MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

RECORD OF INVESTIGATION INTO DEATH (WITH INQUEST)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Stephen Raymond Carey, Coroner, having investigated the death of Leslie John LEARY

WITH AN INQUEST HELD AT the Coroner's Court, Hobart in Tasmania on 16 January 2015

FIND THAT:

(a) The identity of the deceased is Leslie John Leary ('Mr Leary');

(b) Mr Leary was born in Franklin, Tasmania on 7 May 1967 and was aged 44 at the time of his death;

(c) Mr Leary worked from time to time as a rock lobster boat deckhand but was also in receipt of an invalid pension from 1996 due to a back injury and possibly alcohol abuse;

(d) Mr Leary died on 5 July 2011;

(e) Mr Leary died as a result of drowning;

(f) No other person contributed to Mr Leary's death.

CIRCUMSTANCES SURROUNDING THE DEATH:

Mr Leary had many years' experience working on rock lobster boats around the coastline of Tasmania. Although placed on an invalid pension in 1996 he continued to work casually on fishing boats when he could. In 1995 he commenced a relationship with Shanna Garth and they had two children: Adelle Rennae Leary born 20 May 1996 and Lucas Mathew Leary born 9 March 2001. Ms Garth and Mr Leary separated in 2009 and the children lived with their mother in Geeveston however Mr Leary had contact with them every day.

In March 2011 Mr Leary commenced working with Mr Allen Brittain who had purchased a rock lobster fishing vessel "*Tarkine*", which was a 10.4m timber vessel in 3C survey, allowing it to operate up to 30 nautical miles offshore. Mr Brittain had a number of years' experience rock lobster fishing, working initially for about three years from 1981. He had his own rock lobster vessel during the period 1996 to 2001 and in 2010 he worked on two fishing vessels each for short periods of time. On 4 July 2011, Mr Brittain and Mr Leary set 37 pots on the eastern side of Actaeon Island off Southport on the southeast coast of Tasmania. Twenty-two of the pots were set directly from the fishing vessel "*Tarkine*" and 15 pots were set by Mr Leary from an aluminium dinghy closer in shore. At the time Mr Brittain was aware that a south-westerly change was forecast to arrive affecting that area of sea at approximately lunchtime on 5 July 2011.

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The "*Tarkine*" returned to port that night and on the next morning (5 July 2011), after refuelling, the "*Tarkine*" left the Southport jetty at approximately 8:45am travelling to Actaeon Island. When they reached a point approximately 600m from the first pot to be retrieved, Mr Leary alighted from the "*Tarkine*" entering the aluminium dinghy and travelled separately to retrieve pots along the shoreline. Mr Brittain picked up one pot and continued in a southerly direction for about 30m when he noticed that the dinghy was upturned between a "bully" (partly submerged rock) and the shore at the northern end of the island. When last seen by Mr Brittain, Mr Leary was located near that bully apparently observing the breaking swell and Mr Brittain assumed he was just watching the wave sets to ensure he could safely enter the area to retrieve pots. Mr Brittain contacted two other vessels that were in the area and asked one, the "*Sea Hound II*" operated by Julian Thiessen, to contact police. Mr Brittain then took his vessel closer to the bully searching for Mr Leary. He described the wind at that time as coming from north-west to west, there were occasional gusts and although the sea was not rough there was a swell running. Other vessels joined the search and soon after the police rescue helicopter arrived in the area. Mr Brittain had noted that he first saw the upturned dinghy at 9:45am. At 11:50am, Mr Leary's body was located in white-water amongst rocks on the eastern shoreline of the island and search and rescue personnel were landed near the spot. After confirmation that Mr Leary was dead, action was taken to retrieve the body.

It is apparent that Mr Leary has fallen from the dinghy or it has capsized whilst he was attempting to retrieve rock lobster pots. Mr Mathew Clark, who skippered the "*Random Harvest*" was working in the area and described the sea state at the relevant time as south-westerly wind at about 30 knots with a 2 metre swell and a bit of slop. Mr Julian Thiessen who was operating the "*Sea Hound II*" described the conditions that morning as 2-3 metre swell with a wind of 25 knots west-south-west. Given these descriptions I consider that the sea conditions were worse than described by Mr Brittain, even making allowance that they may have been working in the lee of the wind at the time. The conditions for operating a dinghy close to shore, and where the waves may have been breaking, were marginal at best given the size of the swell, especially as the wind was building. It was noted that waves were breaking near the bully where Mr Leary had set 3 pots and both he and Mr Brittain made comments concerning the risk of working in that area. Mr Brittain told Mr Leary to leave the pots if he had to and Mr Leary advised "*Yeah, I ain't taking no risks*".

There are obvious risks of taking a dinghy into an area of broken water or where waves may be breaking; this risk is compounded if the dinghy is sitting idle with the operator not watching the waves and more so if the operator has transferred weight to one side of the dinghy whilst pulling in a lobster pot. Any or all of the above circumstances would significantly increase the possibility of dinghy capsize.

The investigation of this matter identified that Mr Leary was not wearing a personal flotation device (PFD) and the wet weight of the clothing he was wearing was 72kg.

COMMENTS & RECOMMENDATIONS:

It is clear that a number of matters contributed to this accident and tragic outcome. First and foremost was a failure of Mr Leary to wear a PFD whilst in the dinghy and the failure of Mr Brittain as the skipper and operator of the "*Tarkine*" , having responsibility for his crew's safety, to ensure that Mr Leary was wearing a properly operating PFD.

Mr Leary was also wearing clothing of a nature and type that would hinder his ability to stay afloat. The wet weight of his clothing, being 72kg, would negatively impact upon his ability to stay afloat, especially without the aid of a PFD.

One assumes that Mr Leary was experienced in setting and retrieving lobster pots from a dinghy; however there is no evidence that he or Mr Brittain had discussed the safest method of doing this or whether in certain conditions it was not safe to perform this task, especially with only one person in the dinghy. Although I am unable to find positively, it is also possible the dinghy, which was in a very poor condition, may have contributed to the outcome. The dinghy was withdrawn from survey in October 2010 and after the incident and inspection of the dinghy, it was noted:

- Extensive corrosion caused by electrolysis, particularly on the chine and keel extrusions but generally over the hull plating with several fibreglass patches to the bottom plates.

- Several cracks in the framing on the port side, in the side framing to the aft and centre thwarts and the gunwale close to amidships.

However, the dinghy had been fitted with new buoyancy in November 2007 and this was still in good condition.

Finally, there was the failure of Mr Brittain to maintain visual contact with the dinghy and Mr Leary whilst Mr Leary performed the task of retrieving lobster pots. There was apparently no plan or intent that Mr Brittain would maintain observation of Mr Leary and both men appear to have been working independently. This ought not to have been the case and, even if in this case Mr Brittain may not have been able to get to the area where Mr Leary had entered the water, he would have been able to react in a more timely manner than when he did.

The above matters are self-evident but I formally document the following recommendations:

- No matter what the circumstances or experience of those involved, properly functioning and appropriate PFDs must be worn by all persons using a dinghy tender to set or recovery lobster pots.

- Persons involved in operating tender dinghies to set or recover lobster pots must ensure their clothing is not of a type or amount that would add significant body weight when immersed. Where practicable, boots and lower garments ought to be able to be quickly discarded.

- The wearing of PFDs under clothing is likely to adversely affect the operation of the PFD, especially an inflation type device, and such practice should not occur. It ought not to be assumed that there will be an opportunity to discard outer clothing if the need arises to activate a PFD.

- The single-handed operation of a tender dinghy to set and recover lobster pots should only occur in favourable weather and not in circumstances where there is a reasonable possibility of capsize (e.g. in broken water). Such single-handed operation should also only occur where the dinghy has been set up in such a manner so as to allow the work to be done without any marked increase in the risk of falling into the water or capsizing the dinghy.

- The equipment used within the professional lobster fishing fleet must be to the best industry standard and the risk of mishap ought not to exist due to below standard equipment (e.g. tender dinghies). The inherent risks professional fishermen are exposed to by the very nature of their work must not be heightened by the use of poor quality equipment or workplace systems.

- Where a person is operating a tender dinghy single-handed, there needs to be a watch maintained whilst work is being conducted from that dinghy to ensure immediate response should a mishap occur.

I recommend that all those persons involved in the professional fishing industry ensure that they comply with the obligation s of the *Work Health and Safety Act* 2012 as it applies to the manner in which they conduct their enterprise. The inherent risks within the rock lobster industry might well be lessened by the development of a Code of Practice to be adopted by all engaged in that industry.

It also became apparent during this investigation that there was a legal issue as to whether or not Mr Brittain was authorised to be operating the "*Tarkine*" at the time and place where the incident occurred. Although there is no indication that this issue in any way contributed to Mr Leary's death, it is in the public interest that it be addressed by me to ensure that appropriate remedial action is taken by the public authority concerned. Clause 4(2) of the *Marine and Safety (Certificates of Competency) By-Laws 2002* provides that a person must not serve in a "*prescribed capacity*" which is defined to include the capacity as coxswain, in a vessel being navigated in Tasmanian waters unless that person is authorised to do so under a certificate of competency or a temporary service permit issued by Marine and Safety Tasmania ("MAST").

Throughout this incident, Mr Brittain remained in charge of the "*Tarkine*" as the coxswain being the person responsible for steering the vessel while it was being navigated. Under clause 23(1) of the By-Laws, a certificate of competency may be issued as:

- An "*unrestricted certificate*" valid for "*all operational areas and vessels*"; or

- A "*restricted certificate*" that is valid only for "*a specific duty, operational area, vessel or class of vessel*".

The police investigation determined from material provided that it appeared that at the relevant time Mr Brittain was not the holder of an unrestricted certificate of competency or a temporary service permit to serve as a coxswain. According to printouts from the relevant MAST database, Mr Brittain was, from 16 February 2011, the holder of a certificate of competency numbered 0016197 described as "*NSCV Coxswain (restricted)*" until 30 August 2011 when he became the holder of a certificate of competency number 0016205 described as "*NSCV Coxswain*". Apparently these references are intended to refer to the issue of restricted and then unrestricted certificates of competency to Mr Brittain as coxswain. It is noted that the certificate described as "*NSCV Coxswain (restricted)*" is subject to restrictions described in the database as "*limits*" which read as follows:

- "*Command a vessel less than 12 metres in length;*

- *In sheltered water limits only;*

- *Non-passenger operations only;*

- *Take charge of petrol engines less than 250kw within the limits of this certificate.*"

These noted restrictions are significant because on the date that Mr Leary died the "*Tarkine*" was not only equipped with a diesel engine but was also being navigated outside sheltered waters within the meaning of the *Marine and Safety (Limits of Operational Areas) By-Laws 2000*. Prima facie, therefore, Mr Brittain was not, on the date in question, authorised to serve as coxswain on the "*Tarkine*" at the place where the incident occurred. However, further enquiry of MAST determined that the circumstances relating to Mr Brittain's registration were, by no means, clear. Despite the reference in the MAST database to Mr Brittain holding a restricted certificate, advice was received that in fact he was issued on 16 February 2011 with a document entitled "*Interim Certificate of Competency*" bearing number Z001903. Advice was received that the basis upon which this document was issued was as follows:

- Mr Brittain applied to MAST for an unrestricted certificate for coxswain and undertook an approved training program towards gaining that qualification;

- As at 16 February 2011, Mr Brittain had not met all the requirements of the training program to qualify him for an unrestricted certificate for coxswain but had completed sufficient of that program for MAST to accept that he was qualified to hold a restricted certificate for coxswain. Accordingly, it was at that stage intended by MAST to issue Mr Brittain with a restricted certificate of coxswain pending the completion of additional training to qualify him for an unrestricted certificate for coxswain;

- However, because MAST had only received "*interim results*" to that effect from the training program provider, and not formal advice with supporting documentary evidence, the "*Interim Certificate of Competency*" was issued and provided to Mr Brittain instead; and

- Eventually Mr Brittain completed the additional training required to qualify him for an unrestricted certificate for coxswain, which was issued to him by MAST on 30 August 2011.

Advice that I have received is that there is no power under the *Marine and Safety (Certificates of Competency) By-Laws 2002* for MAST to issue "*interim*" certificates of competency and it is suspected that the document issued on 16 February 2011 had no legal status. A doubt arose as to whether or not Mr Brittain was ever actually issued with a restricted certificate of competency and accordingly no prosecution was considered as it could not be established that he was in fact, at the relevant time, the holder of a restricted certificate within the meaning of the By-Laws and accordingly had breached the restrictions on that certificate.

The police investigation concluded that there was a doubt that Mr Brittain held any valid certificate of competency prior to 30 August 2011. However, given the circumstances it was considered that Mr Brittain would have reasonably believed, possibly mistakenly, that he was qualified to serve as coxswain (with or without restrictions) on the "*Tarkine*" at the relevant time. I assume that these matters have been raised by Tasmania Police with MAST as part of this investigation, but if not, I strongly recommend that MAST liaise with Tasmania Police to address its process as to the lawful issue of certificates of competency to operate vessels to ensure this is done in accordance with the applicable legislation.

Before I conclude this matter, I wish to convey my sincere condolences to Mr Leary's family.

DATED: 2015 at Hobart in the State of Tasmania.

Stephen Raymond Carey
CORONER