OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the suspected death of Rodney John BAKER**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR-632/05(8)
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FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, trawler fishing, hydrostatic released life rafts, PFD's, EPIRB's, search & rescue.

REPRESENTATION:

Counsel Assisting:	Mr Craig Eberhardt
Maritime Safety Queensland:	Mr Jeffrey Hardy

Findings of the inquest into the death of Rodney John Baker.

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Pursuant to s28 (1) of the *Coroners Act 2003* an inquest was held into the disappearance of Rodney John Baker. These are my findings. They will be distributed in accordance with requirements of s45(4) and s46(2) of the Act.

Introduction

On the night 29 January 2004, Rodney Baker and his brother in law were trawling in the Tempest 40s trawl grounds off Cape Moreton when one of their nets snagged an unidentified object. The men commenced to haul their nets aboard to free the obstruction but before they could complete this task the boat rolled over and soon sank. Mr Baker has never been seen again.

These findings seek to explain what became of Mr Baker and recommend changes to legislation aimed at reducing the likelihood of similar outcomes occurring in future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because the police officers who were involved in searching for Mr Baker came to suspect that he was dead and that his death, if it had occurred, was likely to have been "*a violent or otherwise unnatural death"* within the terms of s8(3)(b) of the Act, the disappearance was reported to the Office of State Coroner. As a result of considering the report I also came to suspect that Mr Baker was dead and that his death was a reportable death. Accordingly, pursuant to s11(6) I have jurisdiction to investigate the death. Section s28 authorises the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a susepcted death.

The Act, in s45(1)and (2), provides that when investigating a suspected death the coroner must, if possible find:-

- whether the death happened, and if so,
- the identity of the deceased,
- how, when and where the death occurred, and
- what caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, in so far as it is relevant to this matter, the Act authorises a coroner to "*comment on anything connected with a death investigated at an inquest that relates to –*

(a) public health or safety ; or

(c) ways to prevent deaths from happening in similar circumstances in the future.[2]

The Act prohibits findings or comments including any statement that a person is guilty of an offence or civilly liable for something.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are as constrained as courts exercising criminal or civil jurisdiction becuase s37 of the Act provides that "*The Coroners Court is not bound by the rules of evidence, but may inform itself in any way it considers appropriate."*

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear,

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46(1)
[3] s45(5) and s46(3)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I turn now to a description of the investigation into this suspected death.

The initial investigation consisted of a sea and seashore search aimed at locating Mr Baker after the trawler sunk. An extensive search which is detailed later in these findings failed to locate any trace of him. All relatives whom Mr Baker would be expected to contact were he alive have been spoken to. The records of financial institutions with whom Mr Baker did business have been searched with negative results. For the reasons detailed below I am of the view the investigation has been competent and thorough.

The inquest

Pre – inquest conference

A directions hearing was held in Brisbane on 16 March 2006. Mr Eberhardt was appointed counsel assisting and leave to appear was initially granted to the Department of Primary Industries and Fisheries but on familiarising itself with the material the Department decided it did not have sufficient interest to continue its participation in the inquest and so withdrew. Maritime Safety Queensland also sought and was granted leave. The family of Mr Baker was not separately represented but they conferred with those assisting me before and throughout the hearing.

A representative of the Queensland Seafood Industry Association attended the directions hearing but the originisation elected not to seek to appear. After the hearing I wrote to them advising of the preventative recommendations I was considering and inviting any submissions they might care to make.

The hearing proceeded on 19 April 2006. Five witnesses gave evidence and 53 exhibits were tendered. The inquest was then adjourned to enable further inquiries to be undertaken and for the parties to make written submissions. Those matters have been attended to. I found the submissions of the parties most helpful and thank their lawyers for them.

The evidence

I turn now to the evidence. I can not, of course, even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

In the early afternoon of 20 January 2004, Rodney Baker and his brother-in-law Paul Kesby steamed out of Cabbage Tree Creek aboard the trawler Gulf Stream. The boat, a 51 foot steel hulled trawler with a gross tonnage of 33.42 tonnes was built in 1979 and was owned by Mr Baker's parents. It was in

survey. It was in good condition and carrying all safety gear required by the relevant regulations.

They intended to stay at sea for ten days and to fish off shore from Moreton and Stradbroke Islands.

Messrs Baker and Kesby were experienced fisherman; both had a skipper's licence and both had fished on the boat in the same area on numerous previous occasions.

The first nine days of their trip passed without incident. They were catching reasonable amounts of prawns and had fished the Tempest 40s trawl grounds off Cape Moreton and the Jumpin Pin 40s trawl grounds off South Stradbroke Island. They trawled at night and anchored during the day to sleep and perform routine maintenance.

On 29 January at about 4.30 pm the fishermen left their anchorage off Stradbroke Island and began heading north to the Tempest 40s trawl grounds. They were steaming into a north, north easterly wind of about 15 to 18 knots. They also had to contend with southerly current of about 3.5 knots and so made only slow progress at about 4 knots.

They dropped their nets for the first time that night at about 8.00pm. After dinner, in Mr Kesby's words "*nothing much was happening,*" the nets were down and they were trawling northwards in calm to moderate seas and so Mr Baker decided to go below for a sleep while Mr Kesby remained on deck.

At about 10.30pm a storm or squall blew over the boat with strong winds and heavy rain. Mr Kesby turned the boat to run southwards before the weather and current. Shortly after he did so, he noticed the boat was losing speed and pulling to the right or starboard. He knew from experience that this meant that something was caught in the net, that is, the net was not hooked on a fixed object on the sea floor but some unidentified object had been scooped up. He said in evidence that could have been an object dropped or thrown from a ship or it could have been marine life, such as kelp. It was also possible that one of the boards on the starboard net had dug in and was skidding along below the surface of the sea floor scooping up sand.

What ever the cause, the cure was to back off the engine and haul in the nets. To do this Mr Kesby needed Mr Baker's help and so he called him on deck. The three nets were being dragged behind the boat on about 1100 feet of steel cable that had to be wound in on dual winch capstans driven by a common motor. While this was being done the boat had to be kept in line with the trawl wires as much as possible to avoid them crossing and becoming snarled.

It was a difficult job in the bad weather which was driving the boat forward as they attempted to draw back to make the recovery of the nets easier. They had recovered a significant proportion of the cable that was out – in his statements to police Mr Kesby estimated 300 feet had been drawn in, but in

evidence at the inquest he suggested that they were at the point of lifting the nets from the sea floor when the winch started to labour and the boat was pulled to the starboard by the greater resistance in the net on that side. This placed the boat beam on to the waves and the current. Both men knew this was a precarious position to be in, but Mr Kesby says they still thought they could retrieve the nets and so kept winching.

He says that had he realised what was about to happen he would have used the bolt cutters kept on deck to cut the cables. He did not do so but when a couple of waves came over the starboard gunwale they both knew the boat had to be turned so that it was not beam on to the sea.

After brief discussion, both men released the brakes of the winch to let cable out so that the boat could swing down wind. However this did not happen before more water was taken over the starboard side causing the boat to heel more. Because they were low on fuel, the inclination of the boat starved the motor of fuel and it stopped. The lights also went out and almost immediately thereafter, with little warning the boat rolled over. This happened so suddenly that Mr Kesby did not have time to retrieve the EPIRB that was in the wheel house. As the boat was rolling over he grabbed the side rail to stop himself being hit by the boat. He was thrown into the dark sea.

Mr Kesby surfaced next to the boat; it was upside down and there was nothing on the hull he could grab onto. The current quickly swept him away from the boat and it was too strong for him to be able to swim against it back to the boat.

Mr Kesby says he did not see Mr Baker as the boat was capsizing but he knew him to be on the starboard side of the winch motor, near the side of the boat that went under first. As he was swept away from the boat Mr Kesby began calling Mr Baker's name and did so repeatedly over the next few hours. He heard no response and never saw Mr Baker again. He says he could see the silhouette of the upturned boat for about 10 minutes before either it got too dark or the boat sank.

Throughout the night Mr Kesby drifted south. Intermittently he swam in a westerly direction as he hoped to make landfall on Moreton or North Stradbroke Island. He was anxious to reach land at least by the time he got as far south as Point Lookout as after that protuberance the shoreline moves westerly and it would be harder for him to reach it.

By about 6.30am on the morning of 30 January, Mr Kesby had drifted south to the extent that he was just north east of Point Lookout when he saw a trawler he had previously worked on, the Sara Emma, steaming towards him. Mr Kesby made strenuous and successful efforts to attract the attention of those on board. He was rescued: pulled from the ocean cold and exhausted. The skipper of that boat immediately made radio contact with the Southport Coast Guard and telephoned Mr Baker's father to tell him of the accident and its result.

They then steamed to Flat Rock, a small islet north of Point Lookout in the hope that Mr Baker may have clambered onto it. There was no one there so they went to Shagg Rock and waited on anchor for the coast guard to come and get Mr Kesby.

Immediately the coast guard was advised of the sinking, efforts to locate Mr Baker commenced. The Brisbane Water Police were notified and they contacted a Boating and Fisheries patrol officer who was able to interrogate the Vessel Monitoring System that records the position of trawlers by collecting data from transponders on all commercial fishing boats. The last position of the Gulf Stream recorded on this system was broadcast at 11.40pm the previous night which Mr Kesby was able to say was immediately before the sinking. The position of the vessel when this last broadcast was made was conveyed to the Water Police and a rescue helicopter was despatched to the area at 7.30. By 9.00am three more helicopters had joined the search and coast guard and Volunteer Marine Rescue boats were also on the scene of the sinking and searches were undertaken along the shore of Moreton and North Stradbroke Island by National Parks and Wildlife officers. All ships had been advised of the accident and told to be on the lookout for a man in the water.

As the day progressed, assistance was provided by AusSAR, the national search and rescue organisation, which is part of the Australian Maritime Safety Authority, to calcuate a search area with reference to the likely drift line of a survivor having regard to the relative positions of the sinking and the recovery of Mr Kesby.

Boats from Southport and Beenleigh Volunteer Marine Rescuse organisations also joined the search as did numerous trawlers and fixed wing aircraft. From about 11.15am on 30 January and over the next three days various bits of debris were located that were identifed as coming from the Gulf Stream. The search area was adjusted having regard to these findings. Despite these efforts no trace was found of Mr Baker.

I am persuaded the search was thorough and professionally organised and undertaken. I consider it likely that had Mr Baker survived the capsize of the boat, he would have been found during this search. I accept the evidence that he has not been seen since and that there is no basis on which to supect that he has deliberately concealed his whereabouts. All of the evidence points to Mr Baker having died at the time of the sinking of the Gulf Stream.

Findings required by s45(1)&(2)

I am required to find whether the suspected death in fact happened and, if so, who the deceased person was, and when, where and how he came by his death. I have already dealt with the first and last of those matters, in that I have found that Mr Baker is dead and described the circumstances in which the death occurred. I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased was Rodney John Baker

Place of death – Mr Baker died in the sea off Moreton Island in Queensland.

Date of death – He died on 29 January 2004

Cause of death – Mr Baker died as a result of the boat he was on capsizing. The most likely cause of death is drowning.

Comments and preventive recommendations

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

In this case, the most obvious issues that warrant comment from that perspective are the stability of the boat, the crew's ability to respond to the emergency and the safety equipment carried by the Gulf Stream.

Each of these issues are regulated by the provisions of the *Transport Operations (Maine Safety) Act 1994* which, in subordinate legislation and regulations, stipulates aspects of boat design and operation that commercial fishing boats must comply with in order to obtain the registration necessary for them to operate legally.

Boat stability

The capsizing of the Gulf Stream was not a unique event. For example, Mr Adams of Maritime Safety Queensland (MSQ) provided a report to the Court detailing 38 instances of commercial fishing boats capsizing in the 12 year period 1992 to 2004 in the Brisbane region alone. Attached to the submissions made by MSQ was a table showing that 75 boats had been lost on the east coast of Queensland in the period 2001 to 2004 inclusive. Further, a search of the National Coronial Information System indicates that in the ten years 1994 to 2004, 16 trawler men died at sea.

Many of the incidents detailed in the material provided to the Court by MSQ involved trawlers capsizing after their nets hooked onto protuberances on the sea floor or filled with submerged objects.

The ability of a boat to cope with such challenges depends on aspects of hull design and configuration of the trawling equipment. Unfortunately, no data is available concerning these aspects of the Gulf Stream as a provision in the Marine Safety Regulation deems ships registered prior to the commencement of the Regulation in 1994 to comply. Further, changes to the equipment, even if those changes could impact upon stability, are not required to be approved by the safety regulator.

These concessions were made as an understandable response to the costs that could be incurred if all operators were immediately forced to have surveys

undertaken to provide the necessary data and/or to make the changes needed to bring the older boats into line with more modern design criteria. However, as the standard has been in place now for over 10 years and as the National Standard for Commercial Vessels (the NSCV) is again undergoing review, it may be time to reconsider these concessions in order to implement consistent safety standards across the commercial fishing fleet.

Recommendation 1 – The applicability of the NSCV

I recommend that MSQ liaise with the Queensland Seafood Industry Association and other relevant representative bodies with a view to curtailing any concessions that exclude the application of safety design requirements to any commercial fishing boats so that the National Standard for Commercial Vessels is applied to all trawlers and that if necessary regulations be amended to make mandatory the inspection and approval of any changes to trawling equipment that could impact upon a vessel's stability.

Quick release mechanisms

I accept the evidence of Mr Baker's father that the Gulf Stream had survived some very challenging conditions in the past. However, whatever the stability characteristics of the Gulf Stream were, as this incident shows there was always the possibility that given the nature of its work, that it would come across conditions that would overwhelm the boat. A "hook up" was one such possible challenge. Mr Kesby gave evidence that if the crew was unable to free the nets, the last resort in an emergency was to cut the trawl cables with bolt cutters kept on board for that purpose. On this occasion there was not sufficient time to do this before the vessel capsized. I am persuaded by the submission of MSQ that a quick release mechanism is a more appropriate response to such risks.

Recommendation 2 – The installation of quick release mechanisms on trawl cables

I recommend that the installation of quick release mechanisms on trawl cables be mandated for all commercial trawlers

Safety equipment

I turn now to the issue of safety equipment.

The Gulf Stream was only required to carry a life boat and two life rings. This equipment was on board. The life boat was lashed to the roof of trawler's wheel house. When the trawler sunk the life boat went to the bottom of the ocean with it. One life ring was found floating south of Point Lookout, the other has not been seen since the sinking. The boat also carried an electronic positioning radio beacon (an EPIRB) but it was kept in the wheel house and could not be reached by Mr Kesby as the boat was capsizing.

Commercial fishing generally, and trawling in particular, is a hazardous occupation. Fishermen work mostly at night, often in bad weather and usually with small crews, often only two men. They work in wet and slippery conditions on a moving platform performing demanding tasks over long hours. As referred to earlier, capsizes are not uncommon and there is always the hazard of falling overboard. Even if the other crewman is immediately aware this has happened responding effectively in dark and rough seas can be very difficult.

Since they have ventured from the shore, the sea has swallowed fishermen: nothing will eliminate that entirely. However, I do not believe that advances in technology that could reduce the likelihood of that happening have been appropriately utilised. In other dangerous industries, unions have successfully lobbied for legislation to reduce the risks to workers so that when anybody enters a mine or a building site they are required to wear steel capped boots and hard hats. In the fishing industry where many of the workers have limited education and other employment opportunities and unionism is almost non existent, a level of risk that would not be tolerated in shore based jobs is the norm.

The over fishing which has decimated fish stocks around the country, indeed around the world, is well known and well documented, but at least in one respect the fish have more protection than the fishermen.

Commercial fishing boats are required by law to use electronic locating technology so that authorities can keep them under surveillance to ensure they are not fishing in closed waters. It is unacceptable that the same technology is not mandated to be used to guard the safety of the crew.

In a case of a capsize and/or sinking, immediate access to a life raft and to a means of alerting others to its position will greatly increase the chances of the crew surviving. If a person falls overboard, immediate access to a floatation device and a means of alerting others to the floating person’s position are essential.

These dangers are easily ameliorated by equipment that is readily available and relatively cheap when one considers its potential to save lives and the cost of sea and air searches.

An inflatable life raft stocked with survival equipment such as water and flares and secured by a hydrostatic release will break free of the trawler and float to the surface when submerged more than a few meters. An inflatable personal floatation device is a compact harness containing a small gas cylinder that when activated inflates the harness allowing it to support the wearer in the water. An EPIRB, can be as small as a cigarette packet. When activated, for up to four days it transmits radio signal on international distress frequencies that are monitored by search and rescue authorities and enables the position of the device to be precisely located by satellite navigation systems.

The three very experienced fisherman who gave evidence at the inquest were given an opportunity to try on a PDF of the type referred to and agreed that it would not unduly hinder a fisherman at work and they could see no other impracticality with wearing such a vest with an EPIRB attached when ever they were on deck.

Recommendation 3- The mandatory carrying of inflatable life rafts, PFDs and EPIRBs

I recommend that MSQ investigate to identify the most appropriate type and models of inflatable life raft and hydrostatic release, PFD and EPIRB to ameliorate the dangers faced by trawler men and that the Transport Operations Marine Safety Act regulations be amended to mandate that trawlers carry such life rafts, and commercial fishermen wear such PFDs and carry such EPIRBs when working offshore whenever they are on deck.

This inquest is closed.

Michael Barnes
State Coroner
16 May 2006