CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Port Lincoln in the State of South Australia, on the 9th and 10th days of July 2008 and the 16th day of October 2008, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Walter Muir McFarlane.

The said Court finds that Walter Muir McFarlane aged 52 years, late of Lot 1, 614 Hundred of Lincoln, Port Lincoln, South Australia died near Boston Island, Port Lincoln, South Australia on the 27th day of November 2005 as a result of salt water drowning. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Walter Muir McFarlane was 52 years of age at the time of his death on 27 November 2005. On that day, Mr McFarlane was found floating in the water next to his aluminium boat in Boston Bay, Port Lincoln.

1.2. Mr McFarlane's wife was the last person known to have seen him alive. According to her statement Mr McFarlane rose at 6:30am on the morning of 27 November 2005. He intended to go fishing in Boston Bay. The McFarlanes live only 50 metres from the shore where the boat is usually moored. Mrs McFarlane was expecting that Mr McFarlane would return about lunchtime as was his usual habit. She said that he would always wear his waders when he went fishing because the mooring for his boat, which is left in the water at all times, was in the bay some distance through shallow water from the shoreline. Mr McFarlane would wear the waders so that he could get to and from the boat at its mooring. He loved fishing and would go at every opportunity. He was generally in good health and had no serious health problems.

He had been extremely busy at work of recent times and was perhaps rather more tired than usual.

2. The events of 27 November 2005

2.1. Wendy Lambert and her husband were sailing in their yacht, 'Silent Number', from Louth Bay to Port Lincoln that morning. At approximately 11:30am they were approaching the northern entrance to Boston Bay approximately 5 kilometres from Boston Island. At that time, Mrs Lambert could see splashing near the north-eastern tip of Boston Island. She believed it to be approximately 3 kilometres from her position at that time. She thought the splashing was caused by dolphins.

2.2. Mrs Lambert continued to watch the splashing. She eventually realised that the splashing was caused by a boat turning in circles. Her husband looked through the binoculars and remarked that he could not see anybody on the boat. They approached to within approximately 200 metres and saw that it was a small aluminium vessel spinning in tight, clockwise circles at high speed. The outboard motor was revving loudly. Mrs Lambert did not wish to get her yacht close to the boat as she feared that it may cause damage. At about 12:15pm she heard her husband notifying the State Emergency Service (SES) by marine radio of their discovery. At that time, Mrs Lambert observed a body floating in the water and she pointed it out to her husband. She maintained a watch thereafter. At approximately 1:30pm the SES boat arrived with police on board. She observed the police recover the body from the water.

2.3. Senior Constable Hall gave evidence at the Inquest. He was stationed at Port Lincoln in late 2005 and made a statement which was admitted as Exhibit C11 in these proceedings. He said that he was told by the Officer in Charge of the Port Lincoln Police Station that a couple sailing in their yacht had seen a body floating in the water. It was close to a boat which was out of control and turning around in circles. The yacht had been making observations for some time. Senior Constable Hall arranged to meet the SES personnel at the Port Lincoln Marina boat ramp. There were four SES members and three police officers including a crime scene officer. A number of photographs were taken and admitted as Exhibit C10 in these proceedings. The SES vessel proceeded to the location according to coordinates given by Mrs Lambert. When they arrived the Lamberts pointed to the body of a person floating in the water. Senior Constable Hall noted the aluminium Quintrex boat floating in the

water nearby. The boat was a 4.2 metre centre console Quintrex brand aluminium boat powered by a 40 horsepower Yamaha engine.

2.4. Senior Constable Hall said that he and some other members of his crew pulled the body from the water. It was fully clothed in a jumper and denim jeans. There was no personal flotation device (PFD). Senior Constable Hall recognised the deceased as Mr McFarlane, who was a person well-known in Port Lincoln. Mr McFarlane's wallet was removed. This confirmed his identity. Mr McFarlane did not appear to have any injuries to his body or his head and his clothing was intact. However, he was not wearing any shoes.

2.5. Senior Constable Hall explained that according to his later investigations, and the statement provided by Mrs McFarlane, he was not surprised that Mr McFarlane was not wearing shoes because he would generally wear his waders in the boat. Although he was not wearing his waders when his body was recovered, it was inferred by Senior Constable Hall, reasonably in my opinion, that Mr McFarlane had managed to struggle out of his waders while in the water before drowning. The waders were never recovered and were confirmed by Mr McFarlane's wife to be missing. Senior Constable Hall did not consider the circumstances to be suspicious in the sense that any third party had been involved.

2.6. The occupants of the SES vessel turned their attention to Mr McFarlane's boat with the object of towing it back to the Port Lincoln Marina. Senior Constable Hall climbed into the boat with the intention of turning the motor (which was fully turned to starboard at that time) to a straight position in order to assist in towing. He turned the steering wheel but noted that the motor did not respond to the turning of the wheel. There was fishing equipment in the boat and tubs of squid. Senior Constable Hall saw that the throttle of the boat was in the open position at approximately ¾ full throttle. The safety cut-out device which is designed for attachment to the body of the operator of the vessel was in position. It had not been attached to Mr McFarlane's clothing or wrist at the time he exited the vessel. The motor was tilted so that the propeller was out of the water thus enabling the vessel to be towed without the outboard leg affecting the direction of travel.

3. Examination of Mr McFarlane's vessel

3.1. On 28 November 2005 Mr Adam Brancher, a Marine Surveyor with the Department of Transport, Energy and Infrastructure, attended at the SES compound at Port

Lincoln and examined the Quintrex vessel. He was accompanied by Senior Constable Hall. The vessel was on its trailer. Mr Brancher noted that the vessel had a steering wheel pump manufactured by Hydrive™ Admiral matched to a hydraulic ram provided by the same manufacturer which was mounted in the vessel's outboard engine well. He said that the steering operated by turning the wheel at the centre console, which was directly connected to a manual hydraulic pump which in turn operated a hydraulic ram via two hydraulic fluid lines. The ram was connected to a bar at the engine which allowed port and starboard movement of the engine. Mr Brancher concluded that further investigation of the steering pump and ram should be undertaken by a person competent to do so in a properly equipped workshop. His preliminary view was that the hydraulic oil in the steering system may have been low, thus causing the system to fail with the result that engine torque caused the engine to set to starboard. This would have occurred quickly as the power setting on the motor was high at the time of the failure.

3.2. Mr Matthew Young gave evidence at the Inquest. He also provided a statement which was admitted as Exhibit C12. He has been an outboard mechanic for 19 years and is fully qualified in that discipline. He inspected the vessel at the SES compound at the request of Senior Constable Hall shortly after 27 November 2005. He was unable to find an explanation for the failure of the steering in the vessel but his preliminary view was that there was still enough oil in the steering system and that a lack of oil could not properly account for its failure. He concluded, like Mr Brancher, that it would be necessary to examine the vessel in a workshop. He said that when he turned the steering wheel it felt normal, but that the motor was not turning at all.

3.3. Mr Young said that he did not see the boat again for approximately one month. Then it was brought to him by Mr McFarlane's son who wished to have the boat repaired so that it could be used again. Mr Young had no further contact with the police at the time, although they had told him that they would get back to him.

3.4. Mr Young said he repaired the boat in January 2006 and that it is still being used today. He removed the steering ram on the outboard and it became obvious immediately what had happened. In his statement, Exhibit C12, Mr Young provided some diagrams which demonstrate the operation of the hydraulic ram attached to the outboard motor. The ram consists of a cylinder with a hydraulic piston enclosed within it. Oil can enter the piston from either end, thus causing the piston to move from one side to the other side of the cylinder and back again. Attached to the piston

is a rod which has a male thread on the end of it. Attached to that rod is a further rod of slightly wider diameter with a female thread at one end. The other end of that rod is attached to the steering arm of the outboard motor. Mr Young discovered that the threaded rods to which I have made reference were no longer joined together. They had become unscrewed. He was unable to provide any definitive explanation as to why that happened. However, he was able to explain that as soon as the threads separated, the steering torque effect on the outboard motor would be to turn it immediately to the starboard side.

3.5. He said that a material known as loctite is supposed to be used to glue the threads together thereby preventing them from separating and unscrewing by the effect of engine vibration or the tilting up and down of the outboard motor. This was the first time he had ever seen a failure of this type. He said that the thread is 12mm to 13mm long and that it is quite fine. It would therefore take a long time for the two rods to unwind and come apart, but to the operator there would be no warning signs whatsoever. He said that the immediate turning of the outboard motor to starboard would account for the clockwise spinning of the vessel observed by Mrs Lambert[1]. Mr Young thought that the movement of the boat after the failure of the steering would have been very sudden and quite extreme, a manoeuvre that he said he would not attempt himself. He thought it more than likely that the movement of the boat caused by the sudden change of direction would have thrown Mr McFarlane out of the boat.

3.6. Mr Michael Borlace gave evidence. He is a boat fitter in the employ of a firm known as Boat Supplies Pty Ltd. It was that firm which supplied the Quintrex vessel to Mr McFarlane new in July 2004. Mr Borlace recognised his writing on a job sheet relating to the supply of various components for attachment to the vessel including the Hydrive™ steering unit which has already been referred to. Although he could not specifically recall fitting the steering to Mr McFarlane's boat, he said that it was almost invariably he that would perform that function at Boat Supplies Pty Ltd and that he believed it would have been he who fitted this particular steering mechanism.

3.7. Mr Borlace has worked on boats for 25 years. He said that he does nearly all of the steering systems that go through Boat Supplies Pty Ltd. He made two statements which were admitted as Exhibits C13 and C13a in these proceedings. He said that his invariable practice is to put the threads together using loctite and leave them overnight

[1] Exhibit C6a

for the loctite to set properly (not the minimum period of 3 hours recommended by loctite for that purpose).

3.8. Mr Borlace gave evidence, as did Mr Young, that it is possible for the owner of a vessel to carry out his own service work on the hydraulic steering system in the event of a leak in an 'O' ring, which is not an uncommon experience. He said that in order to carry out a replacement of an 'O' ring it is necessary to undo the two rods connected by the thread and the loctite. If the threads are not correctly joined using new loctite after such a service has been carried out, then they will gradually work loose. It is not possible to determine, on the evidence available to me, precisely why the two threads came apart in this instance. The possibility that Mr McFarlane or some other person may have carried out repairs as speculated upon by Mr Borlace in his evidence may offer an explanation, but it is by no means established. However, I do accept that Mr Borlace is an experienced fitter of such steering systems, and have no reason not to accept his evidence that it is his invariable practice to diligently fit and apply the loctite in the manner described in his evidence.

3.9. Mr Borlace said that Mr McFarlane's vessel was not brought back to Boat Supplies Pty Ltd for servicing after it was sold in July 2004, notwithstanding that the manufacturers recommend that the motor be returned for servicing within 3 months of purchase, and that the vessel be serviced at 12 monthly intervals thereafter. Had that schedule been maintained, the vessel would have been serviced in October 2004 and again in October 2005. Thus it would have been serviced at least twice before 27 November 2005. According to Boat Supplies Pty Ltd's records, this did not occur. Of course, it is possible that Mr McFarlane may have taken the vessel to another firm for servicing but Mr Young, who worked at that time for a competitor of Boat Supplies Pty Ltd, gave evidence that he had never seen the vessel prior to December 2005. On balance, I think it most likely that Mr McFarlane never took the vessel to a mechanic for servicing after July 2004. Whether he carried out any service work of his own is a matter of speculation.

4. Personal Flotation Devices

4.1. Mr Richard Franklin gave evidence at the Inquest. He is the National Manager for the Royal Life Saving Society. He helpfully provided three reports in relation to PFDs which were admitted as Exhibits C14, C15 and C16. They are respectively, a discussion paper prepared by the National Marine Safety Committee dated September

2006, a study prepared by the same committee of the wear rate of PFDs prepared in October 2007, and a report entitled Recreational Vessel Fatalities in Victoria 1999-2002. It was the opinion of Mr Franklin and the position of his organisation that accidental deaths by drowning involving recreational vessels can be reduced if people wear PFDs. He drew the Court's attention to legislation which has been enacted in other jurisdictions, most notably Victoria and Tasmania, which require the occupants of power driven vessels up to 4.8 metres in Victoria and 6 metres in Tasmania, to wear PFDs when they are in an open area of a vessel which is under power. In South Australia, the law does not require this. The compulsory wearing of PFDs is limited to particular activities. A helpful table setting out a comparison of the requirements within each jurisdiction is set out at page 29 of Exhibit C15.

4.2. Mr Glen Jones gave evidence at the Inquest. He is the Manager of the Boating Industry Association of South Australia which represents 200 businesses involved in boating in this State. Mr Jones informed the Court that the industry viewpoint is to oppose the introduction of legislation requiring the mandatory wearing of PFDs in South Australia. Mr Jones argued that the waters of South Australia are relatively safer than those of other jurisdictions. He also suggested that the requirement to wear PFDs at all times in a vessel could be counter productive and dangerous (he gave as an example the wearing of a PFD while in a cabin of a vessel which capsizes). With respect to Mr Jones, I did not find his arguments particularly convincing. In particular, there is no reason to think that South Australia's waterways are any safer than those of other jurisdictions. Furthermore, the laws of Victoria and Tasmania specifically only require the wearing of PFDs in an open area of a boat, and then only when the boat is under power. The examples of inconvenience given by Mr Jones which were intended to demonstrate the impracticality of the mandatory wearing of PFDs lost much of its force when they related to circumstances in which, even under the law of Victoria and Tasmania, PFDs would not have to be worn.

4.3. In my opinion the strongest point made by Mr Jones is that any reforms in the area of PFDs and any requirement to make the wearing of PFDs compulsory should be done uniformly throughout Australia and not on an ad-hoc basis. He referred to work being done by the National Marine Safety Committee, the body which prepared Exhibits C14 and C15, and noted that it has been engaging in discussion with the States in relation to this issue.

5. Conclusions and recommendations

5.1. In my opinion the sense in wearing PFDs in vessels below, for example, 4.8 metres in length, while underway and while in an open area, is difficult to dispute. The argument for wearing a PFD in such circumstances becomes all the stronger when one is alone in a vessel. Furthermore, a good argument can be made in favour of a law which would make it mandatory to wear a PFD in one or more of these circumstances. However, the circumstances of this particular case do not lead me to believe that it is appropriate to make a recommendation to this effect. In this particular case the deceased was, on the balance of the evidence, wearing waders which would have caused him to sink quite quickly on hitting the water. A PFD may well have assisted Mr McFarlane and may even have saved him. However, the circumstances of this case are so unusual that in my opinion it would not be appropriate to make a general and far reaching recommendation about the introduction of a compulsory law relating to the wearing of PFDs. In this connection I particularly note that there is work being done by the National Maritime Safety Committee in conjunction with the States and that is a further reason why I refrain from making any recommendation on this occasion. However, the case is very clear that as a matter of common sense all persons should be encouraged to wear PFDs when in an open area on a powered vessel under 4.8 metres which is under way. Certainly, a sole operator should wear a PFD in such circumstances.

Key Words: Drowning; Personal Flotation Devices

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 16th day of October, 2008.

State Coroner