

SECTION 6. EXTERNAL ASSISTANCE

RAN UNITS

RAN Surface Units

6.1 The best overview of the assistance rendered by RAN surface units is to be found in the enclosure to the minute from CAPT LG Cordner, RAN to the Secretary of the Board of Inquiry dated 12 May 1998.[E52] It is summarised in the following paragraphs.

6.2 Upon receipt of the MHQAUST WEST message at 1051, which advised units of WESTRALIA's fire and requested them to be prepared to offer assistance, the OTC (CAPT Cordner) briefed ships in company that he intended to detach units to close WESTRALIA at best speed to provide support. SYDNEY was detached at 1055 and DARWIN at 1102. At 1109, ADELAIDE and SUCCESS commenced passage at best speed to join WESTRALIA which was 38 nautical miles to the east of ADELAIDE.

6.3 The OTC advised all units to prepare fire teams with a priority on teams comprising ex-WESTRALIA sailors and preferably those with an engineering background. While the individual units were to prepare the teams, the OTC maintained the control of the allocation of assets and timings for transfer.

6.4 The CO SUCCESS (CAPT Flint) realised that expert medical assistance would be urgently required and directed the ship's doctor, LEUT Eggerling, to embark in the Sea King helicopter with the firefighting equipment prepared by the ship. The Sea King helicopter launched for WESTRALIA at 1125.

6.5 At 1142 the OTC informed all units he was taking command as On Scene Commander (OSC) in order to co-ordinate support for WESTRALIA. Communications were established between the OSC and WESTRALIA at 1146 and damage control priorities were established as OCCABA, Fearnought suits and Maxon radios.

6.6 WESTRALIA later advised that the priority was for portable pumps and diesel fuel to operate them. SUCCESS had a suitable pump which was to be transferred by air to WESTRALIA. At 1206, the CO WESTRALIA repeated his assessment that a P250 pump was a priority item required to support fire teams fighting the fire with foam.

6.7 At 1210 the OSC executed a screen cordon based on WESTRALIA in order to facilitate transfer of stores and 'deconflict' supporting units. At 1234, the cordon was amended when sector zero was reduced to 500 yards. This facilitated the transfer of stores by boat, which commenced at that time. By 1224 it became evident that sufficient firefighting equipment was either onboard WESTRALIA or en route to the ship. Based on the shift in priorities, a team of Sea Training Group damage control specialists was transferred by air to WESTRALIA.

6.8 Eventually, there was considerable congestion around WESTRALIA while at the same time, navigable waters were decreasing. Accordingly, the OTC cleared non-essential units from the area. At 1300 WESTRALIA reported that the fire was extinguished. At 1310, DARWIN's boat responded to a request from WESTRALIA for IV

fluids. SYDNEY and ADELAIDE supplied water and victuals at 1330. The CISM team from ADELAIDE joined WESTRALIA at 1335.

6.9 By 1330 the situation had de-escalated to the point where various vessels were ordered to detach. DARWIN and the DTV SHARK were ordered to remain with WESTRALIA, to proceed to FBW when ready and provide ongoing support as necessary.

6.10 The close proximity of 4 major warships to WESTRALIA and the ability of the OTC to control the scene played a significant part in the timely assistance provided to WESTRALIA by these ships.

6.11 After WESTRALIA was berthed at FBW, there was some confusion with the firefighting and other equipment which had been transferred to the ship as not all of it was marked so it could be easily identified as belonging to a particular ship.[T830.1]

Recommendation

<p>6.12 Ships' damage control and firefighting equipment should be marked for purposes of parent unit identification.</p>
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The Helicopters – Sea King (HMAS SUCCESS)

6.13 The Sea King was about to land on ADELAIDE when the crew, under LCDR Moncrieff, received a message from SUCCESS that there was an MMS fire in WESTRALIA. The aircraft disembarked a passenger to ADELAIDE and then hover taxied to SUCCESS where the Sea King embarked LEUT Eggerling, a medical officer, a quantity of medical stores and a number of OCCABAs and Fearnought suits. WESTRALIA was about 30 nm away at the time and took about 15 to 18 minutes to reach. There was some initial difficulty in contacting WESTRALIA by radio but eventually the crew learned that the ship was guarding VHF Channel 69. Initially, radio communications were in cipher but after a couple of minutes, the OTC ordered plain language be used as well as plain language call signs.[T849.9]

6.14 WESTRALIA briefed the Sea King that the vertrep deck would only be manned by a marshaller. Winching operations were, therefore, carried out with only a marshaller. It would appear that the greatest majority of the work on the vertrep deck on 5 May 98 was undertaken by the Supply Officer, LCDR Opie, RAN. The Sea King aircrewman, LSA Llewellyn, was winched down by the observer, LEUT Savage, to assist in controlling the deck during aviation operations.[T850.3]

6.15 After LEUT Eggerling was winched to the deck, the stores were transferred in a Billy Pugh net. This net is a search and rescue device originally intended for use in scooping an injured person out of the water. The net has a rigid frame and a rope net, which can be used for stores transfers up to 1,400 pounds. A limitation on the amount of stores, which may be transferred in any single lift, is the aircraft winch, which is rated at 600 pounds. The net is not carried in the Seahawk as it is too large to safely use within the restricted space available in the Seahawk.[T850.1-T851.7] The time taken in transferring equipment from each of the two aircraft used on the day was noticeable, the Seahawk taking much longer because of the absence of the Billy Pugh net.[T863.8]

Recommendation

<p>6.16 A Billy Pugh type net should be developed for use by Seahawk and Sea Sprite Helicopters.</p>

6.17 The Sea King then flew to the Helicopter Support Facility [HSF] at FBW and embarked fire crews from ANZAC.[T851.4] From FBW, the Sea King transitted to WESTRALIA. Again there was only the marshaller on the vertrep deck and LSA Llewellyn was winched to the deck. The fire crews and their equipment were offloaded and towards the end there was an override in the winch cable. The observer, LEUT Savage made an assessment of the situation that it was safe to continue. The aircraft was then able to land on ADELAIDE where there was a Sea King qualified maintainer who, after running the wire out and re-setting it, considered that the winch was serviceable.[T852.8]

6.18 The Sea King's next sortie was to take 14 passengers including members of the Sea Training Group, a hose team and equipment to WESTRALIA. On this occasion, the aircraft was found to be 300 pounds overweight. The conditions of the day were examined and the decision to launch was made. At no time did the aircraft approach its power limitations.[T853.6] Again there was only the marshaller on the vertrep deck and LS Llewellyn was winched to the deck. Once again the Billy Pugh net was used to transfer the equipment to the vertrep deck.

6.19 LS Llewellyn remained on the deck on this occasion to prepare casualties for medevac. While this occurred, the aircraft flew to ADELAIDE to hot refuel and then returned to WESTRALIA. LS Llewellyn was recovered so that the crew were able to ascertain the nature of the 5 casualties. LEUT Savage was winched down and brought up each of the casualties in a double lift.[T854.8]

6.20 When tasked to medevac the casualties to St John of God Hospital, the crew did not know its location. They were advised by the Seahawk TACCO and then LEUT Savage who had attended the University immediately adjacent to the Hospital. The air traffic control authorities assisted greatly and the flight was without incident.[T855.4] From St John of God, the Sea King was flown to SUCCESS and placed at alert 30.[T855.9]

6.21 The aircraft flew a total of six hours and six minutes on that day of which about three hours was in support of WESTRALIA. In all, 47 winch transfers were conducted by the Sea King.[T856] Both the pilot and the observer were fulsome in their praise for the part played by ADELAIDE.[T857.2 and T 863.6] LEUT Savage in his statement said:

I would like to say that whoever from ADELAIDE was overseeing the assistance to WESTRALIA did a great job as far as the aircraft co-ordination was concerned. The operation was smooth, the instructions were clear and concise and at most times we knew precisely what we were to do.[T863.6]

Conclusion

6.22 The Board is of the opinion that the Sea King was the ideal aircraft on the day. Apart from the minor difficulty with the overriding winch wire, the aircraft flew without incident.

The Helicopters – Seahawk (HMAS ADELAIDE)

6.23 Statements were not taken from the crew of HMAS ADELAIDE's Seahawk helicopter due to their overseas deployment.

6.24 The Seahawk was first actioned for the transfer of a ADELAIDE fire team at about 1135. Additional stores in the nature of OCCABAs, Fearnought suits and Maxon radios were carried on the sortie. The aircraft was held on deck while diesel fuel was loaded for a pump which were being transferred to WESTRALIA by the Sea King. The Seahawk eventually launched at 1210 after the load was re-configured. When it arrived at WESTRALIA, the Sea King was transferring its load and the Seahawk held off until it could commence its transfer at 1230.[E52]

6.25 On completion of the transfer of the fire team from ADELAIDE, the Seahawk collected a fire team from SUCCESS and inserted them at 1308. The Seahawk then proceeded to the HSF at FBW and transferred a CISM team to WESTRALIA at 1414 prior to recovering to ADELAIDE at 1420.[E52]

Conclusion

6.26 The Board notes that whilst the Seahawk is not a utility helicopter, the aircraft made a valuable contribution to the timely transfer of necessary resources to WESTRALIA without incident.

Air Traffic Control

6.27 The first helicopter on the scene was from Channel 7 News. WESTRALIA was unable to make radio contact with it.[T134.5] At that time, WESTRALIA's Navigator was aware that the Sea King from SUCCESS was inbound on its first sortie for WESTRALIA and he was, therefore, concerned about clearance between the two aircraft.[T134.5-T135.3] This concern was passed to MHQ West.[T134.8]

6.28 At 1212 WESTRALIA reported a number of helicopters observed within the near vicinity. At 1223 the ship expressed concern by VHF radio over the number of helicopters operating within the area.

6.29 CAPT Cordner as OTC made the following comments in regard to aircraft in the vicinity of WESTRALIA:

The OTC requested FIS Perth to keep civil aircraft clear of the immediate vicinity – as a number of media helicopters were now circling over WESTRALIA potentially conflicting with Seahawk and Sea King operations. The initial request relayed by FIS Perth to civil aircraft was obeyed, however, within a short time congestion returned. At 1322 the message was repeated on Guard frequency and MHQ WEST discussed with FIS Perth and POLAIR options for clearing the area around WESTRALIA. At 1325 FIS Perth established an Exclusion Zone around WESTRALIA and congestion eased noticeably.[E52]

Recommendation

6.30 Consideration should be given to developing a Standard Operating Procedure, with the appropriate authorities, whereby an Air Exclusion Zone is established around an emergency incident.

EXTERNAL AGENCIES***Fleet Base West and Port Services***

6.31 Initially, contact was made by the ship with MHQ West and the Port Services Manager (PSM). This initial contact requested assistance in the form of tugs, helicopters and other ships. In particular, WESTRALIA stated that tugs were urgently required.[T127] At about 1042 the CO STIRLING, CMDR Johnston, took charge of the shore assistance for WESTRALIA using the Port Services office.

6.32 The tug TAMMAR, which is a naval tug operated by Defence Maritime Services Pty Ltd (DMS), was the first of the FBW units to be despatched to WESTRALIA. The vessel slipped after only about 5 minutes notice and proceeded to the ship at full speed.[E387]

6.33 The first surface craft to arrive alongside WESTRALIA was a RHIB from STIRLING. It had departed STIRLING at 1115 and arrived at 1143. Embarked in the craft was a medical officer and a CPOMED from FBW together with some medical equipment.[T1033.1, T1055.6, E387]

6.34 The next unit to depart was the firefighting team from ANZAC which flew from the HSF to WESTRALIA in the Sea King. This team were dressed in full firefighting rig and carried spare OCCABA cylinders.[E387]

6.35 Subsequent to a request by WESTRALIA's Navigator, the PSM arranged for 25 FIMA staff to embark in the DTV Shark to assist WESTRALIA's crew in their firefighting efforts.[T1742.2] Embarked with the firefighters were Fearnought suits, OCCABAs, TICs and drums of diesel fuel.[E387]

6.36 FBW also provided a CISM Team requested by the CO WESTRALIA which was airlifted to the ship by Seahawk helicopter.[E387]

6.37 After the fire was extinguished, the PSM embarked in WESTRALIA as pilot at about 1430 to bring the ship down the channels to FBW.[T1738.1 and E387]

6.38 At the direction of the Minister for Defence, the CO STIRLING held a press conference at 1510 and was otherwise occupied with the media until the ship berthed at about 1815.[E387]

6.39 Every effort was made by personnel from STIRLING to assist the relatives and friends of the crew of WESTRALIA before the ship berthed. Hot food was available on the ship's arrival, accommodation was arranged where considered necessary and telephones for the use of the crew provided.[E387]

6.40 In the best of Naval traditions, the CO STIRLING and members of his ship's company ensured that all appropriate assistance and comfort was given to assist crew of WESTRALIA.

6.41 As to the response and effort of RAN units, the CO of WESTRALIA summarised his view in the following words:

...support from other ships and FBW was outstanding with a rapid response and I was most impressed with how they anticipated our needs with the minimum of communication. The right personnel support and equipment arrived in the right order and in the right time. Obviously this was not a fluke, but flows from the high standard of training conducted over a long period of time.[T3158.7]

Conclusion

6.42 The Board finds that the support provided by naval units was timely, well coordinated and in the best traditions of the service.

Fremantle Port Authority (FPA)

6.43 The Fremantle Port Authority is responsible for the commercial operation of Fremantle. Its area of responsibility covers the inner and outer harbour, including Cockburn Sound and the dredged Parmelia and Success channels. The integrity of these channels and approaches to Fremantle are vital to the commercial life of the port. To minimise the consequences of an incident within the Port of Fremantle and its approaches, the port has developed the 'Port of Fremantle Emergency Plan'. This emergency plan forms part of the Western Australia Emergency Plan and whilst the RAN has been involved with the development of this plan, the plan itself does not cover Naval units.

6.44 At the onset of the emergency the WESTRALIA command team were aware that they urgently required outside assistance [T125.3] but did not declare an emergency by way of a internationally recognised prescribed urgency call (PAN call). Consideration was only given to receiving assistance from other naval units rather than to all help which was available.[T171.1] Naval units were over one hour away, however the port of Fremantle was just some seven miles distance and was called 11 minutes after the fire broke out but assistance was not requested.

6.45 The initial advice to the Port of Fremantle Authority's control centre was made at 1046 on VHF Channel 12, as follows:

This is warship WESTRALIA. I'm in the vicinity of number 1 buoy at the moment. I've had a fire - major fire - in my MMS. I've lost both my engines. I'm about to go to anchor in this position. STIRLING Port Manager is organising assistance in the form of tugs at the moment.[E91]

6.46 The Board is critical of the fact that no further information was supplied to the FPA. The message itself was misleading in that 'I've had a fire' can easily be understood to mean that the fire was out and no assistance was required. This may have been reinforced by the reference to STIRLING Port Manager organising assistance.

6.47 The Navigator in a submission to the Board stated that he had established effective communications and did not require radio priority. The Board does not accept

this submission which demonstrates an apparent lack of understanding of the purpose of a prescribed urgency call.

Conclusion

6.48 The Board finds that WESTRALIA's command team made an error of judgment by not making a prescribed urgency call.

6.49 The Harbour Master (Captain Atkinson) received a telephone message, with respect to WESTRALIA's fire, from the Port Control Centre at about 1046. Following normal FPA procedures, the Port safety and response vessels were immediately placed on standby. These vessels included two pilot launches and a specialised pollution response and firefighting vessel. At about 1050 LCDR Jempson, the Garden Island Port Manager made the first of a number of contacts between the Navy and the port authorities. LCDR Jempson indicated that he was coordinating the support operation from the Port Control Centre, Garden Island.[T2452/2453] The use of tugs was discussed; this included the possibility of Fremantle Tug Operators (FTO) claiming salvage if the ship was outside port limits.[T2452.7-2453.3]

6.50 Neither LCDR Jempson nor the CO of WESTRALIA considered seeking any help from the civilian authorities, other than the provision of Fremantle Tugs. WESTRALIA's CO was unaware of the emergency plan or of the resources, which had been placed on standby just seven miles away.

6.51 At approximately 1115, the Harbour Master received a telephone call from the CO STIRLING, CMDR Johnson, advising that there were casualties in WESTRALIA. As a result, CMDR Johnson requested that the Rous Head helipad be activated to receive the casualties. Captain Atkinson made the necessary arrangements and requested Police assistance to ensure emergency access for ambulances. At the time, there was considerable industrial action and the road to Rous Head was partially blocked.[T2454.7] Captain Atkinson indicated in evidence that FPA and the Police received complete cooperation from the leaders of the industrial dispute.[T2461] In the event, Rous Head was not required as the decision was made to evacuate the casualties to St John's.

6.52 A copy of the FPA 'Emergency Management Plan' is held by the PSM at FBW.[E168, T2465.3] It would appear that a copy of the document was not held by WESTRALIA.

6.53 One possible flaw in the otherwise close working relationship between the FPA and the RAN at FBW was exposed as a result of the fire in WESTRALIA. There is an apparent conflict of responsibilities in the case of events which have the potential to cause the closure of part of the port to commercial and Naval shipping.[T2456.2] There is no clear understanding or agreed procedures between the parties with regard to the handling of Naval vessels in distress. This could result in conflict between the parties, especially in instances where any action taken by the RAN may have the perceived potential to cause harm to the FPA or its assets.[T2456.2]

6.54 If, for example, WESTRALIA had grounded, either in the main approaches to the Deep Water Channel or on one of the reefs in close proximity, she may have caused a blockage of the approaches to the port or, in the worst case, a major oil pollution incident.[T2456.4]

6.55 In early 1997 representatives of the Port of Fremantle assisted in the development of a plan for the provision of a safe haven for damaged or disabled vessels at sea off the Western Australian coast. This plan is specific to commercial shipping and does not include Naval vessels.[T2456.5] In view of the Government's two-ocean policy, Captain Atkinson suggests that a further Memorandum of Understanding (MOU) should be developed between the RAN and the Fremantle Port Authority for the handling of Naval vessels in distress.[T2456.9]

6.56 Such an agreement should clearly set out the areas of responsibility of the parties and clearly identify who has the final say and therefore the liability for any such occasions where the parties may not necessarily agree and an incident results in the temporary closure of the port. This agreement could also be linked into the existing plan for the provision of a safe haven for damaged or disabled vessels at sea off the coast of Western Australia.[T2457.2]

Conclusion

6.57 The Board agrees that a MOU should be developed between Navy and the Fremantle Port Authority for handling naval vessels in distress.

6.58 Captain Atkinson went on to suggest that a second channel should be dredged so as to provide a second access to Cockburn Sound.[T2458.2]

6.59 It would appear that on the day, the most suitable vessel to attend to WESTRALIA was the FPA Emergency Response Vessel (MPERV). The vessel is described in the Emergency Management Plan as being equipped to handle a major fire on a vessel at sea or at a berth. The MPERV has 3 main fire monitors capable of producing water at the rate of 20 tonnes per minute. There is a foam capacity AFFF/ATC of 13 tonnes. The vessel has a quick fill capacity for foam and may be replenished within 20 minutes. There is also a self-protection deluge system, producing 10 litres per square metre per minute. Response time varies, but a constant speed in sea state 3 is 22 knots. The Plan goes on to describe the hydrants, fire branches and nozzles, and hoses carried by the MPERV.

6.60 Captain Atkinson did not despatch the vessel because there was no official request for it nor was a 'PAN' call made by the ship.[T2467.2] In essence the vessel was not called for because the CO was unaware of the FPA Emergency Management Plan [T3211.5] and, therefore, the existence of the vessel. Captain Atkinson did place the vessel on standby, however, and thought that it was appropriate to send it.[T2467.3]

6.61 At no time did the FPA know how much cargo or the type of fuel WESTRALIA was carrying.[T2475.3]

6.62 During the course of a telephone call between the PSM, LCDR Jempson and the Fremantle Harbour Master at approximately 1050, the former requested Captain Atkinson to inform the Chairman of the State Marine Oil Pollution Combat Committee of the situation immediately and activate the plan. This was done and all services were placed on standby, awaiting further developments.[T2452.6] The Navy is a participant in this plan.[T2469.4]

6.63 In his evidence, Captain Atkinson stated that if he had received a request or advice that there was a pollution incident then the Port Manager would have attended the

scene as the on-scene coordinator but no equipment would have been taken to the scene until there was an actual incident.[T2473.9]

6.64 Captain Atkinson and his team were ready and willing to provide assistance to WESTRALIA but a request for their services was not made. The incident has highlighted the need for greater co-operation between the RAN and the FPA. While there is already a mutual professional exchange between the Harbour Master and the PSM, COs of RAN vessels operating/transiting Fremantle Port waters would be better served if they knew of FPA facilities available to them in cases of distress.

Recommendations

6.65 HMA Ships should be made aware of major port facilities that are available to assist in emergencies. The 'Port Guide' should contain details of Port Emergency Plans.

6.66 HMA Ships based at Fleet Base West should be issued with a copy of the FPA emergency plan.

6.67 A MOU between the RAN and FPA should be developed for the handling of Naval Vessels in distress which fall within the bounds of the FPA emergency plan.

Fremantle Tug Operators (FTO)

6.68 Fremantle Tug Operators is a civilian tug joint venture responsible for Fremantle inner harbour tugs. The call for assistance to FTO came in at about 1100 from Defence Maritime Services Pty Ltd (DMS) when it was stated that WESTRALIA required urgent assistance in Gage Roads due to an MMS fire. The FTO management made the decision to provide a tug under the basic hourly hire rate from their standard schedule of charges.[E162]

6.69 The tug WAMBIRI sailed at 1125. Five minutes later, DMS incorrectly advised that the ship had anchored and the urgency was downgraded. At no time were FTO administration or tug personnel, ever advised of the full extent of the situation relating to WESTRALIA.[E162] The tug crew only learned of the loss of life onboard the ship when they were in the Parmelia-Success Channel with WESTRALIA under tow.

6.70 There was apprehension on the Bridge of WESTRALIA that the Master of the WAMBIRI made an open claim for salvage as the tug approached the ship. The Navigator thought that the Master of WAMBIRI used the words, 'I reserve the right to negotiate the terms of this charter at a later date' which he took to be leaving a salvage claim open.[T141.3] Earlier, LCDR Jempson, on advice from Captain Atkinson, had advised the ship about the possibility of a salvage claim if the ship was outside port limits [T1740.3] and, therefore, the radio transmission caused some angst on the Bridge. This was initially relieved by the fact that TAMMAR commenced the tow before WAMBIRI arrived.[T141.5]

6.71 What was read out was in accordance with a general instruction to tug masters in all Adsteam Marine Operations in Australian ports. That instruction is :

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In local emergency cases, that is, within port limits where tugs are called out to assist a ship that has sustained a grounding or collision . . . tug masters must advise the casualty's master as follows:

We acknowledge your call and will render assistance immediately. My owners reserve the right to negotiate the terms under which these services are rendered.[E162]

6.72 First, there is no doubt that WESTRALIA was within the limits of the Port of Fremantle. As far as the FTO administration was concerned, WESTRALIA was in Gage Roads which is well within the Port of Fremantle limits. Evidence was given that originally, a tug other than WAMBIRI was to be sent out. The master of that tug was aware that the tow was for an hourly rate. The contract for an hourly rate was not passed on to the master of the WAMBIRI. In any event, Defence Maritime Services Pty Ltd, on behalf of the RAN had sent a purchase order by facsimile at 1151 for the services of tugs including a cold move to FBW.[E162]

6.73 In an emergency, FTO can have a tug departing from the berth in the Inner Harbour within 5 to 10 minutes. The decision was made to send WAMBIRI which is fitted out for ocean rescue work and has a bollard pull of 61 tonnes; she is also fitted out with firefighting equipment including a water cannon with a capacity of 10,000 litres a minute and 13 or 14 tonnes of foam and can proceed at 11.5 to 12 knots. The tug arrived at WESTRALIA at 1220 and later attempted a hookup using the 48 millimetre wire towing hawser after the synthetic line used by TAMMAR had snapped. There was insufficient crew on WESTRALIA's forecastle to handle the hawser without power and initially the messenger was placed over the bollard. Eventually the towing wire was brought inboard and placed on a bollard and the vessel was under tow at 1310.[T2444.6]

6.74 The tow to FBW was without incident and WAMBIRI and TAMMAR were joined by WYONG at 1515 to assist with the move down the Parmelia-Success Channel. WESTRALIA berthed at FBW at about 1830.[E162]

Western Australia Police Service and the Coroner

6.75 A legal officer, CMDR Vickridge, arranged for the Arson Squad and members of the Western Australia Police Service ('Police') representing the Coroner to attend at FBW. This assistance was sought in order to conduct formal identification of the deceased, determine their cause of death and the cause and the origin of the fire.

6.76 Prior to WESTRALIA berthing, a mobile Police unit was established adjacent to the wharf. This unit was formed at the invitation of the RAN and acted on behalf of the WA Coroner.[E452] The forensic pathologist, Dr G Cadden, formed part of the unit and also attended.[T78] He later presented his report to the Board shortly after it commenced its hearings.[E20]

6.77 When WESTRALIA arrived at FBW, the Police moved onboard and carried out formal identification of the deceased with the assistance of PO Plant.[T1200.6] All relevant areas were secured by Police boundary tape and photographed by both still and video photography. The Arson Squad examined the MMS and, within a relatively brief period, isolated what appeared to them to be the origin of the fire. Last, the Police organised the hearses to convey the deceased and landed each of them with due reverence being shown at all times. The Police did not secure their team until after midnight.

6.78 Various forensic specialists attended onboard WESTRALIA on the following day.

6.79 The Board acknowledges the assistance provided by the Police which includes the professional advice of the Arson Squad in the provision of the report by Detective Senior Constable W A Hawes [E452], photographic board exhibits [E33], the enhanced bridge tape [E49] and arranging the report from the Chemistry Centre of WA [E184].

CRITICAL INCIDENT STRESS MANAGEMENT

6.80 Critical Incident Stress Management (CISM) is a structured process of debriefing that is initiated in response to an event that has the potential to cause significant emotional stress amongst the personnel who are involved. The debriefing is provided to all personnel involved, and is provided by psychologists, social workers and Peer Support Members (PSM). PSMs are uniformed personnel, chosen because of the possession of particular qualities including maturity, who are provided training that allows them to assist in the conduct of CISM activities. They perform PSM activities ancillary to their normal duties. Navy policy on CISM is covered by DI(N) PERS 5-7.[E88]

CISM Support Provided

6.81 In response to a request by WESTRALIA's CO, a Critical Incident Stress Management (CISM) response was initiated, in accordance with Navy policy.[E88] As the worst accident in the RAN since CISM was introduced as policy, the response was the largest seen.

On-Scene Support

6.82 Once the fire was out, CO ADELAIDE offered to transfer his CISM team.[T3156, E52] CO WESTRALIA accepted this, having become aware that some personnel were suffering from stress, although he did not see it as a major problem at that stage.[T3183] STIRLING had earlier assembled a team in anticipation of the requirement.[E387] ADELAIDE's CISM team of two personnel was transferred at about 1335 and STIRLING's Team of five personnel, headed by Senior Naval Psychologist Mr A. Camac, plus a Chaplain were transferred at 1414.[E52]

6.83 On arrival, ADELAIDE's Team identified several personnel grieving for shipmates in the vicinity of RASCO. These personnel were moved to a quiet area, support was provided, and they regained their composure and returned to their duties.[E52] At the time the second CISM Team arrived on board, the number of personnel who were suffering stress difficulties had apparently diminished, and only about half a dozen required support.[T1105]

6.84 CISM personnel spent the remainder of the time prior WESTRALIA berthing talking with and observing the ship's company and others, and assisting with preparations for berthing.[E52, E187]

Informal De-Fusing

6.85 The CO WESTRALIA addressed the ship's company on WESTRALIA's arrival at FBW. This took the form of an informal defusing, with an explanation of the

day's events, details of those killed and injured, and advice on the immediate availability of support should it be required.[T1111, E87] Following this, leave was piped to 1000 the following day.

De-Briefing

6.86 Formal de-briefing was preceded by an information session for the whole Ship's Company the day following the fire. At this time, COs WESTRALIA and STIRLING gave addresses, and a Psychologist (Ms Douglas) outlined the 'normal' elements of 'critical incident' stress.[E87] Personnel were advised that individual counselling was available on request. On 7 May, formal de-briefing commenced, with a total of 83 personnel being seen in six groups. The groupings were based on commonality of activity during the incident.[E87]

Other Support

6.87 Support was provided for the five personnel hospitalised in SJOGHM on the evening of the incident.[E87, T1090] Further support was provided the following day, but, at the request of the injured, no formal defusing or debriefing took place at the hospital.[E87] The casualty who in hospital on 07 May was also visited.

6.88 The CISM Activity Report submitted by the Senior Psychologist WA (Mr Camac) summarises the first three weeks after the incident as follows:

[Eight] Group Debriefings (total of 103 personnel: 82 from HMAS WESTRALIA and 21 from HMAS STIRLING), [two] dyad Debriefings⁴ and [eight] individual Debriefing sessions were conducted; a 'defusing' was held for 10 personnel from HMAS ANZAC; individual counseling was provided by psychologists for 25 personnel with [four] follow-up sessions . . . conducted; and, Peer Support Members . . . provided general and individual support to a wide range of personnel in a number of environments.[E87]

6.89 CISM activities beyond FBW included follow up of personnel involved in the incident from SUCCESS, ADELAIDE, SYDNEY and TORRENS, and psychologists contacted CERBERUS and ADFA since two of the deceased had recently posted from these establishments.[E87]

On-going Contact

6.90 As of 05 Jun 98, 12 personnel were actively maintaining contact with the CISM process for continued counseling. At 13 Jul 98, three personnel were under psychiatric care for depression and anxiety.[E473]

Acceptance of CISM

6.91 The acceptance of CISM Activities was reported to be high, with management at all levels actively involved in supporting the effort. Personnel were readily released to participate.[E87]

⁴ A dyad debriefing is one where two personnel are debriefed together [T1098]

6.92 Many witness statements tendered to the Board commented on CISM, and the majority of these were positive. On-scene support was felt to be helpful, making personnel feel better in themselves.[E382, E399, E178A]

6.93 Some witnesses described the CISM debriefings as good and worthwhile.[E38, E42, E63, E89] Although some witnesses felt that it did not do much for them personally, it was generally helpful, allowing personnel to share their experiences and ventilate their feelings.[E63, E89, E175] A number of the witnesses were equivocal, with some being initially reluctant to attend, but feeling positive afterwards, and others feeling they did not need counselling. Some preferred to deal with the situation their own way and some were interested in hearing what other people had been doing on the day.[E152, E161, E206, E211]

6.94 There was some criticism of the CISM debriefing. One witness stated that it upset her, with graphic descriptions of what the bodies looked like and how they were taken out.[E161] A member of the HQ1 team stated that he was grouped with people from the Bridge, but did not feel he had anything in common with them, since they were not directly involved in fighting the fire.[E157] A number of witnesses felt that the debriefing should not be compulsory, as people should not be placed in a position where they publicly break down.[E211, E205]

6.95 There were two personnel from WESTRALIA who did not attend debriefing - one was a refusal, and one stated he was not ready.[T1097] Two personnel from HMAS SYDNEY also rejected the opportunity for referral.[E87]

Conclusion

6.96 A significant CISM intervention was mobilised during and after the incident. It received a high level of acceptance at all levels.

Possible Contamination of Evidence

6.97 The Board was concerned that there appeared to be some potential for contamination of the evidence presented to it as a result of the debriefing process. The Board noticed that on a number of occasions statements tendered by personnel involved in the same or related activities included very similar, if not identical, wording. There were a number of statements also where the comments by others made during debriefings were included (sometimes with attribution). The perceptions of the incident may have been modified by each individual relating his or her involvement in the incident to a group of personnel who had similar roles or experiences in the incident.

6.98 In a submission to the Board, Dr Richard Bryant, Senior Lecturer in Psychology at the University of New South Wales, opined that:

In the context of recounting one's recollections in the company of others who have been through a similar experience, one risks peoples' memories of events being influenced by others' accounts of these events. . . .[and] it is likely that accounts of an incident may be modified somewhat following CISM relative to memories before CISM's implementation.[E428]

6.99 This issue was put to Mr Camac, and, while admitting the potential for contamination to occur, he stated that similar contamination could occur in general social discussions:

I couldn't deny that that might happen in some instances, but certainly the general observation has been against that being a problematic issue, that the preference has been seen to have psychological debriefings before operational debriefings, making clear the difference between the two, and by people having worked through some of their emotional reactions to incidents, being in a position of being able to provide information for operational briefings in a clearer and less emotive perspective.[T1100]

6.100 Previous Boards of Inquiry have noted the benefit of lowered stress in witnesses giving evidence.[T1110, E478] The Board did observe that, with a number of exceptions, WESTRALIA witnesses seemed comfortable giving their evidence.

6.101 Mr Camac noted in his evidence, that while the optimum time for debriefing is 24 to 72 hours after the incident, on occasions, for various reasons, the process has been extended over a longer period of time.[T1095] He did comment on the potential problems relating to prolonged delay in debriefing:

The risk of leaving it . . .[for] too long a period of time is that you may disrupt the [process of working through their reactions and return to work and taking up their own responsibilities] that people have already started, by introducing some other intervention.[T1095]

Conclusions

6.102 The CISM debriefing process, occurring as it did before the great majority of personnel had made any written record of their recollections of the day, had the potential to contaminate evidence presented to it.

6.103 The Board is of the view that, given the significant resources involved in the provision of CISM, steps should be taken to evaluate the efficacy of the intervention in this incident.

Recommendations

6.104 CISM debriefing should not occur until all personnel involved in an incident have made some written record of their recollections and this record has been secured for future reference in formulating statements. This procedure should be included in the Navy policy on CISM.

6.105 Controlled follow up or other studies should be initiated with a view to contributing to the empirical data available in the scientific literature evaluating the effectiveness of CISM.

Preparation for Critical Incidents

6.106 Navy policy requires CISM awareness sessions be conducted in a variety of Naval courses, including those related to leadership and management. Additionally, all

officers, and all sailors in categories with a high likelihood of exposure to critical incidents receive similar sessions.[E88,B]

6.107 Board Member, CMDR WALSH, put to Mr CAMAC that:

we teach people that . . . we're in a Service which is designed to go out to sea and fight and in doing so, we expect to take damage and deal with that damage, but to make sure you overcome that damage, 90 per cent is done before action. . . . Now, thinking of our people . . . we know today that stress . . . is a natural reaction to pressure . . . it seems to me that part of this CISM work should be done before the incident, and . . . should we not be teaching our people that, 'Hey, you're in a service that fights. You'll be going out there. You will suffer actual damage. You will see damaged equipment, damaged people, and you will react to this and this is just normal.[T1116-7]

6.108 Mr CAMAC responded:

Well, I have no problems with doing that and . . . allowance for that was encompassed within the DI(N). . . . As a Land Commander once put it, . . . his concern about teaching soldiers about stresses [is] that they all experience it the next day, and so there has been an issue of finding a balance between educating in preparation without generating . . . excess anxiety about it. . . . I'm certainly supportive of the idea in terms of preparing people for this and I think it's important to also prepare managers for this element of the reaction that they may encounter in the incident as well.[T1117]

Conclusion

6.109 The Board considers that more extensive preparation of personnel for critical incidents, including pre-training in stress/trauma management, may have resulted in a reduction in the size of the CISM response required for this incident, including the need for On-Scene Support and individual counselling.

Recommendation

6.110 Navy should examine the appropriateness of introducing more extensive preparation of all personnel for critical incidents, including sailors at the time of entry, and expanding that preparation beyond simple awareness to stress/trauma management, both for the individual and for managers.

Peer Support

6.111 Five personnel (two psychologists and three PSMs) were involved in providing On-Scene Support in WESTRALIA. Only two of these personnel came from ships in company, and none from WESTRALIA.[E87] Two Chaplains provided support additional to CISM one of these being from WESTRALIA.[E87]

6.112 Activities at HMAS STIRLING after the incident involved a total of 14 personnel - eight psychologists and six PSMs. Of these, 10 (five psychologists and five PSMs) were involved in the provision of CISM interventions to those directly involved in the incident. None of these was from WESTRALIA.

6.113 Concern was raised that if this incident had occurred either isolated from shore support or in combat, the availability of personnel to provide the initial support could not be guaranteed. Navy CISM policy does not include a requirement for at least one PSM to be posted to each Major Fleet Unit [T1101-2, T1113] as it does with Alcohol and Drug Program Advisers (ADPA).[DI(N) PERS 31-9] To ensure proper support in the event of an incident, Mr Camac noted that, in a combat scenario, the US Navy, for example, would deploy CISM personnel in its hospital ships.[T1103] The RAN is about to introduce into service 40-bed medical facilities in its LPAs, however the Board understands that accommodation constraints may prevent the deployment forward of CISM resources.

6.114 There would be benefit in having an assurance that some degree of support was available at sea without the need to inhibit operations by deploying CISM personnel to a ship where a critical incident has occurred. A policy of having a PSM posted to each Major Fleet Unit, and the training of all Chaplains as PSMs, would provide an assurance that at least one PSM, and often more, would be available at sea to assist in providing support in some incidents.

Conclusion

6.115 The provision of at least one Peer Support Member on each Major Fleet Unit at all times will assist in providing post trauma management to personnel involved in incidents that occur in combat or isolated operations.

Recommendations

6.116 Navy should introduce a requirement for at least one CISM Peer Support Member to be posted to each Major Fleet Unit.

6.117 All Chaplains should be trained as CISM Peer Support Members.

CHAPLAINCY

6.118 Immediate chaplaincy support was provided by PNF and ANR Chaplains in the Perth area. CHAP Gebski was embarked in WESTRALIA and, in his roving role, provided a wide range of support to personnel on board.[E388]

6.119 CHAP Yesberg heard of the fire in WESTRALIA at the time the initial notification arrived from the ship, he being in MHQ Operations West at the time. He received clarification of the casualty situation from the FBWHC later. At about 1200 he notified the Fleet Chaplain, CHAP Raynor, of the incident.[E389], and also asked two Reserve Chaplains, CHAP Raj and CHAP Stubbs to be on standby to provide family support at about 1230.[E389] Later in the day, CHAP Stubbs went to SJOGHM to meet the casualties evacuated there.[E389]

6.120 Two additional Chaplains were embarked in WESTRALIA during the day. CHAP Graue from HMAS ADELAIDE arrived at 1335 as part of the CISM team, and provided support to personnel in the vicinity of RASCO.[E52, E388] At 1410, CHAP Yesberg arrived with the CISM Team from HMAS STIRLING to lend additional support, but not as a member of the CISM Team.[E17A, E388, E387]

6.121 On the ship's arrival at STIRLING, CHAP Gebski participated in the Clear Lower Deck conducted by CMDR Dietrich, leading the ship's company in prayer.[E388] In subsequent days, all Chaplains provided significant support to families and others during the days following the incident.[E388] There is evidence that the availability of chaplains was a source of comfort and support to members of WESTRALIA's crew.[T702, T959]

Conclusions

6.122 There was a significant chaplaincy effort in support of personnel, family and friends on the day of the incident and subsequent to it.

FAMILY LIAISON AND SUPPORT SERVICES

6.123 The impact of the incident extended greatly beyond the immediacy of those on board. Families and friends suffered the twin burdens of:

- a. uncertainty between the time media reports of the accident began and individual outcome (survival, injury or death) was confirmed; and
- b. grief in bereavement and/or trauma associated with supporting distressed personnel involved or other family and friends.

6.124 The Personal Services Officer WA (PSO WA - LCDR RJ Smith RAN) coordinated most of the family liaison in Western Australia, with assistance from STIRLING as necessary.

6.125 PSO WA became aware of the incident at approximately 1115 when NAVCALS Fremantle telephoned seeking the CPO Communicator. In the course of the conversation, the incident was mentioned briefly. PSO WA contacted MHQ Ops West and FBW Health Centre and was told of the fire, and that personnel were missing and injured. He stated that the information he received was limited and conflicting, but 'there was no apparent sense of urgency'.[E391]

6.126 Over the subsequent hour and a half, numerous telephone calls were received from families concerned after hearing media reports of the fire, and LCDR Smith soon became aware that the incident was more serious than first appreciated. He attempted to clarify the situation by telephoning MHQ Ops West and FBW Health Centre but was unable to obtain additional details.[E391]

Notification of Next of Kin

6.127 The major task of family support services on the day was to notify the Next of Kin (NOK) of WESTRALIA personnel of the incident. This was undertaken by the Defence Community Organisation (DCO), through PSOs in the various States, and the Defence Family and Personal Services (DFPS) organisation. The evidence in relation to the notification of NOK was confused, and in some areas conflicting.

6.128 CO HMAS STIRLING contacted PSO WA to advise of the missing personnel, this telephone call being recorded in the Port Services Manager's narrative at 1300.[E121] At this time LCDR Smith proceeded to contact the NOK to offer support; two families

declined this offer, one of which had support already available, and the other had it en route.[E391]

6.129 At 1440, CO STIRLING contacted WESTRALIA by radio requesting the CO call him by mobile telephone as CO STIRLING was about to hold a press conference. During the telephone call, CO WESTRALIA confirmed the four deceased and their names.[E121, E387]

6.130 At 1510, CO STIRLING held a press conference at which the numbers and genders of the four deceased were announced, but no other personal details revealed.[E387]

6.131 PSO WA stated that he received confirmation of the details of the four deceased at 1545, and he was instructed that the families were not to be informed at that time. PSOs in relevant States were notified to place family support on standby. Almost immediately after this, he was advised that a press statement was about to be made, and to be sure that NOK had support in place. The Board is unable to determine with accuracy the timings of these two calls. CO STIRLING in his statement noted that he contacted PSO WA just prior to his press conference at 1510, and this may be one of the calls referred to. One of the press releases issued, DPIO 65/98, which confirmed the deaths, was distributed at 1750K (1550H), and this may be the press statement referred to in the second of the calls. LCDR Smith gave evidence that, because of the times and distances involved, in two cases support could not be put in place before the announcement of the deaths. He gave evidence that one of the families had first heard of the death from media reports.[E391]

6.132 In these days of modern, mobile, communications, with demands from the media for on-the-spot information, the accurate and timely notification of the NOK of personnel before leakage from other sources is a challenge. The use of mobile telephones as a means of disseminating information is difficult to control. Confirmed information regarding the status of personnel who may be casualties should be passed to the DCO as rapidly and clearly as possible. This requires the establishment of simple, formal procedures that emphasise a close working relationship between operational authorities and the DCO. The Board is aware that steps have been taken to ensure this occurs.[E461]

Additional Support

6.133 Prior to WESTRALIA arriving at FBW, STIRLING made arrangements for the provision of accommodation, hot food, STD telephones, transport, press and family liaison. When the ship berthed, the priority was to reunite crew and family.[E387]

6.134 On subsequent days, PSO and DCO staff were involved in finalising travel and accommodation arrangements, other routine administration associated with family support, and providing personal assistance and support to relatives of the deceased and injured. Assistance in arranging funerals was also provided, and also planning and support with respect to the memorial service.[E391]

6.135 STIRLING provided assistance in the arrangements for reception and accommodation of the next of kin of the deceased arriving to attend the memorial service.[E387] A briefing for families of WESTRALIA's ship's company was held on 07 May at the Submarine Training and Systems Centre, where advice on support services available to them was provided.[E387]

EXTERNAL ASSISTANCE

6.136 Following the memorial service on 08 May, the next of kin of the deceased were escorted through the Engine Room of WESTRALIA.[E387]

6.137 The Board received a number of favourable comments on the family support services provided. MIDN Christie stated that her parents were very impressed that the Navy contacted them to let them know she was all right, even before they heard anything about the fire on the news.[E42] LS Daly reported that his wife had heard from two sources, local and Canberra, that he was safe.[T635]

Conclusions

6.138 The Board considers that family liaison and support services of a very high order were provided throughout the incident and the days that followed.

6.139 The Board is of the view that an inappropriate delay occurred in officially notifying PSO WA of the incident and its scope. The mechanisms that were in place to keep PSO WA updated as the incident unfolded were inadequate.

6.140 The Board considers it likely that at least one of the families of the deceased heard, indirectly, of their loss through media reports. This probably resulted from a deduction based on early notification that the member was missing, followed by public confirmation of the occurrence of fatalities. The Board is of the view that, once NOK had been notified that a family member was missing, no further information on the fate of these personnel should have been released until such time as the NOK had been officially notified.

Recommendations

<p>6.141 Operational authorities should include in their headquarters' crisis response teams a member solely tasked with coordinating the interface between the operational authority and DCO/PSO authorities.</p>

EXTERNAL MEDICAL ASSISTANCE

HMAS STIRLING

6.142 FBW Health Centre (FBWHC) was notified of the fire in WESTRALIA by telephone from MHQ Ops West at 1050,[E365] with the information being provided that there were four minor casualties with minor burns and smoke inhalation.[E477] At this time, a request was made for a medical officer to be sent out to the ship by RHIB, and LEUT MJ Stone RAN and CPOMED Bonner were despatched at 1100.[E477]

6.143 At 1115, MHQ Ops West advised FBWHC by telephone that there were now four injured and three or four personnel unaccounted for.[E365, E477] At 1135, Staff Officer, Health Services, (SOHS) relocated to MHQ Ops West.[E477] SOHS provided a valuable liaison service between MHQ Ops West, FBWHC, St John of God Hospital Murdoch (SJOGHM) and MHQ medical staff. SMO STIRLING was on site at SJOGHM, and also provided useful liaison services between WESTRALIA's medical organisation and the Hospital.

EXTERNAL ASSISTANCE

6.144 At 1200, CPO Bonner rang FBWHC to advise that WESTRALIA's intention was to fly the four casualties using SUCCESS's Sea King helicopter to SJOGHM. He advised that there were still four personnel missing. MHQ Ops West were notified at 1205.[E365] Confirmation of the names of the four injured (not Liddell) was provided in a second call by CPO Bonner at 1245.[E365]

6.145 At about 1230 the Submarine Escape Training Facility recompression chambers at STIRLING were placed on immediate notice for the reception of smoke inhalation casualties. They were stood down at about 1600.[E64]

6.146 FBWHC was advised by SOHS at 1505 to prepare for the reception of minor casualties. This advice was subsequently revised to prepare for the reception of personnel for overnight accommodation. A total of 18 beds were prepared by 1535.[E477] FBWHC staff met the ship on arrival and provided general support. The two ambulances stood by but were not required, neither was the accommodation. FBWHC staff were stood down at 1905.[E477]

St John of God Hospital Murdoch

6.147 St. John of God Hospital, Murdoch, was well placed to received the casualties by air, triage, resuscitate and stabilise them, and, if it had proven necessary, transfer them to more sophisticated treatment facilities in central Perth.

6.148 SJOGHM obtained additional medical staff from Fremantle Hospital.[T3227] The Senior Medical Officer FBWHC, CMDR Robertson, attended the hospital, keeping in touch with MHQ Ops West by mobile telephone to maintain accurate casualty information.[T3224, E384] St. John's Ambulance provided two ambulances on site to cater for the possible need for transfer to another hospital, which could have been achieved, after stabilisation, within about 15 minutes.[T3223, T3228]

Conclusion

6.149 St John of God Hospital Murdoch is well equipped to receive casualties by helicopter from ships at sea, and transfer them to other hospitals if clinically indicated.

Recommendation

<p>6.150 Agreements should be developed with civilian health authorities and hospitals on the procedures to be followed in the event of casualties being required to be medevacced by air from ships off the Australian coast.</p>
