



CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION **Non-inquest findings into the death of:
Martin Sydney CUNNINGHAM**

TITLE OF COURT : Coroners Court of Queensland

JURISDICTION : CAIRNS

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Introduction

1. The deceased, Mr Martin Sydney Cunningham (Mr Cunningham), was born on 28 July 1972 and died on 25 May 2016, aged 43 years. Mr Cunningham was the owner and Master of the domestic commercial Fishing Vessel (FV) *Cygnets Lass*.
2. On 25 May 2016 at approximately 10:05am, the tug *Svitzer Nana* collided with the *Cygnets Lass* near Bowen at approximate latitude 20° 00'.343S and longitude 148° 17'.766E. The collision caused the *Cygnets Lass* to break in two; the stern section sank however the bow section remained partially buoyant but upturned on the water's surface.
3. Both vessels departed Bowen Harbour on the morning of 25 May 2016. The *Svitzer Nana* had been heading north on a routine run to Abbott Point Coal Terminal to assist with ship movements, whereas the *Cygnets Lass* was heading out of the North Entrance of Port Dennison (Bowen) to fishing grounds in the Coral Sea.
4. Mr Cunningham and his two crew (Mr Hondow and Mr Cullen) became trapped in the upturned bow section of the *Cygnets Lass*. One of the crew evacuated, resurfaced, and raised the alarm to others being trapped. Another crew member was able to secure himself in a small air pocket from where he was eventually rescued. Mr Cunningham was unable to evacuate the upturned bow section or secure himself in an air pocket.
5. Immediately following the collision, lines of communication commenced from persons in the immediate vicinity of the incident. Those lines of communication included the Master of the *Svitzer Nana*, and an employee of the Port of Townsville who was on a separate nearby vessel. Those lines of communication resulted in a search and rescue operation being set in motion at approximately 10:20am.
6. The objective of the search and rescue operation was the preservation of life. The search and rescue operation resulted in State and private agencies responding and attending the scene of the collision. Sometime between 11:17am and 11:30am those search and rescue efforts resulted in access being gained to the upturned bow section of the *Cygnets Lass*.
7. Shortly after access was gained, Mr Cunningham was located floating and unresponsive in the bridge area. He was recovered to the surface and resuscitation efforts commenced shortly afterward. Those resuscitation efforts continued for approximately 50 minutes. Mr Cunningham did not respond to those efforts and was declared deceased at 12:23pm on 25 May 2016.

Nature of the Coronial Proceedings

8. Pursuant to s.45 of the Coroners Act 2003 I must, if possible, make findings as to:
 - a) Who the deceased person is;
 - b) How the person died;
 - c) When the person died;
 - d) Where the person died; and

- e) What caused the person to die.
9. There is a significant distinction between the criminal jurisdiction (i.e.: the police investigation) and the coronial investigation. I am unable to find that a person is civilly liable or guilty of a criminal offence. I am precluded by law from doing so.
 10. Whilst I retain a discretion to conduct an inquest into a reportable death, I must be satisfied that it is in the public interest to do so. In deciding whether it is in the public interest to conduct an inquest I may consider:
 1. The extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and
 2. Any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.
 11. If I consider a criminal offence may have been committed, then I may refer the matter to the Office of the Director of Public Prosecution (ODPP). Such a referral can only be made when an inquest has been held. Even then, the Coroner cannot determine what charge might be brought against a person. That decision rests solely with the ODPP.
 12. The Coroners Court is not a review mechanism for any other Court or the ODPP. Therefore, where a person has been charged and sentenced, charged and acquitted, not charged or where the charge has been discontinued, it is beyond the jurisdiction of the Coroners Court to revisit or review any of the decisions of those courts that lead to any of those outcomes.

Procedural History

13. By email dated 17 June 2016, Mr Cunningham's mother, Mrs Yvonne Cunningham requested that an Inquest be held in relation to her son's death. One of the concerns raised, was the course each vessel was on prior to the collision, and how the *Convention on the International Regulations for Preventing Collision at Sea* (COLREGs) should have been applied in that instance.
14. Mrs Cunningham held the view that the *Svitzer Nana* was 'overtaking' the *Cygnets Lass* which has implications under the COLREGS.
15. Pursuant to s29 of the *Coroners Act* 2003, upon becoming informed that a person has been charged with an offence in which the question of whether the accused caused the death may (my emphasis) be considered, then I must not start an Inquest until after the end of the proceedings for the offence, including any appeal started within time.
16. On 25 May 2016, a crewmember of the *Svitzer Nana* (Mr Brenton Male) was charged with an offence under s.20 of *Marine Safety (Domestic Commercial Vessel) National Law Act* 2012 (Cth) namely that he contravened s19(3)(3) of that Act in that he failed to keep a proper lookout and at the time he was negligent as to whether the act was a risk to the safety of a domestic commercial vessel. The maximum penalty for that charge was 2 years imprisonment. The prosecution of that charge was conducted by the Commonwealth Director of Public Prosecutions (CDPP).

17. On account of those proceedings an Inquest could not be started, and no decision was taken as to whether it was in the public interest for an Inquest to be held.
18. On 26 November 2018, that charge came before the Magistrates Court at Townsville, at which time the Court was informed the CDPP would offer no evidence. The charge was then dismissed, and the Magistrate went on to make an order for costs against the CDPP. The Northern Coroner's office was informed of that decision on 24 December 2018. The dismissal of the charge meant that the provisions contained in s.29 of the Coroners Act 2003, were no longer enlivened.
19. On 4 January 2019 correspondence on behalf of Mrs Cunningham, via her legal representatives, was received by the Northern Coroner's office. That correspondence renewed the Application for Inquest following the dismissal of the charge against Mr Male.
20. On 21 August 2019, Mrs Cunningham independently informed the Northern Coroner's office of a Statement of Claim that had been filed in the Federal Court of Australia on 7 August 2019.
21. The Plaintiff in those proceedings was North Cape Fisheries Pty Ltd as receivers and administrators for Mr Cunningham's fishing company. The vessel *Svitzer Nana* was named as the defendant.
22. Mrs Cunningham was not a party to those proceedings.
23. On 5 September 2019, the parties to the Coronial proceedings were informed of a decision to hold an Inquest and were given draft Issues for Inquest and were invited to make submissions on them, prior to the Pre-Inquest conference being held. It was proposed that an Inquest would be held at Bowen over a four-day period commencing on Tuesday, 26 May 2020.
24. There was no application by any of the parties to adjourn the Inquest to allow the Federal Court proceedings to take their course first, indeed it may well have been considered advantageous for the Inquest to proceed and findings delivered first in time.
25. Following a pre-Inquest conference on 21 February 2020, the Issues for Inquest were settled as:
 1. *The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death;*
 2. *What knowledge did the crew of the vessel Cygnet Lass have with respect to the presence and course of the vessel Svitzer Nana; and*
 - a. *With regard to the relevant conventions and rules for preventing collisions at sea did the crew of the vessel Cygnet Lass properly discharge any duty imposed on them to*
 - i. *Maintain a proper lookout;*
 - ii. *Identify the risk of any possible collision at sea; and*
 - iii. *Take appropriate action to avoid such collision.*

3. *What knowledge did the crew of the vessel Svitzer Nana have with respect to the presence and course of the vessel Cygnet Lass; and*
 - a. *With regard to the relevant conventions and rules for preventing collisions at sea did the crew of the vessel Svitzer Nana properly discharge any duty imposed on them to:*
 - i. *Maintain a proper lookout;*
 - ii. *Identify the risk of any possible collision at sea; and*
 - iii. *Take appropriate action to avoid such collision.*
4. *What knowledge did the crew of the vessel Diamantina have with respect to the presence and course of the vessels Cygnet Lass and Svitzer Nana; and*
 - a. *With regard to the relevant conventions and rules for preventing collisions at sea did the crew of the vessel Diamantina discharge any duty imposed on them to:*
 - i. *Maintain a proper lookout; and*
 - ii. *Identify the risk of any possible collision at sea.*
5. *With regard to that level of knowledge, was there any duty imposed on the Diamantina, whether by convention or rule, to notify or alert the vessels Cygnet Lass or Svitzer Nana to the risk of collision; and*
 - a. *If such duty existed, was it properly discharged;*
 - b. *If such duty did not exist, should one now be imposed.*
6. *What were the circumstances in which the collision between the Svitzer Nana and the Cygnet Lass was reported, and did the manner in which the collision was reported affect the commencement and or scope of the subsequent search and rescue.*
7. *What standards (if any) apply with respect to the installation on a vessel of:*
 - a. *Automatic Identification System (AIS) equipment;*
 - b. *Equipment that will calculate the closest point of approach (CPA); and*
 - c. *Equipment or systems that will alert crew to the risk of collision.*
8. *With regard to those standards (in effect as of 25 May 2016), were the vessels Cygnet Lass, Svitzer Nana and Diamantina compliant.*
9. *What standards apply with respect to the use of autopilot systems on vessels operating in and out of a harbour, and if no such standards are in effect should they now be developed.*
10. *What standards apply with respect to use of collision alarm systems by vessels operating in and out of a harbour, and if no such standards are in effect should they now be developed.*

26. Due to Covid-19 public health restrictions in effect across all Queensland Courts the Inquest was unable to proceed and was de-listed.
27. In the intervening period additional material was received through the coronial investigation that further informed and illuminated the circumstances surrounding Mr Cunningham's death and resulted in the Issues for Inquest being substantially revised.
28. In that same intervening period, the proceedings in the Federal Court continued. Relevantly, on 30 October 2020, a Joint Statement between expert witnesses for the Plaintiff and Defendant were filed.
29. That Joint Statement set out points of agreement as to the course and conduct of the *Cygnet Lass* and the *Svitzer Nana* prior to the collision. Those points of agreement were material to the Inquest.
30. The Joint Statement also set out points of disagreement, more relevantly as to the location of the collision with there being some 227m variance between the parties. The points of disagreement were not material to the Inquest.
31. On 2 May 2021, a Final Order was made in the Federal Court of Australia that apportioned responsibility for the collision between *Cygnet Lass* and *Svitzer Nana* on a 50/50 basis.
32. On 17 May 2021 the parties were notified of the settled (revised) Issues for Inquest, which became:
 1. *The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused their deaths;*
 2. *With reference to the collision between the Cygnet Lass and the Svitzer Nana on 25 May 2016 at Bowen Harbour and the International Regulations for Preventing Collisions at Sea 1972 ("Colregs") relevant as at 25 May 2016 to establish*
 - a. *The appropriate action required by both the CYGNET LASS and the SVITZER NANA to avoid a collision*
33. It was proposed that an Inquest would be convened for one day on Monday, 7 June 2021 at which time the brief of evidence would be tendered, and the parties invited to make submissions on that material with reference to the revised Issues. It was not proposed to call any witnesses.
34. On 24 May 2021 I was informed (for the first time) of the Joint Statement, and the Final Order of the Federal Court. Upon consideration of those Federal Court those documents I concluded there was no longer a public interest in convening an Inquest to make findings with respect of matters that had been determined in another jurisdiction. There remains however, a public interest in the publication of these findings.

Nature and Configuration of the Vessels

Cygnets Lass

35. The vessel 'Cygnets Lass' was purchased by Mr Cunningham on 24 March 2015. The vessel was previously operated as a pearl diving vessel in Western Australia. After purchase the *Cygnets Lass* was transferred from Western Australia to Queensland.
36. The following historical image depicts the *Cygnets Lass*, prior to its transfer:



37. *Cygnets Lass* was a 16.75 meter 'Westcoaster' Design fiberglass, deep line fishing vessel. The vessel was registered in Queensland as a Domestic Commercial Vessel National Registration 01703. Fishing symbol 'H1 T'. It was registered as a USL Class 3B vessel. The vessel is fitted with two caterpillar diesel motors of 120KW each.
38. At the time of the incident the *Cygnets Lass* was crewed by Mr Cunningham (Master) and two crew members Mr Troy Hondow and Mr Ryan Cullen, neither held formal commercial marine qualifications.
39. In May 2015 the *Cygnets Lass* underwent an electronic refit at Kawana Marina. The following equipment was installed and tested at that time:
- a) Wasp WMB80 multi beam sonar,
 - b) Maxsea Timezero plot,
 - c) Cplot Navplus navigation system,
 - d) Furuno FCV1150 sounder,
 - e) Furuno GP32 GPS,
 - f) Furuno SC30 Satellite compass,
 - g) Furuno Nav Pilot 700 autopilot system, and
 - h) Icom 412 VHF marine radio.
40. The Cplot Navplus navigation system, Maxsea Timezero plot and Furuno radar all had collision monitoring alarm functions that would have required manual activation.

41. The *Cygnets Lass* was also fitted with a 'receive-only' Automatic Identification System (AIS) which would have allowed it to receive static information about the name, call sign, course and speed of other vessels around it.
42. In addition to those modifications, sometime around its transfer from Western Australia to Queensland and possibly at the same time as the May refit, the *Cygnets Lass* underwent additional external alterations in the nature of:
- a) The addition of a large cool box on the aft deck,
 - b) Storage boxes on aft deck and on top of deck awning structure,
 - c) Line reels on the aft and fore decks,
 - d) Tinting of wheelhouse windows on the port and starboard sides, and
 - e) Removal of accommodation area windows in forecastle topside.
43. The following image depicts the *Cygnets Lass* after those external modifications:



44. Master Cunningham was an experienced skipper, he was the holder of a perpetual Skipper Grade 3 Certificate of Competency (C015062) issued 13/12/2000. Searches on the Queensland Licensing data base (Tardis) and the National System (NDMS) do not indicate if he held an engineering qualification.
45. Master Cunningham was held in high regard by many other vessel operators out of Bowen Harbour. He was known to maintain the condition of his vessel and quality of his product to a high standard.
46. Mr Justin McCallum, who holds 30-years marine industry experience, had known and worked with Mr Cunningham for some 20 years. Mr McCallum deposes as follows:

"During the times I have been on board with Martin I have always found him to be an extremely competent vessel operator including in terms of vessel maintenance ... He had a good working knowledge of all aspects of vessel maintenance himself and took great pride in the maintenance and upkeep of his vessels. I would say he took a very professional approach to all aspects of vessel operations".

47. I accept that characterisation of Mr Cunningham. It is congruent with all information before me.

Svitzer Nana

48. The *Svitzer Nana* is a tugboat owned by Svitzer Australia Pty Ltd but operated by Bowen Tow and Salvage Pty Ltd.
49. The *Svitzer Nana* is an 'N Class' tugboat, 33.3 meters long, 13m wide with a draft of 5.7 meters. It was registered in New South Wales as a Domestic Commercial Vessel class 2B. Registration number 31783QB. Primarily used as a tugboat it can also operate as an Emergency Tow Vessel (ETV). It is powered by two eight-cylinder 2206KW Niigata diesel motors.
50. The *Svitzer Nana* was constructed in 2012 at Qianjin Shipyard, Qingdao, China. It was delivered into Australia in November 2012 and became certified under the Transport Operations (Marine Safety) Act (Qld) that same year.
51. It is equipped with the following navigation and communication equipment:
- 2 x Furuno VHF Radios (model FM8800)
 - 2 x Furuno Radars (model FAR2127)
 - 1 x Furuno AIS System (model FA-150)
52. The radar units were configured with automatic radar plotting aids (ARPA). This allows an object such as another vessel, to be tracked according to its speed and course. This data then allows the system to calculate the 'closest point of approach' (CPA) and identify collision risk. This is an automatic system therefore any object or vessel within the radar field (e.g. 3nm or 6nm) is automatically acquired and plotted. No manual input is required from any of the crew.
53. The alarm system on the *Svitzer Nana* was both visual and auditory, it also has a manual override.
54. These systems were all surveyed on 28 April 2016 (one month prior to the collision) and found to be working correctly. A subsequent inspection on 27 May 2016 did not identify any change in the condition of the systems.
55. All systems aboard the vessel including radars were operating correctly.
56. The Nana is equipped with two VHS radios, one set to Channel 16 and the other set to Channel 74; the latter would allow for communications with other tugs.

Diamantina

57. The Diamantina was also a tugboat that operated out of Bowen Harbour; it is unclear whether it was part of the Svitzer fleet although it was being operated by a Svitzer-employed crew.

58. The Diamantina was a different design to the *Svitzer Nana* but was 33 metres long, 11 metres wide and had a draft of 5 metres. It was powered by two six-cylinder engines of approximately 2600hp. It was equipped with radar, autopilot, AIS and GPS.
59. The Diamantina is also equipped with two VHS radios, one set on Channel 16 and the other set on Channel 74 for communication between the tugs.
60. The Master of the Diamantina was Anthony Petersen. He was unaware of any proximity alarm being fitted to the Diamantina or the *Svitzer Nana*.

Events prior to departure

61. The intended voyage of the *Cygnets Lass* was to the Diamond Islets about 200 nautical miles (nm) offshore. Its Certificate of Operation allowed operation to only 100nm from shore. In my view nothing turns on this evidence in as far as the circumstances of the collision, noting that the collision occurred within 100nm from shore.
62. The trip was planned to take 5-7 days to take advantage of a 'weather window' prior to strong winds that were forecast later in the week. Prior to departure Mr Hondow and Mr Cunningham had been based in Innisfail. Mr (Ryan) Cullen (also known to as 'Kiwi') had been living aboard the *Cygnets Lass*.
63. Mr Hondow deposes that he and Mr Cunningham left Innisfail together at 10am on the morning of 24 May 2016. They drove to Bowen, arriving sometime between 4pm and 5pm that same day. Mr Hondow deposes that during that drive Mr Cunningham was not displaying any visible signs of fatigue and remained mentally alert. There were no time pressures to their journey, and they took a break during their drive to rest and eat. Mr Hondow deposes:

"Martin was keen to keep driving and he was fine".

64. I accept each of those observations.
65. After arriving at Bowen, they unloaded their car before heading down to the *Cygnets Lass* where they met with Mr Cullen. They then commenced preparations for departure.
66. Mr Hondow deposes to Mr Cunningham reprimanding Mr Cullen for not maintaining the *Cygnets Lass* in a clean state whilst he was living aboard. Mr Cunningham deliberately turned up at the boat without warning to Mr Cullen (Kiwi) to see how he maintained the boat in his absence. Mr Cunningham commented to Mr Cullen when he saw empty wrappers and take away boxes lying around, and dishes in the sink, that the boat 'was a disgrace' The 2016 summary of police findings indicates "Cunningham kept the boat immaculate, well equipped and well maintained". Mr Cullen himself told police that *"Martin was real OCD about the cleanliness and arrangement of the boat."*
67. After preparations for departure were completed all crew slept onboard. Mr Hondow deposes he may have had two beers that night but:

"Martin's rules were you didn't work on his boat unless you were sober. He was real anti-drug and anti-alcohol. There was no alcohol on the boat during work times. He would only allow drinking after the boat returned to harbour"

and all jobs were done. Martin was not a drinker. He would only ever have a couple of drinks”.

The Collision

Observation from the Cygnet Lass

68. CCTV Footage from a seafood business at Bowen Harbour recorded the departure of the *Cygnet Lass* at 9:29am.
69. The departure of the *Cygnet Lass* was also witnessed by Mr Dean Wagstaff, who was Skipper of the fishing vessel ‘Maharani’. He deposes that as the *Cygnet Lass* passed by (about 10m) he had a clear view into the bridge / wheelhouse and did not observe any of the curtains being drawn over.
70. After departure Mr Cunningham informed Mr Hondow that he was going to clean the top area. He directed Mr Hondow to clean the accommodation area.
71. Approximately 20 minutes into their voyage, Mr Cullen stated he received an SMS message, the relevance of this being that approximately 5 minutes later he heard remarks by Master Cunningham about the presence of another vessel:

“Marty said that he was going to port as there was a tug out there, about a mile and a half away”.

72. It is unclear whether the reference to a mile should be regarded as a ‘nautical mile’ although the difference would not necessarily be appreciable noting that 1 mile would equate to 1.6km and 1 nautical mile would equate to 1.85km.
73. I do however take from this comment that Master Cunningham was proposing a change in course in response to the presence of other vessels in the area although it is not possible to say what the identity of the tug was, noting two were operating (*Svitzer Nana* and *Diamantina*).
74. The reference to ‘going to port’ also suggests that the tug observed by Master Cunningham was appearing on the starboard side of the *Cygnet Lass*.
75. Mr Cullen states the he was in the galley (the location of the steering wheel) cleaning and that Master Cunningham was in the galley area with him. Mr Cullen made the following observation:

“He [Marty] had engaged the autopilot. I don’t remember what course, but it was the same course we usually use”.

76. Mr Hondow states he was aware of the autopilot system but was not familiar with its use. Mr Cullen states at this time he “had a quick look outside” and also made an observation of the radar noting there was “a bit of clutter from our boat on the radar screen then I saw what appeared to be land on the left-hand side. That was it. I didn’t see anything else”.

77. It is unclear how much time had elapsed between Mr Cunningham's comment regarding the sighting of 'a tug' and engaging the autopilot. It is also unclear whether any change in course had been implemented prior to engaging the autopilot noting that it was 'the same course they usually used'; although Mr Cullen states:

"Marty turned five degrees to port ... Marty was standing in front of the wheel. The view is good when you stand at the wheel. There is nothing obstructing you to the right side [starboard]. Directly in front, vision is good. Slightly to the left [port] there are the computer screen, sounder and plotter"

78. I will return to the issue of visibility later in these findings as I have the benefit of evidence that indicates visibility to the starboard side was obscured by other fittings inside the bridge.

79. In relation the collision, Mr Cullen states:

"About five minutes after [the turn to port], it felt like we were getting pushed and then we rolled three times. It seems like it was something that struck the vessel between the engine room and the back end. I had my head down cleaning the microwave, not looking out at the vessel at all. I couldn't see out the back door from where I was".

80. Mr Cullen was not initially aware of what had struck them.

"The first I knew the bow of the boat went up and rolled to the port side. It rolled three times that's what it felt like."

81. Mr Cullen clarified these observations, deposing:

"Marty said, What the hell? What is this? I didn't see or hear any other boats. I looked up straight away and looked at Marty and looked out the back ... I couldn't see the back of the boat it was just water all the way to the back of the boat".

82. I understand by this, Master Cunningham remained on the bridge with Mr Cullen although it remains unclear whether he was actively involved in operating the vessel or whether the autopilot was still engaged.

83. Mr Cullen states that on Master Cunningham's direction he attempted to break open a window but was unable to reach it. He was able to access the Epirb device and activate it.

84. The section of the *Cygnets Lass* where both Master Cunningham and Mr Cullen were located rapidly filled with water. Mr Cullen recalls Mr Cunningham saying: *"Take a breath Kiwi. I took half a breath as the water came up so fast and then went up the front of the boat. I didn't have enough air to follow Marty."*

85. Master Cunningham went underwater to find a way out however Mr Cullen was unable to follow after him and did not see him resurface. Mr Cullen was ultimately able to move forward where he located Mr Hondow in an air pocket.

86. Mr Hondow did not make any observations of Master Cunningham, but he saw and spoke to Mr Cullen. Mr Cullen states that whilst in the air pocket he told Mr Hondow to

“*follow me*”, he then took a breath and went under water. Mr Cullen put his hand out to where he thought the door was. Whilst the precise sequence of events is unclear, Mr Cullen was successful in rescuing himself from the air pocket and was able resurface and secure himself to the upturned bow section of the *Cygnets Lass*.

87. Mr Cullen’s observations thereafter are relevant to understanding the post-collision conduct of the crew of the *Svitzer Nana*.
88. It is unclear from the statements of Mr Cullen or Mr Hondow whether they were aware of the presence of collision alarm systems on the *Cygnets Lass*, and if so whether they were activated at the time. Regardless, neither witness deposes to hearing any alarm prior to the collision, therefore I infer the alarm systems were not activated during this voyage.

Observations from the *Svitzer Nana*

89. The *Nana* was crewed by Sean Stephens (Master), Mr Mark Burley (Engineer), and two crew members Mr Matthew Quadrell (Watch Keeper) and Brenton Male (Lookout). Also on board, in the capacity of a passenger, was Marine Pilot Andrew Hawkins, who was doing a familiarity run with the tug as part of his professional development.
90. Master Stephens had extensive maritime experience and a particular familiarity with the *Svitzer Nana* having been Master of the vessel on 20 to 50 occasions in 2016 alone.
91. *Svitzer Nana* departed Bowen Harbour with Master Stephens at the controls, as part of a routine deployment to assist shipping at Abbott Point. Its intended voyage was to travel south via the main channel then east once south of Stone Island before turning to the north when east of Stone Island.
92. *Svitzer Nana* had duties at Abbot Point One with one vessel sailing off at 12pm and another berthing at 1pm. The journey from Bowen to Abbot Point was 23 miles or 37km and was expected to take approximately two hours and ten minutes.
93. The radars on the *Svitzer Nana* were set to 3nm (equivalent to 5.5km) and the other set to 6nm (equivalent to 11km). In the absence of any direct line of sight, the crew of the *Svitzer Nana* still had significant capacity to identify objects that may have been within their course.
94. The vessel was suitably crewed and equipped for the intended voyage. It was the evidence of Master Stephens their start time was 9am with a departure time from Bowen Harbour at 9:30am. With respect of the departure and travel times, the *Svitzer Nana* was not operating under any time constraints.
95. Against this background there was also evidence that fuel efficiency tests were being run. The *Svitzer Nana* and another Svitzer tug (the *Svitzer Naiad*) were involved in that analysis. The *Svitzer Nana* was required to operate at 680 rpm and the *Svitzer Naiad* at 720 rpm. Master Stephens deposed this “directive” or request came to him by email.
96. Prior to departure Master Stephens conducted numerous checks on the vessels systems as part of standard procedure before sailing off. Master Stephens confirmed that during the checking process, Mr Quadrell checked the general alarm was working

as was the machinery control room and engine room. Stephens was satisfied that the *Svitzer Nana* was seaworthy and safe to continue to sea.

97. Master Stephens confirmed that once the *Svitzer Nana* departed, they took a course using the south entrance as there was insufficient tide to use the north entrance.
98. Master Stephens was looking astern as they departed to ensure the *Svitzer Nana* stayed within the 'leads' i.e. the opening through which the *Svitzer Nana* was able to exit Bowen Harbour. Whilst they were in the leads, Master Stephens deposed "*there was no other traffic around*".
99. When they approached the M2 to M5 markers Master Stephens made a turn to port to 133°T and continued that direction, still manually steering the vessel. After making that turn Master Stephens activated the starboard autopilot and increased engine speed to 680rpm. Master Stephens stated "*there was [still] no traffic around*" at that time. I am not informed whether the reference to "no traffic" was based on a visual observation, radar data or combination of the two.
100. Master Stephens was aware of the autopilot system being fitted with an alert button although he was unaware if it interfaced with the chart plotting system. I ultimately take the view that Master Stephens was never directly asked about his knowledge of collision or proximity alarms nor did he volunteer any information about those systems.
101. During this early stage of the voyage, Master Stephens deposes Mr Quadrell made observations to the starboard side, to check and "make sure" that the area was clear. Master Stephens then "*continued on that heading [133°T] and I just made my normal checks to make sure we were passing by the cyclone moorings off to starboard*". I understand from that evidence, Mr Quadrell's observations did not identify any 'traffic' to the starboard side.
102. As they approached the M1 (9:44am) and took the next heading (067°T) Master Stephens resumed manual steering. After the vessel steadied onto the new heading, Master Stephens reverted to autopilot.
103. Three minutes after being on the new heading Master Stephens made a visual inspection in preparation for handing over. He observed a 'tinnie' on the reef south of Stone Island, the tinnie was visible off the beam portside of the *Svitzer Nana*. Master Stephens also observed another vessel between eight and ten miles (12 to 16 kilometres) off the port bow.
104. I understand the reference to the tinnie to be a reference to the 12-foot recreational boat occupied by witnesses Ms Sharon Bassett and Mr Robert Russell, both of whom provided statements to police. I will refer to those statements in due course. The identity of the other vessel he observed is unknown.
105. Noting the earlier reference to the range settings for both radars I take from Master Stephens reference to the other vessel off the port bow that whilst visible by eye, it would not have been visible on the radar. In his interview with police Master Stephens disclosed that during the handover over to Mr Quadrell he informed him of the presence of both vessels.

106. Whilst Master Stephens acknowledged he could have (but did not) increase the range of the radar to capture the vessel off the port bow in the scanner, he was satisfied that it was sufficiently visible to the naked eye. Master Stephens informed police these were the only other vessels visible to him.
107. In his handover to Watchkeeper Mr Quadrell, Master Stephens informed him that the starboard side autopilot was on. Mr Quadrell acknowledged that and the two vessels that Master Stephens had sighted confirming that he had a visual on them also.
108. After handing over to Mr Quadrell, Master Stephens delivered an induction to Mr Hopkins. That induction took them away from the bridge through various decks of the *Svitzer Nana*.
109. Whilst on deck Master Stephens was able to observe Mr Quadrell at the helm. He also detected a change of course from 067°T to what he thought was 000°T. The change in course was apparent to him from a change in the wash from the back of the *Svitzer Nana*. AIS data places the change to 000°T occurring at 9:52am.
110. Mr Male, the Lookout, entered the bridge sometime between 9:55am and 9:58am. At 9:57am the course was changed by Mr Quadrell from 000°T to 340°T. That input was made after Master Stephens had left the bridge. That change placed *Svitzer Nana* and *Cygnat Lass* (without a change of speed or direction) on a collision course with each other. There was no vessel traffic or other obstruction that required the *Svitzer Nana* to make the change it did.
111. Master Stephens was delivering the induction and about to enter the engine room when he became aware of an incident that on first impression he thought was a wave hitting the side of the *Svitzer Nana*; it was in fact the collision between the *Svitzer Nana* and the *Cygnat Lass*.
112. The general alarm sounded after this event and Master Stephens went to the bridge and observed Mr Quadrell still at the controls. Mr Quadrell told him “*we’ve struck another boat*”. Master Stephens then resumed control of the *Svitzer Nana* and gave directions for other crew members to make preparation to assist the *Cygnat Lass*. Mr Quadrell expressly denied seeing anything prior to the collision.
113. Chief Engineer Mark Burley (who was employed by Bowen Towing Services) was below deck when he felt and heard a loud bang. He then evacuated his work area and proceeded to the bridge. From there he observed an upturned vessel in the wash of the *Svitzer Nana*. He asked Master Stephens “*What did you hit?*” to which Master Stephens replied, words to the effect “*Matt did*” (referring to Mr Quadrell).
114. Mr Quadrell also claims to have not seen any echo on the radars, noting the settings remained as 3nm and 6nm. When asked why the *Cygnat Lass* did not appear on the radar, Mr Quadrell stated that:

“for a vessel that, that length, it is quite squat, it’s of fibreglass construction, if you, if you lined up these boats and said which do you think would give a better radar echo, that [the Cygnat Lass] would be on the lower scale”
115. A subsequent re-enactment with the *Svitzer Nana* and a vessel of similar dimensions to the *Cygnat Lass* demonstrated there was no issue with the radar equipment on the

Svitzer Nana being able to detect a vessel of that size. That re-enactment was conducted in weather conditions very similar to those on the day of the collision. I therefore do not accept Mr Quadrell's statement to the contrary.

116. Mr Male also denied having observed any other vessel in the immediate area prior to the collision.
117. The first instance when Mr Male became aware of the possible presence of another vessel was when he observed a "*white flash on the port quarter*" before hearing what sounded like the sound of a wave slapping against the hull or a minor bang.
118. When questioned about the presence of any blind spots when sitting at the helm and looking forward over the bow, Master Stephens deposed that there was no blind spot. However when Mr Quadrell was interviewed he conceded there were some blind spots such as mullions on the windows but this could be mitigated by moving around the wheelhouse to obtain different lines of sight and conferring with crew members as to their observations.
119. Mr Male also accepted there were blind spots resulting from funnel stacks positioned midship on both sides of the helm of the *Svitzer Nana*. The following image depicts the position of those funnels (abeam) and the mullions on the windows:



The following image depicts the view from the helm of the *Svitzer Nana* looking abeam and towards the port quarter, as described by MALE:



120. When questioned further about the 'white flash' that he observed Mr Male placed it at three points around on the port bow. There is an appreciable difference between that and the port quarter, with the former position (three points around on the port bow) placing the 'white flash' ahead of any visual obstruction created by the exhaust stacks or mullions.
121. As to any knowledge of collision alarm systems aboard the *Svitzer Nana*, Mr Quadrell was aware of the capability to set an audible alarm on the radar. This is done by setting a 'guard' such that if a target entered within the 'guard area' it would sound the alarm. Mr Quadrell disclaimed making use of the alarm function.
122. When questioned about his knowledge of the collision alarm, Mr Male also confirmed his awareness of it. He understood the system required manual input of AIS data but there was no automatic alarm system.
123. Mr Male was supported during his interview by a representative from the Maritime Union of Australia. It was not clear on the material what experience the representative had working in Bowen Harbour, however I do note that when Mr Male was being questioned as to his knowledge of the proximity / collision alarm systems, the representative made the following unsolicited comment:

"Those close proximity alarms, the masters have never used it that I work with in this port here simply because of the close quarter situations that we work under ... and the amount of traffic we get travelling around with the fishing boats and mackerel, spotting mackerel fishing boats and all that. The alarms would be going off all the voyage nearly".

124. I make no findings with respect of those comments, noting the representative was present only in the capacity of a support person and was not a witness to the collision.
125. The statement does however concern me as the representative recognised the very risk (namely large traffic in 'close quarters') that would make collision alarms so essential, yet seemingly considered them an inconvenience to the operation of a vessel.
126. Mr Hawkins, the Marine Pilot who was on board the *Svitzer Nana* in the capacity of a passenger / observer, was present during the handover between Master Stephens and Mr Quadrell. He described it as a "*professional*" and "*proper*" handover.
127. Although Mr Hawkins had not previously worked on the *Svitzer Nana*, or with that crew, I recognise his own experience in the industry and I accept his comments and observations.

Observations of Sharron Bassett and Robert Russell

128. Ms Sharon Bassett and Mr Robert Russell were independent witnesses to events immediately prior to the collision. Ms Bassett was resident at Bowen for some forty years, she and Mr Russell had been fishing together for the same period. I consider them to both have a level of experience and familiarity to provide informed observations about the conduct of vessels in Bowen Harbour, in particular the *Svitzer Nana* and the *Cygnets Lass* on the day of the collision.
129. Ms Bassett confirmed she and Mr Russell were positioned near the tip of Stone Island which she describes as 'their favourite spot'. Their vessel was facing towards the sea and Ms Bassett initially had her back turned to the channel when she looked up and observed the *Svitzer Nana* to the east. She described it as doing "its usual speed".
130. Ms Bassett next observed another boat which she described as appearing at the corner of her eye. Ms Bassett described it as a fishing boat that was "heading straight out". Critically Ms Bassett observed that the fishing boat looked like it was "going to be beat [the] tug". I take from those comments that the vessels were noticeably on a course that would cross each other.
131. Ms Bassett observed that the *Cygnets Lass* was heading 'straight out' which I understand to mean, it did not change course in any way. Ms Bassett observed as follows:

"He [the Cygnets Lass] was absolutely on a collision course with the tug boat, I just thought he was going to try and beat the tug you know ... He was that close I thought he was going to open up and try and get [past] him, he didn't try to go to the left or the right he just went straight".
132. Ms Bassett states she then turned her attention to a second tug (the *Diamantina*), she then turned her attention back to her own vessel and when she looked back again she observed the first tug (the *Svitzer Nana*) had stopped and turned to face the direction it had come from. Ms Bassett observed an object (the *Cygnets Lass*) in the water in front of the tug.

133. Mr Russell observed a large fishing charter heading out the channel towards Holbourne Island. Shortly after this Mr Russell observed another fishing vessel that he estimated to be travelling at 7 to 8 knots. At this point Mr Russell observed a tug (the *Svitzer Nana*) clearing North Head and travelling north towards Abbott Point.
134. Mr Russell's observations of the first fishing charter may account for the vessel Master Stephens observed 8 to 10 miles off the port bow of the *Svitzer Nana*.
135. Mr Russell estimated the tug was travelling at 8 – 10 knots. Noting the availability of independent AIS data, this observation was an accurate one. With respect of the tug and the second fishing vessel he made the following observation:

"After seeing both boats and the direction they were travelling in, I remember having a conversation with Sharon about this. We were both of the opinion that the fishing boat was going to try and beat the tug ... if the fishing boat did not change its course and go astern of the tug it looked they were going to be on a course for a collision".

Observations from the Diamantina

136. Mr Victor McFarlane was a Watch Keeper Deckhand on Svitzer Tugs at Bowen. He had more than thirty years-experience in the industry. He was a member of crew of the Diamantina on the day of the collision.
137. Mr Ross Sorenson was employed as a General-Purpose Hand / Watch Keeper with Svitzer. He also had about thirty years of industry experience. He was a member of crew of the Diamantina on the day of the collision.
138. Mr Sorensen observed that the *Svitzer Nana* was about 1.3nm (2.4 kilometres) ahead of the Diamantina. Once the Diamantina was on a north course towards Abbott Point the Master (Anthony Petersen) handed over the watch and controls to him. At the time of handover Mr Sorensen deposes he did not observe any other vessel in the area other than the *Svitzer Nana*. In his own words:

"visibility was good from both the wheelhouse and on the radar"

139. The evidence of Mr Sorensen does not sit easily with the evidence of Master Stephens or Mr Quadrell of the *Svitzer Nana*, both of whom had the ability to observe the tinnie that contained Ms Bassett and Mr Russell and the other vessel 8nm to 10nm off the port bow.
140. Mr Sorensen makes no comment on any other vessel being in proximity to the *Svitzer Nana*. He states the Diamantina was on a north course for about five or six minutes before turning onto a course of 340 degrees at which time the *Svitzer Nana* was at a stop and was facing the Diamantina side on. Mr Sorensen estimates the Diamantina was still 1.3nm behind the *Svitzer Nana* at that time.
141. Senior Marine Pilot, Kim Macpherson was also aboard the Diamantina. Like Mr Hawkins he was employed by the Port of Townsville and was doing observations on the Diamantina as part of his continuous professional development. He had not previously been aboard the Diamantina.

142. Mr Macpherson was familiar with the run in and out of Bowen Harbour. He confirmed they were travelling at a distance about 1nm behind the *Svitzer Nana* and the visibility was “excellent”. It is unclear from Mr Macpherson’s statement where he was positioned on the *Diamantina* during the voyage or prior to the collision. Mr Macpherson states that shortly after the handover he observed the *Svitzer Nana* had altered course and come to a stop.
143. Mr Macpherson deposes that prior to observing the *Svitzer Nana* at a stop he had not observed any other vessels in the area, but he had not “really” been keeping a watch.
144. The Master of the *Diamantina* was Anthony Petersen. Master Petersen observed that after getting underway there was swell of less than 0.5m and the weather was sufficiently clear to allow the use of landmarks to check navigation.
145. Master Petersen states the *Diamantina* made a course change from 000 to 340. The change to 340 occurred after the handover from Master Petersen to Mr Sorensen. Master Petersen states that about three to four minutes after he was still in the wheelhouse with Mr Macpherson, Mr Mcfarlane and Mr Sorensen.
146. Master Petersen estimates the *Svitzer Nana* was about 1.5 nautical miles ahead when:
- “I also observed a small object, which I can only estimate was within about five hundred metres off the Svitzer Nana. The bearing of the object was approximately 22.5 degrees off the port bow of the Diamantina.”*
147. Master Petersen then observed the *Svitzer Nana* alter course about two to three minutes later:
- “I initially thought at the time the Svitzer Nana was responding in some way to a small stationary vessel”*
148. Master Petersen then resumed control of the *Diamantina* and made course for the *Svitzer Nana*. As he approached, he reduced speed to minimize the amount of wash coming off the *Diamantina* out of a concern that the *Svitzer Nana* may have been rendering assistance. Once the *Diamantina* was about 500m from the *Svitzer Nana*, Master Petersen observed an upturned boat in the water. It was this that prompted Mr Sorensen to contact the *Svitzer Nana* on VHF radio 74.

Post-Collision Conduct

149. There are four aspects to the post-collision conduct:
1. The interactions between the crew of different vessels at the scene;
 2. The manner in which the collision was reported to those on mainland;
 3. The response of emergency services to the information they were provided; and
 4. The efforts at resuscitation of Mr Cunningham.

Interactions Between the Crew of the Different Vessels at the Scene

150. After the collision, Master Stephens ordered the *Svitzer Nana* into a hard-starboard turn to come back to the *Cygnat Lass*.

151. After securing himself to the upturned bow section, Mr Cullen observed a tug (*Svitzer Nana*) approaching them from about 300 metres away. The tug had a dinghy suspended over the side by a crane in readiness to launch it.
152. It seems that when the *Svitzer Nana* was sufficiently proximate to the *Cygnets Lass*, but before any tender was launched, crew were able to call out to Mr Cullen and ascertain there were people trapped in the hull. On hearing this, Chief Engineer Burley worked with Mr Hawkins, Mr Male and Mr Quadrell to retrieve a hammer and a fire axe to assist them in gaining access to the hull of the *Cygnets Lass*.
153. Master Stephens instructed Mr Hawkins to launch the rescue boat. Mr Quadrell, Mr Male and Mr Hawkins then proceed to prepare the rescue boat. Master Stephens maintained VHF contact with the *Diamantina* during this time.
154. Master Stephens effectively coordinated three conversations, one with the Brisbane Operations Centre using a mobile phone, one with the *Diamantina* using a VHF radio and another with his crew on the rescue boat using a UHF radio. Master Stephens was relying on the operations centre to alert '000'. I will address the response of the operations centre in due course.
155. Using VHF radio, Master Stephens communicated with Master Petersen of the *Diamantina*. Master Stephens requested the *Diamantina* launch a recovery boat, however Master Petersen informed him that the *Diamantina* was not equipped with one.
156. Master Stephens observed Mr Quadrell, Mr Male and Mr Hawkins travel in the rescue boat to the *Cygnets Lass*. Mr Quadrell informed police during his interview that when they arrived at the *Cygnets Lass*, Mr Male entered the water to look for the trapped crew. Mr Quadrell then had a conversation with a male [Mr Cullen] during which he asked numerous times, how many people were on board.
157. Mr Cullen deposes to asking one of the crew of the *Svitzer Nana*, "what did we hit". He does not recall who that person was. Mr Cullen further deposes that the crew member who responded, told him words to the effect: "[you] didn't hit anything". Whilst strictly true, it completely failed to convey the fact that the *Svitzer Nana* had collided with the *Cygnets Lass*.
158. Chief Engineer Burley deposes he was the person to whom the question had been directed however he does not depose to giving any response. However, for reasons I will now address I am satisfied that Mr Cullen asked the question more than once, and it was heard by other *Svitzer Nana* crew members that were assisting with the rescue.
159. In his interview with police, Mr Quadrell deposed to a conversation with Mr Cullen. He asked Mr Cullen: "*mate, what were you doing*" or words to that effect. Mr Cullen's response was: "*We were going out ... I was vacuuming*".
160. Mr Male describes Mr Cullen as being 'in shock' and that they were trying to calm him. They transferred him to the *Diamantina* during which Mr Cullen repeatedly asked: "*what did we hit, what did we hit*". Mr Cullen was transferred into the rescue tender that had launched from the *Svitzer Nana*.

161. Whilst I find that Mr Cullen was not truthfully informed of the circumstances of the collision, such did not adversely affect the rescue efforts that were being attempted at that time. Master Stephens had by this time informed the Svitzer operations centre that there had been a collision, and that the operations centre had conveyed the same information to '000'. I do not consider there was any culture of obfuscation operating at the time. Instead, any withholding of information, was likely due to the Svitzer legal response that was operating at the same time.
162. Mr Hawkins deposes that one of the crew members (likely Mr Male) went underwater presumably to identify whether he could gain access. Mr Hawkins deposes that the crew member surfaced and informed them that there were eskies wedging the door and that he was unable to open it. Mr Quadrell remained on the upturned hull of the *Cygnets Lass* and was banging on it to get a response from anyone inside.
163. By the time Mr Cullen had been retrieved from the hull, Master Petersen had brought the *Diamantina* closer to the scene and prepared it to receive any casualties through the bulwark door starboard side. Mr Cullen was taken on board the *Diamantina*.

Circumstances in which the collision between the *Cygnets Lass* and Svitzer *Nana* was reported

164. Analysis of the circumstances in which the collision between the *Cygnets Lass* and the *Svitzer Nana* was reported has identified two channels of information were operating from the scene of the collision.
165. The first channel (the Svitzer Channel), commenced with a call placed by Master Stephens to the Svitzer Command Centre based in Brisbane.
166. The second channel (the Maritime Safety Queensland (MSQ) channel), commenced with a call placed by Senior Marine Pilot (SMP) Kim Macpherson. SMP Macpherson was not employed by Svitzer but was instead employed by the Port of Townsville. His call was directed to the Regional Harbour Master for Townsville Region, Captain Frank D'Souza.
167. The two channels of information were operating independently of each other.

The Svitzer Channel

168. Master Stephens stated during his interview that the first person he contacted in relation to the incident was Svitzer Operations Centre based in Brisbane. He stated this was done in accordance with Svitzer procedures that required their operations centre to be the first point of contact in any emergency. Master Stephens advised the Operations Centre (Brisbane) that there had been a "collision".
169. The person to take that call was Mr Dean Dowling. The details of that call were recorded on a Management Response Checklist. That Checklist records that Master Stephen's call was received at 10:14am. The position of the *Svitzer Nana* was given as 20°00.3S 148° 17.7E. The nature of the incident reported was documented as:

"Incident – vessel collision 30ft yacht upside down"

170. Svitzer Tug Master (TM), Ken Blackband deposes that he arrived at the Svitzer tug base at about 10am on the morning of 25 May 2016. As he entered the office he observed Mr Dowling on the phone in the Operations Centre. TM Blackband deposes that he heard Mr Dowling state “in a surprised tone”:

“Can you confirm you’ve hit a yacht?”

171. Mr Dowling handed the call to TM Blackband and requested he speak to ‘Sean’ [Stephens] who was calling from the *Svitzer Nana*. TM Blackband understood that Mr Dowling was attending to “the relevant checklist for such an emergency” at the time the call was handed over. With regard to the Management Response Checklist I accept that is the case. Mr Dowling and another worker (Mr Rick Goffin) continued to triage the incident.
172. After handing over the call, Mr Dowling made the first Triple 0 call in relation to the incident (at 10:16am). That call was directed to the Queensland Police Service (QPS) Communications Centre and was of eight minutes duration. I have the benefit of that recording.

173. At the commencement of the call Mr Dowling stated:

*“Hello, my name’s Dean Dowling calling from Svitzer tug boats, **our vessel, vessel Nana has collided with a 30ft yacht [my emphasis],** off the coast of Bowen, Abbott Point” ...its [the Cygnet Lass] capsized”*

174. Mr Dowling provided the latitude and longitude coordinates. Mr Dowling also confirmed that there were three people on board the *Cygnet Lass*, one had surfaced and two were still unaccounted for.
175. Mr Dowling was at all times candid and thorough in relaying information to the QPS. At times the Operator would repeat back information to Mr Dowling. The Operator had made some errors which Mr Dowling corrected him on. Mr Dowling reinforced, on more than one occasion that it was the Svitzer tug, that had collided with the *Cygnet Lass*.
176. Notwithstanding the information given by Mr Dowling the Operator entered the following details in the QPS Incident Header (000597-25052016):

“INF ADVISED THAT A YACHT-BOAT 30ft LENGTH HAS CAPSIZED, BUT NOT SUNKEN. HULL IS STILL VISIBLE”.

177. The incident report made no reference to a collision. I am unable to determine why that was not entered in the QPS system, when that information was available to them.
178. Mr Blackband deposes that each tug has a document setting out the emergency procedures to be followed by the tug’s crew. This document is separate to that with the operations centre and is kept in the chart table on the bridge of the tug. The procedures are as follows:

- a) Call the operations centre,
- b) Notify the harbour control (Vessel Traffic Service),
- c) Ring muster bell to summon the crew to the bridge so Master can perform a headcount, and

d) Assess the damage to the tug.

179. In his conversation with Master Stephens, TM Blackband deposes:

*"I recall that he [Master Stephens] informed me that they **had been in a collision [my emphasis]** with a yacht and it was upturned against the hull of the Svitzer Nana"*

180. TM Blackband does not recall being informed of any damage to the *Cygnat Lass* at that time, but he accepts the possibility he was told the crew of the *Svitzer Nana* were "OK". TM Blackband recalls giving the following advice:

"I told Sean three things. The first thing I told him was that he should not say anything until he had lawyers engaged. The second thing I told Sean was that he should secure the hull of the other boat so that the situation did not get any worse than it was. I then told Sean that he should try and stop the hull from sinking without forcing it to flip"

181. TM Blackband cannot recall if he confirmed with Master Stephens as to whether Police had been contacted or not. He does depose that he informed Mr Dowling and another person in the operations centre (Mr Rick Goffin) to inform emergency services so that they could respond.

182. The Management Response Checklist documents that an "emergency situation" was declared at 10:16am and a call (Mr Dowling's) placed to '000'.

183. In addition to calling '000', the Svitzer Operations Centre also notified the Abbott Point Port Authority at 10:17am.

184. The information that was being received at the Brisbane operations centres was also escalated within the Svitzer hierarchy. At 10:23am a call was placed by Mr Goffin to Mr Alistair Martin, Head of Marine Standards at Svitzer Australia. Mr Martin was on board the Svitzer Otway in Melbourne when he received the call. He deposed as follows:

"I received a telephone call from a colleague who informed me that the tug Svitzer Nana had collided with a yacht near Bowen while the tug was on its way from Bowen to Abbott Point Coal terminal in Queensland"

185. Mr Martin instructed Mr Goffin to make additional calls to Svitzer employees so that an Emergency Response Committee could be convened. That meeting was convened and attended by Mr Martin and Mr Andy Perry, Regional Marine Manager for Svitzer.

186. Mr Perry was based in Sydney. I understand he (and others) participated in the Emergency Response Committee by way of an open Skype line.

187. Mr Perry states that at about 10:25am he made a telephone call to Maritime Safety Qld but was instructed by them to contact Queensland (Water) Police instead. Mr Perry attempted to make that call but deposes that it was not answered.

188. In his statement, Mr Perry deposed:

*“Shortly after [the attempted call to Water Police], possibly about 10:30AM, I received a telephone call from a colleague in either Bowen or Brisbane (I cannot now recall which colleague). **They told me that the Svitzer Nana had not collided with a vessel [my emphasis].** They told me that the tug had encountered a small vessel floating upside down. When I received this information, our procedure was changed to a Search and Rescue procedure (SAR).*

189. Noting the conversation between Mr Dowling and the QPS I accept there was discussion of a capsized vessel from the outset, in the context of the vessel having been struck by the *Svitzer Nana*. I am unable to reconcile how Mr Perry was informed that a collision had not occurred which would have been entirely contrary to Master Stephens report, the information conveyed by Mr Dowling to the QPS, and the Svitzer Management Response Team Checklist maintained at the Communications Centre.
190. The Svitzer Management Response Team Checklist does not identify any call being made from Brisbane to Mr Perry.
191. At 10:39am, Mr Perry initiated a telephone call to the Australian Maritime Safety Authority (AMSA). This was the first time AMSA had been informed by any agency, of an incident having occurred between the *Cygnat Lass* and the *Svitzer Nana*. The conversation progressed in the following manner:

AMSA Operator: Search and Rescue, [name] speaking

Perry: Hi [name], it's Andy Perry from Svitzer calling, could I speak to the Manager

AMSA Operator: Uh, which Manager are you after Andy

Perry: Um, well, just briefly let you know what's going on, we've just had a phone call advising us of, a situation that's going on at Bowen, um one of our vessels has not collided with a yacht but a yacht is currently turned over, um we've got very little information at the moment, um and we're just getting a call together to coordinate, it's more of an information call at the moment, um we'll give you an update

AMSA Operator: Alright, alright

Perry: The name of the vessel is the Svitzer Nana, Svitzer Nana

AMSA Operator: Do you have its position?

Perry: No, I just tried to get it on marine traffic, and its not there so I was hoping you might be able to ping it for me

AMSA Operator: What's the call sign do you know?

Perry: Alright, I'll be able to get it for you, one second ...

Unknown Male: Apparently [indistinct] changed

Perry: Could you just hold on one second

AMSA Operator: Yeah sure

Perry: Okay scenarios changed a bit, but in the meantime the callsign is, Victor, Juliet, November 4170, and actually information has just changed in that we've been asked to help a search and rescue for these people

AMSA Operator: Okay, so the Svitzer Nana, has it had a collision?

Perry: No, no, no it hasn't had a collision

AMSA Operator: Okay it's been asked to assist with a search and rescue

Perry: Yeah, that's where we are up to at this stage, I don't have any further information but as soon as I do I'll get on the phone to you

AMSA Operator: Okay, could you tell me, you don't know who their in contact with, they look like they're in Bowen at the moment, or just off Bowen

Perry: *Okay, um no I wouldn't, I, I don't know to be honest, like I said [indistinct] information, but just to let you know we're onto it, um [indistinct] made aware of it the more you start to get a load of panic calls*

AMSA Operator: *Yeah sure, we don't have any incidents up there, that we're aware of at the moment, so I'll give the Water Police a call and find out if they know what's going on, and um if you can let us know of any update, if and when you get it*

Perry: *No worries, brilliant, cheers, thanks very much*

192. Based on the information that was conveyed to AMSA, the Operator initiated a call to Queensland Water Police at Townsville. Two calls, one at 10:44am, the other at 10:46am. As with Mr Perry, those calls went unanswered. However, a third call at 10:49am connected and was answered by an Officer Daniel Gillis. During that call Queensland Police confirmed with AMSA that they were coordinating the search and rescue.
193. For reasons I will identify shortly I accept the reason the calls placed by Mr Perry and the AMSA Operator to Water Police went unanswered, was because search and rescue efforts were already underway at those times.
194. At about 10:42am, Mr Dowling made a second (two minute) call to the QPS Communications Centre, to advise the following:

*"Good morning, I've called up um about 20 minutes ago just reported a **water incident [my emphasis]** a 30ft vessel had capsized or is currently capsized ..."*
195. Mr Dowling went to inform the Operator that he was in contact with the Master of the *Svitzer Nana* and that the Master was requesting an ETA for support teams so that he (the Master) could consider what steps he should be taking next to effect a rescue e.g. breaking glass to gain access to the *Cygnat Lass*.
196. There is an obvious change in the language that Mr Dowling was using during this call. It was of a similar flavour to that used by Mr Perry in his earlier call with AMSA.
197. There was simply no factual basis for this change to occur. This change served no purpose, given that by then, QPS had already been informed a collision had taken place, and as physical evidence would go on demonstrate, there was an inescapable and inevitable conclusion, that the *Svitzer Nana* had collided with *Cygnat Lass*.
198. Whilst these events were unfolding onshore, Master Stephens maintained contact with the Operations Centre at Brisbane and also raised the *Diamantina* using VHF radio. Master Stephens deposes that he informed Master Petersen of "the situation" and requested they launch their rescue boat. Noting the advice that had been given by TM Blackband, it is not clear what the extent of information given to Master Petersen was, with regard to "the situation".
199. Master Petersen deposes that he received a request from Master Stephens to launch their recovery boat but informed him that they did not have one. He then states:

*"I didn't contact the *Svitzer Nana* at that stage because I did not want to interrupt any emergency procedures that he may have been conducting".*

200. Two possibilities arise from this exchange, either:

- a) Master Stephens fully informed Master Petersen of “*the situation*” including the collision, and Master Petersen operated under the same advice not to say anything until lawyers were engaged; or
- b) Master Stephens acted on the advice not to say anything until lawyers were engaged, to the extent that he withheld information about the collision from Master Petersen.

201. In either scenario, I find that a ‘silo’ had developed between the Svitzer employees, whereby information about the true sequence of events was being held within their sphere, albeit communicated through their designated channels (the operations centre) which still enabled an emergency response to be initiated. In the absence of any evidence to the contrary, I find the ‘silo effect’ more likely commenced with TM Blackband telling Master Stephens not to say anything until lawyers were engaged.

The MSQ Channel

202. At 10:13am, SMP Macpherson (onboard the Diamantina) received a call, unrelated to the events at the scene, from Pilot Launch Master Adam Gatkowski, who was employed by Australian Reef Pilots and was Pilot of the vessel, ‘John Rodgers’.

203. At the end of that call (about 10:17am) SMP Macpherson informed PLM Gatkowski that, “the *Svitzer Nana* had come across an upturned vessel”. PLM Gatkowski then ended their call. At 10:17am he received a call from Abbott Point Vessel Tracking Services (VTS), informing him of a delay because of an incident involving a “tug”.

204. With reference to the Svitzer Management Response Checklist, I would accept that the original source of the information from Abbott Point VTS was from the Brisbane Communications Centre. I would also accept that Abbott Point had not been given any specific information of a collision having occurred, only “an incident”.

205. At 10:20am, six minutes after the call that had been placed by Master Stephens to the Svitzer Command Centre, Senior Marine Pilot (SMP) Kim Macpherson, made a telephone call from the Diamantina to Vessel Traffic Services in Townsville (VTS). Prior to making that call SMP Macpherson had observed an upturned vessel with a missing aft section. His initial thought was that the damage may have been caused “by an explosion”.

206. A Form – 005 Incident Reporting document was completed by Manager, Vessel Traffic Management, Tony Melrose, who took the call from MSP Macpherson. Mr Melrose recorded the following incident:

“advice received that tugs Svitzer Nana and SL Diamantina were sailing for Abbot Point terminal for a departure when they observed an upturned boat in the water and a person swimming. The SL Diamantina collected the person from the water. Initial information that five persons were involved was clarified to three persons in total (the one who escaped and two others trapped inside the vessel”

207. Regional Harbour Master for Townsville Region (MSQ), Captain Frank D'Souza deposes that at 10:20am he was notified that: "Tugs *Svitzer Nana* and SL *Diamantina* heading out of Bowen for a shipping movement at Abbot Point had observed an upturned boat, later identified as the *Cygnat Lass*". RSM D'Souza deposes that at 10:25am he initiated a call to SMP Macpherson who was still on the *Diamantina*. RSM D'Souza was informed of the following:

"Tugs Svitzer Nana and SL Diamantina whilst heading out of Bowen for a shipping movement at Abbot Point had observed an upturned boat. He further informed me that 1 person had been rescued [Mr Cullen] and was on board the Diamantina and 2 persons were suspected trapped in the boat".

208. SMP Macpherson deposes that:

"there were some communications via radio between the Diamantina and the Svitzer Nana however I do not know what was said"

209. I accept on that basis the information that was conveyed to VTS and RHM D'Souza by SMP Macpherson was not influenced by any Svitzer employee. SMP Macpherson was making his own observations and forming his own conclusions completely unaware that by then, Master Stephens of the *Svitzer Nana* had already conveyed to his own operations centre there had in fact been a collision.

210. SMP Macpherson could never have been seized of the true state-of-affairs at the time of his call to Captain D'Souza, because either:

- a) Master Stephens withheld information about the collision from Master Petersen; or
- b) Master Petersen had been informed of the collision but was operating under the same advice given by TM Blackband, not to say anything until lawyers were engaged.

211. The scenario conveyed by SMP Macpherson back to Vessel Traffic Services and Captain D'Souza of a 'capsized vessel' was tainted by the silo effect (lack of precise information).

212. Captain D'Souza deposes that after he completed his phone call with SMP Macpherson, he walked directly from his own office to the offices of Queensland Police Service (Townsville Water Police) where he had a conversation with Sergeant Matthew Pegg, the Officer in Charge and requested he organise a Search and Rescue (SAR) response. Captain D'Souza deposes that because it was an SAR response, Water Police would be the lead agency.

213. Captain D'Souza deposes that regardless of whether they were responding to a collision or a capsized vessel the initial response must be "the preservation of life"; further:

*"In all such cases when a vessel is sighted in distress (whether overturned or abandoned and drifting) the priority is to **locate the crew and determine their safety**" [my emphasis]*

214. In that regard, whilst the information received by Captain D'Souza was tainted, I find that it did not impede the initiation of the SAR response.

Convergence of the Svitzer and MSQ Channels

215. By reference to the Svitzer Management Response Checklist, an entry timed at 10:40am documented the following:

"AM [Alastair Martin] called MSQ Frank D'Souza – was advised he was already aware. DD [Dean Dowling] made 2nd call to "000" to give Sean's [Stephens] mobile number"

216. This marked the first convergence of the Svitzer and MSQ Channels. It was a moment in time where if there were conflicting narratives about the circumstances of events between the *Svitzer Nana* and the *Cygnat Lass*, it was more likely to be identified then.

217. I have already referred to the second Triple '000' call (at 10:42am) made by Mr Dowling. I initially considered the possibility the interaction between Captain D'Souza and the Svitzer Operations Centre may have represented a point in time where there was 'contamination' of information, that is Svitzer employees may have developed a genuine belief that what they were dealing with a capsized vessel based on information from Captain D'Souza (through SMP Macpherson).

218. Mr Martin deposes that by about 10:40am, having disembarked from the Svitzer Otway, and now within the Melbourne Svitzer office, the following events transpired:

"When I arrived at Svitzer's offices in Melbourne, I was informed that information had been received which suggested that "Svitzer Nana" had not collided with a vessel. At that time we understood the tug had encountered a small vessel floating upside down and that there appeared to be people trapped inside the hull of that vessel"

219. Mr Martin deposes that information may have come from a phone call or was conveyed through the Emergency Response Committee open Skype line.

220. Noting that Mr Perry and Mr Martin were both participating in the Svitzer Emergency Response Committee, it appears the organizational response became detached, from the events that were unfolding at the scene.

221. With reference to the statement of Mr Perry, he was actively corrected (by a colleague in either Bowen or Brisbane) at about 10:30am, that the situation did not involve a collision. I must accept on that basis that the change in narrative occurred prior to, and independently of any interaction that later took place with Captain D'Souza.

222. By reference to the Svitzer Management Response Checklist I understand there were two occasions when the Brisbane Operations Centre had contact with the *Svitzer Nana*, at 10:18am and 10:35am. The notes associated with those two calls, indeed the document in its entirety, makes no reference to any change in narrative being provided by Master Stephens. Equally there is no note of any call back to Master Stephens seeking to clarify any counter narrative that may have been emerging.

223. I find that there was no cross-contamination of information between the Svitzer and MSQ channels, but more likely a legal response, likely originating from the Brisbane

Operations Centre, came into effect. That in turn affected the manner in which Svitzer employees, particularly those not based in Brisbane, were engaging with external agencies.

Rescue Response

224. Sergeant Pegg deposes that his conversation with Captain D'Souza occurred at 10:23am. Sergeant Pegg was informed of an incident having occurred near Bowen "involving a capsized vessel with people trapped in the upturned hull and other person in the water nearby". Based on the information provided by Captain D'Souza, Sergeant Pegg deposed to the following course of action:

"I commenced coordination of a search and rescue response in respect of the information from Captain D'Souza at 1033 hours on that day I contacted Senior Constable [Michael] Rennie of the Water Police Townsville and recalled him to duty to assist as required".

225. At 10:28am, Mr Douglas McGuire, a Svitzer-employed Marine Salvage Engineer with 7000 hours dive time, including rescues, received a call from the Svitzer Communications Centre in Brisbane, informing him of an "incident", and that he should attend the get the tugboat Svitzer Naiad ready to assist. Mr McGuire boarded the Svitzer Naiad and assisted to get that vessel ready to depart. Prior to its departure he transferred onto a tender with dive equipment so that they could get to the scene sooner.
226. SC Rennie deposes that due to the initially limited information about the number of missing persons involved, he and Sergeant Pegg determined that rescue helicopters should be tasked to commence searching. Sergeant Pegg made a call to Queensland Health at 10:35am to request rescue helicopters from Townsville and Mackay to proceed to the area. Sergeant Pegg deposes to having been placed on hold "for an extended period" during this process.
227. The vessel John Rogers, piloted by PLM Gatkowski, was the first vessel on scene in response to any communications for assistance. It arrived at 10:30am, some thirty minutes after the collision had occurred. When they arrived, PLM Gatkowski and his crew member, recognised the *Cygnets Lass* as the upturned vessel. He observed there were two people in the water (Mr Quadrell and Mr Male) securing a line to the bow of the *Cygnets Lass*.
228. The John Rogers was then tied up to the *Svitzer Nana* to operate as a platform vessel for the recovery of Mr Hondow and Mr Cunningham from inside the upturned hull. The John Rogers left the scene for a period of time, to retrieve 'hookah' diving apparatus from the fishing vessel 'Valkyrie' that was nearby. The John Rogers then brought that hookah set back to the scene to assist with dive efforts to gain access to the *Cygnets Lass*.
229. At 10:45am Sergeant Pegg made a call to Sergeant Pettigrew of the Water Police Whitsunday. He briefed Sergeant Pettigrew with the known information and requested a water police vessel to attend.
230. Sergeant Pegg then made enquiries through his chain-of-command to determine whether it was possible to secure assistance of ship divers with the Royal Australian

Navy. At or about this time, Sergeant Pegg also received information that that a Government survey vessel, the Norfolk, was in the Bowen area and available to assist if required. Mr Brian Harris, an employee with the Department of Transport and Main Roads, Maritime Safety Queensland, was the Master of the Norfolk.

231. At 11:05am, Sergeant Pegg contacted the Queensland Fire and Emergency Services and tasked personnel with cutting equipment to be deployed on the vessel Norfolk. That task was issued by Sergeant Pegg again at 11:20am.
232. At 11:35 Master Harris and his crew departed from the MSQ base at Bowen. They arrived at the scene at 12:00pm (after Mr Cunningham had been recovered). Master Harris noted the coordinates of the scene as 20° 00.383S and 148° 17.766E. I note those coordinates are the same as those provide by Master Stephens to the Svitzer Communications Centre in Brisbane.
233. At or about 11:05am, two police officers with the Bowen Police Station, Constable Mark Gasparotto and Senior Constable Jason Kreymborg were informed of the incident and proceeded under lights and sirens to the Bowen Volunteer Marine Rescue base at Bowen Harbour. They boarded the vessel 'Rescue Bowen' and with a diver (Mr Brian Mecklem), they left Bowen Harbour to attend the scene.
234. Mr Mecklem owns and operates his own recreational dive company and has 30 years diving experience.
235. At 11:08am, Advanced Care Paramedic (ACP) Gene Curtis received a call from his communications centre to be on stand-by at Santa Barbara Parade, Bowen. He arrived there at 11:15am. Shortly afterward, ACP Curtis joined officers with the QPS aboard the tug Svitzer Naiad. Constable Courtney Beaumont was one of those QPS Officers.
236. At 11:17am, Mr McGuire arrived at the scene. Mr McGuire applied his diving apparatus then entered the water. Mr McGuire surveyed the *Cygnat Lass* from underwater and identified a rear accommodation door that could be removed. Mr McGuire resurfaced, obtained a screwdriver, returned underwater and removed the door from its frame. Mr McGuire then entered the vessel. He noted there was limited visibility with bedding, carpet and oil obstructing his view.
237. At this time, a number of other vessels and vessel operators were at the scene, endeavouring to provide assistance. One of those operators was Mr Dean Wagstaff, Skipper of the Maharani, he attended the scene with one of his crew members, Mr Jason Outram.
238. Mr Wagstaff entered the water and observed Mr McGuire removing the door from its frame. Mr Wagstaff was diving using a hookah system, likely retrieved from the John Rogers, whereby an air compressor on the surface delivered air via line to Mr Wagstaff. After observing Mr McGuire, Mr Wagstaff resurfaced for a short period.
239. During this time, the vessel Rescue Bowen arrived at the scene (about 11:30am). Constable Gasparotto and SC Kreymborg were the first officers from any agency (QPS, QAS or QFRS) to arrive at the scene. Upon arrival Mr Mecklem disembarked to a dinghy that then took him closer to the hull to assist with the rescue.

240. Mr Mecklem then entered the water and commenced surveying the *Cygnets Lass* underwater to determine if he could identify an entry point. Whilst he was underwater, he encountered Mr McGuire. Mr Mecklem also deposes to the same conditions affecting visibility as did Mr McGuire and Mr Wagstaff, namely bedding, debris and diesel fuel.
241. Mr Mecklem assisted Mr McGuire in removing some of the bedding and other debris from inside the *Cygnets Lass*. After some time, the diesel fuel in the water began to affect Mr Mecklem's breathing apparatus. He and Mr McGuire surfaced together.
242. Whilst Mr Mecklem and Mr McGuire were on the surface, Mr Wagstaff dived again this time taking a torch with him. He entered the cabin through the doorway that had been opened by Mr McGuire. Mr Wagstaff deposes that he had 1m visibility at the time even with the torch; he continued to assist with clearing the debris. Whilst underwater Mr Wagstaff located Mr Cunningham "floating in the water". Mr Cunningham had not been immediately visible to Mr Wagstaff and his discovery was a cause of shock.
243. Mr Wagstaff then resurfaced and called out "*I found someone*" before diving again. Mr Outram heard the call and followed Mr Wagstaff down. Both Mr Wagstaff and Mr Outram retrieved Mr Cunningham from inside the *Cygnets Lass* and brought him to the surface. Mr Outram observed that when Mr Cunningham was brought to the surface, he had frothy sputum coming from his nose and mouth.
244. Neither Mr Wagstaff nor Mr Outram depose to Mr Cunningham showing any observable signs of life when he was retrieved from inside the *Cygnets Lass*.
245. Mr Hawkins (the Port of Townsville, Marine Pilot) who had been aboard the *Svitzer Nana* was nearby in a tender when Mr Cunningham was brought to the surface. Mr Hawkins called out: "*Is he okay?*" and heard someone call back "*Yes he's alive*". It is not apparent who the person responding was, but noting that efforts were still underway to rescue Mr Hondow from inside the *Cygnets Lass*, and that he was responding by knocking on the hull, it is possible that Mr Hawkins's question was misunderstood as being directed to Mr Hondow's condition.
246. Mr Hondow initially lost his bearings when the vessel rolled and capsized. He then gained his orientation and was able to lift his head above water into an air pocket. He felt as though he was there for a half, to one hour. He then heard tapping on the hull. He returned the knock and continued to answer the knocks he heard from the outside.
247. A diver located Mr Hondow and rigged him up for, and effected, a 'piggyback' out from under the boat. During that maneuver Mr Hondow in his confusion and fatigue pulled his mouthpiece out and grabbed the divers leg. The diver returned and grabbed Mr Hondow and pulled him to the surface as quickly as he could with no oxygen. Mr Hondow gasped and was placed straight into the rubber ducky inflatable rescue boat on standby.

Efforts to Revive Mr Cunningham

248. Mr Hawkins deposes that Mr Cunningham was brought over to his tender and that he helped pull him into the tender. Mr Hawkins further deposes that Mr Cunningham was "unconscious" and covered in oil. He was unable to determine whether or not he had a pulse. Once Mr Cunningham was in the tender he was immediately transferred to

the vessel '*Rescue Bowen*' where Constable Gasparotto and SC Kreymborg were positioned.

249. As Mr Hawkins tender pulled up alongside the *Rescue Bowen*, Constable Gasparotto deposes to hearing a person in the tender say: "*he's got a pulse*". Noting the period of time Mr Cunningham had been immersed, the observations of Mr Outram and Mr Hawkins I am unable to accept that Mr Cunningham had a pulse. The only person he deposes to having checked, prior to the transfer onto the *Rescue Bowen*, was Mr Hawkins who was unable to determine whether or not a pulse was present.
250. Immediately after Mr Cunningham was transferred onto the *Rescue Bowen*, Constable Gasparotto took over efforts at resuscitation. He checked for a pulse but does not depose to finding one. He then commenced CPR on Mr Cunningham. Constable Gasparotto observed that Mr Cunningham was "unresponsive, unconscious and not breathing and that his eyes were open".
251. As Constable Gasparotto performed CPR on Mr Cunningham he observed water flowing from his mouth with each compression. Constable Gasparotto heard SC Kreymborg state: "*I can't feel a pulse*". Constable Gasparotto estimates he continued CPR for another 20 minutes, during which the vessel '*Rescue Bowen*' travelled to meet with the *Svitzer Naiad*, where ACP Curtis was positioned. ACP Curtis boarded the *Rescue Bowen* at 11:53am and assisted with resuscitation efforts.
252. Whilst those efforts were underway, one of the helicopters (from Mackay) that had been tasked by Sergeant Pegg arrived at the scene. Onboard that helicopter was Critical Care Paramedic (CCP) Peter McMillan. CCP McMillan was lowered from the helicopter onto the vessel *Rescue Bowen*. CCP McMillan confirmed that Mr Cunningham was in asystolic cardio-respiratory arrest.
253. Efforts at resuscitation with CPR were maintained. CCP McMillan then intubated Mr Cunningham whilst ACP Curtis gained intravenous access. During resuscitation, Mr Cunningham was administered 3 x 1000 micrograms of adrenaline bolus doses and 100 millilitres of sodium bicarbonate.
254. Mr Cunningham did not respond to any of those efforts at resuscitation.
255. Mr Cunningham was formally declared deceased at 12:23pm.

Post-Mortem Examination

256. A post-mortem examination was performed on 27 May 2016.
257. The only signs of recent external injury were:
- a) A red area to the forehead measuring 8cm x 5cm;
 - b) Bruised abrasions at the right costal margin measuring 2.7cm and 2cm
258. Such injuries would be consistent with the initial impact between the vessels and the subsequent rolling of the *Cygnets Lass*.
259. The (limited) internal examination did not identify any internal injuries

260. Examination of the lungs identified features of congestion and oedema. Microscopic examination of the lungs identified dilated appearance to the alveolar spaces that was typical of drowning; occasional haemorrhage was also noted. There was some gastric content noted in the airway, although the Pathologist considered that may have been a result of resuscitation efforts.
261. Toxicology analysis of a carotid blood sample did not identify the presence of any drugs or alcohol.
262. It was the opinion of the Pathologist that cause of death was:
- 1(a) Drowning
As a consequence of
- 1(b) Capsized boat
263. I accept and adopt that cause of death for the purpose of these findings.

Data

Cygnnet Lass

264. The *Cygnnet Lass* had worked out of Bowen for about 6 months prior to the incident. It was fitted with a Sailor 6150 Inmarsat C terminal Vessel Monitoring System (VMS), this VMS data is captured by the Australian Fisheries Management Authority. The vessel's VMS data on the day of the incident polled within the Bowen Harbour and did not assist with course or speed information when leaving North Entrance prior to collision. The VMS data for the previous 6 months showed the vessel transiting the same area out of Bowen.
265. Three (3) on board computers were recovered from the *Cygnnet Lass* wreckage. All were transported to the Forensic Computer Examination Unit, Australian Federal Police (Canberra) for examination. It was hoped that recent tracking and other data may be recovered from these three items even though they had been submerged in salt water for some time. Some data was retrieved however there was no course or speed data recovered (at that time).
266. In the absence of firm course and speed data a set of reasonable assumptions were developed by the Queensland Police Service as to the likely course, and likely speed of the of the *Cygnnet Lass* whilst in the Harbour and in open water.
267. Those assumptions placed it on a course somewhere between 038 degrees and 47 degrees prior to the collision.
268. The *Cygnnet Lass* was fitted with an Automatic Identification System (AIS) communication device however it was a receiver only, therefore no speed, course or vessel identification data was transmitted from the *Cygnnet Lass* back to the receiver.
269. The AIS system is not a substitute for radar, however the absence of any AIS transmission from the *Cygnnet Lass* meant any other vessel being operated in the area, that was receiving AIS data would not have been able to identify the *Cygnnet Lass*. This

is particularly relevant when considering the observations made by the Master Petersen of the *Diamantina* namely a “small object within five hundred metres” of the *Svitzer Nana*.

270. Noting the importance of ‘black box’ data to understanding the sequence of events immediately before any collision, the capacity of the *Cygnets Lass* to transmit data in real time, and have that data recorded remotely, would also have overcome the issue in terms of the recovered, but degraded, on board computers.
271. On Friday, 4 May 2021, further submissions on behalf of Mrs Cunningham were made by her legal representatives. Those submissions included a Statutory Declaration by her and a Mr David Luckman, who holds experience in computers and data recovery, in which they set out steps taken that ultimately resulted in the successful retrieval of course and speed data from the Maxsea system onboard the *Cygnets Lass*.
272. The last known coordinates (at 9:58am on 25 May 2016) were S20°00.410’ and E148°17.732’. The *Cygnets Lass* was on a heading of 042 degrees as it came through the heads but was closer to 50 degrees (after a slight turn to starboard) before the collision.
273. That data substantially (though not exactly) accords with the assumptions developed by the Queensland Police Service.

Svitzer Nana

274. The *Nana* was fitted with an Automatic Identification System (AIS) communication device that included transmission capacity.
275. AIS data was obtained for the *Svitzer Nana* and showed the vessel on track of 340 degrees true and steaming at 10.5 knots prior to the incident. This recorded data was obtained from the Australian Maritime Safety Authority - ‘Craft Tracker’ system. The data is consistent with the statements given by the crew of the *Svitzer Nana* and the observation of Mr Russell.
276. An examination of the Furuno Navnet system on 27 May 2016 did not reveal any previous navigational records. Importantly enquiries were made with the manufacturer to determine if there was any capacity for a storage card to be inserted or removed. The manufacturer confirmed there was no such capacity on that equipment; whilst there is a port that allows a PC to be connected to the Navnet system it is for software upgrades only.
277. An examination of the Furuno AIS system also revealed that it was working correctly.
278. On 28 April 2016 (less than a month before the collision) a Radio Communications Equipment Survey was conducted on the *Svitzer Nana*. This involved a check of the two Furuno VHF radios. They were both working correctly at that time.

Diamantina

279. No data was sought or obtained from the *Diamantina*.

Investigation

Weather

- 280. At the time of the collision the weather conditions were near-perfect with relatively flat seas and only light winds. Visibility was also very good. Several photographs taken during the time of the rescue show the good weather on the day of the incident.
- 281. There was very little tidal movement that day around Bowen with low at 6:05am that morning of 1.34m, and high tide at 11:33am of 2.04m.
- 282. Data from the Bureau of Meteorology (BOM) monitoring station at Bowen Airport indicates there was a south-easterly wind gust of 13km/h around the time of the collision.

Log-Books

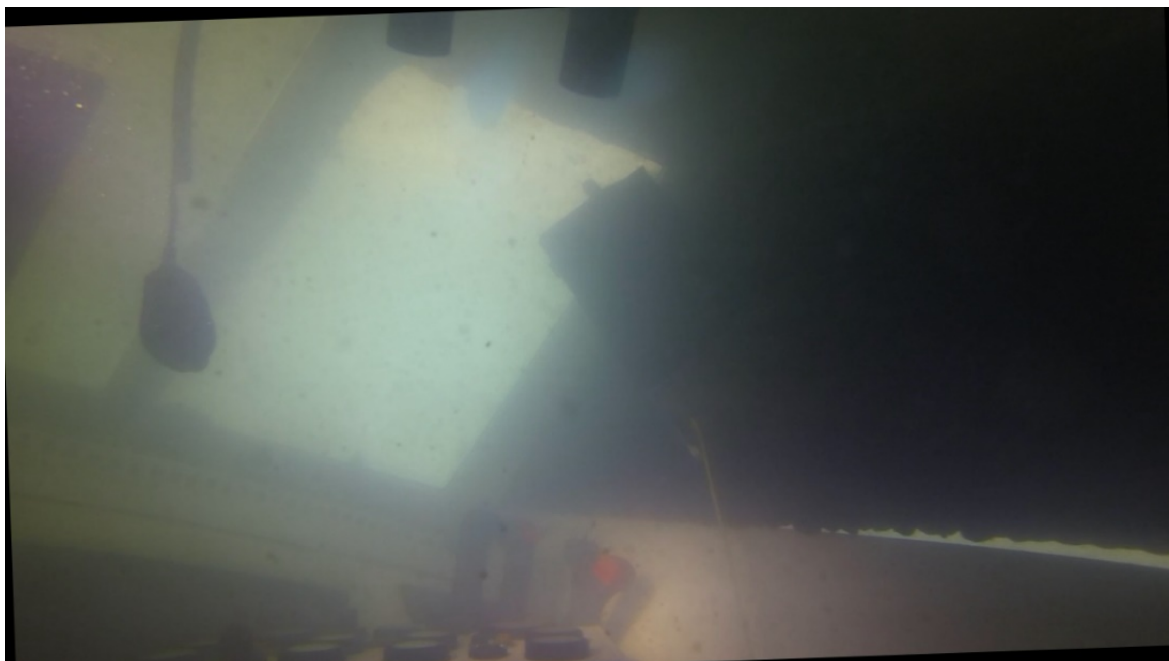
- 283. *Svitzer Nana's* log-books were examined by police and appeared satisfactory with the one exception. Mr Quadrell had not signed the Masters Standing Orders that were located in the bridge area of the *Svitzer Nana*.
- 284. With respect of the *Cygnat Lass*, police found evidence of an Operations Manual aboard and other fishing record books. Police also located a 2016 diary with some maintenance items noted a few months prior, no log-book for the vessel was located. All of these records were severely water damaged and beyond repair.

Forensic Examination

- 285. The collision occurred when The *Nana* impacted on the starboard side of the *Cygnat Lass* slightly aft of amidships. Statements from the surviving crew of the *Cygnat Lass* depose that the vessel rolled over several times. Photographs taken by police divers of the *Svitzer Nana's* hull suggest that the *Svitzer Nana* travelled over the top of the *Cygnat Lass*; this would account for the rolling motion described.
- 286. When the *Cygnat Lass* was sighted by crew of the *Svitzer Nana*, the bow section was upturned and buoyant in the wake of the *Svitzer Nana* and the stern section had broken off the *Cygnat Lass*.
- 287. The *Cygnat Lass* was salvaged, and the two sections were placed together at a holding yard at Bowen for further inspection. Prior to being salvaged, Senior Constable Matthew Guitman (a member of the Queensland Police Service Diving Unit) conducted a dive on the wreckage between. SC Guitman obtained video footage and still photographs from inside the *Cygnat Lass*. During this dive it was documented that starboard side wheelhouse curtain was drawn over. The curtains remained closed after salvage.
- 288. Mr Doug Matchett, Naval Architect and Technical Investigator with AMSA inspected the *Cygnat Lass* on 26 May 2016, and provided and concluded that the curtain was likely drawn at the time of the incident. He deposed:

"These curtains were also sighted as closed in the underwater inspection of this section of the vessel by Queensland Police Divers. The design of the

curtains with cable runners top and bottom required some force to open and close due to the friction of the curtain fabric against the cable – I am therefore of the opinion that the curtains would have had to have been closed prior to the time of the incident occurring and were not closed as a result of the incident.”



289. Whilst I accept the evidence that the curtains were not drawn when the *Cygnat Lass* departed Bowen Harbour I am satisfied and find that at some stage after departure, the starboard side curtain was drawn over.

290. A diagram by Forensic Crash Investigator documented impact marks from the *Svitzer Nana* on the starboard side of the *Cygnets Lass* about amidships. Black marks on the side of *Cygnets Lass* appear to be marks transferred from the large black tire fenders on the front of the *Svitzer Nana*. Fiberglass pieces believed to be from the *Cygnets Lass* were located by police scenes of crime officers on the stern of the *Svitzer Nana*.
291. Police divers inspected the *Svitzer Nana* and both sections of the *Cygnets Lass*. There was scarring and marks found along the underwater section of the *Svitzer Nana* from the front to the rear of the vessel including marks to the nozzles near the stern of the tug.
292. Upon review of the photos taken during the examination it is noted that the door leading from the deck onto the bridge of the *Cygnets Lass* had been removed. This is consistent with the version given by Mr McGuire. I also note that two clear view windows on the bridge were shattered. Noting the obstructions that were detected to the door, it seems more likely that Mr Cullen had been able to successfully exit via one of the clear view windows.



Drugs and Alcohol

293. Crew of the *Svitzer Nana* underwent drug and alcohol testing. No substances were detected in any of the crew.
294. A toxicology report prepared in relation to Mr Cunningham did not detect any alcohol or other drugs in his system.
295. I am not advised whether Messrs Hondow or Cullen, were required to give samples and if so what the results of any analysis was.

Re-enactment

296. A re-enactment of the incident was conducted on 28 May 2016. Vessels were placed on course and speeds similar to the presumed courses prior to the collision.
297. The *Svitzer Nana* was used for the re-enactment and a vessel similar to the *Cygnets Lass* named *Ace IV* was used. The *Ace IV* was operated by its owner Mr Evan Morgan. The *Ace IV* is a Westcoaster design that was 13.97 metres in length and 4.5 metres in beam. To that effect it was smaller than the *Cygnets Lass* which in my view made the re-enactment extremely useful to understand how visible the *Cygnets Lass* would have been to crew on either the *Svitzer Nana* or *Diamantina*.
298. The *Ace IV* was skippered by Mr Morgan, also aboard was Sergeant Matthew Pegg of Townsville Water Police; and Marine Safety Inspector (MSI) Mr Kevin Schindler of AMSA. Video footage was taken aboard the *Ace IV* by Scenes of Crime (SOC) officer Sgt Reece during the re-enactment.
299. During the re-enactment Mr Morgan operated the *Ace IV* at 7.5 knots on a course of 40 degrees true and approached on a collision course with the *Svitzer Nana*. During this approach Mr Morgan commented that:
- "the tug and wake from the tug was obscured from vision by a window frame at the forward starboard side of the wheel house".*
300. Mr Matchett, in his inspection of the *Svitzer Nana*, agreed that there were restrictions on visibility, from the controls panel. Mr Matchett also identified issues with the positioning of the radar monitor.
301. The monitors were not in direct view of the helm when the helm is positioned at the forward end of the conning station. They also appeared to be affected by sunlight when the sun is positioned over the starboard side of the vessel. The screens are not visible when viewed side on (i.e. at a viewing angle towards 90 degrees).



302. The following image depicts the configuration of the controls on the *Svitzer Nana*:
303. During the re-enactment the *Svitzer Nana* was operated on her course of 340 degrees true at 10.4 knots. Aboard the *Svitzer Nana* were Svitzer crew, Sergeant Graeme Pettigrew of Whitsunday Water Police, MSI Doug Matchett (AMSA).
304. Video footage was taken from aboard the *Svitzer Nana* by scenes of crime officer Senior Constable Schubert. It was noted during the re-enactment that there was a good radar echo of the vessel Ace IV throughout the trials. It was noted by officers that large window mullions (supporting structure between the glass windows) of the *Svitzer Nana*'s helm could obscure the view of the Ace IV, depending on where the observer was positioned.
305. I have also had regard to a photo taken during the re-enactment in which the Ace IV was visible to port without obstruction from the mullions or exhaust stack:

Queensland Police Service - Forensic Services

Image 2994838-DSC00018.JPG



Source QP1600924429 FR1523725 2994838-DSC00018.JPG 2016-05-28 11:52:10 4005251 - Svitzer Nana: screen shot from video during runthrough

306. After re-enacting the collision approach the *Svitzer Nana* and Ace IV steamed in opposite directions to test visibility. It was noted that at 2, 3 and 4 nautical miles apart the *Svitzer Nana* was clearly visible to the naked eye and good radar image was received of Ace IV on the radar of *Svitzer Nana*.
307. The visibility of the Ace IV was from the *Svitzer Nana* at 2, 3 and 4 nautical miles is unknown. This would be especially relevant noting, that the Diamantina was between 1 and 1.5 nautical miles behind the *Svitzer Nana* and the Master of the Diamantina (Master Petersen) was able to observe the *Svitzer Nana* and 'a small object' about 500 metres off its port bow. Noting that 500 metres would equate to 0.27 nautical miles this would mean that the Diamantina was no more than 2 nautical miles from the 'small object'.

308. Notwithstanding that, the re-enactment was beneficial in that it showed the vessels closed on a collision course resulting from a crossing situation. It showed that both vessels were clearly visible to the other for quite some time prior to the collision. It also showed that both ships were visible to the other ship on their respective radars.
309. I am not advised whether during this re-enactment, any testing was done of collision alarm systems on the *Svitzer Nana* to determine if, had they been activated, they would have alerted to presence of the Ace IV.

Vessel Inspection – Cygnet Lass

310. At the time the *Cygnet Lass* was constructed, it was subject to survey standards under the Western Australia Marine Act 1948. However, from 1 July 2013, the Marine Safety (Domestic Commercial Vessel) National Law 2012 came into effect and replaced the Western Australian legislation. 'Grandfathering' arrangements as part of that legislative change, meant that the construction, operating and crew requirements for the *Cygnet Lass* (and other vessels) were preserved, provided its operation remained the same.
311. However, under the new National Law I modifications or alterations are made to an existing vessel, that would affect its construction or a change in operation of the vessel that would increase risk [my emphasis], the vessel would need to be re-assessed as a new vessel in accordance with the current standards.
312. It was the opinion of Mr Matchett that the modifications to the *Cygnet Lass* should have been the basis of a notification to the National Regulator. He also considered that the extended operation of the vessel (outside the 100 nautical mile condition), in conjunction with the modifications may have presented more risk, thus requiring it to be re-assessed.
313. Any re-assessment as a 'new vessel' would have included reference to standards for visibility under the Uniform Shipping Laws (USL) Code. It was the opinion of Mr Matchett that some of the modifications would have constituted a contravention of the USL Code. Whilst the presence of the curtains themselves were not identified as a potential contravention, in circumstances where they were drawn over on the starboard side, this would have been a contravention of visibility requirements as well as the lookout provisions for the International Regulations for Preventing Collisions at Sea (COLREGS).

Vessel Inspection – Svitzer Nana

314. Records did not indicate that the *Svitzer Nana* had been subject to any review of its visibility during construction. It was the opinion of Mr Matchett at the time of entering commercial operations in Queensland (like the *Cygnet Lass*), The *Svitzer Nana* would also have been required to comply with visibility requirements. It was the opinion of Mr Matchett that the position of the exhaust stack on the *Svitzer Nana* would have been non-compliant.
315. Mr Matchett considered that there was no one position within the wheelhouse of the *Svitzer Nana* where it would have been possible to obtain 360 degree visibility, as such, the person on watch duty would have been required to constantly alter their position in order to maintain a proper lookout. The positioning of the radar screen

behind the periphery of the forward coning position would have further restricted the ability of any lookout to maintain a view of their surroundings.

316. It was the opinion of Mr Matchett that visibility towards the Rear of the *Svitzer Nana* was “extremely limited” within a 15-20 degree sector due to the presence of the exhaust stacks.

Convention on International Regulations for Preventing Collisions at Sea

317. The rules of avoiding a collision at sea are stipulated by the 'Convention on International Regulations for Preventing Collisions at Sea 1972'; commonly as the 'ColRegs'.
318. The crews of the *Cygnat Lass* and the *Svitzer Nana* should have made visual contact with each other but nonetheless maintained a collision course for some time prior to impact.
319. The Watch keepers on both vessels involved in the incident had a requisite knowledge of the rules and all had many years of experience on the water.
320. If the vessels had both seen each other, then rules relating to a crossing situation would have been applied and the collision avoided.
321. A report was sought from the Assistant Regional Harbour Master (ARHM) at Gladstone Port, Ms Jennifer Tumbers. ARHM Tumbers is the holder of the Master Class 1 and has 7 years-experience as an AMSA Marine Surveyor.
322. The information given to ARHM Tumbers was:
- a) Course of *Svitzer Nana* - 340°T, speed 10.4 knots.
 - b) Assumed course of *Cygnat Lass* was from the North Entrance 'N2 beacon' to the position of collision (38°T and from the North Entrance 'N1 buoy' to the position of collision (47°T)
 - c) *Cygnat Lass* speed at 6.5 knots.
323. Based on the information provided Ms TUMBER deposed as follows:

“Based on the information supplied regardless of whether the Cygnat Lass was on a course from the N1 or N2 or anywhere in between, the Cygnat Lass was a crossing vessel and therefore the give way vessel

Cygnat Lass should have taken appropriate action to avoid collision by either making bold alteration of course to pass astern of the Svitzer Nana; reducing speed, or altering course and reducing speed.

Svitzer Nana was the stand on vessel and would have maintained her course and speed however when it became apparent to the Master of the Svitzer Nana that the Cygnat Lass' aspect was not changing and a risk of collision existed the Svitzer Nana's Master had an obligation to make bold alteration of course (away from the Cygnat Lass), reduce speed, or both alter course and reduce speed so as to avoid collision”

324. These same conclusions were reached by Mr Matchett of AMSA.

Rule 5 – 'Lookout'

325. In accordance with the International Regulations for Preventing Collisions at Sea 1972 (Part B - Steering and Sailing Rules), Rule 5 requires that:

Every vessel shall at all times maintain a proper look-out by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and of the risk of collision.

326. The word 'shall' is not discretionary.

327. In this case it was the responsibility on the Watch Keepers on both the *Cygnat Lass* and the *Svitzer Nana* to 'keep a proper lookout'. The Watch Keeper on each vessel failed in this respect.

Rule 7 - 'Risk of Collision'

328. In accordance with the International Regulations for Preventing Collisions at Sea 1972 (Part B - Steering and Sailing Rules), Rule 7 requires that:

Every vessel shall use all available means appropriate to the prevailing circumstances and conditions to determine if risk of collision exists.

Proper use shall be made of radar equipment if fitted and operational, including long range scanning to obtain early warning of risk of collision and radar plotting or equivalent systematic observation of detected objects.

Assumptions shall not be made on the basis of scanty information, especially radar information.

In determining if risk of collision exists the following considerations shall be among those taken into account:

Such risk shall be deemed to exist if the compass bearing of an approaching vessel does not appreciably change

Such risk may sometime exist even when an appreciable bearing change is evident, particularly when approaching a very large vessel or a tow or when approaching a vessel at close range.

Rule 15 – 'Crossing Situation'

329. In accordance with the International Regulations for Preventing Collisions at Sea 1972 (Part B - Steering and Sailing Rules), Rule 15 requires that:

When two power driven vessels are crossing so as to involve risk of collision, the vessel which has the other on its own starboard side shall keep out of the way and shall, if the circumstances of the case admit, avoid crossing ahead of the other vessel.

330. In this case the *Cygnat Lass* was the 'give-way' vessel as it had the *Svitzer Nana* on its starboard side. The *Cygnat Lass* held the obligation to change course so as not to

cross the path of the *Svitzer Nana*. However this did not obviate the need for the *Svitzer Nana* to also take steps to avoid a collision.

Rule 17 – ‘Action by Stand On Vessel’

331. In accordance with the International Regulations for Preventing Collisions at Sea 1972 (Part B - Steering and Sailing Rules), Rule 17 requires that:

“Where one of two vessels is to keep out of the way the other shall keep her course and speed. The latter vessel may however take action to avoid collision by her manoeuvre alone, as soon as it becomes apparent to her that the vessel required to keep out of the way is not taking appropriate action in compliance with these Rules.

When, from any cause, the vessel required to keep her course and speed finds herself so close that collision cannot be avoided by the action of the give-way vessel alone, she shall take such action as will best aid to avoid collision.

A power-driven vessel which takes action in a crossing situation in accordance with subparagraph (a)(ii) of this Rule to avoid collision with another power-driven vessel shall, if the circumstances of the case admit, not alter course to port for a vessel on her own port side.

This Rule does not relieve the give-way vessel of her obligation to keep out of the way.”

332. In this case, whilst the *Svitzer Nana* was permitted to maintain its course and speed, once it became apparent the *Cygnat Lass* was not taking appropriate action to comply with Rule 15 to give way, and therefore was not taking action of itself to avoid the collision, the *Svitzer Nana* was required to take such action as was best to avoid the collision. It failed to do so.

Installation and use of Collision Warning Systems

333. There are no standards directly applicable to the use of autopilot systems on vessels operating in and out of a harbour. The relevant legislation imposes overarching general safety duties on domestic commercial vessels, including the safe operation of such vessels. It is the responsibility of each vessel to implement, comply with and maintain a safety management system. Best practice suggests that such managements systems should contemplate the use of autopilot systems and consider the complexity of the environment in which a vessel is operating, including the volume of traffic operating in the same area.
334. It was the opinion of AMSA that the *Cygnat Lass* was not required to be fitted with AIS or Closest Point of Approach (CPA) equipment at the time of the collision. In that regard I am satisfied that there were no issues of non-compliance with respect of the radar and navigation systems on the *Cygnat Lass* at the time of the collision.
335. It was the opinion of AMSA that the *Svitzer Nana* was required to be fitted with AIS and CPA equipment at the time of the collision. It was the opinion of AMSA that the *Svitzer Nana* was compliant with its radar and navigation system requirements.

Historical incidence of Collisions

336. In the course of this investigation information was sought as to frequency of marine complaints concerning tugboats operating at Bowen Harbour and Abbott Point.

337. I have been assisted by data from Maritime Safety Queensland as follows:

	Abbot Point	Bowen
2009	1	
2010	2	
2011		
2012		
2013		
2014		
2016		1
2017		
Total	3	1

338. The single incident recorded at Bowen in 2016 was the collision between the *Cygnat Lass* and the *Svitzer Nana*. The collision between the *Cygnat Lass* and the *Svitzer Nana* was the only collision between vessels at any of those ports in the period identified.

339. Incident categories (for other ports) include:

- a) Collisions during berthing
- b) Collisions with wharf / jetty
- c) Mechanical / equipment failure
- d) Onboard injury; or
- e) Person overboard

340. Having regard to the available data I am satisfied that the collision that occurred between the *Svitzer Nana* and the *Cygnat Lass* was an aberration and that otherwise no marine complaints of any nature, or collisions, are recorded for Bowen Harbour.

Other Matters

341. I have been advised since these events Mr Quadrell succumbed to cancer and died in 2017. Mr Quadrell was undergoing cancer treatment at the time of or before the collision. Mr Cunningham's next of kin have raised a concern as to his medical fitness to perform duties on the day of the collision.

342. I have since called in the personnel file of Mr Quadrell, to the extent of his fitness for work. I note that on 18 December 2015, his General Practitioner issued a Medical Fitness Certificate (valid for 2 years from date of issue) confirming his fitness for work.

Findings

343. Both the *Cygnat Lass* and the *Svitzer Nana* closed on a collision course and in those circumstance both vessels were required to take action, regardless if as the stand on

vessel or the give way vessel, both had a responsibilities to avoid the collision in accordance with the International Regulations for Preventing Collisions at Sea 1972.

- 344. In this case a commercial fishing vessel and a tugboat approached on a collision course for an extended period of time and remained unaware of the approaching vessel until the point of collision.
- 345. The collision can be explained by a failure to keep physical watch by both vessels. Further there was equipment installed on each vessel that if utilised or activated, may have mitigated or overcome the human error that was at play. Experienced crew did not make full and proper use of their equipment, including a close proximity alarm which was not activated at the relevant time.
- 346. In circumstances where both vessels were operating with blind spots in place it was imperative for the watch keepers to move about the vessel and obtain different lines of sight from time to time to compensate.

In accordance with s.45 of the Coroners Act 2003 I find as follows:

- 347. The deceased is Martin Sydney Cunningham.
- 348. Martin Cunningham was one of three crew members on board the FV *Cygnat Lass*, when it was involved in a collision with the tug *Svitzer Nana* at approximately 10:05am on 25 May 2016 at co-ordinates Latitude 20° 00'.343 South, Longitude 148° 17'.766 East.
- 349. The collision caused the *Cygnat Lass* to break in two. All crew members were in the bow section when the *Cygnat Lass* broke up. The bow section rapidly took on water but remained buoyant after the collision.
- 350. Mr Ryan Cullen successfully exited the bow section, most likely through one of two shattered clear view windows located on the bridge. He resurfaced and raised the alarm that Mr Cunningham and Mr Hondow were still trapped. Neither crew member observed Mr Cunningham after the collision.
- 351. Following the collision, the first call made by the *Svitzer Nana* was to its communications centre based in Brisbane. That call was placed at 10:14am. That call resulted in a notification being made to the Abbott Point terminal at 10:17am and a '000' call to the Queensland Police Service, which commenced at 10:16am.
- 352. Independently of those calls, at 10:20am Senior Marine Pilot Kim Macpherson, who was onboard the nearby vessel *Diamantina*, initiated a call to the Regional Harbour Master at Townville which resulted in a search and rescue operation being commenced by the Queensland Police Service.
- 353. The search and rescue was facilitated utilising the combined efforts of other vessels operating nearby, the Queensland Police Service, and *Svitzer Australia*. The first people to gain access to upturned bow section were Mr Douglas McGuire, a Marine Salvage Engineer employed by *Svitzer*, Mr Dean Wagstaff, Skipper of the vessel *Maharani* and one of its crew members, Mr Jason Outram.

354. The combined efforts of Mr McGuire, Mr Wagstaff and Mr Outram resulted in locating Mr Cunningham. Mr Cunningham was found floating inside the bridge area of the *Cygnets Lass*, access to which had been impeded by a door and debris until removed by Mr McGuire and Mr Wagstaff. Mr Cunningham was located by Mr Wagstaff sometime between 11:17am and 11:33am, more than an hour after the collision.
355. Mr Wagstaff resurfaced and called out to other people assisting with the search and rescue. Mr Outram, without the assistance of any breathing apparatus entered the water, dived under the surface, and assisted Mr Wagstaff to recover Mr Cunningham from inside the bridge area.
356. Mr Cunningham was then brought to the surface and transferred into a nearby tender. The first person to assess Mr Cunningham was Mr Andrew Hawkins, a Marine Pilot employed by the Port of Townsville who had been on board the *Svitzer Nana* at the time of the collision. Mr Hawkins was unable to determine whether any pulse was present.
357. Mr Cunningham was retrieved into the tender and quickly transferred to another nearby vessel, *Rescue Bowen*, that had arrived at the scene in response to the initiation of the search and rescue. On board were two Queensland Police Officers, Senior Constable Kreymborg and Constable Gasparotto, both of whom immediately commenced efforts at resuscitation.
358. Neither Senior Constable Kreymborg nor Constable Gasparotto were able to detect a pulse. Mr Cunningham was observed to be “unresponsive, unconscious and not breathing and that his eyes were open”. They continued their efforts at resuscitation for about 20 minutes, until the arrival of Advanced Care Paramedic (ACP Gene Curtis) and Critical Care Paramedic (CCP Peter McMillan) at 11:53am.
359. ACP Curtis and CCP McMillan took over efforts at resuscitation. They intubated Mr Cunningham and administered adrenalin to him. Mr Cunningham did not respond to any of those efforts at resuscitation and was declared life extinct at 12:23pm, some two hours after the collision.
360. I find there was no mechanical defect in either the *Cygnets Lass* or *Svitzer Nana*, nor any malfunction in any of their navigation, proximity alert or collision alarm systems that contributed to the collision.
361. Both vessels were equipped with collision monitoring alarms. I find that these close proximity alarm systems were not activated on either the *Cygnets Lass* or the *Svitzer Nana* at the relevant time. I infer from all of the material before me that the alarms on both vessels were intentionally turned off (or not activated) at the time.
362. Martin Cunningham died on 25 May 2016.
363. Martin Cunningham died at Bowen, Queensland.
364. Martin Cunningham’s cause of death was drowning.
365. I find at the time of the collision the *Cygnets Lass* was operating on autopilot whilst Mr Cunningham and the crew of the *Cygnets Lass* were engaged in vessel maintenance. In the absence of any monitoring of the navigation systems or activation of the alarm

systems aboard the *Cygnets Lass*, the only other means by which Mr Cunningham or the crew might have become aware of the presence and course of the *Svitzer Nana* was by visual reckoning.

366. I find there was no active watch being kept on the *Cygnets Lass* at the time of the collision and I find that a drawn curtain on the starboard side of the bridge impeded the ability of Mr Cunningham or any crew member to be visually alerted to the presence of the *Svitzer Nana*.
367. I find that there was a failure by Mr Cunningham to maintain a proper lookout.
368. I find that notwithstanding the presence and operation of navigation equipment and alarm systems onboard the *Svitzer Nana*, capable of detecting the presence of the *Cygnets Lass*, and capable of alerting crew to the risk of a collision, no crew member held any knowledge of the presence and course of the *Cygnets Lass* prior to the collision.
369. I find at the time of the collision the *Svitzer Nana* was operating on autopilot and Mr Quadrell was on watch duty. I find that Mr Quadrell was medically fit to perform duties that day. Mr Quadrell was monitoring navigation systems whilst he was on duty. A subsequent re-enactment confirmed the *Cygnets Lass* would have been visible on those navigation systems as the vessels approached on their collision course. The inference that I draw is that Mr Quadrell did not either check or defer to the onboard navigation systems, or that he did not do so effectively or with sufficient regularity. Those checks were not continuous or sufficiently regular to enable him to identify the presence of the *Cygnets Lass*.
370. The bridge of the *Svitzer Nana* did not afford a 360° view, and peripheral vision was also partially obscured by the presence of window mullions and exhaust stacks.
371. Notwithstanding those obstructions I find that the *Cygnets Lass* was capable of being observed sometime prior to the collision. I find that whilst the Watchkeeper and the Lookout on the *Svitzer Nana* maintained a visual watch of the surrounding waters, they did not maintain continuous or sufficiently regular checks of the peripheral areas of the bridge and failed to keep proper lookout. They would otherwise have observed the *Cygnets Lass*.
372. I find that the collision between the *Cygnets Lass* and the *Svitzer Nana* could have been prevented.
373. Neither vessel maintained a proper lookout. The 'Laws of the Sea (ColRegs)' placed first obligation on the *Cygnets Lass* to maintain a proper lookout (after the change of course by the *Svitzer Nana* at 9.47am), the obligations on the Watchkeeper and the Lookout crewing the *Svitzer Nana* to maintain proper lookout are not negated as a result. The size and power differentials of both vessels are obvious and heightened vigilance is required in a harbour setting shared by fishing, commercial and recreational vessels.
374. The collision could have been avoided, and it therefore follows that the death of Mr Martin Cunningham could have been avoided.

375. The inattention of Mr Cunningham and both the Watchkeeper and the Lookout on the *Svitzer Nana* gave rise to a situation where both vessels were on a collision course for a significant time, such that the occupants of a recreational craft (the 'tinny') in the area at the time could foresee the likely outcome.
376. I can account for Mr Cunningham's activities whilst not on lookout (cleaning duties), however I cannot account for Mr Quadrell's or Mr Male's inattention and note the benefit of the *Svitzer Nana*'s sophisticated onboard navigation equipment to alert. The presence of the *Cygnets Lass* would have been obvious if visually and vigilantly scanning the waters.
377. Both vessels were in the same waters for at least 35 minutes prior to collision, although likely not in sight of each until sometime after.
378. The manner in which Svitzer employees reported the incident to external agencies was inconsistent with the initial information provided by Master Stephens, most likely flowing from a legal response that was then taking effect within Svitzer, however I find that this did not impede, hinder or alter the commencement and continuation of the search and rescue (SAR) mission.
379. The emergency response was timely and appropriate.
380. The divers who undertook the rescue of Mr Hondow and the recovery of Mr Cunningham in difficult conditions are worthy of special recognition. Those persons are Mr Brian John Mecklem, Mr Dean Raymond Wagstaff and Mr Jason Llew Outram and Mr Douglas Glenn McGuire.
381. Martin Cunningham was a competent and professional commercial fisherman and seaman. On 25 May 2016 he set off for a voyage he had undertaken many times before. His commitment to meticulous preparations inside the FV *Cygnets Lass* that day created a diversion that led to a period of inattention from his role as lookout and at the same time crew on the *Svitzer Nana* failed to attend to obligations to maintain a proper watch. Neither vessel was aware of the presence and course of the other because proper lookout was not maintained by either and radars that would have detected the proximity of the other vessel had not been activated by either vessel.
382. The collision resulting in the death of Mr Cunningham was a tragic although preventable accident arising from human error.

Acknowledgements

The draft findings into Mr Cunningham's death were widely circulated in September 2019 with a Notice of Inquest. A pre-inquest conference commenced on 21 February 2020, and on 19 March 2020 the inquest was delisted due to Covid-19 restrictions across all Queensland Courts. Revised draft findings were sent to all with a sufficient interest in September 2020 inviting submissions. The last submission was made to the Office of Northern Coroner on 24 May 2021.

The coronial investigation has therefore been a significant undertaking and I thank all legal representatives for the assistance they have provided to this investigation. All information was

provided in a timely manner and appropriate concessions were adopted such that the inquest was averted in favour of published non inquest findings.

In particular I wish to acknowledge and thank Mr Joseph Crawfoot, Counsel Assisting the Northern Coroner. His thorough evaluation of all available evidence and his insight and assistance has been invaluable to the investigation into Mr Cunningham's death.

I also thank Ms Lisa Carlsen, Investigations and Inquest Officer within the Office of Northern Coroner for her significant efforts in relation to the file management of this matter and her communication with all parties.

Condolences

I offer my sincerest condolences to Mrs Yvonne Cunningham. Her advocacy on behalf of her son Martin, has been unwavering. I also extend my condolences to Martin's siblings, wider family and his friends. Many have been affected by his untimely and shocking death.

Close of Investigation

I trust that these written findings traverse all relevant issues such that an Inquest can be averted. Further avenues of enquiry are unlikely to yield further relevant evidence to better inform this comprehensive investigation and my findings.

I close the investigation.

Nerida Wilson
Northern Coroner
CORONERS COURT OF QUEENSLAND
NORTHERN REGION
16 June 2021