QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Matthew Stephen Barclay**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2012/1091
DELIVERED ON:	15 January 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	13 November 2013, 9-10 December 2013, and 4-5 August 2014. Submissions received November 2014 to May 2015.
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Surf life-saving, risk management

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Barclay Family:	Mr Stephen Courtney (Instructed by Mr Stephen Barclay)
Surf Life Saving Australia:	Mr Mark Gynther (Instructed by Lander and Rogers)
Chairman of SurfProbe:	Mr Guy Sara (Instructed by K & L Gates)
Tourism & Events Queensland:	Mr Damien O'Brien QC (Instructed by Mullins Lawyers)

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Introduction

1. Matthew Barclay was just 14 years of age when he died during competition at the 2012 Australian Surf Life Saving Championships (the Championships) on the southern end of Kurrawa beach at the Gold Coast.

2. On the afternoon of 28 March 2012, Matthew was competing in the second round of the under 15 board race. While he was attempting to negotiate the waves on the outer bank his board was seen to fly into the air. Although Matthew was observed to be in difficulty by fellow competitors and several rescue water craft (jet ski) operators, he became submerged within seconds and was lost in the surf break. His body was not located until after 9:00am the following morning, approximately 2.5km from his last known position.

3. These findings:

    - Confirm the identity of the deceased, and determine how he died and the date, place and medical cause of his death;

    - Consider the adequacy of the policies and procedures in place at the Surf Life Saving Australia (SLSA) 2012 Australian Surf Life Saving Championships relating to the postponement or abandonment of competition for the safety of competitors;

    - Consider the application of those policies and procedures to the conditions present at Kurrawa on 28 March 2012; and

    - Consider the steps taken by SLSA to implement recommendation 2, '*Continuing review of safety devices*', of State Coroner Michael Barnes' findings delivered on 2 August 2011 in relation to the death of Saxon Bird.

4. As State Coroner Barnes noted in his findings in relation to the death of Saxon Bird, while this inquest concerns a death that occurred during the Championships and has examined policies and procedures of SLSA in the context of Matthew's death, it is important to acknowledge the value of surf life saving to the Australian community and our ability to enjoy our many beaches. The 2014/15 Annual Report of SLSA notes that:

    - *frontline surf lifesavers, lifeguards and support operations groups performed 12,690 rescues, 42,424 first aid treatments and 1,255,090 preventative actions.*
    - *total membership numbers by increased 0.6per cent to a total of 169,633.*
    - *patrolling members completed a total of 1.3 million volunteer hours on patrol.*

Coronial jurisdiction

5. An inquest is a fact finding exercise and not a process for allocating blame. The procedure and rules of evidence used in criminal and civil trials are not adopted. "*In an inquest there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish the facts. It is an inquisitorial process, a process of investigation quite unlike a trial*..."[1]

6. The purpose of an inquest is to inform the family and the public about the matters required by s 45 of the *Coroners Act 2003*, including how the person died and what caused the person to die. In appropriate cases, a coroner can also make recommendations with a view to reducing the likelihood of similar deaths. As a result, a coroner can make preventative recommendations concerning public health or safety or ways to prevent deaths from happening in similar circumstances.

7. A coroner is prohibited from including in the findings or any comments or recommendations any statement that a person is, or may be, guilty of an offence or civilly liable. However, the *Coroners Act 2003* provides that if, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant government Department.

The investigation

8. The Queensland Police Service (QPS) was responsible for the investigation into Matthew's death, which was coordinated by Detective Senior Constable Cameron Hardham from the Burleigh Heads CIB.

9. The QPS interviewed witnesses to Matthew's board race and all relevant persons from SLSA who were involved in the organisation and conduct of the 2012 Championships. All relevant planning and policy documents from SLSA were also obtained.

10. Information was also obtained from SLSA with respect to the implementation of recommendations made by State Coroner Barnes in his 2 August 2011 findings in relation to the death of Saxon Bird at the 2010 Championships.

11. Detective Hardham compiled a report at the conclusion of the QPS investigation, which was tendered at the inquest.

12. The Office of Fair and Safe Work Queensland (OFSWQ) was notified of Matthew's death. It adopted the same approach that it took in relation to the

[1] *R v South London Coroner, ex parte Thompson* (1982),126 S.J. 625

death of Saxon Bird, in consultation with the Office of the State Coroner. The QPS was designated as the lead agency for the investigation and no investigation was conducted under the *Work Health and Safety Act 2011* (WHS Act).

13. Following a request from the Barclay family on the second day of the inquest, the Office of Fair and Safe Work Queensland (OFSWQ) was asked to assist with my investigation and provided a helpful report in March 2014 on the following issues:

    - The adequacy of the policies and procedures at the 2012 SLSA Championships relating to postponement or abandonment of competition;
    - The application of those policies and procedures to conditions present on 28 March 2012; and
    - Steps taken by SLSA to implement recommendation 2, '*Continuing review of safety devices*', of the Saxon Bird findings of inquest handed down on 2 August 2011.

14. In retrospect, having regard to the different focus of the QPS investigation to an investigation under the WHS Act, it would have been beneficial for a full investigation to have been carried out under that Act given the objects of the WHS Act and the emphasis on risk management in workplaces.

15. I am satisfied that I was given access to all relevant material produced during the investigation. I acknowledge the detailed and helpful materials and submissions provided by those given leave to appear at the inquest, including the Barclay family. These have been of great assistance in the preparation of these findings.

The inquest

16. A pre-inquest conference was held in Brisbane on 13 November 2013. Mr Johns was appointed counsel assisting and leave to appear was granted to Matthew's family, Surf Life Saving Australia, Tourism and Events Queensland and Mr Bob Wurth, Chairman of an advocacy group known as SurfProbe.

17. The inquest commenced in Brisbane in December 2013. However, following two days of evidence the inquest was adjourned to enable the report from OFSWQ to be prepared. The inquest resumed for a further two days in August 2014. In total evidence was heard from 17 witnesses and 273 exhibits were tendered. After the conclusion of the oral evidence, written submissions were received between November 2014 and May 2015.

Social history

18. Matthew Barclay was born at Buderim on 1 October 1997. He was the only son of Donna and Stephen Barclay. His sister was 2 years younger than

Matthew and also involved in surf life saving. Matthew became involved in surf life saving when he was 7 years old as a member of the Dicky Beach Surf Living Club. His father was also an experienced surf life saver and official.

19. At the time of his death Matthew was in year 10 at Siena Catholic College, Sippy Downs. While Matthew had played rugby league for the Caloundra Sharks and Rugby Union at school, surf life saving was his passion. He was a very fit and healthy young man. He was physically capable and never had any significant medical issues.

20. Matthew had won numerous individual and team medals at the State Championship level from 2009 to 2012. He was also a very successful pool swimmer, having represented the Sunshine Coast and Wide Bay Regions.

21. At the age of 13, Matthew was selected as part of the Maroochydore under 15 surf race team. Matthew was the youngest Australian medallist in the history of the Maroochydore Club, winning a bronze medal at the 2011 Championships as a member of the surf race team.

22. Matthew won the 2011 Under 14 Coolangatta Gold Ironman event. This was an endurance race comprising swim, board and run legs. He had also won a bronze medal in the under 15 board relay in the State titles at Kurrawa earlier in March 2012, where the surf conditions were similar to those at the Championships.[2]

23. Matthew was described as one of the best open water swimmers in Queensland for his age group, and was one of the best competitors from the Maroochydore Surf Club. He had been identified as a future senior champion and had toured with the Queensland Cyclones State Team.

24. His parents' evidence was that in the lead up to the 2012 Championships, Matthew was training up to nine times a week, completing four swimming sessions, two board sessions, one ironman session and two gym sessions per week. His parents stated that Matthew would compete in everything and in all conditions. He was scheduled to compete in board, swim and team events at the Championships. Matthew had no fear of the surf.

25. The outpouring of grief among the surf life saving community and his friends and family after his death showed the extent to which Matthew was loved and respected. His parents were committed to helping Matthew realise his many talents and were on Kurrawa beach at the time he went missing in the surf. They had to endure a protracted wait for his body to be located. I extend to them my sincere condolences.

[2] Exhibit B6

The Australian Surf Life Saving Championships

Venue

26. The Championships are the major surf sports event organised by SLSA. They were scheduled to run from 28 March 2012 to 1 April 2012 at the Kurrawa Surf Life Saving Club at Broadbeach, on the Gold Coast.

27. The option also existed within the contingency planning for the Championships to extend competition to Monday 2 April 2012, in extenuating circumstances. In those circumstances competition would be conducted at an alternative site as determined by the Contingency Plan.

28. The Championships are the largest event of its type in the world and involve over 8000 competitors and officials competing and officiating in over 290 surf and beach events, with up to 310 surf lifesaving clubs involved. It was estimated the Championships would attract 80,000 people to Kurrawa Beach and the Gold Coast.

29. In 2012, the event was conducted over a 2km stretch of beach. The beach was separated into 9 competition areas. At the far northern end of the beach were the rescue and resuscitation areas, which were separated by a buffer zone from the 2 boat areas. There was a further buffer zone, followed by the 2 open and under 19 male arenas, followed by the open and under 19 female areas, which were separated from the men's arena by a buffer zone.

30. The next two areas to the south were the under 17 arenas which were separated from each other by a buffer zone, followed by the 2 under 15 areas. Each of these areas was 100m wide and was also separated by a 20m buffer zone.[3]

31. The event was not new to Kurrawa having been held there in 2006, many occasions prior to that, and in 2010. The 1996 Championships involved the death of Robert Gatenby (aged 15 years), and the 2010 Championships involved the death of Saxon Bird (aged 19 years), a matter referred to throughout these findings. Their deaths also occurred in surf craft events.

32. Following Matthew's death, SLSA has determined that Kurrawa will not be considered as the venue for future Championships until 2020.

Policies and planning for the 2012 Championships

33. SLSA policies and procedures that apply to competition safety and administration, and to each surf sports event were contained in the 34th edition of the Surf Sports Manual (the Manual).[4]

[3] Exhibit C1

[4] Exhibit C2

34. The Manual is a 268 page document. Members were informed of its publication in January 2012 by a bulletin from SLSA and the Manual took effect from that date. The bulletin highlighted the relevant changes from previous editions and noted that "*the changes generally seek to address the recommendations of SLSA's internal report and the Coronial findings in respect of the 2010 Australian Championships"*.

35. Those amendments arose from the 2011 findings in relation to the death of Saxon Bird at the 2010 Championships, emphasising the importance of safety and confirming processes for suspension of competition and rescue.

The Australian Championships Competition Committee

36. The Manual aims to "ensure a safe and fair system or framework within which surf lifesaving competitions are to be regulated and conducted in Australia"[5]. It also notes:

> *Surf lifesaving can be inherently dangerous. Serious accidents can and often do happen which may result in property damage, physical injury and even death. All members are assumed to have voluntarily read and understood this warning and accept and assume the inherent risks in surf lifesaving.*

37. Competition administration, including the role of the competition committee, is articulated in section 12.3.2 of the Manual. In terms of the responsibility for the safe delivery of the 2012 Australian Championships the makeup of the Australian Championships Competition Committee (ACCC) and the Safety and Emergency Committee are of significance. These committees were tasked with the safe delivery of the championships.

38. The ACCC for the 2012 Championships consisted of:[6]

- Rick Wright: Director of Sport (Chairman)
- David Thompson: General Manager – Championship Event Manager
- Rob Pollack: Kurrawa SLSC Club Captain
- Andrew Buhk: Championship Referee
- Dick Bignold: Deputy Championship Referee
- Darren Moore: Safety and Emergency Services Coordinator
- Malcolm Flew: Power Craft Area Referee
- Graham Bruce: Logistics Officer

39. The ACCC met at 6:45am and 11:30am daily and conducted ongoing assessments during the course of the championships. The ACCC also met on an 'as needed' basis throughout the day. The ACCC would review beach conditions and weather predictions among other non-safety related topics.

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[5] Exhibit C2, page i

[6] Exhibit C1, section 3

40. Part of the information presented to ACCC meetings would come from Darren Moore. Mr Moore was a member of the ACCC and was chair of the Safety and Emergency Committee. Brett Williamson, Chief Executive Officer of SLSA oversaw the overall operation of the ACCC and the Championships and was represented on the ACCC by Rick Wright.

41. The Manual conferred the power to postpone, cancel or relocate the Championships (wholly or in part) solely on the ACCC. However, as discussed below, a wide range of other officials had the power to immediately suspend competition, including Area Risk and Response Officers and Sectional Referees.

42. The Safety and Emergency Committee was established for the 2012 Championships. Its role was to consider and advise the Championship Referee and ACCC on all matters relating to competition and non-competition safety and emergency services.

43. Section 13.14 of the Manual provides that the SESC shall:

> *Be aware at all times of the safety and welfare of competitors, officials and other personnel involved in the competition and non-competition support functions and have the authority to immediately suspend wholly or in part the competition whenever there is a credible basis for concluding there is an unreasonable risk of serious injury occurring and refer that decision to the Referee. The Safety and Emergency Services Coordinator also has the authority to immediately implement any search and rescue actions if necessary and notify the Referee.*

44. The Safety and Emergency Services Coordinator (SESC) role was established in 1997. In 2012 the SESC was Darren Moore. He performed the role on a voluntary basis. He was a serving NSW police officer, an experienced surf life saver and had been the SESC at the 2010 and 2011 Championships. Prior to the 2012 Championships, Mr Moore had also obtained a Cert IV in Public Safety (Aquatic Search and Rescue Management).[7] Mr Moore was required, under the Surf Sports Manual to:

> *Formulate and implement a safety, search and rescue guide and contingency plan which will provide prompt and effective safety, rescue and recovery in an emergency situation. This program shall be approved in conjunction with the Referee and the authority conducting the event.*

45. Early in 2012, SLSA contracted independent risk auditor, Paul Chivers, to audit and accredit the Safety, Search and Rescue Guide, Contingency Plan and Evacuation Plans.[8] These documents were comprehensively reviewed before the Championships in the context of ISO 31000:2009 Risk Management-Principles and Guidelines methodology. The auditor was also

[7] It had been noted at the Saxon Bird inquest that Mr Moore had no formal search and rescue qualifications at the time of Mr Bird's death.

[8] Exhibit C37.1

contracted to conduct an audit and assessment of SLSA Risk Management and Workplace Health and Safety processes throughout the Championships. Feedback was provided during the Championships and a written report provided at the conclusion of the Championships.[9]

46. The Safety and Emergency Committee established for the 2012 Championships consisted of:

- Darren Moore: Chair/Safety and Emergency Services Coordinator
- Andrew Buhk: Referee
- Dick Bignold: Deputy Referee
- Malcolm Flew: Powercraft Coordinator
- Rob Pollack: Kurrawa SLSC Club Captain
- Matthew Thompson: Assistant Emergency Services Coordinator
- Charles Harwood: Communications
- Shelly Schultz: First Aid Coordinator

47. The Manual includes the following provisions relating to competition safety which are relevant to this inquest:

"1.1 PRELIMINARY

The provision of a safe environment at all SLSA competitions is paramount.

Prior to the commencement of any competition the Referee must be satisfied that all competition and non-competition arrangements provide the necessary safety for competitors, officials and other personnel involved at the competition. The Referee must also be satisfied that the surf conditions are satisfactory for competition to proceed. Tests may be undertaken to assist in these assessment processes. An Event Safety Guide Sheet/Tool/Application and Referee Pre-Competition Checklist may be used to assist in the assessment processes (refer Appendices A and B for samples or contact SLSA).

Should, at any stage prior to or during competition, there is a credible basis for concluding there is an unreasonable risk of serious injury occurring, officials shall suspend all or parts of the competition. The Competition Committee (refer Section 12), shall then decide whether to postpone, cancel or relocate all or parts of the competition.

Lifesavers compete in SLSA competitions to demonstrate their physical and mental skills. Competition officials and competition organisers conduct competitions to support and encourage competing lifesavers to demonstrate their lifesaving skills and organisational efficiency, whilst patrolling lifesavers and beach support personnel, actively display their prowess as the lifesaving authority in that competition.

At all competitions, the organising group conducting the competition shall provide sufficient and properly equipped and qualified water safety personnel (at each venue) as required by the appropriate lifesaving authority The provision of rescue craft and communications is essential at all competitions.

[9] Exhibit C37

If an emergency arises during a competition, correct control and discipline shall be maintained under the direction of the Referee or Safety and Emergency Coordinator.

During an emergency, any member of SLSA entering the water or handling any rescue gear must only do so at the direction of the Referee or Safety and Emergency Services Coordinator and/or the Area Risk and Response Officer and/or under the direction of the Police or emergency authority.

All members not engaged in actual rescue work should assist in maintaining a clear area so that any rescue attempt can be carried out efficiently.

The above directions are mandatory and essential to the safe and orderly conduct of surf lifesaving competitions.

1.2 SAFETY AND RESCUE PLAN

A safety and rescue plan relevant to the scope of the competition being conducted is essential to the sound planning process. The plan should ensure appropriate procedures are in place if an emergency occurs during a competition.

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1.2.5 Water Safety

The Area Risk and Response Officers, Water Safety Coordinator(s) and emergency safety personnel (including IRBs) are to be appointed and operate as per their position description. In addition, liaison and rescue protocols need to be identified and promulgated.

1.3 COMPETITION SAFETY ASSESSMENT

Before any SLSA competition is conducted, the Referee or their delegate should assess the prevailing and expected weather and surf conditions.

The Safety and Emergency Committee (refer Section 12), should also assess the non-competition aspects including occupational health and safety matters.

Assessments may be undertaken at any time before and during competition. Should an assessment indicate that part, or all of the competition, not be conducted because of adverse weather or surf conditions, or another threat, the Competition Committee will decide whether to postpone, cancel or relocate all or parts of the competition.

The major threat to the conduct of competition relates to the advent of adverse weather conditions, either before or during the competition. Adverse weather can create extremes in heat or cold, storms, dangerous surf or swell and associated dangers for competitors. Secondary natural threats are considered less likely, man-made disasters, such as pollution of the surf and beach and non-competition safety issues including occupational health and safety matters should be considered.

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1.4 COMPETITION CONTINGENCY PLAN

If the Competition Committee decides to postpone, cancel or relocate all or parts of the competition a clear and simple Contingency Plan should be implemented.

The following is a suggested format for establishing a Contingency Plan for surf lifesaving competitions.

1.4.1 Potential Threats

- *Adverse weather and/or surf conditions*
- *Disasters*
- *None competition matters*

1.4.2 Weather Forecasting

Weather forecasts will be used by the Competition Committee to assist in decision making. If adverse weather and/or surf conditions develop, more regular bulletins and information must be sought and obtained. Subject to the size of the competition, and its specific risk assessment, weather monitoring should commence approximately one week prior to the start of the competition.

If the competition extends beyond one day, the Competition Committee should review weather and surf forecasts at least each morning and evening.

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1.4.3 The Chain of Command and Decision Making

The Safety and Emergency Committee shall determine the response to hazards as they occur, or otherwise as required and provide safety advice to the Competition Committee. The sole responsibility for suspension, cancellation, postponement or relocation of part or all of the competition rests with the Competition Committee.

The decision to enact the Contingency Plan is the responsibility of the Competition Committee. The Referee is solely responsible to the Competition Committee for recommendations concerning competition on safety.

1.4.5 Aim and Principles of Relocation

Relocation means relocation of all personnel (competitors and officials) and equipment (including water safety and first aid) necessary to conduct the relevant competition(s). It does not necessarily mean back of beach items such as stands or signage.

The aim of relocating to an alternative venue is to ensure that the competition may be safely conducted within the timeframe set down.

If water conditions prevent water-based competition, and the beach itself is unaffected, then only water events may need to be relocated.

1.4.6 Outline Plan

There are four primary options:

- *Complete relocation of the competition.*
- *Partial relocation, where only those events considered unsafe will be relocated.*

- *Postponement of part, or all, of the competition to a later date.*
- *Cancellation of part, or all, of the competition.*

1.4.7 Reconnaissance of Alternative Locations and Assessment of Conditions

The conduct of the reconnaissance is the responsibility of the Competition Committee. The Reconnaissance Group may consist of the Competition Organiser, Event Manager and their Deputy, the Referee, Deputy Referee and the appropriate Area Referee, where possible, who will jointly assess the situation and report to the Competition Committee for decision.

1.4.8 Relocation Timings and Early Warning

The decision to relocate should be made as early as possible, preferably on the day before.

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1.4.14 Action in the event of Death or Serious Injury

In the event of death or serious injury to a competitor or spectator during the period of the competition the Referee is responsible for any immediate decision to suspend or postpone competition. The Safety and Emergency Services Coordinator is responsible to the Referee for handling the situation. Once the situation is assessed, the Referee shall make recommendations to the Competition Committee."

Contingency Plan

48. The specific Contingency Plan for the 2012 Championships was contained in the Section 3 of the Championships Directory.[10] The Directory noted that the contingency plan "*has been developed as part of SLSA risk management planning and its duty under the Work Health and Safety Act and regulations to ensure health and safety risks are eliminated so far as reasonably practicable"*.

49. The 2012 Contingency Plan identified North Kirra beach as the primary suitable surf location for the relocation of all or part of the Championships. Relevantly, the Marine Stadium at Southport Spit was identified as a suitable protected water location for swim and board events. Lake Coomera was identified as suitable inland location for boat and board events. Secondary alternative locations such as Coolangatta Beach were also identified.

50. The Contingency Plan identified the aim and principles of relocation:

> *The aim of relocating to an alternative venue is to ensure that the Championships can be safely conducted. A risk assessment will be conducted to determine which events will remain at Kurrawa and which alternative location is suitable for which events.*

[10] Exhibit C1

51. The Contingency plan required that each ACCC meeting review the following matters:
    - Risk Assessment of the current conditions of the beach
    - Injury management statistics
    - Current weather predictions
    - Competition Statistics

52. The minutes of the ACCC meetings from 28 March 2012 demonstrate that these matters were considered and, in particular, that members of the ACCC were aware that the prevailing surf conditions could give rise to the need to relocate events.

53. The Contingency Plan also required that the Safety and Emergency Services Coordinator, Darren Moore, carry out a risk assessment at 6:00 am each day and at regular intervals. These were to be provided to the ACCC for review.

54. Mr Moore was also to ensure further assessments were carried out in each area by the respective Area Risk and Response Officer before events commenced in their allocated area and then periodically throughout the day, at regular intervals, while competition was taking place.

55. The 2012 Championship Directory also included a Safety, Search and Rescue Guide. This incorporated a guide to assist in recognising and evaluating risks associated with competition in a surf environment, including references to the iPad application developed for use by officials.

56. Darren Moore's evidence was that following the 2010 Championships there were more risk assessments being conducted of conditions, and more power had been given to people on the beach to suspend or stop competition or to change the program. Meetings were held before and after competition to enable feedback to be received about actual conditions. Competitors, coaches and parents had the capacity to raise issues directly with the area referee or liaison officer, and those concerns were recorded.[11]

Qualification for entry to the Championships

57. The Manual provided[12] that for participation in individual events a competitor who was aged 13 years as at 30 September was eligible to compete in under 15 events. It also provided that a proficient under 13 SLSA Surf Rescue Certificate holder could compete in under 15 age events.

58. In order to qualify for a Surf Rescue Certificate it was necessary to demonstrate proficiency in a range of areas including the completion of a 100m run / 100m swim / 100m run within 5 minutes. Surf Rescue Certificate candidates also have to complete a pre-requisite swim (200m swim in five minutes or less) before any training in the surf is commenced.

[11] T2-25

[12] At 2.3.4

28 March 2012

Risk assessment of surf conditions

59. It is important to note that the surf conditions during the 2012 Championships were not influenced by prevailing weather conditions like those associated with the 1996 or 2010 Championships, when cyclones off the Queensland coast produced extremely large swells. While the surf at the 2012 Championships was smaller it still proved extremely challenging for competitors to negotiate.

60. 28 March 2012 was the first day of the open Championships. This followed the completion of the masters' championships. Surf conditions within the under 15 Blue and White arena were assessed four times during the day by Area Risk and Response Officers using the SLSA iPad application. This application electronically recorded the risk assessment and attached photographs of the surf at the time. Print outs of all relevant assessments along with the photographs were tendered at the inquest.

61. The position of Area Risk and Response Officers was created after the 2010 Championships and was required to report to the Sectional Referee on issues during competition, such as:

    - Number of starters;
    - Number of athlete withdrawals;
    - Number of athletes unable to get through the break;
    - Number of athletes that finish; and
    - Time per race.

62. Mr Harry Hannas was the Area Risk and Response Officer in the Blue and White Area. At the time he was also the chief referee at Life Saving Victoria. Mr Hannas told police that the board race prior to the Matthew's event comprised 16 boys and proceeded without incident. All competitors finished that event. Mr Hannas sought feedback from competitors in that event and found that the competitors had no concerns about the conditions. This event concluded at 15:25pm. Mr Hannas also told police that due to the conditions extra safety measures were deployed for the competitors. These included having two jet skis and three inflatable rescue boats (IRBs) allocated to the Blue and White area for the under 15 events.[13]

63. Peter Burton conducted the first assessment at 8:27am. The prevailing conditions were confirmed as a south-easterly wind of at least 10 knots, swell at ½ to 1 ½ metres, and a spilling wave with a rising tide. The predicted conditions were wind to the south-east at 11 – 16 knots; the same swell size and wave type with high tide to be at 11:24am and low tide at 4:30pm. Hazards assessed at this time were a shore dump and shallow sand bar.

[13] Exhibit B24

However the risks relating to both hazards were assessed to be low. The residual risk was also assessed as low.

64. Graeme Byrne from the Kurrawa Club conducted the second assessment at 10.54am. The prevailing conditions and predicted conditions were the same as those recorded at 8:27am by Mr Burton. The hazards identified at this time were the same as at the first assessment. While the risk relating to both hazards was increased to moderate, the residual risk remained low.

65. Mr Byrne again conducted the third assessment at 12:12pm. The prevailing conditions and predicted conditions were, once again, recorded as the same as the previous two assessments. The hazards were also recorded as the same as the previous assessment, along with the risk rating. An additional hazard was also recorded as the course length. This related to fatigue and increased race duration. The risk rating was assessed to be moderate. The residual risk for all hazards remained low. Mr Byrne told police that he did not consider that the conditions at the time of Matthew's race were dangerous or difficult.[14]

66. Adam Weir conducted the fourth assessment at 2:29pm. The prevailing conditions were confirmed as an easterly wind of 17 – 21 knots with the same predicted winds as earlier assessments. A swell size of ½ to 1 ½ metres was also confirmed, with occasional plunging waves on the outer bar and the tide falling. The wave size and type was predicted to continue to be the same. [15]

67. Hazards recorded during this assessment included a dangerous wave type. The possible consequence was identified as "critical" with a "high" risk rating and a "moderate" residual risk. The proposed risk treatment for this hazard was to move the event. Further risks identified at this time were:
    - long and strong shore drift with a moderate risk rating and low residual risk; and
    - dangerous wave size with a high risk rating and moderate residual risk.

68. The 2:29pm assessment identified the adequacy of the controls in place for each identified risk as being "excellent" and "good". The controls included high visibility vests, water safety, power craft and safety consultation with competitors. The proposed risk treatment was recorded as 'Move Event' and 'Monitor Situation'. The hazard relating to the course length was assessed to be a moderate risk, with a low residual risk.

69. Mr Weir gave evidence at the inquest. He was employed as the Coastal Risk Manager for SLSA at the 2012 Championships. He had an active role in developing the iPad application that was used in each of the areas to perform risk assessments.

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[14] Exhibit A5

[15] Exhibit C13

70. Mr Weir competed in surf life saving until 1999 when he retired due to a shoulder injury. He has a science degree and a master's degree in coastal management, and has been performing coastal risk assessment work for over a decade.

71. His role was to ensure that the application was being used correctly and providing the right data.[16] Mr Weir's evidence was that 2012 was the first year the application was in full use. iPad assessments were sent to a central email address for review by the Safety and Emergency Services Coordinator.

72. Mr Weir said that he and Matt Thompson, the Safety Emergency Services Coordinator's assistant, had been made aware that six female competitors in the under 15 board relay had not completed the event or did not finish due to timing. They consequently went to that area to personally complete a risk assessment.

73. Mr Weir said that proposed treatments were shaped as proposals to be reviewed and raised at the upcoming Safety and Emergency Committee meeting[17], unless it was deemed the treatments should be put in place immediately. Mr Weir said that as they were in the under 15 area Matt Thompson spoke directly to Jenny Kenny, the referee for that area, about the assessment.

74. Mr Weir said that that his intention when he said, "move event" was to propose a small move to enable competitors to take advantage of a rip current on either side of the bank. This was because they were getting stuck on the outer bank and having trouble pushing through. It was not his assessment that competition needed to be moved to another beach such as Kirra.

75. Despite the 2:29pm risk assessment, it appears that officials were happy for competition to continue in light of the fact that additional water safety had been put in place within the blue and white competition arena.

76. Mr Weir agreed in evidence at the inquest that the iPad application was only a tool and not a substitute for the judgement of experienced and trained people on the beach. Mr Moore's evidence was to the same effect. He said that the iPad data was only one source of information relied on by officials. Other information included direct feedback from competitors and team managers, and data on the number of finishers and non-finishers. Mr Moore noted that some team managers were also the parents of competitors.

[16] T1-85

[17] T1-90

Competing views on surf conditions

77. All witnesses interviewed by police were asked to provide a description of the conditions throughout the day, and in particular within the under 15 arena at around the time Matthew went missing.

78. Detective Senior Constable Hardham's evidence was that of the 94 people interviewed by police, 10 stated that they thought conditions were not safe for competition. The other persons interviewed indicated that they had no concerns. The only person to raise concerns during the course of the day on 28 March 2012 was Dean Powell. Unsurprisingly, four of the persons who expressed concern after the day were fellow competitors in Matthew's under 15 board race. The majority of competitors in that race did not consider that the surf was dangerous or that the event should have been postponed.

79. DSC Hardham also said that he had formed the view that the under 15 competitors were aware that if they did not want to race they could choose not to. He also interviewed team managers who could assist the competitors with their decision-making and express concerns to officials on the beach.

80. A common description of the conditions given to the QPS was that the surf was 'testing' or 'challenging', but not necessarily dangerous. The QPS report noted that witnesses seemed to confirm that the officials were correct in allowing competition to continue.

81. Mr Balamanno was performing official duties in the under 15 arena at the relevant time. His daughter was also competing in the under 15 arena throughout the day. He told police that he had no reservations about her competing in the conditions.

82. Mr Phil Clayton is an elite competitor and the head coach of Kurrawa SLSC. He told police that he would have all his athletes train in similar conditions, from nippers through to open competitors.

83. Mr Clint Robinson is an elite competitor and had also been Matthew's coach. His view of the conditions was that they were perfectly fine to compete in. He told police that they were testing and needed a good level of skill. He stated that a person of Matthew's skill and ability would normally have no issue in such conditions.

84. However, not all witnesses who spoke to police believed the conditions were safe for competition.

85. Barbara Bethe was performing official duties as a Recording Judge for the Under 15's in the Yellow Area. She said that she believed the conditions were testing. While they were fine for under 19 and open competitors, she thought conditions were 'a bit big for these kids', with reference to Matthew's age group, which potentially included competitors aged only 13 years. However, at the same time she said that the decision by the "boaties" to

withdraw from Kurrawa Beach and relocate their events was "jumping the gun" as the conditions were not too adverse.[18]

86. Jennifer Mack also believed the conditions were unsuitable for under 15 competitors. She was a Finishing Judge in the Blue and White area for the under 15 boys, who she thought should still be part of nippers' competition. She said that conditions were "pretty rough" with a big break.

87. However, neither Ms Bethe nor Ms Mack approached other officials before the start of Matthew's board race to make their concerns known.

88. Stuart Keay was employed as a Gold Coast City Council life guard. In March 2012 he had been employed in that capacity for 26 years. He was working directly in front of the surf approximately 500 metres south of the under 15 area.

89. Mr Keay said that the surf in the morning was consistently 2 metres. He said that after the high tide at around noon, the receding tide could have made the back break easier to manage but some waves were raking right over and hitting the sand bank which, in his view, made it quite risky.

90. Mr Keay said that he became concerned after watching an under 15 female race in which it appeared that a competitor was injured by a board. After observing this he went to speak to Dean Powell who was 400 metres to his north to express his concern about the conditions. After this Mr Powell went and spoke to officials at the Championships about the council lifeguards' concerns.

91. Mr Keay said that when Mr Powell returned he told him that the competition officials informed him that they had plenty of safety on the water (i.e. power craft). Mr Keay said that he felt that competition in the under 15 area should have been terminated. However, he also accepted that officials on the beach and in the water, and referees, who were closer to the competition area than him, were all well placed to judge risks for competitors. Mr Keay agreed that conditions along Kurrawa beach can vary. He also agreed that he left his area of the beach open throughout the day.

92. Dean Powell was also a Gold Coast City Council life guard. He was working at 400m south of his usual tower on the relevant day, 100 m from the 'Yellow area'. He told police that at about 11:00am he approached three officials in that arena and expressed his concerns about the girls' ability to handle the conditions and their safety in those conditions. During this conversation he was told that the officials were appreciative of his concerns. He was told that the situation was being monitored and there was sufficient water safety in place.

[18] Exhibit E9

93. Mr Powell's evidence at the inquest was that by 3:27pm, the start of Matthew's race, the conditions had worsened and, in his view, were not suitable for under 15 competitors. He said there were more rips, and the waves seemed to be steeper and breaking harder on the back bank with the outgoing tide. However, Mr Powell also agreed that he elected to keep his stretch of beach open to the public for the whole day on 28 March 2012. Of note, contrasting with Mr Keay's assessment, Mr Powell's evidence at the inquest was that the wave heights were 0.5 to 1 metre in the morning.

Powercraft

94. As noted above, Malcolm Flew was the Power Craft Coordinator for the Championships. He was also a member of the ACCC and the Safety and Emergency Committee.

95. Mr Flew's evidence was that he had been coming to Kurrawa since about 1997. He said that he had no concerns about the safety of the under 15 competitors on 28 March 2012.[19] He said that the conditions on 28 March 2012 were a bit choppy and slightly larger than the previous days. He had experienced similar conditions at other carnivals where the conditions had not lead to the cessation or postponement of events.

96. Mr Flew said that the usual power craft resources applied to the two under 15 areas were a safety boat (IRB) and a judging boat in each area, with a jet ski allocated to cover both areas. However, on 28 March 2012 an extra jet ski was allocated at around 2:00pm.

97. Mr Flew said in his evidence that jet ski operators are permitted to leave their craft to attend to someone in need, as long as circumstances permit, as are IRB crew members. However, he agreed that while a jet ski was useful in assisting people who were conscious in the water in need of assistance, it was not of much use where the person was unconscious, unless the operator jumped off the jet ski. He also agreed it would be dangerous for an operator to leave the jet ski in surf when a race was in progress.[20]

98. Brian Lewis was a volunteer jet ski operator in the under 15 area at the Championships. He commenced in the Yellow area on 28 March 2012. His evidence[21] was that the conditions were challenging with a lot of water coming across the back bank. The surf was relentless in that it did not have regular or consistent swells coming through – "it was a bit all over the place". However, Mr Lewis did not have any concerns about the safety of any of the under 15 competitors in the Yellow area. He said that anyone who needed assistance was given assistance and was helped back to the beach.

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[19] T1-9

[20] T1-15

[21] T1-30

99. Mr Lewis said that on average 2 or 3 competitors required assistance in every race or could not get out to the back bank. In those circumstances they were directed to turn around and go back to the beach. Where the competitor's board had been washed back to the beach they were assisted back by laying on a mat at the back of the jet ski. Mr Lewis said that he estimated the waves coming through at the time of Matthew's race were 1.5 to 2 metres. At no stage did Mr Lewis express any concern to his supervisor about the continuation of events.

100. Mr Lewis and Mr Long (the other jet-ski operator in the area) both agreed that they had a discretion to leave the jet-ski to rescue an unconscious person in the water but that an unmanned craft in the water would create an additional hazard for both swimmers and board paddlers. Mr Long's assessment of the surf was that the wave height on the outer bank was 1 metre at most.

101. Mr Lewis said that competition had been suspended in the morning and that after a meeting at 12:30pm it was decided to resume competition without swimming events – there would only be board events that afternoon.

102. Brett Wakefield was an IRB driver and official at the 2012 Championships. His evidence was that at around 1:00pm on 28 March 2012 he was asked to go to the under 15 arena. Mr Wakefield agreed with some reluctance as he had been on the water all morning in a judging boat. Mr Wakefield was assigned to patrol an area on the northern side of the under 15 area between the shore line and break zone. He said there were at least 2 jet skis operating in the area at the same time.

103. Mr Wakefield described conditions in the break zone of the Blue and White area as "nasty". There was a dumping or curling wave, limited to the southern side of the area, which would have dumped people onto the sand bank. However, he said the competitors seem to be "fairly keen to keep going" and did not appear to be daunted by the conditions. He did not consider that the area should be closed.

104. Mr Wakefield said that he returned to the beach because the engine on his IRB was running "rough" and it stopped as he arrived at the start line. Mr Wakefield reported this situation to the area powercraft coordinator, Peter Burst, who called in another rescue vessel. Mr Wakefield was not certain that his craft was replaced with another IRB.

105. Mr Wakefield checked the spark plugs on his motor and was able to get it going again. He later heard "rescue, rescue, rescue" called over the radio. He was unable to go onto the water in the IRB at that time because he was waiting for a new crew member to arrive. Mr Wakefield said that it was 5-10 minutes before he was able to leave the beach. During that time he observed two jet skis travelling around on the water but did not recall seeing any swimmers in the water. After he left the beach in his IRB he proceeded to the position where Matthew had last been seen, where he waited for

instructions in relation to a search pattern. There were swimmers in the water at that time as part of the search effort.[22]

Area Referee

106. Jenny Kenny was the Area Referee in the under 15 areas at the 2012 championships. Ms Kenny is a senior official with over 25 years' experience. She has been director of life saving for Tasmania. As noted above, the under 15 area was comprised of a Blue and White Area and a Yellow Area. Each area had its own assigned referee who reported to Ms Kenny. Other officials working within the area included a chief judge, marshalls, area risk and response officers, competition liaison officers, water safety coordinators and recorders.

107. As Area Referee, Ms Kenny had the authority to immediately suspend wholly or in part the competition in her area and refer that decision to the Referee and Safety and Emergency Services Coordinator.[23]

108. Ms Kenny's evidence was that she relied on the area risk and response officer (ARRO), the water safety coordinator, sectional referees and course judges for advice on safety because they had binoculars and were observing the course. She also liaised with officials in adjacent areas.

109. Ms Kenny said that if she had concerns about the conditions she would speak with Dick Bignold or Andrew Buhk.

110. Ms Kenny's evidence was that when she first inspected conditions on the morning of 28 March 2012 there was a considerable amount of water on the bank. The first scheduled event was a Cameron Relay, a team event involving a swimmer, two runners and a board paddler. She was concerned about having board paddlers and swimmers in the water at the same time. She subsequently sought to adjust the program in discussion with Mr Bignold and Mr Buhk so that swim races were held first.[24]

111. Ms Kenny said that she was also conscious that she would need to make more adjustments to the program as the tide changed. The changes would be required because of the length of the course. As the cans were outside the outer bank events would take a considerable time to complete.[25]

112. At around 11:15am the next scheduled events were the tube races and board rescue races, which involved over 380 competitors in the under 15 division. The distance to the cans was twice that recommended for the swim. Ms Kenny said that the option of reducing the course length by bringing the cans closer to the shore was considered. However, this would have meant

[22] T2-9

[23] Exhibit C2, page 196

[24] T2-43

[25] T2-45

placing the cans within the surf break, causing problems for IRBs and swimmers.

113. Ms Kenny's evidence was that after discussing the program with water safety officials, ARROs and Kurrawa patrol people, it was decided that the board races were the best events to run next because the course length was appropriate. She said that this was a safer event to run. However, Ms Kenny said that the Board rescue was not an appropriate race to run in the conditions because it involved board paddlers being on the water at the same time as a group of swimmers.[26]

114. Ms Kenny spoke with Mr Bignold and Mr Buhk. Mr Bignold subsequently attended at the under 15 area and agreed with Ms Kenny's assessment. Ms Kenny said that she spoke with team managers about the change in the program and all agreed that it would be appropriate.

115. It was then that it was agreed to adjourn the program to enable competitors in board events to be notified and to collect their craft. It was also agreed that the competition would resume at 1:00 or 1:15pm. Ms Kenny said that at no stage had she received any feedback that it would be unsafe to run the under 15 competition.

116. Ms Kenny did not have specific recollection of a discussion with Matt Thompson in relation to the risk assessment that was carried out in the under 15 area at around 2:30pm. Although she had the power to immediately suspend competition, Ms Kenny was not privy to the actual iPad assessments conducted in her area. She did have discussions with the relevant ARROs throughout the day.

117. Ms Kenny did recall having a discussion with Dick Bignold and Darren Moore about the need to relocate swim and board rescue events if the conditions stayed the same at Kurrawa. Ms Kenny agreed that due to the course length she was concerned about the safety of competitors. Her concerns included having a loose board in the water with swimmers.

118. Ms Kenny said that the only concern expressed to her about competitor safety on the afternoon of 28 March 2012 related to a board "popping" in an under 15 girls board relay. This was raised by a team manager at around 3:00pm.[27] She subsequently had the Kurrawa patrol member and the ARRO look at the situation before the under 15 boys' board races commenced.

119. Ms Kenny did not consider that there were any inherent dangers in scheduling the board races as competitors had their craft with them. The main issue was that it was sometimes hard for competitors to get out through the break.

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[26] T2-45

[27] T2-50

120. As Ms Kenny was not aware that the decision had been made by the ACCC to move events to Kirra on 29 March 2012, she was intending to run the under 15 girls board races immediately after Matthew's race until competition ended at 4:00pm. The girls had been marshaled and were ready to compete.

Committee meetings on 28 March 2012

121. The Safety and Emergency Committee met for 15 minutes from 6:15am on 28 March 2012. The minutes of the meeting note[28] that on 27 March 2012 there were 43 injuries and 3 ambulances called.

122. Darren Moore is recorded as stating that a risk assessment was completed for the carnival area and he was happy for the carnival to proceed with current and expected conditions. Andrew Buhk stated that he was "*happy for the committee to report to the ACCC for the carnival to commence with caution due to the upcoming low tide and monitor the waves on the back bank*".

123. Mr Moore's evidence was that he had no concerns about whether competition should be delayed or postponed at the time of the Safety and Emergency Committee on 28 March 2012.

124. The ACCC met at 6:45am. The minutes[29] record that Andrew Buhk advised the "*sea conditions are a little bigger than the previous day and competition needs to proceed with caution*".

125. Later during the morning of 28 March 2012 the ACCC decided it was necessary to move surf boat events to Lake Coomera for safety reasons. Mr Moore's evidence was that he had assessed conditions at Kirra and considered they were suitable for the boat events and he provided this advice by telephone to the ACCC. While he did not at that time consider that other events needed to be relocated, Mr Moore also assessed that Kirra would also be a suitable venue for under 15 events.

The decision to relocate events

126. An ACCC meeting was held at 2:30pm on 28 March 2012. In addition to its formal membership, the meeting was attended by:

- Brett Williamson: CEO of SLSA
- Graham Ford: President of SLSA
- Allison Brennan: Media And Communications Manager
- Sally Fitzsimmons: SLSA Event Operations Manager
- Ian Hanson: Hanson Media Group

[28] Exhibit C22

[29] Exhibit C26

- Charles Harwood: Communication Coordinator / IT Manager

127. The minutes of the ACCC meeting[30] record that the boat course at Coomera Lake had not been set up due to issues with the laying out of courses. It was noted that the boat rowers were refusing to race at the lake. Therefore, all boat competition had been suspended for the day. The minutes note that the rescue and resuscitation, and belt referees supported a move to North Kirra with events to be completed on 29 March 2012 "on the proviso that swims are conducted inside the bank".

128. With respect to the under 15 competition, the minutes record:

- *Darren Moore and Dick Bignold discussed with Jenny Kenny (U15 Area Referee) the safety of her events within the area. The question has been asked if the U15 area needs to be relocated to a contingency site. Jenny advised she had rearranged her program schedule and some U15 events will require to be put in new locations later in the program.*

……

- *Based on the above feedback and to achieve the competition schedules the Committee has advised that R&R (Belts), U15's and Boats will be relocated tomorrow to North Kirra (3:10pm).*
- *The Referee will talk to the Boat Referee and Boat Panel regarding the restrictions of using one area for the boat competition at North Kirra. Meeting to be held at 4.00pm to discuss issues around previous relocation to Coomera Lake.*
- *Data is continually being monitored and assessed in relation to did not finish statistics.*
- *Deputy Referee has advised that there are no problems with the Open and U19 male areas at Kurrawa*
- *Recommendation of U17's area to also be relocated to North Kirra.*
- *Recommendation of Women's area to be relocated to North Kirra.*
- *Mal Flew advised the Committee that the course buoys and equipment need to be moved ASAP as there is a limited amount of daylight available to safely remove from the water areas Kurrawa beach.*
- *The Committee has advised based on the above recommendations the decision has been made to relocate to North Kirra. This includes U15, U17, Women's, R&R and Boats for Thursday Competition.*

…..

- *3.20pm ACCC Endorsed all competition today is to be suspended at 3.30pm to allow for Buoys to be retrieved and the contingency plan to be activated.*

[30] Exhibit C30

- *Safety and Emergency Service Coordinator to conduct a low tide risk assessment at North Kirra with a contingent of senior officials to assess North Kirra at 5.00pm.*

129. The minutes record that the ACCC meeting formally closed at 3:33pm, six minutes after the commencement of Matthew's board race. As noted above, Ms Kenny was unaware at that time of the decision to relocate events in her area to Kirra, and was proceeding with competition.

130. Mr Flew's evidence was that the reason for the relocation of the events was "probably program and events that needed to be conducted that they could not do previously".[31] He was aware that the program of events was running behind because of the conditions – competitors were having trouble negotiating the break.

131. Mr Flew had asked for the competition to cease to enable the course buoys and equipment to be moved as soon as possible. Mr Flew said the suggestion that competition cease at 3:30pm (30 minutes early) was not motivated by the safety of competitors in the surf. It was necessary to send IRBs into the surf to retrieve the buoys and anchors. Mr Flew estimated that he would have needed to retrieve about 100 buoys and 80 anchors with the IRBs before sunset.

132. Dick Bignold was the deputy referee at the 2012 Championships. His role was to assist the carnival referee in the running of the Championships. Mr Bignold said that he had several discussions with Jenny Kenny on 28 March 2012. These related to the program of events and Ms Kenny's desire to run board races instead of the surf teams events.[32]

133. Mr Bignold's recollection of the ACCC meeting was that the primary reason for relocating to Kirra was that events were taking much too long to complete, and as a consequence the Carnival would not be finished by Sunday. Mr Bignold's evidence was that Ms Kenny had not suggested that it was necessary to cease events altogether prior to the relocation.

134. Like Ms Kenny, Mr Bignold said that as Deputy Referee he did not receive the iPad assessments and he had not seen the assessment completed by Adam Weir at 2:29pm.

The fatal event

135. Matthew was competing in a second round heat of the under 15 boys' board race, which commenced at 3:27pm. Low tide was approaching. The board race required competitors to paddle out through the shore break, cross a gutter and then another larger break. After this, competitors followed a set course around three buoys, before paddling back to the shore with the

[31] T1-9

[32] T2-23

aid of the surf. On some occasions, a cut off time was put in place for the competitors to reach the buoys.

136. The evidence indicated that Matthew paddled out through the first break with no problems. Matthew was in the second break between two other competitors, one being Thomas Whittle, about 100 metres from the beach. About thirteen competitors had made it through the break after eight minutes.

137. Fellow competitor, Joshua Collis, described the waves as "continuous".[33] He said that he was stuck with Matthew trying to get past the outer break. He observed Matthew trying to "pop" over and roll through the break for 5-6 minutes. However, he lost sight of Matthew when he turned around with 4 other competitors.

138. Mr Whittle and Mr Collis both told police that they had been told to return to the beach by a jet ski operator because they were not able to get through the break.

139. Mr Whittle's team manager and coach, Michael Byrne, observed the race through binoculars. He told police that he saw a jet ski approach the group of three boys that included Mr Whittle at the back bank. The operator appeared to be signaling to the boys to turn around. At this time the three were 160 to 170 metres from the beach and turned around.[34] He did not witness Matthew become separated from his board.

140. According to Mr Whittle, he and Matthew were returning to shore on a small wave that re-formed on the inner bank and dumped very heavily on Mr Whittle's right hand side, where Matthew was located.[35] Mr Whittle said that Matthew was 5 metres away. Another boy was 5 metres away on his left hand side. Mr Whittle was able to hold a wave to the shore. When he stood up he observed the other competitor also on the shore. However, he could not see Matthew.

141. In contrast, another competitor, Guy Rees, said that he lost sight of Matthew after he saw him attempting to roll under a wave.[36]

142. Brian Lewis' evidence was that he was following the field in Matthew's race just inside the back bank, about 80 metres from the beach. The last 4 or 5 competitors were struggling to get across the bank. After a small lull in the waves, a couple of competitors went across the bank and the others were still struggling.

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[33] Exhibit E20

[34] Exhibit B60

[35] Exhibit E76

[36] Exhibit B40

143. Mr Lewis then observed a person's head in the water just ahead of 2 board paddlers.[37] The person was between the paddlers who were 2-3 metres apart. Mr Lewis said that he continued to monitor these 3 competitors as the white water came through and the 2 paddlers on their boards rolled to go under the water. At the same time a loose board was coming through on the white water on the same path as Matthew.

144. Mr Lewis said that the 2 paddlers then got back to their boards and the competitor on the southern side of Matthew pointed that Matthew was in need of assistance. Matthew was not making any effort to do anything, avoid the board or signal for help. Mr Lewis formed the view that Matthew had been struck by the loose board.

145. Mr Lewis then saw Matthew's body shoot back up out of the water in a "washing machine type action". Matthew then went back under water and that was the last time he was seen. Mr Lewis said that although the water depth was only 800mm he was not able to make out the green lycra vest that Matthew was wearing.

146. Mr Lewis said that the other jet-ski operator in the area, Graham Long, made an attempt to get close to Matthew but was obstructed by the other board paddlers. Mr Long returned to the beach after calling "rescue, rescue, rescue" on his radio.

147. Mr Lewis attempted to hold his position on the jet-ski and continued to look into the water but said that visibility was "next to nothing because it was in the white water. It was being churned. A lot of sand movement".[38] Shortly afterwards, an IRB marked the position with a swim buoy with a flashing light on it. Mr Lewis' evidence was that he saw no other competitor or person from the beach enter the water in an effort to locate Matthew in the time that he was marking the spot. However, he acknowledged that his focus was not on the beach at that time.

148. Mr Long's evidence was that he commenced in the under 15 area at around 1:15 pm on 28 March 2012. Mr Long said that he was positioned on his jet ski in the runway between the Yellow and the Blue and White areas. He was watching a group of three competitors. Matthew was in the middle of the group. After he saw Matthew's board fly into the air, Mr Long moved across towards the group. He saw Matthew surface to just above chest height at a point when he was only 15 metres away. He said that on seeing Matthew he knew that he was in trouble. However, another paddler blocked his access to Matthew. Matthew then resurfaced to around nose height and then quickly disappeared.[39] Matthew had made no effort to reach out or struggle.

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[37] T1-32

[38] T1-34

[39] T1-90

149. Mr Long said that one of the competitors in the Matthews group had pointed over his shoulder to the location where Matthew was last seen but Matthew had already gone.

Rescue and recovery efforts

150. Upon it being evident that Matthew was missing, a search and rescue response was commenced in accordance with SLSA standard operating procedures (SOP). Despite concerted efforts by all involved, Matthew was unable to be located during this initial search. His body was eventually located by the search and rescue response on 29 March 2012 at 9:10am.

151. During the course of the inquest, I was informed by SLSA that, following the Saxon Bird inquest, a new SOP had been developed. This SOP was entitled '*Australian Surf Lifesaving National Events Standard Operating Procedure Search and Rescue*'. It was developed by SLSA in the lead up to the 2012 Championships, in consultation with the QPS.

152. The SOP provided for the immediate deployment of trained life savers in the event that a competitor went missing in the water. In particular reference to the Saxon Bird inquest, the new SOP confirmed that, "*should circumstances dictate, swimmers should be deployed in a coordinated manner to search the surf (shallow/white water) for a missing competitor*."

153. The new SOP called for a focus on a response as the highest priority in commencing a search. Where appropriate, the mass saturation of the area with suitably qualified life savers "duck diving" through the surf was the preferred method of rapid response.

154. The QPS Search and Rescue Mission Coordinator would be immediately contacted and, as an interim measure, the SLSA Safety and Emergency Services Coordinator, Darren Moore, would coordinate the immediate search. As noted above, it is now a requirement that the person in that position hold accreditation in search and rescue in the marine environment.

155. The new SOP was commenced when it was discovered that Matthew was missing in the water. A rescue alert was immediately issued and the rescue plan was put into place.

156. While a number of witnesses described the rescue response as organized and enacted as quickly as possible there was some contention about when the designated rapid response team, lead by Phil Clayton, was actually in the water.

157. There was a degree of inconsistency between the recollection of witnesses and a timeline for the search and rescue effort drawn from information provided by Brett Harrod, who performed the role of 'scribe' for Darren Moore during the search and rescue. His recordings were made in a document titled '*Brett Harrod's record of events 2012 Australian National Championships* 'which was tendered at the inquest.

158. Mr Harrod's log indicated "Search and Rescue confirmed as being fully set up" at 3:56pm and that the four qualified swim rescue groups were not in the water until after 4:00pm.

159. Mr Bignold's evidence was that he became aware that a competitor was missing shortly after the conclusion of the ACCC meeting. He proceeded to the Blue and White area with Darren Moore, who took control of the search effort. Mr Bignold said that he arrived at the area before the rapid response group.

160. Ms Kenny said in her interview with the QPS that at the same time as Dick Bignold arrived *"a guy called Phil Clayton, he had organised a team of high level swimmers in bright vests who were tasked to responding to any shallow water emergency. So they came down and the swimmers went in and started doing searches."*

161. Mr Moore's evidence was that he heard a "rescue, rescue, rescue" call from Ms Kenny at around 3:30pm. He then proceeded to the Blue and White area. In his interview with the QPS he said that:

> *Phil Clayton's guys got there before anyone else. So Phil has mustered them up, started to sweep the floor, we've actually got their once they did their first sweep, they've come back in, we've given them all their proper clothing they're meant to wear and all that type of stuff and then they can do their sweeps. I stayed with the police, Mal the IRB coordinator stays with the police and I and Andrew Buhk the carnival referee also stay with the police. Our deputies all go to the blue and white flag where a police and forward staging area is also set up. So that is how we did this search.*

162. Mr Moore acknowledged that there was a very limited window of opportunity to successfully retrieve Matthew from the surf.

163. Mr Clayton told police[40] that as soon as he heard the rescue call he and the shallow water rescue team ran the 400-500 metres to the Blue and White Area. He arranged a line all the way out to the break comprising around swimmers. This occurred before the swimmers were vested in accordance with the SOP.

164. There are clearly limitations associated with the current SOP, including the fact that members of the rapid response group will generally be elite athletes performing at other locations on the beach. This will mean that there may be some delays in activating the group when time is critical. Notwithstanding, I am satisfied that the search and rescue effort was adequate and was undertaken appropriately.

[40] Exhibit B17

Conclusions of the QPS investigation

165. The QPS investigation ultimately concluded that Matthew drowned while competing in the under 15 boys' board race on Kurrawa Beach on 28 March 2012 during the SLSA National Championships. The investigation found that Matthew was well prepared and well trained to compete in the event and was considered a capable athlete.

166. The evidence gathered during the course of the QPS investigation tended to suggest that although the surf conditions did not play a significant or major part in Matthew's death, they were considered testing for competitors on Kurrawa Beach on the afternoon of 28 March 2012.

167. The QPS investigation concluded that additional safety measures in place since the death of Saxon Bird had increased safety markedly and that the only way of preventing the incident that took Matthew's life would be to stop racing all together. It found that no individual was criminally responsible for Matthew's death, and that no individual had neglected his or her responsibility with respect to safety and subsequently contributed to Matthew's death.

The autopsy and cause of death

168. An experienced forensic pathologist, Dr Dianne Little, conducted a post mortem examination at the Gold Coast Hospital on 30 March 2012.

169. An internal examination revealed the presence of oedema (water-logging) of the lungs with small areas of haemorrhage beneath the pleural surface of the lungs and under and over-inflation. Blood stained fluid was present within both right and left chest cavities, a common feature in cases of drowning. Although there was no frothy fluid within the air passages, the changes were consistent with those seen in drowning.

170. There was no evidence of significant injury to Matthew's body. There was no evidence of head or neck injuries, which may have rendered him unconscious. There was no evidence of significant natural disease to *potentially* render him unconscious or incapacitated. Dr Little stated at the inquest:

> *I did a very thorough autopsy examination. I could find absolutely no evidence of any trauma to his head internally. There was no bruising under the scalp. There was no evidence of any skull or facial fractures. There was no bruising in his face or his neck and there was no evidence of trauma to his brain.*

171. There were a number of superficial injuries noted to the face, shoulders, right elbow and right hip. Many of these had a post-mortem appearance and may have been caused by contact with the sea floor.

172. In her autopsy report of 4 May 2012 Dr Little recorded the cause of death as:

(a) Drowning.

Other forensic evidence

173. Dr Anthony Ansford is a Consultant Forensic Pathologist, presently employed by the Department of forensic medicine in New South Wales. He was formerly with Queensland Health for many years and is a very experienced pathologist.

174. Dr Ansford conducted the autopsy on Robert Gatenby, who died in the surf at the 1996 Championships following a collision between surf boats. After noting that Robert had suffered no obvious signs of injury, Dr Ansford expressed an opinion at that time as follows:

> "*A person can sustain a blow to the head sufficient to cause loss of consciousness without any visible injuries to the head or brain and such a possibility cannot be excluded*."

175. Given this opinion and its potential relevance to this investigation, Dr Ansford was approached by Counsel Assisting to comment on Dr Little's autopsy findings and her evidence at the inquest.

176. Dr Ansford said that he still held the opinion as set out above, but that in the circumstances of Matthew's death it would be uncommon and if one was struck with a surfboard, then some form of injury would be expected. Dr Ansford noted one particular injury described by Dr Little as "an area of blue discoloured depressed skin at the lateral end of the right eyebrow" which potentially could be a bruise.

177. When pressed at the inquest about Dr Anford's opinion that a person might sustain a blow to the head sufficient to cause loss of consciousness without any visible injuries to the head Dr Little stated, "*I wouldn't say that it could absolutely never happen but I think it would be absolutely incredibly rare."*[41]

178. Given his proficiency in the surf I do not consider that Matthew simply drowned in the conditions after being separated from his board. While Dr Ansford could not exclude a blow to the head of sufficient force to cause loss of consciousness, in the absence of any direct evidence that Matthew was struck by a board, I am unable to attach as much weight to his evidence as that of Dr Little.

179. While nobody witnessed a board striking Matthew, it is clear from the evidence that there was some catastrophic event on the outer bank at

[41] T2-71

Kurrawa that caused Matthew to lose consciousness almost instantly after he was separated from his board.

180. Matthew was a very fit athlete and highly competent in the surf. He was actively negotiating the break, either rolling under, or popping his board over the waves. His board was then seen to fly into the air on a shallow sand bank and within seconds Matthew was observed by the two jet ski operators and his fellow competitors to be unconscious, buffeted helplessly by the surf.

181. I consider it most likely that Matthew became unconscious as a result of the impact of a dumping wave on a shallow sand bank and he consequently aspirated sea water. I accept that contact with his board at this time may have contributed to his condition.

Section 45 findings

182. I am required to find, as far as is possible, who the deceased person was, how he died, when and where he died and what caused his death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, the material parts of which I have summarised above, I am able to make the following findings.

Identity The deceased person was Matthew Stephen Barclay.

How he died Matthew was competing in an under 15 board race at the 2012 Australian Surf Life Saving Championships. Matthew died as a result of being rendered unconscious by the effects of a dumping wave on a shallow sandbank. After he lost consciousness Matthew aspirated sea water. Although he was wearing a green high visibility vest, his body was not located until the following day.

Place of death He died at Kurrawa Beach in Queensland.

Date of death He died on 28 March 2012.

Cause of death He died from drowning.

Conclusions on issues investigated

The adequacy of SLSA policies relating to postponement or abandonment of competition for the safety of competitors

183. Although not a traditional workplace, the OFSWQ Report concluded that the WHS Act applied to SLSA and activities within the surf zone. The OFSWQ Report identified that the WHS Act contains relevant approaches to risk management. The WHS Act imposes duties to ensure health and safety by requiring SLSA, as a person holding a duty of care, to eliminate risks to health and safety as far as reasonably practicable. Where it is not practicable to eliminate risks SLSA is required to minimise those risks, as far as reasonably practicable, by implementing risk control measures.

184. The challenge in complying with this duty in sports such as surf life saving, where competitors are likely to be attracted by the inherent risks, is apparent. The fact that some activities engaged in by life savers are inherently risky does not relieve SLSA of its obligations under the WHS Act. At the same time, the Act does not require SLSA to ensure that accidents never happen. It must do everything that is "reasonably practicable" to ensure the health and safety of competitors.

185. It is clear from the documentation provided by SLSA that it was aware of its obligations under the WHS Act and had attempted to develop a risk management framework with those obligations in mind. The risk management framework was developed in accordance with recognised standards with input from organisations and individuals with specialist expertise in that field.

186. The Surf Sports Manual sets out the planning requirements for the safe conduct of the Championships in some detail. The specific policies for the postponement or abandonment of competition set out in the Surf Sports Manual were complemented by the Contingency Plan and the Safety, Search and Rescue Guide set out in the 2012 Championship Directory. These had been formulated by the Safety and Emergency Services Coordinator.

187. I consider that these policies and plans were suitably detailed. They were accompanied by a governance structure involving the ACCC and other committees. Position descriptions and reporting arrangements were in place for each of the roles to be performed at the Championships.

188. The policies had been amended to incorporate the recommendations of the State Coroner arising from the Saxon Bird inquest. The Surf Sports Manual now directs officials to focus primarily on safety. Officials must suspend competition whenever there is a reasonable basis for concluding there is a risk of serious injury. Implicit in this is an acceptance that competition may proceed in circumstances where there is a risk of injuries that are not serious.

189. There is no requirement for officials to consult with the ACCC or other more senior officials before competition is suspended. The definition of official in the Manual encompasses a wide range of roles, ranging from the Carnival Referee to competition liaison personnel and starters.

190. Section 13 of the Sports Manual sets out the range of committees and officials required for competitions. Unfortunately, the role descriptions for officials below the level of Sectional Referee do not clearly articulate the powers of those persons to immediately suspend the competition in their areas.

191. A considerable amount of evidence was heard at the inquest about the utility of the iPad application that was used for risk assessment, and enabled information about risk across the 2km of beach, to be collated by the Safety and Emergency Services Coordinator.

192. I accept that this application was one tool that informed decision-making about risk during Championships. 2012 was the first year that the iPad application was in use at the Championships. The minutes of the Safety and Emergency Committee during the course of the event indicate that Mr Moore was getting assessments of variable quality.[42] This is likely to have reflected the lack of familiarity with risk management matrixes and terminology on the part of volunteers using the application. I accept that the iPad application was not intended to usurp the observations and judgements of experienced officials standing on the beach. I do not consider that its adoption was inappropriate.

193. The procedures provided for the assessment of risk at regular intervals throughout the day and for those risks to be communicated to Sectional Referees, the Safety and Emergency Services Coordinator and the ACCC, and acted upon immediately where necessary.

194. In summary, I consider that the policies and procedures for the postponement or abandonment of competition for the safety of competitors at the 2012 Championships were generally adequate.

The application of those policies on 28 March 2012

195. Whether the policies for postponing or abandoning competition were applied appropriately on 28 March 2012 essentially requires a consideration of whether risks of serious injury were properly identified and mitigated on that day.

196. The OFSWQ Report noted that the surf zone is inherently dangerous in the technical sense. "*Any person swimming is exposed to risk of injury, in particular the risk of drowning, particularly if rendered unconscious. Any person voluntarily entering water does assume some risk*."

[42] Exhibits C18-C24

197. The OFSWQ Report also noted that the risk of exposure to that hazard can never be eliminated, unless the surf zone is not entered.

> *As the risk remains, SLSA must minimise it, so far as reasonably practicable, by implementing administrative controls. These controls would factor in weather, wave and wind conditions, experience and age of competitors, various venues, and availability of control measures such as rescue craft and personnel*.

198. The minutes of the ACCC and the Emergency and Safety Committee from 28 March 2012 indicate that decisions in relation to the competition were informed by a consideration of prevailing conditions, including the risk assessments carried out prior to the respective meetings. The Contingency Plan was actively considered at each meeting. There is no evidence that SLSA lacked the capacity to implement the Contingency Plan.

199. It was clear from the evidence of Ms Kenny and other officials in the Under 15 area that they were actively monitoring surf conditions in consultation with competitors, and were aware of their power to stop events if necessary. Mr Hannas told police:

> *I was monitoring and telling the course water safety supervisor, telling them I got concerns about yesterday as well, about 11.30 yesterday morning, I raised the issue with the patrol duty officer and the water safety supervisor that the conditions are getting bigger, yesterday and in that role I passed on to my sectional referee which is Dick Clark and he relayed to, to the Jenny, Jenny who's the area referee and we shut that area, we shut the events at 12 o'clock approximately to, she relayed it back to the appropriate people to, when can we restart and reassess again.*[43]

200. The evidence indicates that experienced officials such as Mr Hannas and Ms Kenny were willing to stop and adjust the program to suit the conditions. Ms Kenny did not meet any resistance from Mr Buhk or Mr Bignold when she stopped events in the under 15 area, or proposed changes to the program. I do not consider that she pressed on with the program with disregard for the safety of competitors.

201. Ms Kenny's evidence was that she adjusted the program to postpone some events because of a concern that the course was too long. While she was partly motivated by a desire to ensure the program would be completed within the allocated timeframe, safety considerations were also relevant. This included a desire to reduce the number of competitors in the water and avoid swimmers being in the water at the same time as surf craft. Ms Kenny's decision to resume with board races on the afternoon was made in consultation with officials from the respective teams. They expressed no concerns about the revised program.

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[43] Exhibit B24

202. The replacement of events involving swimmers with board races was a strategy that reduced but did not eliminate risks to competitors. Clearly, once a competitor was separated from their board, they and other competitors faced a level of risk from loose boards comparable to those faced by a swimmer in an event such as the Cameron relay.

203. Notwithstanding, the overwhelming majority of persons interviewed by the QPS, including most competitors in Matthew's race, were of the opinion that the conditions were suitable for the conduct of under 15 board races on the afternoon of 28 March 2012. I am unable to find in retrospect that SLSA officials incorrectly assessed the risk posed by the surf conditions on that day.

204. The only person who raised a concern prospectively about conditions was Mr Powell, the Gold Coast City Council lifeguard. While it was unfortunate that his concerns did not find their way to Ms Kenny or Mr Moore, he conceded in evidence that the officials on the beach in the under 15 area were in the best position to assess the surf conditions. Also relevant is that his concerns reflected surf conditions in the morning, some 4 hours before Matthew's race.

205. It is unfortunate that the ACCC's decision to cease competition at 3:30pm was made in close proximity to the start of Matthew's race. I accept the evidence of Mr Flew that this decision was made for logistical reasons so that buoys and anchors could be retrieved by IRBs from outside the break at Kurrawa and relocated to Kirra for competition on 29 March 2012. This is consistent with the ACCC minutes. I accept that the decision to suspend competition at 3:30pm was not made for safety reasons.

206. I also accept Ms Kenny's evidence that she was not made aware of the ACCC decision and she intended to carry on with competition until the scheduled finish time of 4:00pm.

207. The wearing of high visibility vests and the presence of rescue craft such as jet-skis and IRBs were consistently identified in risk assessment documentation completed on 28 March 2012 as controls or risk treatments that mitigated risks to competitors. In my view these are factors that go to the capacity to rescue a person rather than mitigating the risk of a serious injury.

208. It is clear that wearing a brightly coloured vest will only be of assistance when a conscious competitor is above the water line or outside the break zone. The degree of turbulence in the conditions that accompanied Matthew's race was such that it was impossible to see him as soon as he went below the surface.

209. Rescue craft are clearly very useful assets in assisting conscious persons from the surf. However, the utility of rescue craft such as crewed jet-skis or IRBs in retrieving an unconscious person who is not wearing a

flotation device from the surf zone is limited, unless the person can be removed from the water before they inevitably sink. The window of opportunity to prevent death is a matter of 4-5 minutes. In the circumstances this was the only realistic way that Matthew's life could have been saved.

210. I accept that there were two jet skis closely following the course of Matthew's race. While Mr Long and Mr Lewis were both within metres of Matthew when he was unconscious in the water, and witnessed his incapacity, I accept that neither was able to safely abandon their craft to attempt to rescue Matthew.

211. There was a considerable amount of contention at the inquest in relation to whether a crewed IRB was operating within the Blue and White area at the time of Matthew's race. While it was clear that Mr Wakefield's IRB had broken down and was on the beach while he effected repairs, I am unable to conclude that he had been replaced by another crewed rescue IRB when Matthew became incapacitated.

212. I accept that the understanding of officials in the Blue and White area was that the race should not commence unless there was a crewed IRB on the water. I agree that it is not appropriate for races in challenging conditions, particularly those involving junior competitors, to be allowed to start without a crewed IRB (or a crewed jet ski) in place.

213. Officials may have thought that other IRBs working in adjoining areas could adequately cover the Blue and White area, and that the aggregate number of rescue assets in the area was sufficient. However, once it became apparent that Matthew was unconscious it was necessary for him to be removed from the surf within a matter of seconds before he disappeared under the water and was swept along by the strong current. By the time a crewed IRB could reach the spot that was being held by Mr Lewis, it was too late. In the circumstances, only a crewed IRB or crewed jet ski that was shadowing the field closely could have effectively recovered Matthew.

214. Subject to the reservations I have expressed, I consider that the policies relating to the postponement or abandonment of competition were applied appropriately.

The steps taken by SLSA to implement recommendation 2, 'Continuing review of safety devices', of State Coroner Michael Barnes' findings delivered on 2 August 2011 in relation to the death of Saxon Bird.

215. The following sets out the context and the recommendation from the Saxon Bird inquest in relation to a review of safety devices by SLSA.

Floatation devices

Saxon was unable to be saved because approximately 50 minutes elapsed between his being struck and his lifeless body being pulled from the ocean. He was not recovered sooner because when he was hit he lost consciousness and sank in opaque water. Trials have been undertaken with competitors wearing high visibility vests. Apparently these proved not to impede the competitors and made them easier to see but may make little difference if the competitor is on the ocean floor. However, work is also progressing in the design and development of a self inflating vest suitable for use in iron man events. An experienced competitor who gave evidence said he had trialled the device and found it to be suited to its purpose. A designer of such a device was recently recognised in the Australian Design Awards.

Recommendation 2 - Continuing review of safety devices

As it is impossible to eliminate the risk of a competitor in a surf ski or board event being struck by a craft, it is essential that injured competitors be rescued as quickly as possible. This would be enhanced by devices that make the competitors easier to see and cause them to float on the surface even if unconscious. I recommend SLSA collaborate with the designers of such devices with a view to making the wearing of them compulsory once the organisation is satisfied they are suitable. Consideration should also be given to the use of helmets by competitors in surf craft events.

216. SLSA provided a considerable amount of material in relation to the steps it has taken to implement this recommendation.[44] The focus of the inquest was on the introduction of helmets and life jackets in surf craft events. SLSA had commissioned independent testing of buoyancy aids and surf helmets by James Cook University which was quality assured by SAI Global. Helmets have been mandated in surf boat events from 1 October 2014.

217. Anthony Bradstreet, PPE Project Manager and Coastal Risk & Safety Manager, gave evidence at the inquest that SLSA was in the process of developing a new Australian Standard for buoyancy aids and surf helmets. On 13 August 2015, Standards Australia published the revised edition of the AS 4758 series of Australian Standards on lifejackets, including the new L25 buoyancy category for competent swimmers for specialist activities.

218. In May 2015, SLSA released the results of its PPE project.[45] The PPE Report acknowledged "*the primary risk aiming to be mitigated via the employment of PPE is the catastrophic risk of drowning following incapacitation via a range of root causes and mechanisms*." The Report

[44] Exhibits B66, B67

[45] SLSA Personal Protective Equipment (PPE) Project Final Report – Surf Sports

noted that the following key milestones have been achieved to inform the development of fit for purpose technical specifications:

- *Defining the risk and performance requirements (fit for purpose criteria) for both lifejackets and surf helmets.*
- *Identifying that Level 50 Lifejackets were not suitable for use in the surf zone particularly on non-powered craft.*
- *Identifying the minimum buoyancy requirements for low buoyancy lifejackets.*
- *Developing and testing a draft Australian Standard for Level 25 (low buoyancy) Lifejackets.*
- *Delivering and testing a draft Technical Specification for Surf Helmets.*
- *Delivering and testing a draft Technical Specification for Level 25 Lifejackets.*

219. SLSA's submissions indicated that it was not willing to mandate the use of personal protective equipment until any secondary risks arising from the use of such equipment were addressed. It also noted that the use of PFDs and helmets on a voluntary basis was already permitted by the Sports Manual.

220. On 20 May 2015, I was informed by SLSA that the Board had accepted the recommendations contained within the PPE project report. A project is underway to determine how and when low buoyancy lifejackets and surf helmets will be used in competition.

221. This project will determine safety thresholds to be reflected in SLSA policy to be developed and adopted before an implementation date of 1 October 2016. Surf helmets are not being introduced in board disciplines, as current devices were not considered suitable. This was primarily due to comfort issues (rather than issues of secondary risk). However, these devices may continue to be used voluntarily.

222. The proposed SLSA policy will only apply in situations of "heightened risk". What constitutes heightened risk is still to be determined but the concept appears to have been successfully employed in considering when to mandate the wearing of helmets by surf boat crew, based on the use of the Surfboat Hazard Rating System developed by Bond University and included in the PPE Project Report. It is likely that the implementation of a heightened risk scale will also lead to more consistent decision-making in relation to the postponement, abandonment and relocation of events.

223. The announced SLSA policy is a very significant step forward, made in the face of strident opposition from some high profile life savers. In my view, unless events were only conducted at locations or in conditions where an unconscious person could be rescued swiftly, the use of personal flotation devices is the only way that the risk of drowning to unconscious competitors can be effectively mitigated in the surf environment.

224. I consider that SLSA has taken adequate steps to implement the 2 August 2011 recommendations in relation to the 'Continuing review of safety devices'. As the OFSWQ Report noted, "*the adoption of appropriate buoyancy vests and surf helmets is a complex task involving conflicting considerations. It seems clear any such process takes time to develop*".

225. It is still important to acknowledge that PPE is recognised as being least effective in the hierarchy of controls. Risk elimination and substitution (such as abandoning competition or activating contingency plans in hazardous conditions) and administrative controls will still need to be actively considered after competitors have access to suitable PPE.

226. The Bond University research referred to above also noted that the competency of competing crews was an important moderating variable when relating the occurrence of incidents to varying surf conditions. It also recommended that competency ratings be developed which could be combined with the heightened risk values to produce an overall Competitor Surf Safety Index (CSSI). It is not clear whether SLSA intends to pursue the notion of competency ratings for competitors.

227. In the context of events involving children, who can be as young as 13 years in the under 15 events, there is likely to be a very wide range of competency levels. This should be factored into any risk assessment for these competitors in addition to the factors relevant to the assessment of heightened risk, which will focus on surf conditions. A very cautious approach should be taken to the assessment of risk for competitors who are still children. There is no room for complacency.

Other safety initiatives

228. In addition to the steps taken by SLSA to implement suitable PPE for competitors, I acknowledge that SLSA has taken some other steps since the 2012 Championships to enhance safety in competitions. These can be summarised as follows:

- SLSA is investigating the creation of a training program to enable a larger number of crew to be available for jet ski operations;
- SLSA has commenced a review of the use of jet ski crew in situations where a missing person is underwater;
- SLSA has mandated the use of helmets in surfboat competition in conditions of heightened risk;
- Events involving under 15 competitors now form part of the National Youth Championship;
- Eligibility requirements for competitors at the Championships have been amended so that participants must have competed in a Branch or State Championship. In addition, for the National Youth Championship each club is limited to 4 competitors from each gender for each event;
- Any change to the program of events after the commencement of the carnival must be the subject of a separate risk assessment;

- The Surf Sports Manual will be amended refer to the inherent problems associated with rescuing an unconscious competitor from the ocean in competition areas.

Recommendations

229. The *Coroners Act* enables a coroner, when appropriate, to comment on anything connected with a death investigated at an inquest that relates to public safety and ways to prevent deaths from happening in similar circumstances in the future. I make the following recommendations.

1. That SLSA mandate the use of helmets and level 25 lifejackets for all surf craft events (including ski and board races) involving competitors in all age categories up to and including under 17.

2. That SLSA mandate that surf events are not to start unless a viable means of rescuing an unconscious person from the water is in place i.e. a crewed IRB or a crewed jet ski is on the water in the competition area.

3. That SLSA develop protocols to ensure that the safety concerns of persons such as council lifeguards are escalated by officials to the Safety and Emergency Services Coordinator.

4. That role statements for all officials within the Surf Sport Manual clearly state that they have the authority, and are required, to suspend competition where they consider there is an unreasonable risk of serious injury occurring.

5. That in the event of a future death at a surf life saving event an investigation be carried out by the regulator under the *Work Health and Safety Act 2011,* in consultation with the Queensland Police Service.

230. I close the inquest.

Terry Ryan
State Coroner
Brisbane
15 January 2016