QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Bethany Emily Farrell**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Mackay
FILE NO(s):	COR 2015/664
DELIVERED ON:	30 May 2018
DELIVERED AT:	Mackay
HEARING DATE(s):	22 May – 25 May 2018
FINDINGS OF:	Magistrate D J O'Connell, Coroner
CATCHWORDS:	CORONERS: Inquest – death by drowning while engaged on introductory scuba dive in Whitsunday Islands – separation of novice diver from instructor and group – poor visibility – adequacy of instruction of deceased, and of lookout by servants of diving company – recommendations as to conduct of future introductory diving excursions – re-establishment of Dive and Snorkelling Death Review Panel
REPRESENTATION:	
Counsel Assisting:	Mr J M Aberdeen
DL20 Trading Pty Ltd (Wings Adventures)	Mr S Farrell (instructed by Barry Nilssen Lawyers)
Ms Fiona McTavish	Ms M Zerner (instructed by Norton Rose Fulbright)
Office of Industrial Relations	Ms C Hartigan (instructed by the Crown Solicitor)
Family of Bethany Farrell	Mr S McLennan (directly briefed by the family)

[1]. On 17 February 2015 Bethany Emily Farrell died after she became separated from her group while undertaking an Introductory Dive[1]. She was a United Kingdom National who had only been in Australia for six days on a backpacking trip. She had never previously undertaken the activity of scuba-diving. Why her death occurred, whether the conditions were suitable for a novice, whether a Resort Dive should commence in Confined Open Water[2], and whether the dive company complied with the appropriate *Code of Practice*[3] were all matters examined in the inquest. Methods of preventing future deaths in these circumstances was also considered.

Tasks to be performed

[2]. My primary task under the *Coroners Act 2003* is to make findings as to who the deceased person is, how, when, where, and what, caused them to die[4]. In Miss Farrell's case there is no real contest as to who, when, where, or what caused her to die, the real issue is directed to the 'how' she came to die.

[3]. Accordingly the List of Issues for this Inquest are:-

1. The information required by *s 45(2)* of the *Coroners Act 2003*, namely when, where, and how, did Miss Farrell died, and what caused her death.

2. Were the currents, weather, surface conditions, visibility, maximum depths and location on 17th February 2015 suitable for novice divers learning to dive?

3. Was the conduct of Miss Farrell's dive excursion conducted in accordance with the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011,* the *Safety in Recreational Water Activities Regulation 2011* and with best safety principles, including, but not limited to:

    (a) Did the dive instructor conduct a dive site risk assessment in compliance with *s 2.3.2* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011*?

    (b) Was the dive instructor's in-water teaching of skills to Miss Farrell adequate and did the teaching comply with *s 2.3.3* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011?*

    (c) Was the dive instructor's in-water supervision of Miss Farrell during Miss Farrell's dive excursion adequate and did it comply with *s 2.3.2* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011* and *r.9* of the *Safety in Recreational Water Activities Regulation 2011*?

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[1] The dive goes by a number of names including Resort Dive, but it is simply a dive done by inexperienced persons who have not dived before.
[2] This is a specific diving term
[3] The applicable industry code is the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011*, and the *Safety in Recreational Water Activities Regulation 2011*. I will simply refer to it in my findings as the 'Code of Practice', 'Code', or 'Diving Code', and 'the Regulations'.
[4] Coroners Act 2003 s. 45(2)(a) – (e) inclusive

(d) Was an out-of-water lookout and rescuer maintained in compliance with *s 2.3.2* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011, r.8* of the *Safety in Recreational Water Activities Regulation 2011* and DL20 Trading Pty Ltd's procedures during Miss Farrell's dive excursion?

(e) Was the process undertaken to locate and attempt to rescue Miss Farrell after she was separated from her dive group adequate and in accordance with DL20 Trading Pty Ltd's procedures and *s 2.3.2* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011*?

4. Should novice divers first satisfactorily demonstrate elementary dive skills and swimming ability in a controlled environment, such as a pool, before participating in an open water dive to reduce the risk of future diving fatalities?

5. What caused Miss Farrell to become separated from her dive group at Blue Pearl Bay on 17 February 2015?

6. Was Miss Farrell adequately equipped (such as with a whistle) and trained to use equipment (such as a safety sausage) that could have signalled her location on the surface?

7. Was the investigation into Miss Farrell's death and the decision-making as to prosecutions of duty-holders by Workplace Health and Safety Queensland adequate?

8. Whether the Dive and Snorkelling Death Review Panel, as recommended by the Queensland Government's Reef Safety Roundtable of February 2017, should be re-established.

[4]. The second task in any inquest is for the coroner to make comments on anything connected with the death investigated at an inquest that relate to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future[5].

[5]. The third task is that if I reasonably suspect a person has committed an offence[6], committed official misconduct[7], or contravened a person's professional or trade, standard or obligation[8], then I may refer that information to the appropriate disciplinary body for them to take any action they deem appropriate.

[5] ibid s.46(1)
[6] Ibid s.48(2)
[7] Ibid s.48(3)
[8] Ibid s.48(4)

[6]. In these findings I address these three tasks in their usual order, s.45 Findings, s.46 Coroners Comments, and then s.48 Reporting Offences or Misconduct. I have used headings, for convenience only, for each of these in my findings.

Factual background & evidence

[7]. Miss Farrell was travelling as a tourist through Australia with two friends also from the UK. She was university educated, and from all information a young, mature, and responsible adult[9]. She had arrived in Australia about six days prior to the incident. She travelled to Airlie Beach, Whitsundays, Queensland, and booked a three day/three night[10] sailing, diving and snorkelling trip with her two friends on the vessel "Wings III", which is a tourist activity sailing catamaran[11].

[8]. On this trip there were twenty-eight paying passengers, one non-paying employee passenger, and five crew, a total of thirty-four persons on board.

[9]. The trip commenced at Airlie Beach, specifically Abell Point Marina[12], where paperwork was completed, and where manifests and pre-trip checks were conducted. Guests boarded at about 1.00 PM that day. Once on-board, paying guests were instructed to muster in the saloon area of the vessel where they had lunch, which was followed by the staff introductions and an induction/safety/housekeeping briefing with respect to the specific vessel. This briefing did not relate to any dive-related activities, rather it dealt with safety on-board the vessel for the next three days[13]. At about 1:20 PM the vessel left its' berth and commenced the trip to Blue Pearl Bay, which is located on the western side (towards the northern end) of Hayman Island.

[10]. Whilst the vessel was steaming[14] from the Marina to Blue Pearl Bay there was firstly conducted a briefing on snorkelling for all paying passengers. After this those who wished to dive were taken aside to conduct a dive briefing. There were nine people who wished to undertake an introductory dive, then two dropped out, leaving seven. The first group of three were Miss Farrell, her friend Melissa (Mimi) Clark, and a Chinese lady Miss Can Xu (I specifically make mention of her as she highlights certain aspects of how this company conducted their introductory dives which demonstrates, at least to me, serious shortcomings).

[11]. The dive briefing was done using a 'flip chart' which had diagrams and brief information. The instructor demonstrated certain equipment during this briefing and this was done on the boat. Miss Fiona McTavish, the introductory dive

[9] There was never a suggestion she was a risk-taker, rebellious, or would fail to follow instruction. I should add that her toxicology screen was clear of any alcohol, illicit drugs, and even prescription and non-prescription medications. Accordingly any suggestion that any 'substance' played a role in her death is erroneous.
[10] That is what the WHSQ Investigation report termed it.
[11] 17.9 metres in length. Its' capacity was 34 persons including crew.
[12] Previously known as Abel Point Marina, a very slight name change, if it is referred by either in the various reports.
[13] Reportedly that briefing was informative and appropriate on the evidence of Miss Melissa Harper, a travelling companion of Miss Farrell. I have no criticism of this briefing.
[14] they were not under sail, rather they were motoring

instructor, thought this appropriate[15], but it is hardly a classroom-like setting as there are a number of distractions around them such as ambient noise from other persons, the actions of the vessel, and scenery as they travelled. What is clear is that it was simply a brief practical presentation, there were certainly no practical skills assessed at this time. It was never suggested, indeed it was abundantly clear, that there was no in-depth imparting of knowledge at this time. Once the vessel arrived at Blue Pearl Bay it tied up to a dedicated mooring buoy provided[16], and the introductory divers[17] were then taken to the beach area in their diving gear. Near the beach, accessed through the tender channel, they entered roughly waist to chest deep water from the tender. There the group of introductory divers[18] conducted certain elementary or practical diving skills.

[12]. The skills conducted were to clear the mask[19], clear the regulator[20], and recover the regulator[21]. Miss Farrell had difficulty on her first attempt clearing her regulator and so stood up. She had success on her second occasion. This fifty percent success rate hardly inspires confidence that the skill has been appropriately learned so that it can be done in a moment of heightened anxiety. There was no suggestion that any introductory diver was properly instructed about achieving and maintaining positive buoyancy on the surface[22].

[13]. The group of three introductory divers with their instructor then began to make their way underwater along their pre-planned route[23]. The first notable event was that

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[15] And it was suggested this is common in the industry; but just because others do things a certain way does not make it right.

[16] The bay has dedicated or fixed mooring buoys which means there are known locations for calculating distances (depending or allowing for the direction a boat is hanging from the buoy) to various locations such as to the 'tender channel' or the area snorkelers were located. This also assisted in gaining an understanding of distances when viewed on a 'Google earth' map reproduced as exhibit C.12 (which contained a scale). The three vectors on the exhibit (orange lines radiating from a particular moored vessel) have no relevance.

[17] I cannot let certain evidence pass without comment. Miss Xu was a Chinese National who specifically advised that she had no swimming ability. The ship's log was marked "no swim" and "ESW" (meaning 'extra surface watch'). Somehow, and it leaves me baffled, the tour operator thought that an introductory dive was an appropriate water activity for Miss Xu. Surely she is at a very high risk of suffering a serious injury or death in undertaking such an activity with no swimming ability (and this absence of ability was communicated to the tour operator). It would come as no surprise that she could not complete the dive and so rose to the surface where she was collected in a tender. I would have thought that any person who indicates they have no swimming ability would be told that they must wear a life jacket, or a buoyancy vest as a minimum, at all times that they were away from the main vessel and on, or in, the water. They certainly should not be diving, and for the record I state that I do not 'contaminate' my views of any facts relating to Miss Farrell's death by my observations of Miss Xu's activities with this tour operator set-out in this footnote.

[18] Miss McTavish was the Instructor, and the introductory divers were Miss Can Xu, Miss Melissa (or Mimi) Clark, and Miss Bethany Farrell. Miss Xu was a Chinese National and so in evidence some witnessed simply referenced her as the Chinese lady, simply because they did not know her name. There was no disrespect intended, it was simply that they may not then have been introduced.

[19] A mask is sometimes termed 'goggles' by persons unfamiliar with scuba terminology

[20] The regulator is the mouthpiece. It is placed in the mouth through which the diver breathes air from their tank. It is quite common for people new to scuba diving to find breathing through a regulator difficult at first. The only way to overcome this is through familiarity, which requires practice and time.

[21] Where it has fallen from the diver's mouth and is hanging by its' hose at the diver's side.

[22] Which is inflation of the BCD.

[23] The extent of the dive site assessment appears to have been to look from the vessel at the water when the vessel entered the bay, and where it was moored (but this is well over 150 metres away), then to look at the visibility when underwater as the dive progresses (but it is already then underway). The visibility at the

Miss Farrell had a positive buoyancy issue[24], and so the instructor placed a three pound weight[25] in a pocket of her BCD to create a negative buoyancy. I was told by a number of witnesses[26] that with introductory divers it is perceived that the greatest risk is that they ascend to the surface too quickly[27], so introductory divers are deliberately established with a negative buoyancy. This alone is a compelling reason why instructors need to be within arms-reach of introductory divers as they are deliberately weighted so that they sink[28].

[14]. The next notable event was that Miss Xu experienced trouble equalising her ears as they began to descend and so was taken back to the surface[29] by the instructor. Significantly the instructor's evidence was that Miss Clark and Miss Farrell came up with them to a depth of about 1.6 metres below the surface, a little past the end of the instructor's fins when she was at the surface. Miss Clark in her evidence confirmed this. It is of course not ideal that the instructor then had separation from two of her introductory divers but no incident occurred at this time. At the surface Miss Xu was placed in the Wings III tender and the instructor and her remaining introductory divers continued their dive.

[15]. As the dive progressed this introductory group at one point came across the certified diver group and there was a moment where some divers became confused as to which group to follow. Because of this Miss McTavish decided to take a different route from the usual introductory dive route so as to avoid any further group intermingling[30]. The instructor was adopting her usual practice of swimming backwards, in a slightly seated position, so that she could see her introductory divers behind her. The particular benefit of this practise was that she could see their faces to assess any degree of anxiety or panic. It was said this was considered an acceptable practice in good visibility conditions.

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beach was just 0.5 metre, but they appear to rely on prior experience 'that it gets clearer as they move away from the beach'.

[24] She was drifting up towards the surface

[25] Also described by witnesses as 1.5kg, it is relatively the same weight. It was a standard dive belt weight.

[26] Senior Constable James Hall, Ms Kate Wilkins.

[27] Risking a bloodstream air embolism or lung trauma from over-inflation of the lungs.

[28] Perhaps it is thought in the industry that because introductory dives are conducted in depths of no more than approximately six metres that there is a manageable risk in this approach (although PADI, I understood, permits up to 12 metres).

[29] This was done progressively attempting equalisation as they ascended but she could not master the technique. She of course was the person noted as 'no swim', and she also had noted 'av english', see exhibit C.2 at page 1147. Incidentally there was no suggestion that diving tuition was given in Cantonese or Mandarin, being the two dominant languages of China.

[30] I am not critical of that decision.

[16]. The conditions this day[31] were assessed by various witnesses as poor, or very poor[32]. Significantly the visibility was considered to have deteriorated about the time the two diving groups intermingled. I find that the visibility during the dive was 'very poor', perhaps only three metres, and at times 'poor' up to five metres at very best, but that at the time that Miss Farrell became separated it was only three metres visibility. It must also be borne in mind that the dive only commenced after 4.00pm[33], and the date was mid-February, so in addition to the then conditions being overcast[34] the sun was significantly away from being overhead and was well toward the horizon, further limiting in-water visibility, especially as depth increased.

[17]. As the instructor had to negotiate between coral bommies she rolled over[35] to look forward for about ten seconds[36]. When she turned to look back she could only see Miss Clark, and could not see Miss Farrell. The instructor then immediately commenced to retrace her steps to look around for Miss Farrell. She looked up but could not see her[37]. She then thought that Miss Farrell may have followed the certified diver group and so swam quickly, with Miss Clark behind her, to that group but could not locate Miss Farrell there. She then went to the surface with Miss Clark. The dive computer profiles give a time for how long the instructor was searching underwater as between two minutes and four minutes[38].

[18]. The dive computer profiles indicate that at a point during the dive, and it is reasonable to conclude that this is the moment that Miss Farrell realises she is separated from her instructor, she is at a depth of about 7.1 - 7.3 metres, and she then commences to ascend quite quickly, and from 5.6 metres to the surface she

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[31] Current can be discounted as a factor as the vessel's dive log records current as 'calm' (exhibit C.2 at page 1148) and low tide was 3.37pm (see exhibit C.2 at page 475). Whilst the vessel records it as 1445 (2.45pm) Mr Croucher conceded that if the official Meteorology Bureau time was 3.37pm at Hook Island that would be correct, allowing for less than 5 minutes variation at Hayman Island. With tides moving in approximately hourly volumes of 1/12, 2/12, 3/12, 3/12, 2/12, and 1/12, for a six hour range and with only 2.66m of tidal range in the relevant period the total movement was very small, and irrelevant, to the factual matrix of this case. The 1/12 plus of incoming tide in the first hour or so also accounts for the slight increase in depth Miss Farrell's dive computer recorded over the final hour. It did not indicate she was moving.

[32] I discount entirely Mr Keyte's views of '5-6m maybe 10m' as he only viewed a GoPro video and did not dive that day. Various witnesses gave a range of 3-5m away from the beach. The beach was just 0.5m. Some said visibility went from 3-5m, to just 3m at best at times during the dive as visibility was variable throughout the dive. Witnesses who said 3-5m (including poor and very poor in their descriptive terminology) included Miss McTavish, Miss Clark, and Miss Wilkins.

[33] The vessel's dive log says 4.05pm, see exhibit C.2 at page 1148

[34] 'weather overcast' is recorded on the dive log, exhibit C.2 at 1148

[35] Moved from a looking backwards and seated position, to be on her stomach, horizontal, and looking forward, what people may consider as the classic or usual scuba diver position.

[36] Miss McTavish's clear oral evidence (and she conceded this was 'too long' to not have visual observation). I appreciate the difficulty she must have had to make that admission, but it shows reliability in her evidence as to that aspect.

[37] And perhaps from a depth of about 7 metres the poor visibility with overcast conditions meant she could not see the surface

[38] Utilising exhibit D.13 with Dr Sayer's overlay it shows 2 minutes, exhibit D.8 shows approximately 4 minutes. I resolve later which overlaid data appears more accurate as a comparison of the instructor and her students' dives

ascends at a rate which can be described as a very rapid ascent done with purpose[39]. Clearly it was not a planned, controlled ascent, but demonstrates diver panic (or emergency) with an urgency or sole focus to reach the surface. The dive computer then records three moments (or points or 'grabs of data', whichever term you wish to use), each twenty seconds apart[40] when Miss Farrell was at the surface. Accordingly the minimum time she was at the surface was 42 seconds, and it is possible (if the 20 second grab was at the end of the initial 20 second interval, i.e. she had surfaced 19 seconds prior, and she descended just prior to the next grab from the commencement of the last 20 second interval, it is up to 98 seconds[41]). After considering the evidence I find that the time she was at the surface was a little over 40 seconds[42].

[19]. When she surfaced various witnesses described hearing a diver call out in panic or distress[43], or a diver waving their arms in distress[44]. Each of the people who heard her, or saw her, were either a passenger from Wings III (a person then snorkelling,) or a person from another vessel, named New Horizon. The skipper who was allegedly conducting surface watch[45] from Wings III neither heard nor saw Miss Farrell whilst she was at the surface. The earliest he can state was that he '*saw a breach in the surface of the water*'[46], where he later learned Miss Farrell had surfaced. Mr Peter Hall in the tender claimed he saw, and heard, Miss Farrell at the surface.

[20]. What surface watch was being conducted from Wings III needs to be resolved. The evidence of Mr Croucher, the skipper, was, as I said, that he simply saw a breach in the surface of the water. At this time he claims he was on top of the Wings III vessel which was moored about 120-150 metres away from the divers. His attention was drawn to the diver's area when he heard someone from New Horizon call out. He looked over and saw the break in the surface of the water. He said he then radioed Mr Peter Hall who was then in the Wings III tender over near the snorkelers. He directed Mr Hall via the radio to go to the area where he had seen the disturbance on the water. He said that the Wings III tender arrived within a few seconds of the New Horizon tender. He said at this time Miss Clark surfaced and was taken into the Wings III tender.

[21]. Mr Peter Hall, then in the tender, said he collected Miss Xu, and took her over to the snorkelling area. Then he went back to the Wings III vessel to collect other

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[39] In exhibit C.2A Mr Schutte (at page 4) helpfully calculated the vertical metres per minute rate. It demonstrates a rapid, then very rapid, rate of ascent. The printout displays the very rapid rate in a different colour, perhaps to highlight the rate is above a rate pre-set on that computer.

[40] Her dive computer was set to record data points (simply depth in vertical metres, which is converted from the pressure the computer sensor records) every 20 seconds from dive commencement

[41] Theoretically 19 + 20 + 20 + 20 + 19 = 98 seconds. I should highlight that this duration, 98 seconds, appears unlikely as she was 5.6m below the surface 20 seconds before the first surface grab, and 4.2m below the surface at the next grab after the last surface grab.

[42] And this duration can be confirmed as the minimum surface duration due to the time grabs. It also accords with certain witness observations as I later state.

[43] Mr Boyes a snorkeler.

[44] Mr Browne then on New Horizon, a vessel moored approximately level, due west, of the tender channel, and roughly due west of where Miss Farrell surfaced.

[45] Surface watch is where a person is working as a lookout for persons doing water activities. The requirement is that they be "engaged solely" as a lookout to be doing their job appropriately.

[46] The term used by Mr Croucher, the skipper

passengers. He says he was at the stern[47] of Wings III when he said he noticed a diver surface, wave their hands and yelled, and so he 'zoomed over' to the diver. He said the two passengers[48] were still in the tender with him. At the location he had seen the diver surface he saw no sign of the diver, so conducted the three engine rev signal[49]. He then drove back to Wings III, and collected Mr Croucher who he had seen 'waving his arms calling him back'. He went back and together he and Mr Croucher went back to the dive location where Miss Farrell had surfaced and another tender was there. Mr Peter Hall said that when he heard Miss Farrell that Mr Croucher was located towards the stern of Wings III, on the upper deck. Of some interest I note that the version Mr Peter Hall gave at the inquest does not accord with that which he gave in his interview with the Office of Industrial Relations the day after the incident.

[22]. Mr Graham Boyes gave evidence that he was a passenger on Wings III and was snorkelling with travelling companions at the relevant time. He was about 100 metres away from where he saw a diver surface in obvious distress and panicked. He heard the diver scream. He was so concerned that he commenced to swim towards the diver whilst his travelling companion[50] tried to get the attention of the crew member in the Wings tender. It is reasonable to presume that Mr Peter Hall is this person referred to as it was never suggested there was another crew member in the tender at that time. Mr Boyes said that he swam about halfway to where Miss Farrell had surfaced before he saw a small tender get to the scene.

[23]. Mr Jonathan Stewart was the skipper of the vessel New Horizon. He said he heard the first mate on his vessel, Mr Philip Browne, call out indicating urgency and so he went from the stern of his vessel to the side where Mr Browne said he had seen a person in distress, that it was a diver surfacing and then going under the surface. Mr Browne's evidence was that out of the corner of his eye he saw the diver surface waving in distress. He was able to recognise that it was a scuba diver and that they were in distress. He kept his eye on the location and did not look away[51] just calling for Mr Stewart. Mr Browne remained on the deck of New Horizon whilst Mr Stewart went to the location. Mr Stewart's evidence was that at the location (and guided by hand signals from Mr Browne then still back on New Horizon) he picked up a single swim fin, which all parties agreed was the fin lost by Miss Farrell[52]. Mr Stewart looked into the water but without the benefit of a mask could not see anything. Mr Stewart said he called to the tender of Wings III asking for a mask and snorkel but they had none[53]. Mr Stewart then went back to New Horizon where he collected a weight, rope, and pool noodles to create a makeshift diver marker. Mr Browne, who was in scuba gear, got into the second tender of New Horizon and was driven to the location arriving about three minutes after the time he first saw the distressed diver descend below the surface. Mr Browne conducted a short dive, then surfaced saying he could not find anyone. Miss McTavish surfaced a short

[47] He said not tied on, but just off the stern with the motor running
[48] Names are unknown
[49] Apparently to signal to instructors below to surface.
[50] Identified in his evidence just as 'Danny', which would be Danny Smith-Whittle
[51] This is the first rule of marking the location of a person in the water in distress. His presence of mind is admirable.
[52] The parties also agree it was lost at, or very close to, the surface as these fins have a neutral buoyancy
[53] Of note both Mr Boyes and Mr Stewart place the Wings III tender at the snorkelling area at this time.

while nearby and indicated she had lost a diver. Miss McTavish and Mr Browne went down again to search.

[24]. Mr Browne, Mr Stewart, and Mr Boyes were all very good witnesses and had no vested interest whatsoever in the evidence they gave. They impressed me, particularly Mr Stewart, who I observed was cautious in how he gave his evidence. I reject the evidence of Mr Peter Hall[54]. His suggestion that he got to the scene at the same time as the first vessel (Mr Stewart when he went out by himself) is simply not true[55]. Interestingly Mr Hall placed himself at the stern of Wings III when he was first asked to respond to the missing diver. That is of interest when placed with the evidence of Mr Collie, the host on Wings III who said in evidence that Mr Croucher was on the aftdeck, then moved to the aftquarter, up higher, when he was looking at two tenders milling around near the dive area, then appeared to be contemplating for a moment before he said words indicating that there was a serious issue. Mr Croucher then reacted with urgency. Mr Collie observed Mr Croucher then tell Mr Hall who was at the stern of Wings III to 'get over there straight away'. There was no suggestion that Mr Croucher used his radio to indicate this to Mr Hall[56], or that Mr Hall was over in the snorkelling area when Mr Croucher first reacted or knew a diver was in distress. Mr Croucher's evidence is at odds with others, and I do not prefer his evidence. The best, or most favourable to him, that I can say is that his recollection of the sequence of events is very poor. I accept and prefer the evidence of Mr Boyes, Mr Browne, Mr Stewart, and Mr Collie, and I find that the initial response was by the tender from New Horizon, as was the next response involving Mr Browne in the second New Horizon tender. I conclude from this that the persons designated as surface watch, Mr Peter Hall and Mr Steven Croucher, were not conducting an adequate surface watch at the time Miss Farrell surfaced in distress[57]. If they had been then the 40 plus seconds she surfaced for is more than adequate time for them to scan the approximately 30 degree wide field of vision to see the distressed diver. Accordingly I find that the surface watch personnel failed to conduct an adequate surface watch, and at worst did not conduct any surface watch at that point in time.

[25]. After Miss Farrell was lost below the surface Miss McTavish searched for over an hour, with the assistance of Ms Wilkins, and Mr Browne for a time, before Miss McTavish located Miss Farrell at a depth of about 10.7 metres. When she was located her mask was missing, the regulator was not in her mouth, and one fin was missing. Her BCD was not inflated. She still had on her weight belt, and one extra weight in a pocket of her BCD. It is quite evident to me that visibility must have been very poor at the location she was last seen when it took over an hour before she was located on the seafloor. All attempts to revive her were unsuccessful.

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[54] He was quite a combative witnesses to counsel even on simple questions.

[55] Perhaps he simply did not see the first tender's arrival, but clearly he only arrived very well after Miss Farrell had descended for the final time.

[56] Why would he when they are nearby at the stern area of Wings III

[57] at the inquest all parties agreed that the distressed driver who surfaced was Miss Farrell, and there is no suggestion that it was any other person. The evidence was that Miss Farrell surfaced (marked on exhibit C.12 by an arrow with the words 'Beth surfaced') not far from the tender channel, and on the route that the introductory divers were undertaking (indicated by Miss McTavish in her evidence and marked by a series of small circles, see exhibit C.12), so she had not strayed from the introductory diver route

[26]. I should acknowledge that the actions of Mr Croucher, after he first responded, in recording, through Mr Collie, important events and times was appropriate and proper conduct.

Dive Computer reconciliation

[27]. There was tendered at the inquest a number of recorded or downloaded dive profiles[58]. A dive profile is the 2-D data recording of depth captured by the dive computer. 2-D data is a helpful tool, but does not reflect that diving occurs in a 3-D environment. Nonetheless the dive profile is of benefit. Exhibit D.8 presented the entire dive from commencement until final ascent which was over an hour after the dive commenced. It is useful in demonstrating a number of aspects of the entire dive. Data from this dive shows there were times of significant student/instructor separation, particularly around the 360–380 second mark, where the diver separation[59] is around 6.5–6.7 metres. Exhibit D.12 and D.13, which essentially contains the same dive profile overlays, has 'moved' Miss McTavish's profile along the time scale, and various reasons are provided for this which I do not descend into here as it is explained more fully in the exhibit, but it shows that the instructor/student dive profiles effectively 'mirror' each other, with the only notable distance of instructor/student dive separation of about 1.6 metres, when the instructor was at the surface for a period of time (and I leave aside the time that Bethany did her emergency ascent in this analysis).

[28]. It is important to look at the evidence of certain known events that occurred during the dive. The first was that Miss Farrell and her instructor rose until a weight was added to Miss Farrell's BCD to control her then positive buoyancy, giving her a negative buoyancy. There was also an incident where Miss Can Xu was taken to the surface and the instructor remained on the surface for a short while. At that time it was said that Miss Farrell and Miss Clark were just past the end of her diving fins below her. This would be about 1.6 metres. This was confirmed by Miss Clark in her evidence. There was no dispute in the evidence that these two events occurred, and I accept that they did occur. Once that is established, it is evident that the dive profiles overlaid by Dr Sayer, where the two patterns effectively mirror each other as set out in exhibit D.12 and D.13, shows that there was no instructor/diver separation of over six metres (as one overlay shows, exhibit D.7 and D.8), rather it was only ever 1.6 metres vertically at one particular time when near the surface. Accordingly I prefer, and I accept, that the appropriate dive chart overlay comparison is that by Dr Sayer (exhibits D. 12 and D.13).

Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011

[29]. The Code includes various skills introductory divers should be taught[60]. I find on the evidence that this was not adequately 'instructed' (using the Code's language)

[58] Each showed the same linear recorded profile and the same depths, it was only a question of how to overlay Miss McTavish's to Miss Farrell's. This was essentially due to the computers having different start times. An attempt to 'work backwards' from the known same final ascent time was done (and it certainly seems a reasonable assumption), but I explain above why I prefer Dr Sayer's overlay.
[59] and when I say diver separation I mean the instructor Miss McTavish, and her student Miss Farrell.
[60] D.2 at 2.3.3.2

to the introductory divers. The evidence was they were not to use the BCD inflator except when on the surface. Perhaps teaching it as a demonstrated skill, rather than just informing about is a better approach. Where these skills are taught is of concern to me[61]. What was clear is the Code needs much greater clarity as to what are minimum standards or requirements. It was stated at the inquest, and perhaps it was simply the choice of words, that the Code was more like guidelines[62], rather than being a rigid minimum standard which must be met, and hopefully exceeded.

List of Inquest Issues Answers

Coroners Act s. 45(2): 'Findings'

[30]. Dealing with the list of issues for this inquest the answers are as follows:-

[31]. **Issue 1.** The information required by section 45(2) of the *Coroners Act 2003*, namely:

1. Who the deceased person is – Bethany Emily Farrell[63];
2. How the person died – Miss Farrell died when she could not maintain surface buoyancy after she had become separated from her dive instructor whilst underwater. Separation was likely due to poor underwater visibility and a lack of adequate instructor supervision;
3. When the person died – 17 February 2015[64];
4. Where the person died – Blue Pearl Bay, Hayman Island, Whitsundays, Qld[65]; and
5. What caused the person to die – drowning[66].

[32]. **Issue 2**: Were the currents, weather, surface conditions, visibility, maximum depths and location on 17th February 2015 suitable for novice divers learning to dive?

[33]. The environmental conditions, considered alone, were suitable for novice divers learning to dive provided[67] appropriate training and underwater supervision occurred.

[34]. **Issue 3**: Was the conduct of Miss Farrell's dive excursion conducted in accordance with the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011,* the *Safety in Recreational Water Activities Regulation 2011* and with best safety principles, including, but not limited to:

[61] The Code says in shallow water or at a bar hanging from the side of a boat. That of course requires one hand for grip, but what of a student using two hands for performing mask clearing? It's a recipe for disaster when they are deliberately negatively buoyant and not instructed on BCD operation.
[62] and I apologises if this line sounds like a quote by Capt.Barbosa from '*Pirates of the Caribbean'*, but that was the terminology used.
[63] See exhibit A1 QPS Form 1
[64] See exhibit A2 Life Extinct Form
[65] See exhibit A2 Life Extinct Form
[66] See exhibit A3, Form 3 Autopsy Certificate
[67] and I cannot emphasise this aspect enough

1. Did the dive instructor conduct a dive site risk assessment in compliance with *s 2.3.2* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011*?

   Answer: I find that this does not appear to have occurred, or at least adequately occurred, before the dive commenced.

2. Was the dive instructor's in-water teaching of skills to Miss Farrell adequate and did the teaching comply with *s 2.3.3* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011?*

   Answer: This does not appear to have adequately occurred, particularly to a level of competency to minimise risk to the introductory diver, that is the skill has been appropriately mastered, and there does not appear to have been any attempt to instruct on achieving and maintaining positive buoyancy on the surface[68].

3. Was the dive instructor's in-water supervision of Miss Farrell during Miss Farrell's dive excursion adequate and did it comply with *s 2.3.2* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011* and *r 9* of the *Safety in Recreational Water Activities Regulation 2011*?

   Answer: This does not appear to have occurred, specifically for the period of ten seconds that Miss McTavish turned away from keeping her introductory divers under supervision. It was during this period the dive instructor/introductory diver separation occurred which is a moment which led to the chain of events resulting in Miss Farrell's death.

4. Was an out-of-water lookout and rescuer maintained in compliance with *s 2.3.2* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011, r 8* of the *Safety in Recreational Water Activities Regulation 2011* and DL20 Trading Pty Ltd's procedures during Miss Farrell's dive excursion?

   Answer: In accordance with my factual findings this did not occur from Mr Croucher or Mr Peter Hall. It certainly appears to be a reasonable conclusion that if a diver surfaces in distress for a period of forty seconds or so that that is adequate time for an out of water lookout to have recognised that the diver is in distress. Accordingly it does not appear that the required person was solely engaged[69] in being the lookout, nor were able to recognise a diver in difficulty. They were not, I find, conducting the appropriate degree of visual observation required.

[68] a 50% success rate for mask clearing hardly inspires confidence that the skill is mastered, and simply saying that skills were taught in the way that others taught them does not satisfied the dive instructors' obligation under the Code. In fact demonstrates a somewhat lax approach across the industry.
[69] 'solely engaged' is the term used in the Code.

5. Was the process undertaken to locate and attempt to rescue Miss Farrell after she was separated from her dive group adequate and in accordance with DL20 Trading Pty Ltd's procedures and *s 2.3.2* of the *Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011*?

   Answer: Certainly the response undertaken by the Wings III out of water personnel (Mr Croucher and Mr Peter Hall) was inadequate in that they did not respond within the critical first few moments[70], rather the response came from crew of the vessel New Horizon. The underwater response from Miss McTavish appears appropriate, but I commented in my Recommendations on what additional steps should be considered to note the location where a diver separation occurs.

[35]. **Issue 4.** Should novice divers first satisfactorily demonstrate elementary dive skills and swimming ability in a controlled environment, such as a pool, before participating in an open water dive to reduce the risk of future diving fatalities?

[36]. Clearly the focus should be on introductory divers first demonstrating in a controlled environment the necessary diving skills with competency to ensure their own safety in the open water. This is a primary safety system for their welfare. Systems relating to lookouts or recovery of a distressed diver is a secondary system, which is only relevant after the primary system has failed. All parties at the inquest considered that there is benefit in skills being demonstrated in a controlled environment such as a pool. I appreciate entirely that this adds a commercial consideration for tour operators. No doubt arrangements can be made with pools for skill sessions to occur or perhaps particularly enterprising operators will install their own pools, and a shipping container pool is certainly a cost-effective option[71]. What is evident is that the overwhelming percentage of diving and snorkelling deaths in Queensland occurs with overseas tourists who, it is reasonable to conclude, have less ability, and familiarity, and accordingly could be more 'anxious' than Australian residents when in open water. I address this further in my Recommendations.

[37]. **Issue 5.** What caused Miss Farrell to become separated from her dive group at Blue Pearl Bay on 17 February 2015?

[38]. Miss Farrell became separated due to inadequate dive instructor supervision and distance in the then prevailing visibility conditions. It cannot be determined precisely, nor entirely discounted, if she inadvertently followed divers from the certified divers group, or strayed from what was meant to be her intended route due to some other factor[72].

[70] which is when Miss Farrell is at the surface and signalling her distress.
[71] Particularly in view of the court fine imposed on the tour operator in this case.
[72] What can be excluded is that she did not suffer any marine sting (box jellyfish, Irukandji etc and this was specifically noted in the Autopsy Report, exhibit A.4), and there was no suggestion by any person that there was any marine animal which may have caused her anxiety, such as a shark. Accordingly these theoretical possibilities I can exclude.

[39]. **Issue 6**. Was Miss Farrell adequately equipped (such as with a whistle) and trained to use equipment (such as a safety sausage) that could have signalled her location on the surface?

[40]. Whilst I have dealt with the limited training she received, her BCD did contain a safety sausage, but I consider that in her panicked state she would not have been able to operate it. A whistle, even if contained in a pocket on her BCD is unlikely to have been of assistance, in that it is doubtful that she would have the presence of mind to use it, particularly as she was struggling to maintain buoyancy, and noting that instinctively your arms are used to maintain buoyancy or signal for help. Of course all these safety items are dependent on an adequate surface watch being maintained.

[41]. **Issue 7**. Was the investigation into Miss Farrell's death and the decision-making as to prosecutions of duty-holders by Workplace Health and Safety Queensland adequate?

[42]. Whilst I appreciate that the family has concerns in relation to certain aspects of the prosecutions, or the decision not to commence a prosecution, any review by a coroner needs to be approached cautiously as a coroner has available further evidence which may not be able to be used in a prosecution. I do not make any specific criticisms of the decisions taken by the department to date, as most fortunately the time limit for commencing any further action by the department is extended by twelve months[73] following the holding of an inquest. Accordingly that will allow the department to review the evidence, make further enquiries if need be, gather further evidence, and decide if any further prosecution has any reasonable prospects of success and satisfies the necessary tests. I make further comment in this regard in relation to my s.48 Reporting offences obligation.

[43]. **Issue 8.** Whether the Dive and Snorkelling Death Review Panel, as recommended by the Queensland Government's Reef Safety Roundtable of February 2017, should be re-established.

[44]. All interested parties at the inquest agreed it should, and in this regard see my Coroner Comments (Recommendations) below.

Coroners Act s. 46: 'Coroners Comments' (Recommendations)

[45]. This inquest heard that this was the second diving death involving a resort dive, or introductory dive, at a location near Hayman Island. The other death was a 23-year-old female, Miss Elaine Morrow, who was an Irish tourist on a three day/two night sailing trip around the Whitsundays islands. Her very first introductory dive was at Blue Pearl Bay. There are clear similarities between the two deaths less than four years apart[74]. It is evident that Miss Farrell's death occurred due to the introductory

[73] S.232(1)(b) WHSQ Act

[74] Indeed there are haunting similarities (23 y.o. female, non-Australian, backpacker, 2 night/3 day boat trip, location of dives, introductory diver, unskilled on scuba equipment, buoyancy adjusted by their instructor, inadequate underwater supervision, diver separation in poor visibility) between the deaths of Miss Morrow and Miss Farrell, which is why the industry must make changes to ensure the safety of

diver having inadequate, demonstrated or practised, skills with scuba equipment, and her being in an environment (underwater), with which she is not familiar (naturally the level of anxiety is increased). Scuba diving, whether around the inner islands, or along the Great Barrier Reef, is a large and important industry. It is vital that appropriate standards are set, maintained and observed, to ensure that the activity is conducted safely which can be done even though it is recognised it is a 'high risk' activity.

[46]. Accordingly I remake the following recommendations:-

1. That the Office of Industrial Relations (WHSQ), within six months, review and consider for inclusion in the relevant Code of practice issues addressing:-

   a. Introductory Diver: Instructor ratios of a maximum of 2:1, and 1:1 if conditions are poor (such as current, visibility, or surface chop[75]);

   b. Review the term 'resort dive' to be renamed 'introductory dive';

   c. The instructor to always be within arms-length of their resort divers, and to 'link arms' if conditions (whether visibility, current, or surface chop) are assessed as poor or very poor;

   d. Dive instructors must do a dive site assessment, including:-
      a. Assessing visibility with a secchi disk[76] and
      b. Conducting an in-water (at depth) visual inspection for horizontal visibility, and to assess current[77],

      to determine if the site is suitable for introductory divers and to determine the Introductory Diver: Dive Instructor, ratio;

   e. That elementary dive skills including mask clearing, regulator clearing, regulator recovery, buddy breathing, BCD inflate/deflate, and emergency weight belt dropping, are taught until the skill is competently demonstrated to the instructor, and that this is to occur in a controlled water environment[78] such as a swimming pool[79];

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introductory divers. I make clear that in no way do I suggest the practise of introductory diving be banned, rather it simply requires modifications to teach appropriate elementary diving skills (acquired through practical training in-water), and adequate and appropriate instructor supervision when in Open Water or Confined Open Water (theses are each recognised diving terms).

[75] I include current because this can readily cause diver separation, and surface chop as inexperienced divers may inadvertently swallow water whilst floating at the surface causing them difficulty with breathing leading to panic.

[76] This was described as a weighted disk with four coloured quarters (black/white/black/white) at the end of a rope with metre intervals marked along the rope so that when the quarters could not be readily discerned a determination can be made of the visual depth clarity down through the water column when viewed from the surface.

[77] For instance certain locations in the Whitsundays experience very strong currents such as Solway Pass, Fitzallen Passage, and Hook Passage.

[78] This was the Recommendation of the QPS Investigation Officer.

[79] No doubt access to a swimming pool will be an issue, but operators will need to be resourceful, and I am sure can be arranged. There are also options such as shipping container pools (if unsure perhaps try

f. That diving groups[80] are staggered, and that routes are determined in a way to avoid dive group interaction whilst underwater;

g. That the dive instructors solely have the final decision on whether a dive proceeds, or is terminated, and that it not be the skipper, nor the tour operator (who may have commercial considerations influencing their judgement);

h. That safety measures include that the 'Surface Watch' person has an emergency 'grab bag' which includes a weighted lost diver marker[81], and that dive instructors carry on their person (whilst conducting the dive) a suitable underwater marker system[82] to indicate underwater the last known position that the separated driver was seen;

i. That if swimming fins[83] are used, then some style of 'fin-safe'[84] style retainer strap is used with the swimming fins;

j. Whether a policy should be implemented that if any diver becomes separated, that all divers in that group must immediately surface and inflate their BCD, even though it is an emergency ascent[85].

2. That the Office of Industrial Relations (WHSQ), within six months, consider whether the relevant diving Code of practice needs to be mandated as the minimum standard for operations, rather than being "guidelines".

[47]. On 5 April 2017 there was flagged a *Dive and Snorkelling Death Review Panel* within the Coroners Court of Queensland, chaired by the Northern Coroner located in Cairns. It was to comprise persons including representatives of government agencies, a forensic pathologist, and industry representatives. Just three months later, 5 July 2017, the review Panel was ceased with the Chair citing reasons of

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'Google') which I understand are available from approximately $25,000. As to whether this is cost prohibitive dive operators should realise that a fine of $160,000 (see exhibit C.10) was imposed on the tour operator involved in Miss Farrell's death.

[80] If a number of tour operators are in a location at one time then a simple discussion between them, and common sense, can ensure staggering occurs.

[81] This can simply be a weight attached to the end of a floating rope with a surface buoy at the end. No doubt as resort drivers only dive to a set limited depth the length of the rope will be determined for that depth plus the tidal range. Its purpose is to be quickly deployed where the diver was last seen so that recovery efforts can be focused to the lost diver's last known location. This is particularly important when underwater visibility is poor, or very poor. I note, in the circumstances of Miss Farrell's death, the resourcefulness of Mr Jonathan Stewart to use a dive belt, rope, and pool noodles to make a quick 'lost diver marker' for the surface. Unfortunately he had to return to his vessel to obtain these items and to then return to the location where the lost diver was last seen to surface. This can be difficult.

[82] Whether a brightly contrasting weighted disc perhaps with floating streamers to also highlight it, underwater flare, or dye bag. If a flare or dye bag it must be such that its' operation does not produce a 'cloud' which reduces visibility.

[83] by swimming fins I am describing the type that Miss Farrell was using, which is a one piece moulded soft rubber fin, and not of great length, as opposed to diving-specific fins which are generally much longer in length (and usually constructed of a stronger material) so they can generate greater propulsion; and generally (in my experience as a Certified Open Water Diver) are better retained on the foot

[84] This being the simple 'Y' shaped rubber strap worn over the foot/ankle

[85] The considerations I mention are not exhaustive.

"*persistent understaffing*", "*lack of continuity of staff*", and during periods of casual vacancies due to illness or injury "*positions are not backfilled*" with a suggestion that assistance at these times be provided by "*someone from Brisbane is to help me out remotely when needed!*"[86]. In very short compass the Northern Coroner's complaint was a lack of administrative staff support being located with that coroner.

[48]. All parties at the inquest agreed that a sensible and reasonable Recommendation was that the Review Panel be reinstated. 'How' it is conducted is the real issue. It is appropriate, in my view, to be conducted by the Office of Industrial Relations, comprising a panel of diving experts[87], select government representatives, and industry personnel[88]. The coroner then, if they so choose, can seek a report from the panel on any particular death. There needs to be a separation of the coroner's investigation and the work of the Review Panel[89]. Appropriate resourcing of the panel can be achieved by the OIR. Accordingly I recommend that the *Dive and Snorkelling Death Review Panel* be re-instigated by the Office of Industrial Relation. I envisage that this could be achieved within three months[90].

Coroners Act s. 48: 'Reporting Offences or Misconduct'

[49]. The Coroners Act s.48 imposes an obligation to report offences or misconduct. The legislation state that it is mandatory if I reasonably suspect a person has committed an offence.

[50]. After hearing the evidence, and in view of my findings, I have formed the opinion that I reasonably suspect that the tour operator, DL 20 Trading Pty Ltd, its' skipper Mr Steven Croucher, its' employee Mr Peter Hall, and the dive instructor Miss McTavish[91], all may have committed an offence under workplace laws. There is no evidence to suggest any criminal offence by any person or entity whatsoever. Accordingly I will make the appropriate referral to the Chief Executive of the Office of Industrial Relations. Whether or not there is adequate admissible evidence to justify a prosecution is for that Department to determine. It must be borne in mind that no inference against any of those parties may be drawn merely because I make a referral. It is simply because the legislative requirement under the *Coroners Act* is written in mandatory terms.

Magistrate O'Connell
Central Coroner
Mackay
30 May 2018

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[86] See exhibit D.14. Incidentally Brisbane is located approximately 1750 kilometres from where the coroner is located.
[87] Perhaps consideration be given as to whether someone from the QPS Diving Squad is appropriate
[88] Industry personnel must not be the majority of membership as they, understandably, have certain commercial considerations.
[89] And whilst s.71(7) *Coroners Act* 2003 permits the State Coroner to be appointed as a member of certain committees or a specific Review Committee, it has specified limitations. Of course it must always be borne in mind that the role of a coroner is as an independent judicial officer.
[90] Perhaps their first Review should be Miss Farrell's death, and perhaps also Miss Elaine Morrow which on 18 April 2001 at the nearby Langford Island's fringing reef.
[91] Miss McTavish has already been expelled as an instructor by her diving association, PADI, which may be considered her professional organisation.