QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Leila Michelle Trott**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2016/1404
DELIVERED ON:	16 March 2017
DELIVERED AT:	Brisbane
HEARING DATE(s):	9 December 2016, 1-3 February 2017
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Drowning, contribution of possible physical impairment due to coronary artery disease, work place health and maritime safety regulatory framework and investigations, remote area retrievals

REPRESENTATION:

Counsel Assisting: Ms Megan Jarvis

Mr Robert Trott for the family

Counsel for Ocean Premier Reef & Island Tours, Mr P Jones, Ms T Aguis: Mr HA Mellick, Mellick Smith & Associates

Counsel for Retrieval Services Qld: Mr M Hickey i/b Minter Ellison

Counsel for WHSQ: Mr C Cater i/b Crown Law
Counsel for Royal Flying Doctor Service: Ms J Rosengren i/b Barry Nilsson

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Introduction

1. Leila Michelle Trott was 38 years of age when she went missing sometime around 1330 on 6 April 2016, whilst swimming to retrieve a tender (a dinghy) that had come loose from its mooring and drifted away from *Ocean Free,* a tourist sailing vessel Leila was skippering on the Great Barrier Reef near Green Island off Cairns.

2. Leila was located in the water at 1418 and it is estimated she had been missing in the water for around 40 to 50 minutes by that time.

3. CPR efforts were immediately commenced but she could not be revived. Efforts were made for the aeromedical retrieval helicopter to attend but it was unavailable as it was being serviced. Leila's body was taken to the mainland on the Water Police vessel.

4. An autopsy examination revealed that Leila had a severe narrowing to one of the arteries in her heart. No signs of any marine bites or stinger contacts were observed on Leila's body, and no drugs or alcohol were detected in her blood. The forensic pathologist considered she had most probably drowned following a cardiac arrhythmia because of the underlying coronary artery disease.

5. Various investigations into and reviews of the incident were conducted and reports received. These investigations were conducted by the Queensland Police Service, Workplace Health and Safety Queensland and Retrieval Services Queensland (who are responsible for aeromedical retrieval services in Queensland). Coincidentally, Maritime Safety Queensland (MSQ) had attended on Ocean Free on the morning of the incident to conduct a safety audit and some deficiencies were found in relation to its Safety Management System.

6. From these investigations and reviews, no recommendations were made for prosecution or any other actions against any of the individuals or entities involved, apart from the issue of an Improvement Notice by MSQ. Further, no recommendations were made for improvements either within the Great Barrier Reef tourism industry or in relation to government services responsible for providing an emergency response to incidents on the Great Barrier Reef. Community concerns had been expressed in the media in relation to the fact that aeromedical retrieval helicopters were not always available.

7. Information was received about steps taken by Leila's employer since her death to help prevent a similar incident from occurring on one of their vessels in the future.

8. Leila's parents, Janet and Robert Trott expressed significant concerns regarding the finding by the pathologist as to Leila's cause of death, as well as the circumstances surrounding Leila's death, including:

   - how the tender was able to come loose from the vessel in the first place;
   - whether Leila may have felt pressure to swim for *The Tank* rather than call for assistance, given her position as a female skipper in a male-dominated industry;
   - why Leila's colleague left his lookout position that day;
   - whether Leila's employer did enough to ensure her safety, including with regards to staffing numbers on *Ocean Free*;
   - the adequacy of the emergency response to the incident, including the unavailability of a helicopter that afternoon to provide an aeromedical retrieval service for Leila; and
   - whether Leila's death may have in fact been related to a sting by a marine animal (possibly the Irukandji jellyfish) and subsequently covered up in some way, so as not to adversely affect tourism on the Great Barrier Reef.

Issues for inquest

9. Leila's family requested an inquest to help better understand the circumstances of her death and to uncover any other information that may not yet have come to light. In response to this request and having regard to the fact that an inquest into Leila's death may help to identify opportunities for improving the safety of individuals who visit or work on the Great Barrier Reef, a decision was made to hold an inquest.

10. At a pre-inquest conference held on 9 December 2016, the following list of issues for the inquest were determined:

    a) The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how she died and what caused her death.
    b) Whether the deceased's employer took reasonable steps to ensure the deceased's safety on board the vessel *Ocean Free* on the day of the incident.

c) The adequacy and timeliness of steps taken by individuals, other vessels, and police and emergency services to locate the deceased, once she was identified as missing.

d) The adequacy and timeliness of professional retrieval and emergency medical care available and provided to the deceased once she was located.

e) What actions have been taken since the death to prevent deaths from happening in similar circumstances in the future.

f) Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

11. The following witnesses were called to give evidence at the inquest held over three days from 1 to 3 February 2017:

- Senior Constable Darlene WEBB, Queensland Police Service
- Dr Paul BOTTERILL, Senior Staff Specialist Forensic Pathologist, Queensland Health Forensic and Scientific Services
- Angelo CAPALDI, Investigating Inspector, Workplace Health and Safety Queensland
- Dean COGGINS, Regional Investigations Manager, WHSQ
- Filippo MATUCCI, diver instructor, Cairns Premier Reef & Island Tours Pty Ltd
- Jean-Luc GRASSET, passenger and international tourist (statement received but unable to be contacted to give evidence when scheduled)
- Josette GRASSET, passenger and international tourist
- Dr Elizabeth KYLE, specialist medical officer/clinical coordinator, Retrieval Services Queensland
- Dr Catherine VOGLER, Royal Flying Doctor Service
- Rob TOOMEY, Skipper and Maintenance Manager, Cairns Premier Reef & Island Tours Pty Ltd
- Taryn AGIUS, Director, Cairns Premier Reef & Island Tours Pty Ltd
- Perry JONES, Director, Cairns Premier Reef & Island Tours Pty Ltd
- Paul MYERS, Operations Manager, Cairns Premier Reef & Island Tours Pty Ltd
- John DOWNES, Marine Safety Inspector, Maritime Safety Queensland
- Trevor WILSON, Acting Chief Pilot, QGAir

- Dr Clinton GIBBS, Clinical Director – Northern Operations, Retrieval Services Queensland

The events of 6 April 2016

12. Leila was considered to be an experienced dive instructor and skipper and by all accounts was a very fit and healthy individual and a strong swimmer. There had been no evidence of any underlying physical condition or issues with respect to Leila's heart before that day, despite all of the physical activity she regularly engaged in. All who knew her in her capacity as a skipper felt she was more than capable of swimming the distance she set out to swim that day, even with a strong current and choppy waters.

13. Leila had taken the vessel, *Ocean Free*, out to Green Island that morning with nine passengers on board. Also on board was her colleague, Filippo Matucci, a dive instructor who was acting as a snorkelling guide for the passengers that day. Mr Matucci stated that the maximum the vessel can take is 25 passengers with four staff. As they only had one person on board who was planning on diving, he considered that conducting the trip with only two staff was very manageable. The vessel's *Safety Management System* as it existed at the time and in its current form states that two crew members only are required where 10 or less passengers are on board.

14. Mr Matucci stated that he considered Leila very capable as she had been working on boats for 15 years. It is apparent the company had other vessels including *Ocean Freedom* on which Leila would work two days a week as a coxswain and sometimes she would skipper the *Ocean Free.*

15. After a morning of snorkelling moored off Green Island, lunch was served on the vessel. After lunch, seven of the passengers were taken to Green Island via the tender, with Leila as skipper of the tender. The passengers were scheduled to remain on the island for around 45 minutes before being picked up again and returned to the sailing vessel. In the meantime, Leila returned the tender to the larger vessel.

16. Mr Matucci stated he assisted in securing the tender to the *Ocean Free* using a 'painter', which is a loop of rope attached to a short rope approximately 1.5 metres in length. The painter is attached to the tender permanently and slides along a metal bar on the tender. He stated that when Leila arrived back at the base he reached out and grabbed the painter and pulled it through the sternum gap and then put the loop over the cleat on the port side. When he

secured the painter he stated it was definitely through the sternum gap and secured properly on the cleat.

Photograph by way of example, to illustrate how Mr Matucci says the painter line was secured that day, with the painter line over the portside cleat passing through a gap at the stern

17. Leila was still on the tender when Mr Matucci went back to wash the dishes from lunch. Leila then helped Mr Matucci clean up from lunch and he says she then took a break from duties, during which time she lay down above deck to sunbake for a while.

18. At around 1310, about five minutes before Leila was due to return to Green Island to pick up the passengers, Leila noticed the tender had come loose and drifted some distance away from the vessel. Mr Matucci stated that he saw the tender was about 500 metres away and thought it probably had been drifting for a good 10-15 minutes. The current was going in a north-westerly direction and the wind was coming south-easterly at about 16-20 knots. Mr Matucci stated he thought the wind was slightly below 20 knots as he had watched the wind sock on the island jetty.

19. After a very brief discussion with Mr Matucci about what to do, Leila decided to swim to another nearby vessel owned by the same company, a glass bottom boat referred to as *The Tank*, which was anchored some 400-500

metres away. There was some conflicting evidence suggesting the *Tank* was closer to 150-200 metres away, but my own view of the scene conducted prior to the inquest indicated the distance was closer to the range of 400 metres. In any event, the evidence is such that given Leila was a strong swimmer this distance was ordinarily well within her capabilities. Mr Matucci said he offered to go but Leila said she would. Mr Matucci assumed the plan was for Leila to return with *The Tank* to collect him so that together they could retrieve the tender. He said in his evidence that Leila hurriedly put on her fins and mask and jumped into the water before he could discuss the plan much further.

20. As apparently explained by Leila to a male French tourist, Jean-Luc Grasset, the reason they did not take the *Ocean Free* over to the *Tank* was because low tide was at 1330; it was a very shallow reef and the reef might hit the bottom of the boat.

21. Mr Grasset's wife and fellow tourist, Josette Grasset, said she thought Leila had attached the tender to the *Ocean Free*. She had seen Leila clean up after lunch and then do some paper work on a mattress. Twenty to 30 minutes later Leila said something about the tender vessel being adrift. Ms Grasset recalls her husband asking why she did not take the *Ocean Free* to collect the tender and Leila explained that due to the bouncing of the water, navigating the reef would be too hard. Ms Grasset stated that Leila was 'in a panic' to get the tender back so she could pick up the other passengers from the island.

22. Mr Matucci, in retrospect, stated he or Leila could have called for someone else from the nearby Green Island or other nearby tourist vessels to come and pick them up to take them to the *Tank.* He said it all happened so quickly from the time Leila saw the tender missing, to her jumping in the water. He did not argue with her as she was the skipper.

23. Leila, who was already wearing a swimsuit, put on flippers and a mask and dived into the water. Mr Matucci said he acted as lookout whilst Leila swam towards *The Tank*. Whilst the water was rough and 'choppy' that day, and possibly with some current (Leila was seen to be swimming slightly off course), he felt confident whilst watching her that Leila would reach *The Tank*.

24. Mr Grasset stated he also looked at Leila swimming for a little while and then he went and did other things. He said Leila looked like she was a confident swimmer but it did not look like she was swimming directly to the boat due to

the tide moving out from the beach and placing her on the right side direction of *The Tank*.

25. When Leila was about two-thirds of the way to *The Tank* or about 50 metres from it, and feeling confident that Leila was fine and not showing any signs of distress, Mr Matucci left his lookout position to use the toilet briefly. Ms Grasset recalls her husband at one point said he saw that Leila seemed not so far from the other boat (*The Tank*).

26. When Mr Matucci returned a few minutes later he could not see Leila in the water or on *The Tank*. Mr and Ms Grasset stated they had periodically been watching Leila swimming towards *The Tank*, but on Mr Matucci's return also could not see her. All three continued to look out for Leila for a short time. Mr Matucci says he looked for Leila for a minute or two. He was not initially worried and thought she may be on the other side of *The Tank* preparing to climb on board. Ms Grasset estimated it was 10 minutes before Mr Matucci called the alert on the radio. In my view the timing may have been shorter than 10 minutes but it was at least some minutes.

27. Mr Matucci then radioed another nearby tourist vessel, the *Big Cat,* for assistance from their tender. He first called on channel 16 (the emergency channel) and was asked by the receiver to move to channel 15. Mr Matucci did not argue and did so within seconds and asked for the *Big Cat* tender to come over to *Ocean Free* immediately but did not say why. Mr Matucci saw the *Big Cat* tender coming and he then rang Rob Toomey, another skipper with the company who also had a managerial role. Mr Toomey was on the mainland on his day off. Mr Matucci told him Leila was in the water and he could not see her and wanted help to coordinate a search. Mr Toomey realised Mr Matucci was very concerned. Mr Toomey stated he rang a worker he knew at the Green Island Parasailing company to help with a search and to notify all other boats that Leila was missing. Mr Toomey called Mr Matucci five minutes later to say he had called others to help, and a number of vessels began making their way to the area to assist.

28. The area where the tourist boats congregate is quite close to Green Island and the distance from the various moored vessels would be less than a kilometre.

29. Mr Matucci then got on to the tender from the *Big Cat* and they followed the path Leila had swum. He snorkelled on top of the water to look for her yellow

fins. By this time the parasailing boat was also there. Mr Matucci was then told he should send a 'PAN-PAN' emergency call and they took him back to *Ocean Free* for that purpose. By that time there were four to five boats in the area and some divers were in the water looking for Leila. The search was conducted by these vessels travelling in a line parallel to each other moving away from the island.

30. An official 'PAN-PAN' emergency call was made by Mr Matucci via radio at 1406, alerting water police and emergency services to the situation. Mr Matucci stated that his initial thought was to get onto the radio to get another tender to come and help and he did not think to call a 'PAN-PAN'.

31. A short time after the 'PAN-PAN' call, at around 1418, Leila was located by another vessel floating face down on the surface of the water, approximately one kilometre from where the *Ocean Free* was moored.

32. Jason Brown had first aid and oxygen delivery training. He was travelling with Thomas Orland on a *Great Adventures* boat moored at Green Island when they got the call to assist at about 1400. Mr Orland also had advanced resuscitation training including the use of oxygen resuscitation equipment and defibrillators. They were searching downwind of the glass bottom boat tender (*The Tank)* and were about 500 metres from *Ocean Free.* Mr Brown was the first to see Leila floating face down in the water. He jumped into the water and immediately turned Leila over and heard the sound of gas escaping from her. She was not wearing a mask. Leila was pulled from the water into the boat and observed to be unconscious and not breathing, and with her eyes open and pupils fixed and dilated. Leila had been missing in the water for around 40 to 50 minutes by that time.

33. CPR efforts were immediately commenced. Mr Brown stated that it was his impression Leila was already deceased but his training required him to commence and continue CPR until he was told otherwise. Mr Brown did chest compressions and Mr Orland held an O^2 mask in place and at the same time headed towards Green Island.

34. Emma Mather from *Sea Walker* boarded and assisted with chest compressions. She also has CPR qualifications. With her was a trainee paramedic, Lachlan Roberts who also worked on *Sea Walker*. They were met at the beach by an employee of Green Island Resort who had an automatic defibrillator. They also had access to a Royal Flying Doctor Service's medical

kit held on the island. Staff at the island had already contacted RFDS to seek permission to utilise the medical kit and were being given clinical advice over the telephone by Dr Catherine Vogler of RFDS.

35. The defibrillator was attached to Leila and turned on but the machine read that 'no shock' was advised and to continue with CPR. As well, the trainee paramedic inserted an Igel Airway into the mouth and a Cardio Pump onto Leila's chest to provide more efficient compressions. The staff at the island utilised the defibrillator, adrenalin and pulse oximeter. They were asked to check for evidence of marine stings and found none. The trainee paramedic placed a cannula into a vein. At no time did the defibrillator advise to administer a shock. Despite continued efforts Leila showed no signs of recovery and her life was declared extinct at 1519, an hour after she had been pulled from the water.

36. The missing tender was found by another tourist boat and brought back to Cairns. Craig De Courcy noted that the tow line was in the boat and the stern painter line was dragging in the water. The significance of this evidence is that the tow line must not have been used as an alternative or extra securing to the main vessel. The stern painter line would have been just dragging into the water, given its length and would not have interfered with the movement of the tender.

Autopsy results

37. An autopsy and other post mortem testing to determine Leila's cause of death was conducted by Dr Paul Botterill, Forensic Pathologist. There was no significant past medical history. According to her local doctor's medical records there was an episode of ill health in 2014 where an elevated blood creatinine kinase level was noted, but no other investigations or specific symptoms appeared to suggest any known past history of cardiac disease.

38. During the autopsy examination it was revealed that Leila had a severe narrowing to one of the arteries in her heart. This involved a short single segment of narrowing in the mid-course of the left anterior descending artery, associated with a greater than 75% liminal narrowing.

39. No signs of any marine bites or stinger contacts were observed on Leila's body, and no drugs or alcohol were detected in her blood. Dr Botterill stated that although the absence of marine stinger marks did not exclude absolutely the possibility of a marine stinger he considered this to be most unlikely given

the significant coronary artery disease. He stated that there would be thousands of people in Australia at any one time with this condition who would be unaware of the condition as they were not having any adverse symptoms. Sometimes a person would feel chest pain but in many others a cardiac arrhythmia could occur without warning.

40. From these observations, Dr Botterill formed the opinion that Leila's cause of death was *most likely drowning following a cardiac rhythm disturbance due to underlying coronary artery narrowing and it remains possible that this has been exacerbated by the exertion and stress associated with the attempts to retrieve the boat. It remains difficult to exclude potential contribution due to the exertion and stress of the circumstances leading to the death.*

Investigation findings

Queensland Police Service Investigation

41. The QPS investigation was completed by Senior Constable Darlene Webb.

42. Statements were taken from relevant witnesses who were present on the vessel when Leila went missing and from those who were involved in the recovery and initial first aid.

43. The weather at that time was fine, clear and sunny. The wind was reportedly blowing south easterly between 16–20 knots. The current was north westerly with half to one metre of swell and was rough and choppy. Visibility on top of the water was good. Visibility below the surface was approximately four to five metres.

44. Police were first informed of the incident at approximately 1433 by QAS communications that a rescue helicopter was off-line and requested Water Police to attend. Senior Sergeant Coate, the Cairns District duty officer queried why QAS was not charting a helicopter and was advised QAS did not charter helicopters and only used rescue helicopters as available.

45. Investigations later revealed that Rescue helicopter 510 was not available as it was down for scheduled maintenance over 5 and 6 April 2016. The closest rescue helicopter was in Townsville an estimated 1.5 hours away. QPS were subsequently advised by EMQ Air Operations that a helicopter from Townsville would not have reached the incident before Leila had been located, even if they had been requested to respond.

46. The QPS investigation found that Mr Matucci did not call the PAN-PAN until 1406, some possible 40–50 minutes after Leila was noted to be missing. However, the evidence shows he did call for assistance from other vessels in the area approximately 10 minutes after noticing her missing.

47. The investigation report noted that if the PAN-PAN had been sent earlier it would have alerted the Water Police, potentially the rescue helicopter and other vessels in the area to the incident, however the Water Police were an estimated 1.5 hours away in Cairns and would not have made it to the scene before Leila was located.

48. The investigator considered that Leila made a decision to swim for *The Tank.* She concluded Leila may have panicked and knew time was a factor for her to retrieve the tender so the other passengers could be collected from the island. There was no evidence to suggest Leila was unwell and it was believed she should have been able to swim that distance without issue. There was no evidence to suggest she was pushed to or forced to make this decision.

49. The police investigation found, whilst the tender coming adrift from the *Ocean Free* was a catalyst for the events that followed, there were no suspicious circumstances and no one was criminally responsible for the death.

Workplace Health and Safety Queensland Investigation

50. WHSQ was notified of the incident by Queensland Ambulance Service (QAS) by email on 6 April 2016. Inspector Angelo Capaldi conducted enquiries and prepared a report. The Regional Investigations Manager, Dean Coggins oversaw the report and recommended no further action take place, in that the information gathered indicated no identified contravention under the *Workplace Health and Safety Act 2011*.The investigation was also overseen by the Director of Legal and Prosecution Services.

51. It was noted that at one point the investigation was discussed at a case management meeting on 29 April 2016 between Mr Capaldi, Mr Coggins and a member of the Legal Services team. A decision was made that the investigation would be completed as a *Fatality Enquiry Report* rather than as a *Comprehensive Investigation Report*. This was on the basis no contravention of WHSQ legislation had been identified, although noting the company's *Safety Management System* did not cover the situation of recovering a tender that has come adrift.

52. The case management meeting notes also identified there may be an overlap with Marine Safety Queensland/Australian Marine Safety Authority legislation and queried if they (MSQ/AMSA) were aware. The Director of Legal Services noted in a notification dated 1 June 2016 that even if there was criticism, which might be levelled at the employer relevant to retrieval of vessels adrift, the same could not be associated with any breach provable to a criminal standard under WHS legislation. WHSQ's view was to all intents and purposes, the master of a vessel would equate to an 'officer' or a 'person in control' under the WHS Act. It was further noted that the duties of a master may primarily arise from the *Transport Operations (Marine Safety) Act* and the regulatory scheme under that Act, as opposed to the WHS Act, and it may be this incident fits less comfortably under the WHS jurisdiction.

53. What can now be said is that there was no contact made between MSQ/AMSA and WHSQ at any time. AMSA was not aware WHSQ had carried out an investigation until the day before the start of the inquest. WHSQ was not aware that AMSA had conducted an audit of the company's *Safety Management System* on the morning prior to Leila's death and subsequently forwarded an Improvement Notice to the company regarding the very *Safety Management System* that presumably had been examined by WHSQ in the course of its investigation. I will have more to say about this issue later in my conclusions. WHSQ accepts as a general proposition that this case reveals the communication between it and MSQ/AMSA does need to improve.

54. WHSQ concluded that the evidence shows that Leila made an informed decision to swim to *The Tank* in waters that were 'rough' and 'choppy'. WHSQ further concluded that from her 15 years' experience in the industry, and training as the skipper of a marine vessel, it must be assumed Leila had the requisite knowledge to appreciate the potential dangers posed by ocean waters in general, and rough water in particular.

55. WHSQ noted that whilst the policies and procedures of the employer in place at the time of the incident may not have specifically covered the particular situation leading to this incident, the evidence is it was understood assistance could be sought from other vessels in the vicinity for non-standard problems encountered. That may be the case but it is unclear what evidence indicated this conclusion could be reached.

56. It was speculated that personal factors, including a desire as a woman not to be seen in a professional disadvantaged or embarrassing situation by male counterparts, may have influenced Leila's decision. WHSQ stated that while there is no direct evidence of this, such an influence on her decision was outside the direct control of the employer.

57. The WHSQ investigation was unable to establish how the tender came adrift. According to Mr Matucci he secured the painter's line correctly through the scupper hole at the stern of the vessel. The scupper and cleats are in a position above the tender and therefore the painter's line to the tender would always have downwards pressure even when there was slack in the line. With this being the case, the investigation concluded it would be highly unlikely any slack would have caused the painter's line to dislodge. The investigation noted that Mr Matucci could not recall whether he secured the tender with the fore or aft painter's line. The industry standard is always to tie the tender boat to the main vessel using a fore line.

58. WHSQ conclusions in relation to the primary causes of the incident were:–

    i. The tender coming adrift. There was no evidence as to how, or at what time, the tender came adrift from the main vessel. Given the tender was a considerable distance from *Ocean Free* when its absence was noticed, it is possible the tender may have come free from the main vessel shortly after it was attached on arrival from Green Island.

    ii. Leila's decision to swim to *The Tank* in the rough choppy seas. If radio call for assistance from other vessels in the area had been made, there would have been no reason to enter the water.

59. WHSQ found that from the enquiries made there was insufficient evidence to conclude that in conducting its business or undertaking, any action or inaction of the employer can be attributed to the death.

Maritime Safety Queensland

60. On the morning of 6 April 2016, Marine Safety Inspectors from MSQ conducted routine compliance monitoring of *Ocean Freedom* and *Ocean Free* at their berth in the Marlin Marina Complex in Cairns. Both vessels ran snorkelling tours and were operated by a company connected with the owners of the business.

61. The compliance audit was in relation to safety management systems and no inspections relating to equipment were carried out. During the morning audit, a number of deficiencies were detected in the vessel's *Safety Management Manual* that required review and amendment. All other areas of the vessel were found to be compliant. The deficiencies consisted of the recording of emergency response training; *Masters Owners and Designated Person* statement; hazardous occurrence procedures recording and the company had also failed to implement a compliant *Safety Management System* for the two vessels.

62. On 13 May 2016, an improvement notice was issued with a detailed report into compliance monitoring to review, update and implement *a Safety Management System* for the vessel *Ocean Free.* MSQ noted that both the vessels operated by the company were well run and the only issues were restricted to the compliance with the *Safety Management System*.

63. MSQ considered it had an excellent relationship with the operator and consulted extensively with the operator over the following months to improve their *Safety Management System.* On 13 September 2016, the improvement notice was cleared. MSQ was satisfied the company had been compliant and implemented a *Safety Management System* addressing the deficiencies identified.

64. The incident relating to Leila's death was also reported to MSQ on 6 April 2016 but it did not carry out an investigation and did not consult with WHSQ about any investigation it was carrying out. MSQ did have discussions with the Water Police who are located at the same office building. MSQ assisted in obtaining copies of any digital recordings for marine radio traffic from the day of the incident.

Response of emergency services and retrieval

65. CPR and first aid were provided to Leila at the scene by Mr Jason Brown and others and those events are referred to earlier in this decision. This part of the decision will examine the responses of other emergency services and retrieval agencies.

Queensland Ambulance Service

66. Commissioner Russell Bowles of QAS provided a letter to the Coroners Court setting out the QAS response. The records indicated that at 1418 on 6 April 2016 the Queensland Emergency Medical System Coordination Centre

(QCC) received a request for assistance to attend Green Island where a female person was said to be in cardiac arrest. The Cairns Water Police is said to have obtained information from radio transmissions, which indicated CPR was in progress. While the QAS ordinarily receives requests for service via the 000 emergency telephone system, in this instance the QCC received this request directly from the Cairns Water Police.

67. Commissioner Bowles stated that whilst QAS paramedics work with the crew of rescue helicopters, it is ultimately the decision of the QCC clinical coordinator, a specialist medical practitioner, as to whether a helicopter is tasked to an incident. These clinical coordinators are supplied by Retrieval Services Queensland, the designated state-wide aeromedical retrieval service.

68. At times when aeromedical resources are unavailable, the QAS may utilise the services of the QPS, the Coast Guard or Volunteer Marine Rescue to transport paramedics to locations or vessels off shore.

69. Commissioner Bowles stated that in this case, when it became apparent that no aeromedical resources were available, the QPS was requested to provide assistance transporting paramedics to the incident.

70. Commissioner Bowles noted that at 1519 resuscitation efforts were ceased prior to the arrival of paramedics on the scene. The Cairns Water Police vessel ultimately continued to Green Island and retrieved the body.

71. Information available to QAS indicates that a member of the public identifying himself as a graduate or student paramedic was on the scene assisting with resuscitation efforts. This person was not in the paid employment of QAS. Commissioner Bowles said it seems this person was talking to a Royal Flying Doctor Service medical officer who was providing clinical advice to those on scene. Ultimately the decision to cease resuscitation was made during consultation between these parties.

72. Given the extended time that elapsed between the disappearance of Leila and the discovery of her body, the position of QAS was that resuscitation efforts were likely to have ultimately been futile. A similar view was also expressed by Dr Vogler of RFDS, as well as Dr Elizabeth and Dr Clinton Gibbs of Retrieval Services Queensland, to the effect that unless a person is successfully revived within minutes of CPR commencing, it is very likely the person will not be successfully revived over a longer period.

Royal Flying Doctor Service and Retrieval Services Queensland

73. Dr Catherine Vogler was working as a medical officer with the RFDS on 6 April 2016. Her duties included receiving telephone calls for health advice and providing an aeromedical retrieval service for those patients who require urgent transfer to Cairns.

74. At 1421 Dr Vogler received a telephone call from Green Island requesting permission to access the RFDS medical chest on the island in order to take adrenaline to the site on the island where they were anticipating a medical emergency to arrive. Dr Vogler was told a person of unknown age and sex had been pulled from the water and was found unconscious. CPR was in progress. Dr Vogler exchanged telephone numbers with the staff member and gave permission for the five vials of adrenaline in the chest to be used, in addition to syringes, needles and sharp kits in the chest.

75. A second telephone call was received by Dr Vogler at 1443. By this time the patient was on land and a paramedic was on scene although it was not clear if he was staff or a guest of the Island. She was told he had placed a laryngeal mask airway and was providing oxygen delivery whilst CPR was continued. He also placed an intravenous line. Someone had applied the defibrillator pads and the automatic analysis from the machine advised that this was a non-shockable rhythm. That meant the only treatment for the patient was CPR and adrenaline. Dr Vogler advised to give 1mg IV adrenaline at that time and approximately every four minutes after that. Dr Vogler asked if there was any evidence of external trauma to the patient and was advised no.

76. Dr Vogler was provided further information obtained as collateral from the skipper of the adjacent vessel of the circumstances of the incident. Dr Vogler advised that CPR should continue until a plan could be made to retrieve the patient.

77. Dr Vogler contacted the employer to ask for the name and date of birth of the patient, and was provided Leila's details.

78. Dr Vogler discussed the case with Retrieval Services Queensland over the course of two telephone calls. She called initially after receiving the first call at 1421 and advised CPR was in progress and to alert them to the case and ideally to provide retrieval by helicopter as the RFDS fixed wing cannot land on Green Island. The RSQ clinician was Dr Elizabeth Kyle who advised they would look for an available asset to retrieve the patient. The issue of whether

Dr Kyle was informed that CPR was in progress came up as it did not appear to be part of the recorded discussion between Dr Vogler and Dr Kyle. I accept the probable explanation is that the whole of the conversation was not recorded and Dr Vogler had passed on this information to a nurse with RSQ who she spoke to first before being linked in to Dr Kyle. It is likely Dr Kyle was given this information by her nurse colleague.

79. The second telephone call Dr Vogler made to RSQ was after talking through the administration of adrenaline with the Green Island staff, and she was looking to make a retrieval plan. At this time Dr Vogler stated RSQ advised that the Cairns helicopter was off line for maintenance. RSQ had arranged for a police boat to be deployed to Green Island as an emergency. There was some issue as to whether Dr Vogler was informed the Townsville helicopter was unavailable. This does not appear to have been discussed in any conversation with Dr Kyle and it is likely this was something she may have been informed about later. The Townsville helicopter was available but it is clear that it would have taken longer to arrive than the Water Police vessel and therefore was not considered by Dr Kyle as an option, particularly given the decision to cease CPR.

80. Dr Vogler discussed the prognosis of the case with Dr Kyle given the type of rhythm detected on the monitor and the amount of time CPR had already been given with no apparent response by the patient. They agreed a poor outcome was highly likely and that it was reasonable to cease CPR.

81. Dr Vogler then called the Green Island staff back and explained to them that despite 60 minutes of CPR with adrenaline, the lack of any response by the patient suggested they were dealing with a futile outcome. Additionally the police boat would not arrive for another 45 minutes, and prolonging CPR for this time was highly unlikely to change the outcome for the patient. The team agreed to cease CPR and the patient was declared deceased by the trainee paramedic on scene.

82. Dr Elizabeth Kyle was fulfilling the role of Retrieval Services Queensland's Northern Operations Medical Coordinator that day. The role is staffed by emergency physicians based at Townsville Hospital. This role provides clinical advice and coordination of all medical transfers received by RSQ from Northern Queensland. She has regularly worked as a medical coordinator since 2004.

83. Dr Kyle provided no direct clinical advice and her involvement was limited to liaising with Dr Vogler. She recalls being informed a female of unknown age had been pulled from the water some distance off shore and was being transported back to Green Island by boat. Dr Vogler asked her whether a helicopter was available for retrieval of the patient. Dr Kyle checked with the nurse coordinator based in head office in Brisbane prior to advising Dr Vogler the relevant helicopter was off-line and unavailable. She agreed with Dr Vogler that the patient should be transferred to Cairns by boat prior to being met at the Marina by QAS staff.

84. Dr Kyle then arranged for a paramedic and a flight doctor to go to Green Island by boat with the Water Police. She stated she did this because she knew it would be a quicker option than any of the other helicopters available for RSQ tasking, including those based in Townsville. At around 1428 she spoke to Dr Stefan Kuiper, emergency physician on duty at Cairns Base Hospital to put him on notice that he may receive a critically ill patient later that day.

85. At around 1453 Dr Kyle says she spoke to Dr Vogler and was provided an update as to Leila's prognosis, which was very poor. It was agreed that Dr Vogler would continue to be the key clinician providing medical advice to staff on Green Island, and she would focus on arranging for Leila to be transferred back to the mainland.

86. She was informed at around 1521 by Dr Vogler that Leila had been declared deceased and they were awaiting the arrival of the Water Police boat.

Queensland Government Air (QGAir)

87. QGAir was asked to provide information and in particular what policies and procedures are in place regarding the maintenance schedule for the rescue 510 helicopter and also what contingency plans are in place in the event that helicopters are off-line for scheduled or unscheduled maintenance when they are required to respond to a critical incident, which required emergency air rescue assistance.

88. The Acting Chief Pilot Trevor Wilson advised that QGAir operates three base locations in Brisbane, Cairns and Townsville. The government air fleet and some community-based providers formed the State emergency helicopter network.

89. The QGAir helicopter fleet consists of three AW 139 helicopters and two Bell 412 helicopters. The Cairns base operates one AW 139 with no permanent

on-site back up. The Townsville base operates a Bell 412 aircraft with on-site back up of a Bell 412. The Brisbane base operates an AW 139 aircraft. The remaining AW 139 aircraft is located at Brisbane and is redeployed to the Cairns and Brisbane bases as and when the aircraft usually located at either base are undergoing major servicing.

90. It is presently not the practice of QGAir to deploy a backup aircraft to Cairns if that base's AW 139 was off-line for a minor period of one to two days. This is due to the logistics involved in aircraft movement and staffing arrangements with differing pilot requirements to operate a different class of aircraft. It is the normal protocol that the Townsville helicopter will be tasked if the Cairns based aircraft is off-line.

91. QGAir stated the Townsville aircraft was available for tasking for this incident but QGAir received no emergency calls on 6 April 2016. QGAir has no role in the tasking of aircraft emergencies. This is managed through Retrieval Services Queensland. The reserve aircraft at Townsville was not available as it was undergoing long-term maintenance. The AW 139 helicopter in Brisbane was available but the reserve was unavailable as it was undergoing long-term maintenance.

92. QGAir stated that there was also a mixture of private contractors and community helicopter services providing emergency helicopter response at various locations in Queensland. The closest providers to Cairns are located at Horn Island in the Torres Strait or Mackay. The tasking of those aircraft is also managed by Retrieval Services Queensland. Only certain helicopter providers have been approved by the Minister for Emergency Services under the *Ambulance Service Act 1991* to provide ambulance transport in helicopters.

93. A/Chief Pilot Wilson stated that the Queensland Government has strict mandatory qualifications and experience requirements for pilots as well as mandatory equipment requirements for aircraft tasked to carry out emergency services. He stated these requirements were introduced in the wake of various coronial recommendations made following a number of fatal aircraft accidents involving medical and rescue helicopters in early 2000.[1]

[1] Bell Helicopter crash at Marlborough transporting QAS personnel and a child patient and his mother in 2000. Bell Helicopter crash 2003 transporting a paramedic. Inquest into deaths of C. Liddington, S. Eva and A. Carpenter recommendations made by Coroner Hennessy 28/10/2005

94. QGAir programs maintenance and outage in planning for its aircraft based on weekly or monthly average usage graphs. Planned servicing of aircraft may either be brought forward or postponed based upon the volume of tasking to which aircraft are subjected at any given time. It is the policy that if the aircraft based at Cairns is off-line due to long term maintenance servicing a reserve helicopter will be deployed.

95. Mr Wilson agreed it would always be helpful if there were more resources available to him in these situations.

96. Whilst the availability of a helicopter from Cairns would not have made a difference for Leila that day, it was identified early in the investigation into Leila's death that there exists broader community concern regarding availability of aeromedical services for the Cairns community and those who work or visit the Great Barrier Reef.

97. Evidence from Mr Trevor Wilson of QGAir highlighted the difficulties in working with finite resources and attempting to ensure those resources meet the demands for aeromedical services on any given day, particularly given the unpredictabilities associated with when those services might be needed.

98. According to Mr Wilson, those demand and supply issues are managed through a process of verbal communication on a daily basis, to try and ensure the needs of the various communities serviced by QGAir are met as best as possible.

99. Mr Wilson stated in evidence that he and his organisation have continued to lobby for additional resources. When asked by counsel assisting whether QGAir undertakes a process for identifying and analysing supply and demand issues related to its services over a longer period, to assist in justifying additional resources should they be needed, Mr Wilson referred to a review undertaken by the Public Sector Business Agency approximately two years ago involving this type of analysis.

100. It is also noted that the Public Safety Business Agency has sought the assistance of *Building Queensland* to complete a business case to evaluate options available in the context *of an ageing fleet, a lack of aircraft standardisation and need to comply with regulatory changes.*[2]

[2] Building Queensland QGAir strategic Asset management Proposal Summary July 2016 at *buildingqueensland.qld.gov.au-projects*

Retrieval Services Queensland

101. At the request of the coroner, RSQ has also provided further information about other incidents where there may have been a delayed helicopter response. RSQ is aware of 30 cases where there has been a mortality at an offshore location within the northern operations region since 1 January 2015. Of those 30 mortalities, in eight instances there was a delayed helicopter response, either due to conflicting tasks or maintenance.

102. Of the eight instances of delayed helicopter response, four Incident Investigation Reports have been completed. Incident reports were not generated for the remaining four cases as a review of the case showed the outcomes were not a result of decisions made by RSQ, and were not necessarily unexpected. One of the four Incident Investigation Reports which were completed related to the case involving Leila.

103. The Incident Investigation Report for Leila's death noted the Cairns based helicopter was off-line due to scheduled maintenance. There was a delayed response by a medical team due to the need to travel by boat. The use of the backup Townsville helicopter would have resulted in further delays in the arrival of the medical team as it was on the ground in Townsville. The review indicated that the retrieval issues/delay were unlikely to have altered the outcome given there was a delay in CPR being commenced due to the delay in recovery. There was a high predicted mortality in that case.

Conclusions on the issues

Whether the deceased's employer took reasonable steps to ensure the deceased's safety on board the vessel Ocean Free on the day of the incident.

104. There was some initial concerns that on the morning of Leila's death *Ocean Free* had been inspected by Marine Safety Queensland staff and its *Safety Management System* (SMS) had been found to be deficient in some way. The visit by MSQ was part of a routine audit and was coincidental to the tragic events that followed. As it turned out the deficiencies were related to documentation standards, which had been introduced by the Australian Maritime Safety Authority with the introduction of the National Law. The review did not find that *Ocean Free* or its operations were being conducted in an unsafe manner.

105. During the coronial investigation I received a variety of materials evidencing the safety systems and practices related to the operation of *Ocean Free*. The

SMS operating at the time of Leila's death is largely replicated in substance in the new SMS and the changes made related to recording AMSA requirements and in form. There is no compelling evidence to suggest *Ocean Free* was not maintained and operated to a high standard in terms of its safety, and with appropriate training provided to its crew. It is apparent Leila would routinely bring to the attention of the owners any maintenance issues she suggested should be addressed but the evidence does not indicate these suggestions were ignored.

106. The company independently made a decision to improve their safety management in respect to this incident and made a number of additions to their procedures, which are reflected in the amended SMS document including the following:–

- No crew/skipper to swim to *The Tank* mooring from the *Ocean Free* vessel mooring;
- If for any reason *Ocean Free* finds itself without a tender vessel they are to enlist support from either the Big Cat or Great Adventures;
- No crew/skipper to swim further than the distance that could warrant a swim rescue without having a rescue vessel within easy access and close by;
- Tender line/tank line to be checked for security in between transfers by skippers and rechecked;
- A safety line which is secured to the painter line has been included which ensures that in the event the painter line becomes detached from the main vessel, the tender will not come adrift.

107. At the time of the incident there was no specific operator policy or procedure on these issues. There was some suggestion that Leila may have felt some pressure, as a female in a male dominated industry, to swim for *The Tank* herself rather than call other vessels in the area to help retrieve the tender. This was documented as a possible contributing factor to the incident in WHSQ's *Fatality Enquiry Report*. However, it was established at the inquest that WHSQ officers had no direct evidence of this being a factor in Leila's mind at the time. Rather, it was based on speculation raised by persons in the industry with no direct involvement in the incident. Leila's employer, Taryn Agius, rejected this as a factor, saying that in her experience there was a culture of friendly banter amongst and between those working in the industry,

regardless of gender, and that the industry was a very close and supportive one. Ms Agius stated that Leila herself sometimes participated in this friendly banter.

108. There is otherwise no evidence that Leila had experienced any pressure or negative comments from colleagues in relation to her position as a female skipper or that Leila's decision to swim to *The Tank* was as a result of any pressure she felt, as a female skipper, to prove herself in a male dominated industry.

109. Leila may have felt pressure to retrieve the tender quickly, so as to get to Green Island in time to pick up the passengers and keep to the day's schedule. The French tourist, Josette Grasset, in her evidence at the inquest, described Leila as in a 'panic' and 'a little bit of stress' when she noticed the tender missing, just at the time when Leila was due to return to Green Island. Leila did have other options for retrieving the tender, other than to jump in the water and swim to *The Tank*, but at the time she clearly thought this was the quickest way.

110. It is only with hindsight, knowing the condition of her coronary artery disease, that Leila may have made another decision. Otherwise the distance to be swum and the conditions that day would not have been of concern for her. The distance was not so long and the conditions were rough but not so bad that tourists were able to snorkel earlier, albeit under supervision. Given Leila was a good swimmer and was very fit, it is clear she was more than capable of doing so.

111. WHSQ's report identified that whilst the company's policies and procedures did not cover the particular situation, *it was understood assistance would be sought from other vessels in the vicinity for non-standard problems encountered.* However, WHSQ did not speak to any staff of the company other than its directors. There is no evidence as to whether this was an 'understanding' Leila in particular held in her mind. Even if there was some 'understanding', it could not be said to be a company requirement. It cannot therefore be said that Leila breached any company policy or requirement in making the decision to undertake that swim that day.

112. Given this was an unexpected or unusual event, there was also no explicit policy about the provision of a lookout. Filippo Matucci was placed in a difficult

and unexpected situation when Leila decided to jump in the water and swim for *The Tank.*

113. Leila left no instructions for Mr Matucci to keep lookout, and he had no reason to think that Leila was in any particular danger in attempting to make that swim. He did keep a lookout for some time, and his evidence (which is consistent with that of the two French tourists on board) is that Leila was swimming well and showing no signs of difficulty, apart from being slightly off course due to the current. She was only some 50 metres away when he left his lookout duties.

114. Mr Matucci unfortunately made the decision to leave his lookout position for a short period of time to go to the toilet. The two French tourists were there and had also been watching Leila swim. With hindsight, he probably would have made a different decision, however, even if he had seen Leila in difficulty there would have been some practical problems in him being able to provide immediate assistance given he had no vessel to take him to her and the distance was too far away for him to swim and provide immediate assistance. Even if he had requested immediate assistance if he had seen her in trouble, other vessels were some distance away and would have taken some time to get to the site. Any earlier provision of assistance would obviously have been helpful but may not have changed the outcome in this particular case given it seems likely Leila suffered an immediate cardiac impairment rendering her likely unconscious, and not just some difficulty with, for example fatigue, which more immediate assistance may have been able to address.

115. As to how the tender came adrift that day there is insufficient evidence to support a clear finding on this issue. The practice on board *Ocean Free* for securing the tender to the vessel, particularly when it was moored, by passing either the painter line or tow line through the scupper and securing it on the cleat by the painter line loop or a figure of eight if using the tow line, was in accordance with industry standards and recognised as a safe and reliable way of securing a tender.

116. Mr Matucci was confident he secured the painter line properly that day. Leila was seen to be the last to leave the tender. Mr Matucci was unable to say if Leila may have done anything to the line after that time but there is no evidence she did. Given she was regarded as an extremely capable skipper, it would seem unlikely she would have left the tender without ensuring it

remained secure. There was some suggestion that given the rough conditions, Leila may have decided to change the painter line to the tow line, to allow more room between the tender and the larger vessel so the tender did not bang against it. However, the evidence that the tow line was found inside the tender does not support that scenario.

117. In usual conditions the tender is below the *Ocean Free* and there is downwards pressure on the painter line from the cleat. Whether the rough conditions that day caused the loop of the painter line to unexpectedly come free is the only other possibility. Unfortunately, there was no testing of that scenario conducted by any of the investigating agencies so this cannot be stated with any degree of confidence.

118. The solution devised by the owners of *Ocean Free* by installing an additional safety line and clip to secure the painter line to the vessel, should the loop of the painter line somehow slip off the cleat is simple and effective, and in hindsight, could have been adopted at any time.

The adequacy and timeliness of steps taken by individuals, other vessels and police and emergency services to locate the deceased, once she was identified as missing.

119. A potential criticism identified early in the investigations into Leila's death, and in particular by the QPS investigator, was the apparent delay in making a PAN PAN call alerting vessels and authorities to the situation.

120. Mr Matucci probably could have made that call earlier but there is no evidence that an earlier PAN PAN call would likely have made any significant difference to the effectiveness of the search activities that day.

121. Once Mr Matucci became concerned he called a nearby vessel and then Rob Toomey on the mainland, to enlist the help of nearby vessels to help him search for Leila. Those calls for help were responded to within a very short period of time and a number of vessels became involved in the search.

122. Mr Matucci then boarded a nearby tender who had come to collect him, and entered the water near where Leila was last seen to search for her. Mr Matucci said in his evidence he thought this was the best thing he could do for Leila at that time and I accept he genuinely believed this was the case.

123. After some time spent searching in this manner, it was suggested to Mr Matucci that he return to Ocean Free and make the PAN PAN call, which he did.

124. Otherwise. it is apparent the other vessels in the immediate vicinity acted swiftly and professionally in endeavouring to find Leila.

125. As well, the evidence at inquest of Mr Perry Jones, one of the directors of the company who owned and operated *Ocean Free*, indicated the company was frantically endeavouring to ensure a search was being conducted. When he realised the QGAir helicopter was not available he commenced making enquiries for a private helicopter to be involved. Mr Jones' hope at the time was to find Leila alive on the basis she had got into difficulties and was drifting, awaiting assistance. Unfortunately, it appears Leila had likely passed away very close to the time when she was noticed missing, such that early involvement of a private helicopter in the search would unlikely have changed the outcome.

The adequacy and timeliness of professional retrieval and emergency medical care available and provided to the deceased once she was located.

126. One effect of a PAN PAN call would be to alert emergency services earlier to the possibility that an emergency medical response may be required out at Green Island, even before Leila was found. This would have allowed emergency services slightly more time to coordinate any emergency medical response, meaning that the police vessel transporting paramedics to Green Island may have been ready to leave slightly earlier. Unfortunately given Leila's condition when she was found and the length of time it would have taken the police vessel to arrive at Green Island, this would ultimately have made no difference to the outcome.

127. Another concern explored at inquest with staff from RFDS and RSQ was the decision not to make attempts to source other aeromedical assistance as the Cairns based Rescue 510 helicopter was offline, when it appeared the only information RSQ had at the time in relation to Leila's condition was that she had been pulled from the water. However, Dr Kyle stated that she was also aware around that time that CPR was underway, which indicated to her the patient did not have a heartbeat, making her condition very serious and likely not survivable. Dr Clinton Gibbs advised that this was, in his view, an appropriate clinical assessment. Dr Gibbs also explained that in such circumstances, unless a person is successfully revived within minutes of CPR commencing, it is very likely they will not be successfully revived over a longer period.

128. In those circumstances the decision made by Dr Kyle at that time to make an alternative retrieval plan by way of the water police vessel, rather than attempting to identify other aeromedical assets that might be available, was appropriate.

What actions have been taken since the death to prevent deaths from happening in similar circumstances in the future.

Actions by the Operator

129. I am satisfied the actions taken by *Ocean Free's* owners following the incident, including to identify ways of preventing such an incident occurring again in the future, were appropriate. As well, MSQ have ensured that the operator's *Safety Management System* is compliant with the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012.*

Regulatory Investigation Framework

130. Counsel Assisting, Ms Jarvis submitted that given the circumstances of this case WHSQ, MSQ and QPS review the circumstances of this death and the involvement of their respective agencies, and determine whether further action should be taken to update any existing Memoranda of Understanding (MOUs) and/or provide further training to their staff in relation to their operation.

131. The case highlighted the difficulties that can occur where a number of agencies may have concurrent or overlapping jurisdiction in relation to marine deaths or accidents on marine vessels.

132. In very helpful submissions made by Counsel for WHSQ it was acknowledged that further clarity and a possible review and update of current MOUs could assist agencies in more effectively investigating marine deaths such as this one.

133. This is not the first time that the interplay between MSQ and WHSQ in relation to marine deaths has been queried. In 2008, Coroner Brassington recommended that those agencies review the operation of their then MOU to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies, as well as reviewing policies

governing the investigation of marine incidents to ensure they are properly investigated.[3]

134. It is apparent there are two existing MOU's.[4] The WHSQ submission noted that any understanding of the MOUs and agencies must be tempered by a clear realisation that the responsibilities of various agencies investigating marine deaths and accidents are first and foremost defined in statute. The mechanics and logistics of investigations may be covered under the MOUs, but the basis for obligations to investigate reside in statute.

135. The submission noted that the jurisdiction to investigate workplace accidents under the *Work Health and Safety Act 2011* is broad, however it is neither practical nor an efficient use of relevant expertise to hold WHSQ out as a 'catch-all' agency for accident investigations.

136. The submission noted that MSQ has a role to protect Queensland's waterways and is responsible for improving maritime safety for shipping and small craft through regulation and education. The *Transport Operations (Marine Safety) Act 1994 (TOMSA)* imposes a general safety obligation on all vessel owners and operators, masters and crew to operate vessels safely at all times.

137. MSQ is also responsible for delivering a range of services on behalf of the national regulator, the Australian Maritime Safety Authority (AMSA).

138. A national regulatory framework was agreed to and commenced on 1 July 2013 through the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012.* It is noted the MOU with AMSA states it addresses the jurisdiction of WHSQ under the *Work Health and Safety Act 2011* and AMSA under the *Navigation Act 2012* and the *Occupational Health and Safety (Maritime Industry) Act 1993,* but does not address matters relating to *Domestic Commercial Vessels regulated by the Marine Safety (Domestic Commercial Vessel) National Law Act 2012.* The 2010 MOU between MSQ and WHSQ naturally makes no reference to the National Law as it had not been passed. The WHSQ submission helpfully suggests that any new MOU should take into

[3] Inquest into the suspected death of Peter Joseph Trcka, 24 December 2008
[4] Memorandum of Understanding between The Department of Justice and Attorney-General and Maritime Safety Queensland, June 2010, Exhibit K1 and one between the Department of Justice and Attorney-General and the Australian Maritime Safety Authority dated January 2014, Exhibit K2.

account the new arrangement between AMSA and MSQ and that relationship to other bodies in the MOU.

139. The submission noted the MOU between WHSQ and MSQ which stated that WHSQ would assume full jurisdiction for incidents involving a business or undertaking, carrying out underwater diving or snorkelling operations. However, WHSQ determined subsequently that the incident did not involve such an activity and this may have led to confusion as to who was the correct lead agency. The difficulty in this case is there was really no discussion about these issues between MSQ, AMSA and WHSQ and this needs to be addressed.

140. It was submitted that the objectives of *TOMSA* included regulating the maritime industry to ensure marine safety, and to establish a system under which marine safety and related marine operational issues can be effectively planned and efficiently managed. These objectives are to be achieved by imposing general safety obligations to ensure seaworthiness and other aspects of marine safety and allowing a general safety obligation to be discharged by complying with relevant standards or in other appropriate ways chosen by the person on whom the obligation is imposed.

141. This submission stated that AMSA was best placed to review safety management systems similar to the one authored by the company in this case. The submission quoted the findings of Coroner Priestly[5] where he stated *at an operational level, there is a serious need for a standard of SMS against which safety performance of particular operations can be objectively measured and reported. At a regulatory level, AMSA should be able to analyse and report on the overall performance of Safety Management Systems within particular sectors, to identify specific weaknesses and respond with remedial action.*

142. As I pointed out at the conclusion of the inquest when these issues were being aired, the State Government has through the Office of Industrial Relations set up the Serious Workplace Incidents InterAgency Group (SWIIG), which group comprises representatives from the Coroners Court as well as Police, WHSQ, Transport and Main Roads (which would include MSQ) and other relevant agencies. The purpose is to ensure the roles and responsibilities of agencies involved in responding to serious workplace incidents are clarified; to identify

[5] Inquest into the death of Glenn Anthony Wilson, 24 May 2016

opportunities to improve and enhance coordinated and effective agency responses; and to improve the availability of information and support to affected families.

143. Acknowledging there are complexities in cross jurisdictional legislative requirements and overlapping of jurisdictions, it would seem appropriate and uncontroversial to make a recommendation that WHSQ, MSQ, AMSA and QPS consider closer inter-agency cooperation and review the circumstances of this death and the involvement of their respective agencies, and determine whether further action should be taken to update any existing MOUs and/or provide further training to their staff in relation to their operation.

Response by QGAir

144. Subsequent to the inquest, I requested further information from QGAir in respect to the evidence given by Mr Wilson concerning a review of QGAir's service requirements and his evidence that he had consistently raised with senior management over the years that he was not personally satisfied with QGAir's capacity to meet current service requirements. In a further statement to the coroner he provided details of some of those efforts. My intention in asking this question was not in any way doubting Mr Wilson's statement but simply to explore if there was any way forward to address what are no doubt complex issues and not simply isolated to having more aircraft available.

145. I have been provided with a copy of the 2013 review of QGAir (or EMQHR as it then was) noting the complexity of its relationship and responsibilities to the State Government as well as to the Civil Aviation Safety Authority. It is not my intention to refer to the review or critique it in any way as it would be well outside the issues for this particular inquest. I accept as the review noted, that the staff are professional, capable, committed to, and passionate about their work and there is a high level of trust with flight crews, paramedics and doctors, and the engineering team.

146. I have also been provided with the Business Case formulated by the Public Safety Business Agency with the assistance of Building Queensland in relation to QGAir. I thank the PSBA for providing this information. Much of it is of course marked as *Commercial-in Confidence*, and again it is not my intention to critique it or otherwise refer to it in any detail. Not unexpectedly, it is very detailed and considers many options to address how to move forward to 'future proof' the fleet of aircraft and provide the same service levels to its

partners. This includes possible standardisation of its fleet, employing more pilots and a range of other options. I am certainly satisfied QGAir has explored appropriate options and it is now a matter for the project to be completed. QGAir stated *that in very recent times Queensland Health has acted to review the Emergency Helicopter Network to identify strategic options relating to the network configuration, management and service delivery. QGAir has also commenced action of the strategic asset management plan to standardise the rotary fleet anticipated to enhance service delivery and optimise service cost structures.*

Findings required by s. 45

Identity of the deceased – Leila Michelle Trott

How she died – Leila was the very experienced skipper of a tourist sailing vessel moored off Green Island. A smaller tender vessel was attached to the sailing vessel. The tender came adrift in circumstances which remain unclear, but may have been due to choppy seas. Leila was very fit and a good swimmer. She would not have known that she had a cardiac artery that was significantly occluded. Leila decided to swim some 400 metres to another vessel to try and retrieve the tender. She had other options available to her including asking nearby tourist vessels for assistance but clearly thought swimming to the vessel was an available option. She was seen to be swimming strongly and was nearing the vessel when she was last seen. Possibly due to the physical stress involved in the swim, she suffered a cardiac arrhythmia, probably became unconscious and drowned. All appropriate efforts were made by local operators, her colleague, employer and emergency services to locate her and resuscitate her.

Place of death – Green Island, Cairns, 4870

Date of death– 6 April 2016

Cause of death – 1(a) Drowning/Immersion
1(b) Coronary artery atheroma

Comments and recommendations

147. It is recommended that WHSQ, MSQ, AMSA and QPS consider closer inter-agency cooperation and review the circumstances of this death and the involvement of their respective agencies, and determine whether further action should be taken to update any existing Memoranda of Understanding and/or provide further training to their staff in relation to their operation.

148. I also note the Public Safety Business Agency has prepared a Business Case to future proof the capacity of QGAir to deliver services to the people of Queensland. I note aspects of the plan are being commenced to be implemented. On that basis I make no further recommendation or comment.

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
16 March 2017