OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the suspected death of Phillemon Edward MOSBY**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Cairns
FILE NO(s):	COR 870/05(6)
DELIVERED ON:	23 May 2008
DELIVERED AT:	Cairns
HEARING DATE(s):	01 April 2008, 19-22 May 2008
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: Inquest, suspected death, vessel pilot transfer, MSQ monitoring pilot vessels, AMSA stipulating pilotage Standards**

REPRESENTATION:

Counsel Assisting:	Ms Julie Wilson
Torres Pilots & Barton Painter:	Mr Ian Molloy (instructed by Brian White & Associates)
Maritime Safety Queensland:	Mr Michael Woodford (instructed by Crown Law)
Workcover Queensland:	Mr Graham Houston (instructed by MacDonnells Law)
Cessa Mosby & AMPA:	Dr Dayle Smith (instructed by Bottoms English Lawyers)

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Pursuant to s28 (1) of the *Coroners Act 2003* an inquest was held into the disappearance of Phillemon Edward Mosby. These are my findings. They will be distributed in accordance with requirements of s45(4) and s46(2) of the Act and posted on the web site of the Office of the State Coroner.

Introduction

Phillemon Mosby was a deckhand on the pilot vessel '"*Alert*"'. It left Poruma (also known as Coconut Island) at approximately 1.30am on Wednesday, 27 October 2004 to transport a marine pilot to a merchant vessel.

The transfer of the pilot onto the merchant vessel was achieved without incident. However, during the process of transferring the pilot's luggage onto the ship via a heaving line, Mr Mosby disappeared.

These findings seek to explain what became of Mr Mosby and recommend changes to the regime regulating pilotage providers and the manner of responding to such incidents.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Mr Mosby's disappearance was reported to the Office of the State Coroner on 21 February 2005 as the investigating officer suspected that he was dead. In fact it is likely that this had been his belief since the day of Mr Mosby's disappearance in October the year before and the delay in the reporting of the suspected death highlights a lacuna in the *Coroners Act* 2003 which I am seeking to address via an amendment to the Act.

The suspected death is reportable if it was likely to have been "*a violent or otherwise unnatural death*" within the terms of s8(3)(b) of the Act. Accordingly, pursuant to s11(6) I have jurisdiction to investigate the death. Section s28 authorises the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a suspected death.

The Act, in s45(1)and (2), provides that when investigating a suspected death the coroner must, if possible find:-

- whether the death happened, and if so,
- the identity of the deceased,
- how, when and where the death occurred, and
- what caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, in so far as it is relevant to this matter, the Act authorises a coroner to "*comment on anything connected with a death investigated at an inquest that relates to –*

(a) public health or safety ; or

(c) ways to prevent deaths from happening in similar circumstances in the future.[2]

The Act prohibits findings or comments including any statement that a person is guilty of an offence or civilly liable for something.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not as constrained as courts exercising criminal or civil jurisdiction because s37 of the Act provides that "*The Coroners Court is not bound by the rules of evidence, but may inform itself in any way it considers appropriate."*

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear, that includes being given an opportunity

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46(1)
[3] s45(5) and s46(3)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I turn now to a description of the investigation into this suspected death.

The initial investigation consisted of a sea search conducted by the merchant ship and pilot vessel aimed at locating Mr Mosby after he went overboard. Various marine safety agencies were notified and became involved in an extensive search which is detailed later in these findings. The search failed to locate any trace of him.

Thereafter, Senior Constable Glen Robinson of the Thursday Island Water Police undertook a more detailed investigation of the circumstances of the fateful voyage and the adequacy of the equipment and training of the crew of the "*Alert*". He received some assistance from officers of Maritime Safety Queensland (MSQ).

It is of concern that the final report was not received by the Cairns Coroner until 13 June 2007, that is two years and eight months after Mr Mosby went missing.

Notwithstanding that, I am of the view the investigation has been competent and thorough.

The inquest

Pre – inquest conference

A directions hearing was held in Cairns on 1 April 2008. Ms Wilson was appointed counsel assisting and leave to appear was initially granted to the WorkCover Queensland, Torres Pilots, Cessa Mosby and the Australian Marine Pilots Association. Maritime Safety Queensland later sought and was also granted leave.

The hearing

The hearing proceeded over three days commencing on 19 May 2008. Nine witnesses gave evidence and 83 exhibits were tendered. During the hearing, I had an opportunity to view the '"*Alert*"' in Cairns. At the conclusion of the evidence oral submissions were made by counsel assisting and those given leave to appear. They were of great assistance.

The evidence

I turn now to the evidence. I can not, of course, even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Phillemon Mosby – social history

Mr Mosby was born on Coconut Island in the Torres Strait. He was 55 years of age at the time of his disappearance.

In his early life he engaged in the maritime industries for which the Torres Straits is famous: crayfishing, trochus and pearl shell. He also worked as a deckhand on cargo boats.

In his twenties, he moved to Cairns and worked in the railways and construction industries. There, in 1979, he met his partner Cessa. They have eight children; the eldest, Jonathan, is 28 years old.

Soon after their relationship commenced, Phillemon and Cessa moved to Sydney where Phillemon again found work in the construction industry. Their family grew quickly due to Cessa's prevalence for bearing twins; three sets in all.

In 1995, the family returned to Poruma to be closer to Phillemon's aging mother and to introduce the children to the island ways.

Cessa had commenced nursing when she lived in Cairns and as the children grew she returned to that field, working as a health worker at the Coconut Island clinic. She undertook TAFE studies in Cairns to help her advance in that vocation and commenced a Bachelor of Applied Science through the University of Queensland. She postponed her studies when she became ill following the loss of her husband.

When they returned to Poruma, Mr Mosby at first worked for the local council on the Community Development Employment Projects program (CDEP). In 1999, he took up the position as a deckhand on a pilot boat based on the island and operated by Torres Pilots. The boat is based there because the island is close to the northern end of the Great North East Passage, a major shipping channel through which large merchant vessels are required by law to navigate with the assistance of a licensed coastal pilot.

The operators were not able to provide evidence that Mr Mosby received any training or assessment of his competence to discharge the role when he was engaged, but experienced mariners who sailed with him on the pilot boat spoke highly of his seamanship.

He remained in continuous employment with the company from 1999 until he went missing. He usually worked from Poruma but on occasions he worked on pilot boats operating from Thursday Island.

Mr Mosby was of sober habits. He was a hardworking family man. He is undoubtedly missed by his partner and children and the wider Torres Strait community. I offer his family my sincere condolences on his passing.

The launch coxswain

Although the *Alert* and its usual deckhand, Mr Mosby, were based on Coconut Island, the launch was skippered by a coxswain deployed on a rotating roster system that saw one of about eight coxswains come to the island for a few days as required.

One of those was Barton Painter who was employed as a launch master with Torres Pilots from May 2004. He is an experienced and well qualified mariner. He spent his first two years at sea in the Torres Strait before going back to Western Australia where he gained further maritime experience and qualifications. By the time he

returned, he was a master class 5 skipper and a grade 2 marine engineer. He had approximately 2000 days sea time and had worked in a number of challenging and demanding marine situations.

Mr Painter told police he was very familiar with the '*Alert*' and had done extensive mechanical work on it in the few months he had been working for Torres Pilots.

The incident journey

He flew to Poruma on Monday 25 October and collected a pilot who had guided a boat from the southern end of the passage. The next day he did some routine maintenance on the *Alert*, cleaned it up and fuelled it ready for the next assignment which was booked for the early hours of Wednesday 27 October.

Mr Painter finished work at about 4.30 pm and saw his girlfriend off at the airport. She had come to the island for the day in connection with her work. He then relaxed at the company's donga where staff and pilots who do not live on the island stay when there.

The pilot whom he was to deliver to the ship the next morning, Captain Bala Nathan, arrived mid after noon and they met at the donga. They discussed the job; they were due to meet the ship at 3.30am which indicated a 1.30 am departure. Both retired early; Captain Nathan at about 8.00 pm and Mr Painter between 9.30 and 10.00 pm. Mr Painter had one can of beer with his evening meal.

Mr Painter woke at 1.00 am, dressed and drank some coffee and water and walked the short distance from the donga to the dock shortly before 1.30 am. Captain Nathan and Mr Mosby arrived there at about the same time and the crew made the brief preparations necessary before setting to sea. Both men say that Mr Mosby seemed quite normal in his appearance and demeanour and both are certain he displayed no indicia of intoxication.

The pilot boat was due to rendezvous with a bulk oil carrier, the Hellas Renaissance, at 3.30am at a point approximately 20 nautical miles north east of Coconut Island. The weather was reasonable: in his initial interview with police Mr Painter estimated the south easterly wind was blowing at 10 -12 knots but revised that to 15 – 18 knots when he gave evidence. He said the moderate chop made their voyage a little slower than usual. So, about an hour before their expected time of arrival, he radioed the Hellas Renaissance and requested they slow their passage to ensure the two vessels met in the boarding grounds.

The launch master and the pilot agree that nothing unusual occurred during the voyage out to the boarding grounds. They say that Mr Mosby continued to show no signs of any stress or undue fatigue. Mr Painter says that after Mr Mosby had attended to his routine tasks, he lay down along some seating in front of the steering position, but as far as Mr Painter could see he did not go to sleep and he considered that Mr Mosby was simply relaxing.

As they approached the Hellas Renaissance, Mr Painter, on the instructions of the pilot, radioed the ship and instructed that the ladder the pilot would use to climb aboard the ship should be lowered on the ship's starboard side as that would allow the

landing to occur in the lee of the ship. He also advised that the ship should slow its speed to 6 to 7 knots, the optimal speed for the transfer to occur.

The landing of the pilot

The pilot launch approached the ship from the south; passed to the east of it; went around its stern and hung off the starboard beam at a distance of 50 to 60 metres. Mr Painter explained that he did this in order to gauge the speed of the ship and to assess the impact of what is referred to as "interaction." This is the effect of the much larger vessel on the pilot launch as a result of the turbulence caused by the displacement of water as the huge ship moves through the sea. The Hellas Renaissance is 183 metres long and weighs 27500 tonnes. The *Alert* is 11.3 metres long and weighs approximately 10 tonnes. Mr Painter and other mariners who gave evidence, described how this phenomenon impacts on the ability of a skipper to control a smaller boat operating in the vicinity of a large ship.

Once he was satisfied that his boat had "settled," he moved closer to the ship, positioning the launch adjacent to where he could see the ladder hanging. Mr Painter described how he manoeuvred the port bow of the *Alert* hard against the side of the ship. The *Alert* had old tires hanging from the gunwale to minimise damage to the boat. He endeavoured to keep the *Alert* in this position by reducing power on the port engine, increasing power on the starboard engine and steering the boat hard to port.

When he was satisfied the boat was relatively stable, the pilot and the deckhand went to the foredeck by climbing from the aft deck onto the narrow side deck that ran beside the wheelhouse. Holding onto a hand rail attached to the side of the wheel house at about shoulder height, Mr Mosby and Captain Nathan made their way up the starboard side of the vessel to avoid placing themselves between the two moving vessels.

Mr Mosby then took hold of the rope ladder hanging from the ship. When the pilot was satisfied that Mr Mosby had the ladder under control, he scaled it to the deck of the ship, approximately 15 to 18 metres above the deck of the *Alert*. Both Mr Painter and Captain Nathan say the conditions for undertaking this hazardous exercise were very good, "near perfect" due to the protection from the wind and waves provided by the large ship.

On boarding the ship, Captain Nathan was met by a duty officer. They left the landing point for the bridge of the ship where Captain Nathan would assume responsibility for navigating the ship through the passage. Before he moved away from the landing party, he told them that he had two pieces of luggage to come on board. Those seamen then threw down to the *Alert* a heaving line to which the luggage could be tied by Mr Mosby.

Mr Painter recalls the end of the heaving line landing on the roof of the wheel house. Mr Mosby went to collect it and then, while holding on to it make his way back along the port side deck with the intention of fastening it to the pilot's luggage which he had moved from the wheelhouse onto the aft deck before he and Captain Nathan had gone forward.

Mr Painter saw Mr Mosby moving along the port side deck but did not see or hear him climb back onto the aft deck as expected. The crewman who threw the line also saw Mr Mosby take it up and move towards the back of the boat. In his statement he says that shortly after, while he was holding the other end of the line "*it was too heavy and there was something on the sea*."

The landing party thought the pilot's luggage had been dropped into the ocean and called out to this effect. This caused Captain Nathan to run back to the landing point and to look over onto the *Alert*. He called out repeatedly as he could not see anyone on board. After a time he estimated to be *'a minute or two"*, but I suspect was far shorter, Mr Painter appeared and it was apparent to all that Mr Mosby was no longer on board the *Alert*. The time was then approximately 3.44am.

Mr Painter says that the luggage had not been moved from where Mr Mosby had placed it on the back deck of the *Alert*.

I am of the view the evidence establishes that Mr Mosby fell from the *Alert* as he was making his way along the port side deck with the heaving line in one hand. Were he using the other hand to hold onto the hand rail he would have been forced to release his grip whenever he came to one of the seven or eight fastenings by which it was attached to the wheel house. The *Alert* was described as a "wet boat." Mr Painter told police that on the journey out to the ship the back deck was awash with foamy white water. It is likely the side decks were also wet. Whether Mr Mosby, slipped, tripped or stumbled we will never know but I have no doubt that he fell into the sea and unsuccessfully attempted to use the heaving line to save himself.

Man over board response

Mr Painter radioed the bridge of the Hellas Renaissance and confirmed that his deckhand had gone overboard. Captain Nathan instructed the landing party to ring the bells to wake all of the ships crew and to throw the life buoys from the stern of the ship and to illuminate the spotlights. The first instruction was, unbeknown to Captain Nathan not complied with. The crew did however lower ladders and nets on both sides of the ship and Captain Nathan, who by this stage had taken control of steering the ship commenced to turn it in a way that would allow it to retrace its path. He also made radio contact with Vessel Traffic Services Operations in Mackay, who in turn notified Thursday Island Water Police and the Australian Maritime Safety Authority.

Mr Painter immediately activated the "man overboard" function in his boat's GPS system so that the position at which the incident occurred was recorded. He turned on the spot light moved away from the ship and tried as best he could to position his vessel where he thought Mr Mosby might be some 100 to 200 metres aft of the ship. He shut down the motors and called Mr Mosby's name repeatedly. He heard no response and saw no sign of his crewman.

The search

Mr Painter made a note of the man overboard (MOB) incident in the ship's log at 3.50am including coordinates obtained from the GPS. Captain Nathan had proceeded directly to the bridge of the Hellas Renaissance and contacted the Vessel Traffic

Service Operations (known as the Reef Centre) at Mackay. MSQ employee Sean Allen was on duty at the Reef Centre and states he received that call at 3.45am.

He contacted the Thursday Island Water Police (TIWP) but did not get an answer. Senior Constable Robinson was on-call as the Acting Search and Rescue Mission Coordinator for the Thursday Island Search and Rescue Area of Operation. He missed the call from Mr Allen and there was no return phone number left. The Queensland Police Communication Centre at Cairns contacted him at 4.15am.

In the meantime, Mr Allen made a broadcast to all ships in the area and contacted the Australian Marine Safety Authority's Rescue Coordination Centre (RCC) at 4.00am. He also notified Torres Pilots and another pilotage provider, Australian Reef Pilots. While this was happening, Captain Nathan was making contact with fishing vessels in the area which he coordinated to search for Mr Mosby.

RCC assumed coordination of the search and arranged aircraft to search the area. TIWP arranged vessels for the surface search. A Royal Australian Navy vessel, the Malu Baizam was appointed the on-scene command vessel and Sergeant Shaun Skerritt boarded that vessel in the capacity of on-scene coordinator.

Senior Constable Robinson's log of events shows efforts being made from 4.15am onwards to secure all available resources for the search. The time of day and distances presented challenges however I am satisfied that all that could be done was done. Eleven vessels, including fishing vessels, Australian Customs vessels and pilot vessels assisted in the search on 27 October covering approximately 100 square nautical miles. RCC arranged five helicopters and three fixed wing aircraft which flew sixteen sorties covering about 900 square nautical miles. Datum buoys had been dropped into the sea by helicopters in order to establish the search area having regard to the current.

On Wednesday night, a helicopter equipped with infrared technology conducted a search covering approximately 100 nautical miles.

The following day, 28 October the air search continued involving six helicopters and two fixed wing aircraft. The total search area was 1900 square nautical miles. Eight vessels searched the area around Warrior Reefs. There were a further five small vessels assisting with the search that day.

Over the course of the two days, Dr Jeff Brock, a medical survival expert was consulted for his assessment of the timeframe for survival of Mr Mosby in the water. At about 7.00pm on 28 October Dr Brock advised that in his opinion Mr Mosby's prospects of surviving beyond 24 hours was remote.

The search was suspended at approximately 4.00pm on 28 October on account of there having been no sightings of any trace of Mr Mosby. Family and friends arranged to search for their loved one the following day to no avail.

I am satisfied that the search was thorough and that the individuals and agencies involved in searching for Mr Mosby did all that they could. Those involved are to be commended.

Survivability

As mentioned, Dr Jeff Brock is a survivability expert with significant experience at sea. He said that it was likely that Mr Mosby died very soon after he fell overboard. Dr Brock explained that the process of 'interaction' between the two vessels is likely to have pulled Mr Mosby under the larger vessel, probably causing him injury and almost certainly causing him to drown. Conversely, other experts suggested it more likely that he would have been swept away from the ship. These are only theories and could not allow me to conclude with sufficient certainty exactly what happened to Mr Mosby immediately after he fell into the sea.

In the event that Mr Mosby was not pulled under the merchant vessel and remained floating in the ocean, Dr Brock indicated that the chances of Mr Mosby surviving for more than 24 hours in the sea were remote. However, I do not consider that it is likely that he survived more than a few minutes. My finding in that regard is based on the failure of Mr Painter to detect any trace of Mr Mosby when he positioned the *Alert* aft of the Hellas Renaissance in the minutes after Mr Mosby fell overboard. I am of the view that the silence that met his desperate calls and the failure of any of the numerous air and surface craft that joined the search later in the morning to find any trace of Mr Mosby, indicate that he died very soon after falling into the ocean. I can not say whether he was injured in the fall, was injured by being swept into the propellers of either boat or simply drowned.

It was submitted that I could not exclude the possibility that some natural disease or ailment caused Mr Mosby to fall over board. It is true that I can not exclude that as a *possibility*, but that is not the test I am required to apply. Rather, I am to apply the civil standard of proof with regard to what is referred to as the Briginshaw principle. Mr Mosby was fit and healthy. He had neither displayed nor complained of any symptoms of ill health in the hours preceding the event. He was at the time engaged in walking along a narrow, uneven, wet gangway, on a moving boat, holding onto one end of a rope held on the other by a man he could not see or communicate with high above him, in the dark. I have no trouble rejecting the natural disease possibility and finding environmental factors more likely than not explain the fall.

Findings required by s45(1)&(2)

I am required to find whether the suspected death in fact happened and, if so, who the deceased person was, and when, where and how he came by his death. I have already dealt with the first and last of those matters, in that I have found that Mr Mosby is dead and I have described the circumstances in which the death occurred. I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased was Phillemon Edward Mosby

Place of death – Mr Mosby died in the sea adjacent to Yorke Island in the Torres Strait

Date of death – He died on 27 October 2004

Cause of death – Mr Mosby was lost at sea. The precise medical cause of death can not be ascertained. The most likely cause of death is drowning.

Comments and preventive recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety or ways to prevent deaths from happening in similar circumstances in the future.

For the reasons I explain below, I consider the evidence in this case indicates that Mr Mosby's death was preventable. Further, the evidence shows there were many other dangerous aspects to the operation of the *Alert* that posed a risk of death or injury to all who sailed on her. I shall detail these faults and then explore how they came to exist, why the regulatory regime designed to contribute to maritime safety failed to detect and remedy them until after Mr Mosby's death, and what changes are necessary to reduce the likelihood of similar dangers arising in future.

The dangerous flaws in condition and operation the Alert

Walking on the near side deck

Numerous experienced mariners gave evidence that it is unduly risky to move along the side of the pilot launch closest to the ship and the operator's written policies forbade it. Yet, this is exactly what Mr Mosby was frequently required to do when sending the pilots' luggage up onto the ship. If the heaving line landed in the aft deck he could perform that task in relative safety; but if it landed anywhere else, he would have to retrieve it and walk back along the near-side deck, as to go to the off-side would inevitably result in the line fouling on the masts and aerials protruding from the top of the wheelhouse.

It was suggested by counsel for WorkCover that although it may have been contrary to good practice, it was not inherently dangerous in the conditions which prevailed on the night Mr Mosby went missing. I do not accept that. I have already described the manoeuvre. It took place on a narrow, wet side deck. The crewman would have had to turn side on and shuffle along holding the heaving rope in one hand and the rail in the other, when he could, his grip being frequently broken when his hand reached the fittings attaching the rail to the boat. Such a manoeuvre would be prohibited on a building site if the walkway was more than a couple of metres above the ground. When the walkway was situated above the gap between two ships under way, the risk is obviously unacceptable.

Failure to wear a PDF

I consider it is unlikely that Mr Mosby was wearing a floatation device when he fell over board. Eye witness accounts are inconsistent and unreliable having regard to the lighting and the colour of the PDF that was available. Mr Painter states that his

practice was to hang the safety equipment on a hook at the wheelhouse door and when he checked after the event there was one self-inflatable jacket there. Mr Sutton said in evidence that he would expect only one self-inflatable life jacket to be onboard.

Mr Painter says that there was a requirement for all people working outside the wheelhouse to wear life jackets but it is apparent that he didn't enforce this policy.

Had both of these foreseeable risks been avoided I consider it likely that Mr Mosby would not have died.

Other deficiencies not connected with the death

On 29 October 2004, Peter Cramp, a Marine Safety Officer with Maritime Safety Queensland (MSQ), and Senior Constable Robinson inspected the *Alert*. The vessel was found to be unseaworthy.

Fire risk in the engine room

The most serious deficiency related to the inability to isolate the engine room, that is, to close off its air supply. When coupled with the inability to remotely shut off the fuel supply in circumstances where the engine and engine room were coated in flammable fluids, this meant that if a fire broke out it could not be contained. The seriously bad condition of at least one engine – the port engine was reported to consume or spray out a litre of lubricating oil for every nautical mile over which it was operated – meant that the risk of a fire was high.

Loss of water tight integrity

Further unauthorised construction led ducting forward towards the bow of the vessel into what should have been a watertight bulkhead compromising the water tight integrity of the hull so that it could flood almost to the stern causing it to sink.

Mr Cramp said that the engine room was awash with oil and other lubricants to the extent that he could not tell if the fluorescent light was on until he wiped it clean of oil. He identified serious problems with the bilge system. The non-slip surface on the aft deck had been worn smooth and hand rails caused Mr Cramp concern.

Absence of mandatory training, safety and operations manuals

Mr Cramp was also interested to inspect documents the Transport Operations (Marine Safety) Act (TOMSA) prescribes be kept on board. He found the documentation to be entirely inadequate. The technical manual and the maintenance and service manual were void of any details and were essentially copies of pro forma manuals issued by MSQ to assist operators to prepare their own. There were no records of maintenance of the vessel on board. The occupational health and safety manual and safety management plan were inadequate and not tailored to the *Alert* or the passengers and crew who used it. Importantly, the man overboard procedures did not deal with a situation where only one person remained on board after such an incident, an entirely possible event on a boat with a two man crew.

During this inspection Senior Constable Robinson noticed that a document titled 'Procedure for Transfer of Pilots for Launch Masters and Deckhands' had been added to one of the folders of documents he had taken from the *Alert* and copied the previous day. I was not able to establish who had attempted to interfere with the

investigation in this manner but obviously only those connected with Torres Pilots had any interest in so doing.

A Shipping Inspector's Written Direction was issued under the TOMSA by Mr Cramp taking the vessel out of service pending rectification of the defects he had identified and the issue of a Certificate of Compliance. He authorised the vessel to be sailed back to Thursday Island but only after the most serious fire risks had been negated, the crew had been given training in how to respond to a fire and on the condition that the seriously degraded port engine was not used.

Numerous defects and a poor safety culture

Captain Copland, a marine surveyor, inspected the *Alert* on 4 November 2004. He shared Mr Cramp's concerns stating that the vessel was in poor condition and had been neglected. He found cracks and fractures in the hull, deteriorated seals on what should have been the watertight hatches, a disabled bilge alarm, rusted fuel lines, leaking fuel injector lines, loose engine mounts, leaking and misaligned propeller shaft glands and numerous other deficiencies and faults.

Captain Copland wrote that "*this state of affairs has developed over a period of some four years and it is quite apparent that as far as the engine room maintenance is concerned that this has been abysmal*." Insofar as safety gear is concerned, Captain Copland noted, amongst other things, that fire fighting equipment was out of date, there was no harness tracks fitted, signage regarding safety procedures and fire flaps were inadequate and there were no access steps or ladder to the roof where the life raft was positioned.

An audit of the company's management systems was also undertaken by Captain Copland. He said that "*the level of sufficient management and supervision of the maintenance of the pilot vessels was found at the time of our investigations to be below a satisfactory standard*." Captain Copland refers to a "*she's alright Jack*" culture having developed.

Training of crew was inadequate. Mr Mosby had been employed by the company prior to formal procedures and training requirements being developed. There was no evidence that Mr Mosby had received any training in safety, or other, procedures.

This evidence is an indictment on the management of Torres Pilots. It demonstrates a complete disregard for the safety of the company's employees and contracted pilots. The attempts of the managing director and majority share holder, Mr Sutton, to lay all blame on the managers on Thursday Island are unconvincing. As Captain Copland points out, these gross deficiencies did not develop suddenly, but over a number of years. His view in this regard is supported by the accounts of crew who worked for the company in the year preceding Mr Mosby's death. Mr Jimmy Ritchie and Mr Rosario Mangano describe a culture in which safety, training and maintenance were routinely disregarded and just enough was done to keep the boats at sea. Basic principles of safe seamanship were routinely ignored.

In my view, Mr Sutton had an obligation to keep himself better informed of the state of the company's principal assets and the manner in which they were being operated.

I do not accept that he was entitled to rely on survey reports commissioned for insurance purposes. They were clearly unreliable as a means of gauging the condition of the vessels from a safety perspective. For example, the report on the *Alert* dated 2 June 2004 acknowledges it is based on a "*superficial examination of the vessel*" and contains only a few words about the boat's condition. The report lists the equipment, fittings and fixtures of the vessel and concerns itself almost exclusively with market value of the assets. I don't accept that Mr Sutton genuinely believed that those reports informed him about the seaworthiness of the vessel and he apparently made no other adequate inquiries.

Improvements

I acknowledge the company has since Mr Mosby's death taken significant steps to remedy these atrocious breaches of its responsibilities. Work commenced on the vessel soon after the incident to rectify the problems identified by Captain Copland. A Queensland Transport accredited marine surveyor, Graeme Normington, inspected the *Alert* on 11 November and on 10 December 2004 and issued a Certificate of Compliance for Survey and a Certificate of Compliance for Safety Equipment under the TOMSA.

The vessel is currently undergoing a major refit in Cairns and I was able to inspect it. The evidence and my inspection satisfy me that many of the safety concerns associated with the vessel have been addressed. In particular –

- A sail track that allows the deckhand to be harnessed to the vessel has been installed;
- A harness is fitted to the updated self-inflating lifejackets worn by deckhands and those jackets are brightly coloured;
- A loud hailer that allows communication between the launch master and a person on the foredeck has been fitted;
- Steps have been installed between the side decks and the aft well deck; and
- A qualified marine engineer is now employed by the company and based at Thursday Island.

Captain Copland again reviewed the fleet of vessels operated by Torres Pilots and undertook a further review of management systems in April 2008. It is comforting that he formed the view that considerable efforts have been made by the company to address the problems he identified in November 2004.

I referred earlier to the company's Procedures for Launch Masters and Deckhands. While, there is no evidence that Mr Mosby had ever seen these procedures, and it is clear that they were not routinely followed, they are worthy of some attention because of the improvements that have been made to them. The procedure has now been updated to provide that the pilot's bags go up first and come down last so that there are always two people on the launch other than the coxswain during the transfer. Deckhands are required to wear a lifejacket at all times and are to be harnessed to sail tracks fitted to the *Alert* after Mr Mosby's disappearance. Of course, these changes will only increase safety if they are adhered to.

While I accept that Torres Pilots have attended to the significant shortcomings in vessel maintenance and crew safety procedures and training since Mr Mosby

disappearance, the question remains how those shortcomings were not identified earlier when the operators failed in their duties. That this seriously unsafe vessel was allowed to operate undetected by any of the safety authorities is a major concern. It requires I review how that may have occurred.

The regulatory regime

MSQ registration and monitoring

The Great North East Channel is part of a 'compulsory pilotage area' established by TOMSA. Ships traversing it are required to have a licensed pilot on board to navigate. Torres Pilots is a privately owned and operated business which provides a service to such ships by transporting pilots to and from them. It does that using its own pilot vessels and in some cases by chartered helicopters.

In addition to the very poor condition of the *Alert* at the time of the disappearance, issues arose during the course of the evidence about whether the *Alert* was fit for use as a pilot vessel on account of certain design and construction features, particularly the width of the gunwhales, or side decks. It became apparent that neither State or Federal regulation clearly establishes standards to met by vessels operating as pilot vessels.

TOMSA is administered by MSQ, a division of Queensland Transport. It is responsible for "*promoting marine safety in Queensland*". It does that in various ways including through the registration process, through the requirement for operators to submit certificates of compliance relating to various aspects of the vessel in various circumstances and by monitoring vessels.

While TOMSA and the Regulations contain provisions for the safe operation of ships generally, vessels are not registered or classified on a fit for purpose basis and there are no requirements regarding the use of a ship for a specific type of operation. Accordingly, that agency is not charged with determining whether a vessel is fit to be operated as a pilot vessel.

The *Alert* was registered as a class 2C commercial ship allowing it to operate not more than 50 nm from the coast or anywhere within the Great Barrier Reef region or the Torres Strait Zone. A chart of the Torres Strait zone was produced and I am satisfied that the vessel was operating within that zone at the time of Mr Mosby's disappearance.

The legislation requires that a ship not be operated unless it is safe. A ship is safe if it is seaworthy, and is appropriately equipped and crewed, to meet the ordinary perils of the voyage on which the ship is proceeding or about to proceed (section 41). TOMSA also obliges ship owners and masters to ensure a vessel is equipped with safety equipment and carries certain documentation.

However, assessment and certification by an independent surveyor is not required for annual registration renewal. Unless the operator is proposing significant structural changes, the owner of vessel is able to make a declaration that the vessel has been

correctly maintained and is in a seaworthy condition and contains the necessary safety equipment.

Shipping inspectors, appointed under the legislation, have various functions including monitoring ships and their operations to ensure that the general safety obligations and standards, as well as other provisions of the Act are complied with (section 153(a)). Those inspectors have powers allowing inspection of vessels in order to perform that function.

MSQ says it aims to inspect vessels such as the *Alert* on a regular basis. However, in the years preceding Mr Mosby's death this does not seem to have occurred. Even when a former master of the *Alert*, Jimmy Ritchie, complained to the MSQ office in Cairns in May 2004, that the boat leaked severely and the malfunctioning engines made it a fire hazard, no action was taken. He told MSQ that the bilge alarms had been removed, navigation lights were defective and basic pre start checks were almost never done. The *Alert* was not inspected by MSQ following that complaint and no investigation was initiated. It seems that resources hampered the agencies capacity to travel to Poruma to conduct an inspection. No other explanation for this stark abandonment of the agency's responsibilities was forthcoming

Guidelines for time frames for those inspections at the relevant time specified that non-passenger vessels should be inspected every two years. Captain Watkinson said that a risk-management approach to the question of when a vessel should be inspected has been added to the guidelines in an effort to address that issue. He also said that there was now a marine safety officer based on Thursday Island.

Recommendation 1 - Review of failure to action Richie complaint

I recommend the General Manager MSQ establish why no action was taken in relation to Mr Richie's complaint with a view to ensuring there is no repeat of such failings.

Recommendation 2 – Risk based targeting of monitoring activities

Having regard to the evidence put before this inquest there is in my view a sound basis to be concerned about the safety culture within Torres Pilots. I therefore recommend that this information and any future complaints be considered when MSQ monitoring activities are being targeted.

Recommendation 3 – Review of self declaration of seaworthiness

I am aware that self regulation is now the philosophical underpinning of many regulatory schemes. However, in view of the critical nature of the annual declaration that a commercial vessel is seaworthy, in a context where the regulator is unlikely to be able to regularly inspect all craft, I consider there is a basis for winding back this system with its inherent conflict of interest. I therefore recommend the General Manger MSQ review whether the TOMSA should be amended to require an accredited marine surveyor to complete the certificate of seaworthiness on annual applications for renewal of registration of all commercial vessels.

Oversight of pilotage by AMSA

The *Navigation Act 1912 (Cth)* provides AMSA with the power to make regulations for the licensing of pilots, the conduct of pilots and the role of pilotage providers.

Standards for pilotage are contained in Marine Orders part 54 which calls up the Great Barrier Reef Safety Management Code (the Code) which annexes the Pilot Vessel Standard for Queensland Coastal Pilotage (the Standard). Pilotage providers are required by the Code to develop, implement and maintain a Safety Management System.

AMSA conducts 'desktop audits' of those systems to assess compliance. The Standard includes provisions regarding the construction of pilot vessels. Clearly, inspection of vessels is necessary to ascertain compliance or otherwise with such standards. The *Alert* was inspected by AMSA 2 July 2003 and was found to comply.

At that time the *Alert* was not required to comply with the provision in the Standard regarding gunwhale width. That provision says that –

3.1 A pilot vessel shall:

(b) have a continuous deck, clear and free of obstruction with adequate width between the gunwhale and superstructure for safe pilot access.

That provision and other more stringent provisions under the amended MO54, version 4 now apply to all pilot vessels.

The evidence highlighted that it is impossible to ascertain whether paragraph 3.1(b) has been complied with without some guidance as to what is an '*adequate width*' for side decks. The Australian Marine Pilots Association suggests that the Standard should stipulate that side decks of not less than 750mm are required on all pilot boats. However I am of the view that what is adequate will depend on a number of factors, including other safety features and the manner in which a vessel is operated. For example if a vessel were to have a forward hatch allowing direct access from the wheel house to the foredeck the width of the side decks may be irrelevant.

AMSA has appointed a Principal Pilotage Officer who is a master mariner and experienced pilot, to monitor compliance with those provisions. These are matters he should resolve as a matter of priority.

Recommendation 4 – Guidelines for applying the Pilot Vessel Standard

I recommend that as a matter of urgency, the Principle Pilotage Officer develop guidelines and explanatory notes to enable the pilotage industry to understand what is required for compliance with the code

The interaction between the investigative agencies

I have dealt with the failure of the regulatory agencies to intervene before the tragedy occurred: I now need to consider their response subsequent to it.

I have concluded the emergency response was appropriate and professionally carried out. The actions of MSQ to immediately go to Coconut Island and inspect the boat was also appropriate. Mr Cramp took decisive action to "condemn" the boat so as to prevent it being used further until its safety flaws had been remedied.

However, there was no investigation by the safety regulator and no enforcement action was taken, or it seems, even considered. Some explanation of that is required.

As has been mentioned, MSQ is the agency responsible for administering the TOMSA, the legislation principally designed to regulate marine industries and to ensure marine safety in Queensland. However there is nothing in that Act to exclude the operation of the Workplace Health and Safety Act and Regulations which are designed to do the same in workplaces generally. That Act is administered by the Division of Workplace Heath and Safety (WH&S).

Those agencies have entered into an MOU to provide for the sharing of information and the avoidance of unnecessary duplication of investigative effort. The agreement provides a mechanism for nominating a lead agency for enforcing the respective legislation by the regulatory agencies. Unsurprisingly, it provides that as a general rule, MSQ will be the lead agency in respect of marine incidents to which the TOMSA applies and WH&S will discharge that role when its Act is to be brought into play.

The MOU also provides for the agencies to work together on those matters which may be both a marine incident and a workplace incident.

In this case there was no such joint effort and MSQ played only a limited role in assisting the police officer who prepared the report for the coroner. An entry in schedule 2 to the MOU headed *Jurisdictional Examples* may explain the lack of collaboration by the two safety agencies: in relation to the example *Person lost overboard from a vessel*, it is stated that WH&S has no jurisdiction. This is clearly wrong. Mr Mosby lost his life as a result of a workplace incident that raised serious issues about the safety of that workplace.

The failure of MSQ to complete an investigation report or to consider enforcement action despite two of its officers identifying serious breaches of the Act was not able to be explained. The suggestion from one witness that they did not want to do anything to compromise the police investigation for the coroner is not tenable. WH&S, for example, regularly investigates and prosecutes breaches in matters that have been reported to a coroner.

Recommendation 5 – Review of WH&S / MSQ MOU

I recommend the Director of the Division of WH&S and the General Manger MSQ review the operation of the MOU in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies.

Recommendation 6– Review of failure to consider prosecution

I recommend that the General Manger MSQ review the manner in which this marine incident was investigated to establish why no consideration seems to have been given to initiating prosecution action under the TOMSA.

This inquest is closed.

Michael Barnes
State Coroner
23 May 2008