable that he would have been at the back of the building in line with the concealed target. His death was clearly preventable as was conceded by Army at the outset of the Inquest.

²⁷ Paragraph 462

100. The failure to follow doctrine was not the failure of one or two or even a small group of individuals. It was not a mistake, forgetfulness or momentary inattention. It was a failure by the whole chain of command. It was a ‘systemic failure’ in the true sense of that phrase.
101. The reasons for that failure seem either not to have been appreciated or there is an unwillingness to confront them.²⁸ The evidence indicates that the reasons have to do with a difficulty encountered in attempting to change a long held mindset that live fire practice is to be dynamic. Annex K sought that change. However the evidence suggests that there was not a great deal of training or education about the change. One of the results has been an unwillingness to accept that the wording could mean that live fire practice was changed from a dynamic to a staged exercise.
102. The Acting Commanding Officer, Bravo Company said this in evidence:
- “It’s a hard job to maintain a training level. You can’t – I still believe you can’t continuously have to start from the beginning again and work your way up or we’ll never meet the directions of the Australian Government to protect this country if you continually do that. So we have to find a balance. So – ‘cause the training progression if you’ve been in the unit for a while you generally have that. You’ve done the years of build-up work whilst being posted to that unit. If you’re a new IET ... you are training to that standard but you haven’t done the 2, 3, 4, 5 years prior to that.”²⁹
103. That same issue, the perceived change from “dynamic” to “staged”, may have been the reason for the failure or refusal of Army to accept the recommendation of the Cultana Report that there be mandatory walk-throughs. Or, it might have been thought unnecessary if there were mandated dry fire and blank fire rehearsals (and optional walk-throughs when training complexity increased). It is obviously a difficult balance for Army but I encourage them to resolve the competing

²⁸ The broad spectrum of views reflected in the Woodroffe Report would indicate this to be a real possibility.

²⁹ Transcript p54

requirements between safe training and dynamic training (or testing) in an explicit manner.³⁰

104. The Army sought to downplay the characterisation of the facts:

“The army does not accept the characterisation that this exercise was shambolic or that there was chaos on the ground.”

105. However, in my view, the evidence establishes that the exercise that led to the death of this young man was a shambles. Counsel Assisting was correct to use the adjective “shambolic”. The facts noted at paragraph 79 (a) to (g) above make that abundantly obvious.

106. Rather, the Army continued to seek to portray the issue as “vulnerabilities”. One of the final submissions by Senior Counsel for the Army was in the following terms:

“However as already noted the accepted failures: that is the failures to conduct dry rehearsals, blank firing and a lack of control reflects the vulnerabilities within Army’s ability to assess the currency, competency and experience of those participating.”

107. While there may have been issues with “currency, competency and experience”, that was certainly not clear from the evidence. The major issue was that PTE Challis was not given the benefit of even a dry fire rehearsal. To see that as a lack of “currency” ignores the systemic issue: the failure or refusal to appreciate that doctrine mandated a progression of training that included rehearsals.

108. The characterisation of the issues as merely “vulnerabilities” is particularly perplexing given the then Commandant CATC had already concluded that it was clear that the “planning, supervision, development and subsequent war gaming or rehearsals were absent or ineffective”.³¹

109. Be that as it may, the evidence was that the updated version of the doctrine (that now includes walk-throughs and stack counting) was and continues to be the subject

³⁰ It is unlikely that there can be a “one size fits all” solution. I suspect that the answer lies in defining the difference between “training” and “testing” and prescribing what must happen in each

³¹ Woodroffe Report paragraph 431

to significant training. A roadshow was still in progress at the time of the Inquest. I commend the Army for that.

110. There remains the issue of whether ‘no-go’ zones are required by doctrine to be marked or not. There appears to be confusion in the evidence on that point. If it is not in doctrine, I encourage Army to rectify that. It is one more system to prevent our young men and women from being needlessly killed.

Formal Findings

111. Pursuant to section 34 of the Coroner’s Act, I find as follows:

- (i) The identity of the deceased was Jason Walter Challis born 3 February 1992, in Geelong, Victoria, Australia.
- (ii) The time of death was 2.59pm (CST) on 10 May 2017. The place of death was Royal Darwin Hospital in the Northern Territory.
- (iii) The cause of death was a gunshot wound to the head.
- (iv) The particulars required to register the death:
 1. The deceased was Jason Walter Challis.
 2. The deceased was of Caucasian descent.
 3. The deceased was a Rifleman in the 5th Battalion of the Royal Australian Regiment.
 4. The death was reported to the Coroner by Royal Darwin Hospital.
 5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.
 6. The deceased’s mother was Helen Ann Brandich and his father was John Maxwell Challis.

Recommendations

112. I recommend that Army resolve the confusion as to the interpretation of Chapter 6 Annex J, LWP-G 7-3-1 (formally Chapter 15 Annex K LWP-G 7-3-1) by making it explicit what rehearsals are mandatorily required to be undertaken by participants on a range prior to it being used for a live fire exercise.

113. I recommend that if Army determines that a rehearsal or rehearsals are required that the mandatory requirement of those be highlighted in the Annex as has now been done with the requirement for walk-throughs.

114. I recommend that the Cultana Report recommendation, “that no-go areas behind concealed targets be marked on the outside of the walls containing such targets” be included in doctrine.

Dated this 16th day of January 2019.

GREG CAVANAGH
TERRITORY CORONER