OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the suspected death of Ross Frederick IRWIN**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Maroochydore
FILE NO(s):	COR 2012/05(6)
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HEARING DATE(s):	17 March 2008, 02 - 06 June 2008
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: Inquest, suspected death, trawler fishing, adoption of the NSCV and other safety initiatives, MSQ investigation of marine incidents**

REPRESENTATION:

Counsel Assisting:	Ms Julie Wilson
Family of Mr Irwin:	Mr Richard Jefferis (instructed by Cardew Salmon Solicitors)
Maritime Safety Queensland:	Mr Greg Egan (instructed by MSQ)
Owners of *'Lauryn G'*:	Mr Neil Stubbins (instructed by DLA Phillips Fox)

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Pursuant to s28 (1) of the *Coroners Act 2003* an inquest was held into the disappearance of Ross Frederick Irwin. These are my findings. They will be distributed in accordance with requirements of s45(4) and s46(2) of the Act and posted on the web site of the Office of the State Coroner.

Introduction

In the early hours of Saturday 22 April 2006, Ross Irwin, and two deckhands were trawling in the Top 50 fishing grounds about 35 nautical miles east of Noosa Heads when their nets snagged an unidentified object. The men commenced to haul the nets aboard to free the obstruction but before they could complete this task the boat rolled over and soon sank. Mr Irwin has never been seen again.

These findings seek to explain what became of Mr Irwin and consider whether further changes are needed to legislation or policy to reduce the likelihood of similar events occurring in future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because the police officers who were involved in searching for Mr Irwin came to suspect that he was dead and that his death, if it had occurred, was likely to have been "*a violent or otherwise unnatural death"* within the terms of s8(3)(b) of the Act, the disappearance was reported to the Office of State Coroner. As a result of considering the report I also came to suspect that Mr Irwin was dead and that his death was a reportable death. Accordingly, pursuant to s11(6) a coroner has jurisdiction to investigate the death. The matter was referred to a coroner at Maroochydore to allow this to happen. That coroner made findings "on the papers." Mr Irwin's wife then applied to me for an order pursuant to s30(1) that an inquest be held. I granted that application. Section s28 authorises the holding of an inquest into the disappearance.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a suspected death.

The Act, in s45(1)and (2), provides that when investigating a suspected death the coroner must, if possible find:-

- whether the death happened, and if so,
- the identity of the deceased,
- how, when and where the death occurred, and
- what caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in 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.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, in so far as it is relevant to this matter, the Act authorises a coroner to "*comment on anything connected with a death investigated at an inquest that relates to –*

(a) public health or safety ; or

(c) ways to prevent deaths from happening in similar circumstances in the future.[2]

The Act prohibits findings or comments including any statement that a person is guilty of an offence or civilly liable for something.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not as constrained as courts exercising criminal or civil jurisdiction because s37 of the Act provides that "*The Coroners Court is not bound by the rules of evidence, but may inform itself in any way it considers appropriate."*

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that 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 needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46(1)
[3] s45(5) and s46(3)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I turn now to a description of the investigation into this suspected death.

The initial investigation consisted of a air, sea and seashore search aimed at locating Mr Irwin after the trawler sunk. That extensive search, which is detailed later in these findings, failed to locate any trace of him. For the reasons detailed below I am of the view the search was competent and thorough as was the investigation undertaken by Senior Constable Lyons of the Maroochydore Water Police. The matter was reported to Maritime Safety Queensland (MSQ) but for reasons which were not made clear it conducted no investigation.

The inquest

Pre – inquest conference

A directions hearing was held in Brisbane on 17 March 2008. Mr Irwin's family, Maritime Safety Queensland and the owners of the vessel involved were granted leave to appear.

The hearing

The hearing commenced on 2 June 2008 and proceeded over four days. Ten witnesses gave evidence and 74 exhibits were tendered. At the close of the evidence, counsel assisting, Ms Wilson, and the legal representatives of those granted leave to appear made oral submissions regarding the findings and recommendations I could make. I found them to be most helpful and thank the lawyers for them.

The evidence

I turn now to the evidence. I can not, of course, even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Ross Irwin – social history

Ross Frederick Irwin was born in Auckland, New Zealand on 9 December 1956. He was 49 when he went missing. Mr Irwin trained as a fitter and turner and followed that calling for many years. It brought him to Australia in 1978.

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[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

[8] (1990) 65 ALJR 167 at 168

When he was made redundant in the early 80s he turned to professional fishing, the occupation he pursued for the rest of his life. He was obviously successful in the industry and was well regarded as a competent and experienced mariner.

In 1981, he met his future wife Gaylene and they remained together until his disappearance. They have two children who are now aged 12 and 14. The family made frequent trips back to New Zealand to visit Mr Irwin's extended family. It is obvious that Mr Irwin was the head of a close knit and loving family. I have no doubt his loss at sea has grieved them terribly and I offer the family my sincere condolences.

Mr Irwin had suffered a number of medical conditions in the years prior to his death. He had been seeing Dr Christian Morton at Maroochydore since 2001 and his medical records show a diagnosis of unstable angina following an anterior infarction in late 1999. A stent was implanted into the left anterior descending artery and medications prescribed.

A letter from the treating cardiologist to Dr Morton in 2001 said that Mr Irwin remained well following the surgery and continued to tolerate the medication. He had been urged by the cardiologist to reduce his weight.

At the time of his death Mr Irwin was still taking medication for his heart and cholesterol conditions. However his wife told the inquest that he had succeeded in losing a substantial amount of weight and he was in the process of having his medication requirements reviewed. I consider there is no persuasive evidence that any health complaint contributed to Mr Irwin's disappearance, although I will deal with some evidence touching on the issue later in these findings.

The vessel

The *Lauryn G* was a 16.76 metre steel hulled fishing vessel weighing 61.48 tonnes. It was built in 1976 in Tweed Heads. It was designed and built for trawling. At the time of its sinking it was powered by a single Cummins diesel engine.

The regulatory regime which sets standards for commercial vessels and monitors compliance is discussed in more detail later; suffice to say at this point, the *Lauryn G* was appropriately registered and had in place the necessary certificates of compliance for the activities it was engaged in at the time of its sinking. It was registered as a class 3B commercial vessel allowing it to operate as a non-passenger commercial fishing ship within two hundred nautical miles of the coast. It was carrying all the mandated safety gear.

The owners and crew

The vessel was jointly owned by Mr Ian Nye, his wife Marion Nye and Croftlake Pty Ltd, a family company in which the beneficial ownership was vested in Errol Clarke and his wife Valerie.

Mr Clarke and Mr Nye had fished commercially together in various arrangements since the early 80s. They were clearly very experienced and had a detailed knowledge of the demands of prawn trawling in south east Queensland.

Mr Irwin's experience has been mentioned already. There is no doubt he was an accomplished and competent skipper.

His crew were not so well equipped. Mr Mark Sullivan had ten years experience as a commercial fisherman, five of those on trawlers. However the other deckhand, Nathanial Uechtritz had never been to sea on a commercial fishing vessel prior to the night of Mr Irwin's disappearance. He had just joined the boat and was on his first voyage to see whether he was suited to the demands of commercial fishing.

The incident voyage

On Friday 21 April 2006, after the two deckhands had purchased supplies, they joined the skipper Ross Irwin at Lawrie's marina in anticipation of going to sea. As it was Nathan Uechtritz's first voyage, Mr Nye claims he went down to the dock in order to give the new deckhand the induction the ship's operating procedures required. Mr Nye claims that before he could do this Mr Irwin said he would undertake that task as they steamed towards the fishing grounds and that for this reason Mr Nye did not do so. He has a diary entry that effusively records this exchange. Some support for these claims was provided by the evidence of Mr Sullivan, it is clear however that no adequate induction was given to the lad. Mr Uechtritz says he was simply shown where the life jackets and life raft were and where the fire extinguisher was kept when he attended at the dock a few days before when he was assisting to prepare the boat for sea.

The *Lauryn G* departed the marina at approximately 2.00pm. They had enough fuel food and water on board to stay at sea for up to 20 days if the weather, refrigeration space or mechanical failure didn't drive them in sooner.

They steamed north east towards the Top 50 fishing grounds about 35 nautical miles off Noosa Heads. Mr Uechtritz says soon after they left harbour, he accepted the skipper's suggestion that he get some sleep so as to be fit for work later in the night.

The nets were put down or "*shot away*" as the industry jargon terms it, at about 7.00pm. In accordance with usual practice the nets were to be winched up at about midnight and Mr Uechtritz was roused from his bunk to observe that process and to participate in the sorting of the catch. The nets yielded about 100 pounds of prawns which were quickly emptied onto the sorting table and the nets shot away again to recommence trawling within fifteen minutes or so of them being brought up.

The nets "hook up"

As the deckhands were processing the catch, the skipper, Mr Irwin, came out of the wheel house and instructed that the nets be winched up again. Mr Sullivan said in evidence that there were a number of reasons why this might be necessary, however, on this occasion he had not detected any problem and nor did Mr Irwin articulate the reason for his order. Nonetheless, Mr Sullivan complied and it soon became apparent that they had a "hook up."

This is apparently not an infrequent occurrence and involves either the trawl gear snagging on a protrusion from the ocean floor or some heavy, moveable object becoming caught up in the nets or associated cables and boards.

Mr Sullivan and Mr Irwin continued winching up the nets. This was done by manipulating the hydraulic controls at a console situated amidships that activated a drum winch situated at the gunwales on both sides adjacent to the booms that protrude out each side of the ship. By winding up the cables leading to the nets hung out each side of the boat, the middle net which is joined to both is also brought up. Mr Sullivan explained that the winches often varied in the rate they retrieved the cables depending on the weight in the nets and the rolling of the boat. On this occasion, both nets were drawn up initially but the port net was obviously snagged as it became increasingly difficult to retrieve. The starboard gear came to the surface relatively easily.

The portside gear continued to cause problems. All of the main cable to the net had been retrieved but only about 10 wraps of the double bridle that runs to each side of the net could be wound in. This meant that the net and the foreign object were almost certainly clear of the sea floor but there was still a considerable length of cable and net to be retrieved. The winch was not effectively pulling up the port net and the weight in it. It was obvious that the object was placing the gear under extreme pressure. A block and tackle was placed onto the port boom close to the gunwale in an effort to take the load closer into the side of the vessel where it would apply less leverage to roll the vessel.

Their efforts continued for an undetermined time, but it must have been in excess of an hour. During that time they cut the chain that linked the three nets together. The men were then able to haul the starboard net onto the deck. They next tried to pull the middle net onto the boat by winching on a lazy line, a rope attached to the end of the middle net. This failed and the rope was released with the result that all of the trawl gear, other than the starboard net, slewed around to the port side of the boat where all its weight and the weight of the obstruction was borne by the port boom and winch.

Mr Sullivan told the inquest that since their efforts to free the port side net had failed, Mr Irwin telephoned Errol Clarke, a part owner of the vessel, for his suggestions as to how to free the gear without cutting it away.

Telephone records show that Mr Clarke was contacted by Mr Irwin at 3.45am. Mr Irwin was in the wheelhouse when he made the call; it seems he used the fax phone. Mr Clarke says that Mr Irwin recounted the events of the night in

much the same way I have outlined them above. Mr Clarke says that at one stage during their conversation, which we know lasted three minutes and thirty seconds, Mr Irwin left the phone but neither of the deckhands recalls him coming out of the wheelhouse. Whether he did and they failed to observe it, or whether he was engaged in doing something else in the wheelhouse we will never know but nothing turns on that in my view.

Mr Sullivan was becoming increasingly alarmed. He disagreed with some of the actions that Mr Irwin had taken and the attitude of the vessel began to concern him. He noticed that the vessel was not recovering from a port side list and that water washing over the back deck and through the scuppers was not clearing as it normally would. Mr Sullivan says he went to the wheelhouse and called to Mr Irwin to alert him to the problem but was waved away. Mr Sullivan says that he thought Mr Irwin was "*spinning out*" but he could offer no evidence to support this other than to say that Mr Irwin was sitting on the floor of the wheel house and that he made a repeated hand gesture when dismissing him. In my view, Mr Sullivan has read too much into those matters. Mr Clarke, who knew Mr Irwin well, says from what he could tell over the telephone, Mr Irwin was not panicking, he was simply appropriately concerned about resolving the difficulties with the trawl gear.

More water was taken and the boat began to list quite severely to port. Mr Uechtritz says it was almost perpendicular but I consider he is mistaken. No doubt this was a terrifying incident for him and misconceptions on his part are entirely understandable.

The worsening situation caused Mr Sullivan to go back to the wheelhouse door and yell at Mr Irwin, demanding he do something about their predicament. Mr Clarke heard this yelling and says shortly after he heard what sounded like crockery crashing and the phone went dead. Counsel for Mrs Irwin submitted I can not be satisfied that it was Mr Sullivan yelling but I am confident that Mr Clarke could tell the difference between the person he was speaking to on the phone yelling and someone else doing so. Further, having regard to Mr Sullivan's sworn testimony that it was him, I have no doubt that was the case; nor that it was for the reason he described.

Mr Irwin came out from the wheelhouse and appeared to inspect the port side problem. Mr Sullivan then handed him the grinder that had been made ready earlier for just such an eventuality. He saw Mr Irwin go to the port side drum winch and lean over the side of the boat to commence cutting the trawl wire. As he was doing so a number of waves in quick succession inundated that low side of the boat and the water seems to have caused the grinder to fail. The boat healed alarmingly.

Mr Sullivan attempted to redress that by manipulating the port winch drum controls but that had no effect as the main engine, which was needed to drive the winches even when lowering the gear, had been turned off. Counsel for Mrs Irwin submitted that turning off the engines was such an inappropriate thing to do in the circumstances; I should not accept Mr Sullivan's evidence that a seaman as experienced as Mr Irwin would have done so. He submitted

that Mr Sullivan's attempt to use the winch as described earlier indicates that the motor had not been turned off. I don't accept this. It is entirely credible that in a moment of panic Mr Sullivan should try the controls even if with calm reflection he may have realised this was futile. Mr Uechtritz also gave evidence that the engine had been stopped, although I acknowledge that his evidence on this point is less clear. Further, if it was still running it seems more likely that Mr Irwin would have attempted to release the winches rather than cut the wire. The suggestion that if the engine had been turned off the deckhands would have heard an alarm ignores the fact that the alarm only sounds from the time the engine is stopped with a "kill switch" until the ignition is turned off – it may be momentary and could easily be missed. The submission that Mr Sullivan's claim that the motor was shut down should be rejected as a recent invention on the basis that he did not include it in either of his statements, ignores Mr Nye's diary entry of 27 April where it is mentioned. Mr Nye gave evidence that Mr Sullivan was the source of this information.

The shutting down of the engine was a significant factor in my view. It helps explain why the boat which had been relatively stable until just a few minutes before, capsized so suddenly. While the engine was running the boat could be held directly above the foreign object in the nets. The witnesses describe the cables going straight down. But when the engine was turned off the ship was subject to the influence of the wind and the tide that would have moved it away from the submerged object, creating the leverage to roll the boat. That, in my view is a much more likely explanation than a sudden failure of the drum winch or an ill advised interference with it by the deck hand.

The capsize

Mr Sullivan realised the boat was about to roll over. He shouted to Mr Uechtritz to climb off the back of the boat and to hold on. He saw him clinging to the board racks but also noted that the starboard net was tangling about him and that Mr Uechtritz was understandably very distressed.

In his statement to police, Mr Sullivan said that Mr Irwin looked *"shaken*" as the boat commenced to roll over. He said in evidence he grabbed Mr Irwin by the arm or shoulder with the intention of pulling him up to the high side of the boat. He also said that it appeared Mr Irwin at that moment suffered a heart attack but when questioned about this he could give no coherent basis for this assertion, other than Mr Irwin was red in the face and stationary. I do not accept Mr Sullivan's suggestion in this regard, although I can speculate as to a number of reasons he might want to believe it to be the case.

The vessel rolled over. Mr Sullivan and Mr Uechtritz clung on to fittings on the starboard side and waited until the vessel was fully inverted. Mr Sullivan surfaced first. A short time later, Mr Uechtritz popped up near-by and explained that his foot had become tangled in the net. Both men climbed onto the up turned hull of the *Lauryn G*. They looked for and shouted to Mr Irwin but not see or hear any sign of him. I am satisfied that noises emanating from within the hull were made by loose items floating around in the water swirling within the hull.

The rescue

Mr Clarke was so concerned by the sudden cessation of his phone call with Mr Irwin and the failure of repeated attempts to re-establish contact that he telephoned Mr Stephen May, the skipper of another boat owned by Mr Nye, the *Galaxy.* He told Mr May what had happened and asked him if he knew where the *Lauryn G* was. Mr May had been in radio contact with Mr Irwin during the evening and knew they had "*hooked up*." He had also earlier seen the vessel's position on his radar and when first contacted by Mr Clarke, assured him that he could see the boat. When he checked however, its lights were not where he expected to see them. He was also aware however that there were a number of trawlers operating in the area and could not be sure that one of those that he could see was not the *Lauryn G*. He readily agreed to go and look for it, but it took he and his crew about 30 to 45 minutes to get their trawl gear winched up and another 10 minutes to steam to where they thought the boat was. His attempts in the intervening period to contact the *Lauryn G* on the radio were unsuccessful.

Mr Sullivan estimates that they spent an hour on the keel of the hull before seeing the dinghy from the trawler surface beside the hull. This coincided with the sea becoming choppier and the ship beginning to sink; presumably this movement freed the dingy. The two men swam to it, were able to right it and get in. Mr Sullivan said that they bailed water out using Mr Uechtritz's jumper and tried to paddle towards the upturned trawler. The wind hampered these efforts which Mr Sullivan estimates went on for another hour before the '*Galaxy*' was seen steaming towards them. However, telephone records show that Mr May telephoned Iain Nye at 4.47am to notify that he had rescued the two deckhands but that the skipper, Ross Irwin was missing. About ten minutes later Mr Nye telephoned AusSAR.

The search

The hull of the '*Lauryn G*' was still above water when the '*Galaxy*' reached the crew and followed the drift line back to the up turned vessel. In that time Messrs Sullivan and Uechtritz had been calling out to Mr Irwin but received no response.

The skipper of the '*Galaxy'*, turned on the trawler's lights on and set off numerous red paraflares that lit up the surrounding ocean. He searched along the drift line delineated by flotsam and an oil slick escaping from the vessel and searched around the hull to no avail. A distress call to all vessels in the area was made soon after the two crew members had been rescued.

The Rescue Coordination Centre (the RCC) operated by the Australian Maritime Safety Authority (AMSA) was notified at 4.59am, that the two crew had been recovered and the skipper was missing. While I readily acknowledge that Mr Clarke speedily took the most appropriate action available to him in contacting Mr May, I believe he should also have contacted AusSAR as soon as Mr May indicate that he could not raise the *Lauryn G* on the radio.

Mr Clarke and Mr Nye justified their delay in contacting the authorities on the basis that although they were concerned about what had transpired on the *Lauryn G*, until they heard back from Mr May it was not appropriate for them to take any other action. In my view they had ample basis to justify contacting the authorities. Mr Nye's concern that any such contact would be construed as a hoax does not make sense. The contact would have involved the owners sharing with the rescue authorities all that they knew, including that the boat couldn't be raised by phone or the radio, two media that had been functioning well until a precipitous loss of contact, following a sustained period of perilous activity. I readily accept that such earlier contact would not have changed the outcome in this case but it would have provided the authorities with an opportunity to begin scoping the job; ascertaining what search assets were available. Were the vessel found to be in no need of assistance the stand down order could easily have been issued with no harm done.

A helicopter was dispatched at 5.11am and at 5.34am Brisbane Air Traffic Control were asked to advise aircraft to monitor the distress frequency for possible beacon activation relating to the trawler. Senior Constable Lyons was contacted by the RCC at 5.11am and the Sunshine Coast Water Police (SCWP) assumed responsibility for coordination of the surface search at 5.45am.

The first helicopter arrived on scene at approximately 6.30am with the second following soon after at 6.44am. Datum buoys were dropped at the location of an oil spill in order to determine the best search area given the current. There were 7 or 8 vessels searching within one kilometre of that oil spill. Those in the aircraft could make out the outline of the vessel below the surface of the water when they commenced searching.

Senior Constables Lyons and Wickers arrived at the scene in the police vessel '*George Doyle*' at 7.40am. A line search was commenced involving fishing vessels, volunteers from marine rescue groups, the police vessel and Mooloolaba, Noosa and Caloundra Coast Guard. The search followed the drift line established by data collected from the datum buoys.

Conditions deteriorated throughout the day. South easterly winds of 12 to 15 knots and a 1 to 1.5 metre swell were noted by Sergeant Bates at 10.00am. By 2.00pm, conditions were far less favourable with 15 to 20 knot winds, whitecaps and a 1.5 to 2 metre swell, as well as partial cloud cover at 800 feet The sea search was suspended at 2.00pm on account of those conditions. The aerial search continued in the afternoon and involved five helicopters.

On Sunday 23 April aerial searches were conducted in the morning and afternoon. The surface search was suspended on the basis that the search area was by then too big to be effectively covered by boats. I accept the validity of that decision.

Dr Luckin is an anaesthetist with a background in the medical aspects of search and rescue was consulted during the course of the search. Having assessed the information provided by the Sunshine Coast Water Police, Dr

Luckin formed the opinion at 8.00pm on Sunday night that there were no reasonable prospects of Mr Irwin surviving past that point in time.

Had Mr Irwin been trapped in the vessel when it capsized the prospects of survival were nil. Even had Mr Irwin initially found himself in an air pocket, the atmospheric pressure applied on sinking would have compressed such air pocket by half for every 10m the boat sank below the water line. The time it would have taken to refloat the vessel using airbags (even had the necessary equipment been at the surface immediately the vessel sank) would exceed that within which Mr Irwin could have survived.

Likewise, police divers could not have saved Mr Irwin had he been trapped. It would have been unsafe to dive with a sinking vessel and as I have already said, the atmospheric pressure would have forced out any available air such that Mr Irwin would have been deceased by the time divers reached him. In any event QPS divers are not equipped or trained to dive to the depth of the seabed where the '*Lauryn G*' lay.

The Noosa and Fraser Island Police performed shore searches on Monday, Tuesday and Wednesday (24 – 26 April 2006) and no sign of Mr Irwin was found.

David Walton is a specialist mixed gas diving instructor who uses closed circuit rebreather equipment. He was asked by John Irwin to dive the wreck and search for Ross Irwin's remains. Mr Walton said that he was able to reach the wreck on 29 April 2006. The '*Lauryn G*' was upright in about 99 metres of water. He found no trace of Mr Irwin in or near the vessel. Obviously, there are numerous explanations as to why that might be.

I am persuaded the search was thorough and professionally organized and undertaken. I consider it likely that had Mr Irwin survived the capsize, he would have been found during this search. I accept the evidence that he has not been seen since and that there is no basis on which to suspect that he has deliberately concealed his whereabouts. Dr Luckin gave evidence that a man of Mr Irwin's age and condition who had been working through the night would suffer severe stress as a result of the shock and trauma of a roll over in the early hours of the morning. It would be very difficult for him to escape the numerous entrapments of the boat. All of the evidence points to Mr Irwin having died at the time of, or very soon after, the sinking of the *'Lauryn G'* and I find accordingly.

Findings required by s45(1)&(2)

I am required to find whether the suspected death in fact happened and, if so, who the deceased person was, and when, where and how he came by his death. I have already dealt with the first and last of those matters, in that I have found that Mr Irwin is dead and described the circumstances in which the death occurred. I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased was Ross Frederick Irwin

Place of death – Mr Irwin died in the sea off Noosa Heads in Queensland.

Date of death – He died on 22 April 2006

Cause of death – Mr Irwin died as a result of the boat he was on capsizing. The most likely cause of death is drowning.

Comments and preventive recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety or ways to prevent deaths from happening in similar circumstances in the future.

Issues of concern

The capsizing of the '*Lauryn G*' was not a unique event. In the Baker inquest Mr Adams of Maritime Safety Queensland (MSQ) provided a report to the Court detailing 38 instances of commercial fishing boats capsizing in the 12 year period 1992 to 2004 in the Brisbane region alone. Attached to the submissions made by MSQ in that inquest was a table showing that 75 boats had been lost on the east coast of Queensland in the period 2001 to 2004 inclusive. Further, a search of the National Coronial Information System indicates that in the ten years 1994 to 2004, 16 trawler men died at sea.

Many of these incidents involved trawlers capsizing after their nets hooked onto protuberances on the sea floor or filled with submerged objects.

Commercial fishing generally, and trawling in particular, is a hazardous occupation. Fishermen work mostly at night, often in bad weather and usually with small crews, often only two men. They work in wet and slippery conditions on a moving platform performing demanding tasks over long hours. We heard graphic evidence in this case of some of those perils.

As mentioned earlier, capsizes are not uncommon and there is always the hazard of falling overboard. Even if the other crewman is immediately aware this has happened, responding effectively in dark and rough seas can be very difficult.

Since they have ventured from the shore, the sea has swallowed fishermen: nothing will eliminate that entirely. However, as I said in the Baker findings, I do not believe that advances in technology that could reduce the likelihood of that happening have been appropriately utilised. In other dangerous industries, unions have successfully lobbied for legislation to reduce the risks to workers so that when anybody enters a mine or a building site they are required to wear steel capped boots and hard hats. In the fishing industry where many of the workers have little formal education, where other

employment opportunities are limited and unionism is almost non existent, a level of risk that would not be tolerated in shore based jobs seems to be the norm.

The evidence in this case highlights some of the ongoing challenges to improving safety in this industry

In response to legislative requirements, the owners of the '*Lauryn G*' had prepared some documentation dealing with workplace health and safety procedures. There was evidence received in the inquest that indicated that the documentation was deficient, although the marine surveyor retained by the operators was of the view that the marine safety officer who made that assessment a month before the vessel sank was unduly critical. The owners had undertaken to rectify that however it is not known if that had happened.

A hand written document set out points to be covered when a new crew member commenced work on the vessel but there was no process in place to ensure that the induction was conducted, and if conducted, was conducted thoroughly.

In this case 16 year old Nathan Uechtritz was given no more than a cursory 'run down' of the location of safety equipment on the vessel. He was not provided with any information about the use of that equipment or what to do in the event of a hook-up, if the vessel rolled or if a crew member fell overboard. He was entirely unprepared for what transpired on his first voyage.

Mr Sullivan said that he had been shown the safety equipment on board when he commenced work on '*Lauryn G'*. He said that he could not specifically recall seeing the safety procedures on board but did remember a yellow folder which might have been the manual referred to by the owners. In any event, it is clear that his safety induction was inadequate.

Documents from the sister ship '*Galaxy'* produced at the inquest were said to be similar to those on board the '*Lauryn G'*. They include a requirement that safety drills be carried out monthly or when a new crew member starts. Mr Sullivan said no drills were ever carried out in the three or four months that he worked on the vessel.

It is plain that the skipper and crew on '*Lauryn G*' did not regularly use safety equipment provided by the owners. This, as I've said, is not unique in the industry. Mr Sullivan told the inquest that after his experience the night Mr Irwin died he became more vigilant. When he donned a life jacket in a dangerous situation on another vessel he was laughed at by fellow crew.

It is the responsibility of owners and skippers to ensure that crew are properly equipped to deal with the dangers of their work. The TOMSA makes that clear but if the operators who gave evidence in this case are typical of the industry, it seems that responsibility is being shirked. Messrs Nye and Clarke are evidently committed to maintaining their vessel in good order, an essential aspect of safety. However, they demonstrated far less regard for safe work

practices. It is not acceptable to rely on the long held resistance of fishers to use safety equipment to avoid that responsibility. I consider there is far more they could do. For example, insisting on safety drills being practiced and making the use of safety gear compulsory – something that is unlikely to happen when the owners don't believe it is necessary.

It is appropriate to look at the regulatory regime which seeks to deliver greater safety.

The safety regime

MSQ is a division of Queensland Transport. It administers the *Transport Operations (Marine Safety) Act* 1994 (TOMSA) and Regulations and aims to promote marine safety in Queensland. The TOMSA provides the framework for the classification and registration of ships and imposes obligations on owners and masters of ships to ensure their seaworthiness and safe operation. Those safety obligations include obligations to ensure that vessels are equipped with safety equipment prescribed by the Regulation.

The Regulations call up the provisions of the Uniform Shipping Laws Code (the USL Code), however Standard Practice Instructions provide exemptions for fishing vessels in respect of stability and safety requirements. So far as safe design and equipment, the USL code was largely overtaken and replaced by the National Standard for Commercial Vessels (NSCV). It provides guidance to builders and operators as to how they can discharge the general TOMSA obligations to build seaworthy vessels and operate them safely. It encompasses, among other things, safety obligations, design and construction and crew competencies. However, again trawlers and some other fishing vessels have exemptions from the obligation to comply with these requirements on the basis of the cost to an aging and marginally, economically viable fleet.

In 2004, the Marine Safety Committee, set up to advise the relevant State Government Ministers on the divergence between the NSCV and local protocols, recommended these exemptions be withdrawn and that commercial fishing vessels be required to comply with NSCV: so far that recommendation it has not been implemented.

Mr Brightman, a project officer with MSQ said that change was nigh but he could not say with certainty when commercial fishing vessels would become the subject of those more stringent safety standards. He said that it was hoped the necessary legislative changes would be made in 2009. It is pertinent to observe that the current arrangements mean that any fishing vessel that was in survey as at 1 January 1996 still does not have to comply with many of the advances made in marine safety since that time.

The NSCV will require safety equipment to be readily accessible and maintained such that it will function reliably at the time of need. It also requires that all on board have sufficient information and knowledge to effectively use all available safety equipment at the time of need and facilitate

search and rescue operations during daylight or at night. That is all very sensible and demonstrably necessary, albeit has been a long time coming.

The TOMSA provides that a crew member who has worked on a vessel for six months must complete an approved safety course. The rationale for allowing that six month time lag is that it is difficult to have crew complete such a course prior to commencing work because often crew offer their services with little time to spare prior to the commencement of a voyage. That reinforces the need for a proper safety induction by the owner and/or skipper prior to crew commencing work on a fishing vessel. However, it also calls into question the viability of the industry. If working conditions are so unattractive that crew can only be secured by relying on the impulsive decisions of the inexperienced and the untrained it is unlikely the industry has a future unless operators are prepared to make significant changes.

In the meantime, it is appropriate to consider what real progress has been made to enhance safety in the trawl fisheries.

MSQ initiatives

In my findings in the matter of the death of Rodney Baker I recommended that all commercial trawlers be required to comply with NSCV stability requirements, that quick release mechanisms be made mandatory on commercial trawlers, that they carry inflatable life rafts, and that trawler men and women wear PFD and carry EPIRBS while working on deck.

I am satisfied that these recommendations and others safety initiatives identified by the Marine Safety Committee have been actively pursued by the department, principally over the last 18 months through the work of Mr Brightman and marine safety officers stationed in all major fishing centres.

Regrettably, as the responses of fishing industry operatives detailed earlier evidences, there is strenuous resistance in the industry to the adoption of a basic risk management approach that has been adopted almost universally in other industries.

Mr Brightman set out in a schedule the steps that MSQ is taking to implement the Baker and other inquest recommendations, the MSC recommendations and other safety issues his process has identified. The agency has made an informed decision to rely on consultation rather than coercion on the basis that in an environment where enforcement is difficult, cultural conversion is more likely to be effective. I accept that to an extent but query whether the department has had sufficient regard to the capacity of legislation to contribute to attitudinal change. Surely, even among fishers the law is given some regard.

I am also surprised that so much effort is still being devoted to consultation. One might have thought the investigations into the numerous deaths and other incidents, the development of the NSCV and the MSC deliberations would have provided ample opportunity for best practice to be identified. It

seems to me that what is needed now is more commitment to the implementation of these reformed standards and practices.

While I recognise that changing attitudes in the trawling industry will be a slow process, I urge haste in respect of the amendments necessary to incorporate the NSCV into the TOMSA and the Regulations.

Recommendation 1 – Compliance with the NSCV

I recommend that compliance with the National Standard for Commercial Vessels be made mandatory for all commercial fishing vessels to which it relates forthwith and that in particular, the elements concerning crew competencies and safety equipment be made operative immediately.

The interaction between the investigative agencies

There was no investigation by the government agencies charged with ensuring marine and workplace health and safety. Some explanation of that is required.

As has been mentioned, MSQ is the agency responsible for administering the TOMSA, the legislation principally designed to regulate marine industries and to ensure marine safety in Queensland. However there is nothing in that Act to exclude the operation of the Workplace Health and Safety Act and Regulations which are designed to do the same in workplaces generally. That Act is administered by the Division of Workplace Heath and Safety (WH&S).

Those agencies have entered into an MOU to provide for the sharing of information and the avoidance of unnecessary duplication of investigative effort. The agreement provides a mechanism for nominating a lead agency for enforcing the respective legislation by the regulatory agencies. Unsurprisingly, it provides that as a general rule, MSQ will be the lead agency in respect of marine incidents to which the TOMSA applies and WH&S will discharge that role when its Act is to be brought into play.

The MOU also provides for the agencies to work together on those matters which may be both a marine incident and a workplace incident.

In this case there was no such joint effort and MSQ played only a limited role in assisting the police officer who prepared the report for the coroner. An entry in schedule 2 to the MOU headed *Jurisdictional Examples* may explain the lack of collaboration by the two safety agencies: in relation to the example *Person lost overboard from a vessel,* it is stated that WH&S has no jurisdiction. This is clearly wrong. Mr Irwin lost his life as a result of a workplace incident.

This issue was raised in the recent inquest into the death of Phillemon Mosby who was also lost at sea. I made comments and recommendations in that case which I restate here. I am told by counsel for MSQ that his client is taking action in respect of the Mosby recommendations and that safety investigations will be undertaken in similar circumstances in the future. It is

important that that be the case. While the police investigation into the missing person was competently undertaken, understandably it did not focus on the underlying causes of the incident. Presumably, such an investigation is important to the work Mr Brightman and others within MSQ are doing to increase safety in trawling.

The TOMSA provides that the general manager may require a shipping inspector to investigate a marine incident. Following an investigation a report must be furnished to the general manager who might then take action in respect of safety issues raised.

There is little point having a legislative regime which aims to ensure the safety of workers at sea if the bodies responsible for administrating the regime do not investigate incidents which have led to the loss of life.

Recommendation 2 – Review of WH&S / MSQ MOU

I recommend the Director of the Division of WH&S and the General Manger MSQ review the operation of the MOU in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies.

Recommendation 3– Review of failure of MSQ to investigate

I recommend that the General Manger MSQ review the policies governing the investigation of marine incidents to ensure that incidents involving serious injury and loss of life are properly investigated, and that issues arising from such investigations are responded to in the manner most likely to promote marine safety in Queensland.

This inquest is closed.

Michael Barnes
State Coroner
6 June 2008