CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATHS OF PAUL THEODORE ECKERT, THOMAS SEBASTIAN ECKERT, ALAN LESLIE BOTTRILL, DAVID ARTHUR NEAVE, RODNEY JON INGRAM, PETER JOSEPH MARTIN, ROGER MALCOLM WALKER AND VICTOR REGINALD KENT

[2026] SACC 4

Inquest Findings of his Honour State Coroner Whittle

26 February 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the deaths of eight South Australians in four boating incidents on South Australian waters. The inquest explored the circumstances that led to the incidents and whether the use of simple life protection devices might have prevented any of the deaths.

Held:

1. Paul Theodore Eckert, aged 73 years of Wattle Park, died near Buffalo Reef on 25 March 2024 as a result of drowning.
2. Thomas Sebastian Eckert, aged 40 years of Torrens Park, died near Buffalo Reef on 25 March 2024 as a result of drowning.
3. Alan Leslie Bottrill, aged 71 years of Upper Sturt, died near Buffalo Reef on 25 March 2024 as a result of drowning with head and chest injuries.
4. David Arthur Neave, aged 65 years of Kingscote, died off Cape Cassini, Kangaroo Island on 14 August 2024 as a result of drowning.
5. Rodney Jon Ingram, aged 65 years of Kingscote, died off Cape Cassini, Kangaroo Island on 14 August 2024 as a result of drowning.
6. Peter Joseph Martin, aged 77 years of Elliston, died off Cape Finnis near Elliston on 30 November 2024 as a result of drowning on a background of ischaemic heart disease (operated) and cardiomegaly.
7. Roger Malcolm Walker, aged 82 years of Millicent, died off Point Connor, Rivoli Bay, near Beachport on 6 January 2025 as a result of saltwater drowning complicating ruptured spleen on a background of ischaemic heart disease.
8. Victor Reginald Kent, aged 69 years of Millicent, died off Point Connor, Rivoli Bay, near Beachport on 6 January 2025 as a result of cardiac arrhythmia due to non-ischaemic cardiomyopathy complicating saltwater immersion.
9. Circumstances of deaths as set out in these findings.

Recommendations made.

Counsel Assisting: MR D EVANS

Hearing Date/s: 10/02/2026

Inquest No: 01/2026

File No/s: 0787/2024, 0788/2024, 0789/2024, 2298/2024, 2299/2024, 3437/2024, 0052/2025 & 0055/2025

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[2026] SACC 4

Introduction

1 I heard an inquest in relation to the deaths of eight people in four separate incidents which all occurred in South Australian waters. These inquests were heard together to enable me to explore whether there is a systemic issue in relation to the role of lifejackets in the South Australian marine safety regime. Comprehensive investigation briefs were received into evidence in respect of each incident, and I was then assisted by expert advice from a Sergeant of the South Australia Police (SAPOL) Water Operations Unit.

2 I heard evidence that the eight deaths under examination are not the only deaths occurring on South Australian waters during boating activities and that there are and have been many others. I therefore proceeded with this inquest on the basis that the deaths under investigation were a representation of a wider issue.

3 I will first detail my factual findings before turning to consideration of the application of the marine safety regime and whether I consider it to be sufficient.

Port Lincoln

4 The first incident occurred on Monday, 25 March 2024 at Buffalo Reef which is well offshore, some 55 kilometres east of Port Lincoln. This incident claimed the lives of 73-year-old Paul Eckert, 40-year-old Thomas Eckert and 71-year-old Alan Bottrill.

Mr Bottrill, Paul Eckert and Thomas Eckert

5 Mr Bottrill was married and had two children. He was raised in a family of keen fisherfolk who always had boats.[1] He held a boat licence which had been issued in 1983.[2] He completed an apprenticeship as a fitter and turner before changing careers and studying social work and public sector management.[3] He had been diagnosed with stage IV bowel cancer for which he was not receiving treatment.[4]

6 Mr Bottrill would arrange trips about every six months and issue an open invitation to friends and family to join him fishing out of Coffin Bay or Port Lincoln.[5] Mr Bottrill was an experienced boater, having visited Coffin Bay for 30 or 40 years.[6] His boat, named 'Cockleshell III' was a 6.25 metre fibreglass Cruise Craft vessel built in 2008.[7] Over the years, he developed a lot of local knowledge of the waters.

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[1] Exhibit C8 at 2
[2] Exhibit C19 at Annexure A
[3] Exhibit C8 at Annexure A
[4] Exhibit C22 at 11
[5] Exhibit C8 at 2
[6] Exhibit C7a at [11]
[7] Exhibit C13 at [6] and Exhibit C16 at [17]

7 Notwithstanding his local knowledge, in 2020 Mr Bottrill was involved in incidents at Coffin Bay where he became stranded on a sandbar twice on the same day. The SES came out to him on both occasions and on the second occasion, he had fallen in the water leading to hypothermia, which saw him taken to hospital.[8]

8 Paul Eckert was born in New Zealand. His father was a Lutheran minister and the family moved around a bit before they settled in Adelaide.[9] He had two sons, Danny and Thomas. He was a fit, healthy, energetic and positive man who was dedicated to his family.[10] He loved nature and having adventures. When younger, he studied social work at Flinders University, and this led into an impressive career in public service and further study in public sector management. Between 2006 and 2014, Mr Eckert worked in the Mental Health Directorate within CALHN. He quickly formed a friendship with his colleague there, Mr Bottrill, and they became life-long friends.[11] They would often travel together and go fishing.

9 Thomas Eckert was married with two young children. He had studied and pursued a number of jobs before his employment as a regional operational manager at ARA.[12] He was physically fit and sometimes did 10 kilometre runs on the weekend. He was a capable swimmer.[13] He would travel to Coffin Bay and holiday in a shack there with his family. Thomas' brother and his family would also holiday in Coffin Bay. In the previous few years they had fished with Mr Bottrill. In 2023 the weather was rough when the family went out. Mr Bottrill told them to wear lifejackets and he showed them where the Emergency Position Indicating Radio Beacon (EPIRB) was on his boat.[14]

25 March 2024

10 On 25 March 2024, Paul and Thomas Eckert went out fishing on Mr Bottrill's boat with Thomas' brother, Danny and Danny's young son. They drove to Port Lincoln and launched from the boat ramp.[15] Mr Bottrill skippered his boat. The evidence establishes that the conditions were calm with hardly any wind.[16] A professional fisherman in the area described the water as 'like glass'.[17] The Bureau of Meteorology recorded a temperature at Neptune Island at 3 pm of 20.9 degrees and a south-easterly wind speed of 19 km/h.[18] On this occasion, likely guided by the conditions, there was no discussion about life jackets or safety measures.[19] None of the passengers donned a lifejacket, including the young child. As I will explain later when I deal with the applicable regulations, the length of the boat did not give rise to a general requirement for lifejackets to be worn but the child was nevertheless required to be wearing a lifejacket.

11 They travelled for about 45 minutes to visit the tuna nets where the farm manager, Adam Kayser, told them they were not permitted to fish there.[20] After leaving the tuna farm they

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[8] Exhibit C70 at [19]
[9] Exhibit C7b at [2]
[10] Exhibit C7b at [5]
[11] Exhibit C7a at [9] and Exhibit C7b at [6]
[12] Exhibit C6 at [6]-[10]
[13] Exhibit C6 at [12]
[14] Exhibit C7a at [14]
[15] Exhibit C7 at [4]
[16] Exhibit C7 at [3]
[17] Exhibit C9 at [13]
[18] Exhibit C16 at [19] and Exhibit C19b
[19] Exhibit C7a at [16]
[20] Exhibit C7a at [17]-[18] and Exhibit C9 at [8]

travelled near the Sir Joseph Banks Group of Islands,[21] offshore between Port Lincoln and Tumby Bay. In this area, they trolled for fish near Buffalo Reef, where Mr Bottrill had caught snook the week before.[22] The reef is some 10 kilometres south-east of the islands and about 55 kilometres east of Port Lincoln. The waters on one side of the reef were turbulent with a rolling swell breaking on the reef, but the other side was calm.[23] They trolled on both sides of the reef over a number of runs, about 400 or 500 metres from the reef. After a few runs on the calmer side of the reef they caught a snook. They then returned to the other side of the reef and commenced a trolling run.[24] This was at about 4 pm and the wind had picked up a little. They were 350 to 400 metres from the reef.

12 During this run, Thomas and Danny Eckert saw a wave approaching the boat from the side, which was about two-and-a-half metres higher than the top of the boat.[25] Mr Bottrill was heard to exclaim, 'Oh shit' and he then revved the boat hard.[26] The wave dwarfed the boat, enveloping and overturning it as it hit.[27]

13 After being thrown into the water, Danny Eckert was able to swim to and eventually clambered onto the reef. By the time he got to the reef he could not see the boat.[28] He saw his son in the water and assisted him to swim around to the calmer side and onto the reef. Danny's son is an excellent swimmer[29] but by the time he was close to the reef he had no energy left and was floppy as Danny dragged him onto the reef.[30] After dealing with a head injury sustained by his son, Danny used debris from the wreckage to build a wind break. He retrieved an esky from the water that he thought might be useful later as a floating device.[31] While setting up a place of relative safety on the reef, Danny saw the boat upturned at the rough end of the reef.[32] A short time later, a wave released the boat from the end of the reef.[33] Danny and his son stayed there as night fell and they tried to stay warm, as they watched the water rise up the reef and seals come and go. Danny saw life jackets floating in the water but did not take the risk of swimming out to get them as he had already retrieved items which would float.[34] He talked to his son and tried to keep his spirits up as he queried whether he was going to die.

14 After the group did not return home in the afternoon, the family contacted police and efforts commenced to find them. SAPOL asked its Water Operations Unit to become involved just before 9 pm.[35] Local police were tasked to check the boat ramp for Mr Bottrill's trailer, and they advised that it was found at Port Lincoln.[36]

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[21] Exhibit C7 at [5]
[22] Exhibit C7a at [18]
[23] Exhibit C7a at [18]
[24] Exhibit C7a at [23]
[25] Exhibit C7a at [26]
[26] Exhibit C7 at [7]
[27] Exhibit C7 at [7]
[28] Exhibit C7a at [28]
[29] Exhibit C7a at [16]
[30] Exhibit C7a at [28]
[31] Exhibit C7a at [30]
[32] Exhibit C7a at [31]
[33] Exhibit C7a at [31]
[34] Exhibit C7a at 32]
[35] Exhibit C13 at [3]
[36] Exhibit C13 at [8] and [11]

15 A phone triangulation was attempted, but no phones were connected.[37] There was one indication from 5.11 pm from Mr Bottrill's phone and one from 5.07 pm from Thomas Eckert's phone, which gave rise to an extremely large search area around Buffalo Reef.[38] Water Operations briefed the Australian Marine Safety Authority (AMSA) who advised that one of their Challenger jets would be available to assist, but would need to travel from Perth.[39]

16 At around 10.30 pm, SAPOL's Polair was requested to assist[40] but at the time there were two separate medical retrieval tasks being undertaken by helicopters, so a third crew was recalled to duty to assist.[41] In the meantime, one of the retrieval tasks was being completed and a crew soon became available. At the time of this incident Polair and the South Australian Ambulance Service (SAAS) had available for their shared use three helicopters managed by the State Rescue Helicopter Service. The three were not all similarly configured and, depending on the nature of the task, some reconfiguration might be required for different missions.[42]

17 The State Emergency Service (SES) was put on standby and broadcasts were made over VHF radio to boaters in the area.[43] At this time, the SES was not requested to assist searching immediately by boat because they had completed a rescue operation earlier in the night and there were reasonable concerns about exhausting the crew while searching an as yet ill-defined and very wide search area, to the point they might be unavailable if required to perform a rescue later in the night.[44]

18 The AMSA jet was tasked to assist and left Perth at 11.32 pm.[45] Shortly before that, at 11.20 pm, a determination was made that the winch-equipped helicopter was the most suitable SAPOL asset to use and that a paramedic should be on board.[46] It was specifically foreshadowed and advised that a winch operation at night would not be possible unless there was a visual land reference but taking the equipment was thought to be prudent.[47] It took about an hour to equip the helicopter with the equipment required for the mission. In the meantime, at 11.52 pm, SAPOL contacted the Tumby Bay Volunteer Marine Rescue Group to ask them to be on standby.[48]

19 The Polair helicopter, staffed and equipped, departed Adelaide Airport at 12.52 am, arriving at Buffalo Reef at 1.56 am.[49] They commenced searching using night vision goggles and infrared cameras.[50] At 1.59 am the overturned boat was spotted from the helicopter and the location was transmitted at 2.03 am.[51] By then it was about 1.7 nautical miles or 3 kilometres from the reef.[52] A few minutes later, the SAPOL camera operator

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[37] Exhibit C13 at [19]
[38] Exhibit C12 at [12] and Exhibit C13 at [21]
[39] Exhibit C13 at [20]
[40] Exhibit C13 at [23]
[41] Exhibit C12 at [9]
[42] Exhibit C12 at [4]
[43] Exhibit C10 at [3]
[44] Exhibit C13 at [26]
[45] Exhibit C13 at [32]
[46] Exhibit C12 at [13]
[47] Exhibit C13 at [28]
[48] Exhibit C13 at [33]
[49] Exhibit C12 at [15] and [23]
[50] Exhibit C12 at [22]
[51] Exhibit C13 at [36] and Exhibit C15 at [9]
[52] Exhibit C13 at [36]

observed a person holding onto the stern of the boat and turning their head.[53] They made a radio transmission providing details of what had been observed and requested a boat to attend. The Port Lincoln SES was asked to deploy.[54] Advice was received that the SES boat was ready to depart Port Lincoln once a paramedic arrived and then there would be significant travel time.[55]

20 At that point all options for the rescue of this apparent survivor were considered. The helicopter had winch equipment fitted but as previously mentioned was constrained not to conduct a winch retrieval at night without a visual land reference. To do so would require a low hover and the determination was made that to attempt a low hover above the overturned boat would present extreme risk to the person being rescued as well as the crew on board the helicopter. The difficult decision was made that no winch rescue would be attempted. This also meant that they were unable to safely or effectively drop the onboard life raft.[56] As I will detail further below, I find that there is no criticism to be made of this complicated decision.

21 In the time that followed, the helicopter searched the surrounding areas while maintaining observations on the person clinging to the boat.[57] At around 2.30 am, they flew to nearby Spilsby Island and tried unsuccessfully to contact moored boats by VHF radio. They used a spotlight to rouse an occupant of one of the boats, who then made contact. This person advised that he was solo and not in a position to navigate at night to assist. He advised that the other boats around were also all solo.[58] As the Challenger jet was to be arriving in about ten minutes, the helicopter left the area and travelled to a cargo ship, Admiralty Spirit, and made contact. The cargo ship agreed to assist and advised they would be at the location of the overturned boat in approximately an hour.[59]

22 The AMSA Joint Rescue Coordination Centre (JRCC) was also able to engage a cruise liner, Pacific Explorer, to assist, although it was also travelling from some distance away.[60]

23 From about 2 am when the water was about a foot below the portion of the reef that Danny and his son were sheltering on,[61] the helicopter flew nearby and Danny used the green light of a Fitbit to try to attract attention, which he continued to do when he saw the Challenger aircraft in the area.[62]

24 At 2.44 am, the Challenger jet crew advised that they believed there was a person on the reef, although this was awaiting their closer confirmation, which came through at 2.56 am.[63]

25 By this time, the Polair helicopter was nearing the limit of its fuel capability. They conducted a low pass and threw a strobe light to assist the cargo ship to find the overturned

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[53] Exhibit C12 at [25]
[54] Exhibit C13 at [37]
[55] Exhibit C12 at [26]
[56] Exhibit C12 at [27]
[57] Exhibit C12 at [28]-[29]
[58] Exhibit C12 at [31]
[59] Exhibit C12 at [34]
[60] Exhibit C13 at [40]
[61] Exhibit C7a at [37]
[62] Exhibit C7 at [8]
[63] Exhibit C13 at [40] and [42]

boat. At this time, the person clinging onto the boat was waving to the helicopter.[64] At 2.50 am, the helicopter was required to leave to refuel at Port Lincoln. A plan was formulated to fly directly to Buffalo Reef and make an assessment about a winch rescue from the rocks. All unnecessary weight was removed from the helicopter with the aim of extending fuel endurance and preparing the aircraft for an extra passenger should a winch rescue be possible.[65]

26 The SES vessel left Port Lincoln at 2.48 am and located the upturned boat at 4.04 am but sadly found no person around or responding from under it.[66] There was obvious hull damage from a collision.

27 When the Polair helicopter returned to Buffalo Reef, they observed Danny on the rocks waving.[67] They assessed that it would be dangerous for a vessel to approach the reef and that a winch rescue was appropriate at this location. Danny and his son were then winched up between 4.45 am and 4.51 am and taken to Port Lincoln for medical attention.[68] They were met at the airport by an ambulance at 5.12 am.[69]

28 The Polair crew were required to undergo fatigue assessments and apply for an extension to their flight hours, which was approved. They left at 6.09 am and returned to the search area.[70] They continued searching until 7.30 am when they were forced to return to refuel and were not permitted to extend their flying hours.[71]

29 At about 6.30 am, Pilot Vessel Norfolk located the body of Paul Eckert floating in the water.[72] The SES vessel was called in to retrieve Mr Eckert's body and a paramedic on board declared life extinct.[73] Mr Eckert had a phone in a case attached to his belt.[74]

30 Just before it was released from assisting at 8.40 am, notification was received from the Pacific Explorer that the body of Mr Bottrill had been located about 2.3 nautical miles northwest of the reef.[75] The body was then retrieved from the water by the Cowell SES vessel and conveyed to the Port Lincoln boat ramp, where a paramedic declared life extinct.[76]

31 At 7.52 am, the upturned boat was able to be retrieved onto a fishing vessel, Delamere, which was assisting in the search and had a crane.[77] The lifting process was done carefully to ensure that anyone under the boat could be retrieved. However, there was no person underneath. The EPIRB was found in place, not activated.

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[64] Exhibit C12 at [36]
[65] Exhibit C12 at [38]
[66] Exhibit C12 at [39], Exhibit C13 at [41] and [48], Exhibit C14 at [14] and Exhibit C15 at [13]
[67] Exhibit C12 at [40]
[68] Exhibit C7a at [39] and Exhibit C12 at [42]-[43]
[69] Exhibit C12 at [45]
[70] Exhibit C12 at [49]
[71] Exhibit C12 at [50]
[72] Exhibit C10 at [8] and Exhibit C13 at [61]
[73] Exhibit C10 at [11], Exhibit C16 at [11] and Exhibit C19d
[74] Exhibit C10 at [10]
[75] Exhibit C11 at [5] and Exhibit C13 at [66]
[76] Exhibit C16 at [12] and Exhibit C19f
[77] Exhibit C10 at [12] and Exhibit C13 at [62]-[63]

32 The search continued through the morning, but with a number of search assets retiring due to fatigue as time went on.[78] The Cowell rescue boat had returned to the search area after conveying Mr Bottrill's body to Port Lincoln and, at 2.13 pm, about 2.6 nautical miles northwest of the reef, they located Thomas Eckert's body and retrieved it from the water.[79] Thomas Eckert's body was conveyed to the Port Lincoln boat ramp where a paramedic declared life extinct.[80]

33 The search was then completed, and all assets assisting were released. I consider that the efforts to locate the missing boat were comprehensive and well-organised. I particularly note the use of resources from across different organisations and the quick engagement of volunteer and private resources. Appropriate precautions were taken, such as ensuring that there was paramedic support. Additional resources were put on notice early to allow for a quicker response when an appropriately sized search area could be ascertained.

Post-mortem examinations and causes of death

34 Senior specialist forensic pathologist Dr Cheryl Charlwood performed post-mortem examinations upon the bodies of Paul Eckert, Thomas Eckert and Mr Bottrill. In relation to Paul Eckert, Dr Charlwood found areas of laceration, abrasion and bruising to the forehead and scalp, and areas of bruising to the chest and limbs. She found hyperexpanded lungs with fine opacities and fluid within the airways. Dr Charlwood concluded that Paul Eckert's death was as a result of drowning.[81] In respect of Thomas Eckert, Dr Charlwood found areas of bruising and abrasion with disruption of the right arm with ulnar and radial fractures. She found hyperexpanded lungs with fine opacities and fluid in the sinuses and airways. Dr Charlwood concluded that Thomas Eckert's death was as a result of drowning.[82] In respect of Mr Bottrill, Dr Charlwood found head and facial injuries with a subarachnoid haemorrhage over the brain, as well as multiple rib fractures and a right pneumothorax. There was subcutaneous emphysema. She found hyperexpanded lungs with fluid in the airways. Dr Charlwood concluded that Mr Bottrill's death was as a result of drowning with head and chest injuries.[83]

35 I accept the evidence of Dr Charlwood and I enter findings as to the causes of death for Mr Bottrill, Thomas Eckert and Paul Eckert in line with her opinions.

Boat examination

36 Brevet Sergeant Anthony Perchard conducted an examination of the overturned boat and the debris recovered. Brevet Sergeant Perchard found that the canvas canopy and frame were completely missing, as was the windshield.[84] There was extensive damage to the entire vessel with numerous segments of the hull missing as well as holes in other parts and splits and gouges to the cabin. There was impact damage to the bow. I am satisfied that the condition of the boat played no role in the incident.

37 The registration of the boat's EPIRB, which had not been activated, was recorded by AMSA as renewed on 15 March 2022 and expired on 14 March 2024, 11 days before the

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[78] Exhibit C13 at [67]
[79] Exhibit C11 at [14] and Exhibit C13 at [70]
[80] Exhibit C16 at [15] and Exhibit C19e
[81] Exhibit C4a
[82] Exhibit C4b
[83] Exhibit C4c
[84] Exhibit C17 at 21

incident. Expired registration would not have affected its operation if it had been activated. Since then, in November 2024, AMSA stopped renewing the registration of beacons and they are all listed in the database as registered with no registration expiry date.[85]

38 Brevet Sergeant Perchard noted that one lifejacket recovered had a service due tag of December 2022 with a date serviced of December 2021.[86] It had automatically inflated, as it was meant to, when it entered the water. The other, which had a serviced date of November 2021, was entangled with other debris and it was not clear whether or not it had been inflated. There was also a dog lifejacket recovered.[87]

Kangaroo Island

39 The second incident occurred on Wednesday, 14 August 2024, a short distance offshore from Cape Cassini on Kangaroo Island. This incident claimed the lives of 65-year-old David Neave and 65-year-old Rodney Ingram.

Mr Neave and Mr Ingram

40 Growing up, Mr Neave was quiet but cheeky. He was one of three siblings. He was focussed on two things: fishing and football. He was accorded the nickname 'Rock Cod' and became a professional fisherman.[88] As a kid, he had had some swimming lessons, but nothing advanced.

41 Mr Ingram and Mr Neave were essentially step-cousins.[89] Mr Ingram was one of four siblings. He was interested in football, following Collingwood, Norwood and Wisanger locally.[90] After leaving school he did an apprenticeship as a printer, making plates for the local newspaper.[91] He then did some farm work before moving into professional fishing, supplemented by some occasional gardening work. Mr Ingram was not a great swimmer.[92]

42 After some time fishing together for fun, Mr Neave and Mr Ingram commenced fishing together professionally in the early 1990s, launching from Mr Neave's family's land at Cape Cassini.[93] This was chosen because it was a safe location to launch from, although occasionally seaweed would cause obstruction. There was a channel through the reef out to sea.[94] They used a 4.8-metre-long Nesscraft fibreglass boat with a 70 horsepower Yamaha engine.[95] The boat was first surveyed in 1990.[96] Mr Ingram formally held the commercial fishing licence.[97] Under the licence, they were entitled to take nearly three tonnes of King George whiting and more than half a tonne of calamari.[98]

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[85] Exhibit C19 at Annexure D
[86] Exhibit C17 at 15
[87] Exhibit C17 at 19
[88] Exhibit C27 at [7]
[89] Exhibit C27 at [8]
[90] Exhibit C28 at [8]
[91] Exhibit C28 at [6]
[92] Exhibit C28 at [7]
[93] Exhibit C28 at [11]-[12]
[94] Exhibit C33 at [11]
[95] Exhibit C29 at [8], Exhibit C38 at 11, Exhibit C38f and Exhibit C38l at 6
[96] Exhibit C38l at 25
[97] Exhibit C30 at [5]
[98] Exhibit C30 at [7]

43 Mr Ingram's brother observed that if the conditions were 'swelly', they would come in and not fish for the day, never taking risky chances.[99] Colin Joy lived in the house on the beach at Cassini and says that they would fish 'when the weather was right'.[100] Mr Neave's sister says that they would usually circle before coming in to recover the boat and would remove their waders and some clothing so they could jump in the water and bring the boat in.[101]

44 In the weeks before the incident, there was another incident where Mr Ingram was standing in the water holding the boat, waiting for Mr Neave to back the trailer down, when a swell came up against the boat and knocked Mr Ingram into the rocks, causing injuries to his shin.[102] He had to stop walking for exercise and he put on a bit of weight.

14 August 2024

45 At about 8 or 9 am on 14 August 2024, Mr Neave and Mr Ingram launched as usual, leaving their dogs with Mr Joy.[103]

46 Mr Joy recalls that there was a bit of swell, but that it was clearing up when they went out.[104] At about 10 am, a fog rolled in, severely reducing visibility.[105] The conditions otherwise remained calm. Mr Ingram's brother says that he noticed a thick blanket of fog coming into Kingscote which was generally unusual but had happened the week prior.[106] The Bureau of Meteorology recorded a maximum temperature of 19.5 degrees[107] with high tide at 9 am and a dodge tide following. There was a 5 km/h east-north-east wind at 8.30 am with gusts up to 8 km/h.[108]

47 Another recreational fishing group also went out that day, launching from nearby Emu Bay.[109] A retired commercial fisherman on that boat said that the swell was a 'long lazy swell' of no more than one metre. They passed Mr Neave and Mr Ingram at about 1 pm, but did not speak.[110] During the afternoon, the Bureau of Meteorology recorded an increase in wind speed to between 11 km/h and 18 km/h.[111]

48 At about 1.30 pm Mr Joy went down to the beach and saw that there was something in the water, but the fog prevented him from making out what it was.[112] Later in the afternoon, he worked out that it was an overturned boat. It was about 150 metres offshore.[113] Mr Joy tried to call triple zero but encountered difficulty operating his phone and then called a friend, asking him to call triple zero. Police were first notified at 4.17 pm.[114]

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[99] Exhibit C28 at [14]
[100] Exhibit C29 at [4]
[101] Exhibit C27 at [15]
[102] Exhibit C28 at [18]
[103] Exhibit C29 at [8]-[9]
[104] Exhibit C29 at [12]
[105] Exhibit C31 at [4]
[106] Exhibit C28 at [22]-[23]
[107] Exhibit C35 at Annexure C1
[108] Exhibit C35 at [10] and Exhibit C38l at 51
[109] Exhibit C31 at [3]
[110] Exhibit C31 at [7]
[111] Exhibit C35 at [10]
[112] Exhibit C29 at [15]
[113] Exhibit C36 at [4]
[114] Exhibit C36 at [2]

49 At 4.39 pm, police contacted the local Senior Fisheries Officer, Aaron Ledard, to commence assembling search assets and to gain local information.[115] Senior Constable Gary Camac immediately travelled to Cape Cassini, arriving at about 5 pm.[116] Police dispatched a helicopter to the area.[117] There was a delay in the helicopter's dispatch as police had one helicopter committed to a search and a second committed to a medical evacuation.[118] A search area was formulated around the overturned boat to find Mr Neave and Mr Ingram.[119]

50 Simultaneously, the Kangaroo Island Coast Guard was contacted and assembled a team, heading to the area with their boat, 'the Cygnet'.[120]

51 Very shortly after arriving at the search area at 5.18 pm, the Polair helicopter spotted one person about 50 metres east of the overturned boat and 25 metres offshore and another about 250 metres further east.[121] The helicopter notified the location and left the scene to refuel. Police on the shore went to the location and Mr Ingram's body was able to be retrieved onto rocks and then later brought to land using a stretcher.[122]

52 The Coast Guard boat arrived at about the same time as the helicopter returned from refuelling and the volunteers retrieved Mr Neave's body from the water.[123] At that time, the weather was calm with a one metre swell and fog remaining. Mr Neave's body was about 50 metres from shore.[124] Neither man was wearing pants.

53 A paramedic made declarations of life extinct at the scene.[125]

54 Once again, the response of the authorities was swift and robust. It involved numerous SAPOL assets as well as volunteer resources. It resulted in Mr Neave's and Mr Ingram's bodies being found just more than one hour after police were first notified. The delay in notification was not critical. It is clear from Mr Joy's evidence that the incident occurred early in the afternoon, and indications are that Mr Neave and Mr Ingram had been in the water deceased for some hours.

Post-mortem examination and causes of death

55 Dr Charlwood performed post-mortem examinations upon the bodies of Mr Neave and Mr Ingram. In relation to Mr Neave, Dr Charlwood found fluid within the sinuses and airways and overexpansion of the chest wall and lungs with fine opacities as well as pleural effusions. There was evidence of cardiac issues. Dr Charlwood concluded that Mr Neave's death was as a result of drowning.[126] In respect of Mr Ingram, Dr Charlwood found overexpansion of the chest wall and lungs, small pleural effusions, a fluid-filled

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[115] Exhibit C30 at [3]
[116] Exhibit C36 at [3]
[117] Exhibit C35 at [4]
[118] Exhibit C35 at [5]
[119] Exhibit C35 at [4]
[120] Exhibit C35 at [6]
[121] Exhibit C35 at [6]
[122] Exhibit C36 at [6] and [11]
[123] Exhibit C32 at [3]
[124] Exhibit C32 at [9], Exhibit C33 at [7] and Exhibit C34 at [7]
[125] Exhibit C38b and Exhibit C38c
[126] Exhibit C24a

trachea and main bronchi as well as fluid in the sinuses. Dr Charlwood concluded that Mr Ingram's death was as a result of drowning.[127]

56 I accept Dr Charlwood's advice about Mr Neave's and Mr Ingram's causes of death and I enter findings to that effect.

Boat examination and reconstruction of events

57 The next day police returned to the area to recover the overturned boat.[128] Police divers inspected it. They found that the EPIRB was still in its housing in the cabin and that the key was turned to the operating position with the throttle in the forward position.[129] The anchor rope was tied around the cabin railing. In the bow they found lifejackets and life rings secured down. It was a difficult recovery, and the boat had to be towed inverted.[130] The anchor was found nearby. The water depth where the boat was found was about five metres.[131]

58 The boat was examined by Jamieson Marine on Kangaroo Island.[132] There was no hull damage and other than damage to the windshield there were no indications of any impact with any object.[133] I accept that there was nothing about the boat's condition which brought about the incident. The EPIRB battery was within its expiry date. The lifejackets were in good condition. An analysis of the motor recorded between 4,500 and 4,250 revolutions per minute for eight continuous minutes until the engine ceased operating.[134] This reflects a speed of around 18 to 20 knots in the lead-up to the capsizing.

59 AMSA conducted a joint investigation with SAPOL. They identified that the boat had not been issued a Certificate of Operation since last expiry in 2019 and was not exempted from having a current Certificate of Operation.[135] It was identified that Part G of the *National Standard for Commercial Vessels* mandated the use of lifejackets by Mr Neave and Mr Ingram at all times.[136]

60 The investigating officer has provided his opinion that whatever occurred, it was certainly unexpected and sudden and occurred while Mr Neave and Mr Ingram were heading in to retrieve their boat at shore, which explains why they had taken their pants off as was their usual practice. AMSA investigators concluded that it was likely that the fog obstructed visual landmarks that they used to navigate the reef system and that they may have inadvertently navigated close to a fringing reef where the waves are influenced by the reef, resulting in a wave taking them by surprise.[137] I consider capsize in such circumstances to be a plausible and likely scenario.

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[127] Exhibit C24b
[128] Exhibit C35 at [7]
[129] Exhibit C35 at [8] and Exhibit C38l at 15-16
[130] Exhibit C38 at 11
[131] Exhibit C38l at 11
[132] Exhibit C38d
[133] Exhibit C38 at 11
[134] Exhibit C38 at 11
[135] Exhibit C38l at 34
[136] Exhibit C38l at 53
[137] Exhibit C38l at 52

Anxious Bay

61 The third incident under investigation occurred on Saturday, 30 November 2024 off Cape Finniss at the southern end of Anxious Bay, close to Elliston. This incident claimed the life of 77-year-old Peter Martin.

Mr Martin

62 Mr Martin met his wife in 1965 and they married in 1967. They lived in Whyalla and raised two children. Mr Martin was a painter and decorator and an Army reservist. In 1975, they purchased a property in Elliston, and the family moved there the following year.[138] In Elliston, Mr Martin continued his painting and decorating work and took on other work as a handyman. He involved himself in community events. He volunteered as an ambulance driver, assisted with marine rescues and was a Justice of the Peace.[139] From 1977, he worked as a commercial fisherman, taking on his own crayfishing licence in 1982. He was accorded the nickname 'Pedro'.

63 When he was 59 years old, Mr Martin had a double heart bypass from which he recovered fully and returned to work.[140] Around 2020/2021, Mr Martin had an operation to remove a small lung cancer and again fully recovered.[141]

64 In 2014, at the age of 67, he retired but continued to fish recreationally.[142] Sometimes he would fish with friends and at other times he fished alone. He had a 4.75 metre Quintrex ReefHunter Caprice centre console aluminium boat with an electric pot winch fitted.[143] The boat was constructed in 1999,[144] but had recently had a new motor installed.[145] Mr Martin stopped registering the boat in 2020 and continued to use it unregistered.[146] In recent crayfishing seasons, he would regularly set and check cray pots with a friend, Ashley Traeger, who happens to be a police officer, and in that capacity was later involved in the search for Mr Martin.[147]

30 November 2024

65 On 30 November 2024, Mr Martin went out to check his two cray pots, which he had set a few days earlier.[148] A friend, Tim Taylor, met him at the boat ramp at about 6.40 am and helped him launch.[149] The Bureau of Meteorology recorded a temperature of 17.9 degrees at 9 am with a west-south-west wind of 7 km/h.[150] There was a 1.5 to 2 metre swell. Mr Martin put on his usual high-visibility jacket. According to reports he did not

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[138] Exhibit C41a at [4]
[139] Exhibit C41a at [5]
[140] Exhibit C41a at [8]
[141] Exhibit C41a at [11]
[142] Exhibit C41a at [9]
[143] Exhibit C47 at [20]
[144] Exhibit C70 at [30]
[145] Exhibit C70 at [33]
[146] Exhibit C49c and Exhibit C70 at [30]
[147] Exhibit C45 at [3]
[148] Exhibit C41a at [12]
[149] Exhibit C44 at [3]
[150] Exhibit C46 at [33] and Exhibit C47 at [44]

usually wear a lifejacket.[151] Later that morning, Mr Taylor went out to check his own cray pots and noticed that he did not see Mr Martin or his boat.[152]

66 By 1 pm friends had noted the unusual circumstance of Mr Martin having not returned to shore and began to look for him.[153] Mr Traeger received a call from a friend and attended the boat ramp before reporting a potential marine incident through police communications.[154] At 1.18 pm, SAPOL's Water Operations Unit, SES, Polair and SAAS were notified.[155] A search was commenced which initially involved six local fishing boats and a plane from Flinders Island.[156] Further assets were also requested and deployed, including a Polair fixed wing aircraft and winch-capable helicopter as well as water rescue boats from the Port Lincoln and Ceduna SES, with varying travel time involved.

67 A phone triangulation was conducted, returning a very wide potential area as a result of a last connection at 6.36 am.[157]

68 Enquiries were made with the AMSA JRCC, but it was agreed that the number of assets SAPOL was able to commit quickly meant that AMSA resources were not required, although the JRCC commenced work on drift modelling. A command post was established at the Anxious Bay boat ramp before 3 pm.[158] Brevet Sergeant Milsom, who was coordinating the search, also conducted his own drift analysis which provided a search area around Mr Martin's cray pot location, that is about 500 metres off Cape Finniss, the headland between Waterloo Bay and Anxious Bay. The drift analysis showed the majority of drift particles being pushed to shore.[159] Brevet Sergeant Milsom advised local police that if Mr Martin had gone into the water and drowned, then his body would likely be brought ashore by the current in Anxious Bay.[160]

69 Polair advised that the fixed wing aircraft would arrive at 5 pm and the winch-capable helicopter would arrive at 6 pm.[161] Brevet Sergeant Milsom instructed the fixed wing to first search the coast and then to do a search pattern over ocean.

70 Just before 4 pm, Mr Traeger noticed something on the shore and then found several items at the high tide mark which he knew had come from Mr Martin's boat.[162] Then he found Mr Martin's body and retrieved it from the water.[163] He could not find a pulse and noted rigor mortis. Mr Martin was wearing jeans, brown slip-on shoes, a flannel jacket and a high-visibility vest. He was not wearing a lifejacket.[164] All search assets were called

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[151] Exhibit C46 at [23]
[152] Exhibit C44 at [5]
[153] Exhibit C45 at [6]
[154] Exhibit C45 at [7]
[155] Exhibit C49 at 6
[156] Exhibit C45 at [7] and Exhibit C49 at 6
[157] Exhibit C49 at 6
[158] Exhibit C46 at [13]
[159] Exhibit C46 at [20]
[160] Exhibit C48 at [13]
[161] Exhibit C46 at [22]
[162] Exhibit C45 at [9]
[163] Exhibit C45 at [10]
[164] Exhibit C46 at [40]

off.[165] Mr Martin's body was taken to the hospital where a registered nurse made a declaration of life extinct.[166]

71 The search effort was well managed and effective. It involved the quick engagement of SAPOL and volunteer resources, to the extent that AMSA saw no role for their services, other than to provide drift modelling which Brevet Sergeant Milsom also undertook. The limited role required of AMSA highlights the comprehensiveness of the response that was able to be arranged within South Australia. A forward command was set up close to the search area, which was quite close to shore, and resources were used in a methodical and appropriately planned way.

Post-mortem examination and cause of death

72 A limited post-mortem examination was conducted by senior specialist forensic pathologist Dr Stephen Wills. Dr Wills found hyperexpanded crepitant lungs and bilateral pleural effusion as well as evidence of cardiac issues and emphysema. Dr Wills concluded that Mr Martin's death was as a result of drowning on a background of ischaemic heart disease (operated) and cardiomegaly.[167]

73 I accept Dr Wills' opinion as to Mr Martin's cause of death and enter a finding to that effect.

Recovery of the Boat and Reconstruction of Events

74 The marker buoys of one of Mr Martin's cray pots were found floating on the surface with the rope attached as normal to the pot on the sea floor. The floats of the second pot, which would customarily be set nearby, were not found on the surface.[168] On 15 December 2024, members of SAPOL's Water Operations Unit attended Anxious Bay and conducted a diving operation around the known location of Mr Martin's first cray pot.[169] An underwater drone was used to search the area until Mr Martin's boat was located. It was upside down on the sea floor about 488 metres offshore[170] at a depth of 26.6 metres. It was a short distance away from the second cray pot, the rope of which could be seen emerging from under the rear starboard quarter of the boat.[171] Police divers went down to examine the scene.[172]

75 A video taken by the police divers shows a situation which strongly suggests an explanation for the sinking of the boat.[173] Mr Martin's second cray pot was on the sea floor underneath an overhanging section of reef. One of the police divers can be heard to describe it as a cave. Attached to the cray pot was a rope that extended up and over the ledge then along the reef until it met the boat.

76 The positions of the boat, pot and rope indicate that the pot was snagged under the reef, and, as a result, Mr Martin would have encountered difficulty in retrieving it. Mr Traeger

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[165] Exhibit C46 at [26]
[166] Exhibit C48 at [30]
[167] Exhibit C42a
[168] Exhibit C46 at [29]
[169] Exhibit C47 at [5]
[170] Exhibit C70 at [37]
[171] Exhibit C47 at [24]
[172] Exhibit C47 at [17]
[173] Exhibit C49g

explained the usual process, when he was on the boat with Mr Martin, that Mr Traeger would initially pull the pot rope by hand to ensure that the pot was not somehow stuck or caught and once he felt the pot start to move, he would wrap the rope around the electric pot winch and bring the pot to the surface.[174] If the pot was stuck on the sea floor Mr Traeger would hold the rope while Mr Martin drove the boat, circling the area in an attempt to pull it free. On the rare occasions this did not work, the rope would be looped around the rear cleat, to provide increased pulling force to the pot. The rope would not be tied off, to ensure that it could pull through the cleat in the event a large wave came through while trying to free the pot.[175]

77 Brevet Sergeant Doecke, who investigated and provided a final coronial report into Mr Martin's death, states that during the search effort in the afternoon, Mr Traeger provided some information to Water Operations Unit which included that Mr Martin's boat '*has an electric winch to pull up cray pots. The winch grabs fast and needs to be put in reverse quickly if the pot is stuck on the bottom, or else the power of the winch can pull the boat underwater*'.[176] In the circumstances, I regard this as a reliable account of the characteristics of the winch and a clear indicator that using the winch from the outset, instead of first pulling by hand, may not have been out of the question for Mr Martin.

78 In this instance, Mr Martin was working alone and did not have Mr Traeger to help him. If he used the winch from the outset and the pot was snagged, and he failed to reverse the winch quickly enough, this would lead to the winch side of the boat being pulled underwater as described above and the boat would capsize. Sergeant Innes and the other Water Operations Unit police involved in the investigation and retrieval regard this as a plausible explanation for what occurred, an opinion with which I agree. It was also observed that the sinking of the vessel could have been assisted by the pot winch continuing to pull the line until failure of the motor or its electrical supply due to ingress of water. [177]

79 Another possibility might be that Mr Martin attempted to pull the pot free using the power of the boat and a wave swamped the boat while it was pulling on the pot rope.

80 I find that Mr Martin's boat capsized as he attempted to retrieve a cray pot which was snagged on the sea floor, most likely as a result of an accident while winching the pot rope.

Boat examination

Lifejackets

81 The boat contained yoke style inflatable lifejackets and an EPIRB which was still within its cradle.[178] It may be seen from photographs that the lifejackets had not been inflated.[179] I have received no information about whether inflation mechanisms were of a manually deployed type or automatically deployed upon immersion in water, or any details of

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[174] Exhibit C45a at [3]
[175] Exhibit C45a at [4]
[176] Exhibit C49 at 10
[177] Exhibit C70 at [33], Exhibit C47 at [30]
[178] Exhibit C47 at [40]
[179] Exhibit C49a, images 39, 40, 41 and 42

service records, if any exist. I have not asked for further advice about those matters because the evidence is clear that Mr Martin was not wearing a lifejacket.

Buoyancy material

82 The examination of the boat revealed that the buoyancy foam beneath the deck had been removed, likely when hull repairs had been conducted, with numerous empty plastic milk containers placed under the floor instead of original buoyancy material.[180] I heard evidence that the removal of buoyancy material and replacement with milk containers is not uncommon when repairs to the hull are undertaken, and allows easy access in the future.[181] Sergeant Innes explained that this provides less effective buoyancy than the manufacturer's buoyancy material particularly if taken underwater, where pressure increases and would constrict the bottles, as well as condensing air inside them, further reducing their buoyancy.[182]

83 I am unable to conclude whether or not the removal of the manufacturer's buoyancy material had an impact on what occurred. It is certainly clear that the numerous three-litre milk containers, which were presumably thought to be useful to prevent the boat from sinking, were entirely ineffective in doing so. I can readily observe that if the boat had not sunk, Mr Martin might have been able to cling to it until help arrived or even have retrieved a lifejacket from the boat.

Stickers indicating the boat's length

84 The vessel is registered as 4.75 metres in length. Photographs show that the boat originally had stickers on its sides stating '475 ReefHunter Caprice' identifying the vessel as a 4.75 metre vessel. The numbers '475' had been replaced with more recent stickers stating '485'.[183] Brevet Sergeant Doecke observed in her statement that alterations to stickering is done to mislead authorities as to the length of the vessel to avoid being detected not wearing lifejackets where their vessel is under 4.8 metres.[184] Sergeant Innes of the SAPOL Water Operations Unit gave evidence that the practice of modifying stickers to misrepresent a boat's length in order to deceive authorities was first observed by police in 2017 when the law was changed to require all persons on board to wear a lifejacket in vessels less than 4.8 metres.[185]

Beachport

85 The fourth incident occurred on Monday, 6 January 2025 off Point Connor, in Rivoli Bay near Beachport. This incident claimed the lives of 69-year-old Victor Kent and 82-year-old Roger Walker.

Mr Kent and Mr Walker

86 Mr Kent grew up and lived in Millicent with his wife of nearly 34 years.[186] He had four children. He had a career as a farmer and shearer. Later in life, Mr Kent experienced

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[180] Exhibit C49 at 24 and Exhibit C49a at 23-26
[181] Transcript, p60
[182] Transcript, p61
[183] Exhibit C49a images 052 and 053
[184] Exhibit C49 at [71]
[185] Exhibit C70 at [32]
[186] Exhibit C55 at [2] and Exhibit C55a at [23]

cardiac issues and had a defibrillator fitted in 2018.[187] He had high blood pressure and some breathing issues managed with a puffer. He was diagnosed with congestive cardiac failure. He had some sleeping issues and some depression.[188] Mr Kent's doctor said that his physical fitness was poor.[189]

87 Mr Kent owned a boat, 'the Squirrel', which he and Mrs Kent used almost every day. It was a 5.75-metre aluminium hull Surtees Workmate manufactured in 2017. It had a motorised pot winch and a pot tipper.

88 Mr Walker grew up and lived in Millicent with his partner of more than 25 years.[190] He was one of eight children, and he had two children himself. He played and later coached football and cricket. He started his working life on a farm and then at the paper mill before commencing grounds work at the Millicent Hospital.[191] He worked there for about 25 years until his retirement at the age of 67.

89 Mr Walker experienced some cardiac issues, with stents inserted in about 2004 and a pacemaker fitted in about 2020.[192] He used blood pressure reducing medication. He had chronic renal failure. A diagnosis of diabetes was made, but this was managed by diet and was not always detectable. Mr Walker's doctor said that he was mobile and active, but his capability would be very limited if he was required to exert himself.[193]

90 Mr Walker enjoyed fishing. He would go out every day other than when the weather was not suitable.[194] In about 2019, Mr Walker and Mr and Mrs Kent began fishing together using Mr Kent's boat to operate cray pots, usually in the morning.[195]

6 January 2025

91 In early January 2025, the weather was poor, and the seas were rough. They had not been able to check their cray pots for a few consecutive days.[196] In the morning of Monday, 6 January 2025, Mr Walker got up at about 6 am and headed to Mr Kent's house. They left soon after and launched the Squirrel from Southend beach at about 6.30 am.[197] Mrs Kent recalls that the weather was quite windy but not too bad. The Bureau of Meteorology recorded a maximum temperature at 9 am of 17.1 degrees with a south-south-west wind of 22 km/h.[198] By 3 pm, that wind had picked up to 48 km/h.

92 Mr Kent put on a lifejacket. Mrs Kent says she is certain that he was wearing it, as she recalls zipping it up.[199] He usually wore one so that he did not get water on his clothes pots were being pulled.[200] Mrs Kent and Mr Walker did not wear lifejackets and did not

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[187] Exhibit C55a at [25]
[188] Exhibit C55a at [27]
[189] Exhibit C64 at [11]
[190] Exhibit C51a at [2]-[3]
[191] Exhibit C51a at [7]
[192] Exhibit C51a at [8]-[9]
[193] Exhibit C65 at [14]
[194] Exhibit C51a at [16]
[195] Exhibit C51a at [17]
[196] Exhibit C55a at [11]
[197] Exhibit C55 at [4]
[198] Exhibit C63d
[199] Exhibit C55a at [9]
[200] Exhibit C55a at [7]

usually do so.[201] They motored for about three kilometres in the direction of Beachport to the area where their six pots were set.[202] They lifted one and then moved to the second. As they were attempting to retrieve the second pot, the rope became tangled around the boat's propellor.[203] The boat was, by then, pointing towards the shore with an onshore wind and waves coming in against the stern.[204] The rope around the propeller was attached at its other end to the cray pot on the sea floor and was pulling the stern of the boat downwards.[205] Mr Kent leaned over the rear and used a gaff to try to free the rope but was not able to. He then tried to cut the rope, but he could not reach the rope below the propellor.[206] The boat had a rear transom door, essentially an access cutout with a gate, which was open. There was a warning label which stated it was a watertight closure and warned users to keep the door shut when under way.[207] This opening started to take on water from the waves.[208] Mrs Kent turned on the bilge pump, but it did not seem to work even though it had worked the last time the boat was cleaned a few days before.[209]

93 As more water came in, the boat rolled onto its side and then quickly overturned.[210] During this movement, the three people went into the water. Mrs Kent surfaced first and when Mr Kent surfaced, he was face down.[211] Mrs Kent tried to turn him over but could not.[212] He was not moving.

94 Mr Walker then came up beside Mrs Kent. Mrs Kent used a rope that was attached to the boat to wrap around herself and then told Mr Walker to wrap it around him. She clung onto it tightly.[213] When the water had first been coming into the boat, Mrs Kent had handed Mr Walker a lifejacket and told him to put it on. He began to, but very quickly they were in the water and Mrs Kent did not see Mr Walker get the jacket on.[214]

95 Mrs Kent and Mr Walker floated with the boat towards the shore until Mrs Kent was able to touch the bottom. She told Mr Walker that she could feel the sand and he replied to her. She made her way towards the beach thinking Mr Walker was following her.[215] She describes the tide being incredibly strong and it was exhausting getting to shore. After several steps she looked back and Mr Walker was gone.[216] Mrs Kent reached the beach and collapsed on the sand.

96 At about 11 am a local resident Jordan Brooks heard that Mr and Mrs Kent had not returned to shore and drove along the beach looking for them.[217] He knew that their cray pots were usually set near Sherbert Rock. At about 11.30 am when he reached Point

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[201] Exhibit C55 at [5]
[202] Exhibit C55a at [8]
[203] Exhibit C55 at [6]
[204] Exhibit C55a at [12]
[205] Exhibit C55a at [14]
[206] Exhibit C55a at [18]
[207] Exhibit C63c at 5
[208] Exhibit C55 at [7], Exhibit C55a at [13] and Exhibit C55b at [3]
[209] Exhibit C55a at [15]
[210] Exhibit C55a at [19]
[211] Exhibit C55a at [19]
[212] Exhibit C55 at [10]
[213] Exhibit C55a at [20]
[214] Exhibit C55 at [10]
[215] Exhibit C55 at [12]
[216] Exhibit C55a at [21]
[217] Exhibit C56 at [4]

Connor he saw the Squirrel overturned about 20 to 50 metres offshore.[218] Mr Brooks phoned another person who phoned police. After that Mr Brooks noticed Mrs Kent on the beach. He gave her his shirt and a jumper. Other people came to assist. Mr Brooks drove back towards Beachport. About 500 metres away he saw items from the boat. Among the items there was an EPIRB and two lifejackets.[219] He then encountered Mr Kent's body in the shallows. Mr Kent was wearing only a shirt, which was washed up to his armpits.[220] Mr Brooks dragged him onto the beach.[221] He checked for a pulse but found none and he detected no breathing. He rolled him into the recovery position.

97 Mr Brooks then saw another object further up the beach and drove on about 150 metres where he found Mr Walker's body.[222] Mr Walker was wearing underwear, shoes, a shirt and long sleeve top.[223] A leg of his pants was caught on his left shoe.[224] Again, he checked for a pulse and found none, and no signs of breathing. He commenced CPR which produced foam and water from the mouth. Mr Brooks then phoned for an ambulance and continued CPR, with a brief break, until police arrived and took over.[225] The police who arrived split up, giving attention to both Mr Kent and Mr Walker.[226] Police then made a determination that Mr Kent had died and directed that CPR be ceased.[227] The CPR effort continued in respect of Mr Walker. Paramedics then arrived and made a declaration of life extinct in respect of each man.[228]

98 On the beach, police located and seized various items which had been washed up. There was one Stormy Seas vest in a plastic bag and two others loose and unzipped.[229] Following the inquest hearing, I arranged for Senior Constable Halleday, the crime scene examiner involved in this case, to undertake close inspections of the two loose Stormy Seas vests, which I am satisfied are the one which Mr Kent was wearing that day and the one which was handed by Mrs Kent to Mr Walker as the boat was capsizing. Senior Constable Halleday provided a second statement[230] and some photographs which were received into evidence.[231] The labels of the vests provided important information.

99 The medium-sized lifejacket, which I assume to be the one handed by Mrs Kent to Mr Walker, was manufactured in 2004. It complied with Australian Standard AS1512. This was not compliant with the requirement which commenced on 1 January 2025 that all lifejackets worn for boating in South Australia must meet Australian Standard AS4758. The immersion activated inflation system had not activated,[232] despite its immersion in water. The CO_2 cartridge was severely rust affected. There was a stamp on the inflation system stating 'REPLACE BY 02 2015'. Having regard to the manufacturer's recommendations[233] that seven years is the accepted lifespan of an

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[218] Exhibit C56 at [8] and Exhibit C62 at [23]
[219] Exhibit C56 at [23]
[220] Exhibit C62 at [21]
[221] Exhibit C56 at [26]
[222] Exhibit C56 at [29]
[223] Exhibit C60 at [11]
[224] Exhibit C62 at [13]
[225] Exhibit C56 at [36]
[226] Exhibit C60 at [6]
[227] Exhibit C57 at [5] and Exhibit C61 at [3]
[228] Exhibit C60 at [9], Exhibit C63a and Exhibit C63b
[229] Exhibit C62 at Appendix A, Image 013
[230] Exhibit C62e
[231] Exhibit C62f
[232] Exhibit C62e at [12]
[233] See www.stormylifejackets.com.au/faqs/

inflatable lifejacket that is serviced regularly and well-maintained and that 10 years would be the maximum lifespan before it should be replaced, I am confident this notice applies to the entire lifejacket and not just to the inflation system. Although there was a service tag attached to the inflation mechanism, I was not informed of the date of service, but I infer that this was prior to February 2015, the stated required replacement date.

100 I find that Mr Walker did not put on the lifejacket which Mrs Kent handed him, which is unsurprising given the emergency in which he found himself. If he had put it on it would have been of no assistance as, due to its age and lack of service, it did not inflate upon contact with the water. However, if he had managed to get it on, he might have been able to inflate it manually using the mouthpiece.

101 The XL-sized lifejacket, which I find to have been the one worn by Mr Kent, was manufactured in 2006 and complied with the obsolete AS1512, not with the required standard of AS4758. It too was found by the examiner not to have inflated upon immersion, as would have been expected of a compliant and properly serviced lifejacket. The CO_2 cartridge was rusty, and the inflation mechanism was stamped 'REPLACE BY 02 2015'. It also had a tag indicating it had been serviced but I am unable to read the date of that service. Plainly it was not recent. I can safely assume that Taylor Marine, the reputable marine supplier named on the service tag would not have serviced it later than its stated replacement date of February 2015. As the lifejacket was not being worn by Mr Kent when he was found, I infer that it was washed off him in the surf, having failed to inflate. It did not have a torso belt or strap requiring buckling independently of the zip, as would be found in an AS4758 compliant Stormy Seas model. As the lifejacket was about 20 years old, long past its maximum lifespan and replacement date, and had not been serviced for many years, it could not reasonably have been expected to operate correctly as and when the need arose.

Boat examination

102 The boat was examined by police.[234] The top of the cab was crushed but the cab itself was still intact. The left seat was not attached to its mount. The motor cover was missing from the motor and the propellor had minor scuffs. Mr Gordon Panton, Manager of Marine Safety and Compliance with the Department of Transport also inspected the boat. Mr Panton is an AMSA Accredited Marine Surveyor and an AMSA Marine Safety Inspector with extensive qualifications. The boat was said to be well maintained and in generally good condition prior to the capsizing. The bilge pump was of standard capacity for the model of boat (1,100 gallons per hour) but was found by Mr Panton to be not correctly mounted in the bilge, in that it was not secured down. If it was not submerged it would not operate. From Mr Panton's perspective, as it was not secured, it could not be known whether it was submerged or operating correctly at the time it was needed. This might explain Mrs Kent's evidence that she could not hear it working. Mr Panton explained:

> Information provided by SAPOL indicates the transom door was open before and during the incident and a lobster pot rope was entangled in the propeller. The action of the pot being entangled on the propeller would cause the vessel to be stern to the wind and waves. The significant waves which would have been present on the day would as reported come over the back of the vessel. The fact that the transom door was open would significantly

[234] Exhibit C62 at [31]-[36] and Exhibit C63c

> increase the water ingress to the vessel. A pump of the size fitted would not be sufficient to effectively mitigate the free surface effect caused by the water on the deck which is a plausible cause of the vessel capsizing.[235]

I find that the Squirrel capsized following a loss of stability after water entered the boat over and through the transom when the stern of the boat was exposed to the swell, after a cray pot rope became entangled around the propeller, disabling the propulsion system and anchoring the boat by the propellor to the cray pot on the sea floor.

Post-mortem examination and causes of death

103 Senior specialist forensic pathologist Dr Karen Heath performed the post-mortem examinations in relation to Mr Kent and Mr Walker. In respect of Mr Kent, Dr Heath found hyperexpanded lungs with sand in the airways, as well as watery liquid and sand in the stomach. Given Mr Kent's cardiac history, Mr Kent's implanted defibrillator was interrogated. It showed multiple episodes of ventricular tachycardia and ventricular fibrillation on the morning of the incident. It showed that the defibrillator delivered six shocks to Mr Kent's heart without successfully restoring rhythm. Dr Heath opined that the stress of the capsizing with the associated exertion could have triggered the arrhythmia that the defibrillator was unable to reverse. Dr Heath concluded that Mr Kent's death was as a result of cardiac arrhythmia due to non-ischaemic cardiomyopathy complicating saltwater immersion.[236]

104 In relation to Mr Walker, Dr Heath found a ruptured spleen, hyperexpanded lungs with sand in the airways, sand in the oesophagus and stomach as well as evidence of cardiac issues. Dr Heath concluded that Mr Walker's death was as a result of saltwater drowning complicating ruptured spleen on a background of ischaemic heart disease.[237]

105 I accept Dr Heath's evidence and enter findings as to Mr Kent and Mr Walker's causes of death in line with her opinions.

Survival situation

106 The transom door provided access for Mr Kent to attempt to reach the propellor to try to free the boat from the rope tangled about it. Until that was done, the boat was effectively anchored to the sea floor facing stern to the swell, restricted in its ability to rise and fall with the swell, and the engine was inoperable. It was an emergency. The effect was that waves came through the transom door and perhaps over the transom as well, quickly flooding the deck. The occupants then had to make very quick decisions. It appears that there was insufficient time for Mrs Kent and Mr Walker to put on lifejackets before the boat capsized.

Preventability

107 The question of preventability is often one that is difficult to grapple with. To some degree, it involves an assessment of potential sequences of actions that might have occurred had one small thing been different. This matter has been no different. I am expected to assess the likely impact if each of those who lost their lives had been wearing

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[235] Exhibit C63c at p 6 of 8
[236] Exhibit C52a
[237] Exhibit C52b

a lifejacket. This may be affected by many factors. In particular, the prevailing conditions on each occasion play a very significant role in the likelihood of a person surviving and being located by searchers. The answer may or may not be clear.

108 In respect of the incident at Buffalo Reef, I find that Thomas Eckert survived a very serious injury to his arm, as he was seen alive by the Polair helicopter and the Challenger jet close to 2 am. I consider it more probable than not that a lifejacket would have allowed him to float for long enough to be rescued by the boats that arrived soon after that time. I make no criticism of the decision that a winch operation was unsafe and should not be attempted. There is nothing to suggest this decision was not well-reasoned and appropriately cautious. This was, therefore, not a genuine opportunity to prevent Thomas' death as it was simply not possible to achieve in the circumstances that existed.

109 Turning to Paul Eckert and Mr Bottrill, the circumstances which occurred to them following the overturning of the boat are unknown, except by reference to injuries noted at post-mortem examination. Those examinations by Dr Charlwood were comprehensive and in the case of Paul Eckert identified no contributions to death other than drowning. As drowning was the only mechanism of death, I can readily be satisfied on the balance of probabilities that his death from drowning was preventable if he had been wearing a lifejacket. As to Mr Bottrill, it is much more difficult to say. He also suffered head and chest injuries which contributed to his cause of death, in that they provide the setting for his death by drowning. Dr Charlwood opined that his head and chest injuries could certainly account for incapacitation and potential unconsciousness and therefore, predisposing to drowning. I can, of course, say that a lifejacket would significantly reduce the chances of his death from drowning. Each man would have been better able to float for long enough to be found, or even, with enough strength, and the assistance of a lifejacket, to paddle to the reef. Whether either man, or Thomas Eckert, if wearing lifejackets, would have survived many hours' exposure to the sea whilst awaiting rescue cannot confidently be stated, but their chances of survival would certainly have been higher.

110 In respect of the incident at Kangaroo Island, once again, there were no contributions to death other than drowning. Although underlying cardiac issues were identified in respect of Mr Neave, Dr Charlwood did not consider that those issues actually contributed to his death. I place weight on the fact that the boat was so close to the shore, and I consider it more probable than not that wearing lifejackets would have prevented the deaths of Mr Neave and Mr Ingram.

111 As to Mr Martin, he too was put into the water suddenly and unexpectedly. He was not in good general physical health, and it is perhaps unsurprising that he was not able to survive in the water for long enough to be located and rescued. Dr Wills' opinion was that Mr Martin's death was as a result of drowning which was complicated by his pre-existing conditions. On that basis, if wearing a lifejacket, he would have floated and, as his body did, would likely have drifted to shore, which was not far away. Also, the area where his pots were set was said by Brevet Sergeant Doecke to be always busy with other water users so he would have been found quickly.[238] I consider it more likely than not that Mr Martin's death would have been prevented if he was wearing a lifejacket.

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[238] Exhibit C49 at 25

112 In respect of Mr Kent and Mr Walker, the situation is less straightforward. Dr Heath's post-mortem examination of Mr Kent revealed firm evidence of a cardiac episode. Dr Heath opined that the stress of being thrown into the water together with the physical exertion of trying to stay afloat likely brought this about. However, if Mr Kent had been wearing a functioning lifejacket it would have significantly reduced the exertion required for him to stay afloat. If exertion was a precipitating factor in his cardiac arrest, wearing a lifejacket can reasonably be considered to have reduced the likelihood of a heart attack when the boat capsized. I find that wearing a functioning lifejacket would have increased Mr Kent's chances of survival. In respect of Mr Walker, the evidence of Mrs Kent establishes clearly that he was accompanying her to shore shortly before she was able to touch the bottom and began to walk. While there was a strong current and Mr Walker was not physically fit, he had a better chance of being able to continue the effort to come ashore if he was not also exerting himself to stay afloat. Even if Mr Walker had not been able to wade to shore, he may have instead floated in the area and been rescued later. While Dr Heath found that Mr Walker had suffered a ruptured spleen during the incident, her opinion was that this was a secondary contribution to his drowning. I am therefore satisfied on balance that the use of a lifejacket may have prevented Mr Walker's death from drowning and provided him with an opportunity to receive emergency treatment for his ruptured spleen. Both men were close to shore and I consider it likely that, if they were wearing lifejackets, they would have been washed ashore by the surf without drowning.

113 I have detailed my reasons why I have reached specific findings as to the likely outcome in each case if lifejackets had been used. However, I would like to make clear that one thing is unarguable; while it is not *certain* whether these deaths would have been prevented, the use of lifejackets would have given each person at the very least a strong chance of survival.

114 Another thing to be said about lifejackets is that if one is worn and the user nevertheless succumbs to exposure to the sea, with or without contribution by other injuries, their body is much more likely to be recovered, which at least provides comfort to loved ones. Human experience tells us all that a body never found compounds the grief of those left behind.

The Law

South Australian regime

115 Given the number of drowning deaths I have just described, which would have been prevented with the use of lifejackets, attention naturally turns to consideration of why all these people came to not be wearing them or, in the case of Mr Kent, wearing one which was noncompliant and inoperative. I therefore turn to a brief consideration of the law as it applies to these events.

116 In South Australia, the situation is governed by the *Harbors and Navigation Regulations 2023*. In particular, regulation 117 requires a lifejacket to be worn on a vessel with an engine that is not more than 4.8 metres in length when the vessel is underway or at anchor. The requirement varies as to specifically what level of lifejacket must be worn depending on whether the vessel is in unprotected waters or semi-protected waters or protected

waters. Children 12 years or younger are obliged to wear lifejackets even when the vessel is more than 4.8 metres.[239]

117 Circumstances of heightened risk bring an obligation to wear a lifejacket while in the open area of a vessel to any boat less than 12 metres long. Circumstances of heightened risk are defined in sub-regulation 117(7) as follows:

(a) the vessel carries the operator and no other person; or
(b) the vessel carries only the operator and a child or children of or under 12 years of age; or
(c) the vessel is being operated between the hours of sunset and sunrise; or
(d) the vessel is crossing a bar; or
(e) the vessel is disabled so as to be incapable of making its way through water; or
(f) the vessel is operating in conditions of restricted visibility; or
(g) the vessel is operating in an area in relation to which a weather warning of any of the following kinds has been issued by the Bureau of Meteorology:
    (i) gale warning;
    (ii) storm force warning;
    (iii) hurricane force wind warning;
    (iv) severe thunderstorm warning;
    (v) severe weather warning.

118 Applying the regulations to the incidents under investigation, Mr Bottrill's boat was long enough that there was no absolute requirement to wear lifejackets, except for the child on board.[240] While the criteria for circumstances of heightened risk were not met, as established by the events under investigation, operating near a reef may present circumstances of risk in a non-technical sense because of the real risk of unexpected waves rising as swells approach shallowing water.

119 Mr Neave's boat was not more than 4.8 metres long, so there would have been an absolute obligation to wear lifejackets. Also, they were operating in circumstances of low visibility due to the fog. They were therefore in circumstances of heightened risk and so they would be required to wear lifejackets *if* they were required to comply with South Australian laws. I heard evidence that Mr Neave's boat was registered as a commercial vessel prior to 1993 and was therefore required to instead comply with a safety regime administered by AMSA. Under the *National Standard for Commercial Vessels* that was required to be complied with, occupants of boats that are not required to be surveyed (e.g. Mr Neave's boat) are required to wear lifejackets at all times for any vessel less than six metres long.[241] Whether it be under South Australian law or national law, lifejackets were therefore mandated for Mr Neave and Mr Ingram.

120 Mr Martin's boat was also not more than 4.8 metres long (its length was 4.75 metres) despite having aftermarket '485' stickers on it in place of the original '475' stickers. Any user of that boat was therefore required to wear a lifejacket. In addition, a circumstance of heightened risk would have existed even if his boat was 4.85 metres in length, as Mr Martin was operating the boat alone.

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[239] Regulation 17(4)
[240] Under regulation 117(4)
[241] Exhibit C38m at Table 2

121 Mr Kent's boat was longer than 4.8 metres and so there was no requirement to wear lifejackets when they set out. However, at the point that the rope from the cray pot tangled with the propellor, the boat became 'disabled so as to be incapable of making its way in water'[242] and the obligation to wear lifejackets arose. This was an obligation arising in a crisis and too late to be of use, as those on board who were not wearing lifejackets did not have time to don them.

Interstate and international regimes – a useful indication

122 Comparison with the regimes in other jurisdictions is not determinative of much. There are many reasons why different approaches might reasonably be taken. However, I was presented with evidence about other regimes, and I consider it a useful exercise to briefly consider the approaches of other regimes as it places the South Australian situation into a wider context.

123 The position varies markedly around the world. For example, in Norway, a country with a famous seafaring heritage, lifejackets must be worn at all times on any boat less than eight metres.[243] In the United States, requirements appear to be limited only to children, and many States adopt the requirement for boats under 26 feet, which is just shy of eight metres.[244]

124 In New Zealand, there is an overarching set of maritime rules which require lifejackets to be worn in circumstances of heightened risk, which includes passengers who cannot swim.[245] The law allows for individual variations across the country. Some regions have a reverse regime where lifejackets must be worn at all times unless the skipper makes a determination that they are operating in low-risk circumstances.[246] Other regions in New Zealand have a six-metre-inclusive regime.[247]

125 Turning closer to home, in New South Wales, lifejackets are mandated on boats under 4.8 metres in length.[248] In Western Australia, the same size threshold applies, but only when the boat is outside protected waters and more than 400 metres from shore.[249] In Tasmania a lifejacket must be worn when on a recreational motor boat that is less than six metres long while it is under power.[250] In Queensland, lifejackets must be worn when boating alone or accompanied only by children under 12 years in an open boat less than 4.8 metres in length and underway, or when a boat that is underway is less than 4.8 metres and is travelling at night or crossing a coastal bar.[251] In Victoria, lifejackets are required to be worn on a powerboat that is up to and including 4.8 metres when it is under way.[252]

126 In terms of heightened risk, the Victorian Regulations have a heightened risk regime which is extremely similar to South Australia's.

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[242] A circumstance of 'heightened risk' – regulation 117(7)(e)
[243] Exhibit C69 at 35
[244] Exhibit C69 at 28-32
[245] Exhibit C69 at 2-18
[246] Exhibit C69 at 20-21
[247] For example, Exhibit C69 at 23-26
[248] *Marine Safety Regulations 2016* (NSW) reg 123
[249] *Navigable Waters Regulations 1958* (WA) reg 50B
[250] Tasmanian Safe Boating Handbook
[251] *Transport Operations (Marine Safety) Regulation 2016* reg 24
[252] *Marine Safety Regulations 2023* reg 66

127 Policymakers sometimes respond to coronial recommendations with concerns that the implementation of safety improvements identified would put one jurisdiction out of step with others. I will not dwell on whether that should be considered an acceptable response to improvements that a Coroner identifies after hearing an inquest into concerning deaths and where those improvements are expected to prevent further loss of life. I do not dwell on that because in the present case, marine safety, there is not national consistency, except that 4.8 metres seems to have been widely, although not exclusively, chosen as a length at or above which lifejacket mandates do not apply. In my opinion, this ought not to be regarded as a good reason why South Australia could not and should not lead the nation with the safest laws on the water.

Understanding of the law

128 Sergeant Innes gave evidence that there is a generally low level of understanding of the boating safety regime among the boating community in South Australia. He said the main issue seems to be the complexity of the regime itself. In particular, the assessment of circumstances of heightened risk requires a boat user to consider various factors and to make subjective assessments. Some elements of the circumstances require research of the Bureau of Meteorology's decisions. It is not a straightforward task.

129 Sergeant Innes also mentioned that the theory test for a boat licence is administered once only and the licence never requires renewal, which he said is unusual in Australia. I do not see this as a matter for concern, and I do not propose to recommend any change to this part of the regime. There are various effective means available to the authorities to educate and update the boating public about marine safety and the applicable rules.

130 It was submitted that changes to the lifejacket mandate are called for, and greater simplicity will of itself increase the level of understanding of current marine safety regulations among the community. I will consider that further below.

Reefs and the expectedly erratic nature of ocean swells

131 One thing that arose quite clearly during the inquest was the erratic behaviour of ocean swells, particularly where they are affected by reef systems which may or may not be visible from the surface.

132 In the Buffalo Reef incident, Mr Bottrill's boat was trolling between 350 and 500 metres from the side of the reef which was exposed to the ocean swell, which was not described as large. Conditions earlier in the day at Port Lincoln and at the tuna pens had been described as 'like glass'. At the reef this was not the case, but Danny Eckert said that where they were it did not look rough, as it did close to the reef. He said, '*The wind picked up mid-afternoon swell, no whitecaps, light wind*'.[253] Against these conditions they found themselves facing a wave which was two-and-a-half metres higher than the top of the boat '*as though this huge wave had formed on us*'.[254]

133 Sergeant Innes gave evidence that calm conditions are in some ways more dangerous because they leave boaters off guard and not expecting sudden events. He said that while sudden waves should be always expected, their random nature and uncommon occurrence lead to people being unprepared for them. Sergeant Innes made the good point that while

[253] Exhibit C7a at [24]
[254] Exhibit C7a at [26]

an exposed part of a reef gives a clear reference for boaters, there are also submerged structures which may not be known to boaters without an intimate knowledge of the local area, which can kick up waves where there might be no indication on the surface of their likelihood.

134 In the context of boating tragedies, we often hear of 'rogue' waves. Sergeant Innes described this as '*a term thrown out there by people who encounter a wave they are not expecting, and they are not expecting them because they are not aware, or sufficiently aware of the waters in that area*'.[255] The implication is that people who know the particular waters intimately and understand the bottom formations in the area, are more likely to know where waves may be expected from time to time, even irregularly or occasionally, and be constantly aware of the risk. The lesson for those who do not know the waters intimately is to constantly watch in the direction of the approaching swells, particularly on the outer side of reefs, in the expectation that the unexpected will or may occur. In respect of the incident off Port Lincoln, a local professional insight came from the statement of Mr Kayser, the tuna farm manager, also the master of a 16-metre work boat and plainly very experienced in the local waters. Although he said the conditions that day were like glass with not a ripple on the water, he went on to say that in his experience even when it is like this around the reefs in the area there can be unpredictable swell.[256]

135 Mr Bottrill was an experienced boat operator, but it is not clear whether he was carefully watching for warning signs of large waves, or even if the risk was at the forefront of his mind. It is clear from the evidence of Danny Eckert that by the time the wave was seen there was little opportunity to take evasive action.

136 It is the nature of the sea, when we engage with it, to confront us with hazardous conditions and situations which are not predicted. So much is well known and predictable. For recreational (and even commercial) boaters, no matter the precautions which might be taken, things can still go wrong. That too is predictable. Seven of the eight who died, as well as those who survived, did not have time to put on lifejackets during the emergencies which confronted them. This highlights the importance of recreational boaters wearing lifejackets at all times when enjoying the sea, because when an emergency arises, it may well be too late to put them on.

Advances in lifejacket design and the relative ease of use

137 I heard evidence about Australian Standard 4758 first introduced in 2015. I heard evidence that the Department for Transport allowed a period of ten years for boaters to acquire lifejackets that meet the higher standard, and only mandated the AS4758 standard under South Australian law on 1 January 2025.

138 During the inquest, I was provided demonstrations by Sergeant Innes of various styles and types of lifejackets, all of which complied with Australian Standard 4758.

139 While I was shown some lifejackets that were bulky and would understandably be uncomfortable to wear for extended periods of time, that was not the case with all designs available. I was impressed by the ease of use and minimal physical presence of the

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[255] Transcript, p70
[256] Exhibit C9 at [13]

inflatable 'yoke' style of lifejacket that simply sits over the shoulders. Sergeant Innes gave evidence that this is the lifejacket of choice for the members of the Water Operations Unit who spend long days working on the water.[257] To emphasise the point, he said he had just come back from four days working in the Riverland in 47°C heat and did not notice his lifejacket at all.[258] These lifejackets are widely used by recreational boaters and commercial operators. They are inflated by a CO_2 canister which is activated manually by pulling a toggle, or automatically upon immersion. A range of models are available with different features and prices but, for the budget-conscious, my internet search reveals that an AS4758 compliant model may be purchased for as little as $50. They do require regular servicing, but some self-servicing is permissible.

140 The readily apparent conclusion is that wearing lifejackets is not prohibitively costly, particularly not in the context of the overall costs of boating, and need not bring about any physical discomfort. If wearing lifejackets is mandatory, there is an ease of compliance that may not always have existed. Not wearing lifejackets on the other hand exacts a high cost measured in lives lost.

141 I heard evidence that the initial introduction of the limited lifejacket mandate saw a gradual increase in compliance to the point that it is now a routine part of boating that is not considered problematic by the overwhelming majority. This accords with a scientific study conducted in Victoria following the introduction of a lifejacket mandate.[259] I draw a comparison to the introduction of mandatory seatbelt use in cars and mandatory helmet use on motorcycles and bicycles, all of which are customarily used by all except the most stubborn of individuals. In the same way that these mandates gradually changed culture, I anticipate that if there was to be a wider lifejacket mandate, it would gradually change marine safety culture. That is not to say that implementation of a new regime would be easy and that boaters would all comply immediately; instead, it is to observe that a safer regime will become normalised with time and effort of the regulators.

142 These factors weigh in favour of a regime change.

The composition of the South Australian boating community

143 I received into evidence statistics provided by the Department for Infrastructure and Transport.[260] It was point-in-time data that established the number of vessels registered in South Australia broken down by length. The data showed, relevantly:

Boat length	*Percentage of registered vessels*
0-3.1 metres	2.77%
3.101-3.5 metres	3.13%
3.501-5 metres	42.87%
5.001-6 metres	23.39%
6.001-7 metres	10.79%
Personal watercraft (for example, jet skis)	10.34%

[257] Transcript, p76
[258] Transcript, p76
[259] Exhibit C67
[260] Exhibit C70a

144 The evidence did not establish any specific reasons that the 4.8 metre threshold was selected for the limited mandatory life jacket obligation in South Australia. Sergeant Innes gave evidence that the kinds of incidents under consideration, being in their very nature sudden and unexpected, are not confined to smaller boats.[261] All boats are susceptible to the forces of the sea. Testament to that is that three of the boats involved in these deaths were significantly larger than 4.8 metres. Although Sergeant Innes referred to other known incidents involving larger boats it is not necessary to resort to those incidents or to statistics to understand that boats larger than 4.8 metres capsize. In my opinion the 4.8 metre threshold serves to give false reassurance to those in boats larger than that.

145 It is not necessary for me to unearth or analyse the motivations or reasons for previously deciding upon the 4.8 metre threshold. I do not know if one State first fixed upon it or why, and other states just followed suit or whether State authorities (except Tasmania) decided together. I observe that previously in South Australia there was no mandatory lifejacket-wearing obligation and that the introduction of a mandatory obligation of any nature was a positive step forward for boating safety. However, that does not mean that the threshold then selected was the most appropriate or that it needs to remain unchanged indefinitely. There being no solid evidence of 4.8 metres having safety significance, I would place little weight on desires of simply maintaining the status quo.

Regime change

146 It was suggested to me that the time has come to refresh the consideration of boating safety in South Australia and for an increase in the threshold to be introduced. It was pointed out that a threshold of 7 metres would see 93.29% of boats have a mandatory lifejacket obligation.

147 I remind myself of the evidence of each of the incidents and that no boat involved exceeded 7 metres. That is, if the threshold existed at that level, all those who lost their lives would have been required to wear a lifejacket, which probably would have prevented each of their deaths. Numerous specific examples of deaths that could have been prevented is a particularly weighty consideration as to whether a recommendation to change the regime should be made.

148 I also remind myself that life jackets are required to be carried by all boaters. That is, each registered boat already carries a life jacket for each person that boards the vessel. A change in the regime that mandates the wearing of the device therefore does not impose any financial obligation on boaters; they would simply be required to don the lifesaving device that they already carry. It is true that should the regime be changed, many boaters will opt to purchase new lifejackets, such as the lightweight and comfortable yoke style devices, and adopt the cost of servicing. However, they would not be required to make any expenditure if they did not wish to. I place some weight on this factor.

A word about Personal Locator Beacons (PLBs)

149 Sergeant Innes described a lifejacket as a device that buys its wearer time. The Buffalo Reef incident occurred 55 kilometres from Port Lincoln and those on the boat were the

[261] Transcript, p94

only people who knew that anything had gone wrong. Even if the occupants had been wearing lifejackets, those who did not get to the reef were going to be in the water for many hours before the alarm was raised and a response initiated, without anyone even knowing where they were. For them, this was the best case. During those many hours, time was running out for the survivors. For Thomas Eckert there was almost enough time but not quite. The process from capsize to rescue or recovery was a long one and it is not difficult to imagine that incidents with similar features will occur again.

150 For those wishing to maximise their safety and their chances of rescue in the event of mishap, Sergeant Innes gave evidence of an extra level of safety equipment, the Personal Locator Beacon or PLB, as used in the Water Operations Unit.[262] Assuming Mr Bottrill and his crew had been wearing lifejackets, if just one of them had a PLB attached to the lifejacket and activated it, the AMSA JRCC in Canberra would have been notified within a minute or two that the registered holder was in distress at that exact location.[263]

151 SAPOL Water Operations Unit would have been notified straight away and would start calling the nearest boat assets, including rescue services and known members of the public, usually professional fishermen, which would have been dispatched to the known location within a relatively short time. It is entirely conceivable that they would have reached Buffalo Reef in daylight, enormously increasing the chance that those in the water wearing lifejackets would be found and rescued alive. Air assets would still be deployed depending on the circumstances. The details would be for search coordinators to determine.

152 PLBs are available for less than $400.[264]

153 All the boats which came to grief leading to this inquest carried EPIRBs, although not every one was obliged to, but in none of these emergencies was the EPIRB able to be accessed or activated. This demonstrates the advantage of carrying a PLB for the types of sudden emergencies dealt with in this inquest.

154 In my opinion, for ultimate safety, prudent fishermen travelling significant distances from shore, and from rescue services, should consider equipping their personal lifejacket with a PLB with GPS position broadcasting capability. Even fishers operating much closer to shore could benefit from the quick notice of distress and position which these devices can provide to potential rescuers.

Recommendations

155 Having reached the conclusions I have about the likelihood of survival if lifejackets had been used, I am satisfied that each of these people should have addressed the real risks they faced by wearing a lifejacket. Appraised with the benefit of hindsight, the marine safety regime was inadequate and should be improved. I reach that conclusion taking into account the various considerations I have set out above, about the appropriateness of making a significant change to the safety regime.

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[262] Transcript, p94-97
[263] Transcript, p96
[264] An internet search

156 I therefore make the following recommendation directed to the Minister for Infrastructure and Transport:

One *South Australia should lead the Nation by introducing an obligation to wear a lifejacket when aboard any motor vessel up to 7 metres in length. This obligation should not be restricted to when the vessel is under way.*

157 Further, I am satisfied that enhanced public information as to safety would positively contribute to a safer marine safety environment in South Australia and should be provided. Boating carries inherent risk and small measures can highlight those risks for all boaters. I therefore make the following recommendations also directed to the Minister for Infrastructure and Transport:

Two *That the boat operator licensing theory test be modified to include a mandatory component relating to the use of lifejackets.*

Three *That the Boating Safety Handbook be updated to include a chapter devoted to lifejackets to convey the importance of these devices and in particular, the importance of wearing them before a marine incident occurs.*

Four *That the Boating Safety Handbook or Marine Safety website, or both, be updated to encourage the use by fishers and boaters, particularly offshore fishers, of personal locator beacons with GPS capability, regardless of whether an EPIRB is or must be carried.*

Condolences

158 I offer my condolences to the loved ones of the eight people who lost their lives in these four incidents. It is my sincere hope that highlighting the circumstances of their deaths can bring about positive change and an improvement to the future safety of all those who love and derive pleasure from the sea.

Keywords: *Boating accident; Drowning; Lifejackets*