INNISFAIL CORONER FINDINGS

CITATION:	Inquest into the suspected death of Peter Joseph TRCKA
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Innisfail
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FINDINGS OF:	J Brassington, Coroner
CATCHWORDS:	CORONERS: Inquest - Trawler, EPIRBS, Personal Flotation Devices

REPRESENTATION:

Assisting:	Sgt O'Rourke
Maritime Safety Queensland:	Mr Egan (instructed by Mr Osborne MSQ)

INTRODUCTION

1. Peter Trcka, born on 28 January 1952 at Renmark South Australia, was employed as a fisherman/cook/deckhand on board the fishing vessel the 'Shanendale'. On the 28th February 2006 the Shanendale, with Peter Trcka on board, put to sea and sailed from Mourilyan harbour to Otter Reef which is east of Tully Heads.

2. Peter Trcka disappeared while the Shanendale was anchored overnight at Otter Reef. He has not been heard of by his friends or family or sighted by any known person since 1 March 2006.

3. Pursuant to s. 28 (1) of the *Coroners Act 2003* (the Act) an inquest was held into the disappearance of Peter Trcka. These are my findings. These findings and comments will be distributed in accordance with requirements of ss 45 (4) and 46 (2) of the Act.

4. Before turning to the evidence I will make some brief comments about why I have the jurisdiction to inquire into the suspected death of Peter Trcka.

THE CORONIAL JURISDICTION: LAW AND PRINCIPLES

5. I have jurisdiction to inquire into the cause and circumstances of Mr. Trcka's suspected death because the State Coroner, pursuant to s.11 (5) of the Act, has directed me to investigate the suspected death. Section 11(6) of the Act provides relevantly that the State Coroner may direct a Coroner to investigate a suspected death if the State Coroner suspects the person is dead and the death was reportable.

6. A Coroner who is investigating a suspected death must, if possible, find out whether or not a death in fact happened (s. 45(1) of the Act). Section 45(2) of the Act provides that when investigating a suspected death the Coroner must as far as possible also[1] find:-

[1] Subject of course to the Coroner being satisfied there was a death: s. 45(3)(a) of the *Coroners Act 2003* .

- Who the deceased person is; and
- How the person died; and
- When the person died; and
- Where the person died; and
- What caused the person to die.

7. A Coroner may also comment on anything connected with a death investigated that relates to public safety or the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.[2] When such comments are made a written copy of those findings must be given to the persons set out in s. 46 (2).

8. I now turn to matters of law and procedure that I must apply to the conduct of the proceedings and the making of my findings. A coronial investigation is an inquisitorial process. Its focus is finding out what happened and not on determining guilt, attributing blame or apportioning liability. Rather its purpose is to inform the family and public how the death occurred with a view to reducing the likelihood of similar deaths.[3] A Coroner must not include in the findings any statement that a person is or may be guilty of an offence or civilly liable for something.[4]

9. A Coroner is not bound by the rules of evidence but may inform herself in any way considered appropriate.[5] However, the Coroner must act judicially and have regard to the rules of natural justice and procedural fairness.[6]

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2 Coroners Act 2003, section 46.

3 From the summary of functions by the State Coroner in the matter of Wait et al 17 March 2008 cited by Mr Braithwaite.

4 Coroners Act 2003, section 45(5). See also R v Shan Eve Tennent; Ex parte Jager [2000] TSSR 64 where Cox CJ said of the similar Tasmanian provision: the focus of an inquest conducted under the Act being the ascertainment of facts without deducing from those facts any determination of blame, and the mischief sought to be avoided being the public naming of persons as suspected of criminal activity when they may never be charged. Section 46(3) provides the same prohibition with respect to comments.

5 Coroners Act 2003, section 37

6 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

10. When making findings the civil standard of proof, the balance of probabilities, is applied. However the principles of *Briginshaw v Briginshaw* must be adhered too. In the coronial context these are conveniently set out in the often cited judgment of in *Anderson v Blashki* [7] where Gobbo J refers to the classic statement of the civil standard of proof in Briginshaw that *" . . . reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences".*

THE EVIDENCE

11. I turn now to the evidence upon which my findings are made. I have considered not just the evidence heard at the inquest but also the tendered sworn statements which were largely not in dispute, and the investigation report of Senior Sergeant Williamson. I do not intend to summarise all the evidence but set out the evidence that I consider necessary to understand my findings.

INTRODUCTION

12. Bernard Eggins was the skipper of the Shanendale. The vessel was owned by his mother, Stephanie Eggins. The Shanendale was an ex – trawling vessel 13.82 metres long. It had a crew of four (including the skipper) and was used primarily for fishing live cod and trout off the

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McCann (1990) 65 ALJR 167 at 168 makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

[7] [1993]2 VR 89 at 95. In accordance with this obligation Maritime Safety Queensland were given leave to appear and made submissions at the Inquest. Upon adjournment of the Inquest Workplace Health & Safety were advised of the issues arising and a copy of the transcript was released to them.

coastal water of Innisfail and surrounding areas. The vessel towed two dories at the rear of the boat used as fishing boats for the crew. While at sea the Shanendale was a 'dry' ship. That is the skipper did not allow alcohol and/or drugs on board.

13. The Shanendale was fitted with HF long distance radio, a marine VHF radio (used for usual ship to ship and ship to shore communications), a GPS chart plotter, a Furuno depth sounder and an anchor alarm.

14. The Shanendale was lost at sea during cyclone Larry on 20 March 2006 when it went down at anchor in Mourilyan Harbour. All property on board the ship, including log books was lost.

15. The crew for the journey to Otter reef on 28 February 2006 were the skipper: Bernard Eggins, Kyle Cook, Peter Trcka and Marc Luck.

16. The crew were experienced. Although Bernard Eggins was only 22 years old at this time he had held an un-restricted coxswains license for four and a half years. He had been involved in fishing since he was thirteen years old and had chartered and fished the waters around Innisfail since that time.

17. Marc Luck was 44 years old in 2006. He held an assistant Fisher License and had been a fisherman all his working life. He had been fishing out of the Innisfail coastal waters for over 19 years. He had worked on the Shanendale numerous times.

18. Kyle Cook was 19 years old. He had been working as a doreyman on the Shanendale for 4 years.

19. The skipper and the crew were all well known to each other. Bernard Eggins had known Peter Trcka for 13 years through personal and professional connections. Kyle Cook had also grown up knowing Peter

Trcka. Marc Luck had known Peter Trcka for many years. Eggins considered that his crew on the Shanendale was a very happy crew.

A Description of Peter Trcka

20. All of the evidence supports the description of Peter Trcka by Bernard Eggins: he was a good and experienced fisherman who was very confident in his abilities.

21. Peter Trcka had some medical issues that are relevant in this matter. Firstly, he had an artificial leg due to a motor bike accident. Mr. Eggins considered that the artificial leg did not impede Mr. Trcka in any way on the boat. Eggins testified he never seemed to have any problems with balance and unless you knew he had an artificial leg then you would not know he had one fitted. He was also a good swimmer. To swim he removed his artificial leg. On the boat he would wear a reef sandal on his prosthetic leg (but not on his foot) when he was at sea to guard against the fibreglass leg slipping from under him.

22. Venisha Hagan had lived with Peter Trcka for 3 ½ years. She corroborates Mr. Eggins account that Peter Trcka was a good swimmer. She said Mr. Trcka was like a '*fish in the water*'.

23. Secondly, Mr. Trcka had some history of fitting. Doctor Jeremy Furyk, a registered medical practitioner, provided a statement as to his examination of Peter Trcka on 1 November 2002 following an incident on a ship:

> *The patient was aero-medically retrieved from Dunk Island, arrived in the emergency department 1 November 2002. Patient had no recollection of events, and history was obtained from a work friend. While working on a fishing trawler the patient was observed to collapse, at approximately 1800 on 31/10/2002. He was observed to have what appeared to be a generalized tonic clonic seizure of 20 – 30 seconds duration,*

followed by a second seizure of similar duration, which was followed by 60 minutes post ictal state where the patient was confused.

He had a past medical history of MVA and an amputation of his left leg, heavy alcohol use admitting to drinking 6 – 8 standard drinks per day and had a history of a fall at the pub two weeks previously sustaining a laceration.

On arrival to the emergency department the patient was of normal alertness, not confused, observations within normal limits and neurological examination. Blood investigations were normal, and a CT scan performed the following morning was also normal.

He remained in hospital overnight for observation and had no further seizures. His seizures were postulated to be related to alcohol withdrawal as he displayed some signs of alcohol withdrawal the following morning. He was commenced on regular diazepam and an alcohol withdrawal scale and admitted to hospital under the medical unit. He was discharged from hospital on 2 November 2002. There was no indication in the hospital record with regard to follow up, investigations or medications.

24. The degree he was affected by ongoing fits is unclear. Ms Hagan was aware of a fit that Peter had just before she met him. He had told her that he had to be airlifted off the ship. When she knew him he was not on any medication and she did not observe him have any fits while they were together.

25. Brendan Eggins and Marc Luck both testified of knowing of the fit episode when Peter Trcka was transported off a ship. They were also aware of another episode where he may have had a fit but did not know of any details.

26. A number of witnesses noted in their statement that Mr. Trcka, when not at sea on dry boats, continued to drink significant quantities of alcohol. Ms Hagan said that in the months leading up to his final departure on the Shanendale Peter Trcka had spent a lot of time drinking because he was bored not being at sea. In the three months prior to his departure he was drinking up to half a carton of Victoria Bitter stubbies per day.

THE DISAPPEARANCE OF PETER TRCKA

27. The Shanendale arrived at Otter Reef at about 7.30pm on the 28th February 2006. When anchored at Otter Reef Brendan Eggins estimated the Shanendale was in approximately 12 metres of water (a more accurate estimate is not possible as the log book had been lost). The conditions at anchor were very calm and he described the sea as "almost a glass out" while at anchor.

28. At the reef Brendan Eggins instructed Peter Trcka to prepare the anchor. He then observed Peter at the bow of the boat. He was shaking and he shouted "help". Mr. Eggins ran to assist him as he could see Peter Trcka starting to fall over with his legs giving way underneath him. Bernard Eggins grabbed him to prevent him falling and, with the help of Marc Luck and Kyle Cook helped him below.

29. Below deck Peter Trcka was observed by Brendan Eggins to be distressed, sweating profusely, pale and shaking. He settled and resumed his duties cooking the evening meal. Brendan Eggins thought he was very quite throughout the meal and 'not his usual self'. Mr. Eggins went to bed at about 9 pm. He awoke at 3am and observed Peter Trcka asleep in his bunk.

30. In evidence at the inquest Mr. Eggins testified he had suggested to Mr. Trcka that he get him medical help and he return the Shanendale to port. Mr Trcka brushed him off.

31. Marc Luck also observed Peter Trcka's near collapse on the foredeck of the Shanendale. He described him shivering with no control over himself and saying "*don't let me go over the side*". He swore that Peter Trcka appeared to be a bit embarrassed about his 'turn' and appeared 'OK' as he settled down to tea with them.

32. Mr. Luck was more inclined to put Peter Trcka's turn down to hyperthermia then alcohol withdrawal. He, Mr. Luck, testified that he had suffered similar turns at sea. Mr. Luck did not drink alcohol.

33. Kyle Cook's account of the incident is very similar to that of the other two crew members. His last observation of Mr. Trcka was he was still up at about 10pm walking around the cabin area. Brendan Eggins and Marc Luck had already gone to bed. Mr. Cook then went to bed.

34. Mr. Luck next observed Mr. Trcka at 4.30am in the wheelhouse watching television. They had a cigarette together and chatted. Mr. Luck testified Peter Trcka was as "*good as gold*" and he was in a good mood joking that he had gotten up as he had a "*fight with cockroaches*". Mr. Luck told Mr. Trcka that he had seen squid in the water in the rear deck lights. He said his eyes lit up when he said this as Mr. Trcka liked to catch and cook squid for the crew. Mr. Luck went back to bed leaving Mr. Trcka watching television.

35. The rear deck lights were lit up all night to spotlight the dories. The lights attracted bait fish and consequently squid. Otter Reef is also a well known location for sharks. Marc Luck testified that he had seen sharks when they arrived at Otter Reef. One shark had attacked the boom when they anchored. Brendan Eggins testified that Otter Reef was "*renowned for sharks*".

36. Mr. Luck awoke again at 5.30am and went to the wheel house were he saw the television still on. He made himself a cuppa and then,

realising Peter Trcka was not about, went to look for him. On the back deck he saw a bucket with a squid in it.

37. Not being able to find Mr. Trcka in the wheel house or fore deck Mr. Luck went to Brendan Eggins in the bunks – who was awake – and said to him "*I think Peter's gone walkabout*". Mr Eggins said that Mr. Luck said to him "*I think Peter's gone over the side*". Both men searched the boat but could not find Peter Trcka.

THE OFFICIAL SEARCHES

38. Brendan Eggins used his mobile phone to contact his mother Stephanie Eggins so she could inform emergency services of Peter Trcka's disappearance. Brendan Eggins then took a dory and made a search of surrounding water around the boat. He said he went about a quarter of a mile away from the boat in the direction that the tide would have taken Peter Trcka. He could not find him and returned to the boat.

39. When Brendan Eggins returned to the boat Kyle Cook continued to search the seas in another dory. Crew from another fishing vessel 'FV Arafura Queen' also joined the search the area. Before emergency services arrived there were four fishing dories and the FV Arafura Queen searching in the North West (where the current flows) for Peter Trcka.

40. Mark Luck swore that the sea at about 4.30am was like glass but the seas picked up as the morning progressed. The early searches for Peter Trcka were made in good conditions but no sign of him was found.

41. At approximately 7am, following notification by Innisfail Police Sergeant Ibell, the Search and Rescue Mission Co-ordinator for the Far Northern Region instituted a search for Peter Trcka. In summary this included:

- Obtaining a net water movement model for the area to determine direction of drift of a person in the water
- A rescue helicopter carrying out a search of the area around the fishing vessel and to the north west which was the general direction of the drift
- A 30km square search of the area around the fishing vessel and the line of the drift in good visibility
- In addition to the searches by the fishing vessels and crew Coast Guard vessels searched the waters in the vicinity of Otter Reef.

42. At the conclusion of the first day 300 square kilometres or sea had been searched by vessel, fixed wing aircraft and helicopter. There was no sighting of Peter Trcka.

43. On 2 March 2006 the search continued with 7 fixed wing aircraft and 2 helicopters with Coast Guard vessels acting as surface support. Nothing was sighted. Sgt. Ibell considered over the two days the search was in fair conditions with good visibility although the sea was choppy. He was of the opinion that had Peter Trcka been on the sea surface in the search area the probability of locating him was considered high.

44. On 3 March a helicopter search was conducted from Russell Heads south to Mission Beach and around the Family Group of islands. Nothing was located.

45. On 5 March 2006 Danielle Morris found a prosthetic leg on the beach on the eastern side of Russell Island in the centre of a sand bar. The prosthetic leg had a black and blue reef style sandal. Ms Hagan identified this leg and sandal as definitely belonging to Peter Trcka. Dennis Cook and Brendan Eggins corroborated this identification. Sergeant Peter Williamson, the investigating officer, testified that the

location of the prosthetic leg on Russell Island was entirely consistent with the current flow from Otter Reef.

46. Subsequent searches revealed no other relevant material near Russell Island, Normanby Island or High Island.

47. I am satisfied that the search instituted immediately (by the fishermen at the scene) and then by the authorities was thorough, extensive and professionally carried out. I consider it likely had Peter Trcka survived in the water after his initial entry he would have been located by the search.

48. The first police officer to board the Shanendale was Sgt Brett Smith, officer in charge of the Cardwell Police Division. He boarded the Shanendale at about 10.40am. He inspected the boat and observed nothing amiss. He observed the bucket near the railing with a squid within it. He considered the squid's appearance was indicative of having being caught that morning. He also noted that the railing on the edge of the vessel was small and less then a metre in height. It was his opinion that it would be easy for any person to fall from the side or rear of the vessel. Photographs have been tendered in the inquest that illustrate the height of the deck where the fresh squid in the bucket was sighted was about knee high to an average sized man.

49. The Shanendale was released from its anchorage position at about midday and allowed to return to Mourilyan Harbour.

50. Subsequent to Peter Trcka's disappearance he has been reported as missing to the Queensland Police Service Missing Persons Bureau. No trace has been reported of Mr. Trcka since 2 March 2006 from any other Australian police service or various Australian Government departments including Centrelink.

51. Mr. Trcka's bank account has been identified and there has been no unexplained activity with respect to that account since Mr. Trcka disappeared.

52. Those with whom Mr. Trcka might be expected to keep in touch with have not heard from him since 1 March 2006. In particular, his daughter Nicole Cook used to talk with him over the phone about once every two weeks. She has not heard from Mr. Trcka since he disappeared.

53. There is no evidence whatsoever that Peter Trcka somehow managed to leave the Shanendale and conceal his existence.

54. There is no evidence whatsoever that Peter Trcka committed suicide. Those on board the ship saw no evidence of suicidal intent and the evidence of Marc Luck, the last to see Peter Trcka alive at 4.30am was he was joking and happy. His daughter spoke to him about a week before his disappearance and noted he did not sound depressed.

55. There is no evidence whatsoever that any member of the crew of the Shanendale contributed to the death of Peter Trcka. After doing all they could to locate Peter Trcka all remaining crew immediately provided statements to the police investigation and have subsequently cooperated fully with police and coronial investigations. The remaining crew impressed as anxious to assist to try and ascertain what happened to Peter Trcka.

REQUIRED FINDINGS BY SECTION 45(1) AND (2) OF THE ACT

56. Upon all the evidence I am satisfied to the requisite standard that the evidence supports only one finding: Peter Trcka did not return from Otter Reef and he died at sea sometime after 4.30am on 1 March 2006. I am satisfied he fell overboard. How and why is a matter of speculation. Given Peter Trcka's experience, fishing expertise and the calm conditions it may be that he became incapacitated from a physical

ailment or disease and fell overboard. Incapacitation appears more likely then simply slipping and falling into the sea as the evidence of how he coped well with conditions at sea notwithstanding his disability, makes such an explanation inherently unlikely. Given he was wearing no flotation device and his likely physical incapacitation it is unlikely he would have survived in the water for any extended period of time.

57. As already discussed s. 45(1) requires I must find whether a death happened. I am satisfied that Peter Trcka is dead and I have described the circumstances of how he died.

58. I am also able to make the following findings:

Identity of the Deceased: The deceased was Peter Joseph Trcka

When the Person Died: 1 March 2006

Where the Person Died: Mr Trcka died at sea in the vicinity of Otter Reef which is situated approximately 28 nautical miles southeast of Mission Beach.

What caused the Person to die: Mr Trcka was lost at sea when he fell overboard off the Shanendale. The precise mechanism of his death is not able to be ascertained but it is likely he drowned.

COMMENTS AND PREVENTATIVE RECOMMENDATIONS

59. Section 46 (relevantly) permits a Coroner to comment on anything connected with a death investigated that relates to public health or ways to prevent deaths from happening in similar circumstances in the future.

60. As the recitation of the evidence makes plain there are two interventions that may have prevented the death of Peter Trcka (presuming that death did not result from catastrophic physical collapse). These interventions would have been to prevent him falling overboard or, having fallen overboard, to keep him floating until he could be rescued.

PREVENTION MAN OVERBOARD AND THE REGULATORY REGIME

61. Bernard Eggins was asked his opinion as to what might have prevented Peter Trcka falling overboard. His answer cited adherence to the shipboard rule of not going alone on deck. This I accept is a reasonable view. Unfortunately, experienced sea men may become complacent as to their ability and other preventative measures are necessary. Such measures include ensuring a safe workplace.

62. The deck railing of the Shanendale was very low. Where Peter Trcka was likely fishing the railing came to just over the knee of an average standing man. The rail would not provide any real barrier to prevent a fall for someone suddenly incapacitated. The first investigating police officer, Sgt Smith, considered the fall overboard after a "turn" wholly credible as he estimated the stern of the vessel was no more then a foot high.

63. Keith Brightman, a project officer from Maritime Safety Queensland provided assistance to the inquest in explaining the existing safety regime. Presently safety standards for Queensland vessels are essentially determined by when the ship is constructed or substantially modified. From 1 October 2008 the combined Uniform Shipping Laws/National Standard for Commercial Vessels apply. For existing vessels the pre-2008 Uniform Shipping Laws Code applies. That Code commenced in 1983. If the vessel was constructed prior to the commencement of the Uniform Shipping Law Code then transitional provisions provide that if the vessel complied with the standard applicable at the time of construction it would be allowed to operate.

64. The Shanendale was inspected in July 2002. Marine Safety Inspectors would be inspecting the vessel to determine if it was in compliance with the standards in force in 1977 rather then compliance with standards in 2002. They would also of course be examining general safety issues and the stability of the vessel. The effect of such a rule is set out in the following passage of transcript:

But if you have a boat you can take out a crew earlier on a boat that's non-compliant because it was compliant with an earlier safety code that's been recognised is now inadequate; is that essentially how it works?-- Yes, they can go out to sea, and if we see that it is - say, for example, we can see that they are below 500 millimetres, at most our sort of departmental policy was that we would make a recommended corrective action we have no powers to enforce. We could make a recommendation to correct the action. That was the limit of our powers.

And what happens if they didn't change it?-- Well, what happens then, once we've made the recommendation then it alerts the owner and the skipper to the fact that these things are not acceptable, and that they - we would recommend correction action and then the general safety obligation under the Act always is overarching and sort of clicks into place and then there's a requirement for the person to consider the general safety obligation and the general perils of the voyage and those sorts of things before they leave port.

I think it's fair to say - and please correct me, Senior Sergeant and Mr Egan - here the rear deck and the side take us down to what is a deck up to the knee?

SGT O'ROURKE: I would probably say below the knee, your Honour.

CORONER: But clearly that was seen as compliant in 2002?-- If the vessel had, yes. See, when they went through these compliances they did compliances to build in other things. They had nothing to do with the guard rails. If the

vessel came through back in the '70s when it was and it's always been okay to continue to operate the vessel like that, but then there's always this overarching obligation on the owner and the skipper to consider the general safety obligation.

So, in effect, then, you do have to comply with a modern safety code; is that what you're telling me?-- Well, this is the hard part about this is that, in effect, from a construction point of view pre-1983, the vessels are given a big tick and they're allowed to continue through. The current Act says, yeah, well, that's okay, but always remember that you've got a general safety obligation and that's when the Act kicks in.

65. Peter Trcka, as a member of the crew of the Shanendale, was a worker on a ship. As such two government agencies: Maritime Safety Queensland (a division of Queensland Transport) and Workplace Health and Safety were tasked with regulatory responsibility. Maritime Safety administers the *Transport Operations (Marine Safety) Act 1994* which has the aim of promoting marine safety in Queensland. WHS administers the *Workplace Health and Safety Act* that has as its objective *to prevent a person's death, injury or illness being caused by a workplace, by a relevant workplace area, by work activities, or by plant or substances for use at a workplace.*[8]

66. The core issue as to the competing regulatory obligations is succinctly put by Mr. Egan who appeared (following a grant of leave by myself) for Maritime Safety Queensland:

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8 Section 7

> *But with MSQ, it's bailiwick is making sure that the operation of the vessel conforms to accepted Marine practices and standards. It's not there to monitor whether, as in every other workplace, the particular workplace on a particular vessel is satisfactory for the job being performed on that particular vessel.*[9]

67. Sergeant Williamson was not investigating to assess workplace safety. His focus was of course providing a report to the Coroner and ruling out any unlawful conduct. His role was not, and should not be, to assess the adequacy of the safety of the workplace. That is a role that should be undertaken by the appropriate regulatory authority: Marine Safety Queensland and/or WHS. The question for those regulatory authorities was whether the Shanendale was a safe workplace notwithstanding that it complied with an older safety code and more particularly whether the height of the railing compromised the safety of that workplace. It is only by the investigation of workplace incidents, even on ship, that deterrent sanctions can be imposed. It may be that there were sound operational reasons why the existing railing was appropriate in the circumstances. The evidence of the height of the railing is concerning but I do not consider there is sufficient evidence to draw the conclusion that the Shanendale was unsafe or the general safety obligation had been breached. Nevertheless workers on vessels should be afforded the same protection as other workers on land by proper investigation of workplace deaths with a view to regulatory action. The State Coroner has commented on the issue a number of times. I really can add nothing to his comments made in the matter of Irwin (6 June 2008):

> *As has been mentioned, MSQ is the agency responsible for administering the TOMSA, the legislation principally designed to regulate marine industries and to ensure marine safety in*

9 Transcript p. 54

Queensland. However there is nothing in that Act to exclude the operation of the Workplace Health and Safety Act and Regulations which are designed to do the same in workplaces generally. That Act is administered by the Division of Workplace Heath and Safety (WH&S).

Those agencies have entered into an MOU to provide for the sharing of information and the avoidance of unnecessary duplication of investigative effort. The agreement provides a mechanism for nominating a lead agency for enforcing the respective legislation by the regulatory agencies. Unsurprisingly, it provides that as a general rule, MSQ will be the lead agency in respect of marine incidents to which the TOMSA applies and WH&S will discharge that role when its Act is to be brought into play.

The MOU also provides for the agencies to work together on those matters which may be both a marine incident and a workplace incident.

In this case there was no such joint effort and MSQ played only a limited role in assisting the police officer who prepared the report for the Coroner. An entry in schedule 2 to the MOU headed Jurisdictional Examples may explain the lack of collaboration by the two safety agencies: in relation to the example Person lost overboard from a vessel, it is stated that WH&S has no jurisdiction. This is clearly wrong. Mr Irwin lost his life as a result of a workplace incident……….

………………………..

The TOMSA provides that the general manager may require a shipping inspector to investigate a marine incident. Following an investigation a report must be furnished to the general manager who might then take action in respect of safety issues raised.

> *There is little point having a legislative regime which aims to ensure the safety of workers at sea if the bodies responsible for administrating the regime do not investigate incidents which have led to the loss of life.*

68. The State Coroner recommended in his findings that: *the Director of the Division of WH&S and the General Manger MSQ review the operation of the MOU in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies and also recommended that the General Manger MSQ review the policies governing the investigation of marine incidents to ensure that incidents involving serious injury and loss of life are properly investigated, and that issues arising from such investigations are responded to in the manner most likely to promote marine safety in Queensland.*

69. Maritime Safety Queensland has done substantial work since the State Coroner's recommendations were made to continue to improve safety in the industry. In his statement Mr. Brightman said:

> *MSQ considers that developing relationships and rapport with those in the industry is showing encouraging signs with regard to changing work practices and attitudes toward safety. I have conducted over 100 back-deck meetings with skippers and crew from Brisbane to Yorke Islands in the Torres Strait. Marine Safety Officers have also built networks among local operators and use 'industry champions' to promote good practice. This approach has become the foundation for cultural change in the industry. In effect, MSQ has captured and promoted the advice of industry experts to improve their own levels of safety. Taking a regulatory approach at first instance has not had the same impact as the partnership approach currently favoured by both parties. However, regulatory change may still be necessary for those operators*

> *influenced only by the need to comply so as not to void insurance coverage.*

70. Notwithstanding the work of Maritime Safety Queensland more should be done to ensure that those employed at sea are employed in a safe working environment. I make the same recommendation that has formerly being made by the State Coroner with a view to reinforcing the importance of adequate investigation by the appropriate regulatory authorities of workplace deaths on fishing vessels.

> ***I recommend that the Director of the Division of WH&S and the General Manger MSQ review the operation of the MOU in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies and also recommended that the General Manger MSQ review the policies governing the investigation of marine incidents to ensure that incidents involving serious injury and loss of life are properly investigated, and that issues arising from such investigations are responded to in the manner most likely to promote marine safety in Queensland.***

EMPLOYMENT OF SEAMAN WITH DISABILITIES

71. One issue raised at the pre-Inquest was whether there should be any restrictions on the employment of individuals with disabilities. Mr Trcka had an artificial leg. Such matters may be more properly dealt with on an individual basis then a blanket ban. All the evidence with respect to Mr Trcka's ability as a seaman pointed to him been very capable. It was a job he liked and he did it well. There is no evidence his disability contributed to his death. It was far more likely some other medical event that caused him to fall overboard then any issue related to his disability. In those circumstances I make no recommendation with respect to any regulatory regime for employment of workers at sea.

EPIRBS AND PERSONAL FLOTATION DEVICES

72. It is inevitable that those who work on sea going vessels will fall overboard. Sometimes, as in this case, even extensive searches will fail to locate the person. If Peter Trcka had been wearing a personal flotation device (PFD) he may have been kept afloat long enough for a search to locate him or his body. Even locating a body in these circumstances would be of great comfort to his family. If he was carrying a Electronic Positioning Indicating Radio Beacons (EPIRB) small enough to be carried by a man (referred to as Personal Electronic Positioning Indication Radio Beacons), and he managed to activate it or it was activated by immersion, the signal would have been detected and narrowed to an area of approximately 5 km in radius.

73. Given that it is only speculation if Mr. Trcka was incapacitated before or after he entered the water the wearing of such devices may not, in this case saved him. Nevertheless, the benefits of such devices are clear: any person falling overboard can remain afloat and signal their location to search craft. This improves their chances of recovery and reduces the length of the search. The QPS have provided useful submissions on this issue and consider mandatory wearing of Personal Electronic Positioning Indication Radio Beacons and PFDs would increase survivability of persons and reduce air and sea search costs.

74. The QPS advise the issue of the compulsory wearing of PFD has been raised with the recreational boating and fishing industries with no consensus reached. The current legislation only requires each person on board to be aware of the location of PFD and how to wear them if required. EPIRBs are compulsory on all recreational boating and fishing vessels. These beacons are relatively large and are mounted to the vessel in easy reach of the crew.

75. Again the State Coroner has already made recommendations on this issue in 2006 (in the matter of Baker 19 April 2006) and reviewed those recommendations in the matter of Irwin in 2008. Mr. Brightman

provided to me an update of the implementation of those recommendations.

76. In Baker the State Coroner said this about EPIRBs and PFD:

> *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 a 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 PFD of the type referred to and agreed that it did not unduly hinder a fisherman at work and they could see no other impracticality with wearing such a vest with an EPIRB attached whenever they were on deck.*[10]

77. Mr Brightman advises the present situation is

> *MSQ is working with industry to promote "Float-free" EPIRBs on 10 trawlers operating from the Gulf to the Gold Coast to encourage the take up of this equipment by 1 November 2008 in preference to a standard 406MHz EPIRB. Inflatable life rafts and hydrostatic release mechanisms are standard equipment under Part C 7A of the NSCV and operators are being encouraged to switch to the new standard prior to its expected commencement date in 2009.*
>
> *MSQ has introduced fishers to modern safety equipment through its Fishing Industry Safety Equipment Trial run in*

[10] See Baker p. 10

conjunction with industry and current 'real-time' operations. Early indications suggest it is impractical to wear a PFD in certain circumstances, and recommendations are likely to focus on use during high risk operations. A full report on the Southern and Northern trials is due after the expiration of the Northern trial in mid 2008.

78. It is not clear, given the type of PFD tested in Baker, why such an item would be impractical. However, some progress is being made. Given the consequences of not implementing the safety equipment risks life I would support the State Coroners recommendation that once the most appropriate models of PFDs and EPIRBs are identified there be regulatory mandating their use on commercial fishing vessels.

I recommend that MSQ investigate to identify the most appropriate type of PFD and EPIRB for seamen on commercial fishing vessels and then mandate by regulation that commercial fishermen wear PFDs and carry EPIRBS when on deck at sea.

CONCLUSION

79. I extend to the family and friends of Mr. Trcka my condolences for their loss. I also take this opportunity to thank Sgt. O'Rourke for his assistance in this matter.

80. The inquest is now closed.

J Brassington
Innisfail
24 December 2008