Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 16/15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Paul Gregory CLIFTON*** *with an inquest held at the* ***Perth Coroner's Court, CLC Building, 501 Hay Street, Perth*** *on* ***18 May 2015*** *find that the identity of the deceased person was* ***Paul Gregory CLIFTON*** *and that death occurred on* ***2 June 2013*** *at* ***Lancelin Jetty, Lancelin*** *as a result of* ***complications arising from immersion (drowning)*** *in the following circumstances:*

Counsel Appearing:

Ms I O'Brien assisting the Coroner.
Mr D Anderson (State Solicitor's Office) appearing on behalf of the Department of Transport.

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INTRODUCTION

1. At the start of June 2013, Paul Gregory Clifton (the deceased) was with his brother and two friends in Ledge Point for a weekend of fishing and relaxation. The deceased had brought his boat with them for that purpose. On the morning of 2 June 2013, the four men launched the boat in Lancelin. They were all experienced fishermen, who had been out on boats countless times before. They had no expectation that this morning would be any different.

2. Unfortunately, this morning's outing turned out to be very different. For reasons that are still not clear, the boat they were on sank while they were some distance from shore. The four men were quickly stranded in the ocean before they were able to alert anyone to their whereabouts. It was only by good fortune that one of them was seen by a crew member of a passing commercial cray fishing boat. This sparked a search and rescue effort and eventually led to all of the men being rescued from the ocean. However, by the time the deceased and his brother were rescued, it was too late to save the deceased. Despite resuscitation attempts by people on the rescue boat and at the Lancelin jetty where they were taken, he could not be revived and he was declared deceased by an ambulance officer just before 2.00 pm.

3. As part of the investigation into the death, on 18 May 2015 I held an inquest into the death. The evidence at the inquest hearing was primarily directed towards the circumstances surrounding the sinking of the boat and what happened thereafter, as well as whether anything could be learnt from this case to improve aspects of recreational marine safety in general.

4. The documentary evidence comprised a volume of materials obtained during the coronial police investigation.[1]

5. Oral evidence was also heard from two of the men who were in the fishing party that day, the coordinator of the volunteer sea rescue, a Senior Investigations Officer in Marine Safety for the Department of Transport who investigated the boating incident, as well as the General Manager of Marine Safety for the Department of Transport.

6. Oral submissions were made by counsel on behalf of the Department of Transport at the conclusion of the inquest hearing

[1] Exhibit 1.

and the deceased's brother also raised a matter in court. I gave due consideration to those submissions before making my findings and recommendations.

THE DECEASED

7. The deceased was 49 years of age, married with two children. He was fit and healthy and had no known medical conditions.[2] He was a moderate social drinker, who enjoyed a drink with friends but did not drink to excess.

8. The deceased worked as an Occupational Health and Safety Officer for Boral Ltd. His personality suited his profession, as he was known by his family and friends to be very safety conscious.[3]

9. The deceased enjoyed fishing and boating in his leisure time.[4] The deceased was experienced in boating and had owned more than one boat himself, as well as going out on other people's boats. The deceased was issued with a recreational skipper's ticket on 1 May 2012, in compliance with the WA marine safety requirements.[5] He was considered to be competent at handling boats and his friends and family had confidence in his abilities as a skipper.

THE DECEASED'S BOAT

10. The deceased purchased a boat named the "Oo Roo" through a private sale in March 2012.[6] The boat was a 5.20 metre fibreglass runabout with powered by a 90 horsepower Evinrude outboard engine. It is believed the boat was built in 1984.[7] Its registration was current as at June 2012.[8] The deceased stored the boat at his property in Mundaring and would tow it on a trailer to his destination.[9]

11. Although we do not have a photo of the Oo Roo, a photograph of a similar boat was tendered at the inquest, which the deceased's

[2] Exhibit 1, Tab 19.
[3] T 7; Exhibit 1, Tab 19 [18] – [19].
[4] T 7.
[5] Exhibit 1, Tab 26.
[6] Exhibit 1, Tab 27.
[7] T 8; Exhibit 1, Tab 28, 2.
[8] Exhibit 1, Tab 27.
[9] Exhibit 1, Tab 19.

brother confirmed was similar, although the cabin was slightly smaller and, correspondingly, the deck space slightly larger.

The photograph to the left (Exhibit 3) depicts a Stejcraft 18 ft. Fibreglass Halfcab with 90 hp Fuel Injected motor and Bimini.

12. In the time he had owned the boat, the deceased had taken it out many times, including in the open water to Rottnest Island and Penguin Island, as well as in the Swan River.[10] He had not, however, taken it to Lancelin until that weekend.[11]

13. According to the deceased's wife, the deceased always kept his boat in top order and was very conscientious about attending to anything wrong with the boat.[12]

THE FISHING TRIP TO LANCELIN

14. On Friday, 31 May 2013, the deceased drove to Ledge Point for a planned fishing weekend with his brother Neil Clifton, his brother-in-law Colin Guide and a friend from his work, Anthony Nicholson.

15. They stayed in Ledge Point on the Friday night, intending to take the boat out the following day. However, the weather conditions were too windy so they decided not to take the boat out on the

[10] T 8.
[11] Exhibit 1, Tab 18 [29].
[12] Exhibit 1, Tab 19 [18].

Saturday.[13] They had a few drinks on the Saturday night but did not drink excessively.[14]

16. On the Sunday morning, the group started the day with coffee and a cooked breakfast at approximately 8.00 am. It was cold (six degrees) and the weather was still windy like the previous day, but they were hopeful that the wind would drop off, in accordance with the weather forecast.[15]

17. The deceased spent some time in the morning preparing the boat for a day of fishing. He walked around the boat and was seen to check the sides of the boat and he also switched on and off the electrics and the engine.[16] The deceased was also seen to put the bungs in the boat.[17] They loaded the fishing rods and bait into the boat and the deceased made sure the rods were safe on the side and that the deck was clear.[18]

18. They then drove the boat from Ledge Point to Lancelin, arriving at about 9.00 am.[19] They approached the north side of Lancelin jetty. While trying to launch the boat, they bogged their vehicle, which required two of the men to push the boat off the trailer so that they could get the car out of the sand.[20]

19. Once the boat was in the water, the deceased circled in the marina for a while as the other three men walked up to the jetty. The deceased then drove the boat over to the jetty to collect them. Once they were all on board, they headed north out of the bay.[21] Mr Nicholson, who at that time also owned a boat and had a skipper's ticket, noted the boat sat right in the water and there were no apparent issues or concerns with it at that time.[22]

20. The deceased had already mapped out a planned course the night before, as he was unfamiliar with Lancelin waters and had wanted to plan ahead.[23] He and Mr Nicholson had agreed to fish just on the other side of Lancelin Island, tucked in close to the island.[24] They

[13] T 10.
[14] Exhibit 1, Tab 8 [7].
[15] T 10 – 11; Exhibit 1 Tab 8 [8].
[16] T 11.
[17] Exhibit 1, Tab 8 [10].
[18] T 11, 24 - 25; Exhibit 1, Tab 8 [11].
[19] T 11.
[20] T 11 – 12; Exhibit 1, Tab 8 [30].
[21] T 12.
[22] T 25.
[23] T 11.
[24] T 25.

travelled north for some distance before turning west to go to the outside of Lancelin Island. They stopped approximately 1.5 – 2 km west of the island, which was approximately 2 – 3 km from the shore.[25] The witnesses estimated they reached the fishing spot at about 9.45 am.[26] There were other boats out in the area when they arrived.[27]

21. The deceased stopped the engine and they began drift fishing. This was preferable to anchoring, given the weather conditions.[28] The easterly wind was quite strong at that time, making the ocean conditions quite rough. A bit of spray was coming over the side of the boat and it was becoming uncomfortable. After drift fishing for some time without many fish being caught, the group decided to move closer to shore.[29]

THE SINKING OF THE BOAT

22. It was at that time that Mr Clifton noticed water inside the back of the boat, halfway up the batteries. Mr Clifton alerted Mr Gude, who then quickly alerted the deceased. The deceased immediately checked the bilge pumps, which were on. The deceased then started the engine, with the aim of moving the boat forward in order to drain water out of the boat. The engine started and ran for about 10 seconds before cutting out. As the boat moved forward, the nose of the boat came up out of the water as the weight of the water went to the back of the boat.[30] After the engine cut out, the deceased tried to start it again, without success.[31]

23. With the boat sitting up on its end, it quickly became apparent to the men in the boat that they were in serious trouble. Mr Gude and Mr Nicholson tried bailing out the water with a burley bucket and a plastic tackle container but they could not keep up with the amount of water flooding into the boat.[32] They could not see the source of the problem but were simply confronted with an increasing level of water coming up inside the back of the boat.[33]

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[25] T 12; Exhibit 1, Tab 8 [36] – [40].
[26] Exhibit 1, Tab 8 [40].
[27] T 13.
[28] T 26.
[29] T 13; Exhibit 1, Tab 8 [42] – [44].
[30] T 13 – 14; Exhibit 1, Tab 8 [50].
[31] T 14, 27.
[32] T 14 – 15; Exhibit 1, Tab 8 [52] – [53].
[33] T 15, 26.

24. The deceased had enough time to get the lifejackets out from underneath his front seat and hand them around, and the men hastily tried to put them on. The deceased also attempted to make a 'mayday' call on the radio. However, the batteries were underwater at this stage and it wasn't likely that the radio was working.[34] This is supported by the fact that the radio operators in the area did not receive a mayday message.[35]

25. The deceased asked Mr Clifton to get the Emergency Position Indicating Radio Beach (EPIRB) out of the side of his seat, which he did. Mr Clifton was unfamiliar with how to work the EPIRB and he could not read the instructions to activate it, as he was not wearing his reading glasses. Instead, it appears he passed it to the deceased, although by the time of the inquest he was not certain to whom he passed it. Mr Gude recalled a wave striking the boat around this time, causing the EPIRB to be tossed around the boat.[36] Before there was time for any person to activate the EPIRB, the boat suddenly stood upright in the water and began to sink violently.[37]

26. Mr Gude and Mr Nicholson jumped out of the boat and into the water as the boat sank.[38] The deceased and Mr Clifton, who were at the front of the boat, were trapped by the windscreen and the bimini top and were dragged under the boat into the water. Mr Clifton was standing facing the back of the boat at the time they went under, so he was able to see the ocean rushing towards him and take a large gulp of air before he was submerged. The deceased, on the other hand, was in the driver's seat facing forward, and went into the water backwards.

WHAT THEY WERE WEARING

27. In all, Mr Clifton estimated about two minutes had elapsed from the time he noticed the boat was taking on water until the time the boat was totally submerged.[39] Mr Nicholson thought it could have been slightly longer, but it was still a matter of minutes.[40] The short time frame meant the men had limited opportunity to put on their life jackets or change their clothing in any way before the boat sank. As

[34] Exhibit 1, Tab 8 [54] – [58], Tab 9 [19].
[35] T 15, 27; Exhibit 1, Tab 35.
[36] Exhibit 1, Tab 9 [21] – [22].
[37] T 16; Exhibit 1, Tab 8 [61] – [64].
[38] T 28.
[39] T 17.
[40] T 30.

a result, they each went into the water in various states of readiness.

28. At the time they went in the water, Mr Clifton was wearing board shorts with tracksuit pants over the top, a chequered fleecy shirt, a waterproof sleeveless vest and a Driza-Bone jacket.[41] Mr Clifton had taken a red lifejacket.[42] He had not been able to put both arms through the jacket, so he had only one arm inside the jacket. At some stage in the water, he tried to put the other arm through but the lifejacket appeared to be too small and he felt too restricted, possibly due to his clothing, so he stayed with only one arm in. He was comfortable, in the sense that he didn't feel that he was sinking, with only one arm in the lifejacket.[43]

29. The deceased was wearing board shorts and a chequered shirt.[44] He had a red lifejacket on when he went into the water and Mr Clifton was relatively sure the deceased had both arms in the lifejacket at that time.[45]

30. Mr Gude was given a red lifejacket. He managed to get it on but wasn't able to clip it up.[46]

31. Mr Nicholson was wearing board shorts, a t-shirt, a long thin top and a jumper over the top of a jacket and a beanie.[47] As the boat was going down, his first thought was to remove some of his heavy clothes, so he took off his jacket and heavy jumper and called out to the other men to take their heavy clothes off.[48] Mr Nicholson then put on the yellow lifejacket that had been handed to him. His jacket was twisted, so, although he managed to get both arms through the armholes, he had no ability to secure and tighten the lifejacket.[49]

EVENTS IN THE WATER

32. When the boat sank, both Mr Clifton and the deceased were pulled about two to three metres under the boat in the water before they were able to break free. Mr Clifton managed to make his way out

[41] T 11.
[42] T 15.
[43] T 17; Exhibit 1, Tab 8 [79].
[44] T 11.
[45] T 15 – 17, 20.
[46] Exhibit 1, Tab 9 [29].
[47] T 24.
[48] T 27.
[49] T 27 – 28.

from under the boat and surfaced first. He estimated he was under the water for about 15 seconds.[50] The deceased did not surface for some further period of time, which Mr Clifton estimated was probably around 10 seconds.[51]

33. When Mr Clifton and the deceased had both surfaced, they saw Mr Gude and Mr Nicholson not too far away in the water.[52] All of the men grabbed hold of the submerged boat for support, as it was sitting approximately 1 metre below the surface of the water. However, a few seconds later the boat sank completely.[53] Mr Nicholson grabbed a jerry can that had floated up for support, but the smell of petrol was too overwhelming so he let it go.[54]

34. Mr Nicholson called out to the others and suggested they swim to the island, which was within sight.[55] They began to swim in that direction, but were hindered by the swell and the waves, which made swimming very difficult.[56] It was difficult to breathe, as the chop of the waves threw water, salt and spray towards them. The deceased, in particular, seemed to be struggling to get air.[57] They found it too choppy to swim headfirst, so they started to swim towards the island on their backs.[58]

35. Within only a few minutes, the four men found they were separating from each other. They could see each other periodically, but their shock at the speed of the turn of the events, combined with the chill of the water and the difficult conditions, prevented them from speaking to each other. They were largely concentrating on their own survival.[59]

36. After swimming on his back for some time, Mr Nicholson hit something. He turned around and realised he had bumped into the deceased. They spoke to each other very briefly, in understandably strong language, about the seriousness of their situation.[60] Mr Nicholson did not notice the deceased having any difficulty breathing at that time. At that stage, they noticed a recreational

[50] Exhibit 1, Tab 8 [70].
[51] T 16.
[52] T 17.
[53] T 28; Exhibit 1, Tab 8 [75] – [78].
[54] T 28.
[55] T 17, 19; Exhibit 1, Tab 8 [81].
[56] T 17.
[57] T 19.
[58] T 17 – 18, 28; Exhibit 1, Tab 8 [83].
[59] T 17 – 19; Exhibit 1, Tab 8 [84] – [87].
[60] T 29; Exhibit 1, Tab 10 [61].

fishing boat approximately half a kilometre north of them. They tried to get the attention of the people on the boat by waving and yelling, but were unsuccessful.[61]

37. Mr Nicholson then turned onto his back and started swimming again. He lost touch with the other men after that.

38. At some stage, Mr Clifton rolled over to check his position with regard to Lancelin Island. He could see that Mr Gude and Mr Nicholson had separated and were a considerable distance ahead of him. He then looked to his right and saw the deceased was approximately 100 metres away. Mr Clifton began slowly making his way towards the deceased while trying to keep afloat.[62]

39. When Mr Clifton eventually reached the deceased, he could see that the deceased was in a bad way. He was coughing and having breathing difficulties and appeared to be trying to expel water from his lungs. He said something to Mr Clifton about being unable to get any air.[63] Mr Clifton tried to reassure the deceased and encouraged him to swim, but he was in a bad state.[64]

40. About 20 minutes after he had reached the deceased, Mr Clifton saw the windscreen of a boat coming towards them. He turned to the deceased to tell him that he could see a boat coming and noticed that the deceased's had dropped through his lifejacket and was underwater. Mr Clifton bobbed down and pushed the deceased back onto the surface and managed to put one of the deceased's arms through his lifejacket. He was telling the deceased to hang in there as help was coming, but he noticed that the deceased's head was flopping from side to side and he realised the deceased was unconscious or had possibly passed away.[65]

THE RESCUE

41. While he was swimming, Mr Nicholson tried to fix his lifejacket a few times, as it was causing him to cramp in the arm. He continued to swim when he could, subject to the cramps he experienced. Then, as Mr Nicholson turned around to try to get his bearings, he saw a

[61] T 29.
[62] T 18 – 19; Exhibit 1, Tab 8 [88] – [93].
[63] T 19; Exhibit 1, Tab 8 [94] – [98].
[64] Exhibit 1, Tab 8 [97].
[65] T 19 – 20; Exhibit 1, Tab 8 [99] – [106].

commercial cray fishing boat, the Zofia, heading south about one kilometre west off Lancelin Island. Mr Nicholson began calling out as loudly as he could. By great good fortune, the deckhand happened to come out of the cabin of the boat at that time. The deckhand lifted his head and saw Mr Nicholson in the water, although he didn't recognise him as a man at that stage. He alerted the skipper of the vessel to something waving in the water and they went over to investigate. They found Mr Nicholson in the water and used a sling to rescue him, as he was unable to climb the ladder at that stage, due to shock and hypothermia.[66] Mr Nicholson was rescued shortly before 12.25 pm.[67] He had been in the water for approximately two hours by that time.[68]

42. Once in the boat, Mr Nicholson told the skipper about the sinking of the Oo Roo and the three men still in the water. The skipper called one of the local ambulance officers, Bob James, at 12.25 pm[69] and also called another cray fishing boat to assist with a search for the three missing men.[70]

43. Mr James then rang Patrick Shinnick, the Commander of the Lancelin Volunteer Sea Rescue Group. Mr Shinnick has been involved in the sea rescue service for close to 30 years.[71] It is a community-based association that works together with the local ambulance, police and fire brigade services to coordinate and manage sea rescues in the local area.[72]

44. When Mr Shinnick received the call from Mr James on 2 June 2013, he was told that there were three men still in the water unaccounted for.[73] The only person that Mr Shinnick was aware was out on the water that day was a local named Guy Edgar, who was in a small boat pulling cray pots. Mr Shinnick contacted Mr Edgar and asked him to start searching for the missing men. Mr Shinnick then called some other locals, including an experienced skipper, and arranged to put one of the two dedicated rescue boats in the water.[74] Probably no more than 10 - 15 minutes had elapsed from the time Mr Shinnick received the call to the rescue boat being in the water.

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[66] T 29; Exhibit 1, Tab 12 [10] – [19].
[67] T 29; Exhibit 1, Tab 13 [4].
[68] T 29.
[69] Exhibit 1, Tab 13 [4].
[70] Exhibit 1, Tab `1 [21] – [27].
[71] T 36.
[72] T 36 – 37.
[73] T 38.
[74] T 39; Exhibit 1, Tab 14 [10].

They then collected a local volunteer ambulance officer from the jetty and headed out to join the search.[75]

45. At the time the rescue boat headed out, Mr Shinnick described the weather conditions as improving. It had been very cold and there had been a strong south-easterly that morning, but it wasn't a dangerous day to be out on the water and, as forecast, the weather was getting better.[76]

46. While out on the rescue boat, Mr Shinnick was coordinating the search. He worked from the coordinates of where Mr Nicholson was found by the Zofia to estimate, through knowledge of the local currents, an appropriate search area and then organised a grid section search.[77]

47. The rescue boat travelled to a point where they located some debris.[78] Another commercial cray fishing boat, the Highland Spirit, skippered by Mr Shinnick's son, also a member of the Volunteer Sea Rescue Group, had joined the search by this time and travelled to the location of the Zofia.[79] Mr Shinnick Jnr was familiar with the area and the pattern of the local tides and currents so, based upon his local knowledge, he headed towards the southern boundary of where he thought the missing men would be.[80] The glare was making the search difficult, so he posted one crewmember on top of the boat and one at the front of the boat to help with the search.[81]

48. At 1.05 pm, while skippering the Highland Spirit, Mr Shinnick Jnr spotted Mr Gude drifting in the water. He noted that Mr Gude was wearing a life jacket and a high visibility yellow shirt, which made him easier to see in the water.[82] Mr Gude appeared exhausted. They approached him in the water and moved him to the boat's rescue zone, which is by the ladder at the stern. They also notified the sea rescue team and gave their coordinates.[83] They did not take Mr Gude on board, as it is difficult to transfer people between boats on the water and it was considered preferable to put Mr Gude straight onto the rescue boat, which is specifically designed to

[75] T 39 – 40.
[76] T 40.
[77] T 41.
[78] T 42; Exhibit 1, Tab 14 [21].
[79] T 42.
[80] Exhibit 1, Tab 15 [17] – [22].
[81] Exhibit 1, Tab 15 [24] – [25].
[82] Exhibit 1, Tab 15 [28], [50].
[83] Exhibit 1, Tab 15 [28] – [34].

rescue people from the water and where he could receive immediate medical aid.[84]

49. The rescue boat arrived and took Mr Gude from the water. He was acutely hypothermic and immediate steps were taken to warm him and care for him.[85]

50. After Mr Gude was rescued from the water, the Highland Spirit then made its way towards Mr Edgar's boat. Only minutes after spotting Mr Gude and while still en route towards Mr Edgar, the crew of the Highland Spirit spotted Mr Clifton and the deceased in the water. It was apparent that Mr Clifton was holding onto the deceased, who appeared submerged and lifeless in the water.[86] Mr Shinnick Jnr contacted the rescue boat and told them he had found the two men and they required medical assistance, knowing that Mr Shinnick would appreciate the urgency of the situation from that information.[87] Shortly afterwards, the rescue boat arrived and pulled both men out of the water, starting with the deceased.

51. The deceased was grey and not breathing when taken on board. Mr Shinnick and the volunteer ambulance officer immediately started performing cardiopulmonary resuscitation on the deceased. The deceased's airway was suctioned and he was ventilated while on board, but his pupils were fixed and dilated and he remained in asystole throughout the journey back to the jetty.[88]

52. On arrival at the jetty, they were met by more ambulance officers and then some nurses, who assisted with resuscitation efforts, including administering adrenaline. After approximately thirty minutes of resuscitation, the deceased remained in asystole, with no heart sounds on auscultation and no other signs of life. The health practitioners all agreed that it was appropriate at that time to discontinue resuscitation efforts, and death was certified at 1.49 pm.[89]

53. The other men also received some medical treatment and recovered well physically, although it was apparent from the evidence that they all bear mental scars from the ordeal.

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[84] T 42 – 43; Exhibit 1, Tab 14 [31] – [34].
[85] Exhibit 1, Tab 16 [27].
[86] Exhibit 1, Tab 15 [36] – [42].
[87] Exhibit 1, Tab 15 [44] – [45].
[88] Exhibit 1, Tab 16.
[89] Exhibit 1, Tab 2 and Tab 16.

54. A media helicopter was in the area immediately after the incident and it was given the location of the debris seen by the rescue boat. The helicopter made passes over the area looked for the Oo Roo but, due to the ocean conditions, it could not locate the vessel at that time and it has never been located.[90]

CAUSE OF DEATH AND MANNER OF DEATH

55. On 5 June 2013, a post mortem examination was conducted by a Forensic Pathologist, Dr Gerard Cadden. Dr Cadden noted the history of a protracted period of immersion in the ocean, with a high likelihood of hypothermia and exhaustion having occurred. Other than mild atherosclerosis, Dr Cadden found no signs of natural disease. He noted the lungs were heavy and fluid-laden, with a small fluid collection in the right chest cavity. Toxicological analysis detected no alcohol or common drugs.

56. At the conclusion of the post mortem examination and related investigations, Dr Cadden formed the opinion that the cause of death was consistent with complications arising from immersion.[91]

57. I accept the opinion of Dr Cadden and, taking into account all of the evidence before me, I find that the cause of death was complications arising from immersion (drowning).

58. Given the circumstances of the death, I find that the manner of death was by way of accident.

WHY DID THE OO ROO SINK?

59. Following these events an investigation was conducted by Senior Constable Scholes from Lancelin police station into the death of the deceased,[92] and a separate investigation was conducted into the incident by a Senior Investigations Officer, Mr Gary Jess, from the Marine Safety section of the Department of Transport (the Department).[93]

[90] Exhibit 1, Tab 6, 5.
[91] Exhibit 1, Tab 4 and Tab 5.
[92] Exhibit 1, Tab 6.
[93] Exhibit 1, Tab 28.

60. As noted above, the Oo Roo has never been located. Without being able to examine the vessel, it was difficult for the investigators to establish why the Oo Roo began taking on water.

61. The evidence before me was that the deceased was a conscientious boat owner, who actively maintained his boat. He also conducted a safety check on the morning of their ill-fated fishing trip. This would suggest that something happened to the boat when it was launched or after they were in the water, although the witnesses on the boat did not recall hearing any loud noise or seeing an event that could have provided an explanation.

62. One possibility suggested by Mr Jess was that water entered the boat via the vessel bungs, which allows water into the hull and can flood underneath the floors and cause major issues for a vessel out at sea.[94] However, the evidence of Mr Gude and Mr Clifton was that the vessel's bungs were checked before departure and it is unlikely that they would be simply knocked out.[95] Mr Jess indicated that quite often bungs are made of plastic, and they can be cracked or damaged, but he also thought this was unlikely.[96] Given the vessel was not recovered, the bungs could not be checked to be certain that they were intact. As it stands, there is no evidence before me that water entered the vessel through a bung hole.

63. In the end, I am unable to reach any conclusion as to why the Oo Roo began taking on water before it sank that day.

SAFETY ISSUES AND RECOMMENDATIONS

64. What is clear, however, is that a considerable amount of water entered the vessel by some means and when the motor was turned on and the boat moved forward, the water rushed to the rear, causing the boat to upend and quickly sink.[97] The speed of events made it difficult for the men to take action to alert someone to their plight or to activate and utilise safety equipment before they were immersed in the cold water.

[94] T 54.
[95] Exhibit 1, Tab 28, 3.
[96] T 54.
[97] T 56.

65. This raised issues as to what safety features are recommended and/or mandated for boats and their users and whether these can be improved.

66. Senior Constable Scholes and Mr Jess both gave attention to these issues in their investigations. It was also apparent during the inquest that both Mr Clifton and Mr Nicholson had given considerable thought to what they could, in hindsight, have done to prevent the death of their brother and friend. They were keen for something positive to come out of his death and to communicate a strong message about safety to other boat users.

67. Two of the most significant aspects given attention in this inquest were life jackets and EPIRBs, but other safety issues were also raised. I address each of them separately below.

Lifejackets (or Personal Flotation Devices – PFD)

68. When Senior Constable Scholes attended the jetty he seized the four life jackets, one yellow and three red, which were taken off the rescued men.[98] The life jackets were later examined by Mr Jess. Mr Jess noted that the lifejackets were of different sizes and types, which is significant in determining the survivability of a person in the water.[99]

69. In Western Australia, it is mandatory that a lifejacket be carried for each person older than 12 months on board a vessel in unprotected waters. The lifejackets must suit the weight of the person, be maintained in good condition and be easily accessible. There is also a minimum standard of lifejacket required for offshore (400 metres out)[100] use, which is a Level 100/PFD Type 1 (Type 1 jacket).[101] A boat owner can be fined if a marine safety check is conducted in unprotected waters and the proper life jackets are not on board.[102]

70. A Type 1 lifejacket has greater buoyancy than lifejackets rated a lower standard, and are designed to keep the person in a safe 'face up' floating position, with their head out of the water. The collar of the Type 1 will cushion the back of the head in the water and allow a person to lie down and maintain a face-up position for quite some

[98] Exhibit 1, Tab 7 and Tab 24 [36] – [38].
[99] Exhibit 1, Tab 28, 3.
[100] T 56.
[101] T 56; Exhibit 4.1 – Safety Equipment "Lifejackets" pamphlet.
[102] T 71.

time, although this can be hampered if the person is wearing heavy clothing.[103] This feature is particularly important if the person is losing consciousness or is having difficulty swimming, due to hypothermia.[104] Other features of the Type 1 jacket are the colouring and reflective strips, which are designed to be highly visible within the water.[105]

71. The yellow jacket worn by Mr Nicholson[106] was a Type 1 jacket of Adult size. His lifejacket was, therefore, an appropriate lifejacket for him to have been wearing that day in those conditions.

72. The other three lifejackets were red, and were ascertained to be PFD Type 2 jackets (Type 2 jackets). These lifejackets do not have the same buoyancy as a Type 1 jacket and will not rotate the person to a face up floating position. They are normally used for water sports and aquatic activities in fairly calm conditions.[107] They are not required to have reflector strips, although they are always in variations of red, orange and yellow, which are seen to be the best colours to pick out in water.[108]

73. In the choppy conditions experienced by Mr Clifton, Mr Gude and the deceased, the red jackets would have done little to keep their heads above the water. Even swimming with their backs to the water, they were likely to still get waves coming over their heads.[109]

74. In addition, Mr Jess noted that of the three red life jackets, only two were Type 2 jackets of Adult size and the other one was a Type 2 jacket of Small Adult size. The adult size jackets had buoyancy rated for a body mass greater than 60 kg and were suitable for a medium to large adult male. The small adult lifejacket, on the other hand, had buoyancy rated for a body mass of only 40 to 60 kg and was designed for teenagers and small women, rather than the average adult male.[110] It is not clear from the evidence which red jacket was worn by each of the three men, so it is not clear which man wore the small adult size jacket. Whichever man was wearing the smaller red lifejacket would have experienced significantly less flotation from the jacket and would have expended more energy

[103] T 56, 58; Exhibit 4.1 – Safety Equipment "Lifejackets" pamphlet.
[104] T 57.
[105] T 57.
[106] T 27; Exhibit 1, Tab 12 [18].
[107] T 58 – 59; Exhibit 4.1 – Safety Equipment "Lifejackets" pamphlet.
[108] T 59.
[109] T 60.
[110] T 59.

trying to keep his head above the water.[111] Depending on the size of the male, he might also have found it impossible to do it up at all.[112]

75. Although I am unable to determine which of the Type 2 lifejackets the deceased was wearing, the evidence does assist in identifying that, similarly to the other men, it seems the deceased did not manage to do up his lifejacket properly. If he had done so, it was unlikely he would have been able to fall through it, as described by Mr Clifton.[113]

76. In Mr Jess' opinion, it's possible that the fact that the deceased was wearing a Type 2 lifejacket, which was unsuitable for the conditions, and the likelihood that he was unable to secure it properly contributed to his difficulties in the water.[114]

77. It is recommended as best practice to try and secure the lifejacket before going into the water, as it is difficult to put on and secure once in the water. This can be difficult when the vessel sinks quickly, as was demonstrated in this case.[115]

78. One solution to this problem is to wear a lifejacket the whole time when out in unprotected waters. However, traditional lifejackets have been bulky and uncomfortable, making it an unpalatable prospect for the average fisherman to wear for long periods while out fishing for the day.

79. The Department promotes the wearing of life jackets generally[116] and currently recommends that lifejackets should be worn at all times by children over 1 year and under 10 years of age and by adults when boating alone, as well as if the person is a poor swimmer. It also recommends that people don their lifejackets when out in the dark or during restricted visibility, when operating in unfamiliar water or with a following sea (where the wave direction matches the direction the boat is heading) and at the first sign of bad weather.[117]

80. Technological advances mean that there are now better-designed lifejackets than there were in the past, which are lighter and more

[111] T 60.
[112] T 60.
[113] T 60 – 61.
[114] T 62.
[115] T 61 – 62.
[116] T 72 – 73.
[117] Exhibit 4.1 – Safety Equipment "Lifejackets" pamphlet.

comfortable to wear for long periods than conventional foam lifejackets. One example is the CO_2 inflating jacket, which is made out of a fairly light fabric that will either self-inflate or inflate when a cord is pulled.[118] It will perform the same function as a normal Type 1 jacket, but has the advantage of being less cumbersome to wear doing normal activities.[119] Some can even be worn in a pouch around the waist, so they are easily accessible and can be donned quickly if the boat gets into trouble.[120]

81. An initial problem with these options was the cost, but over time they have become more cost-effective to purchase.[121] However, a difficulty that remains with these new jackets is that they have added maintenance requirements. The cylinders expire and, depending on the manufacturer, they expire at different rates, but the expiry date is not always written on the cylinder.[122] The Department recommends that boaters follow the manufacturer's instructions or, if the manufacturer doesn't specify, then they should have the lifejacket serviced every 12 months.[123] As a precaution, the Department replaces the cylinders on their own officers' jackets every year on a certain date to be sure that they remain functional.[124]

82. The cost of replacing the cylinders is moderate, estimated to be around $10 per cylinder. The problem does not appear to be the cost of replacing the cylinders, but rather a level of complacency amongst boat owners who simply purchase the life jackets and store them on the boat, without checking they remain operational over time.[125] There is a real danger in those circumstances that if the time comes that they are required, the life jackets may not be functional.[126]

83. Mr Shinnick also mentioned that the search and rescue members recommend purchasing the manually-activated versions, rather than the water-activated ones, if the vessel is a small one, as the units can be affected by the spray of water experienced in a small boat.[127]

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[118] T 61.
[119] T 62.
[120] T 61, 74.
[121] T 74.
[122] T 74 – 75.
[123] Exhibit 4.1 – Safety Equipment "Lifejackets" pamphlet.
[124] T 75.
[125] T 75.
[126] T 75.
[127] T 51 – 52.

84. Mr Buchholz is the General Manager for the Department and is responsible for the delivery of the Marine Safety Program for Western Australia, which includes everything to do with recreational and commercial vessels. Mr Buchholz gave evidence at the inquest. He advised that the Department plans to undertake a comprehensive review of all recreational vessel safety equipment requirements in 2015/2016.[128] One aspect of the review will be to consider whether the Department should make the wearing of life jackets compulsory in Western Australia in defined circumstances.[129] This includes research into current technology and the requirements of other jurisdictions beyond Western Australia. Mr Buchholz advised that most of the other States in Australia have compulsory life-jacket wearing provisions in their regulations. Only South Australia, Western Australia and the Northern Territory currently do not.[130] The regulations in the other States are not uniform, but vary in their requirements.[131]

85. The WA review will consider firstly, whether the Department supports the compulsory wearing of life jackets and secondly, if so, what conditions would be placed upon that requirement.[132] While the Department is highly receptive to the idea, given its implementation in most of the other states, Mr Buchholz indicated that the Department is mindful that the average Western Australian wants to go out and enjoy a day of boating without too many proscriptive and technical requirements. The Department is, therefore, aiming for simplicity in its requirements.[133]

86. Counsel who appeared on behalf of the Department, Mr Anderson, urged me to not to pre-empt the outcome of the review by making specific recommendations about the circumstances in which the wearing of life jackets should be mandated.[134] I accept that the issue is complex and requires in-depth analysis to reach a conclusion that will be practical to implement. I also accept that, while still considering whether it should be mandated, the Department currently promotes the voluntary wearing of life jackets on boats. In those circumstances, I propose simply to make a general recommendation that the Department give strong consideration in its review to mandating the wearing of lifejackets on

[128] T 73; Exhibit 1, Tab 34, 7.
[129] T 73, 83 – 84.
[130] T 73.
[131] T 73.
[132] T 73.
[133] T 74.
[134] T 89 – 90.

boats in Western Australia whenever a vessel is in unprotected waters.

RECOMMENDATION

I recommend that the Department of Transport give strong consideration in its review of recreational vessel safety requirements to mandating the wearing of lifejackets by persons over 12 months old on recreational vessels in Western Australia, when such a vessel is in unprotected waters.

High Visibility Vests

87. An issue somewhat related to the issue of life jackets is the question of the advisability of wearing a high visibility vest while out on the water.

88. This issue arose from the evidence of the cray fishing boat skipper who found the last three men in the water, Mr Shinnick Jnr. He has been involved in sea rescues with his father since he was 8 years old, has been cray fishing for more than 17 years and, at the time he gave his statement in 2013, had been a skipper for 7 years.[135] It is fair, with that background, to describe him as an experienced seaman.

89. Mr Shinnick Jnr went looking for the missing fisherman at a time of day when the glare on the water was bad.[136] He observed Mr Gude in the water, who was wearing a red lifejacket and a high visibility shirt. He also spotted Mr Clifton and the deceased, who were wearing red lifejackets but not high visibility shirts. At the conclusion of his statement, Mr Shinnick Jnr volunteered that after this incident, he will now always wear a high visibility reflective shirt when fishing as he "could not believe how much easier it was to spot someone in the water with a reflective shirt."[137]

90. Mr Shinnick Snr also appears to have accepted the wisdom of his son's advice, and recommends wearing long sleeve high visibility

[135] Exhibit 1, Tab 15 [3], [5].
[136] Exhibit 1, Tab 15 [24].
[137] Exhibit 1, Tab 15 [50].

clothing in addition to life jackets to the people he teaches, even when they're fishing.[138]

91. Mr Buchholz was asked his opinion about the advisability of wearing high visibility clothing/reflective vests while out in the ocean. He advised that it does not form part of the Recreational Skipper's Ticket program but noted that all Type 1 or above lifejackets have a mandatory manufacturing requirement to include reflective tape in the design as a safety criterion.[139] The colour of the jackets, yellow or fluorescent yellow, is also designed to be highly visible in the water.[140] The life jackets worn by the three men found by Mr Shinnick Jnr were not, however, Type 1 jackets, so they were not this colour and did not have the reflective strips. In those circumstances, the reflective garment worn by Mr Gude was a helpful aid to locating him.

92. I accept that it is reasonable for the Department not to pursue the issue of wearing reflective/high visibility garment as a mandatory component of recreational boating safety, given the mandatory unprotected waters life jacket design requirements. However, it is worth noting that a very experienced commercial fisherman is going to adopt the practice of wearing one voluntarily. Given the Department includes information in its Skipper's Ticket workbook about the importance of wearing clothing that adequately protects from the sun and to wear sunscreen,[141] it could also perhaps consider including a small mention of the advantages of wearing high visibility or reflective clothing if it is readily available.

EPIRB & Personal Locator Beacons

93. Currently in Western Australia, all recreational vessels operating more than two nautical miles from the mainland shore or more than 400 metres from an island located more than two nautical miles from shore are required by law to carry a marine approved EPIRB. The RST workbook indicates the "EPIRB should be positioned in the cockpit or near the helm where it can be reached quickly in an emergency."[142]

[138] T 43, 52.
[139] Exhibit 1, Tab 34, 4.
[140] T 56 - 57, 76.
[141] Exhibit 2, 59.
[142] Exhibit 2, 38.

94. When activated, the EPIRB transmits a signal to satellites that alerts and assists rescue authorities in their search to locate those in distress.[143] It is monitored 24 hours a day, 7 days a week.[144]

95. EPIRBs are designed to float in the water to optimise the signal to the satellite. An EPIRB has a lanyard that is used to secure it to something that is not going to sink, such as a person's wrist, so that it stays with the person in the water but can float free.[145] In this case, the EPIRB was not attached to anyone and the fact that the EPIRB did not float to the surface of its own accord was suggestive of it being trapped in the boat when it sank.[146]

96. There are several different types of EPIRBs available that meet the minimum standards and they vary significantly in price.[147] The cheaper versions require manual operation whereas there are others available that activate automatically when they hit the water.[148] In the experience of Mr Jess, the manually-operated ones are more common.[149]

97. The manually-activated EPIRBs are generally quite easy to operate when the instructions are followed. However, as this case demonstrates, not everyone is familiar with using an EPIRB and in times of crisis, there is not always time for people to read and follow the instructions. For this reason, it is recommended in the RST workbook that the skipper ensures all passengers on the boat are familiar with where the safety equipment is kept and how to use it before they put to sea. The instructions on how to use the EPIRB on board should form part of the safety briefing.[150] Unfortunately, although taught as part of the RST course, in the experience of the witnesses, routine safety briefings are not commonly done.[151]

98. It is also recommended that the EPIRB be tested before the vessel is used as they have a set battery life, marked on the side of the unit, indicating when the battery needs replacement.[152] Straight after this incident, Mr Shinnick checked his EPIRB and subsequently replaced the battery, as it was out of date. He noted at the time that

[143] T 62; Exhibit 1, Tab 34, 1.
[144] T 62.
[145] T 65; Exhibit 1, Tab 34.
[146] T 65.
[147] T 62 – 63, 69.
[148] T 63.
[149] T 63.
[150] Exhibit 2, 38.
[151] T 48, 65.
[152] T 64.

it was very difficult to remove the EPIRB from its storage container, which is another good reason to have a proper look at the EPIRB before setting out for the day, so that this sort of issue can be anticipated.[153]

99. In recent years, another form of EPIRB has become available, known as a personal locator beacon (PLB). They can be worn as a personal device and can be attached to the lifejacket. Due to their small size, the signal does not last as long after activation as a standard EPIRB and the signal can also be more difficult to pick up. Accordingly, while they are considered a handy additional safety device that should be encouraged, they are not an appropriate substitute for the vessel's EPIRB.[154] They are, however, the appropriate device for the few windsurfers, kite surfers and paddle craft users who operate beyond two nautical miles from shore, given the impracticality of those people carrying a normal EPIRB.[155]

100. The failure to activate the EPIRB was a significant feature in this case. Mr Clifton rightly pointed out at the inquest that if the EPIRB had been attached to someone at an early stage, it would not have been lost. They might then have been able to activate it once in the water and this could have saved the deceased's life, as it is very likely they would have been rescued earlier.[156] He suggested that the best practice would be for the skipper to attach the EPIRB to himself or herself. Given the size of an EPIRB, it wouldn't be practical to suggest that a skipper wear one at all times. However, I agree with Mr Clifton that best practice would be for the skipper to attach it to themselves at an early stage when trouble arises, which should be possible if it is kept in the recommended position within easy reach. Mr Buchholz also recommended having all the safety gear, including the EPIRB, together in some sort of bag or flotation device so they can be gathered together quickly and will float if the boat goes down.[157]

101. The Department recommends putting on a lifejacket first, then making the radio call or using other methods to attract nearby boat users' attention if they are visible, before activating the EPIRB.[158] Contrary to how it might read in the RST workbook, the Department

[153] T 47.
[154] T 63 64.
[155] T 70.
[156] T 91.
[157] T 77.
[158] T 79; Exhibit 2, 51.

does not, however, recommend that you should only activate the EPIRB once in the water. It is simply that putting on a personal flotation device and trying to contact local boats and rescue groups is the priority, as the boat may sink quickly and the EPIRB can be activated in the water if necessary.[159]

102. I also note that if the EPIRB on the boat had been the type automatically activated once in water, this might also have been of assistance in notifying the search and rescue group earlier. It underscores the importance of spending more on the best safety equipment available, where possible. I assume that the deceased probably didn't make that choice himself, as it is likely the EPIRB came with the boat when he purchased it. That leads to the issue of the purchase of second-hand boats in general.

Second-hand Boats

103. Although new recreational vessels require some limited safety information (including maximum safe capacity and load and buoyancy information) to be affixed to the vessel in the form of the Australian Builder's Plate, there is no requirement for second-hand boats that are privately sold to have that information, or to be checked for seaworthiness or meet any particular safety standards. The Department's officers will do a safety check if they come alongside a vessel and they do approximately 12,000 vessel checks a year. These checks are generally more to do with safety equipment and skipper/vessel registration, but if the vessel appears to an officer to be unseaworthy they can take action.[160] However, Mr Buchholz noted that this doesn't capture 99.9% of recreational vessels in the State.[161]

104. The onus at this stage is really on the boat owner/skipper to make sure that the vessel is seaworthy. It is possible for purchasers to employ a company to check a vessel for seaworthiness before purchase, and that is something that is encouraged by the Department.[162] The Department also runs education campaigns in the lead up to summer to encourage boat owners to maintain their vessels, check batteries and have engines serviced, as the vast majority of sea rescues relate to mechanical breakdowns.[163]

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[159] T 78 – 79.
[160] T 71, 84.
[161] T 84.
[162] T 55.
[163] T 84 – 85.

105. The evidence generally indicates that the deceased was a conscientious boat owner. However, given the age of the vessel and the fact he had not owned it from new, there was scope for there to be structural problems with the Oo Roo that were unknown to the deceased. Whether that was the case cannot be explored further as the Oo Roo was not recovered.

106. If the Oo Roo had been of more recent construction, it would have been required to have a certain amount of flotation within it, which is designed to keep the boat afloat to a certain extent, even when under water.[164] This has the benefit that the occupants of the boat can hang on to the outside of the vessel (like this group did before the vessel sank completely), which keeps them together and makes them an easier target to spot in the water.[165] However, given the age of the Oo Roo, it was not required to meet the additional flotation construction standard.

107. I am aware that the lack of regulations governing the construction and maintenance of recreational vessels has been raised by Coroners in this state in the past. Some changes, such as the Australian Builder's Plate, have come into effect since that time, but the general maintenance of recreational vessels appears to remain largely unregulated, according to the evidence given on behalf of the Department at this inquest. While this is concerning, given we do not have evidence in this case as to why the Oo Roo took on water, this is not an appropriate case to explore this issue further. I simply note, for the Department's benefit, that it is an ongoing concern from a coronial perspective and worthy of significant consideration in their safety review.

Radio Calls

108. Mr Shinnick, Mr Jess and Mr Buchholz all mentioned the importance of logging on and logging off with the sea rescue groups when heading off shore in a manned area. They explained that this serves two purposes, one being that the sea rescue group knows the vessel is out in the ocean and the other is that it confirms the radio is working at the start of the voyage and tuned to the right channel.[166] Mr Shinnick also explained that it assists them to know

[164] T 55, 76.
[165] T 55; Exhibit 1, Tab 34, 7.
[166] T 47, 65 – 66.

the whereabouts of all boats in the area, so that they can also utilise them to assist in a search, if necessary (as they did in this case).[167]

109. In this case, there was no record of any call being received on a monitored channel by the local sea rescue group from the Oo Roo. It is not known for certain whether the deceased tried to call in before they set out for the day, as there was a period of time when he was alone in the boat on the water, but it is unlikely that he did.

110. The other men in the boat confirmed that the deceased did attempt to make a mayday call before the boat sank, but Mr Shinnick confirmed it was never received on the four channels they monitor at Lancelin.[168] Given the amount of water in the boat by that stage it is very likely the radio batteries were already compromised by the salt water and the radio wasn't working properly.[169] It is also possible that the call was made on a different channel not monitored in that area, as different search and rescue groups use different channels and the deceased may have not had the correct channel tuned, given he was not a local.[170]

111. If the Oo Roo had successfully radioed in before they went out that morning, it is unlikely that the search would have started any earlier as they had not been out for long when the boat sank. If the problem with the radio call later on was because it was not tuned to the right channel, that initial radio call would have identified that problem. However, I accept the evidence of Mr Shinnick and Mr Jess that by that stage it is most likely the radio batteries had stopped working.

General Comment

112. The Department provided information after the inquest that in 2014-2015 there were approximately 820 reported boating-related incidents that required intervention from emergency services, including volunteer marine rescue groups and during those incidents around 2000 people were rescued. During that same period, there were 4 boating-related fatalities.[171]

[167] T 37, 39.
[168] T 49.
[169] T 50, 66.
[170] T 49 – 50.
[171] Email from Raymond Buccholz dated 22.10.2015.

113. While the majority of sea rescues are due to mechanical defects,[172] a major cause of boating deaths is capsizes.[173] That is why there is a focus in much of the Department's education information on equipping a boat with proper safety equipment and ensuring good maintenance and accessibility of that safety equipment, to maximise the changes of survival in the water.[174]

114. The safety message forms a significant component of the RST programme, but it seems that the safety message is not necessarily taken away by all those who complete the programme.[175] A recurring theme throughout the evidence was the concern that boat owners are often prepared to spend a lot of money on their boats, their fishing gear and other accessories, but comparably small amounts on safety gear. There is a perception that the safety gear requirements are mere legislative obstacles, to be met in the cheapest manner, as they will never be needed.[176]

115. The same can be said for the recommended safety briefing. As Mr Nicholson put it, as safety conscious as the deceased was, he and the other men on the boat that day thought a safety briefing wasn't necessary, as they weren't going out far, weren't going to need their safety equipment and weren't going to sink.[177]

116. What this inquest demonstrated was how quickly things can go wrong when out in the ocean and the importance of good planning and safety measures. The four men who went out on the Oo Roo were sober, mature men who were not deliberately putting themselves in harm's way. They never thought it possible that their boat would sink during a simple morning of fishing, not that far from shore. In hindsight, they would have done things very differently that day and want to ensure that lessons are learnt by other boat users from the death of the deceased.

117. The message the experts and the survivors of that day now want others to hear is that you can only afford to buy a boat if you can afford to also buy the proper safety equipment that goes with it, which does not mean buying the most basic standard of equipment available. They urge boat owners to spend more and buy lifejackets

[172] T 85.
[173] Exhibit 1, Tab 34, 4.
[174] Exhibit 2, 38.
[175] T 31.
[176] T 30 – 33, 51 – 53, 63, 81 – 82.
[177] T 33.

that are comfortable, so they will wear them more often, and other safety equipment that is easy to use. They also emphasise the importance of maintaining that safety equipment, making it easily accessible and ensuring that everyone on the boat knows how to use it. It is about spending money and time on the right things, not focussing on buying the latest sounder or finding the best fishing spot and leaving the safety of all on board as an afterthought.

118. The Department is preparing to embark upon a review of both safety equipment requirements for recreational vessels and the adequacy of testing procedures around the recreational skipper's ticket. Mr Buchholz indicated at the inquest that the process is only in the early stages and is unlikely to start until at least the middle of next year and will then take some time to formulate recommendations and a longer period again for their implementation.[178] I was urged by counsel on behalf of the Department not to pre-empt this process with recommendations arising from this inquest.

119. I have since been informed that the review has been formally approved by the Minister and is in its early stages. Work has commenced on establishing an external stakeholder advisory group, including Water Police, Sea Rescue groups and boat using groups, to assist the Department with the review. Two rounds of public consultation are planned for 2015, one on a Discussion Paper and the other on a Position Paper, with recommendations scheduled to be provided to the Minister in late 2016.[179]

120. I am satisfied that the Department is in the best position to consider issues such as the mandatory wearing of lifejackets in certain conditions following such a review, and I don't propose to make any recommendations in that regard without the benefit of the results of that review. However, I hope the Department takes into account in its review the evidence heard at this inquest, particularly from the survivors of the incident and those involved in the rescue, as their firsthand experience of the difficulties that even experienced, sensible men can encounter when using a recreational vessel is a reminder that the Department's current safety message is not necessarily being heard or achieving its goals.

[178] T 83 – 84.
[179] Email from Mr Anderson on behalf of the Department 23.10.2015.

CONCLUSION

121. Recreational boating is an important part of the lifestyle of many Western Australians. Whether it is for fishing, the pleasure of sailing or simply to get to Rottnest, a large number of people are out on boats off the WA coastline every weekend. The deceased enjoyed that lifestyle too, spending time with friends and family fishing and doing something he loved. He had been on boats many times over the years without incident.

122. The events of 2 June 2013 were entirely unexpected. The deceased had taken what he considered to be appropriate safety precautions and all his passengers felt safe and had full confidence the boat would not sink. When the boat went down, they were unprepared and that lack of preparation affected their chances of survival in the water. But for the chance passing of a cray fishing boat and the good eyes of its crewmember, this inquest might well have been dealing with four deaths rather than one.

123. While the Department is undertaking a review of what recreational vessel safety equipment and training should be mandated, it is important to note that much of this equipment and information is already out there and available for voluntary use. Indeed, it is already used by the Department's staff and search and rescue volunteers. So the key safety message to emerge from this inquest for skippers is: take responsibility for the safety of yourself and your passengers and do more, and spend more, than the minimum requirements on safety.

Sarah Linton
Coroner
23 October 2015