

Magistrates Court of Tasmania
RECORD OF INVESTIGATION INTO DEATH
Coroners Act 1995
FOR PUBLICATION

I, Stephen Raymond Carey, Coroner, having investigated the deaths of three fishermen WITHOUT HOLDING AN INQUEST FIND THAT :

The three fishermen died on the 23rd April 2006 at sea in the vicinity of Hippolyte Rocks. Two died as a result of drowning, with a heart condition contributing to the third man's death.

CIRCUMSTANCES SURROUNDING THE DEATHS:

At approximately 0730 hours on Sunday 23rd April 2006 a 5.8 metre aluminium plate boat left Fortesque Bay on the Tasman Peninsula with 5 male persons on board. The boat travelled to the vicinity of Cape Pillar and fished in an approximate 5 kilometre radius east of Cape Pillar. The intention at this time was to compete in the Australian Bluefin Tuna Championship being conducted by the Tuna Club of Tasmania over the period 22nd to 24th April 2006. At approximately 0930 hours it was decided to return to Fortesque Bay because of the cold and the uncomfortable weather conditions. They headed north to Hippolyte Rocks still trawling for fish and travelling at about 8-10 knots. The boat was being skippered by one of the deceased, another deceased was seated on a deck chair located between the skipper's chair (starboard side) and a passenger chair (port side). The third deceased was sitting in the passenger seat. One of the passengers on board describes the conditions when they left Fortesque Bay that morning as "good" with a 2-3 metre south-westerly swell and 20 knot south westerly winds.

However at the time that the decision was made to return to Fortesque Bay, the conditions in the area in which they were fishing were significantly worse with a swell estimated at a minimum of 3 metres and wind at 35 knots with at times heavy rain. A witness who was in his 19 foot power craft vessel entering Munro Blight near Cape Pillar reports that they were side swiped by a wave of some 4-5 metres that "came from nowhere".

Soon after commencing the journey back a large wave broke on the stern of the boat, which was then picked up by the wave and rolled over starboard side first. All occupants, who were wearing PFD 1's, were thrown into the sea. With effort they all managed to climb onto the upturned vessel. An attempt was made by one survivor to use his mobile phone but it had been rendered inoperable by the immersion in water. One of the deceased made attempts to recover the EPIRB which was still attached to the inside of the boat near the skipper's chair. The vessel stayed afloat for approximately 45 minutes before it started to sink stern first. The vessel sunk after approximately another 15-30 minutes leaving all 5 occupants floating in the water.

The occupants spent at least 2 hours floating in the water and during this time they tried to stay together and talk amongst themselves in an effort to maintain morale. One survivor spent a considerable amount of this time holding the back of the skipper's lifejacket to keep him the right way up. He suspects however that given the condition of the skipper when the boat first capsized and the lack of response after they were floating in the water that the skipper was already deceased.

At about 1.00pm the two survivors were located approximately 8 kilometres south east of Hippolyte Rocks by the occupants of another boat. They were brought aboard and directed this vessel to the other persons who were located in the water nearby. These other persons were then brought aboard 'Black Pearl' but were not conscious. Two occupants of the rescuing boat attempted CPR on all three but no pulse could be identified. A volunteer ambulance crew were dispatched on a vessel from Pirates Bay jetty and met up with the rescuing boat. When they arrived another volunteer ambulance officer was noted to be already on the vessel having been transported there previously. CPR was attempted again, however it was determined that all three were deceased.

COMMENTS AND RECOMMENDATIONS:

This was not a case of an inexperienced persons finding themselves in a situation of which they were unfamiliar. The skipper was a lifetime professional fisherman and held a skipper level 3 license and speedboat license. Two other passengers were also experienced professional fishermen. One held a skipper level 3 license and had skippered numerous large fishing boats about the coast of Tasmania. Another had some 22 years' experience as a deckhand on fishing boats. The owner of the vessel had been involved in recreational fishing most of his life but I note had only held a speedboat license since April 2005 and he purchased the vessel in November 2005.

In retrospect it is now possible to identify a number of possible contributors as to why this tragedy occurred. Firstly, the weather and sea conditions. Although there were some differing reports dependent upon where vessels were, the consensus

appears to be that in most areas where the fishing was being conducted the conditions were dangerous with a large and unstable swell driven by high winds. The occupants of the ill-fated vessel obviously decided to head back to shore due to the conditions but by that stage they were already in those conditions and had to return with a large following sea. Being out in exposed waters in the conditions imposed a real risk of the happening of what eventually occurred. The decision to proceed out in those conditions was obviously made by some or all of the occupants and must be said, in retrospect, to have been an error of judgement.

Given those conditions it is also apparent that the vessel was carrying more occupants than was advisable. Although the vessel was registered to carry 6 persons this relates to smooth waters. I do not consider that it was safe to have had 5 persons on board in the conditions experienced on the 23rd April 2006. Occupants of another vessel observed the ill-fated vessel at approximately 8.30am and commented at the number of people in the boat and also observed that it appeared heavy in the stern with little free board at the rear of the boat. Whether this was as a result of the number of people in the boat, the boat design or other factors such as water in the kill tank or water in the bottom of the boat I am unable to determine. Whether or not the fact that the boat was apparently low in the water at the stern played a part in the swamping of the boat I am unable to say, but it could well have been a contributing factor.

The fitting and accessibility of EPIRB is a matter requiring attention by boat operators. In this case the EPIRB was fitted near the boat controls on the starboard side of the boat and had a quick release mechanism. However the events were such on this occasion that the EPIRB was unable to be released before the boat capsized. I recommend that in conditions or circumstances where there is an increased possibility of sudden occurrences such as swamping or capsizing or of the occupants being separated from the boat that a skipper or person in charge of the boat carry the EPIRB on their person or have it affixed in such a manner that it is easily retrievable. If the EPIRB had been able to be activated in this case it is at least possible that the outcome may have been different.

It is not known what internal buoyancy material was fitted to this boat but given that it sunk, it was clearly not sufficient to provide the necessary buoyancy. This boat was constructed before any requirement to fit internal buoyancy to an approved specification. I have been advised that recently a National Standard has been adopted requiring newly manufactured vessels less than 6 metres in length to comply with certain buoyancy specifications and to be fitted with a Builders Plate containing amongst other things a buoyancy statement. It is clear that vessels manufactured prior to the adoption of this standard may not have sufficient fitted internal flotation and I encourage all affected boat owners to examine their vessels and fit additional flotation material if necessary. Marine and Safety Tasmania are able to provide advice on this point to boat owners and I recommend that Marine and Safety Tasmania continue their publicity campaign on this issue.

The final issue concerns the conduct of the tuna fishing competition that was being conducted on this day. Clearly the organisers had in place a plan to control the conduct of the competition and maintain awareness of where individual boats were at selected times. It did this by requiring regular radio checks from the boats that were in the competition. However the implementation of their communication plan appeared to have some weaknesses. The communication plan obliged all vessels to contact competition control (Tuna Base) at the first radio schedule at 8.10 am and each hour subsequently. Each boat was obliged to advise Tuna Base upon return to port and faced disqualification for not doing so. Competitors were advised to relay via another boat or use mobile phone communication to ensure compliance with meeting the obligation to report in each hour. A warning was given to competitors that a failure to meet the communication requirements could lead to an "emergency procedure being instigated".

I am satisfied that Tuna Base was not aware that the ill-fated vessel was on the water on Sunday the 23rd April 2006. The survivors assert that they believe contact was made and on one occasion this was achieved via relay from another boat. The occupants of that boat however do not recall this. It appears that attempts may have been made by those on the ill-fated vessel to contact Tuna Base but through misunderstanding or incomplete communication this was not achieved. Although there is provision for disqualification for not reporting when you have returned to shore, perhaps a similar provision ought apply to all boats who have not achieved communication with Tuna Base by a certain time, say 9.00am. This or some similar procedure needs to be adopted and policed to ensure more certainty by the competition organisers as to what boats are on the water. There needs to be either an improvement in the radio coverage by use of perhaps a dedicated radio relay boat or a more definitive policing of the requirements to meet the hourly radio reports. I note from the records of the competition that on Sunday the 23rd April 2006 there were 4 boats that missed 2 or more reports and were accordingly out of contact for 3 hours. There needs to be firm policing of the communication obligation and a clear policy on what amounts to a failure sufficient enough to lead to the "emergency procedure" being instigated. I note that for a similar competition in April 2007 a Police vessel performed the role as a radio relay vessel and communications were improved. I commend the organisers for having implemented this resource as the application of a strict requirement to maintain communications with a penalty for failing to do so is dependent upon having in place a communication system that provides for a high probability that communication will not be adversely affected by conditions or boat location.

The final issue concerns the role and purpose of the contest/weather committee. Contestants were advised that this committee;

“...may make a decision not to commence fishing on any day, or call off fishing at any time, if in the opinion of members of that committee the weather is unsuitable for fishing. The contest will cease at that time and not resume until the committee advises. If such a decision is made all vessels at sea should return to safe waters immediately.”

There appears to have been some discussion during the morning as to whether or not the event should continue on that day. There were differing reports from boats as to the prevailing conditions obviously dependent upon their size and location. I would recommend that clear guidelines be established for the exercise of this action by the weather committee, and that such guidelines provide objective criteria which if met would lead to the automatic decision to not fish or to abandon fishing on a particular day. Such criteria should err on the side of safety. Organisers of such competitions need to be cognisant of the competitive nature of such events and the likelihood that this might influence some to fish or to continue to fish in conditions they might not otherwise do so.

In conclusion however it must be stressed that the action or lack of action by organisers or others can never displace the responsibility of the operator of a boat and the occupants of that boat to make safe decisions as to whether or not to venture out to sea or to remain out in adverse weather conditions.

I commend the owner and operator of “Black Pearl”, Mr. Matthew Martin and the occupants of the boat, Messrs. Mark Fawkes, John Noble, Robert Wardlaw and Rowan Collins for their efforts in locating and recovering the occupants of the ill-fated vessel. They clearly exposed themselves to added danger in bringing five additional persons on board their boat and their efforts in attempting to revive the deceased persons and safely returning the overloaded vessel to port deserves appropriate recognition.

Before I conclude this matter, I wish to convey my sincere condolences to the families of the deceased persons. This matter is now concluded.

DATED: This 10th day December of 2007

Stephen Carey
CORONER