QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the loss of the *Malu Sara***
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Thursday Island
FILE NO(s):	COR 592/06(4), 593/06(1), 594/06(7), 595/06(3) & 2766/05(1)
DELIVERED ON:	12 February 2009
DELIVERED AT:	Thursday Island
HEARING DATE(s):	15/2/07, 13/4/07, 16-26/4/07, 10/5/07, 27/7/07, 20/8-6/9/07 & 13/6/08
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: Inquest, DIAC procurement procedures, AMSA survey regime, MSQ boat builder accreditation regime, QPS and ATSB investigation methods**

REPRESENTATION:

Counsel Assisting:	Mr Mark Gynther
Family of Mr Wilfred Baira:	Ms Tracy Fantin (instructed by Wettenhall Silva Solicitors)
Families of Flora & Ethena Enosa, Ted Harry & Valerie Saub:	Mr Mark Green (instructed by Legal Aid Queensland)
Maritime Safety Qld:	Mr Jeff Hardy (instructed by MSQ)
Australian Transport Safety Bureau:	Mr Ron Ashton (instructed by Minter Ellison Lawyers)
Australian Maritime Safety Authority:	Mr Peter Dunning SC with Ms Rachel Pepper (instructed by AMSA Solicitors)
Department of Immigration & Citizenship:	Mr Ralph Devlin SC with Mr Mark LeGrand (instructed by Clayton Utz Lawyers)
QPS Commissioner:	Mr Wayne Kelly (QPS Solicitors)
Mr Don Radke:	Mr Kevin Priestly (Corsetti Lawyers)
Mr Gary Chaston:	Mr Michael Fellows (instructed by Farrellys Lawyers)
Sergeant Warren Flegg:	Mr Steve Zillman (instructed by Gilshenan & Luton)
Mr Jerry Stephen:	Mr Ryan Ellis (MacDonnells Lawyers)

Part 1 – Jurisdiction, investigations and inquest

Distribution of these findings

The *Coroners Act 2003* provides in sections 45 and 46 that written inquest findings must be given to the family of the person who died, each of the persons and organisations granted leave to appear at the inquest and to the Ministers and government entities with responsibility for the matters referred to in any comments made by the coroner.

These are the findings of the inquest into the deaths resulting from the loss of the *Malu Sara,* a vessel owned and operated by the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA or the Department).[1]

These findings will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

Introduction and jurisdiction

In a media release announcing the launching of six new immigration response vessels (IRVs) in late August 2005, the then Minister for Immigration and Multicultural Affairs, Senator Vanstone, acknowledged the valuable work undertaken by indigenous Movement Monitoring Officers (MMOs) and predicted, *"These boats will greatly enhance the operations of DIMIA's Torres Strait officers who play a vital role maintaining border control."*

Six weeks later, on Friday 14 October 2005, one of those vessels, the *Malu Sara,* disappeared while travelling from Saibai Island to Badu Island. On board were two departmental officers and three passengers, including a five year old girl. None of them survived.

The boat had become lost in fog and had sought assistance from the Thursday Island office of the Department. In the early hours of 15 October

[1] By the time of this inquiry, "*DIMIA* had become known as the *Department of Immigration and Citizenship* (or "*DIAC*"). In these findings, reference to the "Department" shall refer to either, depending upon the context.

2005, the skipper again made contact with the office and advised that the vessel was taking on water and was sinking.

On 23 October 2005, the body of one of the passengers was located by Indonesian fishermen near Deelder Reef, approximately 50 nautical miles north-west of the *Malu Sara*'s last known position.

The death of that person and the suspected deaths of the others were reported pursuant to the Coroners Act as "*violent or unnatural deaths".*[2] Accordingly, a coroner had jurisdiction to investigate them and to convene an inquest.[3]

The Act requires a coroner to find whether a suspected death has occurred, and if so the identity of the deceased and the date, place and cause of the death. A coroner is also required to find "*how the person died*".[4] The authorities establish that this extends to the circumstances of the death sufficient to understand the contributory causes.[5] A coroner may, whenever appropriate, comment on anything connected with the death that relates to public health or safety.[6]

Issues to be considered

In discharging those obligations these findings:-

- confirm the death of those missing and the identity of all lost with the boat;
- seek to establish the time, place and medical cause of the deaths;
- consider how the boat was lost and whether the manner in which it was acquired by the Department, built and brought into service contributed to the disaster;
- consider whether the Department's officers and the Queensland Police Service officers to whom the unfolding problems were reported, adequately responded to the information they received;
- critique the search for the missing people; and
- make recommendations as to how the problems highlighted by the events could be addressed.

Investigations

The Department conducted a brief investigation into the incident immediately after it occurred. Its conclusions were recorded in a report dated 3 November 2005. The Queensland Police Service (the "QPS") and the Australian Transport Safety Bureau[7] (the "ATSB") each also conducted investigations and produced reports. All of those reports were tendered into evidence at the inquest.

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[2] s8(2)(a)&(3)(b)

[3] s28

[4] S45(1)&92)

[5] See for example, *Atkinson v Morrow & Anor* [2005] QSC 92

[6] S46

[7] The ATSB is a body which operates under the Commonwealth *Transport Safety Investigation Act 2003.*

Police investigation

Sergeant Warren Flegg, Officer in Charge of the Thursday Island Water Police, conducted the police investigation. Numerous statements were obtained by him from the MMOs and other employees of the Department. Statements were also obtained by him from a variety of people involved in events prior to the *Malu Sara* disappearing, and some of those who actively participated in and/or co-ordinated the search.

I have concerns about Sergeant's Flegg's role in the investigation. He was a material witness, having had a central role as Search and Rescue Mission Co-ordinator ("SARMC") on the Friday evening and early Saturday morning when the boat was reported lost and then missing.

He prepared a report to the coroner detailing events, and in doing so relied on his own knowledge and that of other material witnesses and records.

It was submitted on behalf of the Commissioner of the QPS that it was not inappropriate for Sergeant Flegg to be involved in the investigations relating to the disappearance of the *Malu Sara* or in preparing the report for the coroner.[8] I respectfully disagree.

As will become apparent, the adequacy of Sergeant Flegg's actions throughout the evening and early morning when the boat was lost and his involvement with the other search agencies became a major focus of the inquiry.

In the circumstances, Sergeant Flegg had a potential conflict of interest in the outcome of the inquiry. This conflict manifested alarmingly during the course of the hearing as he sought to disavow aspects of his report when it became apparent the evidence may have reflected on him badly.

It is apparent Sergeant Flegg was a material witness. Accordingly, he should not have been the investigator of the incident. It may be whenever a search has failed to locate a missing person; the adequacy of the SARMC's performance will often be in issue. If so, another independent officer should critique that performance and gather statements from others involved so that the SARMC who controlled the search can simply provide a statement addressing his or her own actions.

Australian Transport Safety Bureau Investigation

The investigation into the cause of the accident was undertaken by the ATSB in accordance with the provisions of the *Transport Safety Investigation Act 2003* (Cth).

Generally, the investigation was competently undertaken and I have accepted many of its findings, particularly those relating to the deficiencies in the design and manufacture of the *Malu Sara* and her sister vessels. Those conclusions

[8] QPS submissions at paragraphs 54 – 59.

were arrived at as a result of extensive reviews and practical testing of the remaining vessels.

I was however concerned the investigation team accepted uncritically assertions by the ranking departmental officer, the Regional Director, Mr Gary Chaston, that he did not recall the skipper of the *Malu Sara* expressing concern about undertaking the incident voyage because of the weather and that he refused a request for a passenger to travel on the vessel. Of equal concern was the failure of the investigators to test or question the veracity of Sergeant Flegg's accounts of his conversations with the skipper and other agencies on the night/morning of the incident. Similarly, the ATSB seems to have unquestioningly accepted AMSA's assertion there were no sightings of survivors during the search, despite the evidence to the contrary. These weaknesses in the evidence gathering and analysing, reduced the contribution the report could otherwise have made to improving safety.

In making these comments, I am conscious ATSB investigators are selected for their transport industry knowledge or their qualifications in other disciplines relevant to analysing transport incidents, rather than their ability to test the veracity of witnesses. I also recognise I have had the benefit of extensive public hearings and submissions during which numerous senior counsel and other highly experienced lawyers deployed their considerable forensic skill. Having drawn my concerns to the agency's attention, I shall refrain from making any further comments or recommendations in this regard.

Post-incident "de-brief"

On 9 November 2005, some three weeks after the search, QPS and AusSAR[9] officers arranged a debriefing of those involved and their supervisors. It took place in Cairns and was attended by Senior Sergeant RJ Graham (as he then was) and Sergeant Flegg of QPS; Mr C Wright, Mr C Condon, Mr A Lloyd and Mr M Bettenay of AusSAR; Mr D Shipp of "*Aero Rescue*"; Ms S Hilyear and Mr N Tremain of (or on behalf of) "*Aero Tropics*" (a private aviation company utilized for air searching); Mr W Hepple and Mr M Sarago of *Counter Disaster and Rescue Services*.

The debriefing appears not to have engaged in any critical analysis of Sergeant Flegg's performance during the evening of Friday 14 October 2005 as SARMC, nor the fact that AusSAR did not receive timely information that the vessel skipper reported that it was sinking at about 2.30am on Saturday morning. It also failed to critique AusSAR's characterising of all sightings of people in the water after the vessel sank as "*non confirmed".* To that extent it was a wasted opportunity to improve the performance of the respective organisations through reflective introspection. It may be however that to expect critical analysis of the performance of officers from other agencies in such a setting is unrealistic. I shall leave it to the managers of those agencies to consider whether improvements in this regard are possible.

[9] AusSAR – Australian Search and Rescue - is a section of AMSA – the Australian Maritime Safety Authority, a self funded Australian Government organisation.

Evidence and standard of proof

The coroner's court proceeding is not bound by the rules of evidence. Section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate".* This is the basis on which the various reports and statement were admitted into evidence without the maker of them necessarily being called to give evidence.

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.[10] It is plainly not an adversarial proceeding.

A coroner applies the civil standard of proof but that does not mean that all issues on which a coroner must make a finding will be settled on the balance of probabilities. Rather, applying what is referred to as the *Briginshaw* principle,[11] 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 needs to be for the coroner to be sufficiently satisfied that it has been proven to the civil standard.[12]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[13] This means that no findings adverse to the interest of any person who has leave to appear may be made without that person first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[14] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The inquest

Pre – inquest conference

A directions hearing was held in Brisbane on 15 February 2007. Mr Mark Gynther was appointed Counsel Assisting. Leave to appear was granted to DIAC, Marine Safety Queensland (MSQ), the Australian Maritime Safety Authority(AMSA), the ATSB, Mr Chaston, Mr Jerry Stephen, an employee of the Department who communicated with the skipper of the vessel during the incident voyage, Sergeant Flegg and the Commissioner of the Queensland Police Service. The families of those missing and of the deceased were in the process of applying for legal aid and did not appear at this sitting.

The hearing

The hearing commenced on 16 April 2007 on Thursday Island and proceeded over nine days. At that stage, leave to appear was granted to the Baira and Enosa families. Mr Green was also appointed as a friend of the court on

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[10] *R v South London Coroner; ex parte Thompson* (1982) 126 SJ 625 per Lord Lane CJ.

[11] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J.

[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361-362 per Dixon J.

[13] *Harmsworth v State Coroner* [1989] VR 989 at 994. There is also a useful discussion of the issue in Freckelton "Inquest Law" in "*The Inquest Handbook*" (H Selby), Federation Press, 1998 at 13.

[14] (1990) 65 ALJR 167 at 168.

behalf of the Saub family. Mr Green subsequently sought and was granted leave to appear on their behalf, so that soon after the inquest commenced relatives of all of those who were missing or died in the incident were represented.

The inquest was then adjourned to Brisbane for further directions hearings on 10 May 2007 and 27 July 2007 when the matter was listed for three weeks of sittings on Thursday Island commencing 20 August 2007.

The inquest then adjourned to allow for written submissions. The last of these were received on 11 April 2008. Oral submissions in reply were heard on 13 June 2008.

Forty two witnesses gave evidence. The hearing extended over 28 sitting days and 189 exhibits were tendered. The transcript occupies 2,685 pages.

Transcript references

Transcripts for the first 11 days of sittings were sequentially numbered from 1 to 1163. Due however to use of different transcribing services, transcripts references after day 11 vary. Transcript numbering for the second tranche of evidence - from day 14 - recommences at page 1, and carries through to page 1060 at the end of day 25. The transcript for days 26 and 27 each carry discrete numbering commencing respectively at page 1. I will therefore, wherever possible mention in transcript references the day of the transcript (eg – "t/s D14 341" – indicating the day of the hearing (day "14") and page number on that day), unless the reference is to a transcript page from the first 11 days, in which case there will be no reference to the day.

Findings

i. The QPS investigation was flawed because it was undertaken by an officer whose conduct should have been independently scrutinised.

ii. The ATSB investigation into the design and manufacture of the vessels was effective. However, it uncritically accepted questionable assertions made by the Department's regional manger and the QPS SARMC and failed to adequately critique aspects of the search.

Part 2 – The social and political context

Background – the geopolitical setting

The Torres Strait

The Torres Strait is located between Cape York Peninsula and the south coast of Papua New Guinea (PNG). There are many islands in the Strait, fourteen of them are inhabited by a population of approximately 8,500 people. Thursday Island is located approximately 25 kilometres from the northern mainland of Australia and is the government administrative centre for the Torres Strait region.

Economic development and government services are far behind most of the rest of Australia. There is almost no income producing industry other than fishing. While ABS reports an average income of $33, 431 per annum,[15] this includes a significant number of well paid pubic servants who mostly come into the region for short periods. Seventy nine percent of indigenous members of the community live in a household with an income of $515 per week which is in the bottom 40% compared to the rest of the state.[16]

Inter-island travel by residents in the Torres Strait is commonly and traditionally undertaken by open boat. Despite significant State government subsidies, air travel is prohibitively expensive. For example a return flight from Badu Island to Thursday Island costs over $1000. Even fuel for travel by boat imposes severe restrictions on the ability of the inhabitants to move about.

Evidence during the inquest amply demonstrated the seas of the Torres Strait are some of the most dangerous in coastal Australia. They are susceptible to quickly changing weather conditions, exhibit strong tidal influences and are underlain with reefs and shoals. One significant local feature commonly experienced is strong wind blowing in the opposite direction to the tidal flow

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[15] ABS 2008, *National Regional Profile: Torres (S) (Local Government Area)*, Classifications Code LGA36950, viewed 28 January 2009 , http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/LGA36950Economy12002-2006?opendocument&tabname=Summary&prodno=LGA36950&issue=2002-2006

[16] ABS 2008, *Population Characteristics, Aboriginal and Torres Strait Islander Australians 2006*, Cat no. 4713.0, viewed 2 February 2009, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4DFFB9C944D51A7CCA257418000E540F?opendocument

causing the seas to stand up or steepen – a local name for the phenomenon is "*boxing seas".* It can make sea travel very precarious.

The combined effect of these conditions is that local inhabitants are forced to make quite precarious sea journeys in marginal craft, often with only just enough fuel. In southeast Queensland, people of limited means can take trains or buses. If their car breaks down or they run out of petrol, they can call the RACQ or, at worst, walk. In contrast, residents of the Torres Strait risk their lives when making routine trips for social, recreational or employment purposes and are dependant on search and rescue organisations responding effectively when things go wrong.

The Torres Strait Treaty

The treaty was first signed in 1978 and is designed to resolve uncertainty as to the location and significance of the international boundary between Australia and Papua New Guinea. It seeks to manage the unique immigration issues that arise as a result of a significant number of the islands, all of which are Australian territory, being on the PNG side of the international border. It also seeks to preserve the traditional rights of the inhabitants of the islands and the PNG mainland to travel throughout the region for trade and cultural activities without imposing the usual bureaucratic burdens that would normally accompany international movements.

Under this agreement, and its subsequent iterations, traditional inhabitants from both countries move freely (without passports or visas) for traditional activities within a *Protected Zone*. *The Torres Strait Treaty (Miscellaneous Amendments) Act 1984* (Cth) gave effect to the Torres Strait Treaty (the "Treaty") in Australian domestic law. It acknowledges that, under the Treaty, Australia must allow certain persons free movement into and around the Torres Strait.

Traditional inhabitants are defined by the Treaty as persons who live in the Protected Zone or adjacent coastal areas and are citizens of either Australia or PNG. Such persons maintain traditional customary associations with areas or features in or in the vicinity of the Protected Zone, in relation to their subsistence and/or livelihood or social, cultural or religious activities.

Movement monitoring officers

The position of Movement Monitoring Officer (MMO) was established in 1988 when surveillance of the Torres Strait took on increased importance because of a variety of illegal activities occurring in the region by those transiting the area.[17] They were recruited from among the local island residents. Initially, the MMOs were said to be "*contracted*" to the Department; but by the time of this incident they were full time officers of the Department holding positions at the APS1 and APS2 levels.

[17] See exhibit "E40" at paragraph 5.2.0.1.

Initially, the duties of the MMOs consisted of recording arrivals, subsequent departures as well as weekly reporting to the Department's office on Thursday Island. The MMOs were provided with minimal equipment.

MMOs work closely with the island and PNG community representatives to manage the traditional flow of people and report on any other movement in the region. They maintain a close working relationship with other agencies, including Australian Quarantine and Inspection Service (AQIS) and Australian Customs Service (ACS).

The MMOs are supervised by the two team leaders on Thursday Island who report to the Regional Manager who is also based at the Thursday Island office.

Since the inception of the role, the activities undertaken by the MMOs have increased and diversified. Increased concerns about illegal immigrants, introduced diseases, people, firearms and drug smuggling have all made the region more sensitive to border incursions. Preventing these illicit activities, while facilitating traditional culturally appropriate movements around the region, presents complex challenges.

Commensurate with the increase in function, the sophistication of the equipment available to the MMOs has also been enhanced over time. Quad bikes are now located on some islands to assist land-based patrols and, in 1999, six boats were acquired to assist in discharging MMOs functions.

The Department's Torres Strait workforce in 2005

In the period discussed in these findings, the Department had four full-time officers based on Thursday Island. They provided a range of immigration services and monitored the traditional movement of people in the Torres Strait pursuant to the Treaty. They were:-

Gary Chaston – regional manager. He commenced with the Department in December 2002. Before joining the Department, he was an Australian Federal Police officer for 26 years. He held a Queensland Recreational Shipmaster's Licence[18] and had completed a course in coastal navigation and outboard maintenance at the Cairns TAFE.[19]

He was responsible on behalf of the Department for the occupational health and safety of the MMOs.[20] Mr Chaston accepted that he had an overriding responsibility as regional manager for the Torres Strait to take all responsible and practical steps to protect the health and safety of staff under his management.[21] He had undertaken some training in WH&S matters when employed in the AFP.

[18] T/s D19 382.

[19] T/s D19 382.

[20] T/s D18 262.

[21] T/s D19 380.

The regional manager possessed a veto power over proposed boat operations and all voyages required his approval in accordance with standard operating procedures last updated on 13 September 2005.

Anne-Marie Titasey – office manager at APS5 level. Her functions included managing/supervising staff, everyday running of the office, assistant to the regional manager, organising training and workshops and processing accounts, etc.

Jerry Stephen – team leader at APS4 level. He was responsible for supervising the MMOs from the inner islands and undertaking clerical and administrative duties in the Thursday Island office.

Saliman Binjuda – team leader at APS4 level. He was responsible for supervising the MMOs from the outer islands and providing technical assistance with the boats and other equipment on Thursday Island.

The Department also employed 26 or 27 MMOs who were based on the 14 inhabited islands.

Languages of the Torres Strait

In comprehending the communication difficulties that may have occurred on the night the vessel was lost, and during the inquest, it is necessary to acknowledge that English is not the first language of the indigenous people of the Torres Strait.

Mr Baira, for example was conversant in Torres Strait Creole, English and the indigenous Western dialect of Torres Strait.[22] I have no doubt that in the stressful circumstances when he was speaking to the police over the poorly functioning satellite telephone his limited English would have made effective communication difficult.

Mr Stephen and Mr Baira spoke to each other in creole while using the satellite telephone. Mr Stephen recorded the gist of such communications in his log in English and spoke in English when he passed on information to the police and Mr Chaston.[23]

When giving evidence Mr Stephen spoke in English, but was asked about the words spoken in conversations that evening with Mr Baira. Hence, Mr Stephen had to recall the words spoken in creole and translate them for the court.

Searching for "truth" in a cross cultural setting

Although the pursuit of truth and justice are universal among civilised societies, the methods employed may vary as much as other cultural artefacts such as language and religion. The common law adversarial system is underpinned by a belief that there is an objective truth that can be discovered

[22] T/s 1138.

[23] See t/s 1138. Mr Bin Juda gave evidence to similar effect – t/s 247; line 35.

by the participants in the process of questioning witnesses and asserting contrary versions for their response.[24]

For people not used to it, this process can leave them feeling that they are being accused of dishonesty or not believed. It may also appear fruitless for numerous lawyers to ask the same or similar questions about issues the observer believes are settled and beyond dispute. If, unknown to the examiner, she and the witness do not share a common perspective on the issues under examination, the questions and answers may misalign. These dangers are amplified when the participants come from different cultural backgrounds.

Interpreters can be used, as they were in this case, to translate the words of different languages, but they can do little to overcome the misunderstandings that spring from the questioner and the witness having vastly different perceptions of the subjects being inquired into. For example, none of the lawyers who participated in this case will ever approach the depth of knowledge about the seas of the Torres Strait that the local people have gained from living by them, on them and in them for generations. Nor will questions asked in a court room do much to span the abyss of that ignorance.

I can readily appreciate how frustrating this must be for those wanting the inquiry process to deliver them justice. They could easily conclude the inquirers had insufficient understanding of the context in which the events in question unfolded for them to accurately identify the causes of those events. Such concerns were expressed by some of those connected with this case and their lawyers relayed them to the court. I hope the families and friends of the people who died accept that my efforts to address these difficulties were sincere. I apologise to those who were offended or distressed by my inability to completely redress these insurmountable difficulties.

Generally, commenting on the credibility of a group of witnesses would be inappropriate: it is usually an issue addressed in relation to an individual. In this case however, no impartial observer could help but notice the painstaking efforts of many of the Torres Strait Islander witnesses to answer questions truthfully. On a number of occasions, the lengthy silence which followed a question caused me to be concerned the witness had not understood the question. I then realised the strained expressions and delayed answers were not the result of a failure to comprehend but rather a struggle to ensure truth and accuracy. For example, a witness who had reported being aware of water entering the hull of the *Malu Sara* when it was at Saibai Island was asked if it was sitting lower in the stern as a result. After careful consideration, the witness indicated he could not tell because he was on a jetty looking down into the boat from above and hence did not have a view of the relevant perspective. Such regard for the truth is sadly lacking from many court proceedings in my experience. As a result, with a couple of notable

[24] Although coronial proceedings are said to be inquisitorial in nature when a matter is contested by those participating as occurred in this case the distinction is almost illusory for all but lawyers.

exceptions, I have given great weight to the evidence of the local Indigenous witnesses called at the inquest.

Part 3 - The acquisition of the IRVs

The need for new boats

By early 2003, the six Bermuda class boats acquired for use by the MMOs in 1999 were reaching the end of their serviceable life. As marine patrols were to continue, the boats needed to be replaced. Soon after he commenced with the Department, Mr Chaston initiated the steps needed to achieve this via a protracted process described in detail below.

Production boats or custom built

The Bermuda boats were an “off-the-shelf” production boat constructed by a reputable boat builder. They had a proven operational record in the Torres Strait. However, the Commonwealth Government had a policy of ensuring small and developing manufacturers could compete with larger established business suppliers. Consequently, its procurement policies sought to negate any unfair advantage being gained by such larger companies. The application of that policy in this case had the effect of skewing the process to favour suppliers who offered to design and build a new type of craft and discouraging manufacturers of proven vessels from tendering.

While in theory, there is no reason a custom built vessel could not be as safe and reliable as a production boat, the risk of it being less so are great and needed to be guarded against. As will be seen, this did not occur.

Scoping the boats and settling specifications

Late in 2003 Mr Chaston put together a business case for the acquisition of new boats.[25] It was approved and an allocation of $360,000 was made by the Department for their supply.

[25] See paragraphs 7-11 of exhibit “E44”.

Mr Chaston had no experience in either vessel acquisition or the operation of a marine fleet.[26] Indeed, he had no experience in procurement procedures, tendering or contract management.

Early in the process, he contacted Mr Nemes, the Department's senior contract advisor in the Contracts Procurement and Advice Unit and received some general advice about how the project should proceed. As a result of Mr Chaston advising the then deputy state director of the department, Mr Watters, of his uncertainty about the process he was about to embark on, Mr Nemes was assigned to go to Thursday Island and coordinate the assessment process and assist in drafting the assessment reports.[27] However, as will become apparent, Mr Chaston remained primarily responsible for most aspects of the procurement process.

He accepted advice to constitute a tender evaluation panel that was to have three roles:-

- advise on attributes or qualities for the new vessels;
- consider issues relating to the tender; and
- assess the tenders for the new vessels.

The panel was comprised of:-

- Mr Chaston;
- Mr Saliman Bin Juda, a senior and long standing departmental employee with in-depth local knowledge and experience;
- Mr Gordon Munro, a marine engineer from the Australian Army; and
- Mr Steve Gibson, a marine engineer from the Royal Australian Navy.

Both of the servicemen had been stationed on Thursday Island and had extensive experience in small boat operation in the Torres Strait.

The Department intended Mr Nemes to generally assist the tender evaluation panel with the process.[28] However, Mr Nemes told the inquest that he understood that he was to have a narrow and non-technical role. He understood that this was to be confined to overseeing the probity of the tender process.

Mr Munro and Mr Gibson were engaged to advise only in the evaluation of tenders. As will be seen later, they had no role in, and were not asked to, inspect the prototype vessel or take part in sea trials of that vessel or subsequent vessels.

The first meeting or series of meetings of the tender evaluation panel identified desirable attributes and general characteristics of the new vessels. The MMO skippers were also consulted about desirable attributes of the new boats.

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[26] See for example, t/s D18 348.

[27] Exhibit "E42"; t/s 335.

[28] A senior contracts adviser from the Department's "C*ontracts and Procurement Advice Unit*".

However, before that occurred, the terms of the Request for Tender had to be settled and promulgated.

Some time in early to mid-2004, Mr Chaston made inquiries with the Australian Maritime Safety Authority (AMSA) and Maritime Safety Queensland ("MSQ") concerning the legislative provisions affecting registration and survey requirements for the proposed vessels.

In September 2004, Mr Chaston drafted the Request for Tender (RFT) and sent it to a Canberra based customs officer, Mr Greg Hellessey, for comment.

Mr Chaston told the court that he was put in contact with Mr Hellessey by someone from Australian Customs Service (ACS) on Thursday Island. He understood Mr Hellessey was a "*marine engineer or something along those lines".*[29] He thought it appropriate to rely on Mr Hellessey's input as Mr Chaston knew that ACS operated small craft in the Torres Strait.[30]

An email from Mr Chaston to Mr Hellessey dated 13 September 2004 attached a draft statement of requirements for the boats which was to form part of the RFT.[31]

Mr Hellessey returned a marked up version of the statement of requirements, which included commentary boxes containing Mr Hellessey's notations and advice concerning possible changes to the document or comments drawing attention to certain perceived deficiencies.

Material matters identified by Mr Hellessey included:

- Paragraph 1.12 - Mr Hellessey recommended deleting a requirement that – "*a positive floatation test for the vessel must be completed in the presence of an accredited marine surveyor. The nominated surveyor will then issue the Certificate for Positive Floatation.*"[32]
- Paragraph 1.6 – In the version which Mr Hellessey sent back to Mr Chaston there remained reference to the floatation medium being "*closed cell polyurethane foam to the standard of the Uniform Shipping Laws Code*...".[33] In the commentary box relating to paragraph 1.6 of the draft document, Mr Hellessey had written:

  > "**Comment:** *This paragraph as it stands provides the prospective tenderer with conflicting information over which standard they must follow. You need to choose one or the other, or let the tenderer choose for you, but still specify a minimum acceptable level*."

[29] T/s D18 295; lines 51-59.

[30] T/s D18 319; lines 1-10.

[31] Exhibit "E8" at p 51.

[32] T/s D18 297–298.

[33] T/s D18 298.

Mr Hellessey's reference to "*conflicting information over which standard they must follow*" was a reference to conflict between the *Uniform Shipping Laws Code* and the *Queensland Survey Standard*. I doubt that Mr Hellessey intended to recommend deletion of the specification as to *closed cell polyurethane foam*, but this is what happened. Reference to the Queensland Survey Standard was also deleted.

Mr Chaston told the Court that when settling the statement of requirements he "*relied on what [he] was told by Mr Hellessey".*[34]

I consider the expertise and experience of the tender evaluation panel was adequate for the task of advising on and assessing the design and proposed construction of the new vessels as revealed to them by the various tenders. However, the process was to some extent degraded by the consultation with Mr Hellessey. He may have been sufficiently qualified and experienced to advise on these issues but Mr Chaston was insufficiently experienced or astute to understand and appropriately act on the advice he received. None of the others who participated in the process gave sufficient attention to the changes made to the documentation after his input to raise concerns. It would have been preferable had an external expert in boat design and construction reviewed the final specifications before the *Request for Tender* was settled.

As a result, the *Request for Tender* contained no requirement for the vessels to be built with a floatation medium of closed cell polyurethane foam. Instead, the builder could choose to use air chambers in the vessel as a form of buoyancy. Nor was there any requirement that the vessels' buoyancy be tested and certified by an independent marine surveyor.

Another concerning outcome of the process involving Mr Hellessey was that the statement of requirements as sent to Mr Hellessey included in paragraph 1.4.2 a statement that:

> "The ships are required by the department for **inshore and offshore patrol operations in smooth, partially smooth and open waters** in the Torres Strait, North Queensland." (emphasis added)

When Mr Hellessey sent back his suggestions, the only change to the paragraph, apart from a formatting notation, was to substitute the word "vessels" for the original expression "ships".

However, when the *Request for Tender* was promulgated in early 2005 the corresponding paragraph read:

> "The vessels are required by the department for **inshore patrol operations in smooth and partially smooth waters** of the Torres Strait, North Queensland". (emphasis added)

[34] T/s D18 299; line 10.

The stipulation that the vessels would be operating "offshore" and in "open waters" had been deleted.

In the meantime, Mr Chaston had received advice from Mr Gallagher of AMSA, and had been provided with a pro-forma letter he could use to get the new vessels into survey under a special regime for Commonwealth vessels that did not require them to be inspected by an independent marine surveyor. That regime could only apply if the vessels were to be used in smooth or partially smooth waters.

As will be seen later, the seas where the boats would operate were in waters around the outer islands. Indeed, from not far north of Thursday Island, all areas were classified as "open waters", including around the outer islands of the Torres Strait.

Mr Chaston offered no explanation to the court as to how the reference to intended use "offshore" and in "open waters" came to be deleted from the Request for Tender but it was clearly a decision he took at some stage. The implication is he did it deliberately to avoid having to have the vessels independently examined. It was another fatal mistake.

Regulatory provisions of the request for tender

Various statutory and subordinate legislative provisions were intended to inform the design and construction standards of the vessels. Those provisions were referred to in the *Request for Tender*.

It is apparent from exhibit E42,[35] and Mr Chaston's answers in cross-examination, that the specifications for the vessel and preparation of tender documents were principally his responsibility with input in certain limited respects from Mr Nemes, Mr Bin Juda, the Queensland Water Police and Australian Customs Service.[36]

The design and construction of the vessels was to be governed by the provisions of the *Uniform Shipping Laws Code* ("USL Code") and *AS1799*. To the extent that construction required aluminium welding, *AS1665* was to apply. The boats were to be capable of being registered in Queensland as a commercial vessel under six metres.

The USL Code provided for different classifications of vessels depending on where, and the conditions under which, it was intended to operate them. The *Malu Sara* and her sister ships were specified to be to USL Code "2C" (or class "2C"). That class provided for – "*Seagoing non-passenger vessel for use in all operational areas up to and including restricted offshore operations*".

The USL Code provided in clause 5.1.3, for *"Operational Areas"* in respect of vessels intended to be "*seagoing*" and those intended for operation in "*sheltered waters*". The new vessels were intended to be constructed so as

[35] At pages 21 – 30.

[36] T/s D18 329 – 330.

to be "*seagoing*"; hence the class 2C designation relating to "*Restricted offshore operations".* Clause 5.1.4 defined the meaning of "*Restricted offshore operations*" as – "*operations within a range of 30 nautical miles from the seaward limit of a designated smooth or partially smooth water area or of a safe haven; or operations within such lesser limits as may be specified by the Authority".* This would have been appropriate for the IRVs, had they subsequently been built to this standard.

Assessment of tenders

I accept the findings of the ATSB that the boats when delivered had serious design and construction flaws making them unseaworthy. It is therefore important to examine the process by which a Commonwealth department came to award a tender to an organisation that ultimately failed in a most cataclysmic fashion to deliver a safe, quality product, without this being detected until the boats were put into service.

The *Request for Tender* was promulgated by the Department on 11 January 2005. The closing date for submission of tenders was 4 February 2005.[37] The advertisement inviting tenders indicated the Department was seeking tenders for the "*Design, construction, supply and maintenance of 6 aluminium patrol vessels*" that were to be ***"purpose built"… "****for inshore patrol operations in smooth and partially smooth waters...***"*

It seems likely this discouraged suppliers of production boats not interested in custom building and maintaining vessels: only one tender was received for production boats. Of the eight tenders received, only five complied with the mandatory requirements that the vessels meet AMSA and Queensland Survey standards and be built to AS1799 and the USL Code. The tenders for the six boats with twin motors ranged in price from $867,000 to $414,000. The cheapest quote was ultimately selected.

Two matters arose during early evaluation of the tenders:

- Mr Chaston told the Court, as a result of a discussion by the tender evaluation panel concerning other floatation methods such as closed cell foam, he rang Mr Radke, the proprietor of Subsee Explorer Pty Ltd, to enquire about the positive floatation system based on the enclosed air cells or chambers described in Subsee's bid.[38] He was unable to recall what he was told but it clearly satisfied him and the tender evaluation panel as to the method of floatation proposed by Subsee as no further queries were subsequently raised about that topic.[39]
- There was a request by Subsee for progress payments on the basis it was a small local company and was unable or unwilling to

[37] T/s 317; lines 45-50, and exhibit "D14" at p 42 (Request For Tender document).

[38] T/s D19 385 – 386.

[39] By this time it will be recalled, the "Request For Tender" no longer disclosed any specified method of providing positive floatation, other than in accordance generally with the USL Code or AS 1799.

carry a financial burden for an extended period of time.[40] Mr Chaston's evidence was the request for progress payments did not raise any particular concern amongst the tender evaluation panel members.[41]

The criteria for assessment of the tenders was settled between Mr Nemes and Mr Chaston, and circulated to the other members of the tender evaluation panel for comment. No material changes were requested by them.[42] The weighting of the criteria was 60% for vessel suitability, specification, operational expense and provision of a maintenance arrangement; 20% for trailer suitability, specification and maintenance arrangement; and 20% for company evaluation and assessment comprising demonstrated experience in construction of such vessels, and demonstrated physical and financial resources.

I am of the view there were numerous deficiencies in the manner in which these criteria were applied and with the process in general. For example:-

- To weight a company's experience and financial resources as highly as the trailer when the boats were to be kept on the islands and only towed a few hundred metres to launch seems illogical and unreasonable.
- No weighting was given to a tenderer's history of a successful production run or service in comparable circumstances.[43] Every tender, regardless of reputation for quality, reliability, comfort and safety, was liable to be treated the same.
- There was no focus on whether a manufacturer had an approved quality assurance system.
- The skippers were asked to provide comments on the various tenders. However it appears little regard was paid by the tender evaluation panel to their suggestions. For example, the skippers commented that the Subsee design will result in "nose diving" – plainly referring to a perceived tendency of the proposed vessel's attitude in seas. The skippers also commented that the bow needed to sit higher. Although the tender evaluation panel recorded some concern on the part of skippers about the Subsee design, neither of the specific comments of the skippers were resolved nor otherwise dealt with.[44]
- Mr Nemes told the Court that his understanding of his role was that it did not include input into technical evaluation. He was, he said, merely to "run" the process and procedure and ensure probity.[45] He did not look at the tender documents and in my view failed to raise relevant

[40] Exhibit "E42" at p 51.

[41] T/s D19 466.

[42] T/s D21 641.

[43] T/s D18 325. For example, the 5.9 meter *Cairns Custom Craft* was already in service in the Torres Strait region with ACS (exhibit "E8" PDF page 68).

[44] T/s D21 646-647.

[45] T/s D21 645; t/s 648.

irregularities and patent departures from reasoned assessments. For example:-

- Against the criterion "*Demonstrated physical and financial resources to successfully complete the project*", the tender evaluation panel inserted in relation to Subsee's tender – "*They show they have the physical capacity to deliver, but cannot make financial decision."*[46] Mr Nemes' evidence was the panel did not have sufficient information before it to make an assessment of the financial viability or stability of Subsee.[47] Notwithstanding, Subsee was awarded 6 out of 10; the same score awarded another tender which had provided information sufficient to satisfy the panel on both aspects of the criterion.
- No inquiries were made to ascertain whether Subsee was registered or certified as a boat designer or boat builder.[48] It was neither.

- Neither Mr Chaston nor anybody else contacted any of the referees identified in the Subsee tender.[49]
- Mr Chaston told the Court that his understanding at the time of letting the tender was that – "*Subsee was a well-known company for building marine craft".* He did not make any enquiries of Marine Safety Queensland to see whether Subsee was an accredited shipbuilder or ship designer. Nor did he make any enquiries with MSQ to determine whether Mr Radke, a principal director of the company was an accredited boat designer or boat builder.[50]
- Neither Mr Chaston, Mr Nemes, nor anyone else sought evidence Subsee carried adequate product liability insurance, or indeed any insurance, although such insurance was a requirement of clause 9.2 of the contract.[51]

After assessing the tenders, two preferred suppliers were identified. Mr Nemes undertook a process described to the Court as finding "*value for dollar".*[52] The results of this were submitted to the tender evaluation panel. There was collective agreement with his assessment.[53] Subsee Explorer Pty Ltd thus became the preferred supplier recommended by the panel.

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[46] See annexure "G" to exhibit "E44" (Mr Nemes' statement).

[47] T/s D21 649.

[48] T/s D21 651-652.

[49] T/s D22 633-634.

[50] T/s 326; lines 4-30. As it turned out Mr Radke did maintain current accreditation with MSQ in both of those capacities at the time of contract, but Mr Radke was not the contracting party (see documents in exhibit "C21" from pages 2-27 (PDF)).

[51] The amount of required product liability insurance in item R of the schedule was left blank.

[52] Paragraph 58, annexure "M" of exhibit "E44" (Mr Nemes' statement).

[53] T/s D18 304; lines 27-49.

The recommendation was required to be ratified by Mr Watters. In addition to the problems with the terms of the *Request for Tender* referred to above, there were also gaps in the procurement proposal sent for his approval. For example, no person was nominated as having responsibility for approval of the tender, contract negotiations and signing of the tender or implementation of the contract, despite the Department's processes requiring the nomination of such a person. By default, that role was to devolve largely to Mr Chaston. On receiving the report and recommendation of the panel, Mr Watters signed off on it on about 22 February 2005, apparently without making any further inquiries. His involvement added nothing to the process and detected none of the numerous flaws.

Mr Nemes remained involved for a short period to draw up the contract. He did not further participate in the project. He did not see it as his role to ensure that the new vessels corresponded to the deliverables stipulated under the contract.

When he gave evidence, the Department's First Assistant Secretary, Mr Frew, sought to defend the Department's approach to the assessment of the tenders. In response to the suggestion that Mr Chaston had made clear to the Department that he lacked expertise in the procurement of the vessels, Mr Frew stated that a "*procurement expert was supplied to him",*[54] referring to Mr Nemes. However, as has been made clear, Mr Nemes took an unduly narrow view of his role and did not remain to see out the process of ensuring that what was delivered accorded with the contract or its specifications. As a result, there was significant divergence between what was delivered and what was stipulated under the contract and specifications.

Contractual issues of concern

I am of the view some of the terms of the contract and the management of it were flawed. For example:-

- The contract to supply the vessels was entered into by Subsee. Mr Radke was a director of Subsee but he did not guarantee its performance, nor incur any other type of personal obligation under the contract. The Commonwealth's recourse in the event of defects or other breaches of warranty in respect of the boats was limited to what could be enforced against a proprietary limited company of no known financial substance.
- The Court received evidence that Subsee had been in financial difficulty from about April 2001 to September 2002.[55] A search by the Department of Australian Securities and Investment Commission records would have revealed a recent incident of Subsee undergoing insolvent self-censure.[56] However, despite the contract stating that the

[54] T/s D20 576; lines 1 – 15.

[55] In April 2001, an administrator was appointed in respect of Subsee under s 436A of the *Corporations Act*, a matter requiring the directors of the company to have formed a view that the company was insolvent or was likely to become insolvent at some future time.

[56] Mr Nemes did not do, or, it seems, arrange to be carried out, an ASIC search of Subsee – t/s 651.

Department would need to assure itself as to the financial viability and stability of the prospective contractor[57] no search of the corporate records was carried out.

- There was no provision which incorporated the terms of the *Request for Tender* into the contract.
- Subsee's accreditation with MSQ had lapsed prior to the date of advertising the *Request for Tender*. At the time of the contract Subsee was not an accredited boat builder or boat designer; although Mr Radke was. The absence of accreditation of Subsee may have constituted a breach or non-observance of clause 5.11 in the *Request for Tender* statement of requirements.
- The contract entered into with Subsee did not specify that swamp testing or stability testing would be carried out under the supervision of an independent marine surveyor, or at all. The *Request for Tender* had also not included such a requirement. Mr Chaston was unable to assist the Court as to how the contract came about absent such specifications or requirements. He accepted that a specification or requirement to that effect would have been a "*good idea".*[58]
- Although under clause 2.3 the contractor undertook to ensure that "s*pecified personnel*" undertook the work in respect of the nominated services, no persons were nominated under the appropriate item in the schedule to the contract.

Accreditation issues

As indicated above, the contract with Subsee stipulated the builder was to be an accredited boat builder. This was not the case and the Department did not check. This oversight may not have mattered, as its director, Mr Radke, was. However, for the reasons set out below, I am of the view the system of accreditation administered by MSQ made no significant contribution to ensuring the delivery of seaworthy craft. My concerns in this regard are based on the following:-

- The accreditation of Mr Radke by MSQ was based on a regime described by MSQ as follows:-

> **"***.... accredited shipbuilders [are] required to maintain an operational plan and a production record for the business... These records must include a system for monitoring, at each critical stage, the quality and integrity of the process of building.... these records are inspected as part of the audit processes conducted by MSQ. This regime provides accredited ship builders with the option of using external quality assurance accreditation as a means of satisfying*

[57] Clause 3.21 of the Request for Tender. Clause 4.1 of the Request for Tender stated that the financial position of the tenderer would be considered as well as the risk to the Department in engaging a tenderer. The tenderers were obliged to provide financial data if requested.

[58] T/s D18 303.

MSQ that the operational plan required ... is of a suitable standard....”[59]

- However there is no evidence that Mr Radke had been audited for a number of years. Further, no testing or examination had been required to be undertaken by Mr Radke to obtain initial accreditation, nor was there apparently any inspection or observation of the manufacturing processes or of the as-built records of vessels.

MSQ advised in its submissions that a new national regime for certified boat-building standards is being introduced to apply throughout Australia.[60] Accreditation by the state authorities such as MSQ will become redundant once the regime was established. It is to be hoped that will overcome these inadequacies.

Building and testing of the boats

Following the signing of the contract, Subsee commenced construction of one vessel to enable the Department to examine it and conduct sea trials.

When commencing construction of the IRVs, Subsee employed about eight suitably qualified workers, significantly fewer than would ordinarily be desirable for such a project.[61] This resulted in those workers working longer than normal hours on the Department's project.[62] It also led to delays in delivery of the vessels.[63]

As it transpired, a number of key workers left the company during the building of the IRVs. It is likely that Subsee was left short-handed, at least for some period.[64]

It seems likely the staffing issues had more serious consequences than merely delaying the project. The first vessel, built before labour problems set in, was found after the loss of the *Malu Sara* to be the only remaining vessel that did not leak. Quality diminished in other aspects as well. For example, while the scuppers on the prototype were deficient in that they were only 82% of the size stipulated by *AS 1799*, the other boats achieved only 57% of the required area.[65]

The majority of the work on the boats was carried out in Subsee's Cairns workshop. During the construction phase, Mr Chaston made one trip to Cairns to check on progress. He took some photographs but seems to have been unable or unwilling to critically assess what was occurring; he provided

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[59] MSQ submissions at paras 2.3 – 2.5. The regime existed under the *Transport Operations (Marine Safety) Regulation 2004*.

[60] This is to be under the *National Standard for Commercial Vessels* (*NSCV*). It also has the effect of phasing out provisions of the USL Code. There are indications on a web-site for the National Marine Safety Committee that implementation of the *NSCV* has commenced.

[61] T/s D16 172; lines 30-46.

[62] T/s D16 173; lines 11-16.

[63] T/s D16 173; lines 17-19; t/s 179; lines 7-9.

[64] T/s D16 176 – t/s D16 177.

[65] Exhibit “A2” at paragraph 4.16.

no progress reports to his superiors although there is no doubt that the Department was aware of delays in progress.

Prudence would require a newly designed vessel to be checked during construction by, say, an independent qualified boat builder or marine surveyor. This did not occur.

The contract provided for delivery of the final vessel in 16 weeks, that is 19 July 2005. Mr Chaston conceded that there was some pressure from the Department's head office in Brisbane to have the new IRVs ready for a commissioning ceremony to be attended by the Minister.

The contract specified the vessels had to be capable of being registered under Queensland legislation as a Commercial Ship under 6 metres and under the USL Code as class 2C. They could only have been registered for class 2C service if there was documentation certifying positive floatation and certifying the vessel as suitable for its intended service. The documentation was required to confirm compliance with the buoyancy and stability requirements of *AS1799* or the "*American Boat and Yacht Council*", or Section 10 Appendix N of the USL Code.

If the vessels were to comply with *AS1799* or the USL Code, the builder was required to nominate a recognised standard and to provide calculations on buoyancy and stability and to confirm the basis on which the positive floatation certification was made. No standard was nominated in the contract.

In May 2005, after the prototype had been built but while the remaining IRVs were still under construction; Mr Radke certified on a MSQ form that the IRVs had positive floatation. The certification was made, not as a result of the carrying out of any practical testing, but as a result of a calculation quantifying the volume of air in the void spaces.

The ATSB report under the heading – *"4.3.3 Reserve Buoyancy*"[66] noted that *AS 1799*:

- requires sufficient reserve buoyancy to prevent a vessel from sinking if it is swamped;
- requires the reserve buoyancy material to be fitted in a manner that ensures that the vessel remains upright and level when swamped; and
- guides the calculation of the required amount of reserve buoyancy for any given vessel and the appropriate location of buoyant material to ensure upright floatation.

The ATSB report acknowledged that *AS1799* permits the use of air cells as buoyancy. However, it requires the two largest air compartments to be disregarded in the calculation of buoyancy. The reason for this is obvious: if a compartment is permeable to water or penetrated the buoyancy ceases to exist - spare capacity is needed.

[66] Exhibit "A1" at page 45.

On the *Malu Sara* and her sister ships, the underdeck void space was a single compartment and so should have been disregarded under the *AS1799* formula in the making of any calculations. In failing to disregard that space, Mr Radke's certification of positive floatation was flawed and invalid. It falsely represented the vessels had adequate positive floatation. As the vessels also lacked solid foam floatation (or equivalent) the vessels could not have been certified under USL Code requirements as having positive floatation. The tender evaluation panel were provided with plans of the proposed vessels. It is unclear why none of its members identified this deficiency.

The ATSB findings and observations are based on expert inspection and testing of the *Malu Sara*'s sister ships. As a result of their findings and the evidence given at the inquest I conclude:-

- The IRVs were constructed with negative freeboard: that is, when fully laden water entered the cockpit area through the freeing port in the engine pod and then the scuppers. The vessel simply sat too low in the water.[67] Testing one of the sister ships resulted in the ATSB report stating: "*When stopped ... or at low speed with the vessel fully loaded, the motor-well freeing port was below the waterline regardless of whether or not there was any water inside the void space. This means that water will actually back flood through the freeing port to the extent that the motor-well fills with ... water. Water then flows into the cockpit via the two scuppers"*.[68]

  Based on his observations of the prototype, and it appears, a favourable interpretation of the ATSB report, Mr Radke said in evidence he did not believe that the *Malu Sara* had negative freeboard.[69] I reject Mr Radke's assertions in that regard and prefer the ATSB findings.

- The ATSB carried out swamp and stability testing by flooding the cockpit of a vessel. That resulted in the vessel capsizing after 11 minutes of test time. It remained afloat at least temporarily, but then inverted.[70] Given the attempts to locate the *Malu Sara* after it went missing, it seems likely that the *Malu Sara* sank no more than 3 to 4 hours after it was swamped. The failure of the tested IRV to remain stable demonstrated failure to comply with both USL Code requirements and *AS1799*. I am satisfied the entire fleet exhibited these characteristics.
- The ATSB stated that the intention of the USL Code and *AS1799* stability requirements was to "*safeguard the vessel's occupants by ensuring that as a last resort the vessel will act as a 'lifeboat'*".[71] This

[67] Exhibit "A1" at paragraph 4.3.4 at page 46.

[68] Exhibit "A1" at page 47. The prototype – "*Kuzi*" may have been the exception to this.

[69] T/s D16 187.

[70] Exhibit "A1" at page 47.

[71] Exhibit "A1" at paragraph 4.3.4 page 48.

was a basic seaworthiness requirement. Mr Radke told the Court that he "*ran out of time"* to do swamp testing. However, in other evidence he indicated he had not planned to do a swamp test of the prototype.[72] I find that he did not plan to do a swamp test and did not inform Mr Chaston that a swamp test had not been done, and Mr Chaston did not ask about it.

- The ATSB also carried out testing on the sister ships of the *Malu Sara* to ascertain if the weather deck was watertight. All except the prototype were found to leak.[73] Water accumulated in the under-deck void space. It is likely there was a similar deficiency with the *Malu Sara* having regard to observations made while it was at Saibai Island. That deficiency would have led to the vessel capsizing and limited the time the *Malu Sara* would have floated after this occurred.

  I reject Mr Radke's suggestion in evidence that the compartment below deck was watertight.

  Figure 14 in the ATSB report is a photograph of an incomplete weld on the cockpit floor of one of the boats. The incomplete weld created an aperture between the cockpit floor and the supposedly air-tight void space or bilge. Mr Radke accepted that the missing weld demonstrated:

  - unsatisfactory workmanship;
  - inadequate quality control;
  - unacceptable boat building; and
  - workmanship that may have placed the vessel in danger during operation.[74]

- As stated above, the decks of the IRVs were to be drained by scuppers that unusually, channelled the water into the rear pod or engine well rather than overboard. The pod itself was meant to be drained by a freeing port, an opening in the transom of the vessels. Until water cleared out of the freeing port, after draining from the deck, it remained at least temporarily in the boat thus adding to its weight. In heavy seas that may well have been continuous. As a result, when the pod was flooded, the stern of the vessel would sit lower in the water. This would reduce the flow of water clearing from the weather deck, leaving it awash and making inundation of the bilge likely.
- The ATSB inspections revealed that the scuppers in the four sister ships (other than the prototype) were only 57% of the minimum size stipulated in *AS1799*. Likewise the freeing port for the engine pod should have been nine times larger than that fitted, and fitted to both

[72] T/s D16 230; lines 15-23.

[73] Exhibit "A1" at paragraph 4.3.5, pages 49-50. On the *Zeuber Erkep* ATSB inspection discovered an incomplete welded seam which allowed clear passage of water into the bilge space (see ATSB report paragraph 4.3.5 and *figure 14*).

[74] T/s D16 189.

> port and starboard sides, not merely centrally. This exacerbated the problems referred to above. Mr Radke could give no sensible explanations for these deficiencies that significantly compromised the seaworthiness of the vessels.[75]

The ATSB report sets out a number of other defects concerning the vessels' registered length, their markings; fit out and fuel storage arrangements. In my view, the observations and findings of the ATSB are soundly based and I am comfortable adopting them for the purpose of these proceedings.

Mr Radke told the Court that it was a deliberate decision by him not to comply with *AS1799* in the construction of the vessels.[76] His decision was made despite specific provisions in both the statement of requirements in the *Request For Tender* and the contract. He said he was unaware that he had contracted to this effect.

The delivery of the prototype

On 13 May 2005 the prototype was delivered to Thursday Island for sea trials. Mr Radke travelled to Thursday Island to participate. That same day he also signed positive floatation statements for all six vessels, despite only one of those boats then being in existence.

On 16 May 2005 the test vessel was examined by six of the MMO skippers. They compiled a list of 42 items for further attention. MMO John Coburn, made notes of his observations identifying various items to be rectified.[77]

On 17 May 2005, the vessel was tested in the water by the MMO skippers and Mr Coburn made further notes.[78] Despite the statement in the *Request For Tender* statement of requirements that a representative from the Queensland Police Service - Water Police Unit be involved in the sea trials, this did not occur. No sea trials were undertaken for the further five vessels once they were delivered in August.

Mr Coburn's notes, among other things, referred to the removal of sharp edges or rough spots in the metal work. The addition of steps to assist or facilitate boarding or disembarking was suggested. Two comments raised issue with water coming into the pod of the vessel. It was suggested that the pod "*should be sealed or an extra plate welded in place to stop water coming in from the back*".

In relation to this last issue, during the sea-trials, both Mr Coburn and Mr Harry David observed a large amount of water coming into the pod. Mr Coburn told the Court that all of the skippers present noticed this phenomenon.[79] Mr David was quite concerned.[80] As a result they suggested a

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[75] T/s D16 192.

[76] T/s D16 237; lines 10-30. And at t/s D16 178 and t/s D16 207.

[77] See exhibit "E8" at page 232.

[78] See exhibit "E8" at page 233.

[79] T/s 724-725.

[80] T/s 724; lines 20-40.

metal plate be installed to seal off the bilge area of the pod and hence create a sealed space under the plate. That would also lower the volume of water that could sit in the pod. This modification was carried out in later vessels by installing the plate about 75mm above the inboard surface of the hull. However, even after the installation of that plate there remained capacity for the accumulation of a considerable quantity of water in the pod.

The skippers thought that the vessel otherwise performed satisfactorily. For example, Mr Coburn's notes record:

- the vessel "*is much better 100% performance in running against the wave and down*";
- the vessel "*handles well in turns*";
- the vessel is "*very well balanced*";
- he was very impressed with setting up of battery away from fuel filters in case of faulty terminals"; and
- the vessel "*gets up on the plane very quick and smooth".*

On the second day after the sea-trials the vessel's trailer spring broke and had to be repaired.[81]

Mr Chaston asked Mr Newman, who he knew to be a local marine repairer and aluminium welder, to inspect the prototype. Mr Newman had nearly 30 years experience in the region working with and on small craft.

Mr Newman told Mr Chaston that the pod area of the vessel should not be open; that a plate or platform should be welded across the pod area, and that the boat should be sent back to Subsee for modification.[82] Because of the configuration of the pod, Mr Newman thought that the vessel would not be suitable for use in the Torres Strait. A further criticism identified by Mr Newman related to the scupper arrangement in the prototype. He observed that water drained into the pod rather than to the outside of the boat.[83] Mr Chaston responded that it would be too expensive to send the boat back to Subsee.

Mr Newman told the Court that he had also noticed that the welding was sub-standard. He noticed small balls of metal on surfaces near welded seams. He explained to the Court that this was evidence of the amperage of the welding equipment being too high.[84] This was brought to Mr Chaston's attention. He told the Court that his recollection was that it appeared in proximity to the gunwales and therefore presented a hazard to passengers and crew, rather than affecting seaworthiness. He said that he did not actually inspect the seams on the keel, or the hull of the boat.[85] I accept as accurate Mr

[81] T/s 166; line 40.

[82] T/s D14 50-51. Also at t/s D14 63. Mr Bin Juda's evidence was to similar effect – t/s 167.

[83] T/s D14 65.

[84] T/s D14 52. Also at t/s D14 62.

[85] T/s D18 345; line 40.

Newman's opinion on the welding and other design and manufacturing deficiencies of the vessel.

A list of the issues identified during the sea-trials was sent by Mr Chaston to Mr Radke in late May 2005. However, the prototype remained at Thursday Island after the sea-trials. Some rectification work was undertaken by Mr Newman at his workshop on Thursday Island.[86] This included fitting rubber flaps over the scupper outlets in the prototype and fitting a drain point for the anchor well.

The list of concerns compiled by the skippers did not concern Mr Chaston. He thought they were minor, and to an extent, to be expected.[87]

Mr Chaston accepted that he had had a discussion with Mr Bin Juda to the effect that the old IRVs had been swamp tested before they were pressed into service.[88] He had this knowledge before the contract for the acquisition of the new IRVs was signed but unfortunately a requirement for it was not included in the contract. He said he asked Mr Radke about it and was told it was not necessary; and that the same result could be achieved by making calculations from the plan.[89]

Safety and navigation equipment

The effect of the evidence of the expert mariners who gave evidence is that the boats should not have been deployed without the following equipment and indeed could not have been registered as a class 2C vessel without some of it:-

- distress flags "N" and "C";
- navigation charts;
- a depth sounder;
- a sea anchor;
- a global positioning system/chart plotter;
- a VHF radio; and
- a 406 MHz EPIRB

I accept the ATSB's conclusion that all of the listed items would have enhanced the safety of the *Malu Sara* and that once it became lost on the incident voyage, many of the items would have increased the chance of the vessel recovering its position. I also conclude it was not reasonable to send the vessels to sea without this equipment

None of that equipment was stipulated in the statement of requirements. I found no evidence that budgetary restraint by the Department was

[86] The matters are dealt with in Mr Newman's evidence at t/s D14 52.

[87] T/s D18 308; line 30. See also t/s 307; exhibit "E32" at pages 36-37. Mr Radke's response to the list sent by Mr Chaston (that list is at exhibit "E8" 236-237) appears at exhibit "E32" at pp 38-40.

[88] T/s D18 302.

[89] T/s D18 303; lines 4-9.

responsible for this; indeed Mr Chaston accepted funds to purchase this equipment would have been available had he sought it.

For various reasons, this essential safety equipment was not fitted to or supplied with the vessels.

Either late in 2004 or in early 2005 Mr Moses Mene, an MMO, requested the new IRVs to be fitted with a GPS. According to Mr Bin Juda the issue was raised in the presence of other skippers, Mr Chaston and the tender evaluation panel.[90] The skippers collectively adopted the suggestion. Mr Chaston rejected the suggestion on the spurious grounds that there was insufficient money to purchase those items, but indicated it would be considered at a later time.[91]

During the inquest Mr Chaston contended during the procurement process there was no "*groundswell of opinion or complaint*" for more navigation equipment to be fitted to the new vessels.[92] I do not accept that.

He claimed he had a general understanding or impression that the skippers wished to keep the new boats as similar as possible to the Bermuda class boats; that is to say, with a minimum of electronics. When pressed in evidence he named Mr Mene, Mr Titus Mooka and Mr Solly Bin Juda as persons from whom he obtained that impression. When questioned about the fitting of a chart-plotter (or depth sounder) he could not remember any discussion.[93] His evidence was otherwise general - he had "*spoken to all the skippers either over the phone or in person going back to when we decided to do something to get started on the project*".[94] He suggested that had he attempted to persuade the MMOs differently, they "*would have got the impression that I didn't trust their judgment or knowledge".*[95]

A further ground given by Mr Chaston for not fitting such equipment was that electronic equipment such as a GPS was prone to being corroded and/or was liable to be stolen because of its value.[96]

Mr Chaston did concede the GPS units were able to be detached from a vessel and kept safe while the vessel is not in use.[97] The same situation would seem to me to logically apply to a chart-plotter or VHF radio. Further, it could not have been a complicated matter (or overly expensive) to have constructed a robust locker in or near the vessel's console for such equipment.

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90 T/s 175; lines 50-60; t/s 176; line 50; t/s 177; line 25; t/s 228; lines 20-25; t/s 259; line 21; t/s 263; line 25. There was also a suggestion by Mr Bin Juda that the fitting of VHF radio was raised by Mr Baimop Tapim. Mr Tapim, who gave evidence, did not confirm that such a topic was raised. The evidence given by Mr Bin Juda in relation to the VHF radio issue is too uncertain to form the basis of any finding concerning that topic – eg t/s 261; lines 1-60.

91 For example, t/s 176; line 1; t/s 177; lines 1-25.

92 See T/s D19 409-410.

93 T/s D18 271.

94 T/s D18 271.

95 T/s D18 272.

96 T/s D19 372.

97 T/s D19 372: t/s D19 410.

In my view, the failure to fit electronic equipment on grounds of increased maintenance or increased expenditure on maintenance or theft cannot be justified either with hindsight or the proper use of foresight.

It was submitted on behalf of Mr Chaston that the new vessels were equipped at least to the same standard as the Bermuda class vessels, and that there had not been any complaint about them. That may be so. But looking at what was done in the past while avoiding an opportunity to improve on it on the basis that no one had complained does not seem to me to be a valid approach to matters of work place safety.

An explanation of Mr Chaston's failure to ensure the vessels were properly equipped might be found in the attitude he displayed when discussing the issue with two local marine equipment suppliers, Mr Pope and Ms Sard. Mr Pope gave evidence that when he queried Mr Chaston as to whether a GPS and a VHF radio were to be fitted to the boats, Mr Chaston said words to the effect; "*the MMOs are two generations behind and would not be able to handle that type of equipment".*[98] Mr Chaston said he couldn't recall the conversation that was overheard by Ms Sard but he offered the opinion that "*quite a number of MMOs were not 'technically minded'*".

I find Mr Chaston did make those comments and I reject the sentiment they reflect. The MMOs had generally displayed high levels of competence in all tasks the Department had employed them to undertake and had the same ability as any other person to be trained in new or unfamiliar tasks. I have no doubt training on new equipment could have been successfully undertaken had it been fitted.

A GPS system could have been fitted to the vessels for around $1,000.00 per boat.[99] A VHF radio could have been fitted per boat for between $400.00 and $1,000.00.[100]

The failure to fit a GPS or chart-plotter almost certainly contributed to the sinking of the *Malu Sara*. It is likely it would not have become lost in the fog had a GPS or chart-plotter been fitted and landfall would have been made before water leaking into the hull caused difficulties from which it could not recover.

The vessels were fitted with outdated 121.5 MHz EPIRBs. The ATSB report states that the more appropriate 406 MHz EPIRBs have been "*operational for many years and are being sold in increasing numbers".*[101] The advantage of the 406 MHz EPIRBs is quicker detection and more accurate positioning information.

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98 T/s 673; lines 30-55 (Mr Pope's evidence): and at t/s D19 412; lines 4-27, where Mr Chaston could not specifically recall the conversation with Mr Pope.

99 T/s 504 (valued approximately as at 2005).

100 T/s 505 (valued approximately as at 2005).

101 Exhibit "A1" at 63.

The evidence indicates Mr Chaston was aware of the new EPIRBs coming into service. He could not give a convincing explanation as to why he did not cause the newer EPIRBs to be fitted.

I conclude that Mr Chaston made a conscious decision not to equip the vessels to a reasonable standard for their intended use. He provided no reasonable explanation for this failure.

Certificates to be given by builder

The contract provided in clauses 1.1 and 2.1.1 of the "*Required Contract Material*" that Subsee was to supply six different certificates.[102] Only one of the six was provided, namely the certificate of positive floatation and, as will be detailed later, it was defective and invalid.

The other five concerned:-

- The registration of the trailers for use on Queensland roads;
- Construction of the vessels to USL Code class 2C (although as mentioned below, there was a compliance plate on each vessel stating this, falsely as it turned out);
- Suitability for 15nm operations (USLC partially smooth waters) (although again, as mentioned below, the certificate of positive floatation contained a box ticked by Mr Radke which suggested this characteristic);
- Confirmation the vessel(s) was "*fitted out and outfitted to Class 2C survey standard";*
- Confirmation the vessel(s) complied with *AS1799* and if alloy construction *AS1665*.[103]

The certificate of positive floatation for each vessel was prepared by Mr Radke before completion of construction of the vessels (except perhaps the prototype). Mr Radke said that he was able to make a declaration of positive floatation as a result of making calculations under a recognised formula that relied on estimating the volume of the enclosed air spaces in the hull.[104]

Mr Chaston accepted in evidence that he did not pursue Mr Radke for the outstanding certificates. He agreed that Mr Nemes did not suggest to him a need to do that. The Department submitted it was not part of Mr Nemes' job to supervise or ensure the certificates were obtained.[105]

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[102] The certificates are identified in Item C of the schedule to the contract. Subsee's obligations are to be found in clauses 2.1.1, 2.1.2 and Item C of the schedule. The obligations in the contract essentially mirrored those set out in clauses 1.1, 5.4 and 5.11 of the Request For Tender.

[103] The vessels were in fact alloy construction.

[104] The ATSB noted (paragraph 4.3.3 of exhibit "A1"), and I accept, that Mr Radke's calculations ignored both the USL Code and AS 1799 requirements.

[105] T/s 340; t/s D21 674; lines 40-50; t/s 675; lines 1-10.

The Department defended its processes concerning the contract administration and gathering of certificates by directing criticism at Mr Chaston. It submitted:-

- for reasons Mr Chaston did not adequately explain, the requirements contained within the contract were not adequately enforced against Subsee;
- although Mr Chaston was nominated in the contract as the Department's representative he appears to have adopted a largely passive role in requiring strict compliance with the terms of the contract;
- although Mr Chaston certified the accounts of Subsee for payment and was the nominated project officer, it is apparent from the evidence that he did very little to enforce the terms of the contract and nothing in respect of compliance with *AS1799*;
- Mr Chaston's administration of the contract was a complete abrogation of his responsibility as the Regional Manager and the nominated Project Officer, and was contrary to the Department's policies; and
- Mr Chaston admitted it was his responsibility to secure the receipt of the certificates and, in the absence of the certificates, he had still been prepared to make a declaration that the construction of the vessel *"complied in every way with every requirement with which it should comply".*

I accept Mr Chaston's performance was far below the standard one would expect of an officer in his position. He was dilatory, unquestioning and lackadaisical. However, he had forewarned the Department he was inexperienced and untrained in matters pertaining to procurements and contract administration. It responded by sending Mr Nemes, who left as soon as the tender selection process was completed and added little of value while he was there. The Department can not therefore shift to Mr Chaston all responsibility for the failure to require the builder to discharge its contractual obligations.

When accepting the positive floatation certificates, Mr Chaston relied on Mr Radke's accreditation number, quoted on the certificate, to demonstrate he was a person authorised to give the certificate.[106] In my opinion this was not an unreasonable mistake for a person with the training and experience of Mr Chaston.[107]

Nor was Mr Radke competent to certify that construction was to USL Code 2C. That could only be done by a member of a *Classification Society*, which was defined under the USL Code as – "*an association approved for the*

[106] T/s D18 341.

[107] The *Transport Operations (Marine Safety) Act 1994* (ss 65 and 66) and regulations made under the Act recognised that such a certificate (assuming it was a "certificate of compliance" as defined) could be given by an accredited ship builder.

survey of vessels". Mr Radke was not a surveyor, nor a member of any relevant association.[108]

Neither Mr Chaston, nor anyone else involved in the procurement, considered the qualifications or ability of Mr Radke or Subsee to provide the necessary certification as part of the deliverables under the contract. No cross-checking was done concerning the capacity of Subsee to lawfully deliver what the contract stipulated. Neither Subsee nor Mr Radke could competently have certified:

- Suitability for 15NM operations [USLC Partially Smooth];
- Fit-out and outfitted to Class 2C survey standard;
- Compliance with *AS1799*.

Had Mr Chaston demanded the outstanding certificates of Mr Radke as he ought, an independent surveyor would have had to inspect the vessels and it is highly likely he/she would have detected the various faults that made the vessel non compliant with the standards specified in the contract. This failure by Mr Chaston, as with many others, had far reaching consequences.

The registration and survey of the vessels

"Survey" as it related to the IRVs did not involve the physical inspection of the vessels as one might usually expect. Rather, in this case it describes a procedure by which the vessels were deemed to be fit for purpose and accordingly lawfully used by the Department. The purely paper based regime is underpinned by an expectation that Commonwealth agencies will have in place procurement processes and workplace health and safety arrangements that would make further oversight by the agencies that normally regulate such matters for private operators, unnecessary duplication. As is obvious, both assumptions were false in this case.

When paper based procedures replace physical inspections, strict compliance with process is essential. In this case, lax procedure combined with dubious practice defeated the intent of the regulatory scheme.

The statutory regime

The survey of the vessels was governed by the provisions of the *Navigation Act 1912* (Cth) and Part 62 of the *Marine Orders* (subordinate legislation made under the *Navigation Act*) which provide:

> **6 Surveys and certificates**
>
> 6.1 Subject to 6.2, the structure, machinery, equipment, life-saving appliances and radio installations of a Commonwealth ship of less than 24 metres in length are subject to survey in the manner and at the times set out in the USL Code.
>
> 6.2 Provision 6.1 does not apply to a vessel of less than 7 metres in length if the Chief Marine

[108] See section 1 clause 4 – definition in the USL Code.

Surveyor is satisfied that the operator of the vessel has established and maintained a planned maintenance and inspection system for the vessel.

6.3 Subject to 6.4, the master of a Commonwealth ship of less than 24 metres in length must not take the ship to sea unless:

(a) there is in force such certificates as would enable the ship to comply with sections 206T and 227A of the Navigation Act 1912; or

(b) there is in force in respect of the ship certificates in accordance with the USL Code issued by or acceptable to the administration of the State or Territory in which the ship operates and appropriate to the voyages to be undertaken.
This is a penal provision.

6.4 Provision 6.3 does not apply to a vessel to which 6.1 does not apply by virtue of 6.2.

Paragraph 6.2 of the *Marine Orders* applied to the new IRVs.

The ATSB said as regards the history and application of the *Marine Orders*:

> *Marine Orders Part 62 – Commonwealth ships (Appendix 1) came into force on 1 March 2003. Prior to 2003, nearly all Commonwealth ships (including all vessels less than seven metres) were exempted from compliance with the Navigation Act 1912 (the Act) provided that they complied with 'relevant provisions' of the Uniform Shipping Laws Code (USL Code).*[109]
>
> *The original IRVs, commissioned in 1999, were subject to the exemption from the Act and so had to comply with the relevant provisions of the USL Code. To meet this requirement, DIMIA made the decision to register the vessels in Queensland and thus they were subject to Queensland survey. Compliance with Queensland marine safety legislation meant that the original IRVs had to be designed constructed and surveyed in compliance with the relevant provisions of the USL Code.* [110]

[109] The ATSB report comments that – "[T]he exemption was in the form of an instrument made on 8 May 1985 by a delegate of the Minister for Transport under the then section 423A of the *Navigation Act 1912*."

[110] Exhibit "A1" at paragraph 4.1.1 page 64.

Because the new IRVs were *Commonwealth ships* as that term was defined in both the *Marine Orders* and the *Navigation Act*, it was not necessary for the vessels to be registered under Queensland legislation. Therefore the usual testing or certification required under Queensland law was not required for the new vessels. The ATSB observed - "*unlike similar sized commercial vessels built and operated within State jurisdictions, there was no plan approval process, no construction surveys and no final survey by, or on behalf of, the regulator to ensure that the new IRVs were constructed and equipped to the specified standard...".* [111]

The *Marine Orders* were in a sense supplemented by, or subject in their application to the *Instructions to Surveyors*. Materially, ITS 62-01 provided as follows:

> "**4. Vessels of 7 metres and less in length**
>
> **4.1 General**
>
> 1. The type of vessels considered here are generally lightweight vessels capable of being transportable by a trailer, and used by Commonwealth agencies **for operations in creeks, estuaries, and limited offshore work**. (emphasis added)
>
> 2. Similar vessels fitted to larger Commonwealth craft, such as Customs vessels used in offshore operations will remain as part of the larger vessels equipment for survey purposes.
>
> 3. In lieu of an AMSA survey regime, the operator of a vessel under 7 metres in length may opt to request the Chief Marine Surveyor to issue a letter of survey. The request for the letter of survey should be in the form provided in Annex 1 to this ITS.
>
> 4. The request for the letter of survey should include the maintenance plan and associated inspection schedule. Additionally, the operator needs to satisfy the Chief Marine Surveyor that the vessel is constructed and equipped to an acceptable standard.
>
> 5. The maintenance plan, and associated inspection schedule should cover the vessel's structure, machinery, equipment, life-saving appliances and radio appliances, as applicable. A surveyor may audit the records of the planned maintenance at any time to ensure the operator is maintaining the vessel and its equipment in accordance with the relevant standards.

[111] Exhibit "A1" at paragraph 4.1.1 page 67.

6. The intention of these requirements is to place the responsibility for the safe operation and maintenance of these craft on the 'person in charge' of the vessels.

7. If the maintenance plan, and associated inspection schedule, along with the conditions indicated in the request for the letter of survey are acceptable to the Chief Marine Surveyor, then an Area Manager may issue a letter of survey in the format indicated in Annex 2.

8. The Chief Marine Surveyor may indicate additional operational limitations in the letter of survey. The survey regime for vessels under 7 metres in length is only applicable when the vessels are on Commonwealth business.

4.2 Survey

1. All vessels should be constructed and equipped to a standard acceptable to the Chief Marine Surveyor. Such standards include the USL Code and the Australian Standards AS1799 and AS 2677.

2. **In equipping such vessels, the operator has a 'duty of care obligation' in deciding what safety equipment is appropriate for the intended operation. The operator should base the safety equipment carried on a risk assessment prior to each voyage.** (emphasis added)

3. In undertaking a risk assessment, the operator should take into account the operational limitations of the vessel, the intended area of operation, time and duration of the operation, along with the navigation and weather hazards.

4. As a general rule, vessels should carry safety equipment not less than that required by a State Maritime Authority for similar vessels engaged in similar operations.

4.3 Area of Operation

1. **These vessels may only operate in smooth and partially smooth waters, as defined by the Chief Marine Surveyor. The vessel's letter of survey will indicate the sea state limits**. (emphasis added)

2. As a guide, the Chief Marine Surveyor may use the USL Code as a guide. The USL Code defines smooth and partially smooth waters as:

- *Partially Smooth Water* – where the wave height, under normal conditions, does not exceed 1.5 metres from trough to crest.
- *Smooth Waters* – means waters where the wave height, under normal conditions, does not exceed 0.5 metres from trough to crest."

The ATSB made this observation concerning the application of the *Marine Orders* to the new IRVs:

> *In respect of vessels less than 24 metres, provision 6.1 of the Orders requires that such vessels be built, equipped and surveyed in accordance with the USL Code. The Orders provide in provision 6.2 that for vessels less than seven metres, the USL Code provisions do not apply 'if the Chief Marine Surveyor is satisfied that the operator of the vessel has established and maintained a planned maintenance and inspection system for the vessel'.*
>
> *In respect of vessels of less than seven metres, Marine Orders Part 62 makes no mention of any legislation other than the Navigation Act 1912. Neither the construction standard required nor the general content of the maintenance and inspection document, of which the Chief Marine Surveyor must be satisfied, are specifically mentioned.*

For a vessel such as the *Malu Sara* to be in survey, the *Marine Orders* and *ITS 62-01* required:

- The Chief Marine Surveyor to be satisfied that the operator of the vessel has established and maintained a planned maintenance and inspection system for the vessel (clause 6.2 *Marine Orders*).
- The vessel be constructed and equipped to a standard acceptable to the Chief Marine Surveyor. Such standards included the USL Code and the Australian Standards *AS 1799* and AS 2677 (clause 4.2(1) *ITS*).
- The vessels were to operate in smooth and partially smooth waters.
- A request for a letter of survey:
    - which includes the maintenance plan and associated inspection schedule; and

- an assurance the vessel is appropriately constructed and equipped.

The application of the regime to the IRVs

The *Request for Tender* statement of requirements made reference to the vessels being used to carry out marine patrols in the waters of the "*Torres Strait Protected Zone".*[112]

On or about 30 September 2004 Mr Chaston e-mailed Mr Gallagher of AMSA requesting information on Commonwealth legislation applying to registration of commercial ships. He wrote:

> "... DIMIA Thursday Island currently operates a number of small patrol vessels based on various outer islands of the Torres Strait. These vessels are crewed by Torres Strait Migration Officers (TSMO) who undertake regular marine patrols around their own islands and other uninhabited islands, reefs and cays within 15nm of their home base. Generally each patrols [sic] are only authorised to operate in daylight hours and in under sea state 3 with patrols lasting between 4 – 6 hours. The exception to this authorisation is operations which concern search & rescues. All vessel skippers have recreational Shipmaster's licences, current Senior First Aid Certificates and undergone marine safety training conducted by the Queensland Police Service (Water Police section).
> Currently all vessels are inspected and serviced on a bi-annual basis by an accredited service centre ..."

Mr Gallagher responded and attached a pro-forma letter by which application could be made for a Request for Survey of a Commonwealth Vessel less than seven metres in length under the provisions of paragraph 6.2 of *Marine Orders* Part 62. As Mr Chaston had told him the vessels were to be used around the outer islands, it is doubtful Mr Gallagher should have responded in a manner that could lead Mr Chaston to conclude the *Marine Orders* part 62 might be apposite to those vessels when clearly it could not.

In January or February 2005, Mr Chaston contacted Mr Radke in order to clarify part of Subsee's tender document. A question had been raised by the tender evaluation panel as to whether a remark made in Subsee's tender indicated the vessels would be suitable for offshore use. Mr Radke confirmed to Mr Chaston by reference to a similar vessel of 7 metres that the hull was designed and purpose built for offshore use and could easily "*handle 2-3 metre swells".*[113] Mr Radke said in evidence that he took the reference to "offshore" as being synonymous with "open waters". Mr Chaston recalls

[112] Contrast the reference in clause 5.2 of the Statement of Requirements which particularised the operation of the vessels for "inshore patrol operations in smooth, and partially smooth waters in the Torres Strait ...".

[113] T/s D18 299–300.

specific discussion about use of the vessels in "open waters" by the members of the tender evaluation panel.[114]

I am satisfied that Mr Chaston had a sufficiently informed appreciation of the distinction between smooth waters, partially smooth waters and open waters as at February 2005, such that he knew there were gradations in the severity of conditions that might generally apply in such waters.[115]

I am satisfied that as at February or March 2005, Mr Chaston knew that the outer islands of the Torres Strait were north of Hammond Rock and that the area of operation of the new vessels was also to be largely to the north of Hammond Rock.[116] Mr Chaston also had an understanding that the areas to the north of Hammond Rock were "open waters" in the sense that he knew such waters could experience swells of 2 – 3 metres and greater and conditions were more exposed than in and around Thursday Island.[117]

Mr Chaston was unable to explain why the *Request for Tender* specified a requirement for operation in smooth or partially smooth waters, as distinct from operation in open waters or offshore.[118]

After construction of the new vessels, Mr Chaston completed the pro-forma letter for survey and returned it to AMSA on about 24 August 2005.[119] In it he made a number of statements, some of which are relevant for the purpose of these findings:

First, he asserted the vessels were built to AS1799. He then went on to say:-

> "1. The vessels are suitable for its [sic] intended operations and are in a seaworthy condition prior to each operation.
> 2. ... [not relevant]
> 3. A risk assessment is undertaken prior to each operation and the vessels are equipped and manned taking into account the area, time and duration and the navigation and weather hazards that may be encountered. (Copy of Standard Operating Procedures and Pre-Patrol Checklist attached at Annex A.)
> 4. The vessel's [sic] area of operation is partially smooth waters of the Torres Strait."

Mr Chaston was cross-examined as to why he declared in the letter to AMSA the vessels were to be used in smooth or partially smooth waters of the Torres Strait. He told the Court that he "*thought the Torres Strait was designated as partially smooth waters at the time".*[120] That evidence was

[114] T/s D18 300.

[115] T/s D18 299 - 301.

[116] Hammond Rock was located just to the north of Hammond Island, situated approximately from about 1 NM to 4 NM north of Thursday Island.

[117] T/s D18 300-302.

[118] T/s D18 301.

[119] It is set out at page 147 of exhibit "D14".

[120] T/s D18 324; lines 20-40. Contrast his evidence at t/s D19 402–403.

given despite his earlier evidence mentioned above. I am of the view he sought to mislead AMSA or was at least reckless to the truth of his assertions so the vessels would be registered without further regulatory oversight.

Mr Chaston told the Court that he thought he was able to give the necessary assurances under the pro-forma letter about suitability for operations and seaworthiness because of the tender process and contract providing for compliance with *AS1799*. Yet no certification was sought by Mr Chaston or the Department as to compliance by the builder with that standard.

Mr Chaston accepted that when he applied for survey under the pro-forma letter he appreciated that his setting out of the facts in the pro-forma letter would be taken to be a true statement. He accepted during his evidence that the statement or statements he made in the pro-forma letter were untrue at the time, as he had not received certificates of compliance from Subsee or Mr Radke.

Mr Chaston enclosed with the pro forma letter a copy of the SOPs for the IRVs. They stated the vessels were to be used throughout the Torres Strait and would "*enhance offshore monitoring".* They acknowledged the vessels *"have their limitations when employed in open ocean".* [121]

By letter dated 2 September 2005, Mr J S Price on behalf of AMSA, responded to Mr Chaston's application for survey. On the basis of the declarations that had been made the vessels were accepted as being surveyed to the requirements of paragraph 6.2 of *Marine Orders*, part 62 for a period of one year. The inconsistency between the declaration in the pro forma letter that the vessels were to be used in partially smooth waters and the provisions of the SOPS quoted above seems to have provoked no inquiry.

For the reasons discussed earlier, AMSA saw the primary responsibility for compliance, seaworthiness and overall safety of the vessels granted survey under this procedure as resting with the Commonwealth department which intended to operate the vessels. AMSA's procedures included no mechanism for checking or verifying what was asserted in the pro-forma letter. AMSA submitted it was entitled to rely on the "*representation of a senior DIMIA officer that the vessel had been built to AS1799 as stated in his letter".*

AMSA also submitted that had proper procurement guidelines and procedures been followed, *Marine Order* part 62 would have applied appropriately. That is to say, it would have resulted in the Department taking delivery of vessels that did comply with *AS1799*, and the issue of a letter of survey would then have been unremarkable. AMSA identified the passing of the defective vessels into service under survey as primarily due to procurement failures on the part of the DIMIA. It was also a result of AMSA, the national marine safety agency, devolving responsibility for the safety of certain Commonwealth ships to line departments.

[121] Exhibit D14 p 148

AMSA submitted that "smooth" or "partially smooth" waters were not to be defined by reference to a geographic area but "[R]ather the Chief Marine Surveyor defines smooth and partially smooth waters in the case of the *Marine Orders 62* by reference to the prevailing conditions at the time of travel....". That submission is rejected. The terms are clearly defined and used for general marine purposes. In light of Captain Boath's evidence and reference to the charts made under USL auspices prevailing conditions in a particular area, such as winds, tide, current, depth and other undersea conditions are all taken into account in determining the categorisation of waters depicted on the charts. Such terms form an integral part of provisions of the USL Code. *Marine Orders 62* calls up those terms and they should be given the same meaning in both documents.

Captain Boath made clear in his evidence and by reference to the relevant chart[122] that only waters to the south of Hammond Rock could be characterised as smooth or partially smooth waters.[123]

The USL Code and *AS 1799* contain *design* and *testing* requirements for vessel buoyancy and stability. The AMSA survey regime did not require any evidence of testing. A mere statement by a departmental officer was all that was required as to the vessels being built according to *AS1799*.

It is apparent AMSA's approach to granting survey to Commonwealth vessels was to merely rubber stamp the applications so long as the requisite boxes were ticked in the pro-forma letter.

Perhaps in recognition of the inadequacy of the regime that applied when the *Malu Sara* was lost, AMSA says it has since implemented changes to the survey requirements for Commonwealth vessels less than 7 metres. The new regime apparently involves:-

- An independent assessment of compliance with applicable building and seaworthiness standards.
- A requirement that applicants provide information concerning
    - crew qualifications;
    - the wearing of personal floatation devices by crew and passengers; and
    - the carriage of a 406MHz distress beacon, VHF radio and appropriate navigational equipment for the area of operation.

I consider these reforms will go some way to addressing the shortcomings of the previous survey regime. Closer scrutiny by AMSA of the intended area of operation will also hopefully occur.

[122] A similar chart to that referred to by Captain Boath appears at http://www.msq.qld.gov.au/resources/file/eb0d354ab2d0f6b/Pdf_s8sw17thursdayi.pdf.

[123] T/s 347; lines 20-35. See also exhibit "G2.3".

The delivery and commissioning of the boats

Delivery and commissioning was the point at which the new IRVs were accepted into service by the Department. The commissioning occurred on Thursday Island. Some basic training regarding the new IRVs was coincidentally provided during that week.

It was to be the only training received by the skippers and crews.

The further five completed vessels were transported to Thursday Island on 21 or 22 August 2005. Each vessel was examined on its arrival by Mr Bin Juda. He noted that each vessel was missing items of equipment, such as spare propellers and spark plugs. Mr Bin Juda reported the missing equipment to Mr Chaston by email, and it was then referred to Subsee for attention. Those items were later supplied. Mr Bin Juda also noted that several items that had been raised when the prototype was examined had not been rectified.

The commissioning ceremony, held on 29 August 2005, was attended by the Minister for Immigration and Multicultural and Indigenous Affairs, Senator Amanda Vanstone, all of the staff of the Department's Thursday Island office and all of the MMO skippers other than Mr Baira. A voyage around Thursday Island was conducted during the commissioning ceremony. Mr Bin Juda described it as consisting of a 1 - 1.5 hour cruise. He said that there were up to four passengers on board the vessels during this cruise. No problems were observed with the vessels during the voyage.[124]

Details of the new vessels, as commissioned, were as follows:

DESIGNATION	NAME	SKIPPER	ISLAND	SERIAL NUMBER
IMMI 01	*KUZI*	Mr Moses Mene	Yorke (or Masig) Island	SUBS113
IMMI 02	*ZEUBER ERKEP*	Mr Beimop Tapim	Murray or Mer Island	SUBS114
IMMI 03	*MALU SARA*	Mr Wilfred Baira	Badu Island	SUBS115
IMMI 04	*KANG*	Mr Titus Mooka	Dauan Island	SUBS116
IMMI 05	*MAGANI GUTHAT*	Mr Harry David	Yam Island	SUBS117
IMMI 06	*NAGAGALAYG*	Mr John Coburn	Mabuiag Island	SUBS118

The names each carried an indigenous meaning:

- *KUZI* – traditional name for the sea eagle – Yorke Island;

[124] T/s 173-175.

- *ZEUBER ERKEP* – eyes of the sea – Murray Island;
- *MALU SARA* – the seagull flies out to sea - always searching for prey – Badu Island;
- *KANG* – warrior who protects his people from invaders –Dauan Island;
- *MAGANI GUTHAT* – strong running tide – Yam Island;
- *NAGAGALAYG* – a sea eagle known for its sharp vision and hunting skills – Mabuiag Island.

Findings

As a result of considering all of the evidence I make the following findings in relation to the procurement process and the commissioning of the vessels.

i. No one in the Department had sufficient regard to the far greater complexity and risks involved in procuring custom built vessels as compared to buying production boats.

ii. The Department's regional director, Mr Chaston, had insufficient training and/or experience to enable him to be principally responsible for the procurement of the vessels and the Department should have been aware of this.

iii. The Department's response to Mr Chaston's deficiencies about which it was warned, was inadequate.

iv. Mr Chaston's inexperience was compounded by his incompetence and indolence.

v. The tender evaluation panel was not appropriately constituted. While it contained individuals with sufficient practical marine experience it seems they lacked knowledge about ship building and testing standards. A marine surveyor or experienced boat builder should have been included.

vi. The procurement process expert sent by the department to assist Mr Chaston failed to adequately discharge his responsibilities.

vii. The tender evaluation panel consulted with the MMOs, but failed to undertake sufficient research to identify with precision the characteristics and specifications needed in the vessels. As a result the specifications stipulated in the *Request for Tender* were inadequate.

viii. Before entering into a contract with the manufacturer there was no attempt to examine and test an existing vessel based on the same design; too great a reliance was placed on the builder's assurance that it would be suitable for the Department's purposes. No external expertise in relation to design or manufacturing was sought.

ix. The public advertisement and the *Request for Tender* wrongly asserted the vessels were to be used in smooth and partially smooth waters. Mr Chaston knew this was not the case. He could provide no

explanation as to why confirmation that the vessels were to be operated in open waters and off shore was deleted from the specifications after he became aware that disclosing this would prevent the boats being brought into survey without being inspected by a marine surveyor.

x. The contract was flawed in not specifying the method of positive floatation, fit-out and testing procedures and standards. As a result no independent expert assessment was made of the vessels during construction and no swamp testing or sea trials were undertaken by any suitably qualified and independent person prior to the vessels being put into service.

xi. By failing to ensure the builder provided certificates of compliance stipulated under the contract, Mr Chaston enabled the builder's failure to meet the appropriate design and building standards to go undetected.

xii. The ship design and building accreditation system administered by Maritime Safety Queensland provided no basis on which to have confidence in the capacity or competence of those holding accreditation, although it could easily mislead a prospective purchaser into believing it did.

xiii. The tender evaluation process failed to detect omissions and inconsistencies in the successful tender and failed to accurately assess the relative merits of aspects of the various tenders. The Department's procurement advisor failed to adequately redress these process issues. The concerns of the MMO skippers about aspects of the favoured design were not given sufficient weight.

xiv. The design of the boats was flawed in that when loaded, scuppers and freeing ports meant to drain water away from the floor of the cockpit were below the waterline. This combined with poor quality workmanship and other design flaws to make likely the flooding of the under-deck space.

xv. The boat builder falsely certified the boat had positive buoyancy when he was not qualified to do so and the design and construction of the vessels meant they did not have this characteristic.

xvi. The boat builder had no checklist of regulatory requirements for the vessels, and, obviously did not check on completion of construction and before delivery that the vessels complied with regulatory requirements.

xvii. There was a gross failure by the boat-builder to comply with general boat-building standards and regulatory requirements. The vessels had numerous serious flaws that made them unseaworthy. Some of the deficiencies were insidious in that they would manifest only after some time on the water, or under rough conditions.

xviii. Mr Chaston unwisely accepted the builder's assurances that swamp testing of the vessels, which would have demonstrated they were

unsafe, was not necessary, even though he knew the previous boats had been tested in this manner.

xix. Mr Chaston could not reasonably explain why essential safety equipment such as navigation charts, a GPS/chartplotter, and a VHF radio were not carried on or fitted to the vessels. He agreed that had he requested such equipment, there was no basis to suspect the Department would not have funded its acquisition.

xx. His failure to ensure the vessels were fitted with appropriate navigation equipment directly contributed to the loss of the *Malu Sara.*

xxi. When seeking to bring the vessels within survey as a Commonwealth ship, Mr Chaston falsely advised AMSA the boats were to be used in "*smooth and partially smooth waters"* when he knew this not to be true. He also made other false statements about the quality of the vessels without having a sufficient basis for believing them to be true.

xxii. AMSA accepted these baseless assertions without question or inquiry and admitted the vessels to survey even though the documents accompanying the application contained information inconsistent with it that should have led them to make some enquiry.

xxiii. Mr Chaston was not adequately trained or experienced to inspect or assess the boats during the construction process, or to assess the seaworthiness of the vessels or compliance with regulatory matters when the boats were delivered. He was not capable of assessing whether what was delivered was in accordance with the contract and specifications. The Department should have known this but took no steps to ensure that an appropriately qualified person undertook these checks.

Part 4 – Training of MMOs, SOPs and service of the IRVs

Training of the skippers

The skippers' familiarisation with the new vessels was provided by Mr Bin Juda prior to the vessels leaving Thursday Island after the commissioning ceremony. The skipper of the *Malu Sara*, Mr Baira did not attend that ceremony.

Mr Bin Juda demonstrated or addressed the other skippers concerning the following matters:

- Safety gear;
- Location of items on board;
- Switching for different fuel tanks;
- The filling of the oil tanks;
- The bilge pumps;
- What the alarms on the motors indicated;
- Launching of the boats;
- Keeping the satellite telephone on the console to keep it charged and working;
- Undoing the locker padlocks before the boat could be operated.

It is clear that the training was much less detailed than that given when the old boats were first introduced. At that time, the MMOs were given theoretical and practical training by the Thursday Island Water Police, a presentation by a marine mechanic who demonstrated aspects of the motors' operation and basic maintenance. They were also given a checklist of safety equipment and how to use it.[125] When new skippers were recruited it seems they were given a similar induction although I received no evidence relating specifically to the training Mr Baira received when he was appointed skipper of the Badu Island boat.

When the new IRVs were acquired the other skippers had already undergone training regarding the old boats. Generally, the hull, deck and console layouts of the old and new vessels were similar. There was also similarity in the fact that the old and new vessels were powered by twin outboard engines.

However, the new IRVs had significant differences.

[125] Exhibit C4 pp. 4, 5

The engines on the new IRVs had direct two stroke oil injection from an oil tank mounted inside the engine cowling. On the Bermuda class, two stroke oil was pre-mixed with petrol in the vessel's fuel tanks and delivered along the fuel line to the engine. The oil reservoir level on the new IRVs therefore required checking from time to time. Failure to do so could result in the engine becoming inoperable. The ATSB calculated the capacity of the oil tank was sufficient to operate the engine for about the same time as it took to consume a full tank of fuel.[126]

The satellite phones fitted to the new boats were very different from the phones in the old boats. On the Bermuda class vessels the telephones were housed in a waterproof case, and switched off when not in use. They were used as hand held mobile phones. The telephones had to be removed from the vessels and charged from a domestic supply. The new satellite telephones, while also in a fixed waterproof case, charged while the motors were running. They were most effective when used in a cradle that allowed them to access the network via a large external aerial mounted on top of the boat canopy which assisted in gathering a more reliable and/or stronger signal.[127] The satellite telephones had a feature enabling the operator, by pressing four keys on the handset, to obtain latitude and longitude of the phone's current position. It seems no one in the Department knew this and certainly the skippers were not told of it.[128]

The bilge pumps for the new IRVs were different in configuration to those on the Bermuda class vessels, and potentially counter-intuitive in operation.

There were warning systems on the new vessels for low oil capacity and a fume detector warning.

Some of these matters were mentioned to the skippers; most said Mr Bin Juda explained the differences in the motors to them when they were launching the boats for the commissioning ceremony and in talks around the office in the next few days. However it is apparent that the training they received was limited and inadequate. Mr Chaston explained he did not think about training or familiarisation on the new IRVs, because he felt that there was pressure to get the boats back out to the islands so that patrols could be resumed.[129] There is no evidence this "*pressure"* emanated from any external source. However, he also said that he had suggested the skippers receive training when they were on Thursday Island for the commissioning ceremony but was told they had been booked to go home the next day.[130]

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[126] Exhibit "A1" at paragraph 4.3.12.

[127] The Court was told by Mr Sakker that aerial was "powered", and had a "low noise amplifier" enabling the operator to better listen to signals coming in – t/s D15 93.

[128] The co-ordinates were able to be read on the telephones screen. Apparently the manual for the telephone explained the function (t/s D15 97).

[129] T/s D19 419.

[130] T/S D19 470

Mr Baira's marine qualifications

Mr Baira had been appointed as skipper of the Badu Island IRV following the resignation of Mr Samat Laza in 2004. Mr Chaston had not made any enquiries as to licences that Mr Baira held, or should have held, for the position. Mr Chaston had however discussed with Mr Bin Juda and/or Ms Titasey whether Mr Baira was suitable for the position and received a positive response from both.[131]

In fact Mr Baira did not have a coxswain certificate and did not hold a Recreational Ship Masters Licence (commonly known as a "speedboat licence"). Accordingly, he was not legally qualified for the position he was appointed to, although there is no doubt his practical experience as a local mariner was extensive.

His familiarization with the new boats was entirely on-the-job, made possible by his experience as a crew member on the Bermuda boats, and with years of operating small boats in various capacities in the Torres Strait. As mentioned, he did not attend the commissioning and so did not hear the brief run down Mr Bin Juda gave the other skippers.

The vessels go into service

As there had been no immigration patrols for some months prior to the commissioning ceremony because the old boats had been brought to Thursday Island, Mr Chaston had become concerned that they should recommence as soon as possible after the commissioning of the new boats.[132]

Following the commissioning, arrangements were made to transport the vessels to their respective islands. On 2 September 2005 Mr Bin Juda sent faxes to the six skippers advising of the arrangements and requesting they check each vessel on arrival. Mr Bin Juda spent some time while the vessels were on Thursday Island fitting speakers for the satellite telephones.[133]

In the first few weeks of operation concerns were raised about a number of aspects of the fit out of the boats or their operation. These are summarised in the table below taken from the Department's internal investigation report.

13.09.05	Dauan	P. Mooka reported that communication was down while on patrol and they were not able to communicate with Thursday Island.	Reported to TI but no action documented.
17.09.05	Badu: *Malu Sara*	W. Baira reported that the port side navigation light was missing.	Reported to TI but no action documented.

[131] T/s D19 463; lines 1-19.

[132] T/s D19 415.

[133] T/s 177.

30.09.05	Yorke	M. Mene, MMO Yorke Island reported that water was dripping down the "V" of the boat, and that some 40 litres of water came out of the boat when he unscrewed the bung.	MMO reported to RM who advised that this was normal.
03.10.05	Yorke	M. Mene reported that water had come into the boat between the weld on the starboard side rail.	None documented
08.10.05	Badu: *Malu Sara*	P. Levi reported that the fume sensor siren came on when the vessel was in full throttle.	

The reports by Mr Mene on 30 September and 3 October concerning the Yorke Island vessel were plainly serious issues, particularly bearing in mind that the void space in the hull provided the only reserve buoyancy. The Department's internal investigation noted:

> "*The SOPs mandate that problems with vessels are to be reported to TI office, including by the RM. These procedures however, do not specify any standards of accountability for resultant action, and there appear to be no written instructions on how to affect these checks, what to look for to determine faults or to confirm overall standards..."*[134]

There is no record of steps taken or any further investigation of the issues raised by Mr Mene.

Mr Coburn from Mabuiag Island told the court that he had conducted three patrols in the "*Nagagalayg*" before all the new IRVs were withdrawn from service. One of the patrols was as far as Turnagain Island, nearly 20nm north-north-east of Mabuiag Island. That journey was far in excess of the 15nm "from the coast" expressed in the SOPs. It was also a journey that would have had no part or little part in smooth or partially smooth waters. It seems likely that the voyage was approved.

The *Malu Sara* had also been on patrol: on 17 September it patrolled for about 5 hours around Portlock Island. That voyage was for a distance of about 45nm. Following it, the vessel was refuelled with 100 litres of petrol, but there is no record of any oil being purchased after this patrol.[135] It is likely this was due to the skipper being unaware that petrol and oil reservoirs would be exhausted at about the same time.

The Murray Island vessel was not used after the August commissioning ceremony. It was withdrawn from service in the week commencing 17

[134] At section 5.2 page 26 – exhibit E39.

[135] Exhibit 1 18

October 2005 after the *Malu Sara* disappeared. At that time, six to seven buckets of water flowed from the hull on removal of the bung.[136] Presumably this was rainwater that flowed into the hull through defects in the weather deck.

The standard operating procedures

The Standard Operating Procedures ("SOPs") mandate the circumstances under which the vessels will be used, what approvals should be sought and in what climatic and other prevailing conditions they should be used.

The SOPs had been developed for the Bermuda class vessels and adapted for the new IRVs. There had not been any expert independent input concerning any modifications of the SOPs to make them suitable for operations with the new IRVs. The last modification seems to have been carried out on 13 September 2005, shortly before the Saibai Island workshop. The likelihood is that Mr Chaston made that modification.

Aspects of the SOPs relevant to this matter are:

- Before departing on a patrol a tasking request form was to be sent to the Thursday Island office for approval. Skippers were not to proceed to sea without approval from the Regional Manager.

- Only assistants (or deckhands) listed with the Thursday Island office as "volunteers" should be taken on board.

- All safety equipment was to be checked before proceeding on patrol. If any equipment was found to be inoperable, patrolling was banned, and an "Incident Form" was to be sent to the Thursday Island office requesting repairs or replacement.

- The vessels were to be used *"within 15 nautical miles from the coast or in waters defined as smooth or partially smooth waters".*

- The carrying capacity was 6 persons (of 85 kg) or total including cargo of 510kg.

- The hours of operation were limited to daylight, with limited exceptions.

- Operation in sea state 4[137] and above was prohibited, day or night.

- Operation in sea state 3[138] was limited to 2 to 4 hours in daylight and 0 to 2 hours at night.

[136] T/s 186; line 20; t/s 187; line 25.

[137] Sea state 4 was defined as wind speed greater than 22 knots and wave height 1.15 – 1.31 metres.

- A warning was given that “wind over tide” could result in higher than indicated waves – and extreme caution was urged in areas affected as such.

- Contacts were given for QPS Water Police, Bureau of Meteorology and Queensland Coastal Forecast.

- The range of the vessel was stated as 125 miles at 20-25 knots with 6 persons on board.

- There were directions about personal safety, including:

    - Wearing of life vests at all times;

    - A weather forecast was to be obtained to satisfy the operator (or skipper) of prevailing and expected conditions.

    - All safety equipment was to be inspected before departing on a voyage.

    - There was to be a safety briefing before commencing a voyage.

- When on patrol, satellite telephone contact with the Thursday Island office was to be made hourly advising of the current location and status. If a call was overdue by 15 minutes communication with the IRV was to be attempted by the Thursday Island operator. If communication could not be established within 1 hour**, the QPS were to be notified to initiate search and rescue action.** (emphasis added)

No provision was made in the SOPs for carrying of a navigation chart.

Findings

i. Despite significant differences between the vessels and their communication equipment and those they were replacing, the skippers received minimal training or familiarisation with the new craft. The skipper of the *Malu Sara* received none because he did not attend the commissioning ceremony.

ii. When problems with the vessels developed soon after they were brought into service, no investigation of the causes of those problems was undertaken.

[138] Sea state 3 was defined as wind speed 17-21 knots and wave height 0.6 – 0.88 metres.

iii. Mr Baira did not possess the licence necessary to lawfully operate the vessel. However, I am satisfied that his extensive maritime experience means that this, of itself, did not contribute to the tragedy.

Part 5 - The Saibai Island workshop

Planning for the workshop

The Thursday Island office of the Department ran an annual workshop for the MMOs. In 2005 it was decided to convene this training program on Saibai Island in the far north of the Torres Strait.

It was planned that three of the IRVs would steam to Saibai for use during training exercises. They would be crewed by a skipper and a deckhand. Other staff would fly to Saibai. Initially it was planned that the boats from Yam, Dauan and Mabuiag Islands would be used but just before the workshop was to commence the *Malu Sara* was substituted for the Mabuiag boat.

In order to get to Saibai Island, the crew of the *Malu Sara* had to travel approximately 5nm, much of it across open waters. This was far different from the usual patrolling around their home island.

In considering the forthcoming attendance at the Saibai Island workshop, the Thursday Island management team carried out no risk assessment concerning the proposal to send the *Malu Sara* across parts of the Torres Strait that could yield treacherous conditions. This was in breach of the SOPs. Had it been properly considered it may have focussed attention on the need to ensure the crew knew how to use the new satellite phones to best effect, but it is unlikely it would have made any real difference, as any risk assessment would not have taken into account the possibility of the vessel being fundamentally flawed.

Mr Bin Juda had claimed during his evidence that he warned Mr Chaston against sending the *Malu Sara* because Mr Baira lacked familiarity with the boat, stemming from his non-attendance at the commissioning ceremony. However, I am not able to accept Mr Bin Juda's assertion due to four factors:

- He told the Court that his countenancing against sending the *Malu Sara* was documented, either in email or memo. Despite extensive recovery of documents by the Department, no such document was able to be produced to the Court.

- He informed the Court that Mr Stephen witnessed the exchange with Mr Chaston, but Mr Stephen could not recall any such exchange.

- Mr Chaston did not recall any such exchange.

- When the decision to send the *Malu Sara* was made, it is probable that Mr Bin Juda had left Thursday Island on annual leave.[139]

I am also of the view that had the boats been seaworthy, there would have been no good reason why an experienced seaman like Mr Baira could not have made the trip in safety had the appropriate weather conditions prevailed. However, such a voyage was clearly incompatible with the limitation of the vessel's survey and the SOPs neither of which authorised operation in open waters.

The voyage to Saibai

In accordance with the SOPs, a tasking request form was completed for the *Malu Sara* before the voyage. It sought approval for the purchase of fuel and the carrying of five people to Saibai: Mr Wilfred Baira, Mr Ted Harry, Mr Peter Levi, Ms Valerie Saub and Mr Monty Noe. It was approved, although it transpired Mr Noe did not actually travel.[140] Ms Saub, who was Mr Harry's partner, was authorised to travel in the boat on the basis that she was a volunteer deckhand.

After collecting Mr Levi from Moa Island on the morning of Saturday 8 October, they headed for Saibai. It seems they made reasonably good time and by mid afternoon they were approaching Turnagain Island, about three quarters of the way to Saibai when an alarm sounded. Mr Baira called the Thursday Island office and spoke to Mr Stephen. It was agreed the alarm was due to a lack of oil for one of the motors. Mr Baira didn't have any spare and so Mr Stephen contacted Mr Chaston on Saibai and arrangements were made for oil to be taken out to the vessel.

Mr Beimop Tapim and Mr Titus Mooka went in the Dauan Island IRV with some oil. They found the *Malu Sara* and after oil was added, the two boats steamed to Saibai without further incident.

Training at the workshop

A primary purpose of the workshop was training the MMOs in appropriate procedure for intercepting, interviewing and reporting on the movement of non-residents throughout the islands, a key function of the MMOs. This necessarily involved patrolling in the three IRVs that had been brought to the island for this purpose.

[139] Exhibit "B27.2".

[140] T/s D19 457.

It was also intended to provide training in the use of the new satellite telephones. Mr Chaston said he had contemplated he would carry out that training. However, by the time of the workshop he had not acquainted himself with the operations manual for the telephones. In any event, this training was not included in the timetable for the workshop and due to the crowded program there was no time available to undertake this.

Nor was any other training provided in relation to the operation of the vessels.

Problems with the *Malu Sara* on Saibai

After arriving on Saibai Island on Saturday 8 October, it seems the *Malu Sara* wasn't used until the following Wednesday when two patrols were undertaken as part of a training exercise.

Numerous witnesses told the Court that during the second of these patrols in the afternoon, when the vessel was at anchor, a large amount of water flooded into the cockpit through the scuppers. One witness described the height of the water inside the vessel as above ankle deep near the centre console while others said it was deeper near the stern.

The incident alarmed those on board who responded by bailing and starting the engines in the hope that once underway the water would drain out. This is what happened, but it is apparent that some of the water also seeped into the void space below decks. Indeed it is likely that water had been accumulating there for some time since the boat had not been out of the water since it left Badu. Mr Levi described the vessel as feeling unbalanced, no doubt as a result of that water sloshing about in the bilge.

Mr Chaston readily acknowledged being informed about the episode.[141] He went down to the wharf to inspect the vessel soon after hearing of it. He says he observed water in both the engine pod and on the rear of the weather deck. He could see that the boat was sitting low in the water, *"down at the stern"* and he surmised this was why there was water in the cockpit.[142]

He said that at the time he thought either the bungs had been breached or removed, or the inspection plate in the engine pod had been opened or loosened and water had entered the void space under the engine pod. When interviewed by ATSB investigators Mr Chaston sought to explain the ingress of water on a plastic bag clogging the scuppers. However, under cross examination at the inquest it became apparent this was specious; that at most he had seen a plastic bag floating in the cockpit at some stage.

He had wrongly assumed there was an additional void space under the engine pod separate from the void space under the weather deck. He told the court that he believed that Mr Baira was pumping from that void space because he had heard a comment from Mr Levi to Mr Baira to change the direction of the handle on the pump so that it commenced pumping from the

[141] Exhibit "C19" at paragraphs 121 and 125.

[142] T/s D18 274.

void space.[143] Mr Chaston said he thought Mr Baira kept pumping for possibly up to five minutes.

It was suggested to Mr Chaston that this incident must have alerted him to a safety issue with the vessel. He responded that he *"thought someone may have tampered with the boat".*[144] There was no evidence to support such a conclusion and he took no steps to investigate the possibility. He eventually conceded the information he had received from the crew and as a result of looking at the vessel indicated an operational deficiency.[145] He also agreed the information he was given about water entering the weather deck or cockpit area was "*a matter of some importance".*[146]

Mr Chaston sought no expert assistance to determine the cause of the leak and it was not further investigated. He told the crew to inspect the boat over night to ensure the problem did not recur. He took no further action in relation to the issue.[147]

Other events at the workshop

One witness had concerns about the operation of the compass on the *Malu Sara* when she was on patrol on the same day the inundation occurred. However, as a result of her evidence and that given by an experienced mariner who demonstrated the workings of a similar compass at the inquest, I am satisfied she was confused about how it was meant to be read.

The satellite telephones presented intermittent problems in getting through to the Thursday Island office. This seems to have largely been a result of the crews being unaware that using the phones in their cradle improved their range.

Who made the decision to undertake the incident voyage?

As will be detailed later, the weather was, at best, marginal for the undertaking of the return passage to Badu Island on Friday, the scheduled date for the departure. Of course, the ultimate responsibility for the decision to depart was Mr Baira's. However, there is also evidence Mr Chaston may have refused a request from Mr Baira to delay the departure in circumstances which may have created a cultural imperative for the trip to proceed as planned.

Patricia Mooka gave evidence that on the afternoon before the scheduled departure date, she was doing data entry in a donga used by the Department on the island, when Mr Baira came to speak to Mr Chaston. She says she heard Mr Baira ask permission to stay another night on Saibai "*so that if the wind goes down then I can proceed for here on?"* She says that Mr Chaston

[143] T/s D19 427 – 428.

[144] T/s D18 274.

[145] T/s D18 275.

[146] T/s D18 275.

[147] T/s D19 391.

refused the request on the basis the Department could not afford the added expense.

Mr Chaston says he can not remember any such conversation and that it would not have been correct that the minimal expense would have played a part in such a decision. That may be so, but as noted elsewhere, Mr Chaston on occasions used that excuse when he did not wish to grant a request. There were no operational reasons from the Department's point of view that made it necessary for any of the boats to leave Saibai on Friday, particularly if the weather was not suitable.

There is evidence which corroborates the version given by Ms Mooka. Ms Titasey says she saw Mr Baira waiting to speak to Mr Chaston at the donga; she can't recall whether it was Wednesday or Thursday and she left the vicinity before Mr Chaston got off the phone. Ms Serai Zaro says she was told by Mr Harry that Mr Baira had told him Mr Chaston had refused Mr Baira's request. A number of witnesses recall hearing, or hearing of, Ms Mooka offering Mr Baira accommodation on the island. Ms Mooka says Mr Baira rejected her offer saying; *"If that's what the boss said I can't argue with that".*[148] She also gave evidence that accepting a superior or senior family member's direction without question was a cultural imperative for someone in Mr Baira's position and with his social sensitivity. Numerous witnesses gave evidence that Mr Baira was a quiet and gentle man who was not inclined to argue or complain, particularly in relation to decisions made by those of higher social standing.

In am persuaded Mr Chaston did refuse a request by Mr Baira to stay longer on Saibai. I shall later deal with the issue of whether this means he was responsible for the voyage being undertaken the following day when conditions for travel were far from ideal.

The carrying of passengers on the incident voyage

There were five people on board the *Malu Sara* when she was lost. Two of them, Mr Baira and Mr Harry were departmental employees. Ms Saub had come to the island on the *Malu Sara* and was shown on the tasking request form for the outward trip as *"voluntary crew"*, as was usually the case when passengers were given permission to travel. The other two passengers were Ms Enosa and her young daughter Ethena. This raises the question of who authorised the non departmental employees to travel on the vessel. It would have been reasonable for Mr Baira to have assumed Ms Saub's return to Badu, like his and Mr Harry's, did not require permission additional to that granted on the tasking request form for the trip from Badu Island.

No tasking request form was completed by any of the boats for their return journeys to their home islands. It is likely this was simply overlooked by the skippers, the office manager and the regional director. It is spurious for Mr Chaston to suggest, as he did during evidence, that this failure assists to determine whether permission was granted for the *Malu Sara* to carry

[148] T/s 411 - 412

passengers.[149] It does mean however, there was no written record of the granting of permission to carry passengers on any of the boats.

Mr Chaston agreed Mr Baira sought his permission to carry a female passenger or passengers whose name(s) he could not recall, when they were both at the airport just prior to Mr Chaston's departure on Friday morning. Mr Chaston says he refused the request, although he could give no persuasive or consistent reason for doing so and could not nominate any other occasion on which he had refused such a request. Aspects of his evidence were inconsistent and self serving. For example he suggested a subsidiary reason for directing Mr Baira to return to the Department's donga and retrieve a crab or crabs Mr Chaston was taking back to Thursday Island was to ensure Mr Baira had an opportunity to get spare oil for the boat's engine.[150] He also suggested he refused the request out of spite because he was still annoyed with Mr Baira not bringing enough oil with him on the outward journey, a week before. It is clear passengers were frequently carried on the IRVs.

Later in the afternoon, when the vessel had not reached Badu as expected, Mr Chaston reported it overdue to Thursday Island police. The officer who took that call made a note; "*There is a possibility of a third person on board this vessel however this has not been confirmed at this point.*"[151] Mr Chaston variously denied having made any such statement to the officer and denied having Ms Saub in mind as the possible third person.

I accept he did make such a comment to the officer taking the report and consider it indicates he knew that a person other than Mr Baira, Mr Harry and Ms Saub may be on the boat because he had acceded to Mr Baira's request. He had not contemplated Ms Saub being on the vessel because he mistakenly understood she was staying on Saibai on holidays. Presumably, Mr Baira did not mention her because he considered permission for her to travel back was covered by the earlier tasking request. Hence, it was another individual that Mr Chaston must have had in mind.

While "character evidence" could never be determinative of such an issue, it is relevant that all witnesses agreed Mr Baira was a disciplined officer who complied strictly with departmental guidelines and was most unlikely to have contravened an explicit instruction from his superior. Mr Chaston conceded it would have been *"completely out of character"* for him to do so.[152] Shortly after the conversation with Mr Chaston, Mr Baira told Mr Ned David that he had been granted permission to carry passengers. When Mr Baira contacted the Thursday Island office shortly before he departed Saibai, he told the acting office manager, Mr Stephen, he had four adults and one infant on board, in all probability knowing this would be recorded in a log and that Mr Chaston would likely be in the office and speaking with Mr Stephen later that day.

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[149] T/s D18 286

[150] T/s D19 458

[151] Exhibit B59

[152] T/s 459

On balance, I am persuaded it is more likely than not that Mr Chaston gave permission for Mr Baira to carry a female passenger.

Findings

i. Two days before the incident voyage, Mr Chaston was made aware that a significant volume of water had entered the void space of the *Malu Sara* when it was being used on patrol during the workshop. He failed to adequately investigate its cause or otherwise respond to the obvious safety issue the incident highlighted.

ii. Mr Baira sought permission to delay his departure from Saibai on account of concerns about the weather. Mr Chaston denied his request.

iii. Mr Chaston gave permission for Mr Baira to carry a female passenger on the *Malu Sara* on the journey from Saibai to Badu Island.

Part 6 - The incident voyage

Activities prior to departure

There is no doubt the sea conditions in the Torres Strait can be very difficult: frequently, the effect of strong winds are exacerbated by a very strong tidal flow. Various witnesses gave evidence of the tide flowing at up to 10 knots. This contributes to the generation of waves that will test the limits of a small open boat such as the *Malu Sara.* On the day the *Malu Sara* went missing, searchers reported swells of up to 3 metres.

The wind recorded throughout Friday 14 October coupled with the description of the sea and waves by Mr Harry David and Mr Ned David detailed below indicate the sea state was at least 3 and above within the meaning of the SOPs. Taking account of recorded gusts and the evidence of Messrs David it is likely the sea state was 4 much of the time. Use of the IRVs in sea state 4 or above was prohibited under the SOPs. Even when sea state 3 prevailed, the SOPs limited the vessels duration of operation to 4 hours in daylight or 2 hours at night. The journey from Saibai Island to Badu Island would take about 4 hours in reasonable conditions. It could be argued that voyage should not have been undertaken but the regional director did not think to question the appropriateness of travel on the day in question and the skippers seemed willing to undertake the voyage, albeit with some apprehension.

During the workshop, the skipper of the *Malu Sara,* Mr Baira*,* arranged with Mr Harry David, the skipper of the IRV from Yam Island, the *Mangani Guthat*, to travel together for part of the voyage back to their respective islands on Friday morning.

They had planned to leave at 9.00am, but Mr Baira and other MMOs were involved in collecting workshop participants from their accommodation and transporting them and their luggage to the airport. The flight taking Mr Chaston, Ms Titasey and others back to Thursday Island did not leave until about 9.30am. When Mr Baira and Mr Ted Harry had not arrived at the boat ramp by 10.15, the *Mangani Guthat* set out with another boat also heading for Yam Island.

During the morning, Mr Baira discussed the weather conditions with Mr Titus Mooka, the skipper of the Dauan Island IRV, the *Kang.* The men were concerned about the lack of visibility: Dauan Island, about 4 or 5 miles away was not visible and the southern coast of Papua New Guinea, only about two or three miles away could only just be made out.

A weather report was not available to the skippers before they left Saibai and the *Malu Sara* was not carrying any navigation charts. This means the dead reckoning the skipper would have been obliged to rely on in the fog to travel from island to island would have been extremely difficult: he would have had to steer with reference to the compass, wave and wind direction and his memory of the relative positions of the various islands.

Mr Chaston claimed in evidence that when the helicopter departed Saibai Island he noticed the sea to be calm and he found this reassuring. That is contrary to the evidence of all of the other witnesses and the Bureau of Meteorology records. The most favourable construction of Mr Chaston's evidence is that he looked only at the sea on the sheltered northern side of Saibai Island and due to his ignorance of matters marine failed to have regard to the conditions on the exposed coast. Consistent with other parts of his evidence it could also be self serving mendacity.

The *Kang* left Saibai at about 11.15am and the *Malu Sara* seems to have left about an hour later. The evidence did not establish the reason for this delay, but it is known the passengers loaded some mud mussels onto the boat and Mr Baira purchased a *whap*, a dugong spear. He also assisted the skipper of the Dauan boat make some adjustments to his boat and refuelled the *Malu Sara*.

Witnesses who knew the people well confirm that on board were Mr Wilfred Baira, Mr Ted Harry, Ms Valerie Saub, Ms Flora Enosa and her five year old daughter Ethena.

I have already found Mr Chaston gave Mr Baira permission to carry a female passenger. However, there is no evidence that Mr Chaston was ever told a child would also be travelling on the boat; indeed the evidence is silent as to when Mr Baira became aware that Ms Enosa intended to bring her daughter with her. It may be he didn't know this until just before departure and was as a result put in a difficult position of having to take the child or turn both away. However, whenever he learned of Ms Enosa's wish for her daughter to accompany them, Mr Baira must have known he did not have a child's personal floatation device on the boat. One witness reports seeing Mr Baira passing to Ms Enosa what looked like a life jacket for use by the child as the boat pulled away.[153] Obviously, an adult size PFD would provide little or no security to a young child in an emergency. In those circumstances, carrying a child over such an extended journey was unjustifiably dangerous and something that a skipper acting reasonably would not do.

The decision to sail

When considering who was the primary or dominant decision maker in relation to the determination to undertake the incident voyage, I am conscious of evidence indicating MMO skippers had on numerous occasions postponed scheduled patrols around their home islands on account of the weather conditions. The situation on this occasion was different however. The

[153] Exhibit B40 p3

previous day Mr Chaston had refused a request from Mr Baira to delay his departure from Saibai. There is ample evidence that Mr Chaston had an authoritarian manner that was resented by some of the staff. It is apparent there was little rapport between them. It is significant that on the day of the scheduled departure, the weather had deteriorated further: there was thick fog and strong wind. Neither Mr Baira nor any of the other skippers sought to delay their departure on this account, or raised with Mr Chaston any concerns about the safety of the proposed voyages, although they did discuss it among themselves. It could well be that Mr Baira considered there was no point in approaching Mr Chaston in view of his earlier refusal. It is apparent Mr Chaston made no inquiries as to whether the conditions made travelling by boat unsafe and he certainly took no steps to ensure the requirement in the SOPS to undertake a risk assessment before each voyage was adhered to. The facts remain, on the day of the voyage he wasn't asked for it to be postponed and he didn't direct that it proceed.

Further, the willingness of Mr Baira to carry a number of passengers, including a child, and considerable luggage, contra indicates any serious concern by him about the safety of making the voyage.

I don't consider the totality of the evidence indicates an unwillingness to travel on the part of Mr Baira that was overborne by a direction from Mr Chaston.

The initial leg

At 12.22pm Mr Baira used the satellite telephone on the *Malu Sara* to call the Thursday Island office of the Department and advise he had just departed Saibai Island with five persons on board. He arranged to make further contact when he reached a waypoint at Turnagain Island about 23 miles or 37kms to the southwest of their departure point.

When the *Malu Sara* set out from the settlement on Saibai Island, they travelled on the north side of the island in the lee until they cleared its western extremity and headed southwest towards Turnagain Island. At this stage they would have been exposed to the weather. Records show at about this time the wind was blowing from the south east at about 17 knots and the tide was flowing in a westerly direction. Mr Harry David would have experienced the same conditions and he variously described the sea as "*pretty rough*", "*difficult*" and "*big*".[154] His deckhand, Mr Ned David, estimated the waves at 2.00 metres[155] but after midday when the tide changed and ebbed to the east the wind against tide effect would have made the seas rougher.

Despite these difficulties, the *Malu Sara* was seen passing close by Dauan Island, on course, and Mr Baira made the scheduled call to the Thursday Island office at about 2.08pm, reporting that he was on the south eastern side of Turnagain Island. He advised Mr Stephen he would now steam due south hoping to get into calmer waters on the western side of the reefs that run northeast from near Mabuiag Island. They agreed he would call again

[154] T/s 380, 402, 402

[155] T/s 964

when the *Malu Sara* neared Mabuiag Island, about 21 miles or 34kms south of Turnagain Island.

The boat becomes lost

The next contact with the vessel was when Mr Baira made a number of calls to the office at about 4.00pm. He reported to Mr Stephen he was "a *bit lost in the fog*"; he had not found the reefs referred to earlier, despite steaming south for about an hour, and then west for 30 minutes from where he had made the first call near Turnagain Island. He could not see any landmass.

After the loss of the vessel, its satellite phone records were interrogated and the boat's position when making this call differs from where it would have been had it followed the course described by Mr Baira. Instead of being 10 nautical miles north of Mabuiag it was nearly double that and further to the west, i.e. it was about 18 nautical miles north northwest of Mabuiag.

Of course Mr Stephen could not know this when he was seeking to assist Mr Baira, and so told him to set a course of 160 to 170 degrees, that is slightly east of due south, so that he would come into the lee of the reefs near to Mabuiag.

When he came into the office in the middle of the day after flying back from Saibai, Mr Chaston had asked Mr Stephen to remain duty officer until the end of the day when Mr Chaston would take over as the on call officer. At about 5.00pm, Mr Chaston called Mr Stephen to check the three IRVs had made port at their respective home islands. He was told the *Malu Sara* was still at sea. In response Mr Chaston asked Mr Stephen to remain on duty to monitor events. When he next spoke to Mr Stephen at about 6.00pm nothing much had changed so far as the two men were aware and he was told the *Malu Sara* was still at sea.

When Mr Baira next made contact with Mr Stephen at about 6.22pm, he told him that he had steamed south for about an hour, when he saw an island which he took to be Gabba Island. That island is a considerable distance north east of Mabuiag. He therefore had then steamed west for half an hour so as to get behind the reefs to the north of Mabuiag Island. It was from that position he was calling.

By this time Mr Stephen had returned to the office and with reference to the navigation charts, he sought to understand where the *Malu Sara* was and to give guidance to Mr Baira.

Mr Stephen concluded the island Mr Baira had seen was Mabuiag rather than Gabba and he therefore told him to retrace his course. He also told him if he was unsuccessful in regaining sight of the island, Mr Baira should consider anchoring, if it was safe to do so. Mr Stephen urged Mr Baira to maintain contact and suggested if he couldn't he should consider activating the EPIRB. At about 7.00pm Mr Baira again spoke to Mr Stephen and told him that he had not been able to locate the island or any land mass and he had activated the EPIRB.

QPS SARMC becomes involved

Shortly after this call Mr Chaston again spoke to Mr Stephen. On learning the *Malu Sara* had still not made land at Badu and that its location was not known with any precision, he contacted local police to advise of the overdue vessel. The officer he spoke to, Senior Constable Jones, created an overdue vessel report and advised the local search and rescue coordinator, Sergeant Flegg, of the incident.

Over the next 12 hours, there was frequent contact between the various participants in the response to the vessel's predicament. An appreciation of what was said, when and to who is essential to understand how events unfolded. Unfortunately, apart from the conversations that were tape recorded, such a reconstruction is reliant on notes and logs kept by Sergeant Flegg and Mr Stephen, both of whom made only scant notes they expanded and rewrote the following day. Much time was spent during the inquest trying to untangle these wordy webs. What follows is my understanding gained during that process and as a result of the parties' submissions.

Mr Stephen and Mr Baira spoke next at about 7.45pm. It was clear the boat was still lost and the situation was deteriorating. It was by then dark and the boat had been at sea for seven hours. The weather was not good – it was overcast and windy - and there seemed little prospect of imminent landfall. Communications were proving difficult: the phone calls frequently cut out or did not connect at all. They again discussed the possibility of anchoring but both men knew this could result in the boat being swamped if the conditions were not favourable. Mr Baira confirmed he had activated the EPIRB.

This information was passed onto Sergeant Flegg who at 8.08pm contacted the Australian Search and Rescue organisation (AusSAR) in Canberra as it had access to the satellites which would detect the EPIRB's signal. In conversation with an officer from that organisation Sergeant Flegg wrongly asserted the vessel was equipped with the usual navigation equipment: "*they've got a compass and everything on board".*[156] The vessel in fact had a compass and nothing else. He also told them the vessel in question was operated by DIMIA and that it was travelling from Saibai to Badu Island.[157]

In this first contact with AusSAR and subsequently, Sergeant Flegg conveyed the view the vessel was not in distress or in need of assistance but only required its location fixed. He had no basis for this conclusion as he was never told this by anybody and did not ask the skipper on the two occasions that he may have spoken with him directly.

At about 8.45pm, after failing to establish contact with the satellite phone on the *Malu Sara* despite a number of attempts, Sergeant Flegg advised Mr Stephen that satellite passes would enable the boat's position to be established at around 9.40pm.

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[156] Exhibit 19.1 p 2

[157] Exhibit 19.1 p1

Mr Stephen next spoke to Mr Baira at about 9.28pm. In a relatively lengthy call, Mr Baira advised him they were still lost, the EPIRB was still activated, water was coming into the boat and they were trying to pump it out but water was still coming in. The seas were rough – they had not found sheltered water. He advised Mr Baira to continue those efforts and to ensure the crew and passengers had their life jackets on. He immediately relayed this information to Mr Chaston who did not offer anything constructive in response but it seems he had a conversation soon after with Sergeant Flegg.

In hand written contemporaneous notes Sergeant Flegg recorded *"21.35 hours:- At anchor? Some water:- bilge pumping. 5 p.o.b".* I consider it most likely he received this information from Mr Chaston. The question mark after "*anchor*" would signify Mr Stephen told Mr Chaston the possibility had been discussed with Mr Baira but whether it eventuated was dependant upon the prevailing conditions.

It is alarming that when told water was coming into the *Malu Sara*, Mr Chaston did not tell Sergeant Flegg or Mr Stephen a similar event had occurred when the boat was on Saibai Island two days earlier and that the water on that occasion had entered the supposedly watertight bilge. Mr Chaston could not explain his failure to pass on this crucial information.

In his type written log compiled over the succeeding days, Sergeant Flegg purported to record a conversation with someone on the boat at 9.35pm during which he inquired after their welfare. His log claims he was told the boat was at anchor, the people on board *"When questioned said they were okay"* and *"There was some water coming into the vessel but they were using the bilge pump to get it out. The only time they could see water coming in was when they were anchored and was not there when they were underway."*

The telephone records do not support the claim any such call was made. The contents are self serving in that they enable Sergeant Flegg to better explain his failure to take any decisive action.

When AusSAR called Sergeant Flegg shortly before 10.00pm to advise of two possible positions of the *Malu Sara* as indicated by the EPIRB, he gave them yet another account to those contained in the two logs. Sergeant Flegg deduced that of the two possible positions suggested by the AusSAR data the location placing the vessel 11 nautical miles north northwest of Mabuiag Island was the most likely to be accurate. When speaking to AusSAR he suggested the *Malu Sara* was in an even more tranquil situation than that described in his log entry:-

> *"I've just heard they're at anchor. They've taken – they've got a little bit of water but the water's – its calm water at the moment, which would explain roughly – the Mabuiag position."*

When giving evidence, Sergeant Flegg tried to justify this by suggesting the advice he received about water entering the vessel was consistent with the spray one would expect to splash into a boat at anchor. That is ridiculous: it

would not have been mentioned by the boat's very experienced skipper if it was so unexceptional and Sergeant Flegg had no basis to conclude the water ingress was so benign. Nor would the boat being 11 nautical miles from Mabuiag Island provide any basis to expect it to be in calm waters.

The description of the water entering the vessel and draining out when it was underway is surprisingly similar to what was described to Mr Chaston when the *Malu Sara* experienced difficulties on Saibai. Mr Chaston and Sergeant Flegg met on a number of occasions on Saturday before Sergeant Flegg created the type written log. This may have been the source of the misinformation contained in the SAR log.

Soon after being advised of the EPIRB data by AusSAR, Sergeant Flegg relayed the boat's position to Mr Stephen and asked that he advise the skipper to steam due east.

Phone records show there was a call of 47 seconds duration between the police mobile phone and the *Malu Sara* satellite phone at 10.08pm. It is not recorded in Sergeant Flegg's handwritten log nor the type written version so I have no way of knowing what he told Mr Baira other than to speculate he would have relayed the position of the vessel as advised by AusSAR. The typewritten log purports to record contact between the officer and the *Malu Sara* at 11.15pm. The telephone records show no calls made at around this time and it is not listed in the contemporaneous handwritten log. Either it is a fabrication or Sergeant Flegg has wrongly recorded the time of the 10.08 call. In any event it is clear the call was very short and Sergeant Flegg said in evidence it was difficult to hear. In the circumstances, his notation "*No mention of water on the deck"* is pointless and blatantly self serving.

It seems that after numerous unsuccessful attempts to contact the vessel, Sergeant Flegg may have managed a short conversation with one of its occupants at about 11.41pm. Presumably he relayed the suggested heading for them to follow at that stage. This is consistent with a note in the hand written log for 23.50 hrs.

The handwritten log records a conversation at 1.37am (presumably, the same as that shown in the telephone records as having occurred at 1.33) in which Sergeant Flegg was told the vessel was "*at anchor, believe can see Mabuiag*". He notes he was "*unable to hear rest of conversation"* but ominously records he was told the boat was "*out of oil*". In the type written version of the log this changes to, "*There was a reference to being out of oil or something about oil".*

Sergeant Flegg told the Court he did not think that potential difficulty with the vessel's propulsion required "*immediate activation of resources*". He said he thought it may be just a warning light coming on, despite never being told anything of the sort. He later wrongly told AusSAR that the vessel was "*running low on oil".*

This is the first time there is reliable evidence the boat is at anchor. I conclude the skipper took that action because the motor was no longer operable and the wind and current were pushing the boat away from the light he could then see on Mabuiag Island.

That information did not prompt Sergeant Flegg to take any action even though he knew the open boat had then been at sea for more than 12 hours, had been lost since before darkness fell, the sea was rough and they were in open, unprotected waters, there were women and a child on board, water had been coming into the boat for some hours, communication with the boat was difficult and unreliable and it no longer had means of propulsion.

He sought to explain his inactivity on his view that the vessel could remain at anchor for some time awaiting another vessel to provide extra oil.[158] It was not explained how such an outcome was to be achieved. He certainly did nothing to facilitate it.

The next and last contact with the vessel was a phone call to Mr Stephen at about 2.15am. Mr Baira told Mr Stephen the vessel was taking on water and sinking. Mr Stephen relayed this information to Sergeant Flegg who included it in his later compiled type written log in an entry at 2.21am. Astoundingly, he did not pass the information on to AusSAR when he spoke with one of its officers at 2.26am. Nor did he tell the Thursday Island volunteer marine rescue service this information when he called them at about 2.30am.

Attempts to contact the boat continued but none was successful. The last attempted call made by the phone on the boat is shown by the telephone records to have been made at 2.48am on Saturday 15 October. The records also show that the phone was last recognised by the network as available for connection at some point between 3.28 and 3.57am. I conclude that soon after the boat became submersed or capsized.

During the inquest, Sergeant Flegg suggested he was not told by Mr Stephen the boat was sinking when they spoke at 2.21am and that he had erroneously included it in his type written log the next day as a result of reading a similar entry in Mr Stephen's log. *"(I)f Jerry told me that night they were sinking… I would have informed AusSAR they were sinking."*[159] Only when confronted with the transcript of a call he made to Cairns police headquarters at 2.32am, did he concede he had been told the boat was sinking.

I do not believe his attempt to disavow the entry in his log was a genuine mistake. I am unable to accept Sergeant Flegg would have mistakenly included such crucial information in his log the next day if he had not been told it; and it is not credible to suggest that he could have made such a mistake and then forgotten he had done so. He had numerous opportunities to review the log when he was compiling his report to the coroner and not until the inquest did he challenge the accuracy of that entry. His attempt to

[158] T/s D27 9; lines 12-31.

[159] D25 T/s 1049.

manufacture an excuse for his failure to take appropriate action on being told the boat was sinking by seeking to shift the blame to Mr Stephen is reprehensible. The injustice and unwarranted recriminations that would have ensued had his despicable attempt not been thwarted are alarming to contemplate.

I have summarised only the telephone calls that resulted in information being conveyed. Records show over one hundred calls to or from the *Malu Sara* were attempted during the period in question. This demonstrates the increasingly desperate situation the people in the vessel considered they were in and the severe limitations on their ability to communicate with those who might have been expected to help them. The high failure rate was contributed to a number of factors such as atmospheric conditions and the positioning of the communication satellites. As Mr Baira had received no training in the use of the new telephone, it is likely he attempted to use it out of its cradle because in windy conditions that would normally make hearing easier. However, in this case it meant the phone was disconnected from the external aerial which undoubtedly reduced its efficacy.

Communication with the vessel and the police officer responsible for assisting it, Sergeant Flegg, was further negatively impacted by much of it being relayed via Mr Stephen and/or Mr Chaston. Mr Chaston at no stage returned to the office but made and received calls to and from Mr Stephen. On occasions he relayed some information gleaned in this way to Sergeant Flegg.

Until he called the VMR at 2.30am, Sergeant Flegg took no action to assist the stricken vessel other than to obtain the coordinates of its position from AusSAR. He sought to justify this by claiming he did not consider the vessel was in distress at any stage, even though he knew it had been at sea for ten hours when he was told it was taking water at between 9.30 and 10.30pm. Indeed, even when told it was sinking at 2.26am he disbelieved the report and an hour later he told an AusSAR officer the report about the boat being out of oil was probably an exaggeration because the boat's occupants were "*sick of being out there and want to get home".*[160] At the time he made this flippant comment it is likely the boat was in a parlous state and the people in it were frantically trying to save themselves.

Sergeant Flegg's attitude was coloured by his perception that people in the Torres Strait habitually activate EPIRBs when they are inconvenienced rather than in peril.

Sergeant Flegg gave evidence he was familiar with a corruption of the acronym used by the authorities in the Torres Strait for an activated EPIRB, to the effect – "*Empty Petrol I Require Boat".* He accepted that the slang expression had been used in the past in order to indicate that an emergency beacon had been activated in a situation not necessarily constituting an emergency. Sergeant Flegg said that on occasions EPIRB activations had

[160] Exhibit 19.5 p2

occurred where persons were not in "grave and imminent danger". He told the Court there was a higher incident of EPIRB activations in the Torres Strait than elsewhere in Australia but could not attribute any particular reason for it.[161]

His search and rescue superior, Senior Sergeant (now Inspector) Graham, the state search and rescue coordinator, shared his cynical view of the use of EPIRB's and sought to down play the seriousness of the *Malu Sara's* situation. He had been consulted by Sergeant Flegg after the EPIRB had been activated and had failed to encourage or instruct Sergeant Flegg to take any remedial action in relation the vessel. Inspector Graham said on two occasions during his evidence that even when the boat's circumstances were taken into account and it was reportedly sinking, it was not "in distress" such as would demand an immediate response.[162] If this was intended to be an attempt to support his junior colleague, it failed and it damaged his credibility. If it was an expression of his genuine opinion, it suggests he is not suited to his position.

Sergeant Flegg suggested he had no responsibility to take more decisive action because the skipper of the stricken vessel did not explicitly ask for it. I reject that. He did not even ask the skipper of the vessel about the condition of the boat or its occupants but just recorded bits of what he was told, or in one case, was not told. Having regard to all of the factors of which Sergeant Flegg was aware, I consider it was incumbent on him to take more effective action to resolve the incident before things got worse. He did not act and the situation deteriorated until the occupants of the vessel were beyond help.

It is difficult to be precise about when Sergeant Flegg should have caused direct assistance to be provided to the vessel by tasking the VMR to go out or tasking a helicopter to locate their precise position and hopefully view the boat, because it is impossible to know what he was in fact told about water coming into the boat shortly before 10.00pm. However, at the very latest, when he was told at 1.37am the boat was out of oil, it was obvious they were in danger and their situation was not going to be resolved without external assistance. It was Sergeant Flegg's role to cause that to happen.

As mentioned in more detail in the section dealing with the search, the experts, Mr Marshall and Mr Lloyd, in their reports expressed the view that it was not inappropriate that there was no tasking of an asset at any earlier time than 2.30am on Saturday. However, their assessment was based on the false assumption that Sergeant Flegg's log was accurate. As we now know that was not the case.

By the next day, Sergeant Flegg knew he had failed to respond appropriately. This may explain why he seems to have downplayed the seriousness of the boat's situation when he made entries in the log he created after he knew it had sunk. Those inaccuracies and his trivialising of the situation when

[161] T/s D27 42; lines 10-28.

[162] T/s D22 682 and 689

discussing it with AusSAR officers may demonstrate a consciousness of guilt. His evasive and self serving evidence during the inquest buttress this conclusion.

Findings

i. Contrary to the provisions of the SOPs, no risk assessment was undertaken prior to the *Malu Sara* being detailed to undertake the incident voyage despite it being far more hazardous than its usual patrols.

ii. The *Malu Sara* was inadequately equipped for the return voyage from Saibai to Badu Island in that it carried no charts or any navigation equipment other than a compass.

iii. The sea state and fog made the voyage from Saibai to Badu unduly perilous and it was attempted without adequate planning.

iv. The regional director, Mr Chaston, made no inquiries about the risks of the voyage and the planning for it. He exhibited no interest in the safety of the crew setting off on a long and precarious sea voyage. Although his position and the provisions of the SOPs authorised him to veto the trip, his lack of knowledge of maritime matters made this authority illusory.

v. The skipper of the *Malu Sara*, Mr Baira, had been refused permission to delay departure the day before the incident voyage. However, when travelling conditions worsened on the day of the scheduled departure he did not raise concerns about the safety of the voyage and agreed to carry passengers, including a child, and luggage suggesting he was not unduly concerned about the safety of the trip.

vi. Mr Chaston agreed to a request from Mr Baira to carry a passenger on the return voyage to Badu Island. He did not authorise the carrying of a child. Mr Baira must have known he did not have a child's personal floatation device on the boat. In the circumstances, carrying a child over such an extended journey was unjustifiably dangerous and something that a skipper acting reasonably would not do.

vii. The vessel became lost in the fog soon after passing Turnagain Island. Once that occurred, the lack of charts or GPS/ chart plotter made it very difficult for the skipper of the *Malu Sara* to establish his true position.

viii. When the vessel became lost in the fog, the duty officer, Mr Stephen, who had no search and rescue training or emergency procedures to fall back on, failed to raise the alarm before nightfall.

ix. Mr Stephen took what action he could to assist the stricken vessel but he received inadequate support from Mr Chaston who should have returned to the office and managed the incident in conjunction with Mr

Stephen. It is likely Mr Chaston could have caused more decisive action to be taken by utilising his department's networks and contacts. Communication mix ups would have been reduced. More accurate information would have been provided to the QPS and AusSAR.

x. The lack of any departmental procedures and training for dealing with such emergencies is surprising given the role of the MMOs and may have contributed to the incident being ineffectively managed by departmental officers.

xi. Communication between those on the *Malu Sara* and those on Thursday Island seeking to respond to the incident were hampered by Mr Baira's lack of training in the use of the new satellite telephone on the boat, the failure of Mr Chaston to attend at the office to take charge of the response, and the relaying of information between Mr Stephen, Mr Chaston and Sergeant Flegg.

xii. During the course of the incident, Mr Chaston failed to advise Sergeant Flegg of highly relevant information concerning the *Malu Sara* taking on water when patrolling off Saibai Island two days before the incident voyage. It is likely this contributed to Sergeant Flegg's failure to respond adequately to the incident.

xiii. Sergeant Flegg failed to take decisive, constructive action when he had sufficient information to indicate to a reasonable person the boat was in distress and in need of direct assistance.

xiv. After he knew the vessel had sunk, Sergeant Flegg created a SAR log that contained inaccurate information. I am unable to determine whether this was a result of his being given misinformation by others or was an attempt to cover his inadequate response.

xv. Sergeant Flegg failed to pass on to AusSAR and the VMR service vitally important information concerning the boat's situation, namely that it was sinking.

xvi. Sergeant Flegg was recalled to duty at about 4.00pm on Friday 14 October after working full shift that day. He then remained on duty until after 10.00pm the following day. This was inappropriate and his fatigue may well have contributed to his egregious errors of judgement.

Part 7 – The search

VMR becomes involved

When Mr Stephen called Sergeant Flegg to tell him Mr Baira had just advised the *Malu Sara* was sinking, Sergeant Flegg was on the phone to AusSAR. He terminated that call to take Mr Stephen's. He then called AusSAR back. As already described, he did not tell the AusSAR officer he had just been advised the boat was sinking; rather he told the officer; *"they're starting to take a bit of water in and they're bailing out".*[163] Sergeant Flegg eventually conceded that was inaccurate but he was never able to explain why he withheld such important information.

He asked AusSAR about the possibility of getting a helicopter to go out to the boat as Mr Stephen had requested, but did not follow up the suggestion when the AusSAR officer did not respond. The usual helicopter that would be used for such responses was a Bell 412 fitted out for night flying operated by Coastwatch from nearby Horn Island. Earlier in the evening, Sergeant Flegg had asserted that the Bell 412 was "*down".*[164] He was mistaken and didn't check. In fact that aircraft was available for immediate dispatching if requested.

Despite Sergeant Flegg's denials, there can be no doubt he was told by Mr Stephen at about 2.22am that the *Malu Sara* was sinking. In a telephone call to the Cairns police communications centre at 2.32am he is recorded as saying:-

> "…*we got an eco* (an EPIRB) *going off up here…..an overdue immigration vessel…they're apparently sinking now, so I just want to have a quick chat with the boss just to let him know that I want get the coastguard to duck out there if they've got a crew together."*[165]

[163] Exhibit D19.3 p2

[164] Exhibit D19.1 p3

[165] Exhibit B60 p2

Soon after, Sergeant Flegg called the local volunteer marine rescue organisation (VMR). He spoke to Greg Pope and asked if they had a crew who could go out to the *Malu Sara.* Sergeant Flegg explained where the boat was but did not tell Mr Pope he had been advised the boat was sinking. Mr Pope noted the conversation: "*DIMIA vessel taking water N/W Badu 4 adults & 1 child".* [166]

Mr Pope inquired whether the VMR vessel from St Pauls on Moa Island could respond. Sergeant Flegg undertook to contact them while Mr Pope made inquiries about gathering a crew to man the Thursday Island vessel, the *Pedro Stephen*. Sergeant Flegg quickly established that the St Pauls vessel was not operational. He therefore again called Mr Pope who undertook to put to sea as soon as possible. This call was made at about 2.45am. Sergeant Flegg told Mr Pope there was no "*air support available*". Mr Pope took this to mean the weather conditions were such that a helicopter could not safely operate.

Mr Pope and his wife then commenced preparing the boat to go to sea and arranging for a crew to come to their place where the VMR boat was kept.

In the meantime, at 3.38am Sergeant Flegg again contacted AusSAR to ascertain whether they had any more recent data concerning the EPIRB location. He was told there was no more recent data, but new information could be expected soon. This exchange then occurred:-

> *"…they've just told us that they've started taking a little bit water, so that's why we really haven't gone out to pick them up because they weren't ....in that, that much trouble. They've also run out of oil and they've started taking a little bit of water, so I'd say that the other reason is that they're sick of being out there and want to get home."*

The AusSAR officer joined in the baseless and fatuous attributing of false motives by suggesting; *"For sure, that's probably the likely thing and they've just come up with this oil, so."*[167]

It is pertinent to note the volunteers who agreed to crew the VMR vessel were familiar with the DIMIA IRVs and as they prepared to depart they expressed concern that such a boat would be operating in the prevailing conditions in open waters such as those encountered between Saibai and Badu and that the boat was not fitted with a GPS. The crew realised the severe weather conditions were going to make the mission difficult and so they took extra care with gathering details from the Bureau of Meteorology and ensuring the vessel was well prepared.

The *Pedro Stephen* was launched at about 4.05am and made its way towards the last known position of the *Malu Sara*. The weather conditions slowed the boat's progress. The crew estimated the wind to be blowing at between 25

[166] Exhibit B21.1

[167] Exhibit D19.5 p2

and 30 knots from the south east and the seas to be 1 to 1.5 metres. Visibility was very poor with overcast skies. The moon had set by the time the *Pedro Stephen* set sail.

Shortly before 6.00am the IRV from Mabuiag Island was launched, and after receiving instructions from Mr Stephen, it headed to where the *Malu Sara* was last known to be.

At 6.00am, Sergeant Flegg again contacted AusSAR. After confirming the EPIRB signal was still transmitting from close to its last position, in an exchange that demonstrated the terrible truth was slowly dawning on the officer, he described the course of the incident in these terms: *"And it just started out, you know that they were lost… and now it's gone and turned into 'Oh we're sinking. Can you come and get us?'"*[168] The AusSAR officer failed to apprehend the significance of Sergeant Flegg's remark, due to the manner in which the comment was made.

The difficult sea conditions meant the *Pedro Stephen* had to proceed at less than full speed to the search area. However, by 6.45am they were nearing the last known position of the *Malu Sara* and activated an EPIRB tracker without result. At 7.00am they were where the vessel was expected to be and detecting an EPIRB signal, but radar had detected nothing that resembled a boat.

At about this time the *Pedro Stephen* rendezvoused with the crew of the IRV from Mabuiag, the *Ngagalayg*. They agreed the IRV would head further north towards Mabuiag, while the *Pedro Stephen* would search the area west of Badu Island.

At around this time Mr Whittred, the skipper, noticed a change in the tidal flow; it commenced to ebb in an easterly direction.[169] This increased the size of the waves to approximately three metres making it nearly impossible for the crew of the *Pedro Stephen* to continue using the signal tracking device because of the pounding of the vessel.

At 8.42am the skipper of the *Pedro Stephen* explained to the VMR base station that they were continuing to receive the EPIRB signal but they could not find it, or a vessel. He asked that a helicopter be tasked to assist. In evidence, Mr Whittred explained he had previously been involved in searches during which a helicopter has been used to locate an EPIRB and the location then radioed to the search vessel which steamed to that point while the helicopter "*stayed on station*".

The VMR radio operator passed the request onto Sergeant Flegg who raised the possibility with AusSAR. Sergeant Flegg had in fact raised this issue with AusSAR earlier in a call at 7.26am and had been told there was a customs

[168] Exhibit D19.6 p2.

[169] Mr Whittred's observation appears at odds with tide datum, however, as observed before, there is significant variation throughout the Strait depending on exact location.

aircraft due to over-fly the area in four hours time. Optimistically he had suggested that "*with a bit of luck they'll find them in the next hour and a half anyway".*[170] On this second occasion AusSAR were agreeable to only having scheduled flights listen out for the EPIRB and suggested it was a matter for the QPS to task an aircraft for searching if they considered that was necessary.[171]

Air support is approved

Sergeant Flegg then sought approval from the regional duty officer in Cairns to engage a helicopter to assist with the search. Approval was given at 9.30am and the helicopter was tasked soon after.

Also at about this time, Mr Chaston attended at Mr Stephen's house and collected the office mobile phone, relieving Mr Stephen of responsibility for managing the incident further.

He was advised by the skipper of the *Ngagalayg* that they were returning to Mabuiag to refuel. When the boat was back on the island, Mr Chaston requested that the skipper take out the main bung and check for water. About 40 litres of salt water came out. Mr Chaston then instructed the vessel remain on land.

The *Pedro Stephen* continued searching for another hour without result. At 9.50am they again requested air support and were told by their base that this was being sought.

A helicopter finally reached the search area at about 10.30am. It quickly located the EPIRB floating in the water and radioed that information to the *Pedro Stephen*. The crew of the vessel could see the helicopter hovering a short distance away. They made their way to that position and located the EPIRB. It was trailing a 1.5 metre piece of line, the end of which appeared to have been roughly cut. There was no sign of the *Malu Sara* or its occupants. It was decided to leave the EPIRB in the water initially to act as a search datum.

Sergeant Flegg at last accepted the vessel was in "*distress",* a search and rescue term indicating the occupants were in grave and imminent danger. He therefore asked that AusSAR assume responsibility for coordinating an aerial search. The AusSAR officer said only, *"Yeah I'll get back to you on that. Shouldn't be a drama though".*[172]

The *Pedro Stephen* then headed east to commence searching around the nearby islands, without result. The sea remained very rough and the boat was having difficulty operating. The crew were becoming fatigued and at about 11.50 it anchored in the lee of Badu Island to allow them some rest.

[170] Exhibit D19.9 p2

[171] Exhibit D9.13 p2

[172] Exhibit D19.14 p2

AusSAR accepts responsibility

At 11.54am, AusSAR finally offered to assume responsibility for coordinating the air search, an offer Sergeant Flegg was very happy to accept. It was formalised by facsimile at 12.18pm.

By 2.00pm on Saturday afternoon, the crew of the *Pedro Stephen* were becoming fatigued and their fuel was running low. The vessel therefore returned to port arriving back at Thursday Island at about 4.30pm. It took no further part in searching for the *Malu Sara* over the following week.

When it left the search area, there were no other surface vessels searching. The helicopter continued to make passes over the area but it had to frequently return to its base on Horn Island to refuel.

On Saturday afternoon, Sergeant Flegg contacted the Australian Customs Service (ACS) to inquire about its vessel the *Botany Bay* whose home port was Thursday Island. He was told it was near by and the ACS readily agreed to it steaming north to Badu Island to assist in the search the following day.

Also during the afternoon, Sergeant Flegg reported the obvious seriousness of the incident to his superiors and arrangements were made for extra police, SES personnel and other volunteers to muster on Horn Island to act as observers in search aircraft.

As a result of AusSAR assuming responsibility for the coordination of the air search, seven aircraft were involved in searching an ever expanding area of ocean around the last known location of the *Malu Sara*. The aerial searching covered designated flight paths, each up to 1.5km apart. Searching that day continued as far as *Turu Cay*. The search zones were designated by AMSA/RCC using expert knowledge and datum concerning tides, current, wind and likely drift. Nothing of significance was found.[173]

At 19.30 on Saturday evening, AusSAR assumed responsibility for the overall search coordination. It then sent a senior officer, Mr Lloyd to Horn Island to take charge of the search operation. It is not apparent what had changed to warrant this but it is clear that thereafter, far more search assets were brought into the search area. This may have happened even if QPS had remained in control of the search. Conversely, it may have happened far sooner had AusSAR assumed responsibility for the search on Friday evening.

Searching continues

On Sunday a full scale search continued from first light. Thirteen fixed wing aircraft, three helicopters and three large surface vessels, the ACS vessel the *Botany Bay*, the Navy vessel, the *Malu Baizam* and the Thursday Island water police vessel, the *W Conroy* were involved in searching a large tract of sea and many islands and reefs, with no result.

Searching was also undertaken by Torres Strait island people from Saibai Island along the northern reaches of the Torres Strait as far west as

[173] Throughout the search there were a number of possible sightings of people in the water. Most were fleeting and were made by only a pilot. However in one case three people almost simultaneously saw something. That is detailed below.

Deliverance Island. Deliverance Island was later walked by crew from the *Malu Baizam.*

The search continued over Monday 17 and Tuesday 18 October with 16 and 19 aircraft involved respectively. On 19, 20 and 21 October the search continued but was scaled down. The search extended as far as the southern coast of Papua New Guinea, relying on advice from local people that the current and wind would sometimes sweep flotsam in that direction.

On the last two days a side-scanning sonar device and a magnetometer were deployed to try and detect the vessel, if submerged. It yielded no results.

The families of the missing people were generally kept up to date with search progress and incidents, although perhaps not to the level of detail they would have preferred. QPS also obtained during this time personal information about the missing persons.

The search was suspended at 6.00pm on 21 October, based on expert advice that no one could survive in the water for any longer.

On 23 October, Indonesian fisherman found a body near Deelder Reef about 50 nautical miles west of the last known position of the *Malu Sara*. It was subsequently identified at Ms Flora Enosa.

None of the experts or the parties have criticised the manner in which this search was undertaken from Saturday afternoon onwards.[174] It seems to have been appropriate and exhaustive. I commend the many SES volunteers, other volunteers, police officers and AusSAR officers involved on their efforts.

Sighting of a survivor

Three witnesses gave evidence of a possible sighting of a survivor from the *Malu Sara* at about 2.30pm on Sunday 16 October 2005.[175] Each witness was in the same fixed-wing search aircraft.

The sea was still quite rough. It was described by the pilot of the aircraft as "*choppy*". There was also some sea spray. I am satisfied there was about a 1.5m – 2.0m swell running.

Two of the witnesses gave a similar description along the lines of "*looking like someone in the water waving their arms".*[176] Each described the person as wearing a yellow life-jacket.

The period during which the witnesses had the object in their sight was not long. The duration was variously described as "*a few seconds",* "*a minute*" or *"minutes".* From the description given by the pilot of the aircraft it would be difficult to conceive that the period of observation exceeded a minute.

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[174] Mr Marshall had some criticisms of procedural matters not attended to by AMSA/RCC, but none of those matters had significance in respect of the outcome of the search.

[175] Ms Marshall (t/s D14 6-37), Mr Sterekx (t/s D17 249-250 and 254) and Mr Coote (the pilot of the aircraft – "WZK" call sign) (t/s D15 122-143). For some reason Mr Lloyd's statement records the incident occurring on Saturday 15 October.

[176] For example – t/s D14 11; t/s D15 125.

Common experience is that while humans can easily mistake a person's identity, they have no trouble distinguishing a human from some other object. Ms Marshall described her observation, stating that she actually verified for herself that what she had observed was a person before alerting the others.[177]

It is unlikely that the witnesses mistook marine animals for a person: each said they also saw turtles and dugongs and had no trouble identifying them as such. They were tested in cross-examination on such a proposition and their level of certainty as to what they saw. Each was confident of the accuracy of their impression that it was a person in the water.[178]

The only factor militating against their evidence is that when a helicopter went to the location of the sighting, its observers could not locate anyone.

The pilot of the fixed wing aircraft, Mr Coote, conceded in evidence that the GPS fix on the position of the sighting could have been inaccurate by up to 100 metres or more. In giving that evidence he had made no estimate of the speed of the aircraft or radius of turn that he had put the aircraft into when attempting to return to the position.[179] He saw the object; he circled as tightly as he could, and again saw what he believed was a person waving. When he had to level the plane he lost sight of the person. He then told the person next to him to write down the coordinates then displayed on the GPS.

After this manoeuvre the object was lost from view. The pilot described the difficulties he had in trying to put the aircraft back onto the location, saying in evidence that missing the presumed target area by even 200 metres may have resulted in difficulty re-acquiring sight of the object**.**[180]

The GPS position was forwarded to AusSAR which then relayed the co-ordinates to a rescue helicopter.

Inspector Graham was able to provide evidence from telemetry on the aircraft. The airspeed at the time of the sighting was between 80 – 90 knots,[181] or, assuming a median of 85 knots, about 43 metres per second. Having regard to this, it is not difficult to comprehend just how significant any delay in fixing the GPS coordinates of a sighting may be.

The rescue helicopter arrived at the location within 15 to 20 minutes. Mr Lloyd was of the view that in the time that elapsed before the helicopter arrived, a person would have drifted very little.[182] However, the evidence from local people was that the tide was likely to have been running at between 4 and 8 knots. Further, Mr Coote's impression was that the current was flowing quite fast.[183] That evidence casts considerable doubt on Mr Lloyd's view. If the current was running at between 4 and 8 knots, a person floating in the water would travel between 1 and 2 nautical miles in 15 to 20 minutes.

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[177] T/s D14 10.

[178] For example, the pilot Mr Coote, said in his statement "*I was almost 100% certain that I saw someone waving their arms.*" Exhibit C17 p3.

[179] T/s D15 137.

[180] T/s D15 138.

[181] T/s D22 656.

[182] T/s D25 962; lines 41-47.

[183] T/s D15 138; lines 35-45.

Mr Lloyd did some calculations for the Court based on the position relayed by the fixed wing aircraft when it sighted the person, and the position the rescue helicopter was sent to. He told the Court that the positions varied by about 400 yards.[184] He told the Court that the search by the rescue helicopter would have radiated over about 1.5 nautical miles, but obviously the pilot would have focussed his attention nearer the coordinates provided.

Mr Lloyd told the Court that it was possible to miss someone in searching.[185] It was also possible for an incorrect sighting position to be given or recorded.[186]

Caution must be had when assessing the veracity of news media reports, but I noted an item concerning the survivor of a trawler that sank off the coast of northern NSW recently. He claimed a rescue helicopter flew directly over him while he was in the water. He and his acquaintance were not spotted.[187]

That report tends to confirm Mr Lloyd's frank concession that there is a possibility of missing someone while searching even if one flies quite close.

As a result of considering that evidence I have come to the conclusion that there was a sighting of a person in the water on Sunday 16 October. By inference the survivor was from the *Malu Sara*. No other persons were reported as missing in the region at that time.

It is not possible to determine why the person was not found by the rescue helicopter. There are several possibilities:-

- The person simply remained obscured by wind and wave action while the helicopter searched;
- The person had drifted too far by the time helicopter arrived, and the consequent search overlooked them or did not cover the area the person had drifted to.
- Incorrect co-ordinates had been recorded as to where the original sighting occurred.
- The person had ceased to remain on the surface.

Notwithstanding their failure to rescue this person, I accept the search authorities did all they could to respond to these sightings.

Survivability times

Evidence as to the length of time the occupants of the *Malu Sara* were likely to survive was contained in the reports of Dr Luckin, a specialist in such matters.[188] I accept the opinions expressed in his reports and have relied on them when estimating the dates of death.

[184] T/s D25 964.

[185] T/s D25 965; lines 40-43.

[186] T/s D25 966.

[187] Courier-mail online 29.02.08

[188] Exhibits "C11" and "C11.1".

Consistently with his second report, and the evidence of the eye witnesses it is probable that the survivor sighted on Sunday 16 October 2005 was one of the males.

The survival time for Ethena Enosa, aged 5 years was extremely limited due to her small size, lack of strength, the absence of an appropriately sized PFD and the state of the sea early Saturday morning and then throughout the rest of Saturday.

Having regard to this evidence, I consider that the duration of the search and the decision to suspend it was appropriate.

Critique of the search

Expert evidence

I was fortunate to receive evidence from two eminent experts on search and rescue, Mr Alan Lloyd and Mr Anthony Marshall. The expertise of neither is in doubt but the involvement of Mr Lloyd in the search may have compromised his ability to objectively review what transpired. Indeed, passages of his report suggest support for the position of Sergeant Flegg that demonstrates this concern quite graphically.

For example in paragraph 92 of his report Mr Lloyd seeks to rebut Mr Marshall's criticism of the initial response to the incident by the QPS. He does so by accepting without question an assertion from Sergeant Flegg that "*the 412 was down*" – an assertion we now know was wrong. Indeed a valid criticism of AusSAR is that it also accepted this without checking. Mr Lloyd also supported his rejection of Mr Marshall's opinion that QPS did not do enough by suggesting QPS had contacted another operator - Aero-Tropics. No evidence of such contact ever came before the court.

Perhaps understandably, Mr Lloyd was defensive of AusSAR's role in the incident; for example, seeking to justify its refusal of Sergeant Flegg's request for air assistance as "*in keeping with standard practice*".[189] As will become clear, I do not accept that if this was standard practice, it accorded with the relevant manual or guidelines.

Mr Lloyd asserted in paragraph 93 of his report that the *Pedro Stephen* was an appropriate rescue vessel. However as is clear from the evidence of those on board that boat they found conditions extremely difficult in the search area, causing it to seek sheltered waters at one stage. Illustrative of those difficulties was their advice to Sergeant Flegg that the vessel was unable to make headway. This information was passed onto AusSAR. Mr Lloyd's comments are somewhat inexplicable if he saw that information in his review of the relevant log or transcript. No backup or alternative rescue platform was placed on standby by Sergeant Flegg.

As a result of these considerations I am inclined to view Mr Marshall's evidence as more reliable where the opinions of the two experts diverge.

[189] Exhibit "D17" at paragraph 16.

The regulatory framework

Much of the evidence and submissions focussed on the adequacy of the response by the QPS and AusSAR respectively. Key to an assessment of this is an understanding of the *National Search and Rescue Manual* (NSRM) and the provisions of the *Inter-Governmental Agreement on National Search and Rescue Response Arrangements* (the inter-governmental agreement).

Relevant to this case are the provisions that regulate which agency is to assume responsibility for a search and when and how that might change.

I must say I have had trouble coming to grips with some of AMSA's submissions. Their witness, Mr Lloyd accepted AMSA was primarily responsible for the search of the vessel but considered that in the circumstances the local QPS SAR officers were better placed to respond to the incident. In their written submissions however, AMSA seems to cavil with the assertion that AusSAR is primarily responsible for coordinating a search for a Commonwealth ship or a search for a vessel that is neither recreational nor fishing. It seems to me they confuse two related and unobjectionable propositions concerning the responsibility of the agency which first becomes aware of an incident and the need to receive intelligence from and/or transfer responsibility to local agencies in some circumstances with the question of which agency has primary responsibility. It may be an unwillingness to acknowledge that these issues were not appropriately considered by the AusSAR officers on the Friday night/Saturday morning that is colouring their revision of events.

In its submission, AMSA suggests that the NSRM and the inter-governmental agreement are just guides with no binding authority and the provisions of those documents can be ignored at the whim of those involved in the incident. I do not read them that way. Of course the response of the various authorities to an unfolding SAR incident needs to be flexible and the terms of the manual should not prevent the most efficacious and expedient action being taken. However, departure from the provisions of the manual should be as a result of a conscious, reasoned decision. That doesn't appear to have occurred in this case and AMSA's attempt to justify it by misconstruing the effect of the agreement and the NSRM is not accepted. The AusSAR officers were told it was a DIMIA vessel being used for official purposes. They appear to have failed to consider how that might affect their responsibilities to respond to the incident.

Clearly, when the matter was first reported to police it was a "*maritime SAR incident*" within the terms of para 3.3.3 of the NSRM which includes a vessel that has requested assistance and an overdue vessel. This situation was confirmed soon after the EPIRB was activated.

It is equally clear that at the outset the Thursday Island water police had primary responsibility to manage the incident. The inter-governmental agreement provides that the search and rescue authority first becoming aware of a search and rescue incident shall take all necessary action until responsibility can be handed over to the relevant search and rescue authority under clauses 10 and 12 of the agreement.

Sergeant Flegg discharged his responsibilities in this regard by seeking advice as to who was on the boat etc and then advising AusSAR of the incident with a view to their locating the EPIRB. The key question is; should AusSAR then have assumed overall responsibility for the co-ordination of the incident?

AusSAR was in a position to assume responsibility for the overall coordination of the incident from when it was first advised of it but I am not persuaded that had they done so the initial response to the incident would have changed as it would have remained dependent upon Sergeant Flegg for information about the incident and his reaction to it.

It seems likely the immediate hands-on search management would have been left with Sergeant Flegg until AusSAR became aware that a widening air search was necessary. This is what transpired.

On the other hand, it is also likely that had AusSAR assumed responsibility for coordinating the search but left the tactical operational management to Sergeant Flegg, the AusSAR officers would have begun making the necessary inquiries about the availability of search assets in the event the passive approach being pursued by Sergeant Flegg did not result in the incident being resolved. I set out below some of the shortcomings in the management of the incident. It is difficult not to conclude that had AusSAR accepted its responsibility to assume coordination of the search for the Commonwealth ship, some or all of those matters would have been handled better. Instead, AusSAR limited its role to the conveyor of EPIRB location coordinates and Sergeant Flegg was left to try and run the operation as best he could by himself.

Delay in deploying aircraft

The NSRM provides in paragraph 3**.**4.10 that a distress phase exists when there is reasonable certainty that persons are in imminent danger and require immediate assistance. For overdue craft, a distress phase exists when communications, searches and other forms of investigation have not succeeded in locating the craft or revising its estimated time of arrival in port so that it is no longer considered overdue. Paragraph 3.4.11 provides that for ships or other craft, a distress phase is declared when information is received which indicates that the operating efficiency of the ship or other craft has been impaired to the extent that a distress situation is likely.

The *Malu Sara* was overdue from the time police were first advised of the incident. A revised estimated time of arrival in port was never established. By 1.33am the vessel had been lost at sea for over nine hours, it was taking on water and its engines had failed or were compromised. It was obvious it was not going to make port without outside assistance. In my view Sergeant Flegg should have made arrangements for that assistance to then be provided forthwith.

One aspect of the initial response that might have been better managed had AusSAR accepted its responsibility to assume overall coordination from the

outset is the deployment of the Bell 412 helicopter that sat unused on Horn Island until well after the *Malu Sara* had sunk. It seems likely AusSAR officers would have more effectively checked the availability of search assets rather than just relying on a baseless assumption that it was unavailable, as was done by Sergeant Flegg.

The question then becomes when should the helicopter have been tasked? The Bell 412 has a heavy duty search light and a forward looking infrared detector, both of which have been used to assist with night searches of people in the sea. However the aircraft can not drop a life raft at night nor operate at search height unless the weather conditions permit. There are no helicopters routinely available in the Torres Strait that are adequately equipped to perform night rescues.

An experienced pilot gave evidence the Bell 412 could certainly have flown in the conditions forecast on the night in question, although the conditions over the search area during the night are not known with certainty.[190] The combined preparation and flight time meant that the Bell 412 could have been at the last known location of the *Malu Sara* 80 minutes after being tasked.

I am of the view the helicopter should have been sent out, at the very latest, as soon as Sergeant Flegg learned the *Malu Sara* was sinking. It would have been able to pinpoint the vessel's location and, had cloud cover allowed, it could also have determined whether the vessel was still afloat, and/or people in the water. That information would have allowed the search authorities to determine the urgency with which other search assets should have been tasked.

Irrespective of whether the conditions precluded night searching, the helicopter should have been sent to the search area at first light. It would have arrived over an hour before the *Pedro Stephen* and could have alerted its crew that no vessel was visible and that the *Pedro Stephen* was then looking for people in the water. Weather conditions allowing, in daylight the helicopter can undertake winch rescues.

When told at about 2.26am the vessel was sinking Sergeant Flegg made no inquiries about whether any air assets were available. The only action he took was to contact the local VMR knowing their vessel would take some four to five hours to get to the last known position of the *Malu Sara*.

He did however inquire of an AusSAR officer whether a helicopter could be sent out. That request was not responded to. Indeed, Sergeant Flegg suggested or requested AusSAR provide air support on four occasions, namely at 2.26am, 7.07am, 7.26am and 8.49am. On no occasion did he receive a definitive and reasoned response, except on the last occasion when he was told to take care of it himself. The AusSAR responses are inconsistent with the NSRM paragraph 1.3.37 which advises SAR bodies not to hesitate to seek assistance from RCC Australia during a SAR operation and assures them that where resources are available, AusSAR can deliver a range of services. One wonders whether request for air support might have been more

[190] Evidence of Craig Peters transcript 21.08.2007 p149 - 155

seriously considered if AusSAR had at an earlier stage accepted its responsibility for overall coordination of the incident.

The failure of any aircraft to over-fly the search area until some seven hours after the skipper of the *Malu Sara* reported the vessel sinking is an indictment on those whose duty it was to mount a rescue.

Failure to investigate other search assets

Some thought was given by Mr Bettenay of AusSAR to the search assets potentially available in the region in a conversation with Sergeant Flegg at about 10.38am Saturday. The matters raised by Mr Bettenay should have been raised with Sergeant Flegg some hours earlier to check that Sergeant Flegg had properly considered all possible options. It is apparent this didn't happen.

One asset which should have been considered for earlier involvement was the Customs vessel, the *Botany Bay,* which was stationed at Thursday Island at the relevant time. On the night of Friday 14 October 2005, it was in the vicinity of Friday Island, some 3 to 4 kilometres west of Thursday Island. The *Botany Bay* is 38 metres overall with a cruising speed of 20 knots and a range of 1000 nautical miles. The Australian Customs website indicates it has "*two 6.4 metre tenders capable of carrying two crew and four passengers on excursions of up to 30nm from the mother ship. Tenders are powered by twin 90HP outboards. Internal fuel capacity provides an adequate cruising range."*[191] It is noted that the ACVs may "*operate in conjunction with Coastwatch and are often deployed in the joint operations involving Coastwatch aircraft and naval patrol boats."* A list on the website of work carried out by the ACVs includes "*search and rescue*".

Mr Marshall told the Court that it would have been worth contacting Australian Customs so as to ascertain what the captain of the *Botany Bay* thought could be achieved in using it in the search.

The vessel has a shallow draft which is likely to have made it capable of operating in most of the search area. It was far faster than the *Pedro Stephen* and I have no doubt able to better cope with the rough conditions encountered on the morning of 15 October.

Other search and rescue air assets existed in Cairns. It is some 6 or more flying hours to the search area. Re-fuelling at Horn Island would probably be necessary before deployment. None of the proprietors of these assets were contacted by Sergeant Flegg. Some of the assets were later used in searching once AMSA had taken over responsibility for the air search.

The Royal Australian Navy operated two vessels from Thursday Island similar in size to the *Botany Bay*. Sergeant Flegg did not contact the Navy to ascertain the availability of those vessels, although evidence at the inquest revealed that neither was in the vicinity on Friday night but did participate in the search from Sunday.

[191] http://www.customs.gov.au/site/page.cfm?u=4242.

"Non confirmed" sightings

Of concern is AusSAR's conclusion that because the person sighted on Sunday afternoon by three people in a fixed wing aircraft could not be found by a helicopter pilot who went to the locality 15 to 20 minutes later, the sighting was "*non confirmed".* For the reasons detailed earlier, I have found that this sighting did occur, although through no fault of the helicopter pilot a rescue did not ensue. Not only is AusSAR's approach to this issue illogical, it hinders a constructive review of the operation and deprives the organisation and other search authorities of lessons that could be learnt from the incident. For example, Mr Coote's description of having to rely on coordinates read off the GPS by one of the passengers and then recorded on a note pad in an effort to preserve the location data seems far from ideal.

The debriefing undertaken by the search organisations on 9 November 2005 did not even review whether people had been seen alive after the vessel sunk. It assumed as those sightings had been "*non confirmed"* nothing was to be learnt from further considering the issue. Indeed in the minutes of this meeting it is recorded there were "*no sightings".*[192] The review also proceeded on a version given by Sergeant Flegg that differs significantly from the facts established by this inquest. This approach does not encourage insightful, reflective practice.

Findings

i. When he spoke to them shortly after being told the *Malu Sara* was sinking, Sergeant Flegg failed to convey that information to AusSAR or the local VMR operators.

ii. In subsequent conversations with AusSAR and the VMR Sergeant Flegg again failed to advise that he had been told the *Malu Sara* was sinking and trivialised the predicament which had been reported to him.

iii. The crew of the local VMR vessel, the *Pedro Stephen*, did all they reasonably could to locate the *Malu Sara*. They operated the vessel in difficult and dangerous conditions. Their efforts are to be commended.

iv. At 6.00am Sergeant Flegg finally advised an AusSAR officer that he had been told the vessel was sinking. However, he did so in terms that made it likely the officer would not take his comments literally. In the circumstances, that officer cannot be criticised for failing to respond as would otherwise have been expected.

v. Sergeant Flegg failed to make appropriate enquiries as to what search assets were available. Had he done so it is possible a more timely response may have ensued. Sergeant Flegg should have made enquiries with Coastwatch, Australia Customs Service and the Australian Navy as to whether they had search assets that could be deployed.

[192] Exhibit B9.2 p4

vi. In accordance with the NSRM and the inter-governmental agreement Sergeant Flegg, as the person to whom the incident was first reported, was responsible for making the initial necessary responses. This he did by obtaining some details of the vessel and seeking AusSAR's assistance to locate the position of the activated EPIRB.

vii. However, pursuant to the provisions of the abovementioned manual and agreement AusSAR was primarily responsible for overall co-ordination of the search. It did not discharge that responsibility. Its officers did not discuss with Sergeant Flegg which agency was primarily responsible. It seems the AusSAR officers aware of the incident did not consider the question.

viii. The failure of the AusSAR officers to recognise the agency had primary responsibility for coordinating the search had the following effects:-

- Sergeant Flegg was left to carry on through the night as best he could with minimal assistance from the national SAR agency.
- The availability of other search assets was not ascertained.
- The AusSAR officers did not communicate directly with any DIMIA officers and did not try and contact the skipper of the *Malu Sara*.
- The AusSAR officers were not proactive in offering advice or assistance to better manage the incident.
- Numerous requests by Sergeant Flegg for an aircraft to be sent to the search area were either ignored or deflected.

ix. More search assets should have been sent to the last known location of the *Malu Sara* sooner. The first surface vessel to get to the vicinity, the *Pedro Stephen*, arrived nearly five hours after the *Malu Sara* had been reported sinking. The first aircraft arrived on scene seven hours after the vessel was reported sinking. I accept the opinion of Mr Marshall that this was "*too little, too late*".

x. Once AusSAR accepted responsibility for coordinating the air search at midday on 16 October more search assets were rapidly engaged. The search that occurred over the next five days was intensive, wide ranging and professionally managed. I commend the AusSAR officers, the SES volunteers, other volunteers and the Queensland Police Service officers who took part in it.

xi. There were a number of possible sightings on Saturday 15, Sunday 16 and Monday 17 October. I am persuaded that a sighting reported by three occupants of a fixed wing aircraft at about 2:30pm on Sunday 16 October occurred.

xii. I accept the helicopter pilot and observers who searched for that person did all that was reasonably able to be done to locate the person. There are numerous reasons as to why this was unsuccessful.

xiii. The failure of AusSAR to recognise that a survivor had been sighted but not rescued, deprived search authorities of an opportunity to constructively critique their practices.

xiv. The interaction between Sergeant Flegg and the AusSAR officers was less than professional. Their failure to analyse the incident in accordance with the framework contained in the NSRM and to use the incident phases set out in it may have contributed to their failing to have sufficient regard to the seriousness of the incident as it unfolded.

xv. Sergeant Flegg failed to reconsider the situation as it developed. When he was first advised of the incident, it involved an overdue vessel lost in fog in the early evening. As the evening progressed and the situation deteriorated overnight, he failed to make an adequate reassessment of the perils facing the occupants of the *Malu Sara* or what was required to assist them.

xvi. The inability of the SARMC on Thursday Island to task a helicopter to attend to a rescue without first obtaining authorisation from a superior officer in Cairns had the potential to delay life saving action.

xvii. The search and rescue assets permanently available in the Torres Strait are inadequate for the prevailing conditions. Socio-economic and geographic circumstances combine to ensure that travel in small open vessels will frequently occur and inevitably mariners will become lost or in need of assistance. Such assistance needs to be available on demand. It requires a search and rescue helicopter with night winch and auto hover capabilities.

Part 8 - Findings required by s45(1)&(2)

I am required to find whether the suspected deaths in fact happened and, if so, who the deceased persons were, and when, where and how they came by their deaths.

As detailed earlier, a body subsequently identified as that of Flora Enosa was found on 23 October 2005 at Deelder Reef. None of the others who have been missing since the *Malu Sara* sank have been seen since. However, I have no doubt they are dead.

An autopsy examination conducted on Ms Enosa's body indicated the most likely cause of her death was immersion – or drowning. The others may have died the same way but as their bodies have not been recovered I cannot rule out their being fatally attacked by marine life.

In determining the time of death, I have had regard to the expert evidence concerning the length of time people are able to survive in the sea in the conditions prevailing when and where the *Malu Sara* sank. It does not allow a precise finding as to the time of death.

Accordingly, it is also not possible to make a precise finding as to the place of death.

I have dealt with "how" the five people died in my findings detailing the circumstances in which the vessel was lost.

I make the following findings in relation to the other matters:

Identity of the deceased:

Wilfred Baira, known to many by his nickname Musu, was born on 9 April 1967 and was 38 years of age at the time of his death.

He was born on Thursday Island and moved to Badu Island at the age of three by way of a traditional adoption by Morris and Elma Nona. Ms Nona had no biological children, however, raised nine children, including Mr Baira through adoption. He grew up on Badu Island as part of that large and happy family.

Mr Baira attended Badu Island primary school and then Thursday Island High School to grade 8. He then went to Herberton College until grade 11 and later completed his final year of high school at Wangetti Educational Centre in Cairns. After school he studied at the Bangarra Indigenous Dance School in Sydney for 8 months.

In 1988 Mr Baira went to Darwin and worked as a cray fisherman, a cleaner, a carpenter and on pearl farms. While there he met and married Francina Rieman and the couple moved to Palm Island. He separated from Ms Rieman in the mid 1990's and returned to Badu Island in 1997 where he lived with his adoptive mother Elma. At the time of his death he was in a happy relationship with Taipo Nona. He is also survived by a son and a daughter from other relationships.

He was employed in various roles throughout his time on Badu Island, primarily with the Badu Island Council and then with DIMIA. I wish to thank those who have provided an extensive amount of material on Mr Baira's background; in particular his younger brothers George and Dennis Nona. It is clear that both of these men attribute much of their success and happiness in life to lessons taught to them by Wilfred.

It is evident that Mr Baira took on a father figure role for the other children in the household on the death of Morris Nona in 1997. Indeed he had taken on the wider role of provider for that large extended family and his death creates a big gap in many lives.

Mr Baira was a strong swimmer, talented fisherman and seaman who could navigate by the stars. He enjoyed playing guitar and was quick to make his friends laugh with his jokes and imitations. He had an intimate knowledge of the local landscape and sea and of traditional culture and customs; knowledge which he made a point of passing on to younger family members.

He was clearly a charismatic person who has had an ongoing and positive impact on many lives. He was very much loved and admired by his many friends and family.

Flora Rose Enosa was born on 13 August 1971 and was 34 years of age when she died.

Ms Enosa was the 13th of 20 children to John and Elma Enosa. At the time of her death she was the eldest surviving female sibling and in the preceding years had taken on the responsibility of caring for her younger brothers and sisters, along with her mother, who survives her. This involved frequent trips to visit her family members on Sabai Island to ensure there was always food on the table and that they were looked after in myriad other ways.

In 1998, Ms Enosa met Fred Joe and they formed a relationship which resulted in two daughters, Ethena and Rhonda. Ms Enosa was working at Kubin Village on Moa Island in the months leading up to the disappearance of the *Malu Sara.* At various times Mr Joe was required to travel to Perth to undertake study for a Bachelor of Science degree and on these occasions Ms Enosa would spend time bringing up her daughters on Badu Island. Ms Enosa's younger brother and his partner live on Badu Island and her daughter Rhonda, now five years of age, lives with them while Mr Joe continues his studies.

I am grateful for the information on Ms Enosa's background provided to me by both Mr Joe and Ms Enosa's only surviving younger sister Seppi Baira. I am told she was a caring and quiet person who had a natural tendency to take a genuine interest in other people; and as such was widely liked and respected. She was a keen fisherwoman and seamstress. She was a committed Christian and practised her faith, in particular when spending time with her sister.

It is clear to me from the information supplied that she was a loving and committed mother. It seems she was a crucial cog around which her immediate and extended family revolved and on whom they very much relied. Her absence is therefore intensely felt by her family and in particular Mr Joe and Ms Baira who have kindly assisted the inquest as representatives of the family. She is of course very much missed by all of them.

Ethena Enosa was Flora Enosa's eldest daughter and was 5 years of age at the time of her death having been born on 15 January 2000. She was the eldest of two girls born to Ms Enosa and Mr Fred Joe and is survived by her younger sister Rhonda, who was 2 years of age at the time Ethena passed away.

I have heard from Ethena's paternal aunt, Gina Joe, who spent much time with her from birth. Although Ethena spent more time with her mother she was close to both parents and would always look forward to her father returning from his studies in Perth with presents for her. She loved dressing up and is remembered as a happy, inquisitive and talkative child.

Ethena had started school at the beginning of 2005 and was doing well. Her absence leaves a sad gap in the lives of her large extended family.

Ted Cyril Harry was born on 7 August 1951 and was 54 years of age when the *Malu Sara* went missing.

Mr Harry was the middle child of three and is survived by his sisters Abigail and Seai. The three children grew up on their traditional home, Yam Island before Mr Harry moved away to join the Army. He spent 20 years as a serviceman in both the Army and Royal Australian Air Force before returning to live in the Torres Strait Islands in the early 1990's.

I am told by his sister, Abigail, that Mr Harry was a proud man, in the best sense of that word, and was particularly proud to be a Torres Strait Islander. He had lived in every state and territory in Australia during his lifetime and was able to adjust to any conditions. He always wore his uniform on ANZAC day and was still a member of the Army Reserve at the time of his death.

Although he had no children of his own, his sisters had 13 children between them and Mr Harry was a wonderful uncle to them all. He took on the role of provider to his sisters and their families as well as to his mother, who was still alive, when he returned to live in the Torres Strait. He also helped provide for

the four children of Valerie Saub, with whom he was in a relationship at the time of his death.

Mr Harry was living on Badu Island where he was working for DIMIA in the years prior to his death. He was heavily involved in community activities and had a particular love of rugby league, supporting his local team the Magun Warriors.

The close involvement of Mr Harry's family and in particular his sister Abigail's regular trips from Western Australia to follow the progress of the inquest are a measure of his significance in their lives. He was clearly a valued and committed public servant throughout his lifetime and was obviously loved by his wide circle of friends and family.

Valerie Saub was the eldest of three children born to John and Henrietta Saub. She was born on 25 July 1971 and was 34 years of age when the *Malu Sara* disappeared. She is survived by her parents and her younger siblings, Abiu and Daisy.

Ms Saub had five children although sadly one passed away many years ago. The four surviving children, Edau, Henrietta Jnr, Boston and Dopha are now aged between 5 and 15. The children are now being looked after by extended family members on Badu and Thursday Islands while Ms Saub's parents continue to deal with ongoing health problems.

Ms Saub was living on Badu Island and in a happy relationship with Ted Harry at the time of her death. She was working in a cleaning and maintenance role for the Island council. She is remembered as a caring and committed mother and, along with Mr Harry, was an integral part of the community on Badu Island.

Her parents and children in particular have found her death extremely difficult to deal with. She was clearly much loved by them and is very sadly missed by the community as a whole.

Place of death: All the deceased persons died in the waters of the Torres Strait.

Date of death: They died on or between 15 and 20 October 2005.

Cause of death: The precise medical cause of death can not be ascertained but it is likely they drowned or suffered the predation of marine life.

Part 9 - Recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

That requires the coroner to consider whether the deaths under investigation were preventable and/or whether other deaths could be avoided in future if changes are made to relevant policies or procedures.

Coroners, of course, do not have the expertise that would enable them to rely on personal knowledge when approaching this task; they rely on the evidence of experts with qualifications and experience in the relevant field.

The systemic issues which were raised by the circumstances of this case are identified in the findings I have made in the earlier sections. My recommendations in relation to them are set out below.

i. **Review of SARMC training**

The QPS should review the performance of the SARMC in this case. The QPS should consider whether further training is necessary for all officers likely to fulfil this role on Thursday Island. The evidence suggests senior members of the water police with search and rescue responsibilities have developed a cavalier attitude to marine incidents.

ii. **SARMC to task rescue helicopter**

QPS polices should be reviewed to ascertain whether the SARMC on Thursday Island should be authorised to task a rescue helicopter at his/her discretion.

iii. **Independent investigation of SARMC's performance**

Whenever a QPS officer is involved in search and rescue activities and the person in distress is not rescued alive, the death be investigated by an independent officer who has not been involved in the attempted search and rescue and who is sufficiently trained and experienced to critique the performance of those who were.

iv. **Review of DIAC's procurement policies**

If it has not already done so, DIAC should review its procurement policies and procedures to ensure the flaws and weaknesses illustrated by this case are addressed.

v. **Rescission of MSQ's boat builder and designer accreditation**

If it has not already done so, Maritime Safety Queensland should either address weaknesses in its boat builder and boat designer accreditation regime or take steps to immediately rescind all such existing accreditations and advise the public that it has done so.

vi. **Review of AMSA's paper based boat surveys**

If it has not already done so, AMSA should review the deficiencies in its procedures which allowed defective vessels to be brought into survey without any physical inspection or testing by any AMSA officer or any evidence that any independent expert had inspected and tested the vessel.

vii. **Vessels, equipment and training for MMOs**

If it intends to continue to engage MMOs in marine patrols, DIAC should ensure it supplies them with appropriately equipped and sea worthy vessels and that it trains the MMOs in the use of the vessels and the equipment. Further, steps should be taken to ensure the standard operating procedures for the vessels are updated to reflect the current operating conditions and mechanisms should be put in place to ensure they are complied with.

viii. **DIAC Torres Strait emergency response plan**

If it has not already done so, DIAC should develop an emergency response plan and ensure all staff of the Torres Strait region are trained in relation to it.

ix. **Training for AusSAR officers**

AusSAR should review the training it provides to its operators to ensure they fully understand the provisions of the National Search and Rescue Manual and the Inter-Governmental Agreement on National Search and Rescue Response Arrangements.

It should ensure its officers interact with other search agencies in a manner consistent with the framework set out in that manual and agreement. In particular AusSAR officers should be trained to ensure they recognise circumstances in which the agency should immediately assume primary responsibility for the overall coordination of a search and rescue incident.

AusSAR should review the basis on which it assesses whether a report from observers of sightings are confirmed or otherwise.

x. **Search assets in the Torres Strait**

AusSAR and the Queensland Police Service should review the adequacy of search assets routinely available in the Torres Strait. In my view a search and rescue helicopter with night winch and auto hover capabilities is essential for the safety of the local population and others traversing the area by boat.

Part 10 – Referral for prosecution or disciplinary action

Prosecution

Although coroners are not involved in ascribing blame or apportioning liability, the Act does create an interface between coronial processes and the criminal justice system and vocational disciplinary regimes.

Section 48(2) provides that if information obtained by a coroner while investigating a death leads the coroner to reasonably suspect that a person has committed an offence, the coroner must give the information to the appropriate prosecuting authority.

However, s45(5) provides that a coroner must not include in inquest findings any statement that a person is or may be guilty of an offence. I am of the view that a coroner could not reasonably suspect someone has committed an offence without concluding the person may be guilty of the offence. Therefore, in my view, s45(5) prohibits a coroner from including in inquest findings, the fact that a referral had been made under section 48(2).

Disciplinary action

The situation with respect to disciplinary matters is not so complex. The Act provides in s48(4) that a coroner may give information about a person's conduct to a disciplinary body for the person's profession or trade if the coroner believes the information "*might cause the body to inquire into, or take steps in relation to, the conduct."*

As I have made obvious, I have concerns about the way in which Mr Chaston and Sergeant Flegg discharged the duties of their respective positions. While neither public administration nor policing would usually be described as either a trade or a profession, in the context of the section I consider the provision authorises my referring their conduct for the consideration of disciplinary action.

Mr Gary Chaston

The *Public Service Act 1999* (Cth) in section 13 creates a code of conduct that binds all members of the Australian Public Service. In clause 1 it provides "*An APS employee must behave honestly and with integrity in the course of APS employment*." Clause 2 provides *"An APS employee must act with care and diligence in the course of APS employment."*

Section 15 of the Act provides an agency head may impose sanctions ranging from a reprimand to a fine, demotion, redeployment or termination on an employee who is found to have breached the code.

I am of the view there is a significant body of evidence which could lead the head of DIAC to conclude Mr Chaston, breached clause1 and/or 2 of the code in that he:-

- Failed to carefully and diligently manage the procurement and commissioning of the replacement IRVs.

  In particular he:-

  - Wilfully, recklessly or negligently deleted from the draft statement of requirements in the *Request for Tender* the necessity for the vessels to be able to operate in open waters and/or offshore
  - failed to ensure the contract fully reflected the terms of the request for tender,
  - failed to ensure the vessel was built to the terms stipulated in the contract and request for tender;
  - failed to ensure the boat builder provided the certificates of compliance stipulated in the contract;
  - failed to ensure they were fitted with the appropriate navigation and communications equipment;
  - failed to ensure the vessels were appropriately inspected and tested before being put into service;
  - failed to ensure the MMO skippers were adequately trained in the use of the new vessels, their motors and satellite telephones

- Wilfully provided false information to the AusSAR when seeking exemption from the usual requirements for a vessel to be brought into survey;

- Failed to carefully and diligently consider the safety of the proposed voyage to and from Saibai Island;

- Failed to carefully and diligently respond to the evidence that the *Malu Sara* had a dangerous design or construction flaw; and

- Failed to carefully and diligently manage the incident when the Malu Sara did not safely return to Badu Island.

  In particular:-

  - He failed to take control of the incident when the vessel was over due and darkness fell, and failed to manage it to conclusion; and
  - He failed to pass onto the police search and rescue coordinator information about the vessel's recent history of taking water that was obviously relevant the response to the incident.

Sergeant Warren Flegg

Disciplinary action against Queensland police officers is taken pursuant to the provisions of the *Police Service Administration Act 1990.* It provides in section 7.4(2) *"An officer is liable to disciplinary action in respect of the officer's*

conduct, which the prescribed officer considers to be misconduct or a breach of discipline on such grounds as are prescribed by the regulations."
The *Police Service (Discipline) Regulations 1990* prescribe such grounds in regulation 9 which, in so far as may be relevant to this matter, lists unfitness, or incompetence in the discharge of the duties of an officer's position; negligence or carelessness or indolence in the discharge of the duties of an officer's position; the failure to comply with any direction, instruction or order given or issued by the commissioner; or misconduct;

That Act defines "misconduct "in section 1.4 to mean conduct that:-

- is disgraceful, improper or unbecoming an officer; or
- shows unfitness to be or continue as an officer; or
- does not meet the standard of conduct the community reasonably expects of a police officer.

I am of the view, a prescribed officer could conclude Sergeant Flegg's conduct amounted to misconduct or that he acted incompetently in the discharge of his duties in that there is a substantial body of evidence indicating he:-

- failed to keep an accurate log of the search and rescue incident concerning the *Malu Sara;*

- failed to adequately respond in a timely manner as the seriousness of the incident escalated throughout Friday evening and Saturday morning; and

- failed to pass onto AusSAR information he well knew was crucial to its assessment of and response to the incident.

Part 11 – Summary, acknowledgments and condolences

Summary

I have described the antecedents and circumstances of the fatal incident in extensive detail. However an understanding of the sequence of events is best achieved by considering a summary of the key occurrences.

The people lost when the *Malu Sara* sunk didn't die because some unforeseeable, freak accident swept them away before anything could be done to save them. Rather, they died because several people dismally failed to do their duty over many months.

The Department failed to consider the added risk of buying custom built boats, and despite being alerted to its regional manager's lack of training and experience in procurement processes, it failed to adequately respond.

The boat's builder failed to meet the most basic standards of workmanship, and concealed his defective work with false certificates of compliance.

The hidden danger he created would have been detected and defused had the regional manager checked the boat complied with the terms of the contract for its supply, and ensured it had the necessary safety and navigation equipment.

Instead, he rushed the defective vessels into service without ensuring those who were to cross miles of open ocean in them had been trained in their use.

When he received graphic evidence the *Malu Sara* leaked, the regional manager failed to address the problem, despite knowing that in two day's time the vessel would set out on a long and difficult passage.

When the vessel became lost in the fog, the duty officer failed to raise the alarm before nightfall.

When the incident was reported to police and the national search and rescue authority, the danger to the people on the *Malu Sara* was continually trivialised, and reports of their worsening predicament were disbelieved, ignored and even mocked.

The regional manager and other staff had flown home in helicopters, and were dining with family and friends while two Commonwealth public servants were struggling to get the Department's vessel back to its base. The regional manager failed to take charge of the incident, leaving a junior officer to manage as best he could.

Those on the *Malu Sara* were searching in the dark for specks of land in a roiling sea. They were struggling to pump out water that kept surging into the

cockpit of the boat. The tide, the waves and the wind swept them away from safety. As the skipper, Wilfred Baira, continued to seek assistance over a telephone that only sometimes worked, his calm manner, likely a masquerade to minimise the fear of his passengers, was used as an excuse for inaction.

I am sure Mr Baira would have done all he could to get himself and his passengers back to land. As more water leaked into the bilge and sloshed around the cockpit, the vessel would have become increasingly difficult to control. Undoubtedly, the older and experienced serviceman, Mr Harry, would have provided resolute support. It is likely Ms Saub and Ms Enosa helped, although the latter also had to calm and console a frightened and exhausted child.

When no help came and the engines failed and water leaked into the supposedly watertight bilge faster than it could be pumped out, it is likely the boat capsized and soon sank.

The wretched dread of a mother seeking to cling to her terrified child as they were dumped into the dark and wild sea is too terrible to contemplate.

Survival in the rough conditions would have been very difficult, and it is likely the people passed quickly under the waves. However, at least one poor soul struggled on in vain for more than a day. His hopes surely soared when search aircraft came into view, only to be devastated as they disappeared, before he too succumbed.

A totally avoidable disaster was complete.

Acknowledgments

Sitting in Thursday Island was demanding for those participating in the hearing: the courtroom was very crowded, and facilities for taking instructions and conferring with witnesses were limited. The high standard of the advocacy and the minimal friction manifested between the parties' legal representatives was a testament to their professionalism. They effectively represented the interests of their clients without seeking to obstruct the inquest's search for answers. I was greatly assisted by the lengthy written submissions of all of those granted leave to appear.

I also wish to record my appreciation for the support, encouragement and assistance given to me by counsel assisting, Mr Mark Gynther, case manager, Mr Daniel Grice, and witness liaison officer and inquiry coordinator Detective Inspector Gilbert Aspinall. Their extensive and ongoing contributions made my task much easier than it would otherwise have been. I also wish to acknowledge the significant assistance provided by the President and staff of the Aboriginal and Torres Strait Islander Legal Service (TS NPA). Mr John Abednego, Mr David Yorkston and Ms Heron Loban assisted with the location of local witnesses, acted as friends of the court to comfort witnesses while giving evidence and, when necessary, arranged for translators to assist witnesses. Finally, I want to acknowledge with gratitude

the welcome hospitality offered to all involved in the proceedings by the registrar and staff of the Thursday Island Court House.

Condolences

Last, I want to acknowledge the terrible loss to the families and friends of those who died. To lose five people in a single incident would always have a terrible impact on such a small and close community. The circumstances of the loss can only have intensified their grief.

As coroners' cases almost always involve sudden and unexpected death, they are invariably sad. The unnecessary loss of any life is distressing. However, the circumstances of the loss of the people on the *Malu Sara* are as wretched as any I've been exposed to. It was not a case of an isolated, unavoidable accident. Rather, five people died as a result of a terrible protracted chain of events that could have been stopped if any one of a number of those involved in purchasing, building, operating or searching for the vessel had faithfully and diligently discharged his duties. The compounding effect of error upon error, rather than any single action, led to the disaster. Over months, so many opportunities to defuse the disastrous sequence of events were passed up.

Some of these failings were caused by defective systems, and some by the poor performance of individuals.

None of those responsible for this catastrophic chain of events acted maliciously. However, some of them were incompetent, indolent and ineffectual.

Family and friends of those who passed on have waited long and patiently for answers as to how these terrible events were allowed to occur. Suggestions they might resort to violence during these proceedings were wrong and insulting. Despite hearing evidence of incomprehensible incompetence, sustained neglect and disregard for the safety of those on board the *Malu Sara*, they have throughout remained cooperative and dignified.

They will never forget these calamitous events, nor cease to miss those lost in them. Nothing I can say can alleviate their anguish or assuage their grief. I hope, however, they will accept my sincere condolences for their heart-rending loss.

I close this inquest.

Michael Barnes
State Coroner, Queensland
Thursday Island
12 February 2009