QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Wai Kim Lam**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2010/1746
DELIVERED ON:	11 August 2014
DELIVERED AT:	Cairns
HEARING DATE(s):	21 July 2014 to 25 July 2014
FINDINGS OF:	Jane Bentley, Coroner
CATCHWORDS:	Coroners: inquest, drowning, Great Barrier Reef, Office of Fair and Safe Work Queensland, non-compliance with investigation; breath hold diving.

REPRESENTATION:

Counsel Assisting:	Ms Stephanie Williams
Office of Fair and Safe Work Qld:	Mr James Sheridan, Counsel
Mr John Heuvel:	appeared unrepresented

Introduction

Section 45 of the Coroners Act 2003 provides that when an inquest is held the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to officials with responsibility over any areas the subject of recommendations. These are my findings, comments and recommendations in relation to the death of Wai Kim Lam. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

These findings, comments and recommendations:

- confirm the identity of the deceased person, the time, place and medical cause of his death;

- consider whether the actions or omissions of any third party, in relation to workplace safety, contributed to his death; and

- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Circumstances surrounding the death of Mr Lam

At the time of his death Mr Lam, a Chinese resident of Hong Kong, was visiting Australia.

He was an experienced spear fisherman and diver. He held a certificate in open water diving from the Professional Association of Diving Instructors. He obtained that certificate in Hong Kong in January 2010.

Mr Lam left Cairns on the morning of 21 May 2010 onboard the vessel *Reef Experience* and transferred to the vessel *Reef Encounter*. *Reef Experience* operates daily and conducts recreational diving and snorkelling activities for day trip clients as well as transferring passengers, crew and supplies from Cairns to the vessel *Reef Encounter*. *Reef Encounter* remains at the reef for extended periods and offers recreational diving and snorkelling activities and overnight accommodation.

The registered owner of both vessels is Reef Encounter Enterprises Pty Ltd. That entity holds Great Barrier Reef Marine Park permits to conduct snorkelling activities at reefs off Cairns including the reef Breaking Patches. The sole director of Reef Encounter Enterprises Pty Ltd is John Dennis Heuvel.

Mr Heuvel is also the sole director of the company Hostel Reef Trips Pty Ltd which previously held similar permits and organizes reef trips on the vessels for paying passengers.

Whilst onboard the *Reef Encounter* Mr Lam completed documentation setting out his diving experience. The documents included a medical declaration and general information about the risks of diving and a liability waiver. All passengers completed such a form. On the back of the form it was stated that all snorkelers should wear wet suits, snorkel in pairs and remain within 100 metres of the vessel.

At about 1pm on 24 May 2010 Mr Lam, along with twelve other passengers, transferred from *Reef Encounter* to *Reef Experience*. Onboard *Reef Experience* were 82 passengers and eleven crew members including Michael Chee, Cody Polglase, and master, John Heuvel.

Reef Experience arrived at a location known as Breaking Patches at Michaelmas Cay at about 1.15pm. A safety briefing was given and then passengers entered the water for snorkelling and diving. Weather and sea conditions were good with a slight breeze and current and underwater visibility of approximately ten metres. Mr Lam entered the water and commenced to snorkel.

Mr Heuvel was acting as the 'look out' from the upper deck of the vessel.

At 3pm the crew took a head count before leaving the reef. This involved checking numbers previously issued to passengers against a list. Mr Lam was number 112. The head count indicated that he was missing. Mr Heuvel was notified of that at 3.10pm and a search commenced. The search was initially carried out onboard the vessel but Mr Lam could not be found.

Mr Polglase took the tender from *Reef Experience* to check two other tenders moored in the vicinity. He then entered the water and snorkelled over the reef to search for Mr Lam. He located Mr Lam lying on the sea floor.

Mr Lam was taken to *Reef Experience* and a passenger who was a doctor, Dr Michelle Murti, assisted the crew with CPR. Dr Murti advised investigators that the crew members were unable to utilize the oxygen resuscitation equipment on board because it was not functional due to there being a part of it missing. Mr Lam remained unresponsive with no pulse and no respiration. Mr Lam was transported by helicopter to the Cairns Base Hospital where he was pronounced deceased.

Mr Lam's diving watch shows that his last dive was to a depth of 16 metres and he remained at that depth for 90 minutes. The last image on his underwater camera was taken at 2.10pm.

Autopsy

An autopsy revealed that Mr Lam died from drowning and at the time of his death he was suffering from coronary artery atheroma. The pathologist noted:

> *The cause of death was drowning most probably following cardiac arrhythmia complicating coronary artery atheroma, but the exact underlying precipitant was not completely clear, and the role (if*

any) of the marine environment was difficult to ascertain. On the basis of the autopsy findings, it appears unlikely that the recent SCUBA experience had any significant role in the death.

Office of Fair and Safe Work Queensland investigation

OFSWQ and Queensland Police Service investigators boarded the vessel and obtained information from passengers and crew. Mr Heuvel told investigators that the snorkelling equipment used by Mr Lam could not be located. He stated that the equipment had belonged to Mr Lam. The resuscitation equipment had been removed from the vessel.

Investigators took statements from passengers Bansal, Lingen and Eisenberg. Documentation was provided by Mr Heuvel being:

- *Reef Encounter* transfers;
- *Reef Experience* transfers;
- Crew time sheet for 24 May 2010 (which recorded that Michael Chee was a senior diver and Cody Polglase was a dive master);
- Ship's log;
- Some notes which had been written on 'sick bags';
- A document entitled 'cash summary'.

Investigators examined the personal effects of Mr Lam and took photographs of a Swatch dive watch and an underwater camera and seized his passport and PADI dive certification card.

The last image found on the camera was taken at 2.10pm. There were video sequences depicting Mr Lam breath hold diving.

Mr Lam's medical declaration form had been sent with him on the rescue helicopter and investigators obtained that document.

Investigators made repeated attempts to obtain statements from Mr Heuvel, Mr Polglase and Mr Chee but they were unable to do so.

OFSWQ inspectors requested Mr Heuvel complete a 'Form 3' i.e. an 'Incident Notification' in relation to the death of Mr Lam. Mr Heuvel advised that he would provide a statement as part of the notification and he would not provide a further statement.

The Form 3 was deficient in that Mr Heuvel failed to complete all parts – there was no information provided as to details of the legal entity that was responsible. Attached to it was an unsigned document which set out, as a time line, the events from 3.10pm on 24 May 2010. This document addressed only the events of the search and rescue and did not provide other relevant information that Mr Heuvel could have provided in relation to e.g. safety procedures, briefings and lookouts on the day.

On 26 May 2010 Mr Chee told investigators that he had been told not to provide a statement but was unwilling to disclose from whom he had received that advice.

On 26 May 2010 Mr Polglase failed to attend the appointment he made at which he said he would provide a statement.

On 31 May 2010 Mr Heuvel told an investigator (Mr Leighton) that, prior to the incident, he had told his crew that providing statements to OFSWQ or QPS was 'unlikely to be in their interests'.

Also on that day Mr Leighton was provided by QPS with letters written by passengers Patrizia Warren and Michaela Bowden.

In June 2010 OFSWQ requested the following information from Hostel Reef Trips Pty Ltd:

1. policy and procedure documents regarding the conduct of snorkelling from *Reef Experience* on 24 May 2010 including those re advice and instruction, lookouts and supervision, accounting for snorkelers, advice to non-English speaking snorkelers, emergency procedures for missing persons and rescue and first aid for snorkelers;
2. records of training or assessment for any workers conducting recreational snorkelling from *Reef Experience* on 24 May 2010 including records for Kimura, Chee and Polglazer (sic);
3. certificates or qualifications of any such workers;
4. certificates or qualifications for any workers who provided first aid to Mr Lam including Polglazer (sic) and Chee;
5. records of any checks made of the oxygen equipment used to attempt to resuscitate Mr Lam;
6. any assessments made of the environmental conditions at the snorkelling site;
7. any assessments made of the number of lookouts required on 24 May 2010;
8. dive safety logs for all dives undertaken by Mr Lam between 21 and 24 May 2010;
9. pay slips for Chee, Kimura and Polglazer (sic) for 24 May 2010;
10. record of payment made by Mr Lam for his trip on *Reef Experience* and *Reef Encounter.*

In response, Hostel Reef Trips Pty Ltd provided the following information:

1. Operation Manual;
2. crew induction forms for Polglase and Hunt;
3. diving qualifications for Hunt, Kimura and Polglase
    a. Kimura's qualification as an Open Water Instructor had expired on 1 March 2010;
    b. Hunt was a qualified Open Water Instructor;
    c. Polglase's qualification as an Advanced Open Water Diver had expired on 19 December 2009;
4. invoice for Polglase for first aid training and O2 provider; first aid

qualification for Kimura; first aid qualification for Hunt; first aid certificate for Heuvel;

   a. Kimura had a valid first aid certificate – his certificate for oxygen had expired on 21 September 2009;
   b. No certificates were provided for Hunt – two invoices were provided stating that he had undertaken a Senior First Aid course and an Oxygen First Aid Provider course on 26 August 2008 – expiry dates unknown;
   c. No certificates were provided for Polglase - an invoice was provided stating that he had undertaken a Senior First Aid course and an Oxygen First Aid Provider course on 22 December 2009 – expiry dates unknown;
   d. A certificate was provided stating that John Heuvel had undertaken a First Aid Instructor Certificate and an Oxygen Provider Instructor Certifier on 22 June 2009;

5. no documentation provided;
6. said to be recorded on dive safety logs;
7. no documentation provided;
8. logs for 8 dives completed by Mr Lam;
9. payroll advice for Kimura, Polglase and Chee;
10. record of booking and deposit in regard to Mr Lam.

During June, July, August and September 2010 OFSWQ and QPS investigators made repeated attempts to obtain statements from Mr Polglase and Mr Chee. All attempts proved to be fruitless.

In October 2010 it was decided by Dean Saunders, Legal Officer, OFSWQ, that the statements would not be pursued and the investigation file was finalized. The following information remained outstanding at that time:

- statement from Mr Heuvel;
- statement from Mr Chee;
- statement from Mr Polglase;
- documents from Hostel Reef Trips Pty Ltd being:
  - records of checks/audits conducted of O2 equipment;
  - confirmation of the legal entity conducting the activity on the reef;
  - records of assessments made in relation to lookouts required on 24 May 2010.

The outstanding issues arising out of the investigation at that time included:

- Supervision by lookout – awareness and additional supervision;
- Number of lookouts;
- Snorkelling briefing content;
- Language issues in relation to communicating with Mr Lam.

Investigators also wished to explore whether Mr Lam, as somebody believed by the crew to be ‘breath hold’ diving, had been provided with an adequate briefing regarding that practice and adequate supervision whilst he was in the water.

It was decided to finalise the investigation for the following reasons:

- The contraventions identified during the investigation had been suitably dealt with by way of improvement notices;
- Those contraventions did not directly contribute to the incident occurring or the resultant injury;
- The information identified as outstanding was required if the investigation was to continue and it was unlikely to be obtained.

The OFSWQ investigators concluded that Mr Lam was breath hold diving at the time of his death.

Crew members/guests

Some of the crew members were tourists who worked on the boat for some of the trip rather than pay the full fee for the tour. Mr Lam was one such guest/crew member. He was working on the boat on 23 May 2010.

Tzachi Eisenberg was also a guest/crew member. He was on the boat for four days – he worked for two days and paid to dive for two days. He had dived with Mr Lam and said that Mr Lam could hold his breath for a long time. He said that Mr Lam seemed very compliant with regulations and rules. He said that the equipment Mr Lam used was that on board the boat and was not his own except for his shirt.

Anthony Lingen was also a guest/crew member. Duties of such persons included cleaning rooms, kitchen duties and laundry. In return they received accommodation and diving at a reduced rate.

Mr Lam's diving

Others on the boat who saw Mr Lam diving and/or dived with him said that he seemed to go off by himself, that he was not conscious of the need to stay with a group or buddy, that he seemed to dive deeper than the others and that he could hold his breath for a long time whilst underwater. He did not wear a wet suit although that was recommended by the crew.

On 21 May 2010 Mr Lingen was diving and saw Mr Lam swimming along the bottom of the ocean whilst looking at his watch. He was staying underwater for about 60-90 seconds. He said that Mr Lam never wore a wetsuit when diving.

Mr Lam told Mr Eisenberg that he did a lot of breath hold diving at home. Mr Eisenberg saw him stay underwater for 60-90 seconds on one occasion. When they went diving on the first day Mr Lam swam to the bottom and took photos.

Ms Bansal saw Mr Lam diving on the afternoon of 24 May 2010. She saw him going down to depths of about five metres. Ms Bansal said that Mr Heuvel told her, when it became apparent that Mr Lam was missing, that he had seen

Mr Lam swimming out to the right of the boat in the direction of some buoys (where he was found) and that he was breath hold diving.

Lookouts and safety procedures

Ayesha Bansal stated that there were differences in safety procedures between the *Reef Experience* and the *Reef Encounter.* She said that on the *Reef Encounter* there was always a lookout on the middle section of the boat when people were out diving and there were never more than twenty people in the water at a time. The lookout would blow a whistle and indicate to people to move back into the correct area if they were not swimming where they should be.

Ms Bansal said that on the afternoon of Mr Lam's death the skipper was the lookout. He was wearing an orange vest. There were about 30 people snorkeling. Before they left the boat there was no checking of numbers. She did not hear the whistle being blown at any time. Ms Bansal got into the water at about 1.30pm and got out at about 2pm. It was not until about an hour later that anybody came and checked her number.

Ms Warren was on board the *Reef Experience* with her husband. Before they went swimming they were given a safety briefing by 'Mick' which included information about hand signals, and asked to complete medical forms. She went snorkelling and at about 2.30pm returned to the boat. She was looking out over the reef and to the right of the glass bottom boat and she saw something splash and then flashes on the water which she thought was unusual.

Ms Warren heard a crew member tell another that there was someone missing and she saw about six crew members looking overboard. Ms Warren told them about the flashes she had seen but they did not seem to take any notice of her. The crew got into a boat and started dropping off snorkelers. About ten to fifteen minutes later they went to the location she had pointed out and they found Mr Lam.

Ms Warren said that the crew was told that her husband was a trained search and rescue officer in the US military but refused his offer of assistance. There was no medical equipment on board except a first aid kit – no defibrillator and the oxygen equipment was not serviceable. Nobody on board was told where the first aid kit was in the event of an emergency. She said there was no lookout or lifeguard watching the snorkelers. In her opinion the crew did not appear to be sufficiently experienced to deal with an emergency.

Michaela Bowden was a guest on the *Reef Experience*. They were given a briefing about hand signals etc whilst snorkelling. Snorkellers were not told to stay at the rear of the boat and were swimming around the three sides. She did not see any lookouts in strategic positions on the boat. She believes that there was no one on board who would notice if a snorkeller needed assistance. It was more than two hours between when swimmers entered the water and when a safety check was done to make sure everybody was back on board.

On the afternoon that Mr Lam died Mr Eisenberg was on the top deck and the Captain was there also. They were talking for some time. They saw someone who was not wearing a wet suit diving at the location where Mr Lam was located. He stayed on the top deck with the Captain until they were told that Mr Lam was missing.

Dr Murti told investigators that the area where Mr Lam was found was outside the area which was designated as the snorkelling area.

Improvement notices

On 4 June 2010 OFSWQ issued Improvement Notice 719826 to Hostel Reef Trips Pty Ltd which alleged that the company did not ensure that the lookout or guide was able to provide first aid including oxygen resuscitation or direct a person who was immediately available to provide the first aid. The contravention was to be remedied by 11 June 2010. Improvement Notice 719827, in identical terms, was issued to Reef Encounter Enterprises Pty Ltd on 21 June 2010 and required compliance by 28 June 2010.

Death of Shaun Corrigan

Shaun Corrigan died on 17 January 2012 on board *Reef Experience* during a day trip to the reef off Port Douglas. Rebecca Wright, inspector, OFSWQ, was tasked to investigate the matter and went to the Marina to meet the vessel. She was approached by Colin MacKenzie and his wife who said that they were aware that Mr Heuvel could be difficult and did not have a good relationship with OFSWQ and they hoped they could be of assistance to ensure matters went smoothly. Mr MacKenzie said that he operated a company which assisted dive companies with safety issues and his wife was a member of Dive Queensland.

Mr MacKenzie said that it was his understanding that a passenger on the vessel had gone snorkelling and on coming back onto the boat suffered some kind of seizure and died.

Ms Wright and QPS officers who were also present agreed that QPS would speak to Mr Heuvel and any passengers who had witnessed anything of relevance and Ms Wright would speak to crew members who had assisted Mr Corrigan out of the water and/or acted as lookouts, etc.

The vessel docked and QPS officers were about to board when Mr Heuvel stood in front of them and stated, 'I am the master of this vessel and I do not give you permission to board this vessel. You cannot board without my permission and you are to leave now. You have no right to detain my passengers. You have no right to talk to any of my passengers. Stand back down and let them leave.'

One of the passengers standing on the top deck leaned over and called out to Mr Heuvel, 'You're an idiot mate. Let them come on board and do their job.'

QPS officers then stood on the marina and asked the passengers for their names and contact details as they departed the vessel.

Ms Wright approached a crew member and said that she wanted to speak to any of the crew who had been with Mr Corrigan when he got into or out of the water and may have been on lookout duties. The crew member said that he had relevant information.

When all the passengers had departed, Mr Heuvel gave permission for QPS and OFSWQ officers to board the vessel. Ms Wright began to question the crew member and Mr Heuvel approached and stated that there was no reason for her to speak to anyone but him as nobody else saw anything. The crew member told him that it was ok and Mr Heuvel walked away and Ms Wright continued to question the crew member. When she had taken some notes she asked the crew member to read through them and sign them. Mr Heuvel walked over to them and told him that he did not have to sign anything and advised him not to sign anything. The crew member then said he was not prepared to sign the document.

An autopsy revealed that Mr Corrigan died from natural causes due to heart disease.

Marine Parks permits

Marine Park Permits are issued by the Great Barrier Reef Marine Park Authority (GBRMPA).

Permit No. G09/23794.1 was issued to Reef Encounter Enterprises Pty Ltd on 30 July 1999 and is in force until 30 June 2015 unless sooner surrendered or revoked. It allows the company the use of and entry into certain zones in the Great Barrier Reef Marine Park for the purposes of conducting a tourist program involving swimming, snorkelling, scuba diving, fish feeding, coral viewing, passenger transport, non-motorised watersports, reef walking, fishing and fuel transfer and conduct of a vessel charter program being the provision of transport and services to persons other than tourists.

The permit states that all activities must be undertaken in accordance with the provisions of the laws in force from time to time in the State of Queensland. It also states that the Permittee must notify GBRMPA and the Chief Executive in writing of any death, injury, loss or damage immediately upon the Permittee becoming aware of such death, injury, loss or damage.

Permit G06/19936.1 was issued to Reef Encounter Enterprises Pty Ltd on 2 February 2007 and was in force until 1 December 2012. It was in similar terms to permit G09/23794.1

The Manager, Permits, Environmental Assessment and Management Section, GBRMPA, provided a statement in relation to this matter in which he listed the matters of which GBRMPA had been notified by Hostel Reef Trips and Reef Encounter. That list did not include the death of Mr Lam or the death of Mr Corrigan (as discussed below).

The Inquest

A pre-inquest conference was held on 20 March 2014.

At that time Counsel Assisting advised of the issues to be explored at the inquest. Mr Mellick had advised the office of the Northern Coroner by letter that he acted for Mr Heuvel and his companies but neither Mr Mellick nor Mr Heuvel appeared at the pre-inquest conference.

The inquest commenced on 21 July 2014. Eleven witnesses gave evidence. Mr Heuvel appeared unrepresented at the inquest and chose not to give evidence. During the inquest Mr Heuvel was given the opportunity of engaging legal representation and having the inquest adjourned until a date in September or October 2014. He chose to continue unrepresented and without an adjournment.

During the inquest I prohibited the publication of the names of certain entities. Prior to making these findings I advised the parties that I intended to revoke those non-publication orders and invited submissions in that regard. I received no submissions.

I now revoke all non-publication orders that were made by me during the inquest.

Witnesses

Paull Botterill

Dr Botterill, Senior Staff Specialist Forensic Pathologist conducted the autopsy on Mr Lam. He gave evidence that it was impossible to determine whether Mr Lam's death had been the result of shallow water blackout, due to breath hold diving. He agreed that it was a possibility and it was also possible that breath hold diving had put extra stress on Mr Lam's compromised heart arteries and caused his death.

Dr Botterill explained that 'breath hold' or 'free' diving refers to the practice whereby persons hyperventilate before going underwater so that they can stay underwater longer before having to surface to breathe. Hyperventilation reduces the urge to breathe as it is the level of carbon monoxide in the blood which triggers the urge to breathe. As hyperventilation reduces the level of carbon monoxide in the blood the urge to breathe is also reduced. The danger with the practice is that decreased levels of oxygen in the blood can cause a person to black out without any warning. Obviously this is potentially fatal if the person is underwater as the immediate response of the body upon the person becoming unconscious is to breathe which results in water being drawn into the lungs, and ultimately, death by drowning.

Michelle Bowden

Ms Bowden was a passenger on the *Reef Experience* on 24 May 2010. She gave evidence that, whilst snorkelling off the boat, she experienced a cramp in

her leg. She raised her hand for assistance, as she was advised to do during the safety briefing which had occurred on the boat, but she did not receive any assistance from any of the crew members. Her sister was also in the water and swam back to the boat with her. Ms Bowden believes that crew members were not keeping a sufficient lookout on swimmers when she was in the water. She said that she was looking for a crew member so that she could attract their attention but could not see any lookouts on the boat.

Michelle Murti

Dr Murti was a passenger on the *Reef Experience* on 24 May 2010. She and her mother had also been on the vessel the previous day and had returned because they had enjoyed it so much.

Dr Murti was present when Mr Lam was brought aboard and she saw the crew members administering CPR to him. She believed that the crew did all they could to assist Mr Lam but that he had been deceased for some time when he was found and any efforts they made were futile. She stated that the oxygen equipment was faulty which necessitated the crew having to administer oxygen mouth to mouth rather than use the equipment. Dr Murti said that had the equipment been working it would not have made any difference to the outcome for Mr Lam as he when he was brought to the boat he was the past the point where he could have been successfully resuscitated.

Cody Polglase

Cody Polglase was a qualified dive master and one of the crew on 24 May 2010. It became apparent during his evidence that he was not on duty on the afternoon Mr Lam died as he had been relieved as dive master by Tim Beckett after the morning shift. This information was not known to investigators due to Mr Polglase's refusal to provide a statement.

Mr Polglase has, since Mr Lam's death, obtained further qualifications and is currently the master of an off-shore vessel in Western Australia.

Mr Polglase was not a helpful witness and it is doubtful whether he was totally honest and forthright in his answers.

It became clear that, although he professed to have little to no recollection of his dealings with OFSWQ investigators, he knew that investigators wanted him to provide a statement in relation to the death of Mr Lam and he refused to do so. He could not provide any reasonable explanation as to why he refused. He disagreed with the suggestion that Mr Heuvel had told him he should not provide a statement or that Mr Heuvel had spoken to him in any way about providing a statement to investigators.

Mr Polglase gave evidence that it was the policy on the *Reef Experience* that all snorkelers and divers wore wet suits as it increased their buoyancy and was therefore a safety factor. He said that crew told prospective snorkelers and divers that they would not be leaving the boat without a wet suit.

Mr Polglase had no recollection of any specific details of events on 24 May 2010. Had he given a statement at the time his recollection would have been much better and may have led investigators to pursue further information from other relevant parties. That opportunity was lost because of his refusal to assist.

Michael Chee

Mr Chee was a qualified Dive Instructor on the *Reef Experience* on 24 May 2010. He also had first aid and oxygen delivery qualifications.

Mr Chee now has the qualification of MED2 –Marine Engine Driver.

Mr Chee was involved in the search for and retrieval of Mr Lam. He became aware some time in the afternoon of 24 May 2010 that Mr Lam was missing from the vessel. He assisted in the search of the vessel and then went out in the tender to search for Mr Lam. His recollection is that he went out with Cody Polglase and Jed Polglase.

Mr Chee was aware that OFSWQ investigators wanted to obtain a statement from him. He refused to provide one. He stated that he did so on the basis that he considered that he could not provide any information which had not already been provided to them. This is not a reasonable explanation. He did not know who had or had not provided statements or the focus of the investigation and he was one of the main participants in the search for and retrieval of Mr Lam. It is evident that he would have had relevant information to provide to investigators.

Christopher Coxon

Mr Coxon was an inspector with OFSWQ in 2010 and is now the Principal Advisor (Diving) in Cairns.

Mr Coxon was one of the first investigators to respond to the report of Mr Lam's death. He organized an investigative team and met Mr Schutte (another inspector) at the Marina to greet *Reef Experience.* When Mr Coxon arrived he saw that the vessel had already docked. He went on board, met with Mr Heuvel and commenced inquiries. There were about 80 passengers and 11 crew members on board. It was agreed that Mr Schutte would talk to the passengers and identify those who had been in contact with Mr Lam. Mr Coxon spoke to Mr Heuvel and identified the crew members who were most relevant to the investigation as having been involved in the search and retrieval. Those were Mr Heuvel, Mr Polglase and Mr Chee. Mr Chee was identified as the person who had given the safety briefing, searched for Mr Lam in the tender and helped retrieve Mr Lam. Mr Polglase was the person who had found Mr Lam on the sea bed.

Mr Coxon asked to see the oxygen equipment which had been used in CPR of Mr Lam and was told by Mr Heuvel that it was not on board. Mr Coxon was also unable to locate Mr Lam's snorkelling equipment.

Mr Schutte identified the passengers that had transferred from *Reef Encounter* with Mr Lam and Dr Murti. Mr Coxon spoke to those passengers and identified Mr Lingen, Ms Bansal and Mr Eisenberg as the passengers with the most relevant knowledge.

Mr Coxon said that Mr Heuvel was reasonably co-operative on the evening of the death.

The next day Mr Coxon contacted Mr Heuvel to provide a statement and he said would give one in the company of his solicitor. That did not occur and at a later date Mr Heuvel told Mr Coxon that he, 'didn't do statements'.

On 31 May 2010 Mr Heuvel told Mr Coxon that he had told his crew that giving statements to investigators was, 'unlikely to be in their interests'.

After numerous attempts to obtain statements from Mr Chee, Mr Polglase and Mr Heuvel, Mr Coxon concluded that they were not going to provide statements voluntarily. He then considered whether to attempt to obtain statements from other crew members but the response of Chee, Polglase and Heuvel as well as previous dealings with Mr Heuvel, led him to believe that he would be unsuccessful.

Mr Coxon also considered using the compulsory powers contained in the *Workplace Health and Safety Act* 1995 but, in the end, decided to request QPS to assist in obtaining the statements.

Mr Coxon said that over the years he has had various dealings with Mr Heuvel, in his duties as a workplace health and safety inspector, and that he concluded from those dealings that Mr Heuvel was a difficult man to deal with.

Mr Coxon said that OFSWQ inspectors usually audit vessels which take passengers to the reef for resort diving every couple of years. The operators of all vessels which operate out of Cairns allow the inspectors on board for this purpose, with the sole exception of Mr Heuvel.

Mr Heuvel put to Mr Coxon that OFSWQ was provided with the medical declarations that were completed by each of the passengers on board the vessel. Mr Coxon stated those documents had not been provided.

Mr Heuvel put to Mr Coxon that his vessel had been audited by OFSWQ on 27 September 2010 but Mr Coxon explained that the audit was one of business systems and was done across the industry at that time. It was not an audit of Mr Heuvel's vessels or the safety procedures etc utilized on board.

Murray Leighton

Mr Leighton is a Principal Inspector (Diving), OFSWQ. He said that he has not audited any of Mr Heuvel's vessels for a number of years as Mr Heuvel has not allowed inspectors to board the vessels for that purpose.

Mr Leighton said that the refusal of Mr Polglase and Mr Chee to provide statements was his first experience of such non-cooperation with an OFSWQ

investigation. When he obtained legal advice as to how to proceed he was surprised to be told that there was really nothing that could be done about it.

He said that since he commenced investigations this was the first time that crew members had refused to provide statements – usually those involved in the diving industry are more than willing to assist in investigations.

Mr Leighton said that he did not request statements from any other crew members or passengers as Mr Coxon had identified Mr Polglase and Mr Chee as the key people to speak to as they had knowledge of the safety procedures as well as the events that had taken place that day.

Mr Leighton said that he spoke to Mr Warren (Acting Regional Investigations Manager, OFSWQ) who looked at the investigation and the preliminary autopsy report and said that Mr Leighton should cease investigations and update the investigation report, and speak to the Legal Officer, Dean Saunders, about the matter.

Mr Leighton spoke to Dean Saunders the next day and Mr Saunders told him to close the investigation and submit his updated report.

Mr Leighton said that generally investigations don't proceed where it is found that there is an underlying cause of death. He did not know the reason for this and agreed that the cause of death is not relevant to considerations of workplace health and safety and the relevant legislation.

Mr Leighton said that he received some documents from Mr Heuvel but that some documentation was still outstanding. He sent a letter to the solicitor nominated by Mr Heuvel as acting for him seeking that outstanding documentation but did not receive a response.

Dean Saunders

Mr Saunders was, in 2010, a principal legal officer with OFSWQ. Mr Saunders accepted that Mr Leighton's recollection of their conversation in 2010 would be accurate. He said that in the decision making process the causation of death is relevant in that, where there has been a serious outcome of a breach, the matter has to be investigated comprehensively (which is defined as an investigation which is allocated to a principal inspector).

Mr Saunders said that he had not formed an opinion as to the sufficiency of the investigation into Mr Lam's death but agreed that few statements had been taken from a large number of crew and passengers on the boat. Mr Saunders said that the key issue for investigators was the lack of statements from those crew members who had been identified as the most relevant.

Mr Saunders said that the use of coercive powers has been identified by OFSWQ as an issue of importance. Since Mr Lam's death there have been legislative amendments which have increased the maximum penalties for non-

compliance. Inspectors will receive training in relation to those amendments and the use of coercive powers.

Mr Saunders said that, at the time of Mr Lam's death and the subsequent investigation, it was time consuming to prosecute persons who refused to provide information and the maximum penalty was only $1000. The results of the amendments are that the privilege of self incrimination has now been abrogated (although there is a restriction on the use of information provided under compulsion) and the maximum penalties for con-compliance have been increased.

David Marsh

Mr Marsh is the Senior Officer, Office of Legal Counsel, Australian Marine Safety Authority (AMSA).

Mr Marsh stated that AMSA is the national regulator for vessels and is responsible for issuing certificates of survey and operation for vessels and certificates of competency for individuals e.g. masters tickets. To issue a certificate of operation AMSA must be satisfied that the individual has sufficient capacity and competency and that the applicant is a fit and proper person to hold such a certificate.

Colin MacKenzie

Mr MacKenzie is the executive director of the Association of Marine Park Tourist Operators which is a lobby group for the diving industry. Mr MacKenzie has been a qualified diver for many years and has extensive experience in the diving industry. He has a diploma in workplace heath and safety and, as the industry delegate, was involved in the drafting of the Workplace Health and Safety Code of Practice in relation to the diving industry.

Mr MacKenzie said that Queensland is the safest place in the world to scuba dive and snorkel, recording only one fatality per 400,000 dives.

Mr MacKenzie estimated that Mr Heuvel has taken approximately 700,000 people to the reef since he commenced in the industry. Mr Heuvel is one of the most experienced resort diving instructors in Australia and has been responsible for training many dive instructors and dive masters.

Mr MacKenzie stated that, in his opinion, as a person who has conducted numerous audits of diving vessels, the safety procedures on Mr Heuvel's boats are about average.

Mr MacKenzie accepted Ms Wright's recollection of events in 2012 following the death of Mr Corrigan on board *Reef Experience.* He said that Mr Heuvel was in an excited state that afternoon because of the death and it was an extremely stressful situation.

Mr MacKenzie said that the industry has now tried to agree on procedures whereby operators provide contact details for passengers to OFSWQ. He said it is unusual for crew members to refuse to provide statements to investigators. He said that he would advise people to get legal advice and have legal representatives attend interviews with investigators.

Mr MacKenzie stated that he did not realize that, since 2009, it has been a requirement of permits issued by GBRMPA to use the Marine Park that permittees report deaths and injuries to GBRMPA and that a number of tour operators also did not know that.

Submissions

Ms Williams submitted that I should make the following recommendations:

1. That Hostel Reef Trips Pty Ltd, Reef Encounter Enterprises Pty Ltd, John Heuvel, and/or John Van Den Heuvel permit OFSWQ to conduct a comprehensive audit of all vessels used by those entities for recreational diving and snorkelling activities on the Great Barrier Reef;

2. That AMSA consider reviewing whether Hostel Reef Trips Pty Ltd, Reef Encounter Enterprises Pty Ltd, John Heuvel, John Van Den Heuvel, Cody Polglase and Michael Chee are appropriate people to hold the certificates of operation and competency with which they have currently been issued.

OFSWQ submitted that at the time of Mr Lam's death the provisions of the *Workplace Health and Safety Act* 1995 pertaining to non-compliance with investigative powers were deficient but that the amendments introduced in the 2011 Act have adequately addressed those deficiencies.

OFSWQ agreed with the recommendation (1) above, as submitted by Counsel Assisting.

OFSWQ submitted that the response of that Department to the death of Mr Lam was timely and appropriate but obstructed by Mr Chee, Mr Polglase and Mr Heuvel. I agree with that submission.

Mr Heuvel submitted that if OFSWQ required further information from his companies then investigators should have obtained that information from his operations manager. This submission is ill founded. Investigators identify those responsible for companies and request information from those people. Mr Heuvel is the sole director of both of his companies. Investigators cannot be expected to attempt to identify which employees of a company may hold specific information and have authority to release information. The onus was on Mr Heuvel to cooperate in any way he could – he knowingly and deliberately did not do so and neither did he attempt to raise any exemption to the requirement to provide information by way of providing any reasonable excuse to refuse to comply.

In relation to the OFSWQ investigation into the death of Mr Corrigan on board one of Mr Heuvel's company's vessels in 2012, Mr Heuvel stated in submissions that he decided that QPS and OFSWQ officers did not need to speak to anyone on board the vessel when it docked at the Marina. This was not his decision to make and reveals his belief that it is up to him to decide who and what should be investigated and audited by OFSWQ and when and if such investigation will occur. Mr Heuvel stated that he does not like the OFSWQ investigators so he can't see why he should let them on his boats unless they buy a ticket like all other passengers. Again, his statement reveals his attitude of non co-operation with those responsible for monitoring the safety of his employees and his many paying passengers.

Comments, recommendations and findings

The scope of the Coroner's inquiry and findings

An inquest is not a trial between opposing parties but an inquiry into a death. The scope of an inquest goes beyond merely establishing the medical cause of death.

The focus is on discovering what happened; not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and, in appropriate cases, with a view to reducing the likelihood of similar deaths.

As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.

A coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable.

Proceedings in a coroner's court are not bound by the rules of evidence. That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

A coroner should apply the civil standard of proof, namely the balance of probabilities. However the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven.

If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant

department. A coroner may also refer a matter to the Criminal Misconduct Commission or a relevant disciplinary body.

Comments

Mr Lam died on 24 May 2010. OFSWQ closed their investigation on 23 November 2010. At that time, OFSWQ had possession of three formal statements from passengers, a notebook statement of Dr Murti and two statements which had been volunteered to authorities. The department also had documentary evidence, including the preliminary autopsy report and some company records of Hostel Reef Trips including dive logs, emergency drill records and the oxygen and first aid qualifications of Mr Polglase, Mr Heuvel and some other crew members.

At that time OFSWQ had insufficient information to be able to determine whether there were any breaches of safety legislation or regulations on board *Reef Experience* on the day of Mr Lam's death, other than identifying that the oxygen equipment on board the vessel was faulty.

The lack of information available to OFSWQ was a direct result of the lack of cooperation of Mr Polglase, Mr Chee and Mr Heuvel.

Mr Chee and Mr Polglase both accepted in evidence that they knew that OFSWQ were seeking a statement from them. Neither could provide a reasonable explanation for why they did not provide a statement in the most serious circumstances – that is, where a passenger has died.

Mr Heuvel and his companies failed to provide all information requested.

Mr Heuvel, as the person responsible for the vessel and all that occurred on it that day, as well as being the lookout at the time of Mr Lam's death, was a person who had information which was crucial to the OFSWQ investigation.

From evidence adduced at the inquest it has been established that the crew of *Reef Experience* held appropriate diving and first aid qualifications on the day of Mr Lam's death. The vessel had an appropriate Operations Manual and safety procedures and Mr MacKenzie said that the safety procedures normally employed on the vessel were about average compared to the rest of the industry.

However, because of the lack of information provided it cannot be determined whether the safety procedures utilized on *Reef Experience* on the day of Mr Lam's death were in accordance with legislation, regulations and the Operations Manual. Although Mr Polglase and Mr Chee gave evidence at the inquest they had very little recollection of what occurred on the day in relation to procedures and safety briefings etc. Had they given statements at the time they would have provided information which may have indicated that proper procedures were followed. They were discouraged from doing so by Mr Heuvel, who was their employer, instructor and probably mentor at the time and undoubtedly had the ability to influence their decisions.

Mr Heuvel put to OFSWQ investigators at the inquest that he had two sets of oxygen equipment on board the vessel and the one utilized in the CPR of Mr Lam was taken with him on the rescue chopper. Since it is clear that it was faulty such that it could not be used, this is extremely unlikely. If there were two sets it would seem reasonable that crew would have brought out the complete set so that it could be used but this was not the evidence of Dr Murti. Further, Mr Heuvel failed to provide the documentation evidencing the checks/audits carried out on the oxygen equipment, as requested by OFSWQ. If he had done so it would have revealed whether there was one or two sets on board and whether they had been properly audited and maintained.

It is clear from evidence at this inquest, including Mr Heuvel's submissions, that he does not believe that he should be subject to audits by OFSWQ and that he is uncooperative with OFSWQ inspectors. Such an attitude, in a person responsible for vessels which have taken approx 700,000 people to the reef and continue to take passengers, is unacceptable and poses a possible danger to public safety.

Snorkelling and diving on the Great Barrier Reef are activities which can be dangerous if proper safety procedures are not adhered to. It is insufficient for Mr Heuvel to declare that his boats are safe – all other operators allow their operations and vessels to be monitored and audited and cooperate with OFSWQ when there is an incident which requires investigation. There is no reason why Mr Heuvel and his companies should not provide a similar level of cooperation or why his vessels should be exempt from similar audits.

Mr Polglase was not a credible witness and did not attempt to assist the inquest. It is clear that he knew, in the days and months following the death of Mr Lam, police and OFSWQ wanted to obtain a statement from him. He had knowledge that could have assisted the investigation in that he was the person who searched for Mr Lam, found Mr Lam on the sea bed, helped to retrieve his body, provided CPR and took Mr Lam back to the Reef Experience. Mr Polglase refused to assist in the investigation in any way. At the inquest he could provide no reasonable explanation why he refused.

It is concerning that Mr Polglase is now the master of an off shore vessel and still he does not seem to understand the importance of workplace health and safety investigations and compliance with relevant provisions. When asked whether he would now cooperate with such an investigation should a death or injury occur on a vessel of which he was a master, Mr Polglase wavered in his response. One would expect a definitive positive response from a person in such a position of responsibility but he seemed unwilling to agree that he would or should provide information, stating ambiguously, 'I would deal with it accordingly'. When pressed he repeated that vague response.

As Mr Heuvel did not provide a statement or give evidence and Mr Polglase and Mr Chee had very little recollection of the events of 24 May 2010 there has been no explanation provided as to why Mr Lam was allowed to swim without a wet suit which was in contravention of the safety procedures at that time on board the vessel, why he was snorkelling in an area outside of the

designated zone and no information provided as to whether he was warned of the dangers of breath hold diving.

The evidence did reveal that Mr Heuvel, as the lookout on the day, was aware that Mr Lam was snorkelling in the area in which he was found and that he was breath hold diving. There has been no information provided as to whether, Mr Heuvel, being aware of the fact that Mr Lam was breath hold diving monitored him closely or sought to have him come back into the appropriate area around the boat.

Had Mr Heuvel, Mr Polglase and Mr Chee complied with their obligations to provide statements and information to OFSWQ in 2010 in relation to Mr Lam's death it is likely that there would have been no need for this inquest. Their lack of cooperation has resulted in the unnecessary use of public resources – both in relation to this inquest and also the many failed attempts of investigators to obtain information from them.

The question of whether appropriate safety procedures were followed on the *Reef Experience* on the day of Mr Lam's death remains unanswered.

Recommendations

I make the following recommendations:

1. That OFSWQ request Hostel Reef Trips Pty Ltd, Reef Encounter Enterprises Pty Ltd, John Heuvel, and/or John Van Den Heuvel permit OFSWQ inspectors to conduct a comprehensive audit of all vessels used and/or owned by those entities for recreational diving and snorkelling activities on the Great Barrier Reef and that such audit include inspectors travelling on the vessels during usual trips to the reef in order to conduct such an audit and should such a request be refused or inspectors obstructed in their audits in any way that such information be provided to AMSA and GBRMPA.

2. That AMSA consider reviewing whether Hostel Reef Trips Pty Ltd, Reef Encounter Enterprises Pty Ltd, John Heuvel, John Van Den Heuvel, Cody Polglase and Michael Chee are appropriate persons to hold the certificates of operation and competency which they currently hold.

3. That GBRMPA consider reviewing whether Hostel Reef Trips Pty Ltd and Reef Encounter Enterprises Pty Ltd are appropriate entities to hold permits allowing those entities to conduct tourist activities on the Great Barrier Reef.

Findings required by section 45

Who the deceased person is: Wai Kim Lam

When the person died: 24 May 2010

Where the person died:	Michaelmas Reef, in the waters off Cairns Queensland
What caused the person to die:	Drowning against a background of coronary artery atheroma
How the person died:	Wai Kim Lam died while snorkelling. It is possible that he was 'breath hold' diving at the time of his death.

I close the inquest.

Jane Bentley
Coroner
Cairns
11 August 2014