REPORT OF COMMISSION OF INQUIRY
CONCERNING THE DEATHS OF
SGT CRAIG MARTYN LINACRE
CPL MICHAEL ANTHONY McAVOY
CPL DAVID GRAHAM O'NEILL

("SWAN ISLAND COI REPORT")

3 SEPTEMBER 2008
PREFACE

The President of the Report of the Commission of Inquiry concerning the deaths of Sergeant C.M. Linacre, CPL M.A. McAvoy and CPL D.G. O’Neill, Mr P.R. Callaghan, RFD, SC, forwarded the Commission’s report to the Appointing Authority, Air Chief Marshal A.G. Houston, AC, AFC, on 3 September 2008. The version here includes a number of deletions. Changes are listed in the Table of Amendments.

Material not published

As identified in the Table of amendments there are elements of the report which have not been published. Some material has not been published because publication would be an unreasonable disclosure of sensitive personal or operational information. These parts are not material to the findings or recommendations in the report. Where there are multiple amendments within a paragraph, the number will follow the paragraph number in parentheses.

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SWAN ISLAND COI REPORT

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SWAN ISLAND COI REPORT
SECTION 1 – THE INQUIRY

Instrument of Appointment and Terms of Reference

1.1 By Instrument of Appointment bearing date 04 October 2007 Air Chief Marshal Allan Grant Houston, AC, AFC, Chief of the Defence Force appointed a Commission of Inquiry constituted by myself, Peter Raymond Callaghan RFD S.C., for the purposes of inquiry into the circumstances surrounding the deaths of Sergeant Craig Martyn Linacre,
Corporal Michael Anthony McAvoy and Corporal David Graham O’Neill, as specified in the Terms of Reference.

1.2 The Terms of Reference, bearing date 23 November 2007, include a statement of the background to the Commission of Inquiry (which I will also refer to in this report as “the COI” or “the Inquiry” or “the Commission”):

“It is reported that the deceased members died in a single vehicle car accident 9 Apr 07 at Swan Island in Victoria.

Sergeant Craig Linacre, Corporal Michael McAvoy and Corporal David O’Neill were members of the Australian Army when they died. I have appointed a Commission of Inquiry pursuant to Part VIII the Defence (Inquiry) Regulations.”

1.3 The Terms of Reference specify the Inquiry Task:

“The Commission of Inquiry is to obtain evidence and to provide me with a report detailing, with reasons, the findings of the Commission as to:

a. the circumstances proximately surrounding the deaths of the deceased members including, without restricting the generality thereof;
i. the date and place of each death;

ii. the manner and cause of each death; and

iii. any facts and circumstances establishing that the deaths of any of them arose out of, or in the course of, their service.

b. the sufficiency of any actions or decisions materially relevant to the deaths of the deceased members, both prior and subsequent thereto; and

c. any weaknesses (isolated or systemic) in Defence systems, policies, equipment, practices, procedures and training perceived in the context of the deaths of the deceased members."

1.4 Under Regulation 110 of the Defence (Inquiry) Regulations, the Commission of Inquiry is empowered to make recommendations arising from its findings. The Terms of Reference provide further:

"The findings and recommendations of the Commission may be used by me:

a. primarily as the basis for appropriate remedial action in respect of any weaknesses or deficiencies (isolated or systemic) in Defence systems, policies, practices, equipment, procedures and training as may be identified in the Commission's report; and

b. also to inform, subject to Regulation 63, the deceased's members' next-of-kin and other family about the circumstances surrounding their deaths.

Without limiting the scope provided for by Regulation 110, I am particularly interested in considering recommendations regarding actions that the Commission believes should be taken with respect to any weaknesses or deficiencies (isolated or systemic) in Defence systems, practices, policies, procedures and training associated with the death of the deceased members."
1.5 The Instrument of Appointment directs pursuant to Regulation 117 that the Commission must not conduct its Inquiry in public and that

"And pursuant to Regulation 117(2)(b) of those Regulations, persons who are, in the opinion of the President, immediate family members or close friends of each of Sergeant Linacre, Corporal McAvoy and Corporal O'Neill may attend Commission hearings, other than those hearings which involve the disclosure or discussion of classified information above the SECRET level – PROVIDED THAT, for Commission hearings which involve the disclosure or discussion of any classified information, such persons are made subject to a direction issued by the President under Regulation 62 prohibiting absolutely, disclosure of security classified information from that part of the Commission's hearings."

1.6 The Terms of Reference direct:

"The Commission is not to conclude or find that a disciplinary or criminal offence has been committed by any person. Nor is it to use the language of the criminal law when describing particular conduct or behaviour."

1.7 Security issues are specifically addressed in the Terms of Reference, in particular as follows:

"Sensitive capabilities. Commonwealth activities at Swan Island are very sensitive in nature and directly related to national security. The need to protect these national security interests is imperative. In performing the inquiry task at paragraph 4, the Commission should proceed on a strict 'need to know' basis in seeking and obtaining any classified information relating to activities conducted by the Commonwealth at Swan Island. The President is to notify me as soon as practicable if evidence about such security-sensitive activities is received by the Commission..."
Security Liaison Officer. A SLO will be provided in support of the Commission Administrative Support Team. The SLO is the principal adviser on issues of security to the Commission, counsels assisting and representing, and the Administrative Support Team. The Commission and counsel assisting are to liaise closely with the SLO when conducting its scoping and planning for this inquiry.

Hearings
1.8 The Commission of Inquiry conducted hearings at Defence Plaza, Melbourne from 14 April to 18 April 2008 (including a view on the afternoon of 14 April) and between 28 May and 6 June 2008. Some written submissions were lodged with the Commission during July 2008. Oral evidence was taken from 12 witnesses and statements and reports from another approximately 25 witnesses were tendered. A list of documents which became exhibits at the Inquiry is an attachment to this Report. The exhibits themselves and a copy of the transcript should accompany this Report.

Appearances
1.9 Squadron Leader Edwin Lorkin RAAFSR and Major Leah-Barbara Maguire appeared as Counsel assisting the Inquiry. In respect of each deceased member, his partner was, in accordance with Regulation 121, appointed as a single representative of the member and authorised to appear before the Commission and to be represented there by Counsel. Commander Gary Barrow RANR appeared for Mrs Taryn Linacre, as the single representative of Sergeant Linacre, Lieutenant Justin Lewis RANR appeared for Ms Vanessa-Calvert as the single representative of Corporal McAvoy and Lieutenant Peter Billings RANR appeared for Ms Sara Cole as the single representative of Corporal O'Neill.

1.10 Having regard to the directions in the Instrument of Appointment and the Terms of Reference concerning the privacy of the hearing, I permitted various
members of the families of the three deceased soldiers, and also personnel from the Defence Community Organisation ("DCO") and the Special Air Services Regiment ("SASR") who were assisting the family members, to attend the Inquiry from time to time as they wished.

1.11 Prior to the commencement of hearings, Soldier 17 and Soldier 2 (I will explain these references below) were notified that I considered that each of them may be affected by the inquiry conducted by the Commission. They were each authorised to appear before the Commission and to be represented there by Counsel. Commander John Rush RFD QC RANR appeared for Soldier 17 and Colonel Gary Hevey RFD appeared for Soldier 2.

Security

1.12 On the first hearing day of the Inquiry, I made a direction as follows:

"1. **By way of direction in the interests of the defence of the Commonwealth pursuant to regulation 62 of the Defence (Inquiry) Regulations 1985 I prohibit the disclosure (other than for the proper performance of a role associated with this Inquiry) outside the Inquiry by a person who has been present at the Inquiry of any information contained in oral evidence given before the Inquiry or any document received by the Inquiry and accepted as evidence, which:**

(a) **indicates the identity of any Special Operations Command operational personnel; or**

(b) **is the subject of a security classification.**

2. **I further direct that each person permitted to be present at the hearing (other than Inquiry staff, Counsel and transcript personnel) is to sign a written acknowledgement of this direction and leave that with the Inquiry staff."**
That was issued having regard to the direction in the Instrument of Appointment pursuant to Regulation 117 set out above, to Chief of Army Directive 15/07 dated 30 August 2007.

1.13 I also orally directed a procedure of numerical reference to SOCOMD personnel in the Inquiry as follows:

"Subject to anything that might arise from time to time and such submissions as may be made to me, I see Counsel Representing as also having demonstrated a clear need to know that information. Protected identity status is ensured to some extent by the privacy of this Inquiry. But further steps should be taken, and that is why I have been referring to certain Army persons in a numerical way this morning rather than by reference to their respective ranks and names. So far as practicable, that arrangement should prevail throughout the hearing in relation to those persons and all other operational SOCOMD personnel who may give evidence or be referred to in evidence or in material tendered.

A reference card, classified restricted, in respect of such personnel has been produced for use in the inquiry room. Sometimes it may be impractical for some names of operational SOCOMD personnel not to be mentioned in the course of evidence, particularly from non-service
personnel. We will have to handle that as best we can as we go along."

1.14 In accordance with the foregoing directions, SASR personnel (apart from the three deceased soldiers) were referred to during the hearing, both in documents (by redaction) and orally, and are referred to in this Report, by number, not by name and as "Soldier" without designation of rank. The reference card referred to in the previous paragraph became Exhibit C1 in the Inquiry, and is classified RESTRICTED. Some documents were tendered to the Inquiry in redacted versions with other security sensitive, but not directly relevant, material removed.

1.15 Documents which had a security classification were given a "C" marking to distinguish them from the other exhibits and, as classified exhibits, listed and held separately from the other exhibits. Those documents, except for two were classified RESTRICTED and the other two had a SECRET classification and were held by the Inquiry Secretary in a separate and secure situation.

1.16 Oral evidence was taken from Soldier 2 in a classified section of the hearing with the transcript marked RESTRICTED. While various classified exhibits were tendered on that occasion I see no reason why the classification of the transcript (but not those exhibits) should not be downgraded to IN-CONFIDENCE.

1.17 The Security Liaison Officer was in attendance at the Inquiry and assisted with the above security arrangements, including by delivering security briefs to persons permitted to attend the Inquiry.
2.1 SGT Linacre, CPL O’Neill and CPL McAvoy were all members of SASR and were participants in a course conducted at the Swan Island Army Detachment ("SIAD") on Swan Island near Queenscliff, Victoria in March and April 2007. Soldier 2 was the Officer Commanding SIAD. There were about 12 course members and they flew into Melbourne on 11 March 2007. The course was scheduled to conclude on 15 April 2007.

2.2 Upon arrival at Melbourne Airport, the course members collected about 12 rental cars and drove them to Swan Island.

2.3 Those rental cars were to be used by course members on occasions during the course and the cars were available for use by them outside course duties, for personal administrative purposes, providing they were not taken off the Bellarine Peninsula.

2.4 Over the Easter weekend 2007, Friday 6 April 2007 to Monday 9 April 2007, the course members had some duties but the Sunday was a free day subject to such obligations as they had to complete some report writing. Shortly before 2130 h (9.30 pm – in this Report I will endeavour to use the 24 hour clock for time references, in the military style) on Sunday 8 April 2007, a group of five of the course members, including SGT Linacre, CPL McAvoy and CPL O’Neill, went into Queenscliff to the Esplanade Hotel.

2.5 They drove to the hotel in two of the rental cars. SGT Linacre, CPL McAvoy and CPL O’Neill were in one car ("Vehicle 1") and Soldier 10 and Soldier 17 were in another one ("Vehicle 2").

2.6 Swan Island lies within Port Phillip Bay on its western side, behind Point Lonsdale. It is separated from the mainland at Queenscliff by a channel. The
channel and adjacent marshland are spanned from the mainland to the island by a road bridge. The bridge runs in a general north-south line, is of concrete and steel construction, rises to a crest in the middle, is only one lane wide, is about 300 metres in length, has a concrete road surface and has steel guard railing on each side.

2.7 Access to the bridge from the south is reached from Bridge Road, Queenscliff through a check point ("Gate "). The road north of Gate  is called Main Road. Gate can be operated only by authorised military and security personnel.

Access to the island as well as for the military establishment, is for a golf club on the western side of the island and a yacht club on the southern side of the island. After the northern end of the bridge and a run-off causeway-type section of about 100 metres, Main Road becomes a single lane two way road with bitumen surface at the start of which (on an area known as "Rabbit Island") is a moderate curve towards the east, with a positive crossfall. Adjacent to the bitumen edge of the road on both sides of the road are grass verges leading to long grass and bushes. After about 70 metres, the north western side of the roadway runs beside the water and there is a sea wall from the level of the roadway down to the bed of Swan Bay (this area is sometimes referred to as "the causeway"). The road continues for a further 400 metres or so, including another (level) bridge, after which there are turnoffs to the left to the golf club and to the right to the yacht club and then there is a check point in a perimeter fence blocking off the military section of the island ("Gate "), with the road thereafter proceeding north-easterly within the military section for about 2 kilometres to SIAD buildings. Gate can be operated only by authorised military and security personnel. Northwards from Gate there is no street lighting.

2.8 At about 0115 h on Monday, 9 April 2007 the five soldiers left the Esplanade Hotel, travelling in the same groups in the same two cars. Vehicle 1 preceded Vehicle 2. After leaving the bridge and at about the end of the right-hand
curve Vehicle 1 ran off the roadway, crashed into the waters of Port Phillip Bay and became substantially submerged. None of SGT Linacre, CPL O’Neill or CPL McAvoy was able to escape, or be removed, from the car before they all drowned. I will use the expression “the Incident” to cover those events.

2.9 By expert Police evidence, it has been deduced from closed circuit television footage, and it is not disputed before the Inquiry, that Vehicle 1 had been travelling at an average speed of 109 kilometres per hour over a distance of 415m finishing at a point about where the vehicle began to run off the road. Similarly, the evidence before the Inquiry is that Vehicle 2 had been travelling at an average speed of 107 kilometres per hour over the same distance, behind Vehicle 1.

2.10 Post-mortem toxicological analysis showed, and it is not disputed, that the blood alcohol readings of SGT Linacre, CPL McAvoy and CPL O’Neill were respectively 0.22%, 0.08% and 0.17%.

2.11 Investigations by the Major Commission Investigation Unit of the Victorian Police could not conclude which of the three deceased soldiers had been the driver of Vehicle 1. Soldier 10 had been driving Vehicle 2.
SWAN ISLAND COI REPORT
SECTION 3
THE INCIDENT AND SURROUNDING CIRCUMSTANCES

Briefing to Course Members at Swan Island Army Detachment

3.1 After arrival at SIAD on 11 March 2007 the Officer Commanding ("OC") SIAD, Soldier 2, provided the course members with an oral briefing in accordance with a document entitled "Swan Island army detachment administration brief". The briefing included references to the use by course members of the rental cars.

3.2 Defence Instructions (General) Administration ("DI(G)-Admin") 20-28 comprises the Defence Road Transport Instructions ("DRTI") of about 100 pages and some 17 Chapters. The Glossary within the DI(G) Admin 20-28 defines "defence vehicle" as:

"Any vehicle that is owned by, or leased or hired by, the Department of Defence. It can be plated with Defence, Commonwealth or civilian plates."

The rental cars would thus constitute defence vehicles for the purposes of DRTI.

3.3 Clause 5.24 of DRTI dictates a strict regime (which could be termed "no alcohol consumption whatsoever") in relation to drinking by the driver of a Defence vehicle:

"Drivers of Defence vehicles:

a. are not to consume alcohol whilst operating a Defence vehicle;

b. are to maintain a zero blood alcohol reading if operating a Defence vehicle;"
c. are not to operate a vehicle if they are considered to be under the influence of alcohol or drugs; and
d. are not to enter a licensed premises whilst on duty except in the performance of duty or to obtain meals."

3.4 Relevant speed requirements are specified in Clause 5.35 of the DRTI:

"The maximum speed at which a Defence vehicle is to be driven is the lesser of:

(a) the maximum authorised speed imposed to cater for prevailing road, traffic and weather conditions and displayed on civilian or military sign-posting...
(b) the maximum permissible road speed limit imposed by the National Road Transport Reforms with a maximum speed limit of 110 kmh;...
"

3.5 Apart from use of the rental cars for course purposes, the members were permitted to use them for private purposes, explained by Soldier 2 in a tendered statement:

"SIAD is a sub-unit remotely detached from its parent unit, SASR. The provision of motor vehicles for course members is necessary and appropriate. The location of Swan Island is such that personnel need to have access to transport to Queenscliff and other off-island areas."

In oral evidence, he said as to content relevant to driving in his briefing:

"As always in all the briefs, if we're going to work with vehicles it's always mentioned about the state road laws, island road laws. We also then go and expand on speeding and not to drink and drive."
3.6 As noted in Section 1 of this Report, prior to the Inquiry commencing, Soldier 2 was notified that I considered that he may be affected by the inquiry conducted by the Commission and he was authorised to appear before the Commission and have legal representation there. In the written notification to him from Counsel Assisting he was informed that he was a person who might have adverse findings made against him in respect of the following matters:

- “Your decision as Commanding Officer of Swan Island Army Detachment to permit members of a course undertaken at Swan Island commencing 11 March 2007 to utilise defence vehicles in circumstances where you failed to take all reasonable steps to ensure that such use was undertaken consistent with the requirements of Chapter 5 of the Defence Road Transport Instructions and in particular paragraph 5.24 which relevantly provides...”

- “As Commanding Officer failing to adequately brief course members as to the requirements of Chapter 5 of the Defence Road Traffic Instructions and in particular paragraph 5.24”

3.7 In answer to questions at the Inquiry from Counsel Assisting Soldier 2 maintained that he had briefed the course members “don’t drink and drive”, that “my intention was don’t drink and drive” and later, in the context of a visit to an hotel, that “...I would have expected the driver not to drink.”

3.8 Soldier 2 agreed at the Inquiry that when he briefed the course members he was unaware of the requirements of DRTI and was also unaware of the zero alcohol requirement when driving a defence vehicle. He stated “I was unaware of the specifics of that DRTI and I would say I was unaware personally of the absolute no drink before you could drive. But when I gave the brief, as I say, it was no drink and driving” later corrected to “don’t drink and drive.”
3.9 He acknowledged that he had, when spoken to by Counsel Assisting before the Inquiry commenced, he said, among other things:

"Well as far as I know, you can drive a Defence vehicle as long as you're under the limit. If you have a beer with tea, as far as I know anyway, you could drive a Defence vehicle. I could be wrong in that, but as far as I know..."

3.10 There was no item expressly dealing with drinking and driving in the brief document to which Soldier 2 referred.

3.11 Soldier 17 was asked at the Inquiry about the briefing given by Soldier 2 and he said that Soldier 2 said: "don't drink and drive" and that his "...assumption of that was in our own time was just under the normal civilian road laws, as long as you're under .05 it was okay, but that was my assumption. That was not dictated." He also said that as to using the cars for non-course business:

"There was restrictions in that if you were to go off the peninsula, the Bellarine Peninsula that you'd let the CO know, he'd give you permission to go up, like on weekend activities, to watch the football or something like that on your day off, but general transiting around the peninsula was fine."

3.12 Soldier 10 was asked questions about the briefing provided by Soldier 2 and said that he did not recall the exact words "...but the substance of what was said was 'don't drink and drive' and I believe – I interpreted that as not to exceed .05".

3.13 It is clear that Soldier 2 did not make any reference, in briefing these course participants, to Clause 5.24 of DRTI and did not make explicit the "no alcohol consumption whatsoever" regime for the drivers of the rental vehicles as called for by that provision. Nevertheless, there is, I think, a measure of
realism in explanations given by Soldier 2 in a statement by him which has Counsel tendered to the Inquiry:

"This particular course consisted of experienced, senior soldiers."

"During the brief I did not refer to Defence Road Traffic Instructions. In thirty one years in the Army I have attended numerous courses and have never heard any brief getting into the details of specific Defence Instructions whether it be for traffic, security, financial matters, equipment maintenance or any other matters. The purpose of the brief is to provide an overview and to reinforce the basics to the members. I think that it is impractical to go further."

3.14 Clause 5.24 is directed to the actual drivers of defence vehicles and its terms themselves do not impose any obligation of those who are above the drivers in the relevant chain of command.

3.15 With hindsight it could perhaps be said that it would have been preferable, particularly in the circumstances now before the Inquiry, if Soldier 2 had referred to DRTI and been more detailed on the issue of drinking and driving in his briefing to these course participants. However, I find Soldier 2's explanations concerning the briefing to be acceptable and in my opinion, he should not be criticised for any such deficiency in his briefing. That said, there has thus been presented in this Inquiry a salutary reminder of the responsibilities under DRTI for drivers of defence vehicles (including rental vehicles), which reminder should, I think, be reinforced by a recommendation concerning future briefings in courses where defence vehicles may be used.

Recommendation

3.16 In all ADF courses where members may be driving defence vehicles, including rental vehicles, briefings to members must include a reminder
of the requirements of the DRTI including in particular the mandate of no alcohol consumption whatsoever for the driver of a defence vehicle.

Allocation of Keys to Course Members

3.17 At or about the time of the administration briefing, the course members were issued with so-called "keys" with which to operate Gate and Gate. The keys are remote control electronic devices which can be activated from within a car at, or approaching, the gate to trigger the gate-opening mechanism. The keys have individual identifiers which are logged electronically at the gates to record the key used for each gate opening, the time of which is also recorded. Notwithstanding that particular keys were allocated to particular course members the common (though not invariable) practice was to leave keys in the course vehicles together with the car keys so that the vehicle was fully functional for anyone wishing to use the car.

Sunday 8 April 2007
Swan Island to Esplanade Hotel

3.18 As noted in Section 2 of this Report, over the Easter weekend 2007, Friday 6 April 2007 to Monday 9 April 2007, the course members had some duties but the Sunday was a free day subject to such obligations as they had to complete some report writing. Shortly before 2130 h on Sunday 8 April 2007, a group of five of the course members, comprising SGT Linacre, CPL McAvoY and CPL O'Neill, and Soldiers 10 and 17 went into Queenscliff to the Esplanade Hotel. They drove to the hotel in two of the rental cars. SGT Linacre, CPL McAvoY and CPL O'Neill were in one car, a charcoal grey Falcon XR6 with Victorian registration UOW-220 ("Vehicle 1") and Soldier 10 and Soldier 17 were in another one, a blue Falcon XR6 with NSW registration AK 08 77 ("Vehicle 2").
3.19 Soldier 10 drove Vehicle 2. It is not clear who drove Vehicle 1 or who sat where in that vehicle.

3.20 The key issued to CPL O’Neill is recorded as having operated Gate 1 at 2126.55 h and Gate 2 at 2127.45 h as the vehicles travelled south off Swan Island. There is no key entry record at Gate 2 for Vehicle 2 at the relevant time. There is however an entry for the key issued to Soldier 10 at 2128.10 h when Vehicle 2 exited Gate 2. It appears that Vehicle 2 followed Vehicle 1 in close convoy through Gate 2 earlier without the need for Gate 2 to be again opened by an occupant of Vehicle 2. I add first, that times shown on the gate opening records and the CCTV films on Swan Island are synchronised but secondly, that no Swan Island CCTV records of this time period were preserved.

3.21 The fact that the key issued to CPL O’Neill operated Gates 1 and 2 does not necessarily suggest that he was the driver of Vehicle 1 for at least the following reasons:

- The range of the key was such that anyone in the car could have activated the gate;
- As I have noted, the common (though not invariable practice) was to leave keys in course vehicles together with car keys so that the vehicle was fully functional to anyone wishing to use the car;
- The key allocated to SGT Linacre is recorded as opening Gate 1 on two occasions recorded after the Incident, namely at 0146.14 h and again at 0200.25 h on 9 April 2007, thereby demonstrating there be no actual connection between a use of key and the person to whom the key had been allocated; and
- Vehicle 1 had been rented out in SGT Linacre’s name and the Vehicle Authorisation and Task form recorded it as having
been driven since then by him and a number of other course members.

At Esplanade Hotel

3.22 The Esplanade Hotel is situated within a kilometre from Gate , down Bridge Street and around a couple of corners. Vehicle 1 arrived first and parked in a street car parking area near the hotel. SGT Linacre, CPL O’Neill and CPL McAvoy went into the hotel. Vehicle 2 parked in the street car parking area further along from Vehicle 1 and Soldiers 10 and 17 joined the other three members in the hotel. They had all arrived at the hotel by approximately 2130 h.

3.23 The five members each had a number of drinks mainly full strength beer but there were some glasses of spirits (Jaegermeister shots) consumed by some of the members at least. Soldier 17 had no recollection of having had a Jaegermeister shot and Soldier 10 stated that he believed that he had consumed one Jaegermeister shot. The group of five conversed amongst themselves and then joined some other patrons. Without exception, statements tendered at the Inquiry from patrons and hotel staff are to the effect that the members were all well behaved and, although relaxed, they did not appear to be badly affected by alcohol. Closed circuit television (“CCTV”) film from the hotel shows the group leaving the premises in an orderly way.

3.24 Nevertheless, as has already been noted in Section 2 of this Report, the toxicology reports on the three deceased members indicate the following blood alcohol readings: SGT Linacre .22%, CPL McAvoy .08% and CPL O’Neill .17%. A preliminary breath test performed on Soldier 10 at approximately 0340 h returned a reading of .053%. A decision was taken by Victoria Police not to further test Soldier 10 as they wished him to make a statement concerning the circumstances of the Incident. Given the fact that a formal breathalyser test was not conducted on him it would not be safe to conclude that Soldier 10 had a particular concentration of alcohol in his system when he
drove back from the hotel. However, it is not in issue that he had been drinking alcohol prior to driving.

Monday 9 April 2007
Esplanade Hotel to Swan Island

3.25 Shortly before 0115 h on Monday 9 April 2007 the group of five Soldiers left the hotel and returned in the same cars in which they had arrived. Once again it is unclear which of SGT Linacre, CPL O'Neill or CPL McAvoy drove Vehicle 1 and the seating positions in the car are also unknown. Soldier 10 drove Vehicle 2 with Soldier 17 as a passenger and their evidence is to the effect that they did not see the others getting into their car.

3.26 There is evidence suggesting that the cars drove at some speed back to Gate One of the hotel patrons who had been drinking with the soldiers commented to another at the end of the night "I just saw a car speed off around the corner", which she said she thought the soldiers were in. More significant, however is evidence from Mr Paul Reid whose family has a holiday house at Queenscliff.

as he described:

"The property runs between ... and ... on the right hand side of the road as you look down to the bridge. The cottage is houses down from the end of ... so we are around metres from the gate that blocks access to the bridge over to Swan Island. Our bedroom window is situated a bit over 10 metres from the fence, probably 15 metres to the road. The window is on the south side of the house, facing away from where the bridge is located to the north."

He explained what occurred initially:
"On Sunday, the 8th of April 2007, I was at my holiday house with my family. That Sunday night, my wife and I were in bed asleep with our bedroom window open. We were both awoken in the early hours of Monday morning by the sound of a car accelerating along Bridge Street. From the times I have been at Queenscliff, I am not usually woken by traffic in the streets outside unless the car is very loud.

Because this car was accelerating quickly, it woke me up. It is usually very quiet at night in Queenscliff and you can easily hear noises outside. The car going along Bridge Street woke both of us. I am a fairly light sleeper, but my wife is a very heavy sleeper and it was loud enough to wake the both of us."

He also said that he could:

"...recall hearing a car accelerating and travelling very quickly across the bridge that runs from Bridge Street towards the golf course and army barracks. I base the speed on both the noise of the engine, because the car accelerates, and also the short time intervals between the car passing and joints in each bridge span as it picked up speed."

3.27 It is apparent from Mr Reid's further evidence which I will refer to shortly, that what Mr Reid heard was either or both Vehicle 1 and Vehicle 2.

3.28 On CCTV film taken by a camera the following is shown:

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>0115.41 h</td>
<td>Vehicle 1 arrives at the barrier and Vehicle 2 straight thereafter</td>
</tr>
<tr>
<td>0115.42 h</td>
<td>Barrier commences to open</td>
</tr>
<tr>
<td>0115.48 h</td>
<td>Barrier open</td>
</tr>
<tr>
<td>0115.49 h</td>
<td>Vehicle 1 enters</td>
</tr>
<tr>
<td>0115.51 h</td>
<td>Vehicle 2 enters</td>
</tr>
</tbody>
</table>
The record at Gate shows that the key issued to CPL O'Neill was used to open Gate. As I have said above, in relation to the departure earlier through Gate, the fact that the key issued to CPL O'Neill was used does not establish that he was, at that time, the driver of Vehicle 1.

Gate to Scene of Incident

There is then CCTV footage from a camera at which shows the vehicles cresting the bridge apparently a short distance apart. There is another camera which recorded Vehicle 1 cresting the bridge at 0115.50 h, Vehicle 2 doing so at 0115.52 h, travelling down the single lane roadway apparently a short distance apart, braking near the entry onto the two lane roadway, and going into the right hand curve, when the cars' lights went out of camera range.

The Incident

Leading Senior Constable Schultz of the Victorian Police Major Collision Investigation Unit ("MCIU") arrived on Swan Island at about 0415 h on 9 April 2007. He has qualifications in, among other disciplines, surveying and technical drawing. From his observations and measurements (using a Geodimeter Total Survey Station) that day he prepared a scale plan of the Incident scene. He recorded his examination of the scene thus in a statement which he prepared:

"I then walked through the collision scene familiarising myself with it. I found the road surface to be dry with the weather clear and cool with no cloud cover. There was no provision for street lamps. The regulatory speed limit on the bridge and onto Rabbit Island was 40 km/h."
On the eastern side of the road and facing north, approximately 118 metres from the end of the bridge I observed a stationary Grey coloured Ford Falcon XR6 sedan bearing Queensland registration – 110 JPZ. The two occupants of the vehicle were said to have been involved in post collision rescue. This vehicle appeared to be undamaged. It was removed from the scene.

The road configuration leading into the scene north from the bridge was that of a single lane, two way undivided carriageway with a sealed bituminous surface in average to below average condition by virtue of degrading bitumen and patching. The road was approximately 5.3 metres in width. The roadside edges consisted of short cut grass extending approximately 1.6 metres out from the bitumen edge and at the same level as the bitumen surface. Adjacent to the cut grass on the western side of the road were shrubs and native grasses approximately 1.0 metre in height. Beyond this was a concrete sea wall approximately 370 mm in width and approximately 1.5 metres in height to the sand level below. The sea wall extended from a point approximately 93 metres north of the end of the bridge to the next bridge for Swan Island. The sea wall was located, on average, approximately 2.5 metres out from the western roadside bitumen edge. Beyond the sea wall was a stretch of water forming part of Swan Bay.

Within the water approximately 63 metres north of the end of the single lane bridge and approximately 20 metres out from the sea wall was a submerged vehicle. Initially only the opened rear boot lid top was showing but as the tide ebbed, more of the vehicle was exposed. On salvage this vehicle was identified as a charcoal coloured Ford Falcon XR6 sedan bearing Victorian registration of UOW 220.

On the western roadside shoulder bitumen/grass junction and approximately 68 metres north of the end of the single lane bridge was a single rolling tyre print. This rolling tyre print measured approximately 15.7 metres in length and in my opinion was made by
the left side tyres. The tyre print led directly off road towards the start of the sea wall. The clarity of the tyre print was lost as the vehicle travelled over the higher roadside grasses. Over the last 1.5 metres of this rolling tyre print on the cut grass surface, light scuffing suggested to me that there had been some steering input to the right. This observation, in my opinion, was supported by a second rolling tyre print commencing on the western roadside shoulder bitumen/grass junction approximately 18.3 metres from the start of the first rolling tyre print. This tyre print was approximately 3.5 metres in length and was angled slightly towards the right away from the line initially travelled by the vehicle as it left the road. This tyre print was, in my opinion, left by the right side tyres of the vehicle.

A further ill defined tyre mark was observed through the higher roadside grasses. This mark was approximately 32.5 metres north of the first tyre mark and was approximately 2.87 metres in length. This tyre mark was, in my opinion, left by the right side tyres of the vehicle. The tyre mark ended at the sea wall. No tyre or scrape markings on top of the seal wall were evidence suggesting that the vehicle had cleared the top of the wall albeit that there was only a slight drop from road level to the top of the sea wall. The front under tray of the vehicle was located on the rocks beside the sea wall immediately adjacent to the location the vehicle was airborne over the wall. Gouge marks were evident in the sand approximately 14.1 metres north and in line with the end of the last tyre mark immediately prior to the sea wall. Here there was a vertical drop of approximately 1.65 metres. Given the attitude the vehicle left the road and the narrowness of the gouge marks it appeared to me the vehicle had dropped onto its left side prior to striking the water and sea floor.

Approximately 45 metres north of the start of the gouge marks was a submerged Ford sedan. The vehicle was facing generally south opposite to its original direction of travel. The front skirt from this
vehicle was located on rocks approximately 22.2 metres south-east of the vehicle and approximately 1.65 metres out from the sea wall."

3.32 Senior Constable Urquhart of the Victoria Police Major Collision Investigation Unit attended the Incident scene at 0950h on 9 April 2007. He inspected Vehicle 1 which had been recovered from the water and was on the roadway. He recounted what he saw:

"It had an automatic transmission with the gear selector in "P". The handbrake lever had been pulled upwards. The headlight switch was "on". The heat selector switch was about half way between cold and hot. The fan speed selector was at three quarters. A set of keys were located in the drivers footwell, with the ignition key snapped off. No airbags had deployed. The boot compartment was empty and had been opened. The bonnet was open. The rear window glass had been broken out. Information received indicated that this had occurred during rescue. Both stop/tail globe filaments were inspected and showed no evidence of distortion. The rear passenger side door handle had been pulled from its mounts from inside the vehicle.

It had sustained impact damage to the front end, and passenger side panels. The front bumper bar had broken away from its mounts on the passenger side. Both passenger side door panels had sustained impact damage and were not able to be opened. The front windscreen had cracked from impact by the rear passenger side corner of the bonnet. All tyres were of serviceable tread depth. Both passenger side tyres were deflated, with the rim impact damage visible on the front.

The front drivers door was able to be opened. I opened the rear drivers side door from the inside of the vehicle by reaching through from the front. Located lying across both front seats was the deceased, LINACRE..."
3.33 Senior Constable Urquhart made a walk-through examination of the scene, part of his observations being:

"Located on the western side of the roadway, on the grass verge was a series of tyre marks. These marks commenced about three quarters the way through the right hand curve. The marks had the characteristics of being rolling tyre prints. That is, they were not emergency braking marks, nor were they the result of an oversteer input to the right. Additional marks were located near the concrete wall. Given the location and orientation of the marks it was apparent that the passenger side tyres had crossed the edge of the wall while the driver side tyres were still in contact with the ground, before the vehicle became airborne and landed on the water.

A gouge mark was located in the mud surface at low tide 14.1 metres north of the last contact on the concrete wall. The vehicle was recovered 56 metres north of the last contact point. Information received indicated that the vehicle had 'floated' for some time and been carried with the current before coming to a stop."

3.34 He subsequently conducted a series of measurements and comparative tests of the scene and reviewed the CCTV footage. He said: "It is clear from video footage that both vehicles have accelerated heavily as they came through (Gate )." He established distances travelled and times elapsed and concluded that first, over the bridge Vehicle 1 was travelling at an average speed of between 103 kph and 113 kph and Vehicle 2 was travelling at an average speed of 103 kph and that secondly:

"For the distance of 415 metres from the bridge crossing to the extreme right hand edge of the view afforded by camera the average speed of Vehicle 1 was 109 kph and for Vehicle 2 107 kph."

His reference to "bridge crossing" in the last quoted statement was to the commencement of the view from Camera which is located
His calculations were not challenged at the Inquiry. He also concluded that Vehicle 1 left the roadway and entered the waters of Swan Bay at 0116.06 h.

Another aspect of his oral evidence as to speed should be noted:

"How would you describe this corner?---Given that it has a -- given that it has a critical curve speed of around 105 kilometres an hour, with a positive cross-fall through the corner, I would describe it as a moderate -- moderate to gentle -- curve. If you knew there were no vehicles coming the other way, you've actually got more than what would typically be a single car lane on a road and, if you took the racing line through that corner, you could -- you could travel at in excess of the 105 kilometres an hour I've suggested."

3.35 From his examination of the tyre marks and other indications on or adjacent to the roadway he expressed the view in oral evidence that the driver of Vehicle 1 had "in effect, straightened up as you would to exit a corner, but too early... and, if you like, misjudged the curvature of the road." He noted that at 100 kph a car travels at 27 metres a second and that from the position where the first tyre of Vehicle 1 left the bitumen to where it left the sea wall was around 19 metres. He said that studies "show that a driver unaffected by fatigue, drugs or alcohol will react to a situation in less than 1.5 seconds". He expressed the opinion that there "...is no indication that the car was going anywhere other than where the driver was steering it" and that "...it is apparent that the driver has misjudged the curve and failed to negotiate it through to the exit."

3.36 Senior Constable Urquhart also assessed from the CCTV film that at the time the vehicles went in to the right-hand curve they were 1.8 seconds apart which at a speed of 100 kph would correspond to a distance of 50 metres.

3.37 According to Soldier 10 and Soldier 17 neither of them actually saw Vehicle 1 leave the roadway and enter the water. Soldier 10 said in a statement tendered by his Counsel:
• "On 9 April 2007 I made a statement to police. The statement records that I signed it at approximately 0635 h on 9 April. I have no recollection of the time but have no reason to disagree with the time recorded.

• In looking back at the morning of 9 April 2007 I have no doubt that I was in shock. I had witnessed the death of three close mates despite attempts to rescue them. I was traumatised and I believe this had and continues to have some effect upon my recollection of events on the morning.

• I still have no precise recollection of the entry to Swan Island. The CCTV shows the vehicle I was driving entered through the gate following Vehicle 1. I clearly did not activate the gate as indicated in my first statement. I can only say that at the time of my statement I was doing the best I could to reconstruct what happened on the night.

• After gate entry my recollection is following Vehicle 1. The area is dark with no lighting. In my earlier statement I said that 'I'm not able to say how far the other car was in front of me at this time'. This remains the position. I followed Vehicle 1 along the causeway. I could see its rear tail lights. I remember noticing the glow of its headlights in front of me but I am unable to state the distance between our two vehicles.

• The statement to the inquiry of Constable Taylor refers to a conversation I had with her at the time of the arrival of police sometime around 1.35 am. I do not recollect the conversation. The statement records in part that I stated 'I saw the car heading for the water. I saw the headlights disappear into the water and the car go in. That was the last thing I saw'. The statement of ambulance paramedic Kyle Lee refers to a
conversation I had with him. The statement records that I said to him that I "...saw the car veer off the side of the road and into the water'.

- These versions are partly correct in their reference to my observation of headlights. I saw the headlights of Vehicle 1 after I had taken the bend in the road. The headlights appeared to flicker and caught my eye. Because of the position of headlights I realised the vehicle had left the roadway but I did not see the vehicle leave the roadway. It is difficult for me to determine exactly where I was at the time I observed those headlights. I was concentrating on my driving.

- I am unable to say at what speed my vehicle was travelling across the causeway. I find it difficult to believe that I was travelling at the speed indicated by police i.e. in excess of 100 kms per hour.

- To the best of my recollection there was at least a couple of seconds between my vehicle and Vehicle 1. I applied the brakes on my vehicle prior to the bend. I stopped the vehicle I was driving approximately adjacent to where Vehicle 1 had come to stop in the water off the roadway.

- I note that SGT Peters says that I would have '...seen the vehicle containing the three deceased leave the road and the sequence of events in their entirety.' This is not so. My best recollection is set out above.

In oral evidence, he was asked "...Looking back, do you have any recollection of the sort of speed you were travelling at?" and he responded:
"No, I wasn't looking at the speedometer, so I cannot either – I mean I can't refute the methodology used by the police but I have no reference as to the speed at which I was travelling."

He told Counsel Assisting "...I have done a lot of driving in the military" and in response to a question from Counsel Assisting whether he perceived himself to be a highly-qualified motor vehicle driver said:

"...I would say I am a qualified vehicle driver in varying elements but I would not necessarily use the term 'highly'."

He said that he did not observe whether the lights of Vehicle 1 were on high beam or not.

3.38 It should be added that, as has already been noted, Soldier 10 was notified, prior to the hearing, that he was a person who may be affected by the Inquiry. He was informed that it may be open for the Commission to make adverse findings arising from his conduct concerning the following matters:

- "Your intake of alcohol prior to commencing to drive the vehicle which followed the vehicle in which the deceased members were travelling in the course of and upon returning to Swan Island at or about 0115 hours on 9 April 2007; and
- The manner and speed of your driving in the course of and upon returning to Swan Island at or about 0115 hours on 9 April 2007."

3.39 Soldier 17 said in a statement which he made to the Police on 9 April 2007:

"Once at the gates we activated the system and accessed the base. Nobody got out of the cars on the way in either. The charcoal coloured XR6 drove up a slight rise and onto a bridge which is only wide enough for one car at a time going in one direction. I lost sight
of the other car when it went up onto the bridge. Soldier 10 followed it up onto the bridge a short time later, but when we got onto the bridge I couldn't see the other car, but to be fair I wasn't specifically looking for it either. I was talking with Soldier 10 who I assume was watching the road, and he certainly didn't mention the other car to me at that point.

We were about fifteen to twenty seconds behind the others, and were on a straight section of road that I would describe as a causeway of some type between the first and second bridge. I recall yakking away to Soldier 10, then seeing the other car off the road, in the water on our left, somewhere from fifty to a hundred metres away. The other car was facing back almost in the direction of Queenscliff but not quite. Its lights were on and the front of the car partially submerged at that stage."

He said in oral evidence at the Inquiry, in relation to his above remarks that he "couldn't see the other car" and that "I wasn't specifically looking for it either":

"What do you mean by that?----By that statement, sir, I mean I don't recall seeing the other car but at the time I may have been looking at the radio station, looking at the foot well of the car, any manner of things, but I actually didn't see that vehicle at that time, in my – that's the way I recall it."

When asked by Counsel Assisting whether he could give any indication of speed he responded:

"No, sir, I can't give any indication of speed".

He was questioned more about speed:
"That the average speed for Vehicle was 107 kilometres an hour. Would you be able to express any view about that?—I've got no view on the deductions, sir. I don't know what speed the car was doing."

Rescue Attempts

3.40 Soldier 10 stopped Vehicle 2 on the roadway facing forward. He described that situation at that time thus in his statement later that day to the Police:

"As I reached the bend, I sort of put two and two together, and realised that the vehicle which had been in front of me was now actually in the water off to the left of the causeway.

I was not in a position to tell what speed the vehicle in front of me would have been travelling at prior to going off the causeway, because were weren't that close to it. I then just stopped the car as I realised that things were serious, that it was a serious accident. I didn't take time to think where the vehicle was or its actual position in the water. I stopped my car on the causeway on the middle of the road and facing towards the base itself.

On stopping I thought 'Fuck' and then got out of the car. At first I could hear voices and I guess we were watching and waiting to see if they got out, for a few seconds, as we took everything in. I was getting rid of my 'phone, as I told Soldier 17 to get in and see if he could help them at all. I was getting rid of my 'phone as the battery was flat, and I was going to go in and see I could help them also.

I could actually see their car at this time. At this time it was only a little bit of 'front end down' in angle, and probably up to the window level with water, but most of the car was still well up out of the water. The headlights of the car were still on at this time.
Soldier 17 went in first, then called me to help him and to bring something to break the window. I grabbed a large sized rock and went in also. I just swam out to the car."

3.41 Soldier 17's description in his statement to the Police was:

"I recall yakking away to Soldier 10, then seeing the other car off the road, in the water on our left, somewhere from fifty to a hundred metres away. The other car was facing back almost in the direction of Queenscliff but not quite. Its lights were on and the front of the car partially submerged at that stage.

Soldier 10 pulled over and we both got out. I jumped into the water and swam over to the vehicle. Prior to getting into the water, I could hear the sound of voices inside the car in the water. I could hear one of the boys saying 'Keep his head above the water'.

It took me maybe thirty seconds to make my way through the water and mud and reach the car. The water was very cold. Once I reached the car, I swam to the west to the rear left of the vehicle and took hold of the spoiler. I would guess that the water at this point was in excess of two metres in depth, because of my height. I am 1.9 metres tall roughly and couldn't touch the bottom."

3.42 Determined efforts to recover the three occupants of the car were made by Soldiers 10 and 17:

- First Soldier 17 and later Soldier 10 attempted to open both the near-side (passenger-side) doors but the doors could not be opened.

- Soldier 17 endeavoured to punch in the near-side windows and to kick in the rear window but the windows did not yield.
• Soldier 10 had swim out with a rock which Soldier 17 used against the rear window but it bounced off.

• Soldier 10 swam back with a larger rock with which eventually Soldier 17 succeeded in smashing the rear window.

• While Soldier 10 was swimming back with the larger rock, the boot of the car popped open and Soldier 17 swam into the boot and unsuccessfufly kicked repeatedly at the back seat but it did not give way.

• When the rear window was smashed, they were able to pull CPL McAvoy out of the car and they took him to shore. Soldier 17 dragged him onto rocks on the shore and commenced Expired Air Resuscitation followed by Cardio-Pulmonary Resuscitation. Soldier 10 returned to the car.

Calls for Help

3.43 When it became apparent that his attempts at resuscitating CPL McAvoy were unsuccessful, Soldier 17 retrieved his mobile phone from Vehicle 2 and made a 000 call.

3.44 In the meantime, Soldier 10 had brought CPL O’Neill ashore and commenced resuscitation on him. He yelled to Soldier 17 to ring people at the SIAD barracks.

3.45 Also in the meantime, Mr Reid had responded to what he was hearing, as he described in a statement to the Police:

“After the car reached the end of the bridge, when the noise of the car crossing the joints stopped, there was silence for a few seconds
followed by a very short screech of brakes. Then I heard what sounded like a car sliding off the road through undergrowth, then a dull thud...

I could not be sure at the time that it was a serious accident and I lay in bed listening for any further clues to what was happening, and debating whether I should have a look. Within a couple of minutes or less, I heard voices. There were quite loud and sounded distressed. I turned to my wife and said, 'They're in trouble' and got up to investigate.

I put on my shorts, went outside, and hurried to the end of Bridge Street. This took me about three minutes to change and get to that location. From there I could quite clearly hear voices of two men who sounded quite distressed. I could see no sign of them, however. It sounded like they were fairly close. The sound travelled across the water and I thought they were less than fifty metres away. I could clearly hear everything they were saying. At the end of Bridge Street, there is a guard house at the start of the causeway with a security gate. Because of the guard house and security gate, I could not get on to the bridge.

There were no lights coming from anywhere along the bridge or causeway. From where I was standing, you can see right along the bridge and across to the second Security Gate out on Swan Island. I heard one of the men say he could not find or could not get Dave. He repeated this a number of times. Although I could see nothing of them, I surmised from the desperation and the conversation that they were in the water. There wasn't a lot of conversation but they were clearly desperate.

I called out to them asking if they needed help, but got no reply. So I ran back to the house, put on some shoes and a shirt, got my car keys and 'phone and drove to the end of the street and shone my lights on
high beam down the right side of the bridge. It probably took me about five minutes to return to the bridge in my car.

My high beam reached to almost the end of the bridge, but I could see no sign of the men or the accident. I again yelled out to them asking if they were alright, and again got no answer. I moved my car to different angles to see if I could see any sign of them across the water, but could see nothing of the accident. I decided that the only thing I could do was ring triple zero to notify police.”

The CCTV shows high beam headlights, obviously Mr Reid’s, shining onto the eastern side of the bridge at 0125.38 h.

3.46 The 000 Emergency Services recorded the call from Soldier 17 coming through to the police at 0126.41 h. However, in terms of precise times, it is to be remembered that the Swan Island records of times may not directly correspond to other time records such as those of Emergency Services and Telstra. The call concluded about two and a half minutes later as Soldier 17 had given all details requested and indicated that he wished to make other calls. During the call, Soldier 17 had commenced running back to Gate to let assistance in. Soldier 17 then rang, over the next few minutes following the 000 call, Soldier 4 (this call rang out) and Soldier 15 at SIAD barracks and OC SIAD, Soldier 2, to alert them to the tragedy. Mr Reid could hear some parts of these calls when Soldier 17 was at or near Gate.

3.47 At Gate Soldier 17 was unable to open the gate with his key which had evidently been in his pocket and was wet. He smashed a window on the gatehouse to obtain entry. During this period he is also shown by the CCTV camera as apparently continuing to make or receive telephone calls, one of which was with Soldier 4 at SIAD barracks.
Military and Civilian Responses

3.48 At 0138.56 h a grey Falcon XR6 with Queensland registration 110 JPZ ("Vehicle 3") is filmed coming out of Gate. This contained Soldier 15, who was the driver, and Soldier 8 and on arrival at the scene, they went to assist Soldier 10 with CPL McAvoY and CPL O’Neill. They were lifted from the rocks onto the roadway. Resuscitation attempts continued.

3.49 A police vehicle arrived at Gate at 0141.52 h and was followed within a minute or so by a County Fire Authority ("CFA") vehicle and another police car. There was a swipe card in the CFA vehicle which was used to open Gate at 0144.37 h and the two police vehicles went through at 0145.12 h. Soldier 17 stayed at Gate for a time to ensure that it stayed open.

3.50 In the meantime, Soldier 2 had rung Mr Stephen Bartlett, the security contractor then on duty on the island, advised him of the incident and requested that he meet him at the scene to assist. Mr Bartlett’s vehicle exited Gate at 0144.43 h. On arrival at the scene, Mr Bartlett was told, and observed, that the two soldiers whose bodies were lying on the grass verge, appeared to be dead. He saw flashing lights and heard sirens near Gate. He had positioned his vehicle diagonally across the roadway at the northern end of the incident scene and he turned on both its roof mounted spotlights. He used binoculars to look at Vehicle 1 in the water; the vehicle was totally immersed with only the boot fascia, spoiler and what appeared to be a white number plate visible with the boot apparently open and raised; and he could not see any tail lights or headlights operating under water.

3.51 At 0145.30 h the lights of a motor vehicle are recorded by CCTV camera coming from the Incident scene towards the bridge. At the same time the two police vehicles were coming over the bridge. This vehicle is then shown to stop short of the bridge, and do a U-turn and follow the police vehicles. Mr Bartlett, in oral evidence, was certain that it was not he or his vehicle that performed that manoeuvre. Written statements from Soldiers 8 and 15 which were tendered are not clear in these respects but it does appear
that Vehicle 3 was initially stopped at the scene facing south and was later turned around. The probability is that what was shown in the footage I have just mentioned was Soldier 8 or Soldier 15 driving Vehicle 3 (the likely purpose being to assist with entrance through Gate ) and also that Vehicle 3 was afterwards parked, north facing, near Vehicle 2. It is appropriate to mention that situation as this stage as it bears on the removal, a little later, of Vehicle 2 from the scene.

3.52 At 0146.14 h and 0146.48 h two other vehicles came out of Gate from the military area. The first of two ambulances came through Gate at 0147.52 h. Soldier 2 arrived at Gate at 0150.59 h and after speaking to Soldier 17 there, drove in and parked his vehicle at the southern end of what by that time was a number of police, ambulance, CFA and perhaps State Emergency Services vehicles.

3.53 Among occurrences which then took place at or near the scene were the following:

- Paramedics immediately examined CPL McAvoy and CPL O’Neill. It was obvious that they were deceased and no further resuscitation attempts were made.

- Paramedics treated Soldier 10 and Soldier 17 (Soldier 17 had left Gate to return to the Incident scene at 0155.41 h). Both elected not to have further treatment and to return to the SIAD barracks with other soldiers, after preliminary discussions with police officers.

- Vehicle 2 was driven from the scene probably by Soldier 15 with Soldier 8 and possibly another or other soldiers as passengers. It passed through Gate at 0155.48 h.

- Other soldiers returned to the barracks in the other vehicles which had been driven down to the scene.
The removal of Vehicle 2 led people at the scene, for example Mr Bartlett and Senior Constable Urquhart, mistakenly to assume that Vehicle 3 which was left behind, had been the second vehicle involved in the Incident.

Gate records show the use by the key which had been issued to SGT Linacre to operate the gate at 0146.12 h and 0200.25 h.

Senior Constable Michael Burge from Queenscliff was one of the first police officers on the scene and he undertook an initial supervisory role. Among other things, he had notifications sent to the MCIU, the Water Police and the State Coroner. He also spoke himself to the Water Police and a decision was made that the Water Police and Search and Rescue would not dive until daylight.

Soldier 2 left the scene from time to time to, among other things, make telephone calls from a secure line at the barracks.

3.54 Soldier 10 was interviewed by a MCIU officer at the barracks at about 0340 h. He acknowledged that he had been driving the second vehicle involved in the Incident and that he had consumed "a couple of beers" beforehand. He underwent a preliminary breath test. The result was .053%. It was decided by the police that a statement from Soldier 10 was required. No further alcohol testing was administered to Soldier 10.

3.55 A statement was then taken from Soldier 10 by Senior Constable Jeffrey Smith of Geelong Traffic Management Unit. The taking of the statement is recorded as having concluded at 0635 h. It was eventually put into typescript form comprising some 6 pages. In the statement the vehicle which had been driven by Soldier 10 is specified, correctly, as Vehicle 2.
3.56 At about the same time, a statement was taken from Soldier 17 by Acting
Senior Sergeant Brad Peters of the MCIU. That statement in eventual
typecript form comprised some 5 pages. It is recorded as having concluded at
0722 h.

3.57 Soldier 20 acted as support officer for Soldiers 10 and 17 during those
interviews and a statement from him tendered at the Inquiry includes these
comments:

"There were discussions between myself and Soldier 10 and Soldier 17
concerning the proposed police interviews however we did not discuss
what they were going to say to the police. I was present when they told
the police what had happened but I heard it for the first time at that
stage. In the course of both interviews it had become clear to me that
Soldier 10 had been driving the blue Ford XR6 registered number AK
08 ZZ that I had signed for at Tullamarine Airport.

I had probably heard an abbreviated version of the events prior to that
stage but it was limited to travelling into Queenscliff, having a couple
of drinks at the Esplanade and then on the way back the car went into
the water but no real details had been mentioned."

Retrieval of Vehicle 1

3.58 Constable Gregory Bliss is a police diver attached to the Victorian Police
Search and Rescue Squad. With other police divers he had been summoned to
the Search and Rescue Centre at the Police Rescue Co-ordination Centre at
Williamstown earlier that morning, and they arrived at the Incident scene at
about 0630 h on 9 April 2007. At about 0800 h a diving operation was
commenced with Constable Bliss making an inspection of the partly
submerged vehicle and taking an underwater video camera recording. Among
the observations of the exterior of the vehicle which he detailed in a statement
which was tendered to the Inquiry were:
“The vehicle was resting on the sea floor with wheels down facing in a south/south easterly direction. The vehicle had substantial damage to the front panels. The front lower grill and bumper section was partly removed, both front guards had considerable damage. The bonnet of the vehicle was fully raised but appeared to be intact. The passenger side doors of the vehicle were both closed and the windows both intact and fully shut. Both doors had received damage. Due to the angle the vehicle was on, being slightly passenger side down, the front wheel was almost buried with only the top third to half being visible.

The boot of the vehicle was fully open and a small black pelican case was visible inside. This was removed by myself and returned to the shore line. No other items were in the boot. The rear window of the vehicle was smashed with a large opening in the middle of the window. There was a large rock on the roof of the vehicle. The driver’s side of the vehicle had sustained damage to the front guard, but the two driver’s side doors appeared relatively damage free. Both driver’s side doors were both closed and the windows both intact and fully shut. The driver’s side front wheel was also partly buried and not to the same degree as the passenger side front.”

He later (about 1000 h) returned with another police diver and they placed tow snatch straps through the rear wheels of the vehicle, pulled them to the centre rear and connected them to a large wire tow cable. The vehicle was then removed from the water. Senior Constable Urquhart’s detailed evidence as to the state of the vehicle after it had been brought onto the roadway has been set out above.

Autopsies

3.59 On 12 April 2007, autopsies were performed at the Coronial Services Centre, Southbank, on the bodies of SGT Linacre, CPL O’Neill and CPL McAvoy.
SGT Peters from the MCIU was in attendance. In respect of each, a principal finding by the pathologist was:

"The cause of death in this case is most probably one of drowning."

There was also in respect of each a comment that:

"There were no findings at autopsy to definitely indicate the position of the deceased within the vehicle at the time of the collision."

In respect of CPL O’Neill there was a particular finding:

"In addition there was evidence of blunt head injury.

These head injuries could be associated with impairment of the conscious state."

SGT Peters’ account of his observations at the autopsies included:

"No injuries or marks were visible on the bodies of the deceased that were indicative of or even assist in indicating seating positions in the vehicle at the time of collision."

3.60 Toxicological examinations of specimens taken from the three bodies were conducted by the Victorian Institute of Forensic Medicine which, as has been previously indicated in this Report, showed blood alcohol (ethanol) readings in respect of SGT Linacre of 0.22g/100ml, in respect of CPL McAvoy of 0.08g/100ml, and in respect of CPL O’Neill of 0.17g/100ml. In respect of each, the examinations also showed that no common drugs or poisons were detected.
Mechanical Examination of Vehicle 1

3.61 Vehicle 1 was taken into police custody and on 17 April 2007 SGT R.G. Le Guier carried out a mechanical inspection of it at the MCIU Compound, Dawson Street, Brunswick. SGT Le Guier is a qualified Mechanical Investigator with 37 years of practical experience in the automotive field. He performs duty with the Mechanical Investigation Unit inspecting vehicles which have been involved in fatal or serious collisions within Victoria to determine their pre-impact roadworthiness and mechanical condition. His inspection of Vehicle 1 led him to conclude:

"Prior to and at the time of impact, this vehicle as inspected would have been classed as being roadworthy. My inspection did not reveal any fault that could have caused or contributed to the collision."

The vehicle was evidently then released to the rental company who passed it to their insurer who scrapped it.

3.62 Following questions raised by the Linacre family at the end of the hearing, enquiries were made through the Inquiry Secretary of SGT Le Guier whether there had been any modifications to the vehicle. The response was to the effect that he observed none. OC SIAD, Soldier 2, has also confirmed by a subsequent statement that all the vehicles used on the course were standard rental vehicles and not modified.

Other Aspects of MCIU Investigation

3.63 Some other aspects of the MCIU investigation should be mentioned. First, there were some skid marks observed on the roadway near the scene of the Incident, for example, by Mr Barrett. SGT Peters explained that these were considered to be irrelevant, in oral evidence:
"...initially the tyre marks were there on the night of the collision and, relying on the expertise of Mr Urquhart, I asked him to, as part of his examination of the scene, determine the involvement or the relevance of the tyre marks to which you refer. From my memory, he took a series – he measured the wheelbase – or the track measurement of the two tyre marks and indicated to me that it was inconsistent with the track measurement of a Ford SR6 sedan, and he also indicated that the tyre marks on the road appeared to him to have been left by a vehicle that did not have ABS, or antilock braking, and on that basis, given the facts that we knew in relation to the collision, those tyre marks were ruled out of our inquiry."

3.64 The possibility of DNA testing to help in determining the suspected locations of the three deceased was contemplated. A Forensic Scientist at the Victoria Police Forensic Services Centre expressed a negative opinion as to the worth of any such testing:

"Based on information provided by Sergeant Brad Peters, Major Collision Unit, on the 1st May 2007, I have formed the opinion that examination of the vehicle in relation to trace amounts of DNA would be unlikely to yield a result due to the vehicle involved in this case being submerged in water. Further, it is also my opinion that a determination of the possible seating positions of the individuals at the time of the accident would also be restricted by the amount of access to the vehicle that each of the three individuals involved had prior to the incident and the inability to age any DNA present."

3.65 The issue of the fitness of the roadway up to the Incident scene, particularly in terms of road markings and so forth, was canvassed in evidence. For example, Senior Constable Urquhart made the following comments:

"...based from what I've seen over a number of years, the greatest control on this is the speed limit of 40 kilometres per hour. Having said that, if we want to look at prevention, what would make that
corner safer, a simple and inexpensive method would be to simply paint solid white fog lines – they're called fog lines, you see them down the sides of freeways – around the edge of both sides of the bitumen road. What that does is give the driver a visual cue and something that in the darkness would distinguish between the road and possibly the verges on either side of the road. The headlights will pick up – that would be, to me, the simplest solution that would highlight the fact that there's a corner here, to provide a visual cue to the drivers that the road is curving to the right. You could extend that by putting what's called cats' eyes, raised reflective pavement markers, down the middle of the road – probably not necessary in this instance. I expect it's a fairly low-volume trafficked road, low speed. Often on corners now we see little black and yellow signposts erected on the outside of a corner, sometimes on the inside of a corner, with a little arrow, and again that's a very visual cue to the driver that this road is veering to the right. In combination with a white line, I think that would be a relatively simple solution, if we wanted to look at one. Ultimately, I suppose, if you wanted to prevent something like this occurring again, you would look at putting a steel barrier on the outside of the corner."

Against these suggestions, there are to be balanced considerations as to the speed limit, such as expressed by SGT Peters:

"...remembering it's a 40 kilometre an hour speed zone and, at 40 kilometres an hour, that bend, even in poor lighting conditions, that shouldn't pose a huge risk or a huge insurmountable task to a prudent driver."

3.66 For a time, it appears, the Police questioned the accuracy of the respective accounts concerning the Incident given by Soldiers 10 and 17 after formal statements were taken by the Police from them early on the morning of 9 April 2007. Each of the soldiers was subjected to a record of interview on 10 May 2007, but neither interview progressed when on legal advice to the soldiers
they exercised their right to further silence. The Police seem not to have persisted with any such question.

3.67 Finally, there is the perplexing and seemingly insoluble question why any of the occupants was not able to get out of the car. There is evidence (the comment from inside the car “keep his head above water” heard by Soldier 17 and the signs of head injury on CPL O’Neill’s body noted at autopsy) suggesting that one of the occupants may have been unconscious. The interior condition of Vehicle 1 when retrieved from the water had pertinent signs including:

- The automatic transmission gear selector was in the Park position.
- The hand brake was on.
- The ignition key was broken off in the lock.
- The rest of the key and the electronic locking/unlocking device were on a ring in the driver’s footwell.
- The rear side doors could not be opened because of impact damage.
- Both offside doors could be manually opened.
- The rear nearside passenger door handle had been pulled from its mount from inside the vehicle.

It should also be noted that there was a boot opening button on the dashboard.

Senior Constable Urquart’s attention was taken to this issue a number of times during his oral evidence and some of his evidence was:

“I just can’t offer as an explanation as to why no one was able to escape the vehicle.”

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(As to the pulled-off door handle)

"My recollection is that within the fabric adjacent to where the handle was an imprint of a shoe. There was a foot imprint basically adjacent to the shoe in the fabric of that, my conclusion being that someone had placed their foot against the door and, if you like, levered against it. I can't say that those two things happened simultaneously, but there was a shoe impression that was significantly hard that it had remained between when the collision actually occurred and when I inspected it some eight or nine hours later, and that the handle had come off, so that was my conclusion."

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(As to a test carried out for the purposes of a recent Victorian criminal trial)

"A test was carried out with a same make and model vehicle as the one involved in the case. It was an older Holden Commodore. We placed that vehicle by the use of a crane on to a body of water and had a police diver rigged up within the vehicle. The harness securing the vehicle was released and the vehicle was essentially floating on the water. A number of tests were carried out to determine the ease or otherwise at which a person could open a door whilst the vehicle was afloat rather than submerged, so I'm not – when I talk about these tests, they are not escaping a fully submerged vehicle; they're a vehicle that was floating on the surface, and the ease at which an occupant could open the doors in that vehicle. What we found was that the vehicle went on its own, unsupported, actually floated at quite a distinct angle, with the engine weighing it down, obviously, and the airspace of the boot basically making it buoyant, and in that scenario about 50 per cent of the driver's doors were covered by water to the outside level, whilst it's on that angle. The diver then undertook a series of tests for opening the door and getting out of the vehicle. What we found was that, once a door was opened, the vehicle sank in about three seconds; it sank very, very quickly once the water came in. However, there was time for a person opening the door to be able to
exit the vehicle before it submerged. Without opening any of the doors, this particular vehicle, again an older-model car, from memory, floated and slowly sank over a period of about 13 minutes."

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"Would there be, in your opinion, if you're able to say, any difficulty in opening a door and exiting from a door in a submerged situation?---I don't know how appropriate this is, but the best example I've seen of that was on a television show called Mythbusters, where they actually tested that exact premise of opening a door underwater. A fully-submerged vehicle that was containing air alone, they weren't able to open the door; there has to be an equilibrium of pressures inside the vehicle and outside the vehicle. Once the vehicle filled with water, the door could quite easily be opened, you have that equilibrium, and, as it was getting close to full, the door was able to be opened but, in a vehicle that's got no water in it, they weren't able to open it."

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"Sir, are you able to say — or able to hypothesise as to any impedence, either electrical or mechanical, that may have prevented those doors from being opened while the vehicle was fully-submerged and allowed to be opened when the vehicle was taken out of the water?---I can't speak of electrical. Mechanical, I can't see any reason why it couldn't have been opened mechanically. I drove the same model vehicle — not the XR6, just a standard Falcon — for a number of years and, even with the ignition switched off and the doors locked from inside the vehicle, as soon as you — as soon as you pulled on the handle the door would come open. Now, working that through, if there was an electrical fault which prevented that happening, then the doors wouldn't have been able to be opened when it was pulled out of the water. I base that on saying that — on the basis that the vehicle as it was in the water was the same as it was when it came out of the water and that it wasn't locked when it came out of the water."

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(As to the handbrake and gear selector)

I couldn't possibly hypothesise as to what was occurring but, from the time the vehicle was travelling to when it was recovered, an occupant within the vehicle has — either deliberately or inadvertently — put the handbrake on and put the gear in park."

SGT Peters said in his statement:

"My view is that the boot was opened by one of the occupants inside the vehicle, in an attempt to find a way out. This may have accelerated the rate at which the vehicle sank, as any air trapped inside the boot that may have assisted with buoyancy would have escaped. It would have been impossible to foresee this at the time."

SGT Peters' oral evidence included the following:

"You ascertained, as did Acting Sergeant Urquhart, that the driver's side door was operable?—That's right.

Easily opened?—Yes.

Did you observe Acting Sergeant Urquhart open the rear door from the inside latch?—Yes.

Having made those observations and read the statement of Soldiers 10 and 17, are you able to say, or not, if either of those soldiers had tried the driver's side door or the rear driver's side door that the doors would have opened?—In my view, they — they most likely would have but, in fairness to both those soldiers, it's — it's a fairly arduous task that they're trying to perform and in the heat of the moment they may have assumed, and I'm only — I'm second-guessing but they may have assumed that if the two passenger side doors weren't opening — that they may have been locked and all four doors may have been locked,
or they just may not have had time to get around to that side of the car while it’s filling up with water.

Also as a matter of logic, was there any reason, in your opinion, that the occupants, or the deceased, were not able to exit the motor vehicle?—I’m afraid I’d have to say that in respect to that your guess is as good as mine.”

3.68 On behalf of one of the families, complaints were made in submissions concerning an asserted lack of expert evidence having been placed before the Inquiry on this issue (as to escape from the vehicle) and in particular, concerning the disposal of Vehicle 1 before this Inquiry took place. It was put to the Inquiry that the vehicle should have been kept for specific tests relating to this issue and also that “fatal accident vehicles should remain available until after any Inquiry has concluded, and a recommendation should be made to that effect.” It is to be remembered that this Inquiry was set up some months after the event. I am not persuaded that any additional investigation of the vehicle would have produced any further assistance to the Inquiry nor do I see any basis for a view that the vehicle was disposed of prematurely; the Police inspections of the vehicle at the scene of the Incident, particularly by Senior Constable Urquhart, and subsequently by SGT Le Guier, seem to me to have been sufficiently comprehensive. Further, given in particular the Police control over the vehicle, I do not see that there was any inattention by Defence to the condition of the vehicle. Overall, I am not persuaded that I should make a recommendation to the effect submitted; other considerations apart, it is too particular and cases such as these can be quite varied in their circumstances. Nevertheless, I do suggest (short of making a formal recommendation because this is a consideration which has not been sufficiently developed) that Defence give consideration to whether it would be appropriate in the future in the event of any death of a service member in a motor vehicle accident or otherwise having a connection with what I might term some other “civilian” situation, for Defence promptly to task a service member at Military Police (or equivalent) level to liaise with civilian Police so that first, Defence interests are not overlooked in the Police investigation, and secondly, a separate
Defence brief of information is built up and available for the assistance of any ensuing COI or other Defence investigation.

3.69 Finally, SGT Peters’ ultimate conclusions expressed in his statement should be noted:

“As a result of this investigation, I am not in a position to provide any evidence whatsoever that identifies the person driving the vehicle containing the three deceased soldiers. Irrespective of that, in my opinion, the major causative elements involved in this collision were excessive speed and the consumption of intoxicating liquor.”

Conclusions Concerning the Incident

3.70 The evidence before the Inquiry does not indicate which one of SGT Linacre, CPL McAvoy and CPL O’Neill, was the driver of Vehicle 1 at the time of the Incident.

3.71 At the time of the Incident, Vehicle 1 was being driven at a speed which was well above the applicable 40 kph limit and inappropriate in the prevailing conditions. The vehicle failed to negotiate the right-hand curve. It is clear, in my opinion, that excessive speed was a factor in the Incident. All the occupants of the car had been drinking but particularly in the absence of identification of the driver, it is impossible realistically to assess to what extent alcohol was a factor in the Incident. The absence of street lighting or indicators on or beside the roadway was also a possible factor, but one of much less significance than the factors of speed and alcohol.

3.72 The addition to Main Road and/or its surrounds or indicators of this right-hand curve whether by way of fog lines, reflective pavement markers, signposting or otherwise as referred to by, in particular, Senior Constable Urquhart, would be a helpful and not expensive step toward adding to its safety.
Recommendation

3.73 I recommend that the appropriate Commonwealth agency forthwith arrange for the installation on and/or adjacent to the right-hand bend on Main Road, Swan Island for north-bound traffic, of appropriate indicators, whether by way of fog lines, reflective pavement markers, signposting or otherwise.

3.74 The first thing that I wish to say concerning Soldiers 10 and 17 is to praise them. They strove, in vain, to save the occupants of Vehicle 1 with great courage and persistence. I commend them for their brave efforts.

3.75 Nevertheless, some comments adverse to Soldier 10 (and possibly 17) are required. First, Soldier 10 had consumed alcohol before he drove Vehicle 2, despite the "no alcohol consumption whatsoever" mandate of DRTI Clause 5.24 and had driven Vehicle 2 at a speed which was well above the prescribed 40 kph limit and inappropriate for the prevailing conditions. As to the first point, it has also to be borne in mind that the evidence does not establish that Soldier 10 had consumed alcohol to excess and that his attention had not been specifically drawn, for the purposes of the SIAD course, to that DRTI provision. It has to be noted as well that the high speed at which he drove Vehicle 2 cannot be said to have contributed directly to the fate which befell Vehicle 1.

3.76 Secondly, I feel constrained to say that I have reservations concerning the evidence of Soldier 10 as to the speed of Vehicle 2 before the Incident. I have some difficulty in accepting his professed inability to recall this detail, particularly when the high actual speed and his military training and experience are considered and notwithstanding the traumatic time he had endured. It is possible that similar questions could be raised concerning Soldier 17 but in the absence of any sufficient notice to him concerning that possibility, I do not take it any further.
3.77 The removal of Vehicle 2 from the Incident scene was, on the material before
the Inquiry, done unwittingly by a SIAD soldier, probably Soldier 8, by reason
of confusion arising from the proximity of the then locations and the model
identity of the vehicles, and not for any ulterior purpose. This removal did not
come to the attention of persons at the scene, and led to the preliminary
identification there by persons including by Soldier 10, of Vehicle 3 as the
second vehicle involved in the Incident. This was an unfortunate occurrence
but not one which caused any problem ultimately nor which calls for criticism
of any person.

3.78 The operational decision made, principally at Police level, not to seek to
recover SGT Linacre’s body until when Vehicle 1 could be safely and
effectively recovered from the water in daylight was soundly based. There
can be no suggestion, in my opinion, other than that, unfortunately, SGT
Linacre had, like CPL McAvoy and CPL O’Neill, already perished and that
the collision scene should be preserved for full investigation. Obviously, there
were numerous persons on the scene who would have willingly sought to
rescue SGT Linacre had there been any hope at all that he was still alive.

3.79 The response to the Incident by the Police, Ambulance, CAF and SES was
prompt, efficient and effective and the ADF is, I have no doubt, very grateful
to those services. I express my own thanks to the Police and especially the
MCIU, particularly SGT Brad Peters, for their assistance to this Inquiry.
Procedures Generally

4.1 The ADF procedures for the notification of the death of a service member were described to the Inquiry by Mr Michael John Callan, the Director General of the Defence Community Organisation, in general but reasonably comprehensive terms:

"In notifying the death of a member, personal contact with the Primary Emergency Contact/s (PEC) and the Next of Kin (NOK) is to be achieved. In all notification procedures, the three guiding principles are accuracy, speed and compassion.

Personnel Management Key Solution (PMKeyS) is the single official source of emergency contact data for the ADF. Each member of the ADF is required to nominate at least one person who is to be notified in the event of an emergency or casualty.

Army Notification Teams (ANT) normally comprises the Commanding Officer or his/her representative and a Chaplain, preferably of the same denomination as the deceased. When it is not physically possible for an ADF notification team to access the emergency contact/s and the next of kin in a reasonable time frame, the Commanding Officer may request that the local Police undertake the notification.

Defence focuses on notifying the Primary Emergency Contact and taking guidance from the PEC as to who else must be notified in priority order. If the member’s Next of Kin (‘NOK’) is not listed as their primary emergency contact, the Commanding Officer ensures the NOK is personally notified as quickly as possible.
The PEC and NOK may request the ANT to assist in advising additional people of the death. This assistance is provided either by supporting the PEC to communicate the news themselves, or by deploying extra team to conduct the additional notifications, responsive to the wishes expressed by the emergency contact. The guiding principle is that the family's wishes are paramount.”

4.2 Advice of a service death has to be disseminated within the ADF and Government as, for example, referred to in DEFGRAM No.297/2008 dated 2 June 2008, dealing with amended instructions concerning notification of ADF casualties (and referred to further below):

“The new procedures ensure that PEC/NOK are advised of casualties as quickly as possible and information flow to senior leaders and Government is not compromised.”

The breadth of dissemination of advice of a service death required within the ADF and Government is illustrated by a list of agencies set out in clause 10 of Defence Instructions (General) Personnel ("DI(G) PERS") 42-6 “Defence Community Organisation Support for Next of Kin of Deceased Members…”

“The death of a member produces responsibilities for different Defence and other Government agencies and may include the following:

a. Minister’s offices.
c. Single Service Headquarters.
d. Local Unit Commanding Officer.
e. Members of the deceased’s unit.
f. Chaplain.
g. DCO Headquarters (DCO HQ).
h. Local DCO Office.
i. Military Compensation and Rehabilitation Scheme (MCRS).
j. Veterans’ Affairs.
k. Commonwealth Superannuation (ComSuper).
l. Defence Pay.
m. Defence Health Service Agency.
n. Defence Safety Management Agency.
o. Directorate of Resources and Special Projects – Cadets.”

Fatal casualty messages

4.3 OC SIAD instigated advice of the subject accident and deaths, to persons within and associated with the ADF during the early hours of 9 April 2007. In particular, a Fatal Casualty (“FATALCAS”) message in respect of each death was raised and released by SASR on 9 April 2007 at about 0430Z (which in Eastern Australian Time was about 1430) and classified SECRET; downgraded versions of the messages were later issued. SASR also promptly issued a Quick Assessment Report, and a Defence Occupational Health and Safety Incident Report in respect of each death.

Initial SASR Notifications to Primary Emergency Contacts

4.4 Notification of the death of each of the soldiers was made personally by an SASR officer and a padre to the nominated PEC (Mrs Linacre for SGT Linacre, Ms Calvert for CPL McAvoy and Ms Cole for CPL O’Neill) early on 9 April 2007. In the case of CPL O’Neill, Ms Cole was with her parents in and due to concerns over possible media reports, she was first contacted by telephone call to her father and then visited (in the company of her parents) on her return to at about 1300 hours.
Instructions for Notifications of Deaths

4.5 The current ADF procedure relating to notification of casualties including deaths is detailed in DI (G) PERS 11-2 authorised for issue on 5 May 2008 and promulgated under DEFGRAM No.297/2008 dated 2 June 2008.

4.6 At the time of the Swan Island Incident, there was in force a predecessor edition of DI (G) PERS 11-2 issued on 18 December 2001. There were also then in force other relevant instructions, namely, CDF Directive 29/2006 of 11 November 2006, Chief of the Defence Force Directive on Notification Responsibilities When a Member Becomes a Casualty ("CDF Directive 29/2006"); CA Directive 18/06 of 15 December 2006, Chief of Army Directive – Casualty Notification Responsibilities ("CA Directive 18/06"); and SASR Instruction 1-6-1 of February 2007, Notification of a Casualty – SASR ("SASR Instruction 1-6-1"). Each of CDF Directive 29/2006 and CA Directive 18/06 included provisions to the effect that DI (G) PERS 11-2 was in the process of revision and in respect of any conflict between the Instruction and the Directive, Commanders were to be guided by the Directive and that the Directive was to be cancelled on promulgation of the amended DI (G) PERS 11-2.

4.7 Counsel Assisting have drawn attention to some inconsistencies among these various instructions, particularly between CA Directive 18/06 and SASR Instruction 1-6-1 on the one hand, and the 2001 DI (G) PERS 11-2 and CDF Directive 29/2006 on the other hand. A particular suggested inconsistency is that the former in effect dictated that the notification team for the purpose of initial personal advice to the PEC's was to be raised by the Army (with support from DCO) and the latter indicated that the notification team was to identified and activated by DCO. In the result however, it appears that on this occasion SASR implemented the notification teams with concurrent consultation with DCO. Such an arrangement would be consistent with the new DI (G) PERS 11-2 and seems to have been acceptable to all concerned. With the new DI (G) PERS 11-2 now in effect and promulgated under DEFGRAM 287/2008, this issue has historical interest only and having noted it, there seems to be no point in taking it any further in this Report.
Defence Community Organisation Background

4.8 Following the Pratt Review of ADF Personnel and Family Support in 1994, the Defence Community Organisation ("DCO") was created in 1996 as an integrated personnel and family support organisation out of the then single service family organisations of that sort. DCO is staffed by civilians and military personnel. Its organisation, role and operations are set out in Defence Instructions (General) Personnel 42-3 Defence Community Organisation of 4 October 1996 ("DI(G)PERS 42-3"), which in Clause 5 states the purpose of DCO as:

"To contribute to the operational effectiveness of the ADF by providing a comprehensive range of social work, family liaison and education liaison support services and related programs, projects and research that enhance the well-being of ADF personnel, their families and communities."

4.9 This Inquiry has had the benefit of evidence from the present Director General of DCO, Mr Michael John Callan, who was appointed in December 2007, and from Mr Kenneth Alan Brownrigg, who was Director General of DCO between February 2007 and August 2007. Apart from assisting the Inquiry with details of DCO activities consequent upon the deaths of these three soldiers, evidence from those gentlemen covered some broader issues relating to DCO which, to the extent that they may have relevance to the Terms of Reference of this Inquiry, are dealt with in the latter part of this Section of the Report.

DCO Activation and Early Contacts with Families

4.10 Very early in the morning of 9 April 2007, a control unit was set up at DCO headquarters with staff called back from their Easter leave. A Case Management Team, comprising a Defence Social Worker ("DSW") and a
Military Support Officer ("MSO") was established for each of the three bereaved families. Following the initial SASR contacts with the PEC's, as detailed above, members of the respective case management teams personally called on Mrs Taryn Linacre on the afternoon on 9 April 2007, Ms Vanessa Calvert on 10 April 2007, and Ms Sara Cole on 10 April 2007 (after telephone discussion on the evening of 9 April 2007). There was contact by SASR and DCO personnel with various other members of the three families during 9 and 10 April 2007. Included in early DCO communications with each of Mrs Linacre, Ms Calvert and Ms Cole was a letter to her from the Director General of DCO expressing his condolences and detailing the Case Management Team, their functions and other matters; there was further such correspondence a little later confirming financial payments and other details.

Early Contact with O'Neill Family

4.11 Initial contact with CPL O'Neill's family calls for additional comment. CPL O'Neill's parents were overseas travelling with children at the time. was in Holland and was in Thailand. CPL O'Neill's aunt, became involved around 0815 on 9 April 2007, following telephone information from another family member. Telephone calls which made for information about the accident to Simpson Barracks and Victoria Barracks yielded no result and ultimately she established telephone contact with the Campbell Barracks at Swanbourne WA during which she shared information with SASR personnel as to contact details in Holland where she and a daughter were staying with relatives. had spoken by telephone to the relatives in Holland who were delaying advising who was asleep, pending a call from SASR. After waiting for about an hour for a call from SASR, the relatives chose to wake and tell her of the tragedy. A call from SASR to came in shortly afterwards. The precise whereabouts in Thailand of and a son with whom he was travelling, were not known and their mobile telephones were out of range; it was a couple of days before they received the tragic news.
DCO Advice to other Agencies

4.12 On 10 April 2007 the Manager Deceased Estates at DCO Headquarters faxed written details concerning the deceased to the following offices:

- Defence Ministerial Parliamentary Liaison Service ("DMPLS")
- Defence Health
- ComSuper
- Defence Housing Authority
- Acting First Assistant Secretary Personnel ("A/FASPERS")
- Head Personnel Executive ("HPE")
- Chief of Defence
- Chief of Army

It might be noted that one of the relevant functions of DMPLS was to disseminate information within Government by way of Hot Issues Briefs ("HIB's") and other means.

Wills

4.13 DCO obtained the Wills of the three deceased from Soldier Career Management Agency ("SCMA") on 10 April 2007 and had these delivered to the respective Executors. The Executor of SGT Linacre’s Will was of CPL McAvoy’s Will and of CPL O’Neill’s Will,
Death Certificates

4.14 In respect of each deceased, the Soldier Career Management Agency issued a Certificate of Death dated 11 April 2007 under the Defence (Certification of Death) Regulations, 1953.

Bereavement Payments

4.15 DCO administers a bereavement payments system whereby the equivalent of 8 weeks’ pay is gratuitously granted on a tax exempt basis to provide short-term support to a deceased member’s dependants. That occurred in each of these cases with initial payments of 4 weeks’ money being made within a few days of the deaths and 2 fortnightly payments afterwards.

Leave Entitlements

4.16 Payments in lieu of accrued recreation and long service leave were duly made to the respective dependants of each deceased within a few days of the deaths.

Superannuation

4.17 Following advice from DCO to ComSuper, Military Super established contact with the dependants. While only few details concerning superannuation have been placed before the Inquiry, apparently all accrued benefits in respect of each of the deceased’s membership of the Military Superannuation Benefits Scheme were duly paid to the respective dependants.
Funerals

4.18 The funeral of SGT Linacre took place at Karrakatta Cemetery, Western Australia on 18 April 2007 and there was a memorial service for him in St Paul’s Cathedral, Melbourne on 23 April 2007. On 19 April 2007 CPL O’Neill’s funeral was held at the Town Hall in Ivanhoe, Victoria. CPL McAvoy’s funeral was conducted at the Chapel at RAAF Base Laverton at Point Cook, Victoria on 20 April 2007. All these occasions appear to have been conducted with appropriate regimental and other military, and DCO, support. All funeral expenses, including travel and accommodation for relatives, were paid by DCO.

Letters of Condolence

4.19 In early May 2007, DCO arranged for letters of condolence to be sent by the Minister for Defence and the Minister for Veterans’ Affairs to the respective partners of each deceased. In the cases of SGT Linacre and CPL O’Neill, letters of that kind were also forwarded to their parents; CPL McAvoy’s father predeceased him and his mother was unwell, so it seems that no similar letter was deemed appropriate in the case of that family.

Personal Effects

4.20 By early May 2007 comprehensive checks of the deceased soldiers’ personal effects had been carried out by Committees appointed by the Commanding Officer of SASR. Inventories were raised of the military equipment and personal items involved. The military equipment was returned to the Base Main Quartermaster Store at Campbell Barracks. The personal items were returned to the personal representatives of the deceased through the DCO.
Military Compensation

4.21 Each of 

lodged a claim for compensation in respect of the death of her partner with Military Rehabilitation and Compensation Commission under the Military Rehabilitation and Compensation Act 2004. Liability was accepted by the Military Compensation Group within the Department of Veterans' Affairs and compensation was determined by the Commission and paid. In each case, the Reasons for Decisions issued by the Commission for the finding that the death was connected with the soldier's defence service centred on an addition to the FATALCAS signal when it was re-issued on 29 May 2007 that "Member was on duty at the time of the accident" and correspondence around that time from the Chief of Army and the Commanding Officer of SASR to the effect that the soldier was rendering service at the time of the accident; there was also reference to a determination by the Victorian Transport Accident Commission in respect of claims to that Commission in respect of SGT Linacre and CPL O'Neill to the effect that the accident was in the course of their employment. In the case of SGT Linacre, it was also determined that was a dependant and that compensation was payable in respect of her and in the case of CPL McAvoi it was similarly determined in respect of

fortnightly periodic payments of compensation, an aged based lump sum; in respect of that election each of the beneficiaries was offered by the Military Compensation Group a payment for the cost of financial advice. The compensation in each case included for a service related death and eligibility for health care at Department of Veterans' Affairs expense for all illness or injuries, together with small quarterly payments on account of pharmaceutical and telephone expenses.
Psychological Counselling

4.22 Through DCO each of had the service of counselling from civilian psychologists. DCO funded those treatments. Counselling was available to the SASR members through the psychologist at Swanbourne Barracks and Soldier 17 was asked about that:

"Were you given counselling?----Yes, I have seen the psychologist for the unit.
I don’t want to go into any details, but you were given counselling?----Yes.
Have you been given satisfactory assistance in relation to counselling?----I believe so, yes.
You’ve got no problems with the way you were assisted by the regiment or otherwise after the event in terms of personal assistance to you?----None whatsoever."

It should also be noted that OC SIAD arranged a gathering of the course members at the scene of the Incident at about 1800 h on 9 April 2007 and closed the causeway for it. He terminated the course and the members left Swan Island on 11 April 2007 to travel home.

Other Aspects of DCO Involvement

4.23 Much of the above account of DCO (and other) assistance to families of the deceased soldiers calls for no further coverage in this Report as, while involving what were at times difficult situations, that assistance seems to have involved no controversy. A few aspects of the DCO involvement, however, have been the subject of comment during the Inquiry and do warrant specific mention.
4.24 The MSO who was initially part of the DCO Case Management Team in respect of the O’Neill family was not favourably received as an individual by Ms Cole, other members of the family and the SASR Unit Representative. Unfortunately, that reaction was not communicated to DCO until around the time of CPL O’Neill’s funeral. DCO immediately replaced him with another MSO. At the Inquiry Mr Brownrigg spoke well of the initial MSO:

"(He) had been a very successful Military Support Australia prior to his interaction with (this family) and after, subsequent to his interactions with (this family). That was part of the reason he was selected. Another reason was his preparedness to travel at what was extremely short notice to go over to Western Australia to try and help."

In my opinion, this situation was unfortunate but it was retrieved by DCO at the first opportunity. No further comment, let alone any criticism, is called for.

4.25 In late May 2007 Mr Brownrigg, as Director General DCO in the company of CO SASR, met with each of Ms Linacre, Ms Calvert and Ms Cole in Victoria. Mr Callan described his understanding of the purpose of those meetings:

"In order to ensure that DCO were responsive to client needs and to ensure that the families had access to the professional services if required..."

4.26 Earlier in May 2007 Ms Calvert had written to the then DSW in the Case Management Team dealing with the family of CPL McAvoy expressing dissatisfaction with the assistance which she had been giving Ms Calvert and advising that "...I will not be requiring your assistance again...". During the Inquiry, it emerged that DCO may have misinterpreted that communication by thinking that, as Mr Callan understood it:
"HQDCO also received a letter from Ms Calvert indicating that she no longer wanted DCO assistance."

Ms Calvert informed the Inquiry through an email to her Counsel that:

"Just because I have not called the DCO constantly, does not mean that I do not need them for ongoing support or information, and despite what has happened to date, I still welcome their support and hope this can occur in the future."

That communication has been referred to DCO and they are, I understand, re-establishing contact with Ms Calvert. This also was an unfortunate situation but it is understandable and is now being retrieved. I do not think that it calls for any further comment, let alone any criticism, in this Report.

4.27 Matters relating to the SAS Association ("SASA") also warrant some discussion.

SAS Association

4.28 The SASA is a body of former SASR members and it also was significantly involved in rendering assistance to the families of three deceased soldiers. No material directly from the SASR has been placed before the Inquiry. Counsel Assisting spoke to the President of SASA in Perth before the Inquiry commenced but no response was received to invitations made to SASA then and later by email for, as the email expressed it, "...a summation of any key issues that you wished to bring to my attention for possible inclusion in the evidence to be considered by the COI". One of the particular situations of SASA assistance to the families was in relation to military compensation.
Mr Brownrigg spoke at the Inquiry of the relationship at the time between DCO, SASR and SASA:

"...in terms of the way that those three bodies attempted to look after families, that was not in concert, in my view, and there was a lot of tension in that relationship."

He also said:

"There was a difference in the expectation of what DCO could do and what it was charged to do by the Department; for example, the SAS Association felt that the DCO ought to be able to provide more than what it was charged to provide, particularly with regard to assistance with compensation matters."

Mr Callan expressed agreement with those remarks when they were drawn to his attention by Counsel Assisting. He explained in a little detail:

"...I believe there is, generally, an expectation that we would move in and assist with filling out compensation forms and maximising the return for the families. That's not our core business, that's not our role. In terms of providing that level of support we would put the families in contact with personnel that can provide that sort of support and advice, such as the RSL, the SAS Association and other ex-service organisations. We should be putting them onto the ADF Financial Consumers Council as well, to assist with finding financial advice. When it comes to filling out compensation forms, whilst that would be very nice, we're not trained to do that and there's an ethical tension here between a government employee assisting a non-government employee to maximise their return from the government. Filling out forms then begs the question, of course, is 'What you filled out, was that 100 per cent the truth?' and so, therefore, puts that public servant in a very invidious position in terms of the APS Code of Conduct and Values. So, my perspective of it is, my is opinion is, that we should not
get engaged in that activity, it's not our core business. I would not put my staff in that situation where they're actually having to make an ethical decision on what's been put down on a particular form. In terms of moving them onto the proper advice and linking of those services, yes, I think we have a great role to play in that but I think, when you're talking about that sort of support, that's what the ex-service organisations are trained to do and they have a role in that activity.”

Rigby Review

4.30 After the Swan Island Incident, Mr Brownrigg was involved in discussions with SASR and SASA and in particular following further discussions he had with Special Operations Command, a decision was made that there should be a third party review of the procedures of all concerned in such a case. Mr Colin Rigby, whose background includes military service, service with the Department of Foreign Affairs and Trade and a period as head of the Vietnam Veterans’ Counselling Service, was requested by Mr Brownrigg in June 2007 to undertake such a review. Mr Rigby’s Report was issued in August 2007 and, as put in its Executive Summary:

“...the review recommendations create the basis for one Directive to manage casualty notification and provide optimal support to families of deceased Australian Defence Force (ADF) members.

The recommendations are based on the conceptual premise that a single position designated as a Family Support Officer is the most efficient and effective way to deliver specialist support services to families of deceased ADF members”.

In relation to the death of an SASR member the recommendations were, more specifically, that there be a Family Support Officer within SASR who must meet DCO training competencies and who would replace the current DCO
case management team comprising a DSW and an MSO and also the SASR Unit Representative (performing a liaison role with the family).

4.31 There was a comprehensive response to the Report by CO SASR by way of minute dated 21 November 2007 to Special Operations Command. That response followed a workshop which the Regiment had conducted over a day to address the Report's recommendations. While a number of ancillary aspects of the recommendations were accepted, the response did not agree that the Family Support Officer should replace the Unit Representative and in further answer, suggested that a DCO representative be "embedded within the SASR manning establishment".

4.32 Mr Callan gave evidence to the effect that he also did not favour Mr Rigby's recommendations. He said that following discussions he had had with SASR, HPE and COA it was his intention to embed a social worker within SASR. He explained:

"...I made my own determination that based on the fact that SASR is a strategic ADF asset, it is not located close to my area office down in southern Perth, my area manager has re-established a very good relationship with the unit and the CO ...for us to understand the culture within the unit and for the unit to be educated in our culture I've determined that we'll embed a social worker. I've added an additional resource from the eastern states, taken it from one of the eastern state offices and I've opened it up to my staff to go across and be the embedded social worker in SASR. And that means that social worker will be there for three days a week, the fourth day they will be assisting with RAAF Pearce, which is closer to SASR than it is to the area office, and on the fifth day they will be back in the area office to do training and administration and review of cases. And I think that will re-establish that relationship and strengthen it and so DCO won't be the stranger coming to the unit next time we have this sort of death."
4.33 When he gave evidence to the Inquiry in May, Mr Callan anticipated that the placement of the DCO officer within SASR would have been achieved by the end of July. No doubt DCO and SASR will each be making ongoing assessments of how that arrangement is working. A joint evaluation perhaps should be made after an appropriate period to assess the effectiveness of the arrangement.

Recommendation

4.34 By February 2009 representatives of DCO and SASR should confer and produce a joint evaluation report of the effectiveness of the placement of a DCO social worker within SASR.

Legal and Financial Advice to Families

4.35 In my Report dated 4 March 2008 in the Commission of Inquiry concerning the death of I made a recommendation in these terms:

"ADF Legal Services should consult with DCO with a view to putting in place, or regularising, a system whereby prompt preliminary legal advice following the death of a serving member of the ADF can be offered to the member's family and also to putting in place a system of preliminary financial advice to such family."

I explained that recommendation in that Report at paragraphs 4.46 to 4.56 thereof and I will not repeat that detail here. What I have heard in this Inquiry leads me to adhere to what I said there and to repeat the recommendation. Mr Callan's point about potential conflict of interest (referred to in his evidence quoted above in paragraph 4.29) is valid and I note again the financial aid which was offered by the Military Compensation Group to the family representatives here for financial advice concerning the election to take lump
sum military compensation. Nevertheless, I am of the view that neither of those points detracts from the appropriateness of ADF initial or introductory legal and financial assistance being available generally to the families of deceased members. Referral lists of lawyers and/or financial advisers can later be given to the families as appropriate. I add that during this Inquiry reference was made to AD Financial Services Consumer Council evidently set up in September 2006 (quoting from a web page) "to offer in consultation appropriate Regulators independent, professional financial evaluation (not personal advice) and relevant source material to all ADF personnel" and any relevance which that body may have to the situation under consideration here could be taken into account when this recommendation is assessed.

Recommendation

4.36 ADF Legal Services should consult with DCO with a view to putting in place, or regularising, a system whereby prompt preliminary legal advice following the death of a serving member of the ADF can be offered to the member's family and also to putting in place a system of preliminary financial advice to such family.

Strategic Review of DCO

4.37 Included in the material placed before this Inquiry were some details concerning a Strategic Review of DCO. That issue is probably beyond the Inquiry's Terms of Reference but it might be as well if some note is made here of some of that material for the information and consideration of others. In doing this, I am not seeking to express any comment or opinion.

4.38 The Strategic Review was set up within DCO in 2007 when Mr Brownrigg was Director General and he explained in evidence some of the background to it:
"...My view was that the Defence Community Organisation required to be reviewed much more strategically than just going through the guiding policy documents that it operated under. The organisation was created in the late 1990s and it was pretty much three separate organisations that once belonged to the single services, crashed together; and as a result of that, I think it was in some ways suffering through the absence of precise policy guidance and direction. So whilst there were policies developed over the years for aspects of DCO's work, I think the real issue was that it was time – in fact, the time was well past – that the organisation's central purpose and function needed to be reviewed, and indeed then the policy that flowed from that central purpose required review as well. So there were many moving parts at the time of the Swan Island tragedy in DCO..."

"...Now as I mentioned to you, as part of the Defence Efficiency Review, DCO was created out of three single service organisations, and this was part of an efficiency drive. DCO was, in some ways, cobbled together as a result. The list of tasks that it had was something like 160 tasks because the individual tasks of the three single services had simply been added to a list and then as new tasks came up they had been added to the list as well. So it was an organisation that I believed did not have a clear idea of what the needs were of the community that it was serving. So as a result of that we undertook to consult widely through the Defence Families Association, directly with Defence families, with units – all units, not just special units – and with commanders and any other interested parties in order to capture the real need of Defence families today. Because it was clear that a lot had changed in the nature and structure of families since 1987, and so had their needs. And indeed, the ADF was engaged in sequential, sometimes high tempo and highly dangerous operations that we weren't engaged in in 1987 when the Hamilton Report was commissioned."
4.39 Mr Callan told the Inquiry that the Strategic Review had been taken out of DCO's hands before his arrival at DCO and given to the Personnel Services Division to conduct. Other details of the Review given to the Inquiry are brief but it appears that a report was issued in or around March 2007 and some consequent recommendations were made at at a COSC (Chiefs of Staff Committee) meeting on 27 May 2008 (while Mr Callan was in Canada). Mr Callan proffered some other comments which seem to bear on this issue:

"...when I came in on 6 December, I was concerned that DCO did not have an evidence-based approach to developing policies and procedures. I have implemented an evidence-based approach to our policies and procedures. As of recently, we have drawn in around over a hundred case files of all the bereavement files that we've had ... in our area offices, brought them into the headquarters they're being reviewed. A report is going to be given to me on the things that we can see in those files that show the good practices that have led to some successes and the bad practices that have actually created problems for us on the ground. This is pretty normal procedure for any organisation that provides a service delivery, that you do an evidence-based approach to it, rather than a theoretical-based approach. So, yes, we are training people at the present moment and my intention is to normalise that process into our induction training for social workers but we will review that training and we will review the guidelines again once we've completed this evidence-based review of the bereavement files."

Release of Inquiry Material to Families

4.40 At the conclusion of the hearing the families requested that there be released to them the CCTV film from the Esplanade Hotel on 8 and 9 April 2007, showing the deceased soldiers, and also their Army personal files. In my opinion, copies of that material should be released to them, as I indicated at the time. Regulation 63 of the Defence (Inquiry) Regulations dealing with
disclosure of records or reports of Court of Inquiry is quite restrictive in its terms and I understand they are to be amended. That provision may even require some Ministerial authorisation for this release but it may also be that the Regulation should not be read as applying to me as the COI President. In any event, whether on my authority (which I give) or the Minister's, the release of that material to the families should be attended to promptly.
SWAN ISLAND
SECTION 5 – FINDINGS

5.1 I now set out findings in respect of each of the matters specified in the Terms of Reference Paragraph 4 as the Inquiry Task, with reference back to the parts of the Report that principally bear on them.

5.2 The first matter comprises:

"The circumstances proximately surrounding the deaths of the deceased members including, without restricting the generality thereof:

i. the date and place of each death;

ii. the manner and cause of each death; and

iii. any facts and circumstances establishing that the deaths of any of them arose out of, or in the course of, their service."

5.3 The death of each of SGT Linacre, CPL McAvoy and CPL O’Neill occurred on 9 April 2007 (at about 0130 h) in Swan Bay near Swan Island, Victoria. The cause of each death was drowning. The deaths occurred when the vehicle in which they were travelling ran off Main Road into the waters of Swan Bay. The principal cause of that occurrence was the excessive speed at which the vehicle was travelling. It cannot be determined which one of the deceased soldiers was the driver of the vehicle. Paragraphs 3.25 to 3.47 and 3.69 to 3.71 particularly relate to these findings.

5.4 The soldiers were all members of SASR and at that time were on course, and resident, at SIAD. The Military Rehabilitation and Compensation Commission has, as detailed in paragraph 4.21, determined that in the case of each soldier, his death was connected with his defence service. Full compensation has been determined and paid and other benefits awarded, accordingly.
5.5 The second matter specified in the Inquiry Task is:

"The sufficiency of any defence actions and decisions materially relevant to the deaths of the deceased members, both prior and subsequent thereto;"

5.6 The only such matter prior to the deaths which calls for comment is the matter of the SIAD briefing to course members and the requirements of the DRTI, as covered in paragraphs 3.1 to 3.15 and the subject of the recommendation set out in paragraph 3.16:

"3.16 In all ADF courses where members may be driving defence vehicles, including rental vehicles, briefings to members must include a reminder of the requirements of the DRTI including in particular the mandate of no alcohol consumption whatsoever for the driver of a defence vehicle."

5.7 It is convenient to add here that the only other recommendation I have made in Section 3 relates to the state of the roadway, which I do not appreciate to be a Defence responsibility. That recommendation is:

"3.72 I recommend that the appropriate Commonwealth agency forthwith arrange for the installation on and/or adjacent to the right-hand bend on Main Road, Swan Island for north-bound traffic, of appropriate indicators, whether by way of fog lines, reflective pavement markers, signposting or otherwise."

5.8 I might also repeat the suggestion that I proffered in paragraph 3.68 that Defence give consideration to whether it would be appropriate in the future in the event of any death of a service member in a motor vehicle accident or otherwise having a connection with what I might term some other "civilian" situation, for Defence promptly to task a service member at Military Police (or equivalent) level to liaise with civilian Police so that first, Defence interests
are not overlooked in the Police investigation, and secondly, a separate Defence brief of information is built up and available for the assistance of any ensuing COI or other Defence investigation.

5.9 Actions and decisions materially relevant and subsequent to the deaths are canvassed in Section 4. Overall I would assess such matters as having been at least sufficient. I felt it appropriate to make only two recommendations concerning such matters:

"4.34 By February 2009 representatives of DCO and SASR should confer and produce a joint evaluation report of the effectiveness of the placement of a DCO social worker within SASR.

4.36 ADF Legal Services should consult with DCO with a view to putting in place, or regularising, a system whereby prompt preliminary legal advice following the death of a serving member of the ADF can be offered to the member’s family and also to putting in place a system of preliminary financial advice to such family."

5.10 The third matter is specified as:

"Any weaknesses (isolated or systemic) in Defence systems, policies, equipment, practices, procedures and training perceived in the context of the deaths of the deceased members."

I saw no such weaknesses except to the extent that what I have referred to in paragraph 5.6 above may constitute one.

3 September 2008

P. R. CALLAGHAN RFD S.C.
COI President