OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Sridhar SHEKAR**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Southport
FILE NO:	COR 2454/08 (4)
DELIVERED ON:	11 March 2010
DELIVERED AT:	Southport Magistrates Court
HEARING DATE(s):	28 October 2009 to 30 October 2009
FINDINGS OF:	Southern Coroner Hutton
CATCHWORDS:	CORONERS: Inquest – Jet-ski, personal watercraft, licensing, helmets, Hire and Drive Standard 2007

REPRESENTATION:

Counsel Assisting:	Ms D Franklin for the Office of the State Coroner, Southern Coroners Office
Maritime Safety Qld:	Mr G Egan instructed by Maritime Safety Queensland
Shane's Watersports:	Mr D Atkinson instructed by Barry Nilsson Lawyers

CORONER'S FINDINGS AND DECISION

1. These are my findings in relation to the death of Sridhar Shekar who died at the Broadwater, Labrador near Southport in Queensland on 28 April 2008 as a result of a personal watercraft (PWC), also known as a jet-ski, incident. These findings seek to explain how the death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act* provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with that requirement and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

2. A coroner is required to inquire into the cause and the circumstances of a reportable death. If possible the coroner is required to find:-

    a) whether a death in fact happened;
    b) the identity of the deceased;
    c) when, where and how the death occurred; and
    d) what caused the person to die?

3. An inquest is not a trial between opposing parties but an inquiry or inquisition into the death. An English case described it this way: - *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."*

4. The purpose of an inquest is to discover what happened, not to ascribe guilt, nor attribute blame or apportion liability. It is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. A coroner may make recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future. However, a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or civilly liable.

The Admissibility of Evidence and the Standard of Proof

5. A coroner's court is not bound by the rules of evidence and the court "*may inform itself in any way it considers appropriate".*

6. An inquest is not a trial, but rather a fact finding exercise. A coroner may require a witness to give evidence which would tend to incriminate the witness if the Coroner is satisfied it is in the public interest to do so. That evidence, when given and any derivative evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.

7. The civil standard of proof is applied in inquests, that is proof on the balance of probabilities and the *Briginshaw* sliding scale is applicable. This means the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence is needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

8. A Coroner is obliged to comply with the rules of natural justice and to act judicially.

9. If at an inquest or during a coronial investigation, a coroner reasonably suspects a person has committed an indictable offence, the coroner must inform the Director of Public Prosecutions. In the case of a non-indictable offence, the coroner should inform the chief executive of the relevant department.

Background

10. The circumstances surrounding the death of Dr Shekar were investigated by Queensland Police and Maritime Safety Queensland (MSQ). Queensland Police investigated the cause of the incident and the investigation by MSQ focused on legislative compliance.

Circumstances

11. Dr Sridhar Shekar and his wife, Dr Divya Patel, were on two weeks holiday in Queensland from England. They arrived on 20 April 2008. On 27 April 2008 Dr Shekar booked a PWC ride for 10:30am on 28 April 2008 with Shane's Watersports World.

12. At the time of the incident Shane's Watersports World operated from a tent on the edge of the Broadwater, in Harley Park, Labrador. Shane's Watersports World was and is the trading name for Latrema Pty Ltd. Shane's Watersports World is a hire and drive business, which hires PWC to unlicensed persons. The PWC are driven around a circuit. The business has been operating in fundamentally the same area for many years. Shane's Watersports World has been operated by Laurence Beattie and Trevor Gibson since January 2008.

13. At about 9:15am on Monday 28 April 2008 Mr Beattie began setting up the red buoys to outline the PWC circuit on the Broadwater immediately to the west and north of the sandbar. The circuit rounded the north-west corner of the sandbar. The circuit was usually set up about 30 metres from the sandbar and varied between 100 to 170 wide over the length of the circuit. At the time the buoys were set up there were no other vessels in the vicinity of the sandbar. Mr Beattie put out three yellow and white PWC and the safety sign on the sandbar at the eastern end of the circuit. This was his usual practice.

14. The day was clear and fine. The water was smooth.

15. The Broadwater is a well utilised Gold Coast waterway.

16. John Galea arrived at the sandbar in his 8.2 metre Bayliner at about 9:45am. At the north-west corner of the sandbar, Mr Galea moored his boat, the stern to the sandbar and the bow to the north-west. The boat was set with front and rear anchors. Mr Galea noticed the buoys and thought they were mooring buoys. The boat was moored between the sandbar and the first row of buoys which were about 30 metres from the sandbank. Mr Galea walked his dogs on the sandbar.

17. When Drs Shekar and Patel arrived at the tent in Harley Park on 28 October 2009 at about 10:10am they signed the waiver and indemnity form and paid for the PWC hire, as did two other persons who also booked a PWC ride at the same time – they have since returned home to India and could not be located for the inquest.

18. When each of the parties was ready Mr Beattie took them to the sandbar in a boat. The sandbar is located in the Labrador Channel and can be easily seen from the tent site. When the parties arrived at the sandbar Mr Beattie gave everyone a life jacket, told them to travel around the circuit in a clockwise direction, stay away from the moored boat and provided a safety briefing. Mr Galea stated that both parties were on their respective PWC and in the water within 10 minutes of arriving at the sandbar. Dr Shekar was on the front of the craft with Dr Patel as a pillion passenger. The other two users were also positioned with the male as driver and female as pillion passenger.

19. After each party began their trip around the circuit Mr Beattie followed until he reached Mr Galea's boat when he stopped to speak to Mr Galea and advised him that he was moored in the circuit and that it would be a good idea if he moved his boat "*as these people don't drive too well*". Mr Galea said he would and began preparations to leave. Mr Galea washed his dogs, which takes about 5 minutes, and checked everything was stowed for travel. Mr Galea was not breaking any law by being moored at the sandbar.

20. There is a disagreement as to how many times Dr Shekar drove the PWC around the circuit or even if he rode the craft the length of the circuit; but what is clear is that Dr Shekar was having problems operating the craft. Dr Shekar had poor control over the PWC. He had not driven a PWC previously.

21. Mr Galea noticed the problems that both parties were having on the PWCs. Dr Shekar lacked control – the PWC was going from side to side and was travelling too close to Mr Galea's boat. After talking to Mr Galea, Mr Beattie had returned to where the safety sign was positioned and beckoned Dr Shekar in to shore to remind him of the safety requirements of which he had been advised earlier. There is disagreement over exactly what was said but it is agreed that Dr Shekar was told that increasing speed would assist with control of the craft. Dr Shekar had managed to control the PWC sufficiently to pass the moored

boat at least once, possibly twice, before he was able to manoeuvre the craft in to the sandbank when waved in by Mr Beattie.

22. Mr Beattie left Dr Shekar to drive the PWC again with Dr Patel as pillion. At inquest Mr Beattie said that Dr Shekar then took off at full throttle and seemed to head straight for the moored boat which was on the outside of the buoys. Dr Patel said that Dr Shekar was still travelling close to the boat and she told him to turn away or "*we are going to hit*". Dr Shekar then collided with the anchor chain from the bow of Mr Galea's boat. Mr Galea heard the engine pitch of Dr Shekar's craft, increase and decrease then heard a woman yell and felt an impact when his boat moved suddenly. Mr Galea saw the unmanned PWC and Mr Beattie heard the impact. Mr Galea and Mr Beattie dragged Dr Shekar out of the water. Dr Patel was also taken from the water. Dr Patel who had been momentarily knocked out woke and saw Dr Shekar on the shore. She went to Dr Shekar and began CPR with the assistance of Mr Beattie. Mr Galea called the emergency services.

23. When Queensland Ambulance Officers arrived they pronounced Dr Shekar dead. Dr Patel was taken to hospital for treatment for relatively minor injuries and shock.

24. The police investigation concluded that Dr Shekar's unlicensed PWC inexperience was the reason for the incident and therefore his death. Constable McInnes' report notes that Dr Shekar did not "*possess the necessary skills to successfully navigate past a moored vessel, and a consequence of this was his eventual demise"*. I agree with this conclusion.

25. MSQ's investigation report notes that Shane's Watersports World were non-compliant with the following:

    1) The Transport Operations (Maritime Safety – Hire and Drive Ships) Standard 2007; and,
    2) The conditions of the PWC registration.

    However the report concluded that these deficiencies did not cause the death of Dr Shekar.

26. MSQ's report also notes several issues of non-compliance in relation to record keeping and monitoring of hire and drive businesses in Queensland.

PWC

27. The PWC that Dr Shekar was using is a 1997 Seadoo GTI 3.235. It is registered as a commercial hire personal watercraft. The registration of the PWC is conditional upon the following:
    - It is to operate as a commercial hire ship within defined smooth waters;
    - When operated by an unlicensed person the ship's operation is confined to the geographical area endorsed by the regional

harbour master as defined in the ship provider's safety management plan and all other conditions of operation specified in the safety management plan;

- It is to operate in daylight hours only; and,
- It is to carry a maximum of 3 persons.

The PWC used by Shane's Watersports World were modified for use by inexperienced drivers. The power of the craft had been reduced and the top speed would have been about 52 knots. This is considered normal practise for PWC hire and drive operators.

28. Shane's Watersports World did not have a registered area of operation with MSQ. A hand drawn copy of the circuit was later found attached to other documentation with MSQ. It seems the circuit was well known by MSQ officers and had been adapted over the years to changing safety concerns.

29. Constable McInnes, of the Queensland Water Police, is trained and licensed to use PWC, which he uses with Gold Coast Water Police. The Constable's statement highlighted to the court the fact that inexperienced operators of a jet-ski may have problems remedying any dangerous or emergent situation in which they find themselves, and they are more likely to have difficulty in operating the vessel generally, in that the natural instincts to slow or stop if faced with danger is contrary to what is required if driving a PWC. There is also a real possibility that an inexperienced operator may panic and use the throttle to gain too much speed too quickly, thereby limiting the control of the craft when the PWC surges in whichever direction the steering column may be facing.

Transport Operations (Marine Safety – Hire and Drive) Standards 2007 (Hire and Drive Standard 2007)

30. The Hire and Drive Standard 2007 was developed by MSQ after review of the 2000 Standard with stakeholders and the community. The Hire and Drive Standard 2007 allows for unlicensed operation of PWC if there is full compliance with the Standard and other Maritime Legislation. The purpose of the Standard is to provide for the safe operation of PWC by unlicensed users as they generally do not have the knowledge and experience of licensed PWC users. The Standard imposes restrictions and obligations on the hire and drive operator and user of the craft.

31. MSQ, as a result of this incident, audited all hire and drive PWC operators in Queensland assessing compliance with the Hire and Drive Standard 2007 and safety obligations imposed by maritime legislation and found a significant number wanting. Mr Anton Alback a shipping inspector for MSQ conducted the audit of hire and drive PWC operations on the Gold Coast. The audit of Gold Coast operators found all had some level of non-compliance. That non-compliance ranged from relatively minor record keeping through to far more serious issues like staff training and safety plan breaches. The approach of many operators and MSQ to the requirements imposed by the Hire and Drive Standard

2007 and enforcement of those requirements seemed casual and cavalier and alarming in nature.

32. The most significant aspect of non-compliance was the Safety Management Plan required by section 8. Many operators were found wanting on this aspect and since this incident MSQ have developed a pro forma Safety Management Plan for hire and drive operators to assist with compliance. The audit found many operators were non-compliant with some aspects of the Plan's requirements, which in some cases may have been an oversight. Other operators were blatantly non-compliant.

33. Section 10 of the Act requires a safety briefing be given to the user of the hire and drive PWC and practical demonstration is considered necessary. This section is too subjective especially for an industry that is focused on fun, excitement and approached casually.

34. Section 12 requires that hire and drive operators keep thorough records of their PWC and users. While many operators kept some records these were poor or difficult to follow. A few operators kept next to no records.

35. As a result of the death of Dr Shekar several issues were highlighted in relation to monitoring of hire and drive operations specialising in PWC hire in Queensland. The MSQ report notes that while the Gold Coast region office of MSQ regularly interacted with local hire and drive businesses there is no record of this interaction. The quality and regularity of the interaction is therefore unknown. When Mr Cummings, the investigator, asked for all documentation on Shane's Watersports World area of operation, he was advised that a file did not exist.

36. Significantly the legislation being relied on to provide the safety for unlicensed users of PWC from hire and drive operators was not being complied with or enforced.

37. The court was advised that the audit has resulted in MSQ assisting hire and drive operators so that there is now full compliance with the current legislation, increased monitoring of hire and drive operations and better record keeping by MSQ to maintain this compliance. Continued random, covert and thorough monitoring is obviously required to maintain full compliance.

Licensing of PWC riders

38. A licence is required for use of a PWC on Queensland waters **unless the PWC is hired through a compliant hire and drive operator**. While the legislation outlines strict conditions of use of hire and drive PWCs the legislation was regularly, if not constantly, breached by many hire and drive operators prior to the MSQ audit after Dr Shekar's death. To obtain a PWC licence in Queensland requires training and testing to assure a certain level of knowledge is held by the licence holder.

39. There was some discussion at inquest of the status of PWC licensing requirements in other jurisdictions of Australia.

40. To obtain a Queensland PWC license a person must understand basic navigation laws and have basic practical experience on a PWC. Mr Beattie informed the Court that people travelled to Queensland to ride PWC because a licence to hire and ride was not required in Queensland as it was in New South Wales and Victoria. There is a concern that more unskilled hirers and users may use PWC in Queensland and while this has a beneficial impact on tourism it may also have disastrous consequences, as in the present case.

Helmets

41. The issue of helmets was raised during the inquest and whether they would assist or hinder safety of the user of PWC. Some racers of PWC wear helmets and some helmets are commercially available. MSQ officers have differing views on helmets. Mr Cummings, a senior investigator with MSQ, said that head injuries were a frequent type of injury with PWC incidents.

The Autopsy

42. Dr Peverill performed an external autopsy examination and took toxicology samples. Dr Peverill found a 20mm cut on Dr Shekar's chin and a CT scan showed he had multiple skull fractures including the left and right occipital and parietal bones of the skull. Neither Dr Shekar nor his pillion passenger were wearing helmets at the time of the collision. In addition Dr Shekar's sternum and third rib were fractured. No alcohol or drugs were found as a result of toxicological examination.

Findings required by s45

43. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with the last of these issues, being the circumstances of Sridhar Shekar's death. As a result of considering all the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

    (a) The identity of the deceased was Dr Sridhar Shekar;

    (b) The place of death was the Broadwater, Labrador in the state of Queensland;

    (c) The date of death was 28 April 2008.

    The formal cause of death was:

    1(a) multiple injuries, due to, or as a consequence of
    1(b) personal watercraft accident

Concerns, Comments and Recommendations - s46

Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the

administration of justice or ways to prevent deaths from happening in similar circumstances in the future. As a result of this incident I make the following recommendations:

Recommendation 1

That all PWC hire and drive operations be inspected and audited on a regular basis, including at least one yearly covert audit. That full records and documentation be maintained of all interaction between Maritime Safety Queensland officers and PWC hire and drive operations. That a quality assurance program for all hire and drive operations be developed.

Recommendation 2

That legislation be developed requiring all persons who use a PWC in Queensland be licensed.

Recommendation 3

That legislation be put in place requiring all PWC users to wear appropriately designed helmets for PWC.

Recommendation 4

That Maritime Safety Queensland develops guidelines for all enforcement agencies to assess compliance with the Transport Operations (Marine Safety – Hire and Drive Ships) Standard 2007 and facilitate the sharing for information between enforcement agencies.

My condolences are expressed to Dr Patel and Dr Shekar's family and friends.

I close this inquest.

John Hutton
Southern Coroner
11 March 2010