OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Nathan Kevin Robinson and Scott Tschannen**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	2009/2195; 2009/2195
DELIVERED ON:	10 December 2012
DELIVERED AT:	Cairns
HEARING DATE(s):	16/08/2012; 04/09/2012; 05/09/2012
FINDINGS OF:	Kevin Priestly, Northern Coroner
CATCHWORDS:	**CORONERS: Inquest - prawn trawler, hook-up and rollover, two crew trapped within, trawler sinks, cause of rollover, location of Master on trawler at moment of rollover.**

REPRESENTATION:

Counsel Assisting the Coroner:	Ms Stephanie Williams
Counsel for Mr and Mrs Robinson:	Mr Derek Kordick
Counsel for Paul Taylor (Master)	Mr Graham Houston
Counsel for Rachel Tschannen	Mr Peter De Plater

Background

Nathan Kevin Robinson was 21 years of age and resided with his parents Randall and Narelle Robinson at 1149 Frankston Flinders Road, Somerville. He had one child who lived with his former partner. Mr Robinson had worked onboard Dynasty with its master Mr Paul Taylor for two years.

Mr Scott Tschannen was 28 years of age and resided with his wife Rachael Tschannen at 4 Rifle Range Road, Nambour. It was Mr Tschannen's first season on Dynasty.

The FV Dynasty was about 17m long and built of steel construction in 1982. Mickeyport Pty Ltd, a company in which its master Mr Paul Taylor was a director, purchased the vessel in January 2007. It was registered in Queensland for operation as a commercial fishing vessel within 200nm from the coast and authorised to carry up to five persons. It operated as a prawn trawler using four nets, two from each boom.

Mr Paul Taylor was 42 years of age and started commercial fishing in 1984 working throughout the Torres Strait in family fishing operations. He was the holder of a Grade 3 Masters Certificate and Marine Engine Drivers Grade 2 Certificate. He skippered Dynasty in the Torres Strait in the 2007 and 2008 seasons.

Fishing in the Torres

Dynasty departed Brisbane on 21 February 2009 and arrived in Torres Strait on 28 February. It started trawling on 1 March, the start of the season. On 2 March it was boarded by Fisheries Officers in the course of routine patrols and a safety inspection revealed expired flares. Arrangements were made for replacements. Officers noted an aluminium lifeboat on the aft section of the wheelhouse and an EPIRB located on the port side wall of the wheelhouse. On 2 April Dynasty was again boarded in the course of a routine fisheries patrol and the replacement flares were noted as compliant.

On the evening of 23 April Dynasty started trawling about 6.30pm. At about 1.53am on 24 April the EPIRB from Dynasty was detected transmitting in the position 09'41.3' South and 143'39.9' East, about 7nm south west of Darnley Island. The Australian Maritime Safety Authority Search and Rescue Centre used the registration details of the EPIRB to contact Mrs Taylor but she was unable to be reached. The Coordinator contacted the Reef Vessel Traffic Service (REEFVTS) and established that organisation's last known position for Dynasty was at 10.28pm. REEFVTS attempted to contact Dynasty without success. Radio communications followed with other vessels in the area who reported last sightings of Dynasty. One of those vessels, FV Crystal Enterprise was asked to assist in going to the position of the distress beacon. At 3.20am Water Police at Thursday Island were alerted to the existence of the distress beacon. The Customs vessel Corio Bay was released from its patrol duties to participate in the search. At 3.30am, contact was made with Mrs Taylor and she provided information about the vessel and crew to the Coordinator. At 4am, AMSA tasked its dedicated search and rescue, fixed wing aircraft, Rescue 441, in Cairns to go

to home to the transmitting EPIRB. In the following hours, more aircraft including a helicopter from Horn Island, Rescue 700, and vessels were tasked to participate in the operation.

At 6.14am Customs vessel Corio Bay located the distress beacon. At about 6.43am Rescue 441 found debris. Rescue 700 arrived on scene and dropped a self locating datum marking buoy to assist in gathering data to calculate likely movement of the distress vessel or crew. At 8.23am, Rescue 441 sighted an aluminium dinghy with one person on board. Helicopter Rescue 700 went to that position and retrieved Mr Taylor. He was initially transported to Yorke Island and then Thursday Island Hospital.

The information initially available from Mr Taylor was recorded in the Search and Rescue (SAR) report:

> *Information was passed to RCC Australia indicating that Mr Taylor reported that the vessel had snagged while trawling and that he had heard a loud bang after which the vessel had rolled. The fishing vessel stayed on its port side for about one to one and a half hours before it sank and the skipper believed that the other two crew members, who were in the forecastle and freezer, had not been able to get out.*

At about 10.03am, Corio Bay reported it had located the likely position of the vessel in 50m of water. A commercial fishing vessel had identified an object on the floor consistent with a trawler wreck. This was located 09'40.844 South and 143' 35.288' East. It was not possible to dive on the likely wreck given the depth of water and the high risk associated with entering a wreck. The search and rescue operation focused on looking for survivors in the vicinity of the wreck.

At 12.51pm, Dr Paul Luckin, a medical survival expert, assessed the prospect of a person surviving in a vessel submerged at 50m even if there was an air pocket. He considered there was no prospect due to the pressure that would be experienced at that depth. He also assessed that, given the weather conditions; survival in the water would be limited to the last light on 24 April.

Weather in the search area deteriorated in the afternoon with heavy rain and low cloud base down to 3000 feet and visibility reduced to 2 kms in rain.

Search operations were suspended at 4pm on 24 April. Coordination of the search and rescue operation was handed over to the Queensland Police Service that evening.

On 5 May 2009, police divers attended the location of the wreck with the assistance of Maritime Safety Queensland and conducted side scan operations. A number of images were produced of the vessel on the seafloor. The images are reported as consistent with the known length and its profile closely resembled the structures of Dynasty. The vessel was found in an un-surveyed area where a number of obstacles were found. There was also a distinctive anomaly located on the reef that could have been the snag point on which the nets of Dynasty

'hooked up'. It was also reported that the wreck had not been in that location for any significant period. Police also report that the wreck is located close to the last known position of Dynasty. No other vessels of a similar description were lost in that area in recent times.

Police initially considered obtaining the use of a Remote Operated Vehicle (ROV) to obtain video of the vessel on the sea floor. However, there was very limited opportunity to obtain access to such sophisticated equipment, those available did not have the power to operate in the strong tidal flow at this locality and a usual condition to deployment is the requirement for a diver to standby to retrieve the ROV in the event of entanglement. Given the configuration of this fishing vessel, the risk of entanglement was considered extremely high. The deployment of an ROV was not considered viable.

The next issue that the Water Police had to address was the option of attempting to dive on the wreck to confirm the identity of the vessel. QPS Dive Squad was asked to assist in considering how safe and practicable this possibility was. QPS Dive Squad did not have the capability to dive to that depth. Although SA and NSW Police Dive Squads had the necessary capability in terms of depth of dive, there were other considerations that militated against such a dive. The Australian Defence Force reviewed the dive requirements and assessed the risk to personnel as unacceptable. Considerations include limited window of opportunity when tides were favourable (around 18 December 2009), unpredictable tropical weather likely at that time, recent crocodile sightings in the area from aerial surveys with the expectations of increased activity as temperatures increased, local advice that the area was well known for its resident population of tiger sharks, and the high risk of entanglement.

It must be appreciated that at the time of considering a dive on the wreck, the likely evidential value was limited to confirming the identity of the wreck, some appreciation of its physical state and the location of its nets relative to the vessel. Entry into the wreck to recover any bodies was always considered too dangerous at that depth. As to the risks associated with diving near the vessel, I accept without hesitation the evidence of the high risks to which the divers would be exposed and agree that the evidential value of the information that might be obtained did not justify the taking of that risk. Further, I am satisfied that the available evidence, although circumstantial, is sufficiently strong to support the necessary findings of fact that I am required to make in the absence of that additional information.

In so finding, I understand that the family and friends of Mr Tschannen and Mr Robinson would have highly valued and greatly appreciated any additional information that might help explain what happened.

Police Investigation of the Capsize and Sinking

Police investigated the surrounding circumstances. The only witness is Mr Taylor.

The investigation took the form of an interview with Mr Taylor in hospital at Thursday Island shortly after his retrieval. A statement was prepared based on

that interview and further interview at the police station a few days after his release from hospital. Other information about the movements of the vessel during the days and hours before its capsizing was accessible through various sources including the REEFVTS and its fishery polling.

There is no issue about the track of the vessel in the hours before capsizing.

Mr Taylor provided another statement at the start of the hearing that was more detailed than that provided to police on Thursday Island. Indeed, one of the considerations in deciding to convene an inquest was the need for a more detailed narrative from the only surviving crew member.

According to Mr Taylor, the usual fishing routine starts about 5.30pm when the crew wake after sleeping during the day, clean around the deck, empty product from the snap freezer on deck into the freezer in the hold and raise the anchor. The first shot (lowering of nets to fishing depth) is normally made around 6.30 to 7pm. Mr Taylor said that he would remain at the helm while the crew attended to other duties including preparation of dinner. The first shot would normally be retrieved about 9-10pm, the nets emptied and the second shot made. The deckhands would sort the catch, taking anywhere from 30 minutes to two hours depending on the size of the catch. The catch is packed into cartons and placed in the snap freezer on deck. Mr Robinson would leave the deck to get rest before the second shot was retrieved in the expectation that he would relieve at the helm during the third shot to allow Mr Taylor to rest. The second shot is normally retrieved between 12-1am. Mr Taylor would take over from Mr Robinson for the duration of the fourth shot, starting normally about 3.30-4am. Mr Taylor also said that he normally tried to retrieve the nets at the end of a run as it avoided turning with the nets out.

On the evening of 23 April, Dynasty was anchored on the north west of Campbell Island. The anchor was raised and Dynasty steamed south towards Stewart Reef to start trawling. The wind was about 15-20 knots from SE with seas of 1-1.5m. The sea was sloppy with no swell. The current was running south at about 1.5knots.

Mr Taylor said that Dynasty used four standard 4 by 5 fathom towing nets with number 5 Bison trawl boards. The first shot was made at about 7pm by easing out about 900 feet of 14mm trawl wire so that the nets were working on the sea floor at a depth of about 50m.

The first shot was retrieved, sorted and processed. The second shot was made about 9.30-10pm. About 50-70 kgs of tiger prawns was processed into cartons and put into the snap freezer on the aft deck. Dynasty headed north and then south over the same area before turning south again. Mr Taylor was fishing an area known as a paddock and was nearing its ‘edge’. Mr Robinson had gone to the focsle to sleep. Mr Tschannen was in the freezer counting meat so an order for supplies could be placed the following day.

Mr Taylor appreciated that he was nearing an area where ‘there were bad hook-ups’ and started to turn to port for another run to the north. He said it was about

midnight and was nearly ready to retrieve the second shot. The engine revs were about 1650-1700 rpm and the vessel was making about 3.5-3.9 knots in a following tidal stream.

About half way through the turn to port, Mr Taylor said he felt the gear on the port side snag on something, causing the vessel to heel to port. Mr Taylor jumped from his seat and reached for the throttle. As he was pulling the throttle back, the front stay on the starboard side gave way. Mr Taylor continued to pull the throttle right off. The vessel continued to roll to port and onto her side. Mr Taylor said he was tossed up against the portside window in the wheelhouse. The auxiliary engine cut out and all electronics and lighting was lost.

Mr Taylor said that in a state of panic and confusion, he scrambled in the darkness to the door on the starboard side, aft of the wheelhouse. While the vessel remained on its side, he pulled himself outside and stood supporting himself in the vessel rigging near the tri-winch. Mr Taylor then found a secure position and sat, regaining his breath and considering his options. He could hear Mr Robinson screaming, 'going crazy in an absolute panic'. Mr Taylor could not work out where his screaming was coming from, whether from the focsle or galley. Mr Taylor yelled back, trying to calm him but could not bring himself to go back inside the wheelhouse. He said, 'I just physically could not do it'.

There was water splashing all around Mr Taylor. He hung onto rigging while the vessel jerked and bobbed in the sea. He could hear the main engine continuing to work.

Mr Taylor could not see the hatch on the deck to the freezer. Judging by the water level around him, the hatch was below the sea surface and the freezer was flooded. Mr Taylor realised that the vessel was going to sink; it was just a matter of time. He did not see or hear Mr Tschannen.

Mr Taylor made his way to the stern, through the rigging, to where the dinghy was stowed. He noticed that the starboard boom, on failure of the forward stay, had extended fully aft to the stowed position. Mr Taylor described waves constantly surging and splashing around him. On reaching the dinghy, he found it partially submerged in its stowed position. He had to duck under the water to reach into the dinghy and retrieve a knife kept beneath its seat. With the knife, he started to cut the securing lines. Mr Taylor said he lost all sense of time. Every task seemed to take forever. The water level appeared to keep rising and he heard air venting from the hull. Mr Taylor released the dinghy, relocated it and tied it in a position clear of debris. He returned to the wheelhouse to retrieve the EPIRB just inside the wheelhouse door. On returning to the dinghy he attempted to activate the EPIRB, it started blinking then stopped. He hit it a couple of times, switched it off and on a few times but nothing happened. In boarding the dinghy, he lost the EPIRB.

Once clear of Dynasty, Mr Taylor said he watched the underside of the hull as it continued to sink. He thought it was upside down at this stage as most of the underside was visible. Mr Taylor sat in the dinghy as it floated away, not seeing or hearing Mr Tschannen or Mr Robinson.

Although it is possible that both Mr Robinson and Mr Tschannen suffered injury in the initial heeling of the vessel from moving objects in their locations, they are ultimately likely to have drowned due to immersion as water inundated their locations from which they were unable to escape.

The Location of Mr Taylor on Hook-up

An issue arises about where Mr Taylor was when the hook-up happened. Was he in the wheelhouse as he reported to police shortly after rescue or on deck handing cartons of prawns to Mr Tschannen in the freezer?

The latter allegation arises from an email from Mr and Mrs Robinson to my office dated 25 June 2009, the relevant part of which reads:

> *Why wasn't the helm manned at time of accident, i.e. boat was on "auto pilot" Nathan sleeping, Scott working in freezer with Paul assisting, passing boxes, down to Scott. Paul told Randall, 3 days after the accident that as boat hooked up he struggled to get to wheelhouse, when he did; he was unable to get to controls to kill throttles because of the violent movements of boat.*
>
> *How can Paul be allowed to be both working the deck and manning the helm with no chance of getting to controls when the accident occurred.*

Due to an oversight in my office, the difference between the account given by Mr Taylor to police and the understanding of Mr and Mrs Robinson as to the location of Mr Taylor at the time of the hook-up was not recognised and investigated. At the hearing, I extended my apologies to Mr and Mrs Robinson for that oversight. The issue was explored at the hearing.

If Mr Taylor was on the deck assisting to load boxes in the freezer by handing them down to Mr Tschannen, it opens up the question whether any delay in accessing the wheelhouse and pulling off power affected the prospect of retrieving the roll over situation.

On arrival in Cairns shortly before the hearing, a statement was obtained from Mr Robinson about his conversation with Mr Taylor as reported in his email. Mr Robinson was also questioned during the hearing about his recollection of the telephone conversation with Mr Taylor.

Before considering the strengths and weaknesses of evidence, it is relevant to note the timeline. There is no dispute about the fact of a phone call between Mr Taylor and Mr Robinson on 26 April 2009, a few days after the incident. The email from Mr Robinson was sent on 25 June 2009, two months afterwards. However, it was not until September 2012, a period of over three years, that Mr Robinson was asked to recall the detail of that conversation.

There are others factors that should be borne in mind when assessing reliability of each witnesses account. Mr Robinson was in the Navy for fourteen years

including an operational period on a naval tug. He had some understanding of maritime matters. Mr Taylor telephoned Mr Robinson shortly after release from hospital (where he was interviewed by police) and from a motel room before leaving Thursday Island to return home. The capsizing was a traumatic episode for him. He was also anxious about the call, telling the court that he knew the call would be the most difficult thing he'd ever had to do, to speak father to father about the circumstances of the loss of a son. Finally, Mr Robinson was at home in Victoria and anxious to hear news about what happened to cause the loss of his son. It was clearly a telephone call that each anticipated would be very difficult.

I return to consider the email from Mr Robinson for its content.

While the email properly raised an issue about the location of Mr Taylor, the text did not give any details of the conversation. Rather it reported a concern premised on a particular understanding about what occurred and not the basis for that understanding. Further, the understanding was markedly different to what Mr Taylor had reported to police a day or two earlier. I was also concerned that on the face of the email, there was opportunity for confusion and misunderstanding.

In his statement, Mr Robinson said that he recalled a telephone conversation with Mr Taylor at about 6.50pm on Sunday 26 April. Mr Robinson asked Mr Taylor to tell him what happened, '… just tell me straight out, what happened?'

In his statement, Mr Robinson reported the following conversation:

> *He said words to the effect, "We'd just finished a shot, recovered it from the water and got the catch out. Nathan had gone to bed and we had done a 180 degree turn to Port when the net hooked up twice." He said, "When the net normally hooks up the motor normally tears or pulls it from the reef but the net hooked up again and this time it was full on and dragged the arse of the boat down. The starboard boom broke and the auxiliary power went off and I was in pitch black darkness. I was standing on the starboard side of the boat because it went over on its port side. I couldn't get to the throttles to kill the power because I was passing boxes of prawns to Scott in to the freezer.*

Mr Robinson reported more conversation but the balance attributed to Mr Taylor is consistent with the account he provided police.

In evidence, Mr Taylor denied the suggestion that he was on deck handing boxes of prawns to Mr Tschannen in the freezer and denied saying so to Mr Robinson. Mr Taylor also commented on a sentence by sentence basis to the statements attributed to him in the quoted paragraph. He often reported that language attributed to him is not language he would use to describe those situations addressed.

Throughout the evidence of Mr Robinson, I was very careful to caution Mr Robinson about the need to hear his actual recollection of the conversation with Mr Taylor as opposed to his understanding. Not surprisingly, after the passage of considerable time, Mr Robinson struggled with any word for word, first person narrative. For example, in response to a question about whether Mr Taylor told him whether or not he was able to get back to the wheelhouse, Mr Robinson replied that that he 'couldn't get to the throttles'. This might be an example of how Mr Robinson has heard a statement of fact and interpreted it in light of his deductive reasoning.

I have also considered the plausibility of the suggestion that Mr Tschannen and Mr Taylor were loading cartons of prawns from the deck into the freezer. The vessel had a snap freezer on deck. The routine was to process prawns into cartons and then place them into the snap freezer during the night for snap freezing. The cartons would remain in that freezer until the following afternoon when, in preparation for the night's fishing, they would be transferred to the below decks main freezer. The snap freezer capacity was sufficient for its use in the manner indicated. There was no need to transfer cartons during the night.

I have no doubt about the genuineness of Mr Robinson's efforts to provide an accurate recollection of his conversation with Mr Taylor. However, there are a number of considerations that suggest Mr Robinson misunderstood Mr Taylor's account including:

- the emotional context to this phone conversation;
- the passage of substantial time before a detailed recollection was attempted;
- a narrative on the part of Mr Robinson that used language not normally used by Mr Taylor;
- the account of Mr Taylor as explained to Mr Robinson would be a substantial departure from the account given to police at the same time and the more detailed account given to the court (which are entirely consistent); and finally
- the reason attributed to Mr Taylor being on the main deck and not the wheelhouse (to assist Mr Tschannen in transferring prawns into the below deck freezer) is operationally implausible.

Therefore, I am not satisfied that Mr Robinson's account is sufficiently reliable to displace that of Mr Taylor.

Even if Mr Taylor was on the deck and not in the wheelhouse, the issue about whether or not earlier reduction of throttle would have changed the outcome is problematic. The description of Mr Taylor about the failure of the forestay and the extent which the vessel initially heeled, suggests that any continued application of power to the propeller (Kurt nozzle) is unlikely to significantly contribute to the heeling forces. Mr Taylor's description depicts a scenario whereby the starboard forestay failed and the boom smashed, rearwards assuming a location similar to the stowed position. This coincided with a progression from port edge immersion to a rolling beyond the point of return. Again, it is impossible to know with an exact science or engineering how, if at all, the outcome might have been different

if the true position was that Mr Taylor was on the deck and not in the wheelhouse in a position to reduce main engine power.

Accepting that Mr Taylor was in the wheelhouse, I note that there was no suggestion of any criticism of him in not going below to the focsle to assist Mr Robinson on hearing his voice. The incident happened at night time and the generator failed shortly after the vessel was heavily laid to port. It was clearly a sudden and extremely frightening event. It took a matter of minutes before Mr Taylor could even orientate himself and gain an appreciation about what had occurred. It also became immediately obvious that the vessel had heeled beyond the point of return and would sink. Mr Taylor was unable to know how quickly or slowly that might take. Very experienced skippers within the Water Police and MSQ reviewed the circumstances of the rollover and none were willing to offer any criticism of Mr Taylor on the basis that unless you were there to fully experience the circumstances, you couldn't comment. I endorse those remarks.

Risk Management – Deck Operations

There were a number of apparently disparate aspects about management of the vessel that combined to contribute to this mishap. The following analysis of the situation is not intended in any way to be critical of Mr Taylor's decision making. It is hoped that this situation may serve as a reminder to skippers of the risks that require careful management.

Mr Taylor was operating his vessel in a location that was known to have a greater risk of hook-ups. At that time, he tasked Mr Tschannen to check on stores in the freezer. That task necessarily involved opening and leaving open a hatch on the port side of the main deck while Mr Tschannen was below. An open hatch exposed the vessel to the risk, in the event of a hook-up and heeling action, to flooding the freezer thereby adversely affecting stability at a time when stability is already under challenge by virtue of the heeling action.

Mr Taylor conceded in evidence that basis training as a Master addressed the importance of maintaining watertight integrity. Indeed, that topic was the first question he was asked in his oral examinations. He agreed that hatches were not to be left open at sea unless absolutely necessary. It is evident from the events surrounding Dynasty, a hook-up during a port turn would lead to port edge immersion and flooding of an open port side deck hatch. A flooded freezer compounded the stability problem by creating a free flowing surface area within the vessel.

However, when asked whether the outcome for his vessel might have been different if that hatch was closed, Mr Taylor responded in the negative. He said that the vessel had healed over beyond the point of return before the ingress of water into the freezer hold had the opportunity to affect the situation. He said the vessel had heeled beyond the point of recovery and remained tethered in that position by a combination of boom now located aft and the snagged trailing wires.

There is no evidence to refute that assertion.

The stability of this vessel was investigated. MSQ provided a report dated 1 October 2010 addressing aspects of stability. Mr Ron Chubb, an accredited ship designer with MSQ since the start of accreditation in 1996, designed Dynasty in 1979. The design included a stability assessment applying the then standard stability criteria that had its origin in the 1930's. However, he was not retained to do an 'as built' verification or to prepare a final stability report. No stability report was required by the Marine Board of Queensland as part of the initial survey of the vessel. It was not a legislative requirement for vessel under 20m at that time.

Therefore, although it appears likely the design took into account the relevant stability requirements, it is not known whether the vessel's final construction achieved the design parameters.

Since 1994 there has been major legislative reform in the area of regulatory standards applicable to vessel construction and registration, particularly in relation to stability requirements. However, the regulations made under the Transport Operations (Marine Safety) Act provided for a 'grandfathering' of ships designed in accordance with earlier requirements of the Marine Board of Queensland. In the past decade or so, there has been increased adoption and reliance within Queensland legislation of the Commonwealth Uniform Shipping Laws, in particular, sections of the National Standards for Commercial Vessels. The more recent standards on stability require assessment of dynamic stability and with fishing vessels such as trawlers; this includes the possibility of hook-ups. The standards also include intact stability as well as stability after flooding.

A number of coronial inquests have examined the issue of stability requirements following the rollover of the fishing vessels the subject of those inquests.

The report of Mr Werner Bundschuh, Director Safety Standards, MSQ, dated 1 October 2010 noted:

> *The 2005 inquest into the loss of the Eastern Leader in July 2002 recommended that the "grandfathering" provisions in the Transport Operations (Marine Safety) Act 1994 (the "Act") be repealed and fishing vessels made to comply with the NSCV.*
>
> *Following the Easter Leader fatalities, Queensland Transport and the Department of Primary Industries set up an interdepartmental committee. Its main purpose was to reach agreement with the fishing industry on the timing for the removal of the "grandfathering" provisions in the Act. The committee's recommendations were endorsed by the Minister on 28 November 2004. The Coroner recommended the adoption of the committee's recommendations in his 2005 findings.*
>
> *Two more trawler roll-overs in 2004 led to inquests that built on the earlier recommendations in findings handed down in April 2005 and May 2006. The 2008 inquest into the Lauren G which rolled over in 2006 added no further stability related actions other than to make*

the general recommendation that compliance with the NSCV be made mandatory for commercial fishing vessels to which it relates.

In summary, the recommendations to adopt the NSCV have been completed with the exception of retrospective application to the existing fleet which is not required by the NSCV. MSQ actions in this regard have been limited to repealing the "grandfathering" provisions. The application of the NSCV to the existing Queensland vessels has been confined to the safety equipment standard, vessels captured by the further building provisions, upgrades in class of service or risk.

MSQ reports that there are a number of fishing vessels operating in Queensland waters that were registered before 1996 and which continue to benefit from the grandfathering provisions and therefore avoid compliance with current stability requirements. There are limitations to the extent to which MSQ can act to address this issue, particularly given the trend towards a national approach and the mutual recognition requirements between states of registered vessels. Finally MSQ estimates that the costs of stability assessments for the limited number of vessels that are subject to the grandfathering would be in the range of $15,000 to $20,000. Presumably, that takes no account of the cost for any remedial action to cure any inadequacy, if that is possible. There is also the question of capacity to address the risk by means other than meeting the current stability requirements.

MSQ also reported on initiatives in the fishing industry to raise awareness of the risk to stability through hook-ups and to incorporate approaches to emergency management of high risk situations in onboard management plans with training of crew on its implementation.

It is not possible to decide whether the later standards of stability that might have applied to this vessel would have reduced the risk of overturning but for the grandfathering provisions. Therefore, I have not further investigated the need for vessel constructed and compliant with the 1996 standards to meet current stability requirements. I merely observe that many crews who agree to work on fishing vessels assume that they are designed and constructed to a safe standard. I doubt that they would understand that the relevant standard is that which applied at the time of construction as opposed to more recent standards.

Finally, and most importantly, it appears that the cause of the failure of the vessel to recover its stability as it had on past hook-ups was the failure of the starboard forestay. Its failure had the effect of transferring the load via the trailing wires diagonally across the stern of the vessel and held it heeled over to port; flooding the freezer hold.

Mr Taylor was examined about his maintenance of the rigging including the forestay and was able to give a reasonable account of inspections and replacement of associated rigging during a recent refit. There was no evidence to suggest that the rigging, in particular the forestay was not kept in good condition. The fact that it failed cannot, of itself, found an inference that it was not suitable

for the purpose nor properly maintained. The loading to which it was subjected can not be calculated or assessed and then compared to any known benchmark.

Findings required by Section 45

I am required to find, as far as possible, whether or not a death in fact happened, who the deceased is, how the person died, when the person died, where the person died and what caused the person to die. In light of the material evidence that I have summarised and the reasons surrounding its analysis, I am able to make the following findings:

Whether or not death in fact happened:	Nathan Robinson and Scott Tschannen died
How they died	They died due to drowning when the prawn trawler on which they were crew members capsized. Its nets hooked up on an object on the sea floor during a port turn causing it to heel heavily to port. The starboard forestay then failed causing the starboard boom to crash towards the stern and the vessel to roll past the point of no return. The freezer hatch was open and flooded. The trawler sank. The Master, Mr Taylor, was in the wheelhouse and able to get clear. Mr Robinson was sleeping in the focsle and Mr Tschannen was in the freezer hold checking stores. Both were unable to escape the sinking vessel.
Place of death	Both died where the vessel sank, a location about 7nm southwest of Darnley Island, Torres Strait.
Date of death	About midnight – 23/24 April 2009
Cause of death	Drowning due to immersion when trawler sank.

Concerns, comments and recommendations

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

I have carefully considered the need for further guidance to regulators about the application of current stability requirements to vessel constructed and compliant with the 1996 standards. However, the extent to which the current standards may have had an influence on the outcome of this situation is very much in debate. The primary cause of the rollover was the failure of the forward stay. Then there is the degree to which the flooding of the freezer hold would have exacerbated an already precarious position.

I don't consider there to be a sufficient evidential basis to further consider the policy setting underlying the current regulatory approach to stability requirements for these older vessels.

The issue will continue to be monitored by coroners and reviewed when the opportunity arises.

I therefore decline to make any recommendations or comments.

I close this inquest
Kevin Priestly
Cairns
10 December 2012