Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 21/17

I, Sarah Helen Linton, Coroner, having investigated the death of ***Damien Mark MILLS*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***6 to 8 June 2017*** *find that the identity of the deceased person was* ***Damien Mark MILLS*** *and that death occurred on or about* ***31 October 2014*** *in the* ***Indian Ocean approximately three nautical miles off Leighton Beach*** *in circumstances* ***consistent with immersion****:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Mr B Bradley with Ms R Capararo (Bradley Bayly Legal) appearing on behalf of Nicole Mills.
Ms K Vernon (instructed by Metaxis Hager) appearing on behalf of Daniel Lippiatt.
Mr P Urquhart (instructed by K & L Gates) appearing on behalf of Pepper Group Ltd.
Mr T Foley (AGS) appearing on behalf of AMSA.
Ms D Underwood (State Solicitor's Office) appearing on behalf of the Department of Transport.

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INTRODUCTION

1. Damien Mills (the deceased) was last seen alive while a passenger on a charter boat off Rottnest Island on 31 October 2014. His body was found floating in the Indian Ocean about three nautical miles off Leighton Beach just after midday on 1 November 2014. A forensic pathologist later concluded that Mr Mills' death was consistent with immersion (drowning).

2. The circumstances of Mr Mills' death raise questions about how he came to be in the ocean; in particular whether he fell from the charter boat during the return voyage from Rottnest Island to Fremantle. If he did, then this raises further questions as to how his fall was not seen by anyone on the charter boat and why he was not reported missing when the boat returned to Fremantle Harbour.

3. On 28 September 2015 the State Coroner ordered that an inquest be held pursuant to s 22(2) of the *Coroners Act 1996* (WA), in order to explore the circumstances of the death and to assist the coroner to make findings under s 25(1) of the Act.

4. I held an inquest at the Perth Coroner's Court from 6 to 8 June 2017. The documentary evidence included a comprehensive report of the investigation into the death by the Water Police and a report from the Department of Transport, as well as other relevant information.[1] A number of witnesses were called to give oral evidence, including a number of the people who were on the charter boat on 31 October 2014 as well as various witnesses who were involved in the investigation into the death.

5. The inquest focussed primarily on identifying the circumstances of the death, in so far as witness accounts and other evidence were able to shed light on how Mr Mills came to be in the Indian Ocean. In addition, the inquest explored how the charter boat industry is regulated and whether the current system adequately provides for the safety of passengers.

6. At the conclusion of the inquest some oral submissions were made by counsel on behalf of various parties and written submissions were later filed on behalf of Mr Daniel Lippiatt[2] and Mrs Nicole Mills.[3] Further, some information was provided on behalf of AMSA in response to correspondence from counsel assisting, following on from discussions I had with counsel appearing on behalf of AMSA at the inquest.[4] I have taken all of those submissions into account in forming my conclusions.

BACKGROUND INFORMATION

7. The deceased was born on 29 August 1979 and raised in Queens Park. He was 35 years old at the time of his death. The deceased was married to Nicole Mills and they had three children together, all of whom were under

[1] Exhibits 1 and 2.
[2] Closing Submissions on Behalf of Daniel Lippiatt filed 16 June 2017.
[3] Submissions in Response to Closing Submissions filed 23 June 2017.
[4] Letter to Counsel Assisting from AMSA dated 27 October 2017.

nine years old at the time of his death. He was described as a kind person and a dedicated family man. As a mark of his love for his children the deceased had a tattoo of his three children's names, within a tree of life, on his right shoulder blade.[5]

8. The deceased worked as a senior mortgage broker with a franchise from Loan Market. He had been working hard to ensure that the business was successful. His hard work had paid off, as in recent times the deceased had won a number of awards for his work.[6] The franchisee of Loan Market, Mr Ken McLennan, considered the deceased to be a friend as well as a colleague. They often socialised and their discussions indicated the deceased considered his work and home life to be 'fantastic'. Mr McLennan knew the deceased enjoyed a social drink, and the deceased would sometimes stay up late drinking and socialising, but he never drank until he blacked out and was always reliable and ready to meet his work and family commitments the following day. Mr McLennan described the deceased as dedicated to his wife and children.[7]

9. Another close friend of the deceased also confirmed that the deceased had not mentioned any personal problems, was successful in his work and had no money problems. The deceased did not do any drugs other than a very occasional small amount of cannabis and, while he liked to drink, he was not known to drink until he lost control and he was never aggressive when drunk. A day or so before he went missing the deceased had been making plans with his friend to go to the races in a few days' time.[8]

10. The deceased had some medical issues, including gout (for which he was prescribed medication) and a number of skin cancers that had recently had to be removed. These relatively minor health issues did not generally impact upon his lifestyle, and he was described by his wife as a healthy and active man.[9] The deceased had no history of mental health concerns.[10]

11. The deceased enjoyed watching sports and also enjoyed being active and assisting with his children's sporting activities. He followed the West Coast Eagles and had recently received a life membership to the local Kenwick Football Club for his services to the club.[11]

12. The last time that the deceased saw his wife and children was on 31 October 2014 when he left to go on a day trip to Rottnest Island. He was in good spirits and excited about the trip as it was his first visit to the island. The deceased's father dropped him at the jetty in Fremantle that morning and observed the deceased was excited and bubbly about going on the charter when he left him.[12]

[5] Exhibit 2, Tabs 43 and 44.
[6] Exhibit 2, Tabs 6 (Statement 7.11.2014) and 43.
[7] Exhibit 2, Tab 45.
[8] Exhibit 2, Tab 46.
[9] Exhibit 2, Tab 43.
[10] Exhibit 2, Tab 58.
[11] Exhibit 2, Tab 44.
[12] Exhibit 2, Tab 44.

13. When he left that day the deceased had his wallet but was not carrying a bag. He also had his Apple iPhone with him, which he always carried. During the day the deceased sent a text message to his son congratulating him on a win his son had had that day. The deceased's wife later sent a text message to the deceased, at about 5.30 pm, with a photo of their children dressed in their Halloween costumes. The deceased did not reply and had no further phone contact with his family.[13]

THE CHARTER BOOKING

14. In October 2014 Joanne Hill worked as a Business Development Manager for Pepper Australia Pty Ltd (Pepper), which was affiliated with Australia Mortgages and was involved in arranging third party mortgages. Ms Hill's role involved strengthening business relationships with external supporters by arranging professional development days and events. In particular, once a year the company would arrange an end of year function as a reward to current mortgage brokers for their business. It was also anticipated it would be useful as a networking event. In 2014, this event was held in Western Australia on Friday, 31 October 2014 and involved a charter boat cruise. The boat charter was booked by Pepper (via Ms Hill) with Swan River Boat Charters (Swan River Charters).[14]

15. Mr Daniel Lippiatt was the Managing Director of the business Swan River Charters. Mr Lippiatt was also the sole director of a company, Dolphin Dive Centre Fremantle Pty Ltd (Dolphin Dive). That company owned and operated a boat named the 'Ten-Sixty Six', as well as two other boats. As part of a commercial arrangement, Dolphin Dive supplied the Ten-Sixty-Six to Swan River Charters for the purpose of conducting charter boat cruises.

16. The Ten-Sixty-Six was booked to be used by Swan River Charters for the Pepper function at the end of October. Ms Hill made the arrangements by email through Alma Keogh, who was employed by Dolphin Dive, and as part of her employment was the customer services manager for Swan River Charters.[15] The arrangement was that Swan River Charters would provide morning snacks and lunch for the guests and Pepper was to provide all drinks (alcoholic and non-alcoholic) and ice, as well as some potato chips. Ms Hill was notified the day before the charter that Mr Lippiatt would be the skipper for the charter cruise.[16]

17. Mr Lippiatt was told by the booking office an approximate number of guests (less than 50 – which was the maximum the boat was surveyed to carry) and that it was a social event being held by Pepper. He was given Ms Hill's details as the contact person.[17]

18. Mr Lippiatt arranged for Aaron Crane, who usually worked as a deck hand for another company but had been working casually for Swan River Charters

[13] Exhibit 2, Tab 43.
[14] Exhibit 2, Tab 6 (Statement 7.11.2014).
[15] Exhibit 2, Tabs 6 (Statement 7.11.2014), 60.5 and 60.12.
[16] Exhibit 2, Tabs 6 (Statement 7.11.2014) and 60.5.
[17] T 298.

during the previous month, to assist with the charter cruise.[18] Mr Crane had not worked on the Ten-Sixty-Six before, but had worked with Mr Lippiatt before.[19] Mr Crane had a First Aid Certificate and had completed a Certificate of Elements of Shipboard Safety and partially undertaken training for his Master V course. The rest of his skills and knowledge as a deckhand came from many years of 'on the job' training.[20]

19. The invitation sent by Pepper to the mortgage brokers indicated that the group were to meet at Sardine Jetty in Fremantle by 8.45 am, with the boat to depart at 9.00 am. Ms Hill understood that the plan was that they were going to travel to Rottnest Island but that the guests would not land at Rottnest Island due to the landing fee costs.[21] Information provided by the Chief Executive Officer of the Rottnest Island Authority to the court confirms there are admission fees to visit the nature reserve, which include fees for passengers who enter the marine waters on a charter vessel as well as admission fees for any passenger that lands on the island.[22]

20. A total of up to 50 passengers were expected to be attending, including the four Pepper staff (Ms Hill, Kathryn Mortimer, Paul Place and Tony Wood). One of the invited guests was the deceased. Ms Hill had known the deceased for approximately three years through her work. Mr Place, the State Manager for Pepper, had also known the deceased for about five years on a professional basis.[23]

EARLY EVENTS ON 31 OCTOBER 2014

21. The deckhand, Mr Crane, and the skipper, Mr Lippiatt, began work on the Ten-Sixty-Six at approximately 8.30 am on 31 October 2014 to prepare for the cruise to Rottnest Island.[24] Mr Lippiatt gave evidence that he checked the boat over and quickly went through the safety equipment to make sure it was in order before showing Mr Crane where it was located.[25] Mr Crane agreed that Mr Lippiatt showed him where the safety equipment was on the boat. He was not told anything about the group of people who would be the passengers but Mr Crane understood it was to be a casual day at Rottnest with a barbecue but no fishing or diving.[26]

22. Ms Hill and other Pepper staff arrived at Sardine Jetty at about 8.35 am. The deceased was already there when they arrived, as were some of the other guests. At 8.45 am the boat had not arrived so Ms Hill telephoned Mr Lippiatt, who indicated he was just leaving the boat pen. While they were waiting for him to arrive Ms Hill started making introductions.

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[18] Exhibit 2, Tab 40 – Unsigned statement but Mr Crane adopted it in his oral evidence – T 193 – although he later disputed the accuracy of [7] – [8] – T 206.
[19] T 197.
[20] T 193 - 199.
[21] Exhibit 2, Tab 6 (Statement 7.11.2014).
[22] Exhibit 2, Tab 53.
[23] Exhibit 2, Tabs 6 (Statement 7.11.2014) and 8..
[24] Exhibit 2, Tab 40.
[25] T 298.
[26] T 219.

23. The deceased had attended the event alone and did not know any of the other guests, although he had had some previous dealings with Pepper staff. One of the guests, Scott Gillespie, was introduced to the deceased on the jetty. Like the deceased, Mr Gillespie only knew the Pepper organisers. The deceased and Mr Gillespie spoke mainly about business and Mr Gillespie recalls the deceased saying it was the best job that he had ever had.[27]

24. The boat arrived at Sardine Jetty at about 9.00 am.[28] When the boat arrived at the jetty Ms Hill introduced herself to Mr Lippiatt, who then introduced her to Mr Crane.

25. Ms Kathryn Mortimer, who also worked as a Business Development Officer for Pepper, recalled that before they boarded the boat she was asked by the 'Captain' (Mr Lippiatt) how many more people they were expecting. She told him that originally they expected 50 people to attend in total. Ms Mortimer then did a head count of the group standing on the jetty and told him the total was 33, although it's not clear whether she included herself in that number.

26. Other evidence provided by Ms Hill and Mr Place to police suggests that there were 34 passengers in total (30 invited guests and 4 Pepper staff).[29] Ms Hill provided a list of the 32 attendees (other than the deceased and herself) by email to police on 1 November 2014 and police interviewed all 33 people, including Ms Hill, who each confirmed they were on the boat that day and described who they were with and what they did that day.[30] None of those people nominated any additional person who had been missed off the list and there is no evidence to suggest that another, unnamed, passenger was on board, other than Mr Lippiatt's evidence that he counted 35 passengers.

27. I detail later in this finding Mr Lippiatt's evidence as to how he counted and recorded 35 passengers. I will address his evidence in due course, but for now it is sufficient to indicate that I am satisfied on all of the evidence before me that there were a total of 34 passengers (including the deceased) and 2 crew members on board the Ten-Sixty-Six that day, being a total of 36 persons on board the boat.

28. Robert Tracey attended as a guest of Pepper that day with two work colleagues. He was an important witness as he remained sober throughout the day because he had to attend to another function after the cruise. Mr Tracey gave evidence that when he arrived at the jetty that morning he was aware that some of the Pepper staff were checking to make sure that all the invited guests had arrived, and he was aware that at least one of his party was not attending, which he advised Ms Mortimer on the day.[31] Mr Gillespie thought Joanne Hill from Pepper had paperwork and checked him off at the jetty.[32]

[27] T 78 - 79; Exhibit 2, Tab 9.
[28] Exhibit 2, Tab 40.
[29] Exhibit 2, Tab 6 [22], Tab 7 [17] and Tab 8 [6].
[30] Exhibit 1, Tab 16.
[31] T 114; Exhibit 2, Tab 12.
[32] T 99 – 100.

29. The chips, ice and drinks brought by Pepper were loaded onto the boat and the crew loaded the eskys with the ice and drinks. The alcohol provided included beer, red wine, white wine, and champagne.[33] A receipt provided by Ms Hill to police shows there was a total of 7 cartons of beer, 2 dozen bottles of wine and 1 dozen bottles of champagne (or sparkling wine) purchased for the event.[34] There was a blue esky at the back of the boat that was filled with the alcoholic drinks and another esky and tub were filled with the non-alcoholic drinks.[35]

30. When all the passengers were on the boat Mr Lippiatt did an introduction and then gave a safety briefing. Many of the guests recalled it covered the lifejackets (where they were located, how to use them and how to hold onto them when jumping into the water) but others also remember there was information given about the lifeboats, first aid kits and where the toilets were. They were also told that there was to be no raucous behaviour, they were not to touch the controls and they were given information about where they could smoke and similar such information.[36] It was described generally by the passengers as a clear and comprehensive briefing. Mr Crane did not participate in the safety briefing.[37]

31. There was then a discussion between the crew and Pepper staff about their destination, which had been originally booked as Rottnest Island. It was agreed that they would continue with the original plan and go to Rottnest. It was agreed that they would go to the northern side of the island, which is more sheltered from the southerly breezes.[38]

32. Many of the guests also recalled a crew member, either the skipper or deckhand, conducting an obvious head count around the time of the safety briefing and some had also seen a headcount being done as they boarded the boat.[39]

33. Mr Crane indicated that he was not specifically asked by Mr Lippiatt to do a head count, but after all the passengers were on board and the boat was leaving the jetty he performed a head count of his own accord. Mr Crane did so by walking down the boat and pointing at people and counting their heads as he went. He did not write the final number down but Mr Crane apparently told police that he counted 35 people, although he could not be sure at the inquest that this was the number he had counted or the number he later told police.[40] Mr Crane's evidence at the inquest was that he wasn't sure of the final number but his count included only the passengers, so the number he reached was not inclusive of the crew.[41] Mr Crane did not have any involvement in recording the head count in the log book.[42]

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[33] Exhibit 2, Tab 6 (Statement 19.11.2014).
[34] Exhibit 2, Tab 60.7.
[35] Exhibit 2, Tab 6 (Statement 7.11.2014).
[36] T 79, 105, 115; Exhibit 2, Tabs 6 (Statement 7.11.2014), 7, 12, 14 and 24.
[37] T 221.
[38] T 302; Exhibit 2, Tab 7 [24].
[39] T 80 – 81, 114 – 115, 147, 180; Exhibit 2, Tabs 9, 12, 13 [10], 16, 21 and 25.
[40] T 202 - 203; Exhibit 1, Tab 40.
[41] T 205.
[42] T 205.

34. Although he could not remember the number of his headcount, Mr Crane had a recollection that he told Mr Lippiatt what he had done and the total he had reached, and Mr Lippiatt informed him that he had already done a headcount and his number was different. He recalled Mr Lippiatt then did a recount and Mr Lippiatt indicated he was happy with the accuracy of his original total, which he still believed was correct. This evidence is different to the information included in Mr Crane's draft police statement, where he seemed to indicate that he had counted 35 people and Mr Lippiatt had counted 35 persons as well.[43]

35. Mr Lippiatt gave evidence that he conducted the headcount immediately after the safety briefing and discussion about the day's destination. He had earlier counted people as they walked onto the vessel (which some passengers had noted) but Mr Lippiatt did a final headcount at the end of the safety briefing as he believed this was the best point in time to have people's attention. Mr Lippiatt described his usual manner of conducting a headcount, which involved walking from the front to the back of the boat, as well as checking the cabin, toilets and flybridge.[44]

36. Mr Lippiatt concurred with Mr Crane that they had a discussion about headcounts and their amounts didn't match up, being out by two or three. However, Mr Lippiatt recalled this discrepancy related to the initial count that he did when people were boarding the vessel.[45] Mr Lippiatt's evidence was that he then did his final headcount after the safety briefing, and to the best of his recollection he then told Mr Crane that he had 35 people and Mr Crane agreed that he had the same.[46] This differs from Mr Crane's evidence that Mr Lippiatt told him that he was happy with the correctness of his earlier count.

37. Mr Lippiatt's evidence was also that the 35 people counted did not include the crew (namely himself and Mr Crane). He later wrote an entry in the logbook, with a notation of 35 POB, which he said in his evidence stood for 35 passengers on board, and then the additional noting of himself and Mr Crane. Based on Mr Lippiatt's evidence, that would mean there was a total of 37 persons on board the boat that day, although as I have already indicated I am satisfied there were 36 people (including the crew) on the boat that day.[47] I will come back to the issue of the logbook entry later in this finding.

38. The boat left Fremantle for Rottnest at approximately 9.20 am and the journey over took about an hour and a half. The weather was sunny and windy and the temperature was about 23°C. Ms Hill recalls there was a bit of swell and a few passengers felt seasick, but it was nothing particularly concerning. Mr Place described the conditions as good and Mr Gillespie described them as pretty calm.[48] Mr Lippiatt gave evidence that he had foreshadowed the favourable conditions going over during the safety briefing

[43] T 203 - 205; Exhibit 2, Tab 40 [7] – [8].
[44] T 302 – 305.
[45] T 305 - 306.
[46] T 306 - 307.
[47] T 310 - 311.
[48] T 85.

but had still suggested the passengers stay seated as much as possible because they were on a moving boat.[49]

39. The passengers started drinking as soon as the boat left the harbour.[50] Some of the passengers helped themselves to alcoholic drinks from the blue esky and Ms Hill offered guests champagne and/or orange juice or water. Ms Hill also put chips into bowls and handed them around. Mr Tracey recalled that most people on the boat had a lot to drink on the way over, mainly beer and wine, although he acknowledged that there was also a lot of water available.[51]

40. During the trip to Rottnest the passengers were mingling, including the deceased. Mr Gillespie sat with the deceased and a couple of other people at the back of the boat near the blue esky. Mr Gillespie described the boat as a 'typical fishing cray boat" that had been converted into a recreational vessel with a few seats, an esky and a barbecue. Mr Gillespie noticed that people were sitting on the esky throughout the day as there was not enough seating for everyone. He also noticed that the esky was roughly the same height as the railing. He thought the railing was too low and warned a female passenger to be careful sitting on the esky while they were motoring as he was concerned that she might fall in.[52]

41. Felicity Goodwin, who was on the charter as the friend of invitee Danielle Johnson, recalled meeting the deceased on the journey to Rottnest. Ms Johnson already knew the deceased as they had previously worked together. Ms Goodwin remembered the deceased as one of the nicest people she spoke to on the boat that day. Ms Goodwin, Ms Johnson and the deceased sat together at the back of the boat until they reached Rottnest and they spoke mainly about business. Ms Goodwin and Ms Johnson also spoke to the deceased again while they were anchored at Parakeet Bay. Ms Goodwin and Ms Johnson were both drinking beer throughout the day, as was the deceased. Ms Goodwin noted that the majority of people on the boat were intoxicated but she still thought everyone was capable of walking and talking.[53] Ms Johnson acknowledged that she was getting drunk so she wasn't really able to comment on whether the deceased or others were intoxicated.[54]

42. Ms Mortimer did not recognise the deceased but he was identified to her by other Pepper staff. She had known him for approximately five years but the majority of their dealings were by correspondence or on the telephone and not in person. Ms Mortimer recalled having a brief conversation with the deceased initially when they were both looking in the esky to find a specific drink, and also some brief general conversation a while later when the deceased was sitting on the esky. Ms Mortimer was uncertain as to how much alcohol the deceased drank during the day but she indicated the deceased "appeared fine"[55] during their conversation, was not slurring his

[49] T 302.
[50] Exhibit 2, Tabs 6 (Statement 7.11.2014), 7 and 8.
[51] Exhibit 2, Tab 12.
[52] T 83 - 84; Exhibit 2, Tab 9.
[53] Exhibit 2, Tab 14.
[54] Exhibit 2, Tab 15.
[55] Exhibit 2, Tab 7 [50].

words and did not appear intoxicated, although I note that Ms Mortimer was described as quite intoxicated later in the day, so her ability to estimate the intoxication level of others would have been impaired. Ms Mortimer did not speak to the deceased again, but she did see him a number of times throughout the day and she recalled he was always sitting or standing near the blue esky at the back of the boat.[56]

43. Mr Place also recalled generally seeing the deceased towards the back of the boat, and only had one short conversation with him. He recalled the deceased was drinking Carlton Dry but did not notice if he was intoxicated.[57]

44. Ms Hill recalled speaking with the deceased once they had reached Rottnest. She remembered he was drinking Carlton Dry (which she had confirmed in an earlier email was his preferred drink).[58] Carlton Dry is a full strength beer. Ms Hill could not recall how many beers the deceased drank although she did not notice him slurring his words or stumbling. Ms Hill did recall a joke being made about needing more than one carton of Carlton Dry as another passenger was also drinking the beer.[59]

45. Another passenger, Shaun Symington, who is a police officer but was off duty that day, saw the deceased around the time they arrived at Parakeet Bay. Mr Symington thought that by the look on his face the deceased had already "had a few beers by then."[60] It is worth noting that Mr Symington would have had considerable dealings with intoxicated persons as part of his work as a police officer, and experience in making some preliminary assessment about a person's level of intoxication. Mr Symington himself drank a few beers but was conscious of the fact that the return crossing was likely to be rough (based on his previous experience) and he didn't want to be intoxicated during such a journey, so he limited his drinking.[61]

46. After arriving at Rottnest the boat was anchored in Parakeet Bay. While there the crew cooked a BBQ lunch for the passengers. There had already been chips, dips and cold meats available and with the addition of lunch one guest indicated there was an abundance of food available, for those who chose to eat it.[62]

47. Another passenger, Steven Ayris, recalled seeing the deceased at lunch standing near the esky. He didn't think the deceased was intoxicated when he saw him, but he was also drinking and didn't see the deceased again after lunch.[63]

48. Another guest, Antonio Peccia, drank only two mid strength beers throughout the entire day, so was effectively sober. He recalled the deceased,

[56] Exhibit 2, Tab 7.
[57] Exhibit 2, Tab 8.
[58] Exhibit 2, Tabs 6 (Statement 7.11.2014) and 60.4.
[59] Exhibit 2, Tab 6 (Statement 7.11.2014).
[60] Exhibit 2, Tab 24 [23].
[61] T 181.
[62] Exhibit 2, Tab 27.
[63] Exhibit 2, Tab 11.

who he met for the first time that day, had quite a bit to drink during the day, as did a number of the passengers.[64]

49. Ms Hill recalled that while at Rottnest there was some concern that the Carlton Dry beers were running low. She noted that beer appeared to have been the preferred choice of alcohol for the guests. Ms Hill specifically recalled speaking to the deceased about the beer running low and the deceased told her that he had seen some alcohol towards the front of the boat, including a carton of Carlton Dry. The deceased asked if this alcohol belonged to Pepper.[65] Ms Hill and Mr Place asked Mr Lippiatt and were advised that the alcohol the deceased had seen did not belong to Pepper. Mr Lippiatt then had a discussion with Ms Hill and Mr Place about their dwindling beer supplies and it has been found in other proceedings that Mr Lippiatt supplied two further cartons of beer (a carton of Corona and a carton of Carlton Dry)[66] from his own personal supply. The agreement was that a reasonable cost for the two cartons would be taken out of the security deposit that had already been paid by Pepper.[67]

50. Ms Hill also recalled helping the deceased to charge his mobile telephone during the trip.[68]

51. Nobody swam while the boat was at Rottnest as it was too cold.[69] They also did not land on the island. No other activities were offered, so as one guest commented to police, there was nothing much else to do other than to consume alcohol.[70]

52. A guest took a photo at about 1.50 pm, which shows the deceased sitting on the blue esky at the back of the boat with other people.[71]

53. As the afternoon progressed Mr Lippiatt spoke to Ms Hill and indicated that it was approaching the time for them to start moving again. At about 2.30 pm the two crew began packing up the boat to prepare for the return to Fremantle. The four Pepper staff gave a small speech and took a few photos, including one of the deceased with three other people at the back of the boat. The deceased was near the blue esky when the photo was taken.[72] This photograph establishes that the deceased was still on the Ten-Sixty-Six at the time the boat began its return journey to Fremantle at about 2.30 pm.

54. At the time they were ready to make their return trip, Ms Mortimer believed that the majority of the people who had been drinking all day were intoxicated, including herself. She could not, however, specifically recall the state of the deceased at that time and she did not recall seeing or speaking to him on the return journey.[73]

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[64] T 133 – 134; Exhibit 2, Tab 13 [15].
[65] Exhibit 2, Tab 6 (Statement 19.11.2014) [8] – [10].
[66] Exhibit 2, Tab 6 (Statement 19.11.2014) [18]/
[67] Decision of Magistrate M. Flynn in WA Police v Lippiatt, FR 3837 of 2015, 15 December 2016.
[68] Exhibit 2, Tab 6 (Statement 7.11.2014).
[69] T 231; Exhibit 2, Tabs 6 (Statement 7.11.2014)[84] and 9.
[70] Exhibit 2, Tab 16.
[71] Exhibit 2, Tab 60.8.2.
[72] Exhibit 2, Tabs 6 (Statement 7.11.2014) and 60.8.1.
[73] Exhibit 2, Tab 7 [58] – [59].

55. Mr Crane agreed that the general state of the passengers was that they had been drinking, but he didn't think they were exceptionally drunk or overly rowdy.[74]

56. Mr Lippiatt gave evidence at the inquest that prior to the boat leaving Parakeet Bay, he turned the music down and spoke to the passengers. His evidence was that he told them they were heading back to Fremantle and made them aware that the conditions would be considerably rougher on the way back due to the sea breeze and they should stay seated when possible. He also said that he mentioned the crew would be putting the side curtains down to limit the sea spray coming into the boat.[75] Mr Lippiatt also gave evidence that he told the passengers that when they reached Fremantle they were not to get off the vessel until they had shut down the engines, as this was when the vessel would be securely fastened to the jetty.[76]

57. Mr Crane was asked whether he recalled Mr Lippiatt telling the passengers that it was going to be a bit rougher going back, and he said, "I think he had said something like that, yes."[77] However, his evidence was that Mr Lippiatt had not told him to do anything to prepare the boat or prepare the passengers for the rougher conditions before they left the bay.[78] Mr Crane was also asked whether he recalled Mr Lippiatt telling the guests it would be better if they remained seated on the return journey or they should be more careful, but he did not recall him doing so.[79]

58. As detailed below, none of the guests recalled being given any instructions about what to do or to expect on the journey back when they were leaving Parakeet Bay, other than one witness who made specific enquiry with Mr Lippiatt.[80]

59. Mr Lippiatt also gave evidence that he conducted another headcount before the boat left Parakeet Bay, again walking from the front of the vessel to the back. He indicated that the number was the same as his original headcount conducted at Sardine jetty (35 passengers) so he did not make an entry in the logbook. Mr Lippiatt stated, "I would have no reason to make another entry unless the number changed."[81] There is no other witness evidence, or any objective evidence such as a separate logbook entry, to corroborate Mr Lippiatt's claim to have conducted a second headcount. In particular Mr Crane, the other crewmember, did not see Mr Lippiatt do another head count at Parakeet Bay although he conceded Mr Lippiatt may have done one and Mr Crane was simply not aware of it.[82]

[74] T 231.
[75] T 309.
[76] T 318.
[77] T 223.
[78] T 207.
[7979] T 223.
[80] T 97, 105.
[81] T 310.
[82] T 206.

THE RETURN JOURNEY

60. After they left Parakeet Bay and began the return to Fremantle the conditions became rough as the boat headed into the ocean. As noted earlier, this was considered normal due to the sea breeze being in at that time of day.[83]

61. Mr Lippiatt described the journey as "a little bit rougher, but still fairly smooth."[84] Mr Lippiatt had plotted a course that took them past the windmills or Southern leads on the northern side. The boat drove back on autopilot, with Mr Lippiatt maintaining a lookout and monitoring the engine instruments.[85] Mr Lippiatt's evidence was that he spent most of his time in the helm/wheelhouse but did a walk around once or twice on the deck.[86] He maintained that he could still clearly see the back deck even when inside the cabin and he could see that most of the passengers were sitting down along the benches and a couple were standing up and holding onto the railing.[87]

62. If Mr Lippiatt did keep an eye on the passengers, it was not observed by the passengers. Nicholas Aves, for example, told police the crew were facing the front of the boat and did not keep an eye on the guests on the return trip, most of whom congregated on the rear deck.[88]

63. Mr Crane gave evidence that most of the passengers were seated or hanging onto awnings for much of the journey. It was his perception that most of them were "reasonably comfortable"[89] and they were "quite safe",[90] although as will be seen below the passengers' accounts do not accord with that description.[91] Mr Crane was asked if he saw passengers sitting on the eskys out the back and his evidence was that he did not but he also indicated that it would not have caused him concern if they were.[92] It is of note that Mr Crane spent most of the first part of the return journey in the wheelhouse talking to Mr Lippiatt, which might explain why his perception of where passengers were placed and their level of comfort doesn't accord with the accounts of the passengers.[93]

64. Ms Hill recalled several large waves on the way back, although she could not be sure of what exact time these happened. Ms Hill did recall that after the initial big waves the sea conditions became more stable, but were still what she would describe as "rough."[94] Ms Hill recalled that the guests were moving from side to side on the boat and some were staggering due to the swell. She also noticed that those who were not holding on found it difficult to stay still.[95]

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[83] T 310.
[84] T 314.
[85] T 314.
[86] T 315.
[87] T 315.
[88] Exhibit 2, Tab 16.
[89] T 208.
[90] T 209.
[91] T 208.
[92] T 208 – 210.
[93] T 227.
[94] Exhibit 2, Tab 6 (Statement 7.11.2014) [102].
[95] Exhibit 2, Tab 7 (Statement 7.11.2014).

65. One guest, Roger Turner, who had experience sailing, described the sea as rough with a big side swell measuring approximately 2.5 to 3 metres high from the bottom of the wave to the top. Mr Turner was sitting on a bench about halfway down on the right hand (starboard) side of the boat. During the swell Mr Turner described the boat as being at a 30 degree angle and the bench he was sitting on nearly tipped over. Mr Turner got wet up to his knees, which caused him to move inside the boat for the last third of the trip.[96]

66. Another guest, Mr Peccia, described the conditions as "extremely rough"[97] and described how he was "hanging on for dear life to a railing."[98] Mr Peccia had originally been sitting but offered his seat to one of the ladies. Mr Peccia observed people slipping and sliding and at one stage there were four people on the deck.[99] Mr Peccia who had not been drinking, noted that "alcohol levels were quite high on a number of people," which perhaps made it easier for people to lose their footing.[100]

67. Mr Gillespie also described the sea conditions as rougher on the way back and he considered that "the seating wasn't appropriate for that type of swell."[101]

68. Another guest, Sharon Merritt, was sitting on the right hand side of the rear of the boat. Ms Merritt was seated on a very small esky nestled in the far back right corner for the entire trip. Ms Merritt described herself as a "nervous passenger"[102] and she found the return journey "[p]articularly unpleasant."[103] For the first part of the journey she noted it was fine for people to move around, getting drinks etc, but then "it turned nasty quite quickly and then continued to get worse and worse."[104]

69. At that time Ms Merritt was married to Andrew Merritt, the other guest wearing a white hat. Ms Merritt recalls seeing the deceased sitting on the esky on the left hand side because she recalls her former husband approaching the deceased and asking for a beer from the esky.[105] Mr Merritt similarly remembered that he asked the deceased for a beer from the esky on the journey home. The deceased told him it was empty and there were no drinks left. Mr Merritt was quite intoxicated and didn't remember much more of the trip back but he did not recall seeing the deceased after the conversation about the beer.[106] Ms Merritt did not recall seeing the deceased move away from the esky later in the journey, but her last clear memory of him was at that early stage in the journey.[107] It had occurred to Ms Merritt that anyone seated on that esky might be in danger of sliding overboard in the rough conditions, given the rails were quite low on that side of the boat,

[96] Exhibit 2, Tab 18.
[97] T 131.
[98] Exhibit 1, Tab 13 [17].
[99] Exhibit 1, Tab 13.
[100] T 133.
[101] T 86.
[102] T 148.
[103] T 148.
[104] T 148.
[105] Exhibit 2, Tab 35.
[106] Exhibit 2, Tab 36.
[107] T 150 - 151.

and she was concerned for their safety, but she did not pay close attention to who in particular was sitting on the esky at that time.[108]

70. One passenger, Kathryn Mortimer from Pepper, was actually thrown to the floor on a couple of occasions but she didn't want to stay seated as she said she felt seasick. Ms Mortimer was assisted to stand by Ms Hill and Tony Wood, who was the Regional Manager for Pepper, while holding onto a rail.[109] Ms Mortimer recalls that while standing with Mr Wood and Ms Hill, approximately 20 minutes into the return trip, the boat hit a wave and she lost her grip and footing. She fell over onto the deck of the boat and tumbled into the BBQ area, where Mr Tracey was standing. Each time Ms Mortimer fell it would have a "domino effect" on other passengers, so that a few would fall down. Mr Tracey remembered having to turn to his right side and catch Ms Mortimer twice and Ms Merritt recalled that Ms Mortimer fell over a few times. Ms Merritt recalled that she said that Ms Mortimer needed "to sit down before someone ends up overboard"[110] and Mr Wood was also concerned for Ms Mortimer's safety at that stage.[111] Ms Mortimer eventually sat down near Ms Merritt and she was seated there when the large waves described by many of the guests struck the boat.[112]

71. Mr Tracey, who I have noted previously was not drinking alcohol that day, also recalls the weather being extremely rough on the way back, "to the point where people were stumbling and falling over."[113] He recalled seeing a couple of people falling and, as noted above, assisted Kathryn Mortimer a couple of times. Similarly to some other witnesses, Mr Tracey recalls seeing the deceased sitting on the big blue esky at the back of the boat on the left side during the return journey to Rottnest. He did not know the deceased by name and had not spoken to him on the day but Mr Tracey recognised the deceased from a photograph as being the only person on the boat wearing a white hat (as Mr Tracey recalled the other guests were wearing red or black hats provide by Pepper staff).[114]

72. It seems many of the witnesses recalled Mr Mills by the fact that he was wearing a white hat that day. However, I note that in a photograph from the day it is apparent another man, Andrew Merritt, who I have mentioned above, was also wearing a white hat that day.[115] This does affect the reliability of their identification of the deceased as 'the man in the white hat', except for those witnesses who were able to distinguish between the deceased and Mr Merritt. Nevertheless, given the evidence of Ms Merritt and Mr Merritt, I am satisfied the person Mr Tracey was describing matches the description of the deceased and the weight of the evidence puts the deceased on the blue esky at least during the early part of the return journey.

[108] T 151 - 152.
[109] Exhibit 2, Tab 6 (Statement 7.11.2014).
[110] T 148.
[111] Exhibit 2, Tab 20.
[112] T 152; Exhibit 2, Tab 7.
[113] Exhibit 2, Tab 12 [15].
[114] T 115; Exhibit 2, Tab 12 [17] – [20].
[115] T 141; 150; Exhibit 2, Tab 60.8, Photo 2.

73. Mr Tracey had positioned himself along the back of the boat between the barbecue and the left corner of the boat.[116] He recalled the deceased had come down looking for a drink and then sat on the esky. Mr Tracey remembers seeing the deceased for about 10 to 15 minutes but then the deceased moved into the main part of the boat because there was nowhere to hold onto and because people kept asking to look in the esky to see if there was anything else to drink.[117] According to Mr Tracey, the deceased "was quite pissed, he was gone."[118] When he left the esky Mr Tracey saw the deceased stagger up the boat, knocking into people as he moved across the boat deck, but Mr Tracey conceded that the weather conditions may have amplified this movement as the boat was being pushed around by the waves at the time.[119] Other guests were also noted to be intoxicated and were falling over and bumping into each other.[120] Mr Tracey said that he wasn't focussing on anyone in particular, so he didn't see where the deceased went to after that. After the deceased got off the esky Mr Tracey recalled a blonde woman took his position (who would appear to be Kylie Symonds, referred to below).[121]

74. Later, when Mr Tracey felt the journey had "got really rough," he moved in to the centre of the boat himself, but then the canopy was ripped and Mr Tracey moved back to his former position next to the barbecue, where he stayed for the remainder of the journey.[122] Mr Tracey did not recall seeing the deceased again after approximately 30 minutes into the return journey, when he had moved away from the esky.[123]

75. Ms Hill did not recall seeing the deceased during the journey back to Fremantle.[124] Ms Hill remembered seeing Kylie Symonds, Robert Tracey and John Hartley being around the blue esky at the back of the boat.[125]

76. Jon Hartely remembered seeing the deceased (who he did not know but later identified from a photograph) near the back of the boat holding onto the blind for about 5 to 10 minutes before he moved into the main part of the boat. He could not remember when during the return trip this occurred. Similarly to Mr Tracey, Mr Hartely remembered that at this time the deceased seemed intoxicated and was staggering around, which he put down to a combination of his intoxication and the rough conditions. Mr Hartely had positioned himself in the far back left hand corner of the boat, near the blue esky, which is why he would have had a good view of the deceased, at least at the early stage during the return journey.[126]

77. Kylie Symonds was seated on the blue esky for most of the return journey but she was facing towards the front and described herself as being slightly blind to the rest of the esky due to her position. She kept her feet on the

[116] T 117; Exhibit 2, Tab 12, diagram.
[117] T 119; Exhibit 2, Tab 12 [17] – [20].
[118] Exhibit 2, Tab 12 [24].
[119] T 129; Exhibit 2, Tab 12 [25].
[120] Exhibit 2, Tab 16.
[121] T 119.
[122] T 120 – 121.
[123] T 120.
[124] Exhibit 2, Tab 6 [93].
[125] Exhibit 2, Tab 6 [120].
[126] Exhibit 2, Tab 26.

ground and slightly apart to assist her balance. She had to get off the esky a few times to allow guests to get drinks, and each time she leaned hard into the side of the esky to keep her balance.[127] Interestingly, she was asked whether she thought the deceased could have fallen off the esky, and she expressed the view that he would have been more likely to fall onto the deck beside the esky.

78. Another guest, Robert Waters, told police he had seen the deceased on the return journey sitting on the left hand side of the boat, about five people down from where he was seated. The deceased was sitting on the blue esky at that stage but was blocked from Mr Waters' view by the other guests.[128]

79. Richard Ezzard was asked whether he had seen the deceased on the journey home and he recalled being introduced to the deceased on the day and seeing the deceased standing in the middle of the boat, about halfway across the deck on the port side, at some stage. Mr Ezzard had been sitting on the central bench facing the back of the boat. The map attached to his statement showed the deceased standing near the bench on the left hand side of the boat, towards the blue esky.[129]

80. Mr Place did not recall seeing the deceased on the journey home and did not recall seeing him get off the boat. He remembered the passengers on the return trip being civil and not rowdy.[130] Mr Gillespie also remembered everyone on the boat being quite friendly and "quite merry"[131] from drinking alcohol, but no one was acting aggressively. Mr Turner had been drinking moderately and he noted that some other people were drunk, but he thought they were still capable.[132]

81. One guest, Nicholas Aves, told police that he had had concerns about safety during the trip and he could see in hindsight how people might not have noticed if someone fell overboard. His reasons for saying this were because it was very busy on the deck and people were moving all the time and bumping into each other. There were also a lot of intoxicated people on board.[133] Mr Aves speculated that the most likely places someone might have fallen off at the rear of the boat, where there were no hand rails or seats, or alternatively on the port side near the cabin where one of the blinds remained up.[134]

82. Another guest, Simon Kahl, was sufficiently concerned on the trip home to ask one of the staff members whether anyone had ever fallen off the boat before, as he considered it was absolutely possible a person could easily fall off the boat. He was told by the staff member that no one had fallen off the boat before.[135]

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[127] Exhibit 2, Tab 37.
[128] Exhibit 2, Tab 21.
[129] Exhibit 2, Tab 38.
[130] Exhibit 2, Tab 8 [22].
[131] Exhibit 2, Tab 9 [32].
[132] Exhibit 2, Tab 18 [32].
[133] Exhibit 2, Tab 16.
[134] Exhibit 2, Tab 16.
[135] Exhibit 2, Tab 27.

83. Another passenger, Geoffrey Burden also described it to police as a big drinking day and thought there were lots of people who were drunk.[136] However, Mr Jose, who had started drinking alcohol later in the day and did not believe he ever became drunk, described the other guests as quite well behaved and happy and he did not see anyone out of control at any time.[137] Mr Joe, who knew the deceased but couldn't recall his name on the day, remembered seeing the deceased sitting at the back of the boat somewhere early in the journey back to Fremantle. The deceased was sitting on the blue esky at the back of the boat on the port or left side. He was sitting on the esky with a female wearing a black top and a Pepper hat. As Mr Jose approached the blue esky the deceased stood up and handed Mr Jose a beer then sat back down. Mr Jose estimated this event occurred about 5 to 10 minutes into the return journey and he also recalled this happened before Linton Allen hurt himself (which is described below), which helps to put some timeframe on this event. He did not see the deceased again.[138]

84. Linton Allen was one of the few passengers who actually recalled speaking to the deceased on the return journey. He estimated it was about 20 to 30 minutes after they had left Rottnest. Mr Allen was standing on the rear deck in the middle of the boat and scrolling through the iPod music list. He was in the middle of the deck towards the front of the boat. The deceased came up to Mr Allen's right hand side from the back of the boat and asked Mr Allen whether they had any heavy metal music on the iPod. He then saw the deceased walked away towards the back of the boat. He estimated the conversation occurred approximately 15 minutes before the large waves hit the boat. This was the last time Mr Allen saw the deceased.[139]

85. As generally described by the guests and crew, sometime about halfway through the journey home the boat was hit by two large waves. Some water came across the deck and the boat tipped sideways. When this occurred Mr Allen slipped and fell forward and hit his nose on a bench, causing it to bleed. This occurred after Mr Allen had spoken to the deceased. Mr Symington recalled that at the time this event occurred the wave had tipped the boat sideways to a point where his feet were dangling in the air for a bit and other people on the bench were thrown forward. It was suggested the bench may have actually lifted off the ground and struck Mr Allen in the nose. After some initial horseplay by a few people who hadn't realised Mr Allen was injured, people assisted Mr Allen, including the deck hand Mr Crane. Mr Allen was offered ice, which he declined.[140] According to most passengers' evidence the commotion around Mr Allen's fall focussed quite a bit of their attention on him at that time.[141]

86. Mr Tracey thought this event occurred about 10 minutes after the deceased got up off the esky and walked into the middle of the boat.[142] He estimated the incident occurred at about 3.20 – 3.30 pm, approximately half an hour

[136] Exhibit 2, Tab 34.
[137] Exhibit 2, Tab 17 [29].
[138] T 139; Exhibit 2, Tab 17 [12] – [17].
[139] T 107; Exhibit 2, Tab 10 [11] – [14].
[140] T 107 – 109, 112; Exhibit 2, Tabs 10 and 24.
[141] T 153, 211; Exhibit 2, Tab 11 [38].
[142] Exhibit 2, Tab 12 [26] – [28].

before they reached Sardine Jetty.[143] Mr Tracey had not seen the deceased in the area of the esky around this time and said at the inquest that he was "pretty confident he wasn't there."[144] Mr Tracey was aware that people fell over due to the sudden movement of the boat. Mr Tracey was asked whether he thought the deceased might have fallen overboard at this time. He agreed it was possible, but did not think it was likely it happened on the left side of the boat. This was because for most of the journey Mr Tracey was standing watching over the left side of the boat and he thought he would have seen it happen, unless it occurred "in a split second."[145] However, I note that Mr Tracey did admit he was distracted by Ms Mortimer once or twice and also moved to hold the canopy for a short period.

87. Mr Gillespie also recalled the incident when the large waves hit the boat and he thought the back of the boat seemed to slam into a trough. He remembered some people being seated outside in the back area of the boat and had earlier recalled seeing the deceased sitting on the left side somewhere near the esky as they left Parakeet Bay. Mr Gillespie couldn't recall whether the deceased was sitting on the esky or sitting between the esky and the side of the boat. He did not speak to the deceased on the way back as there was no room in that area for him to sit comfortably and he had thought it was "pretty miserable"[146] at the back, so Mr Gillespie had moved forward under the canopy for the return journey.[147]

88. When the boat lurched, Mr Gillespie described it as the port side moving to just above water level, making it a possibility that someone in that area could be top heavy and fall in.[148] After Linton Allen hit his nose his head landed near Mr Gillespie's feet. Mr Gillespie believed that it was at this time that the deceased could have fallen off the boat as everyone was concerned with what was happening at the front of the boat. Mr Gillespie believed it was possible the deceased could have fallen into the ocean at this time and "no one would have been able to see."[149] Mr Gillespie also didn't believe Mr Mills would have been easy to see once he was in the water and everyone's attention had left Mr Allen, as by then they had travelled some distance and the sun was reflecting off the water. In particular, Mr Gillespie was not wearing polarised sunglasses, so he had little vision of what was in the water behind them.[150]

89. Mr Turner remembers that at this time the boat rolled severely to the left. The movement dragged the iPhone off the table and the music stopped. The deck hand, Mr Crane, also remembers the music stopping at this time.[151]

90. Mr Crane was asked about a large wave hitting the boat on the return journey and he indicated that he recalled that event happening and the boat

[143] Exhibit 2, Tab 12 [28].
[144] T 122.
[145] T 128; Exhibit 2, Tab 12 [37].
[146] T 86.
[147] T 85 – 87, 102; Exhibit 2, Tab 9.
[148] T 89.
[149] T 88.
[150] T 92 – 93.
[151] Exhibit 2, Tabs 18 and 40.

"lurched up to one side and…back down a couple of times."[152] Mr Crane's description was that "it wasn't huge"[153] but it did take people by surprise. Mr Crane gave evidence he was in the wheelhouse when this occurred and couldn't see the passengers. However, he heard some yells and the music stopped, which drew him back out to the deck where he observed a person who had fallen over and injured his nose (Mr Allen).[154] Mr Crane thought that Mr Lippiatt slowed the boat a bit after this occurred and then continued on after everyone had resettled.[155] Mr Crane gave evidence that he spent more time out the back of the boat after this incident (the latter part of the journey home).[156]

91. Ms Merritt also recalled that after Mr Allen was injured the skipper slowed the boat temporarily, which caused the conditions on the boat to become even worse for a short period, "making it a bit of a washing machine" before it increased in speed again.[157]

92. Mr Lippiatt disputed that the large waves were the reason for Mr Allen falling over. He expressed the opinion that the waves were "fairly insignificant"[158] and the reason Mr Allen fell over was "because he was standing up when he was simply told to sit down,"[159] although there was evidence from passengers that there were not enough seats for everyone to sit down comfortably and some evidence suggests Mr Allen was actually sitting when the incident occurred.[160] Mr Lippiatt also denied slowing the boat or changing his course after Mr Allen was injured.[161]

93. As noted above, Mr Crane said he watched the passengers from the wheelhouse for a period of time after the fall to make sure they were okay in the rough conditions.[162] It was generally reported that the boat felt calmer after this last incident and the guests were more subdued and largely kept their positions, so there were no other incidents.[163] The beer had also run out by this stage.[164]

94. The journey back to Fremantle took about an hour and a half in total.[165] The boat arrived at Sardine jetty at approximately 4.00 pm.

[152] T 210.
[153] T 210.
[154] T 210, 227.
[155] T 212.
[156] T 231.
[157] T 158.
[158] T 316.
[159] T 315.
[160] T85, 132; Exhibit 2, Tab 13 [18].
[161] T 316.
[162] Exhibit 2, Tab 40.
[163] Exhibit 2, Tabs 6 [118] – [119] and 24.
[164] Exhibit 2, Tab 24.
[165] T 224.

EVENTS AFTER REACHING SARDINE JETTY

Evidence of a Final Headcount

95. There was a Safety Management Plan that had recently been prepared for Swan River Charters that included the Ten-Sixty-Six, which indicated that "Passengers will always be counted on and off the vessel and the numbers recorded in the vessel's log."[166]

96. Mr Crane gave evidence that he believed he would have had a conversation with Mr Lippiatt as they headed to the jetty about where they were going to tie up, but there was no discussion about doing a headcount or the manner in which the passengers were to disembark.[167]

97. As noted earlier, Mr Lippiatt maintained he had told passengers not to disembark until the engines had been shut down,[168] although no other witness recalled this being said. Mr Lippiatt described how he drove the boat in to the jetty from the flybridge. Mr Crane tied off the bowline to the jetty and then Mr Lippiatt brought the stern of the vessel in to the jetty so that Mr Crane could tie off at the stern. Mr Lippiatt said he could generally see Mr Crane from his position on the flybridge, although he conceded there were some blind spots.[169] Although he could not recall exactly, Mr Lippiatt suggested it would not have taken more than a couple of minutes to tie up the vessel.[170] The engines are shut down from the cabin, so this required Mr Lippiatt to move from the flybridge to the cabin to complete this task.[171] Mr Lippiatt's evidence was that he then undid the side curtain and he counted the passengers as they were getting off.

98. I note that Mr Lippiatt clarified that some of his evidence about this part of the events relied upon his usual practice, rather than an independent memory of events. However, he indicated that he did have a recollection of conducting the headcount as passengers disembarked. Mr Lippiatt's evidence is that he remembered he counted the same amount of passengers that got off the vessel as the amount of passengers who were at Rottnest Island.[172] Mr Lippiatt relied, in part, on the fact that he didn't alter his original logbook entry for his certainty about the number.[173]

99. As will be seen below, the accounts of the passengers and Mr Crane differ significantly from Mr Lippiatt's evidence about the engines being turned off and a final headcount occurring, in that they do not recall a headcount being conducted as they disembarked at Sardine Jetty and many refer to the impossibility of this task being able to be done in any accurate way.

100. Ms Mortimer recalled people talking about going to the Norfolk Hotel when they reached the jetty in Fremantle, but she was getting a lift home with

[166] T 19; Exhibit 2, Tab 60.12, p. 11.
[167] T 212.
[168] T 318.
[169] T 318 - 319.
[170] T 319.
[171] T 320.
[172] T 320 – 321.
[173] T 319.

Mr Tracey and they left immediately. Ms Mortimer could not say whether a head count was done before they left the boat and Mr Place also did not notice a head count being done.[174]

101. Ms Merritt had been asked to move by Mr Crane so that he could tie up the boat to the jetty. She did not see anyone getting off there at the back right hand side, although Ms Merritt was in the last third of people to disembark. Ms Merritt could not recall if the engines were still running at that stage.[175] In Ms Merritt's opinion it was improbable that a headcount was conducted as passengers disembarked, given the circumstances.[176]

102. Mr Gillespie did not recall seeing the deceased as they left the boat. He got off the boat immediately and said that everybody else clambered off fairly quickly as "[e]veryone was sort of a bit fed up with the journey" and wanted to get on dry land.[177] Mr Gillespie did not recall the crew counting any passengers off the boat.[178] He recalled the boat was still being tied up and the engines were still going at that stage.[179]

103. Mr Peccia was one of the first people off the boat as he had an appointment in Mosman Park at 4.15 pm, and given the boat did not dock until 4.00 pm he was concerned that he was going to be late for his meeting. Mr Peccia was asked whether it was possible a head count was conducted on their return, which he said was possible but observed that if it was done then the headcount was less organised than it was at the beginning.[180]

104. Mr Tracey also left the boat as soon as they reached the shore. He had seen a head count conducted at the beginning of the trip but he did not see the crew doing a head count at the end of the trip. In Mr Tracey's opinion it would have been difficult to do one because people were leaving the boat. For example, he estimated he was off the boat within 45 seconds of the boat reaching the jetty and there were already people on the jetty at that stage. He believes the crew member was still busy docking the boat with the ropes at that time and was not standing at the side of the boat where the passengers disembarked.[181] He recalled the diesel engines were also still running.[182] As he left Mr Tracey saw a few people leaving the jetty area and understood they were going to the Norfolk Hotel. He did not see the deceased walking in that group and did not see the deceased anywhere else before he left.[183]

105. Ms Johnson thought that people also got off the boat at different points, making it difficult for anyone to keep track. She recalled that it looked like some people jumped off the back of the boat onto the jetty, while others were exiting on the right side of the boat with her.[184]

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[174] Exhibit 2, Tabs 7 and 8.
[175] T 155 - 156.
[176] T 156.
[177] T 94.
[178] Exhibit 2, Tab 9.
[179] T 95, 97.
[180] T 136; Exhibit 2, Tab 13.
[181] Exhibit 2, Tab 12 [43] – [48].
[182] T 125.
[183] Exhibit 2, Tab 12 [38] – [41].
[184] Exhibit 2, Tab 15.

106. Mr Turner stated he did not believe a head count was done at Sardine Jetty as when the boat returned everyone on board was in a rush to leave. He left the boat immediately after the boat returned.[185]

107. Mr Hartely was also in a rush to get off and said he left the boat as soon as it was against the jetty and while the crew member was still tying the ropes. Mr Hartely recalled that most of the people got off about the same time he did. He did not see the deceased get off the boat, but wasn't looking for him either.[186]

108. Mr Symington and his wife noted that people started getting off the boat straight away when the boat docked at the jetty. Mr Symington recalled that while the deckhand was still tying up the boat to the jetty and the engines were still running, a male passenger was already climbing out of the boat on the right hand side and then more people got off while he was still completing the tying off.[187] Mr Symington did not see anyone do a head count and doubted they would have had time as people got off the boat so fast.[188]

109. Another passenger, Richard Ezzard, had found the conditions rough on the journey home and he expressed relief to get off the boat. He also did not remember a head count being conducted.[189]

110. One passenger, David Foster, recalled that the crew were at the steps when the passengers got on and off the boat, but he was unaware if a head count was ever done.[190]

111. Mr Jose said he was in no hurry to leave the boat, and he remained on board for a time. He did not recall seeing the skipper while the passengers were disembarking and did not recall seeing anything resembling a headcount.[191]

112. Nicholas Aves had remained on the boat as he wanted to thank the organisers, and he recalled that there were between six and ten people still on board the boat when he left. He had seen some guests exit the boat immediately after they had reached the jetty, and he did not believe that a head count was completed before that occurred.[192]

113. Ms Goodwin was one of the last people to leave the boat as she was trying to find her handbag. She did not recall seeing the deceased on the journey back to Fremantle. After getting off the boat she went to the Norfolk Hotel, which I refer to below.[193]

114. Ms Hill and Mr Place were some of the last passengers to leave the boat. Ms Hill did not pay attention to who was leaving as she was busy packing

[185] Exhibit 2, Tab 18 [36].
[186] Exhibit 2, Tab 26.
[187] T 185 – 187.
[188] Exhibit 2, Tab 24 [50].
[189] Exhibit 2, Tab 38.
[190] Exhibit 2, Tab 33.
[191] T 144; Exhibit 2, Tab 17.
[192] Exhibit 2, Tab 16.
[193] Exhibit 1, Tab 14.

things and assisting people to collect their belongings. Not all of the alcohol provided by Pepper had been drunk during the trip. Ms Hill recalled looking in the blue esky at the end of the trip and noting that there were no Carlton Dry or Corona beers left (which included the additional beer provided by Mr Lippiatt). There were, however, a total of 21 bottles of wine and sparkling wine left.[194] Ms Hill and Mr Wood recalled there being some pressure from Mr Lippiatt to get off the boat quickly as he indicated to them he had another function booked (although there is no evidence this occurred). As a result, Ms Hill and Mr Place decided to leave the remaining alcohol behind. Ms Hill recalled it was about 4.00 pm when they alighted from the boat and the boat left immediately. By the time Ms Hill, Mr Wood and Mr Place left the boat most of the guests had dispersed.[195]

115. Mr Crane's evidence was that Mr Lippiatt was driving the boat from the fly bridge as they pulled in to the Fremantle Harbour and he was pretty sure that Mr Lippiatt remained up there as they approached the jetty and Mr Crane tied up the boat.[196] Mr Crane gave evidence that he did not conduct a headcount as the passengers were leaving the boat, and in fact he noted the passengers "were pretty much all off the boat before we had even really finished tying up."[197] Mr Crane had rolled up one of the clear blinds on the right hand side of the boat before they had reached the jetty in order to put the bow line on, so the passengers would have been able to leave the boat through that area. Mr Crane also noticed that people were getting off around him where he was tying up at the stern of the boat.[198] He described them as getting off 'quite fast,"[199] with only one or two staying back

116. Mr Crane did not see Mr Lippiatt conduct a headcount when the guests were leaving and in Mr Crane's opinion, given the timing of events and the way the passengers were getting off the boat, there was not any opportunity for Mr Lippiatt to conduct a head count before people got off the boat.[200] Mr Crane confirmed that Mr Lippiatt would not have been able to see the passengers disembarking from the flybridge, where he was driving the boat in towards the jetty, as his view would have been obscured by the canopy.[201]

117. Mr Lippiatt was asked whether any passengers had disembarked before he conducted his final headcount. Mr Lippiatt accepted that this can occur and conceded it was possible some passengers had done so, although he did not believe that it had happened on this day.[202] Mr Lippiatt claimed that if any passengers had disembarked before he began his final headcount, it would have been very easy to see them and he would have included them in his headcount.[203] Mr Lippiatt did not accept that it was possible that passengers may have got off the boat so quickly that he was unable to include them in a headcount.

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[194] Exhibit 2, Tab 6 (Statement 19.11.2014) [25] – [28].
[195] Exhibit 2, Tab 6 (Statement 7.11.2014 and 19.11.2014).
[196] T 213 - 214.
[197] T 213.
[198] T 216.
[199] T 228.
[200] T 217.
[201] T 217.
[202] T 329, 340 - 341.
[203] T 329 – 330, 340 – 341.

118. Mr Lippiatt agreed that his purpose in conducting a final headcount when they returned to Fremantle was "quite simply to make sure that the amount of people that went out have come back."[204] At the conclusion of his evidence Mr Lippiatt maintained that he had achieved this objective and that the deceased got off the vessel at Sardine jetty.[205]

119. Weighed against all of this evidence of the passengers and Mr Crane about the general impossibility of a headcount being conducted when the boat returned to Sardine jetty, is the evidence of Mr Lippiatt that he did conduct a headcount when the boat returned to the jetty. Further, Mr Lippiatt maintains that the headcount was accurate and reliable, and should be taken as persuasive evidence that the deceased returned to shore that afternoon.

120. As noted above, Mr Lippiatt did not make a recording of this final headcount in the vessel's logbook. There was only the single entry of a headcount in the logbook, which was dated but not timed. Mr Lippiatt gave evidence at the inquest he had made the entry into the logbook at Rottnest Island when they were anchored.[206] This related to the first headcount conducted at the start of the day. The Logbook entry read "35 POB. Crew Dan, Aaron". Mr Lippiatt told Senior Constable Brandhoff when he was interviewed by police that he used POB to stand for passengers, which he recorded as 35 POB, and the crew were in addition to that amount, making a total of 37 persons on board that day.[207] However, Mr Lippiatt conceded in evidence that he may have initially told police, when spoken to by telephone on the afternoon of 1 November 2014, that his headcount had recorded 33 guests and two staff (a total of 35 people on board). His evidence was that, if he said this, it was a mistake.[208] Mr Lippiatt acknowledged that at the time he would have been on a charter, so he would have had access to his logbook to provide that information.

121. It is interesting as evidence was also given by Senior Constable Brandhoff that in his experience it is commonly known in the marine environment that the abbreviation 'POB' refers to 'persons on board,' meaning the total number of people on the boat including the crew. In comparison, 'PAX' is used to indicate the number of 'passengers on board' or the full word 'passengers' would be used.[209] Senior Constable Brandhoff accepted in questioning that it was possible a skipper might use the terminology in a different way, although that was not his experience of how 'POB' is used.[210] Mr Lippiatt's first conversation with police was consistent with this practice.

122. If this was what had been done, it might explain how, even if Mr Lippiatt did a final headcount he might not notice the deceased was missing. If he incorrectly thought there were only 33 passengers, rather than the actual 34 passengers on board, then he wouldn't notice if the deceased was missing at the end.

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[204] T 332.
[205] T 344.
[206] T 312.
[207] T 73.
[208] T 324; Exhibit 2, Tab 39.
[209] T 68 – 71.
[210] T 71.

123. However, Mr Lippiatt maintained at the inquest that his entry referred to passengers only, and not all persons on board.[211] He also emphasised that he did three headcounts, including the second one at Parakeet Bay when the deceased was definitely still on board, so he maintained there were always 35 passengers on board and his headcounts were all accurate.[212]

124. Mr Lippiatt was asked what his purpose was in conducting headcounts, and he responded, "From my perspective, the more head counts that you can do, the better."[213] When asked the reason for his view, he indicated "for the reason that you've got people on board who are drinking alcohol and are in water."[214] He also accepted that it was to make sure that he had the right number of people on the boat.[215]

125. There was evidence before me from a Rottnest Island ranger to indicate that Mr Lippiatt had a practice of not logging in when arriving within the Rottnest Island boundaries and underreporting the number of passengers. On the day of the Pepper Australia charter, Mr Lippiatt had to be prompted by a ranger to log in, and when the trip was logged it was recorded that there were 12 adults and 5 children on board.[216] The ranger had made their own assessment of approximately 30 adults on board and no children visible, and the evidence in this inquest establishes that there were no children on board and 36 adults on board (or 37 on Mr Lippiatt's count). The visit was also logged as a 'non-charter', which is for vessels that are not carrying passengers for reward and equates to a visit for private use; a description that would obviously not apply to this commercial charter.[217] Mr Lippiatt's logbook entry had the same reference as was generated by the Rottnest Island Authority Charter Management System, so it is clear the entry relates to the call Mr Lippiatt made.[218]

126. Mr Lippiatt was asked about these discrepancies during the inquest. Mr Lippiatt denied that he had provided the information recorded about the number of adults and children on board. Mr Lippiatt's evidence was, "Definitely not, so obviously there's – there's a …major mistake there. So that is just ridiculous."[219]

127. I asked Mr Lippiatt whether the effect of that error was that he wouldn't be required to pay an admission fee as it was classified as a 'non-charter', but Mr Lippiatt confirmed that they would always have to pay a fee.[220] However, it was clear from the evidence that the fee is higher for adults than for children, and is charged per person, so the impact of the error would be that a lesser total of admission fees was payable by Mr Lippiatt to the Rottnest Island Authority. Based on the recorded information, $293 was payable to

[211] T 325.
[212] T 325.
[213] T 313.
[214] T 313.
[215] T 313.
[216] Exhibit 2, Tab 41.
[217] Exhibit 2, Tab 53.
[218] Exhibit 2, Tab 60.17.
[219] T 356.
[220] T 357.

RIA, whereas based on the 35 adult passengers Mr Lippiatt says he believed were on board (35 and two crew), $595 would have been due (assuming no fee is payable for the two adult crew). So the 'mistake', as Mr Lippiatt labelled it, was fortuitously in Mr Lippiatt's favour.[221]

128. Interestingly, the following day (on 1 November 2014) Mr Lippiatt again went to Rottnest Island and again had to be prompted by a RIA ranger to log in.[222] Mr Lippiatt's boat was seen by the ranger near Cathedral rocks, at the West End of the island and from what he could see, the ranger counted 35 persons on board. He sent a text to Mr Lippiatt to log on, to which Mr Lippiatt replied that he would. However, later that day Mr Lippiatt was seen in Thomson Bay by the same ranger, who noted Mr Lippiatt still had not logged on and again asked Mr Lippiatt to do so. The sole entry for that day is then recorded at 3.57 pm as a tour, with 22 adults and 3 children registered. The reference RI4486 was given.

129. Looking at the Logbook entries for the Ten-Sixty-Six on 1 November 2014, Mr Lippiatt has recorded two separate trips to Rottnest Island, the first being a whale watching trip from 8.00 am to midday that went to the West end of Rottnest. The Logbook records 49 POB and the names of two crew, which according to Mr Lippiatt would mean there were 49 passengers on board. There is no Rottnest Island Authority logon recorded for this trip, yet this would appear to be the group seen by the ranger out near Cathedral Rocks, given the location recorded in the logbook and the number of people counted by the ranger.

130. The second trip recorded in the logbook was in the afternoon, from 2.00 pm that day, and travelled to Thompson Bay. The login RI4486 is recorded next to this entry as well as 25 POB plus two crew members' names, including Mr Lippiatt. The Rottnest Island logon entry records 22 adults and 3 children, which would match the number of passengers recorded in the logbook (working on Mr Lippiatt's evidence as to how he recorded passengers as POB).[223]

131. The evidence strongly suggests to me that Mr Lippiatt omitted to log in the first tour to the Rottnest Island Authority, and when prompted by the ranger a second time, logged the second trip only. I acknowledge that this was not put to Mr Lippiatt in his evidence. However, if I assume that he would once again attribute this to a 'mistake', it was once again a mistake in Mr Lippiatt's favour, as he was liable to pay less money to the Rottnest Island Authority.

132. Considered within the context of the other evidence available to me, including that it was to his financial advantage to underestimate the number of passengers and age of the passengers, I do not accept Mr Lippiatt's evidence that he had no role in the incorrect information being recorded in the logon on 31 October 2014. The evidence of the incorrect login to the Rottnest Island Authority does not take the investigation into whether the deceased returned to Fremantle much further, although it certainly doesn't

[221] T 357 - 358.
[222] Exhibit 2, Tab 41.
[223] Exhibit 2, Tab 60.17.

assist in confirming that Mr Lippiatt's entry in the logbook stood for 35 passengers on board. In addition, it is relevant to my assessment of Mr Lippiatt's credibility generally.

133. Senior Constable Brandhoff gave evidence that the police gave consideration to whether a head count had occurred upon the Ten-Sixty-Six returning to Sardine Jetty that afternoon. Their investigation found "that there was no corroborative or specific information in those statements to indicate that there was a head count."[224] The witness statements indicated that a head count was done when the vessel was embarked in the morning, prior to leaving for Rottnest, but no similar evidence that one was done on their return.[225] The only evidence that any headcounts were done other than the first one, came from the skipper, Mr Lippiatt. The evidence heard at the inquest has not altered this position.

134. After considering all of the available evidence obtained during the police investigation, including the evidence of Mr Lippiatt and the vessel's logbook, Senior Constable Brandhoff formed the view that a headcount was not done when the Ten-Sixty-Six returned to Sardine Jetty at Fremantle Fishing Boat Harbour.[226]

135. The weight of the evidence strongly supports the conclusion that a final headcount was not done. I did not find Mr Lippiatt a convincing witness on this point. However, even giving Mr Lippiatt the benefit of the doubt and accepting that he did attempt to conduct a final headcount, I am not satisfied that any headcount he did was accurate. There was strong evidence that many of the passengers disembarked almost immediately at different parts of the boat, while Mr Lippiatt and Mr Crane were still tying up, which made any proper headcount an impossibility. Further, I note the confusion as to what 35 POB might mean (given Mr Lippiatt accepted he may have told the police initially it included the crew), the inconsistency with the known numbers of passengers and crew on the day, and the lack of any additional notation by Mr Lippiatt in the logbook, either by way of further entries of headcounts or even ticks to confirm he had counted the same number of people. All of these factors cause me to consider the evidence of a final headcount unpersuasive in establishing that the deceased made it back to shore in Fremantle that day.

Norfolk Hotel and any other evidence the deceased disembarked

136. After disembarking a number of passengers went on to the Norfolk Hotel in Fremantle. There was some early suggestion, when the deceased's family were trying to locate the deceased the following day that he might have gone with those passengers to the Norfolk Hotel. However, as the evidence set out below shows, there is no reliable evidence that he did so.

137. Mr Allen was one of the passengers who went to the Norfolk Hotel that afternoon. Mr Allen, who had spoken to the deceased during the day, was

[224] T 16.
[225] T 16.
[226] T 18.

definite that the deceased did not go with them to the Norfolk Hotel and was not at the Norfolk Hotel with them at any stage.[227]

138. Mr Ayris, who had also met the deceased during the day, also went to the Norfolk Hotel with a group of four or five other passengers and was certain the deceased was not with them.[228] Mr Waters, who was part of the group at the Norfolk Hotel, similarly did not see the deceased there.[229] Mr Kahl, who was with the group, also did not recall seeing the deceased there.[230] Nilan Chandratilake had met the deceased on the boat and he was another guest who went on to the Norfolk Hotel. Mr Chandratilake also did not recall seeing the deceased at the hotel.[231]

139. Ms Symonds had walked to the Norfolk Hotel with Holly Rogers, Mr Chandratilake, Mr Jose and two other males (one possibly being Mr Allen). Ms Symonds recalls meeting up with Mr Hill, Mr Wood and Mr Baroni at the hotel and they all gathered around two tables in the courtyard. Ms Symonds says she cannot recall if the deceased was there or not, but it is clear she was there with other guests who are certain the deceased was not part of their group.[232]

140. Mr Jose also gave evidence he went on to the Norfolk Hotel with some of the other passengers, all of whom congregated at a table together. He did not recall seeing the deceased in that group.[233]

141. Ms Hill, Mr Place and Mr Wood decided to follow the guests to the Norfolk Hotel after they left the boat.[234] When they arrived at the Norfolk Hotel a number of the guests from the charter were already there. Ms Hill did not recall seeing the deceased there.[235]

142. Ms Goodwin also did not remember seeing the deceased get off the boat or later at the Norfolk Hotel.[236] Ms Goodwin's friend Ms Johnson initially thought she saw the deceased walking with them to the Norfolk Hotel (which is not consistent with Ms Goodwin's recollection) but she became unsure about this and indicated in her police statement, which she signed on the 3 November 2014, "now I don't know."[237]

143. Because of Ms Johnson's initial suggestion that the deceased may have gone with them to the Norfolk Hotel, police officers later obtained CCTV footage from the City of Fremantle and the Norfolk Hotel of that afternoon. The footage shows a number of the passengers en route to the Norfolk Hotel, but the deceased is not with them or in front of them. There is also footage of the passengers at the Norfolk Hotel but the deceased is not amongst them.[238]

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[227] Exhibit 2, Tab 1 [17].
[228] Exhibit 2, Tab 11 [43].
[229] Exhibit 2, Tab 21.
[230] Exhibit 2, Tab 27.
[231] Exhibit 2, Tab 30.
[232] Exhibit 2, Tab 37.
[233] T 144; Exhibit 2, Tab 17.
[234] Exhibit 2, Tab 20.
[235] Exhibit 2, Tab 6 [132].
[236] Exhibit 1, Tab 14.
[237] Exhibit 2, Tab 15 [41].
[238] Exhibit 2, Police Report, p. 14 and Tab 49 and Tab 50.

This is consistent with the accounts of all the passengers except Ms Johnson, who was uncertain as to her recollection of events.

144. The deceased's father said that the deceased did not have a backpack with him in the morning when he dropped the deceased at the jetty, so no surprise that none of his belongings were found by the crew or the Pepper staff at the end of the charter.[239]

145. Police obtained call charge records for the deceased's mobile telephone, which we know he had with him on the day, from Telstra. The records indicate that the deceased last used his phone to send an SMS at 2.10 pm Perth time on Friday, 31 October 2014 (which was around the time he sent a text to his son). All calls after that time were diverted calls or calls to the deceased's telephone, and he did not make any calls out.[240]

146. The deceased also had his wallet, but a search of the deceased's bank records show that he did not access his bank accounts on 31 October 2014 or thereafter.[241]

147. Senior Constable Bret Brandhoff from the Water Police gave evidence that the police investigation concluded that there was no evidence of the deceased having disembarked the boat at Fremantle.[242]

MISSING PERSONS REPORT

148. On the evening of 31 October 2014 Mrs Mills went to bed at midnight. She had not spoken to or heard from the deceased since that morning, other than being aware of the text the deceased had sent to their son around 1.00 pm. Ms Mills indicated that this lack of contact wasn't unusual as they would generally wait to see each other to talk about things, rather than talking to each other on the phone during the day. At the time she went to bed Mrs Mills did not believe there was anything out of the ordinary as the deceased would often return either late in the evening or early hours of the morning when he had gone out drinking on a social occasion.[243]

149. Mrs Mills woke up at about 4.00 am on Saturday, 1 November 2014 and noticed that the deceased had not returned. Again, given he sometimes stayed out until the early hours of the morning, she was not unduly concerned. Mrs Mills woke again at about 6.00 am and the deceased was still not home, which began to cause her some alarm. Mrs Mills sent the deceased a number of text messages expressing her concern about his whereabouts and welfare. When she did not receive a response, Mrs Mills attempted to call the deceased's telephone, but the calls were diverted from his mobile telephone to his office phone.[244]

[239] Exhibit 2, Tab 44.
[240] T 11; Exhibit 2, Tab 52, p. 11.
[241] T 11; Exhibit 2, Tab 52, p. 12.
[242] T 10.
[243] Exhibit 2, Tab 43.
[244] Exhibit 2, Tab 43.

150. Mrs Mills then contacted Joanne Hill, to see if she could shed any light on the deceased's movements.

151. Ms Hill recalls speaking to the deceased's mother at 8.45 am that day, who advised that the deceased was missing and asked for the name of the charter company. Ms Hill recalls being asked if the deceased was "pissed" and she "advised that he had been drinking but he did not make a spectacle of himself."[245] After speaking to the deceased's mother Ms Hill spoke to Ken McLennan, the deceased's State Manager at Loan Market, who mentioned that it wasn't uncommon for the deceased not to go home after a night of drinking (as confirmed by Mrs Mills).[246]

152. Ms Hill then left a message on Mr Lippiatt's phone advising him that someone from the charter was missing.[247]

153. Ms Hill was informed by Kathryn Mortimer that one of the guests, Danielle Johnson, remembered the deceased being at the Norfolk Hotel with them that evening. Ms Hill passed this information on to the deceased's mother but then Ms Hill spoke to Ms Johnson, who indicated that she wasn't sure she had seen the deceased at the hotel. Ms Johnson said that Paul Place was there, and it was made clear to Ms Johnson that Mr Place did not see the deceased at the Norfolk Hotel, which also made Ms Johnson doubt her recollection of seeing the deceased there.[248]

154. Ms Johnson and Felicity Goodwin, who were friends and accompanied each other to the Norfolk Hotel, then discussed the matter and it seems they thought that they recalled the deceased walking ahead of them to the Norfolk Hotel, but couldn't be sure he went inside.[249]

155. Ms Hill spoke to the deceased's mother again to update her and was told that it was believed the deceased had telephoned a friend from a hotel that afternoon, although his phone records do not reflect that a call was made.[250]

156. It is apparent that there was a lot of confusion around this time as to whether the deceased had gone on to drink at the Norfolk Hotel or another pub the previous afternoon. When the deceased's whereabouts had still not been able to established despite everyone's best efforts, including looking at bank account activity etc, the deceased's family sought the assistance of police. At about 11.15 am Mrs Mills and the deceased's parents attended at the Cannington Police station and reported the deceased as a missing person.[251]

[245] Exhibit 2, Tab 6 (Statement 7.11.2014) [140].
[246] Exhibit 2, Tab 6 (Statement 7.11.2014).
[247] Exhibit 2, Tab 6 (Statement 7.11.2014) [142].
[248] Exhibit 2, Tab 6 (Statement 7.11.2014) [143] – [146].
[249] Exhibit 2, Tab 6 (Statement 7.11.2014) [147].
[250] Exhibit 2, Tab 6 (Statement 7.11.2014) [148].
[251] Exhibit 2, Tab 52, p. 10.

DISCOVERY OF THE DECEASED'S BODY

157. At the same time on the morning of 1 November 2014 a Perth family were out fishing on their boat off the WA coast. When they were 3 nautical miles off Leighton Beach they saw something in the water. As they got closer they realised it was the body of a male person floating face down in the water. They reported their discovery to the police and then waited near the body to ensure it was undisturbed.[252]

158. At about 12.10 pm on Saturday, 1 November 2014, Senior Constable O'Meara was on patrol in a police vessel when he received a radio call from Water Police Base to attend the vicinity offshore from Leighton Beach at a specified latitude and longitude due to the report of the body found floating on the surface of the water. Senior Constable O'Meara and his partner arrived at the location approximately five minutes later. They immediately noticed what appeared to be the lifeless body of a male person floating face down in the water. They lifted him on board the vessel, which was a difficult process due to his weight and the movement of the ocean.[253]

159. Once the body was on board it was evident the person was deceased as rigor mortis was present. It appeared to Senior Constable O'Meara, based on his experience dealing at Water Police, that the person had been in the water for at least several hours. The person was wearing only a pair of black underpants and had a yellow metal chain around his neck and a wedding ring on his left finger. They returned to the Water Police base.

160. Shortly after their return Sergeant Michael Wear examined the body and noted that the person had no identification on him and that his clothing was definitely underpants and not speedos, which suggested that the person was not a swimmer who had come into difficulty. Shortly afterwards the Water Police received a telephone call from Cannington Police Station who notified the Water Police that they had received a missing person's report from Mrs Mills, indicating the deceased had last been seen on a charter the day before. They were provided with a description of the deceased and information about the deceased's distinctive tattoo, by which means the body was identified as being that of the deceased.[254]

CAUSE OF DEATH

161. On 4 November 2014 Dr C T Cooke, the Chief Forensic Pathologist, conducted a post mortem examination of the deceased at the State Mortuary. The examination showed minor injuries to the skin, with no significant internal injury. There was congestion and hyper-expansion of the lungs, with some increased fluid in the small airways. The body organs appeared to be otherwise healthy.[255]

[252] Exhibit 2, Tab 42.
[253] Exhibit 2, Tab 1.
[254] T 272; Exhibit 2, Tabs 1 and 3.
[255] Exhibit 2, Tab 61.

162. Despite evidence that the deceased had been drinking alcohol on 31 October 2014, toxicology analysis detected no alcohol or common drugs. I will come back to the significance of this evidence later.[256] A small amount of acetone was found in the urine, but it was considered it was unlikely to be relevant to the cause of death and was thought to be possibly a post mortem phenomenon.[257]

163. At the conclusion of all investigations Dr Cooke formed the opinion that the cause of death was consistent with immersion; in other words, drowning. I accept and adopt the conclusion of Dr Cooke as to the cause of death. I note that Dr Paul Luckin, who has considerable expertise in search and rescue operations and is often asked for his advice on survivability during such operations, also expressed the opinion the deceased probably died of drowning with contributory factors of exhaustion, hypothermia and dehydration.[258] I refer to Dr Luckin's evidence in further detail below.

HOW DID THE DECEASED COME TO BE IN THE WATER?

164. There was no dispute at the inquest that the deceased drowned in the Indian Ocean some time before he was found around midday on 1 November 2014. The question is how and when he came to be in the water?

165. Senior Constable Bret Brandhoff from Water Police prepared a report following his investigation into the events of 31 October 2014 and gave oral evidence at the inquest. Senior Constable Brandhoff noted that the course and speed of the vessel on the return journey would have placed them in the vicinity of the Southern Leads at about the time the passengers reported a series of larger waves hit the boat. The Southern Leads is an area in the Indian Ocean approximately two-thirds of the distance from Fremantle to Rottnest Island. It is marked by two metal pylon markers in the ocean at that point, which are used for navigation purposes, although the channel is not generally used for shipping anymore.[259] The Southern Leads is also often referred to as the 'Windmills.' Although all the water between Rottnest Island and the mainland is designated as protected waters, it is commonly known locally that on the boat journey between Rottnest and Fremantle the most likely place to experience rougher conditions will be in the vicinity of the Southern Leads. Other parts of the journey are sheltered by Rottnest Island, Garden Island or reef, but in the Southern Leads area it is more exposed, hence the rougher conditions experienced in that area. This area is also more exposed to the wind when it is coming from a southerly direction, as it was on this day, particularly with the sea breeze.[260]

166. Based upon the general knowledge of the rough seas experienced at this location and the witness accounts of events, and with no reliable sighting of the deceased after this point, one working theory at the outset of the

[256] Exhibit 2, Tabs 61 and 62.
[257] Email correspondence between Dr Moss and Counsel Assisting dated 7 June 2017.
[258] Exhibit 2, Tab 51.
[259] T 274.
[260] T 9 – 10, 270; Exhibit 2, Tab 52, p. 7.

investigation was that the deceased fell from the boat in the vicinity of the Windmills.

167. However, putting that working theory to one side, without any knowledge of witness accounts or suggestions as to exactly how the deceased may have come to be in the water other than knowing the charted course of the charter boat, Sergeant Wear, who is a trained Marine Search & Rescue Coordinator and was working at the Water Police at the time, did some mapping to see what possibilities might be worth considering. Sergeant Wear used a computer software program known as SARMAP, that is used by all Search and Rescue agencies across Australia. It is a sophisticated drift modelling system developed by oceanographers and oceaneers that factors in variables as to how objects may drift. Those variables include sea currents and wind directions, as well as known details about the object (for example, if a person is wearing a lifejacket).[261]

168. As a simple explanation of how SARMAP works, Sergeant Wear described the program as effectively dropping 500 balls into a position and then calculating where those balls will drift based on the known variables. It is commonly used in Search and Rescue to try to locate a missing vessel or person, projecting forward from their last known location, but can also be used to backtrack from the location of a known object to plot its path. In this case, Sergeant Wear used SARMAP to backtrack from the known location where the deceased's body was found to try to determine the most likely possibility as to where his body may have come from.[262]

169. Sergeant Wear ran a backwards SARMAP program from 12.00 pm on Saturday, 1 November 2014 to 12.00 pm on Friday, 31 October 2014. It showed that if the deceased's body had remained on the surface of the water then over the 24 hour period it would not have drifted very far over this period, travelling a distance estimated as no further than two nautical miles.[263]

170. Plotting a course from Parakeet Bay back to Fremantle, Sergeant Wear also used the SARMAP to determine the most likely location where the deceased might have fallen off the charter boat, if that is what occurred. The modelling indicated that it was very unlikely the deceased entered the water at Parakeet Bay or Thomson Bay at Rottnest Island, with the probability scoring very low. This accords with witness accounts, that discounted this as a likely option given the deceased was seen on the boat at the early part of the journey.[264]

171. Sergeant Wear also ran modelling based on the scenario that the deceased fell or jumped into the water after the charter boat had returned to Fremantle Fishing Boat Harbour, to see whether his body could have drifted from the harbour out to sea. The modelling showed that 99% of the balls stayed within Fishing Boat Harbour, and none of the balls moved to the location where the deceased was found. The results indicated to Sergeant

[261] T 13; 272.
[262] T 273.
[263] Exhibit 1, Tab 7, p. 3.
[264] T 275 – 279.

Wear that it was highly unlikely the deceased entered the water inside Fishing Boat Harbour.[265] Senior Constable Brandhoff later ran the same modelling and concluded there was zero chance that the deceased entered the water at the harbour.[266]

172. In addition, Sergeant Wear modelled a scenario based upon a person entering the water and/or swimming out from Port Beach/Leighton Beach, in the vicinity of where the deceased's body was found in the water. The modelling found that the majority of the balls stayed within the vicinity of the coastline, suggesting it was very unlikely the deceased entered the water at that location.[267] Senior Constable Brandhoff also did the same modelling and found zero probability that the deceased had gone for a swim from that beach, as the modelling showed he would have been pushed back to shore.[268]

173. The mapping therefore supported the conclusion that the deceased did not reach the location where his body was found by entering the water from, or near, the mainland shore. This focussed attention on the deceased coming off the charter boat that afternoon. The only other real possibility was that after leaving the charter boat the deceased somehow embarked on another boat or watercraft afterwards, which suffice to say is very unlikely.[269]

174. Sergeant Wear's evidence was that the results of the modelling based on a scenario where the deceased fell off the charter boat in the vicinity of the Windmills showed it was highly probable that the deceased had come from that location and only drifted a few miles overnight to where his body was located.[270]

175. Based on his experience, Sergeant Wear considered the fact that the deceased was found wearing only his underwear was consistent with the deceased being alive when he came off the boat and attempting to swim. Sergeant Wear explained that it was common in Search and Rescue operations in water to find people naked as they will kick of their clothing to prevent being dragged down, as well as due to hypothermia, which is accelerated by swimming. The SARMAP does not include as a variable that a person in the water might be swimming, as it is too difficult to estimate. It works on the basis of a drifting object only. Nevertheless, if the deceased did attempt to swim, it did not take him outside the area where he might have drifted without any swimming effort.[271]

176. Based upon all of the modelling and information available to Sergeant Wear (which did not include a review of the witness statements), Sergeant Wear formed the opinion that the deceased fell from the back of the charter boat somewhere between three and six nautical miles from the entrance of the Fishing Boat harbour on the Friday afternoon in the window of approximately 3.15 pm to 3.45 pm. He then tried to swim, hence kicking off

[265] T 276 - 277.
[266] T 15.
[267] T 278.
[268] T 15.
[269] T 295.
[270] T 282 – 283.
[271] T 280, 285.

his clothing, and stayed on the surface for quite some time, rather than going under the water and re-floating.[272]

177. An expert opinion was obtained from Dr Paul Luckin, who has extensive experience in Search and Rescue and regularly provides advice on survivability during Search and Rescue operations conducted by AMSA and police around the nation. Dr Luckin provided an opinion as to the length of time the deceased may have survived in the water if he had fallen off the boat at approximately 3.30 pm on Friday, 31 October 2014. Dr Luckin indicated that at the speed the vessel was reported to be travelling the deceased would be unlikely to have received any injury other than by striking the boat itself. He noted the results of the post mortem examination were consistent with the deceased not having sustained any significant injury.[273]

178. Dr Luckin also noted the presence of chafing on the rear of the deceased's knees and under his armpits, which suggests that he swam for some time before his clothing was removed. Dr Luckin was unclear if the deceased's clothing was then removed by wave action or intentionally. However, the chafing does suggest the deceased survived for at least a short while in the water. Further, the absence of alcohol in the deceased's blood, following reports that he had been drinking alcohol steadily throughout the day, indicated that the deceased survived long enough to metabolise the alcohol in his blood when he entered the water. Dr Luckin used a widely accepted rate of elimination of alcohol to estimate a minimum survival time of loosely 4 to 6 hours based on the available information. However, the lack of any sea water inside the deceased suggests the death may have been earlier rather than later in that timeframe.[274]

179. Based upon all the information provided to him, Dr Luckin anticipated the deceased's maximum survival time under the prevailing conditions was in the order of 12 to 18 hours (ending before he was first reported missing) and a more probable survival time was about 10 to 12 hours. The reduced time took into account factors such as the absence of a life jacket and the effect of hypothermia and darkness. In conclusion, Dr Luckin proffered the opinion that the deceased's likely time of death in those circumstances was between 5.30 pm on Friday, 31 October 2014 and 3.30 am on Saturday, 1 November 2014.[275]

180. Senior Constable Brandhoff's conclusion was that the evidence he compiled supported the conclusion the deceased died at sea due to being a 'man overboard' from the Ten-Sixty-Six on the afternoon of Friday, 31 October 2014.[276]

181. Despite the compelling nature of the Water Police SARMAP testing, as well as the other evidence obtained (although I note Mr Lippiatt indicated he had elected not to sit in and listen to the other witnesses' evidence so he had not

[272] T 285 – 286; Exhibit 1, Tab 7, p. 3.
[273] Exhibit 2, Tab 51.
[274] Exhibit 2, Tab 51.
[275] Exhibit 2, Tab 51.
[276] Exhibit 2, Tab 52, p. 18.

heard, for example, Mr Crane's evidence), Mr Lippiatt maintains that the deceased was delivered safely back to Sardine Jetty after the charter trip. Mr Lippiatt stated definitively "I don't believe he fell overboard, no."[277] Mr Lippiatt did not accept there was any risk that a person may have inadvertently or unintentionally gone overboard. He maintained that it would only have occurred if they jumped in or were pushed. In his opinion, this included any passenger sitting on the blue esky.[278] Further, Mr Lippiatt expressed the opinion that there was zero likelihood that this occurred without being seen by another person.[279] Mr Lippiatt conceded in evidence that he had no specific recollection of the deceased leaving the boat, but he indicated he relied upon the accuracy of his headcount and his firm belief that the deceased would have been seen by passengers, crew, or other vessels travelling in the area if he had fallen overboard.[280] He also relied to a lesser extent on the suggestion the deceased may have gone on to the Norfolk Hotel.[281]

182. I have indicated above my views on the inherent unreliability of any final headcount, if it was done, as well as the uncertain evidence of Ms Johnson in relation to seeing the deceased walking to the Norfolk Hotel. The accounts of the various passengers and Mr Crane also explains why the deceased may have fallen from the boat and not been seen or heard. Most of the guests mentioned that it was noisy on the journey back. There was a lot of noise from the engines and the iPod was playing loud music over the top of this. The noises were loud enough to limit the ability of people to speak to each other, unless they were very close.[282] They were also focussed on holding on and distracted by other passengers falling.

183. Having considered all of the evidence Senior Constable Brandhoff obtained, and the additional evidence heard and received at the inquest hearing, including the evidence of Mr Lippiatt about doing a headcount, I accept Senior Constable Brandhoff's conclusion that the deceased fell off the Ten-Sixty-Six on the afternoon of Friday, 31 October 2014.

184. Given the lack of an eyewitness to this event, I am unable to determine exactly when this event occurred. However, I note there was general agreement amongst the passengers on board that it would have been possible for the deceased to have fallen overboard during the return trip and not be seen. Many of them nominated the occasion when the two large waves hit the boat as the time this was most likely to have occurred and not attracted the notice of the other passengers, given they were largely focussed on Mr Allen. In addition, Ms Merritt, who I found to be a very credible and reliable witness, expressed the view that it was equally likely the deceased may have fallen over due to a domino effect of people falling when Ms Mortimer fell. Each time this occurred it drew the attention of many of the passengers, including importantly Mr Tracey, who had to turn to his right side and catch Ms Mortimer at least twice. This was prior to the large

[277] T 359.
[278] T 333 - 334.
[279] T 335.
[280] T 345, 359 - 360.
[281] T 359 – 360.
[282] Exhibit 2, Tabs 9, 10, 11, 18.

waves hitting the boat, but the conditions were still rough.[283] The deceased was not seen again after the large waves hit the boat, so the evidence supports the conclusion he fell off either shortly before the large waves hit, as suggested by Ms Merritt, or when the large waves hit, as suggested by most of the other passengers.

185. There is no suggestion that anyone else was involved in causing the deceased to fall off the boat, other than the suggestion he might inadvertently have been knocked off balance as others fell. There is also no evidence to suggest that he would have deliberately jumped from the boat. On the contrary, the evidence supports the conclusion that he was a family man with a thriving business and everything to live for, and he was happy and well that day. There was evidence that the deceased was intoxicated. Although there is no suggestion he was at the point of being unable to care for himself, it may have made him unsteady on his feet, which would have made it harder to keep his footing in circumstances where the boat moved suddenly and he was perhaps knocked sideways. Once in the water, he tried to swim but eventually succumbed and drowned.

186. Based upon all the evidence available to me, I find that his death occurred by way of accident.

COMMENTS ON PUBLIC SAFETY

187. Under s 25(2) of the *Coroners Act 1996*, where a death is investigated by a coroner, the coroner may comment on any matter connected with the death, including public safety.

188. I note that during the inquest I was provided with some evidence about actions taken against Mr Lippiatt's company that operated the Ten-Sixty-Six and other vessels, including a suspension of the certificate of operation, following an investigation by the WA Police and the Western Australian Department of Transport on behalf of the National Regulator, AMSA. I was then advised that, following some steps that were taken by the operators to meet the suggested conditions of operation and after AMSA received legal advice, the suspension was removed and ultimately no National Law charges were pursued against Mr Lippiatt or his company.[284] Given the outcome of the investigations, I have not given much regard to them in this finding.

189. Nevertheless, separate to those proceedings, there are general safety issues that have been raised in this inquest that deserve some attention and comment.

Keeping a watch and general safety

190. As noted earlier, there was general agreement amongst the passengers on board that it would have been possible for the deceased to have fallen overboard during the return trip and not be seen. Many also described the

[283] T 153 – 154.
[284] Exhibit 1, Tab 15.

rough conditions and the loud music playing on board, noting it would have been hard to hear anyone calling out if they had gone overboard.[285]

191. Mr Tracey, who recalled the initial safety briefing at the start of the trip and described it as "quite good,"[286] commented that "[t]hey should have made people sit down on the way back because it was too rough."[287] Another passenger, Ms Merritt, gave similar evidence that she believed a briefing prior to the return journey should have been done, with an instruction to passengers to stay seated as much as possible because it was going to be rough. Ms Merritt suffers from sea sickness so she actually made enquiry with the captain before their return journey to ask if it was going to be rough. He told her that it would be, so she was appropriately forewarned. However, Ms Merritt felt that the rest of the passengers should also have been properly warned about the likely rough conditions.[288]

192. Similarly, Nicholas Aves told police that there was no notice from the crew that they were leaving Parakeet Bay, prior to their departure, and he believed there should have been some advice given to the passengers about the types of conditions to expect, given the conditions they then experienced. Mr Aves also stated the crew did not supervise the guests on the trip back.[289] Mr Aves told police that he did not find it an enjoyable day as he had been concerned throughout the trip that someone would get hurt, although it had not occurred to him that someone might go overboard.[290]

193. I acknowledge Mr Lippiatt gave a relatively thorough safety briefing on the way over, but I do not accept his evidence that he gave a briefing to passengers before they returned, advising them of the likely rougher conditions and telling them to remain seated. I also do not accept Mr Lippiatt's evidence that he and Mr Crane were supervising the passengers on the return trip, prior to the incident involving Mr Allen being struck in the nose. The weight of the evidence of Mr Crane and the passengers was that there was no additional safety briefing when they were leaving Parakeet Bay and there was no supervision of the passengers in the early stages of the trip. This was despite the fact that there was clear evidence that many of the passengers had been drinking alcohol throughout the day and were affected by that alcohol. The fact that guests were known to be intoxicated increased the onus on the crew to ensure that people were aware of potential safety issues on the return trip and monitored for their own safety.

194. From that safety point of view, the passengers should have been informed of the likely rougher conditions on the return journey and the need to stay seated and then for a crew member to remain on watch outside to ensure that those instructions were followed, that passengers did not require assistance and that all passengers remained safely on board. In effect, largely what Mr Lippiatt said afterwards was done, but which I do not accept

[285] T 87, 127.
[286] Exhibit 2, Tab 12 [49].
[287] Exhibit 2, Tab 12 [50].
[288] T 146; Exhibit 2, Tab 35.
[289] Exhibit 2, Tab 16.
[290] Exhibit 2, Tab 16.

was in fact done that day. Noting the evidence below of the likelihood that the deceased would have been found and saved if a man overboard had been reported at the time he went overboard, the importance of oversight of the passengers by sober and trained crew cannot be underestimated.

Lifejackets

195. Sergeant Wear gave evidence that if a person in the water is wearing a lifejacket it makes them easier to locate.[291] He also agreed that a lifejacket is likely to extend the person's survival timeframe in the water, as it will assist them to stay afloat even when fatigued. However, Sergeant Wear qualified this comment on the basis that the lifejacket needs to be put on correctly for it to be of use.[292]

196. Senior Constable Brandhoff also expressed the opinion it would have made a difference to his survivability if the deceased had been wearing a lifejacket, as it would have assisted him to keep his head out of the water, which would have reduced the risk of immersion. From a search and rescue perspective, lifejackets are obviously recommended for this reason, as well as the fact that it makes people easier to locate.[293]

197. There is no requirement that a passenger on a commercial charter must wear a lifejacket. The only requirement is that the vessel must have a life jacket on board per person for the number of persons that the vessel is surveyed to carry.[294] The evidence of the Water Police officers raises the question whether I should recommend that it should be mandatory for lifejackets to be worn in open seas on a commercial charter such as this one?

198. While not being against the idea, Senior Constable Brandhoff accepted in his evidence that there would be issues with ensuring compliance, if wearing lifejackets was mandated[295]

199. The General Manager of Marine Safety at the WA Department of Transport, Mr Raymond Buccholz, provided a report to the Court[296] and gave oral evidence at the inquest. He advised that the Department of Transport is undertaking a review into the wearing of lifejackets on recreational boats, acknowledging that "information we've received from key stakeholders such as Surf Life Saving Australia and … police and others is that if you are wearing a lifejacket and you find yourself in the water your chances of survival increase significantly."[297] With that in mind, the Department of Transport has a requirement that each of its employees must wear a lifejacket at all times on board any Department of Transport boat and the Department tries to promote the wearing of lifejackets at all times. Similarly, the master of a commercial charter boat can require passengers to don

[291] T 289.
[292] T 289.
[293] T 31 – 32.
[294] T 27.
[295] T 31 – 32.
[296] Exhibit 1, Tab 9.
[297] T 250.

lifejackets at any time, if they consider it necessary for their safety.[298] However, Mr Buccholz noted "the question is whether it should be mandated or not."[299]

200. Mr Buccholz noted that one problem is that the lifejackets used on board such charter operations are not comfortable to wear. Changing them to other types would have financial implications for commercial operators such as Rottnest Express, both in terms of purchase but also in service costs.[300] It is a significant issue when balanced against the fact that the incidents of people falling overboard accidentally are rare.

201. I am aware from another inquest that AMSA is looking into the viability of making wearing a lifejacket a requirement in some circumstances with commercial operations, such as for commercial fishermen, where the risk of going overboard without being observed is statistically higher, and this was acknowledged by Mr Buccholz.[301]

202. It was not urged upon me by counsel on behalf of the deceased's family that I make a recommendation in relation to the mandatory wearing of lifejackets. I acknowledge that it is a complicated issue and that it would require careful consideration, and industry input, before any such step was taken. I indicated at the conclusion of the inquest that, given the complexity of the issue, I was not minded to make a recommendation that the wearing of lifejackets should be mandated. However, it is important that people are aware that their ability to survive in the water, and to be found by searchers, is greatly increased when wearing a lifejacket. I know that the Department of Transport currently disseminates such information and promotes the routine wearing of lifejackets, and hopefully the message will continue to be spread. It is a matter for the individual whether they choose to heed that message.

Requirement to do a headcount

203. Sergeant Wear's opinion, based upon previous search experience, was that if police were informed of a man overboard situation immediately after the deceased entered the water in the vicinity of the Windmills, there was an extremely high probability that the deceased may have been found alive.[302] Sergeant Wear was prepared to put the probability of successfully finding the deceased if he was alive categorically at "99.9%."[303] This was true even if the deceased was alive but unconscious, although Sergeant Wear noted he believed the evidence suggested the deceased had been conscious in the water, at least for a period.[304] Sergeant Wear explained that the Water Police could have had vessels and helicopters in the vicinity of that location within minutes and 15 to 20 vessels there within half an hour. With those resources, he estimated that he would expect them to find the deceased

[298] T 252.
[299] T 250.
[300] T 251 - 252.
[301] T 252.
[302] Exhibit 3, Tab 7, p. 4.
[303] T 286.
[304] T 295 – 296.

within one to two hours, at most.[305] That would fit within the time frame of survival given by Dr Luckin.

204. If police had been notified that the deceased was missing at the time the vessel returned to the Fremantle Fishing Boat Harbour, at approximately 4.00 pm, Sergeant Wear indicated that the Water Police would have tasked helicopters to run the route taken by the charter boat from Fremantle Harbour back to Parakeet Bay as an immediate starting point. They would also have got vessels to run that route, breaking up the route into sections for them to search, with the knowledge that he couldn't have drifted far from the track line in that space of time. The timing of the notification is important in that regard, as the closer in time the search and rescue can begin, the more confined the area that is required to be searched.[306]

205. In that regard, as well as getting assets immediately on to the scene, police officers would have attended the charter boat to interview the crew and other passengers to try and ascertain the last time the deceased had been seen and any unusual events that had occurred, in order to narrow the search area and increase the probability of finding the deceased.[307] Police officers would also have spoken to the deceased's family to try to find out information about the deceased, such as his swimming ability, general health and medications, and even any known demeanour in a fight or flight situation to ascertain a timeframe of survival. Experts such as Dr Luckin would also assist in that regard.[308]

206. Based upon his own experience, Sergeant Wear expressed the opinion that notification at 4.00 pm, or even 4.30 pm, would still have given the Water Police a fairly high chance that they would have found the deceased, and found him alive.[309] Expressed another way, Sergeant Wear stated that it was "highly likely" a Search and Rescue team would have found the deceased if they had been notified when the charter boat returned to the harbour.

207. Senior Constable Brandhoff also expressed the opinion, based on his own experience of police water search and rescue operations, that in this instance, if police had been notified promptly of a missing person at sea, the coordination and tasking of search and rescue assets would have significantly increased the likelihood of locating the deceased on the afternoon of Friday, 31 October 2014.[310]

208. I accept the evidence of Sergeant Wear and Senior Constable Brandhoff that the fact that the deceased was not identified as missing when the boat returned to Sardine Jetty resulted in a missed opportunity to save the deceased. I accept it was highly likely that he might have been found alive if a prompt search had been able to be initiated, and at the very least it is almost guaranteed that they would have found his body in a timely manner.

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[305] T 286.
[306] T 286 – 287.
[307] T 30, 287, 289 - 290.
[308] T 13, 288.
[309] T 288 – 289.
[310] Exhibit 2, Tab 52, p. 20.

209. I have not mentioned thus far the other aspect of the National Law that might relate to headcounts, and that is the part relating to a requirement to have a Safety Management System. Aside from the conditions imposed on the certificate of operation, the owner and master of the vessel have general safety duties imposed by the National Law. Among other things, the National Law requires that the owner must implement and maintain a safety management system (SMS), and the skipper must implement and comply with the SMS.[311] The risks identified and addressed in an operator's SMS are a matter for the operator to determine, but guidance is provided as to general safety duties and twelve operational requirements set out in Schedule 2 of the current version of the National Standard for Commercial Vessels Part E.[312]

210. In this case, Mr Lippiatt as the operator and skipper of the Ten-Sixty-Six had implemented an SMS. Mr Lippiatt gave evidence that he did not write the Safety Management Plan but had one of his employees write it. Mr Lippiatt said it was done in anticipation of the change in legislation, and implementation of the National Law, that would require a safety management system for a certificate of operation. Mr Lippiatt described his SMS as in "its very, very premature stages"[313] and claimed it had only been brought in a couple of weeks prior to the charter. Mr Lippiatt acknowledged he had read it at that time but maintained it would have undergone a lot of changes before being finalised. It was Mr Lippiatt's evidence that he did not believe it had any legislative effect until the relevant changes to the law came into effect in 2016, but indicated it was put with the certificate of operation in the wheelhouse to try and bring in the plan so "we could be at the top of our game when we were actually made to have it."[314] Mr Lippiatt accepted that most of the things included in the safety management plan were common sense and formed a sound safety management plan, based at least to some degree on practices already in place on his boats.[315]

211. Relevantly to this inquest, the SMS on the Ten-Sixty-Six set out that "[p]assengers will always be counted on and off the vessel and the numbers recorded in the vessel's logbook."[316] Mr Lippiatt agreed that on 31 October 2014 the accepted procedure was that the passengers were counted on and off the vessel and the passenger numbers were recorded, as per the plan.[317] There was, however, no set procedure as to how those headcounts were to be conducted.[318]

212. I note that Mr Lippiatt gave evidence that he complied with his SMS, by counting the passengers on and off the vessel, as well as performing an additional headcount at Parakeet Bay. I have also expressed my view that the evidence in support of any headcounts being conducted other than the initial headcount is limited and unpersuasive. Further, if I am to accept his evidence of having done three headcounts, the process was flawed as the

[311] Exhibit 1, Tab 15.
[312] Exhibit 1, Tabs 12 and 15.
[313] T 350.
[314] T 351.
[315] T 352 – 353.
[316] T 354.
[317] T 354.
[318] T 355.

numbers he reached were incorrect, which at least at the time of disembarking is not surprising given the way passengers were able to disembark before the boat was tied up and the crew were in place to count them getting off.

213. Mr Lippiatt expressed his view "that the more head counts that you can do, the better" particularly where you have "people on board who are drinking alcohol and are in water."[319] I agree with his view, as there is an obvious increased risk of a passenger falling overboard when they have been drinking, but it seems to me that Mr Lippiatt did not follow through with his actions in support of his beliefs on this occasion. Alternatively, he did not follow them through with a sufficiently thorough process to ensure that all passengers were returned safely to shore, as was his stated aim. If a proper process of headcounts had been done, with correct numbers taken at the start and end of the charter, it would have been noted that a passenger was missing and hopefully an investigation into the identity of the person, and a search for them, could have been started much sooner and perhaps saved a life.

214. The unfortunate thing on this occasion was that the deceased had attended on the day without any close friend or companion, so it was less likely that someone else would notice that he was missing. A friend or colleague would have served as an extra layer of protection to ensure that his absence was noted. There was some discussion in the inquest about a 'buddy system', whereby passengers are allocated another person to keep a lookout for them, similar in a way to a diving buddy. This was not supported generally by the witnesses so I don't pursue it. However, it is something that organisers, such as Pepper, might think about when organising such an event, to ensure people's safety when networking, which often involves people unknown to each other, is the aim. I do not mean by this to make any criticism of Pepper for not doing so on the day, but raise it as one suggestion for increasing safety generally for the future. It does not, however, replace careful and accurate headcounts.

215. Accepting that a headcount is the best way to determine whether all passengers are accounted for, so that a timely search can be commenced if a passenger is identified to be missing, there was considerable discussion at the inquest about whether headcounts (and how many headcounts) were at the time of the deceased's death, and are currently, mandatory for small charter operators.

216. Ms Clare East, the Manager of the Maritime Regular Standards division of AMSA gave evidence at the inquest in relation to the legal requirements for headcounts on domestic commercial vessels such as the Ten-Sixty-Six. The requirements arise from the *Marine Safety (Domestic Commercial Vessel) National Law 2012* (Cth) (the National Law), which commenced on 1 July 2013. AMSA is the National Regulator the National Law. The National Law is complex due to distinctions between various classes of vessels as well as

[319] T 313.

various transitional provisions relating to existing vessels (as compared to new vessels).[320]

217. To put it in simple terms, as I have understood the evidence put before me, in order to operate, a domestic commercial vessel such as the Ten-Sixty-Six must hold a certificate of operation under the National Law. That certificate of operation then brings with it certain standards that must be met. Failure to meet those standards can result in an offence being committed under the National Law. Because the Ten-Sixty-Six was an existing vessel at the time the National Law came into effect it was 'grandfathered', so the provisions that applied to it at the time of the deceased's death were actually the requirements that had been applied to that type of vessel by the Western Australian government, prior to the National Law commencing.[321]

218. The Western Australian provisions that applied provided that for a passenger carrying vessel like the Ten-Sixty-Six, a headcount of all passengers on board was required to be maintained, which meant that the master of the vessel would be required to know how many people were on board the vessel at any given time and to document that information.[322]

219. Since that time, the law has changed and the applicable section now requires that for such a vessel, on a voyage that is less than 12 hours long, at least one headcount must be conducted of all passengers on board the vessel and the number of passengers on the vessel known by the master at any time.[323]

220. In comparison, the evidence of the Water Police was that they recommend that a first headcount be conducted and corroborated by another crew member and that another one be done when passengers are disembarking.

221. I expressed the view during the inquest that it was difficult to see the benefit of a single headcount, and that the Water Police position was obviously to be preferred, if safety is the objective. I raised this issue with Ms East, and counsel who appeared on behalf of AMSA, so that they could explain why the National Law does not mandate at least two headcounts, one at the start of the journey and one at the end of the journey.

222. AMSA's position, as articulated by Ms East in her evidence, is that there is a very significant diversity in terms of the types of vessels and the kinds of operations that are operating, which makes it difficult to be too prescriptive in what headcount procedures should be performed. It is AMSA's preferred approach that different types of operations should be able to calibrate their headcount procedures and requirements in accordance with the nature of their operation, with information provided by AMSA to industry to guide them as to what is appropriate and reasonable in the circumstances. Ms East gave the example of the difference between Manly Ferries operating on Sydney Harbour with hundreds of passengers hourly, and a small charter

[320] Exhibit 1, Tab 15.
[321] T 163 – 167; Exhibit 1, Tab 15.
[322] T 24, 167, 239; Exhibit 1, Tab 15.
[323] T 168; Exhibit 1, Tab 15.

vessel with relatively few passengers for the day, to support the need for a more calibrated approach.[324]

223. After the inquest, Ms Mary Dean, Manager of the Office of Legal Counsel for AMSA, provided further information to the Court, and indicated that "AMSA has an expectation that it will be necessary and desirable to conduct two headcounts (or more) on certain operations." It is AMSA's belief that it is best done in an operator's SMS, noting that as "part of the risk assessment process an owner/operator of these type of operations will be best placed to identify that a second headcount is necessary (for example, on passenger vessels).[325]

224. Mr Buccholz, appearing on behalf of the WA Department of Transport, who have been the body supervising marine safety of commercial boat operators until recently with the advent of the National Law, expressed a different view. Mr Buccholz acknowledged what had been said by AMSA as to the large and diverse fleet it must administer but from his own experience, Mr Buccholz expressed the view that for small operators, it is better to be prescriptive rather than to leave it to the operators' own ability to assess what they believe is safe without clear guidance.[326] Mr Buccholz noted that, "[t]here would be a high level of expectation from the public that every measure is undertaken to get people safely back" on a commercial vessel.[327] In Mr Buccholz's view, "the more prescriptive you are for those smaller operators the more likely they are to act in a safe manner."[328] He acknowledged that this differs from the position of AMSA, which is that the best people in place to understand the risks associated with their operation and put in place appropriate mitigators through the safety management plan is the operator.[329]

225. I was informed at the inquest that AMSA will take over fully delivery of the national system on 1 July 2018. Accordingly, it is only AMSA's view that is determinative of what will be done. In that regard, Ms Dean has indicated that AMSA intends to undertake safety initiatives to communicate the need to undertake two headcounts for certain operations. These include:

- Through AMSA's committees, details of which have been provided and include the Domestic Commercial Vessel Industry Advisory Committee;
- In AMSA's publications, such as the Safety Awareness Bulletin and E-news marine notices, which are regularly sent to over 29,000 subscribers;
- Via direct educational activities such as SMS workshops, which are organised by vessel operation type and complexity to ensure the target audience receives the right message; and

[324] T 169.
[325] Letter to counsel assisting from AMSA dated 27 October 2017.
[326] T 240 – 241.
[327] T 263.
[328] T 245.
[329] T 243.

- Using other interventions that AMSA and its delegates are pursuing to ensure systematic and proactive processes for managing safety risks are in place.[330]

I am informed that this will be done in a targeted manner.[331]

226. I am reassured that AMSA intends to take an active role in promoting the need for multiple headcounts in domestic charter operations. Although, similarly to Mr Buccholz, I have a preference for such an issue to be made mandatory as I believe it is more likely to ensure compliance, I accept that under the new system it is difficult to legislate such a requirement in a simple way. The system proposed by AMSA of encouraging inclusion of such a system in the SMS of operators of charter operations similar to that of Mr Lippiatt, which would then require compliance, would appear to be the most practical option.

227. A submission was made by counsel on behalf of Mrs Mills that AMSA needs to be more active in the regular review of all charter operators to ensure that safety standards are being maintained.[332] In keeping with the deceased's family's expressed concern, AMSA has indicated that it aims to maintain "a clear compliance presence, with a focus on the headcount issue for high risk operators."[333]

CONCLUSION

228. This was a particularly tragic case, involving the death of a hardworking father of a young family who went out for a simple day of socialising and networking as part of his business and never returned home. While his death was an accident, there was evidence that it may have been preventable if his disappearance had been identified sooner. The evidence underscored the need for simple processes, such as performing careful and orderly headcounts and supervising passengers properly while on board, to be undertaken by the crew of charter boats to ensure the safety of their passengers. If that had been done in this case, the deceased might still be alive today.

229. With the transition to a new national regulatory body, it is difficult to make any meaningful recommendations. However, I am informed by AMSA, who participated actively in the inquest, that they have understood the safety issues raise by the death of the deceased and it is AMSA's intention that steps will be taken, within the National Law framework, to promote headcounts as a safety measure. It is also important that AMSA do its best to ensure that safety systems implemented are duly carried out by operators with care and diligence. The knowledge gained from the tragic outcome of

[330] Letter to Counsel Assisting from AMSA dated 27 October 2017.
[331] Letter to Counsel Assisting from AMSA dated 27 October 2017.
[332] Submissions in Response to Closing Submissions filed 23 June 2017.
[333] Letter to Counsel Assisting from AMSA dated 27 October 2017.

this case must form part of the safety message for the future, with the aim of ensuring that similar deaths are prevented.

S H Linton
Coroner
30 October 2017