FINDINGS, RECOMMENDATIONS and COMMENTS of

Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Allan Geoffrey Russell

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Allan Geoffrey Russell with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

17 December 2018 and 18 January 2019 at Hobart in Tasmania.

Representation

S Thompson, Counsel Assisting the Coroner

I Hallett for Clark Fishing Pty Ltd

Introduction

1. Allan Geoffrey Russell, known to all as Joe, was born on 21 July 1942. He was married to Lavinia Alice Russell. Mr and Mrs Russell celebrated their golden wedding anniversary in July 2014.

2. Mr and Mrs Russell raised 6 children. One son, Paul, sadly recently passed away.

3. Mr Russell died on 14 April 2015 in the water south of Red Point, roughly half way between Cox Bight and Louisa Bay on the remote and rugged south coast of Tasmania.

4. At the time of his death Mr Russell was working as a deckhand (or 'dinghy boy' as it is sometimes called) for Clark Fishing Pty Ltd ("Clark Fishing"). Clark Fishing was and is a single shareholder and single director company, owned by Darren John Clark. Mr Clark is also the company's secretary.

5. Mr Clark was, and is, an abalone diver. His company owned the vessel *Breaksea*, an 18-metre wooden, aft wheelhouse, displacement fishing boat.

6. The *Breaksea* had a 4.6 metre Midnight brand aluminium dinghy as tender. Dinghies of that type are common in the abalone fishing industry. The dinghy was powered by a 60hp Yamaha outboard engine, with tiller steering. Mr Russell's job was to operate the tender. He worked alone following Mr Clark as he dived for abalone and sent them to the surface in catch bags. Mr Russell had to retrieve the bags and place the abalone in bins as well as ensuring Mr Clark's air supply (he was diving on a hookah) was maintained.

7. Mr Clark had known Mr Russell all his life. Both men had spent their lives in the fishing industry. Both were very experienced. They had worked together before 14 April 2015.

8. Because Mr Clark died in the course of his employment an inquest, subject to an exception in the *Coroners Act* 1995 (the '*Act*'), was mandatory.[1] Mr Clark's senior next of kin did not request that no inquest be heard. Accordingly, the inquest was held. It occurred after the criminal prosecution proceedings against Clark Fishing for alleged breaches of the *Work, Health and Safety Act* 2012 (*WHS Act*) had been finalised.

The Role of the Coroner

9. Before an analysis of the circumstances surrounding Mr Russell's death is undertaken it is important to say something about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. In this case, as has already been mentioned, because Mr Russell died in the course of

[1] See section 26A(3).

his employment the *Act* makes an inquest mandatory.[2] An inquest is a public hearing.[3]

10. When investigating any death at an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28(1) of the *Act* asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions. A coroner is also able, if she or he thinks fit, to make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

11. The role of the coroner in making recommendations is especially important in the context of workplace deaths.

12. A coroner neither punishes nor awards compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of an offence.[4]

13. As was noted above, one matter that the *Act* requires is finding how the death occurred.[5] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[6] Any coronial inquest necessarily involves a consideration of the particular circumstances

[2] See section 24(1)(ea).
[3] See section 3.
[4] Section 28(4).
[5] See section 28(1)(b).
[6] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.

surrounding the particular death so as to discharge the obligation imposed by section 28(1) (b) upon the coroner.

14. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved should be approached with great caution.[7]

Issues at Inquest

15. In addition to the formal matters required by section 28(1)(a)-(d) of the *Act*, the following issues were the subject of specific attention at the inquest:

    a. What led to the tender dinghy capsizing?

    b. The circumstances surrounding Mr Russell's wearing of a personal floatation device ("lifejacket") and the adequacy of the steps taken by Clark Fishing to ensure that it was worn.

    c. Mr Russell's inability to swim, the relevance of that to his death, and the steps taken by Clark Fishing in that regard.

Events Prior to the Fatal Trip

16. Mr Clark gave evidence that deckhands such as Mr Russell were engaged casually for each fishing trip. The industry practice was that deckhands were paid by reference to how much was caught. Mr Russell was engaged by Mr Clark on that basis for the trip that commenced on

[7] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

13 April 2015. The evidence was that Mr Russell had worked for a number of abalone divers over the years, (including Mr Clark) and was regarded as very experienced.[8]

17. Mrs Russell gave evidence that Mr Russell owned two lifejackets, both red in colour and manufactured by Stormy Seas. One was older than the other. It had long sleeves. On his final trip Mr Russell took the older of the two lifejackets and his own wet weather clothing. Mrs Russell estimated that that lifejacket was purchased for her husband by their children as a gift some 5-6 years before his death. The evidence does not allow the lifejacket's condition at the time of Mr Russell's death to be ascertained. According to Mrs Russell the lifejacket was serviced casually, the last time by another diver. Despite enquiries conducted as part of the investigation into Mr Russell's death no evidence was found of the lifejacket ever being serviced by the manufacturer.

18. Mr Clark's evidence was that there were spare lifejackets on the *Breaksea*. However, he said that Mr Russell, like most other deckhands, preferred to use his own.

The Circumstances Surrounding Mr Russell's Death

19. Most of the evidence available in relation to the lead up to Mr Russell's death came from Mr Clark. Broadly speaking there is no reason not to accept his account of events. In addition to giving evidence at the inquest, Mr Clark made two coronial affidavits and participated in two audio recorded interviews with inspectors from WorkSafe Tasmania. The accounts he gave were all consistent. Further, where objective evidence exists from another source that evidence supported various elements of Mr Clark's account. When giving his evidence he appeared to be doing his best to give an accurate account of what happened and honestly answer questions directed to him. With one exception relating to Mr

[8] See exhibit C10 affidavit of D Clark sworn 30 April 2015, page 2.

Russell's lifejacket, which I will deal with later, I accept Mr Clark's evidence.

20. Mr Clark told the inquest that on Monday, 13 April 2015, he and Mr Russell, left the wharf at Dover on the *Breaksea* at about 2.30pm. The two men were the only people on board the vessel.

21. Mrs Russell gave evidence that she spoke to her husband by telephone between 2.45pm and 3.15pm as he and Mr Clark were going past Hope Island (an island in Port Esperance not far from the Dover Wharf). She reported no concerns being expressed by her husband about the weather.

22. Mr Clark said that as the vessel steamed past Acteon Island (not far from Recherche Bay) there was a 2 metre southerly swell with a 2 metre sea and the wind was blowing 20 knots from the south. Mrs Russell said she spoke to her husband again by telephone at about 5.00pm. He told her that a 4 metre swell was running and it was the intention of the men to spend the night in Recherche Bay and that they planned to leave for the far south coast at about 4.00am the next morning. I note there is an apparent discrepancy between the two accounts of the sea state that afternoon, but nothing turns on it in my view. It is clear enough that there was a reasonable swell running. I also note that Mrs Russell did not suggest that her husband expressed any concern as such about the weather conditions. In fact, she said that her husband seemed to regard the trip and conditions as nothing out of the ordinary.

23. The couple's final telephone call was at about 7.30pm. Again, Mrs Russell did not report her husband expressing any concerns about the weather, or anything else.

24. Mr Clark confirmed that the men anchored the *Breaksea* at Recherche Bay and spent the night there. They both checked the weather forecast

on the boat's VHF radio at 7.03pm and noted a favourable forecast for the following day.

25. At approximately 4.00am the next day the *Breaksea* left Recherche and headed south before turning west at South East Cape. At approximately 7.00am the *Breaksea* entered Louisa Bay on the far south coast of Tasmania. By then the weather had improved markedly from the previous day. Mr Clark said the wind was negligible and the swell between 1.5 metres and 2.5 metres. These conditions were regarded as good for the area. Apart from Mr Clark's evidence about the weather, I had evidence in the form of a record of observations taken at Maatsuyker Island Weather Station approximately 3.5 nautical miles south of Louisa Bay.[9] Those observations show that at 9.00am on Tuesday 14 April 2015 there was no wind and little cloud.

26. Mr Clark told the inquest that his practice was not to dive from the *Breaksea* as it would be too large and difficult to manoeuvre. Instead, he dove from the dinghy. The dinghy contained a compressed air system, known as a 'Hookah', which provided a continuous supply of air to Mr Clark by a hose. As already mentioned Mr Russell's task was to operate the dinghy and maintain Mr Clark's air hose. As Mr Clark harvested the abalone he placed it in catch bags which, when full, he sent to the surface using inflatable bags. Mr Russell retrieved those bags, placed them in the dinghy and stacked the abalone in bins on the boat. He also maintained the air compressor.

27. Mr Clark said that he and Mr Russell left the *Breaksea* in the dinghy at 8.30am, and that both he and Mr Russell were wearing Stormy Seas lifejackets as they travelled in the dinghy towards Red Point. Mr Clark entered the water at approximately 8.50am on 14 April, just off Red

[9] Exhibit C25.

Point.[10] When he entered the water Mr Clark said that Mr Russell checked the time (as he apparently always did). At the time he entered the water, Mr Clark estimated the swell height to be approximately 2 metres and said there was no wind. This evidence is consistent with the weather records for the area.

28. Mr Clark said he dived for 3 and a half to 4 hours, during which time he estimated that he harvested, and Mr Russell retrieved, approximately 250-300 kilograms of abalone.

29. Between 1.00pm and 1.30pm that afternoon Mr Clark said he felt his airline tighten. Upon surfacing, he saw that the dinghy was upside down in the water. At first he could not see Mr Russell. After about a minute and a half Mr Clark found him about 10 metres from the dinghy, in the water. He said that Mr Russell did not have a lifejacket on. Mr Russell was holding his head above water and coughing. Mr Clark swam straight to Mr Russell and hooked the airline under his arms. He told Mr Russell to hold onto the airline, which he did with one hand but Mr Clark said his grip was very weak. Mr Clark swam Mr Russell back to the dinghy.

30. Mr Clark said he tried to get Mr Russell to hold onto the bow of the dinghy which had handles and floatation fitted. However, Mr Russell was unable to hold on and did not appear to give any indication he understood Mr Clark.

31. For the next 40 or so minutes (the time is necessarily only an estimate as Mr Clark said he was not wearing a watch) Mr Clark fought to keep Mr Russell afloat. He described Mr Russell as incoherent and said he was “coughing and spluttering like he was full of water and couldn’t get it

[10] See exhibit C 10, page 2. Red Point is at 43 degrees 32’72” South, 146 degrees 18’ 3” East.

out".[11]

32. Mr Clark said that each time he let Mr Russell go (as he attempted to remove his sea boots to try to help keep him afloat), Mr Russell would begin to sink. After about 10 minutes (of the estimated 40 minutes) Mr Clark was unable to detect Mr Russell's pulse or breathing. He said that Mr Russell's mouth was full of water. Eventually Mr Clark was unable to support Mr Russell any further and let him go. Mr Russell immediately sank. I am satisfied that when Mr Clark was forced to let Mr Russell go he was dead or close to death and that he had no realistic alternative. In my view Mr Clark's efforts to try to save Mr Russell were extremely commendable.

33. As noted, Mr Russell did not have his lifejacket on. Mr Clark did not see it anywhere close in the water, although he said he thought he saw a lifejacket or something red near the rocks, but it could have been his lifejacket rather than Mr Russell's as they had the same type (and of course since Mr Clark was underwater diving he was not wearing one).

34. Mr Clark described then retrieving a safety pod from the dinghy and swimming to a rock some 300 metres away. He set off an EPIRB and flares (both contained in the safety pod) and waited exhausted on the rock.

Search and Rescue Response

35. At about 3.00pm Tasmania Police Search and Rescue officers were notified by the Australian Maritime Safety Authority that an EPIRB signal had been detected from Red Point on the south coast of Tasmania. The Westpac Rescue Helicopter was quickly airborne and arrived at Red Point at about 4.10pm. When the helicopter arrived at the scene Sergeant Paul Steane saw Mr Clark in his wetsuit sitting on a rock near

[11] See exhibit C 10, page 3.

the shore. About 200 metres west of Mr Clark's position Sergeant Steane noticed the upturned dinghy floating bow up in the water.

36. The helicopter hovered near Mr Clark who was able to climb into it. He told the Search and Rescue team what had happened. The helicopter flew to a nearby button grass plain where Mr Clark and Sergeant Steane got out and the helicopter resumed its search of the area. Using a satellite phone, Sergeant Steane notified Tasmania Police headquarters as to what had happened and requested that police divers attend to search the area.

37. Just after 5.00pm, Mr Clark and Sergeant Steane returned to the helicopter and flew back to the area where the dinghy was still floating. By now a fishing vessel, the *Montunui*, had arrived from nearby Maatsuyker Island. A diver from that vessel, Mr Bryan Denny, was in the water searching the area around the capsized dinghy. Another helicopter brought police divers to the area near Red Point but by the time they arrived it was almost dark. After a discussion between police and the fishermen who were in the area it was decided that the risks of working in a dinghy close to the shore in the dark were too high and that no further searching would take place that night. There is no basis to criticise the decision.

38. Police divers returned at daybreak the next day, 15 April 2015, and searching for Mr Russell resumed. The overturned dinghy was in essentially the same place as it had been the evening before when the search had been suspended. While searching continued a police officer assisted Mr Clark to return the *Breaksea* to Dover.

39. At 7.39am helicopter crew members sighted Mr Russell's body floating face down approximately 2 nautical miles south of Red Point. The *Montunui* was directed to the area and the crew retrieved Mr Russell's

body.

40. Police were also able to recover the dinghy and other various pieces of equipment including a compressor hose, a diver's weight vest, and an abalone catch bag, an anchor rope coil and a standard 'danforth' type dinghy anchor. Notably, although a red Bourke brand water-proof jacket was found floating not far from Mr Russell's body, his lifejacket was not located despite an extensive search.

41. The evidence at the inquest satisfies me that the response of the search and rescue authorities was both timely and appropriate.

Forensic Pathology Evidence

42. After recovery from the water, Mr Russell's body was formally identified by Mr Denny (who had known him for many years) and then transported to the mortuary at the Royal Hobart Hospital.[12] At the mortuary an autopsy was carried out by highly experienced forensic pathologist, Dr Donald Ritchey. Dr Ritchey found that the cause of Mr Russell's death was consistent with drowning. He found moderate natural disease in Mr Russell's heart and blood vessels and also early signs of emphysema. Dr Ritchey did not find any significant injuries to suggest that Mr Russell had hit his head when he entered the water.

43. Samples taken at autopsy were subsequently analysed toxicologically at the laboratory of Forensic Science Service Tasmania. No alcohol or illicit drugs were found to have been present in Mr Russell's body at the time of his death.

[12] See Exhibits C3 and C11.

The Condition of the Dinghy

44. Whether the dinghy in which Mr Russell was working at the time of his fatal accident was in good condition or not was a fundamental issue at the inquest, and a significant focus of the investigation. It was particularly important because Mrs Russell said that, on the day before he left on his final trip, her husband discussed the dinghy's condition with her. She said that her husband told her that the dinghy had a crack in it and that he had asked Mr Clark to have a welder have a look at it. She said that Mr Russell told her that Mr Clark said he wanted to "get another trip out of it".

45. Mrs Russell also said that her husband told her that there was some water coming into the bottom of the dinghy. Mrs Russell's account is consistent with Mr Clark's evidence of the conversation he had with Mr Russell.[13] I accept that a conversation took place between Mr Russell and Mr Clark along the lines outlined by Mrs Russell. It occurred at the Dover wharf, likely in the presence of Mr Russell's (now deceased) son, Paul.[14] However, the mere fact that there was a crack in the dinghy and that some water was coming in does not necessarily lead to a conclusion that the dinghy was unfit for the purpose for which it was being used or, more generally speaking, unsafe. The evidence of the two marine surveyors, Mr Peter Keyes and Mr Adam Brancher, is critical in this regard. I turn to consider that evidence.

46. Firstly, I note that while the dinghy was not in survey, there was no legal requirement for it to be so. The evidence was that the dinghy was usually present with the *Breaksea* when the latter vessel was surveyed and thus considered as part of its survey.

[13] Exhibit C10a Affidavit of Darren John Clark sworn 13 April 2017.
[14] Exhibit C9 Affidavit of Paul Russell sworn 5 April 2017.

47. Second is the question of if the dinghy was overloaded, was such overloading the cause of or a contributing factor to the dinghy overturning? Mr Keyes gave detailed evidence in relation to a series of calculations he had performed. Those calculations were not challenged and I can see no reason not to accept them. I am satisfied that the evidentiary foundation used by Mr Keyes for the calculations, i.e., what was thought to have been in the dinghy on the morning of 14 April 2015, is accurate. On that basis I am satisfied that the dinghy was not overloaded. Having reached that conclusion it could not be the case, as a matter of logic, that overloading caused or contributed to the dinghy capsizing.

48. Third is the question of the physical condition of the dinghy. As has already been noted, the dinghy was recovered following the accident. This enabled it to be inspected by both Mr Keyes and Mr Brancher. I accept both men as experts qualified to express the opinions that they did in their reports. I note that each conducted his inspection and authored his report independently of the other. Their evidence was essentially the same and may be summarised as follows (and for the following summary I am grateful for the helpful written submission of counsel assisting, Mr Thompson):

> *"Although the dinghy was not in perfect condition,[15] there was no evidence that any defects contributed to the accident. In Mr Brancher's words, 'the general watertight integrity of the hull [was] not of concern', and the boat's condition 'was not atypical of other working boats of this type and it did retain its watertight integrity'.[16]…Mr Brancher went on to say that he regarded the vessel as seaworthy, although he 'probably would have given advice to repair some of the general cracking that I saw but in*

[15] There was, for example, a minor crack above the bunghole. Similarly, some of the screws joining the sole board (floor of the boat) to the hull were worn. (Transcript 17 December 2018, page 6).
[16] Transcript 17 December 2018, page 5.

general terms, yes… [it was seaworthy]'. The defects were not critical failings that needed to be immediately repaired."[17]

49. Mr Keyes was of the same view. He said that the dinghy was one typical of its type with various scratches and scrapes, but nothing that could cause it to take on water. Both men were of the view that there was merit in repairing the small crack that existed near the bunghole but that crack did not make the dinghy unseaworthy. Both surveyors were of the opinion that the crack did not affect the dinghy's watertightness.

50. Mr Brancher said, when asked whether it was appropriate for the dinghy to have been used on the day in the condition in which it was:

> *"I believe it was acceptable at that point but that it would…merit repairs before too long… [T]he difficulty is in saying how long and that really would be a function of the areas they're working in and the – you know the way they were bringing it on and off the vessel. So it would be largely a case of the routine maintenance of the owners determining you know (a) that there was an issue and (b) that it would be done. Because these vessels aren't regularly seen by third parties."*[18]

51. Finally, and tellingly, Mr Brancher said in his evidence at the inquest that having regard to the condition of the dinghy as he observed it, and what he understood to be the weather conditions and the use to which the dinghy was being put, he would have been happy to go out in it.[19]

52. I am satisfied that whilst there were minor defects in the dinghy on the day of Mr Russell's death, which defects Mr Russell and Mr Clark were both aware of, the defects did not adversely affect the dinghy's seaworthiness and were not such to mean that the dinghy should not have been used in the manner it was on 14 April 2015.

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[17] Transcript 17 December 2018, page 9.
[18] Transcript 17 December 2018, page 7.
[19] Transcript 17 December 2018, page 17,22-33.

Why Did the Dinghy Capsize?

53. Obviously no one saw the dinghy capsize. The only person who may have been in a position to cast some light on what happened was Mr Russell. Neither Mr Keyes nor Mr Brancher were able to say what caused the dinghy to capsize and neither identified any defect, structural fault or design flaw on the part of the dinghy which may have caused or contributed to it capsizing. In addition, as has already been noted, I am satisfied on the evidence that the dinghy was not overloaded. Counsel assisting submitted that the two most likely hypotheses are:

    a. Something happened whilst Mr Russell was in the dinghy, such as it becoming unbalanced or a rogue wave breaking, causing it to capsize and Mr Russell to be thrown into the water; or

    b. Mr Russell fell into the water and in attempting to get back on board he caused it to capsize.

54. While something can be said for both hypotheses, the evidence does not allow me to reach any view as to what caused the dinghy to capsize. As should be clear from my comments earlier in this finding I am satisfied that neither overloading nor any defect caused or contributed to the capsize of the dinghy.

Mr Russell's Wearing of a Lifejacket

55. As counsel assisting correctly submitted as a matter of law, Mr Russell was required to wear a lifejacket when he was working as Mr Clark's deckhand on 14 April 2015.[20] In addition to the personal obligation on the part of Mr Russell, Clark Fishing, as his employer, had obligations to ensure that he wore a lifejacket.[21]

[20] *Marine and Safety (General) Regulations* 2013 (Tas), reg 9.
[21] *Work, Health and Safety Act* 2012 (Tas), sections 14-16.

56. As I have already alluded to earlier in this finding, the evidence from Mr Clark was (and I accept) that when he surfaced and attempted to save Mr Russell, Mr Russell was not wearing a lifejacket. I note also that no lifejacket identified as belonging to Mr Russell was recovered. Counsel assisting submits that there are 2 possibilities for Mr Russell not wearing a lifejacket when Mr Clark swam to attempt to rescue him. Those possibilities being:

    a. Mr Russell removed his lifejacket sometime while Mr Clark was diving; or

    b. Mr Russell's lifejacket was worn incorrectly and came off when the dinghy capsized or he entered the water, or shortly thereafter (but in any event prior to Mr Clark finding him).

57. It seems to me that there is a third possibility that either Mr Russell did not have a lifejacket with him or, if he did, he was not wearing it when Mr Clark went into the water or indeed at any time subsequently. I note that Mr Clark said in the affidavit he swore on 30 April 2015 that Mr Russell "always" wore a lifejacket (at least when the dinghy was moving).[22] In addition Mrs Russell said that her husband "always wore a lifejacket when he was in the boat",[23] but she was referring to trips the couple made together in runabouts or dinghies 'over the years' and not whilst Mr Russell was working. However the fact that Mr Russell was found in the water by Mr Clark not wearing a lifejacket rather proves that he did not always wear a lifejacket. Further, Mr Clark himself said that he had witnessed occasions in the past when Mr Russell did not wear a lifejacket (although he had responded to a verbal direction to put one on).

58. However, once again the evidence does not allow me to reach a concluded view about why Mr Russell was not wearing a lifejacket other

[22] See exhibit C10, at page 2.
[23] See exhibit C8a

than to say the obvious, which is, at the time Mr Russell was found near death in the water by Mr Clark he was not wearing a lifejacket and no lifejacket attributable to him was recovered by searchers.

59. The importance of wearing a lifejacket cannot be emphasised enough. Expert evidence was received at the inquest from Dr Watzl (MBBS FACRRM), Deputy Chief Medical Officer of the Australian Antarctic Division, about cold water immersion, cold shock and swim failure. Dr Watzl said that a lifejacket "is obviously critical to survival to any person who finds themselves suddenly immersed in water deeper than their height, who cannot swim, and irrespective of water temperature." Thus aside from the regulatory and legislative requirements to wear a lifejacket there existed an unquestionable practical, common sense reason for Mr Russell to wear such a device.

60. In Dr Watzl's view, the type of inflatable lifejacket is not as important as it being properly and regularly serviced. However, if a situation impairs a wearer's ability to think clearly, a self-inflating lifejacket is preferable. Conversely, if the wearer is underneath a capsized dinghy, an automatically inflating lifejacket would make it difficult to get out from under it. Whatever the case, it was Dr Watzl's view that it is critical to "wear, service and wear correctly" a life jacket.

61. I have already said that I consider Mr Clark's efforts to save Mr Russell's life were extremely commendable and worthy of recognition. However, as counsel assisting submits, correctly in my respectful view, as commendable as those efforts were, I must, as part of discharging my functions under the *Act*, consider the appropriateness of his actions in the lead up to Mr Russell's death.

62. Mr Clark gave evidence at the inquest to the effect that, having reflected upon the matter, he did not think he would (or could) do anything differently that could have changed the outcome. With all due respect to Mr Clark there are a number of things he could have done differently. He

could have made the very simple enquiry of Mr Russell whether he could swim. He could have, but did not, ask to see Mr Russell's paperwork documenting his qualifications. He could have taken steps to ensure Mr Russell's lifejacket was correctly serviced. It is recognised that there is no evidence of a failure of servicing of the lifejacket playing any role in Mr Russell's death, but it seems to me that such a level of attention to detail may have helped emphasise to Mr Russell the importance of wearing his lifejacket. Any of these things, simple actions and inexpensive to implement, may well have, in my respectful view, altered the outcome when Mr Russell found himself in water.

63. As has already been noted the fact that Mr Russell was found without a lifejacket suggests strongly that the system of verbal instruction with respect to the wearing of a lifejacket was inadequate. The inadequacy of the system should have been known to Mr Clark as he conceded in evidence that there had been occasions in the past where he had seen Mr Russell not wear a lifejacket on the water.

64. It seems to me that Clark Fishing's provision of lifejackets and verbal policy in relation to the wearing of lifejackets was, self-evidently, insufficient. I do not for a moment underestimate the difficulty of developing and implementing safety policies in a small organisation like Clark Fishing. For that reason I do not criticise Clark Fishing for not having a written safety management policy as such. However, Mr Russell's tragic death starkly illustrates why such policies are necessary and must be rigorously implemented.

Mr Russell's Inability to Swim

65. Mrs Russell gave evidence that Mr Russell could not swim. I accept her evidence that he could not. Although Mrs Russell believed that it was well known that Mr Russell could not swim, Mr Clark said he did not know and there was no other evidence that anyone else knew of Mr

Russell's inability (other than Seafood Training Tasmania).[24]

66. In view of the state of the evidence, I am not satisfied that Mr Russell's employer knew he could not swim. However, the point I made above that Mr Clark appears not to have asked Mr Russell whether he could swim or to ever view any of his documentation in respect of his qualifications is relevant to this point, especially given that Mr Russell had told representatives of the training authority of his inability to swim (and that fact is documented).

67. I do not consider Mr Clark's assumption that Mr Russell could swim was a sufficient discharge of his obligations to him in the circumstances. Mr Clark engaged Mr Russell as a deckhand. The job involved working alone, unsupervised, in a small dinghy in remote areas subject to extremes of weather. Never having seen Mr Russell swim and simply assuming that he could was not enough. In my view an enquiry as to the ability to swim when employing someone to work as a deckhand is a basic precaution that should have been undertaken. Plainly, as this case tragically illustrates, an assumption that a prospective employee had that ability is not enough.

68. I have already referred to Dr Watzl's evidence. I accept him as an expert appropriately qualified to express the opinions he did. I accept the opinions he expressed. His evidence included an opinion about the physiological response to accidental immersion of a person in cold water. Dr Watzl said cold shock causes decreased muscle function and a consequent reduced ability to swim. The phenomenon has various stages, leading to incapacitation and death. Based on weather data, the temperature of the water into which Mr Russell entered is estimated to have been around 14ºC. This falls within the definition of 'cold water' for the purposes of assessing cold water immersion. Critically this falls

[24] See exhibit C29, document 12.

below the threshold of 15ºC identified by Dr Watzl's as being the temperature at which most effects of cold water immersion occur.

69. According to Dr Watzl even a competent swimmer may be affected by cold shock. That is because, particularly with the panic following a sudden immersion, more energy is required to stay warm and afloat. Without a lifejacket, more energy is spent trying to stay afloat. Treading water takes warm blood from the core to extremities, thus speeding up a person's cooling. Similarly, a less competent swimmer will use more energy trying to stay afloat than a competent swimmer.

70. Dr Watzl considered Mr Clark's description of Mr Russell coughing and spluttering to be consistent with symptoms of cold water immersion. Similarly, Mr Russell's sinking without support is consistent with the second stage of cold water immersion.

71. Dr Watzl opined that based on Mr Clark's evidence that Mr Russell was managing, albeit struggling, to remain afloat, he had some ability to swim or stay afloat. However, the relevance of an inability to swim is clear. A competent or strong swimmer would expend less energy in attempting to stay afloat than someone who could not. The corollary of this is that a competent swimmer could remain afloat and alive for longer. Mr Russell was not, on any view of it, a competent swimmer. His chances of survival once he entered the water were low and made lower by his not wearing a lifejacket.

Enhancing Safety Within the Abalone Fishing Industry

72. At the inquest it became clear that, doubtless because of the size of the operation and community of Dover, Mr Russell's engagement by Mr Clark was informal. It was equally clear that informality was the hallmark of engagement of deckhands throughout the abalone industry in the state. It was equally clear from Mr Clark's evidence that such an informal

method of engagement is necessarily based on a number of assumptions and was, in real terms, an abrogation of managerial responsibility. In the context of Mr Russell's death, Mr Clark assumed Mr Russell could swim and assumed that Mr Russell would wear a PFD that was "in-service". Neither of those things proved to be correct and Mr Clark took no steps to ensure his assumptions were correct.

73. The evidence at the inquest was that a Code of Practice had been approved for the Tasmanian Abalone Industry. That Code was in evidence. It is many years old and has no regulatory or statutory force in the sense that compliance with it is not mandatory (although failure to comply would likely be a relevant matter to consider for a court dealing with a prosecution under the *WHS Act*).

74. The code focuses almost entirely upon the safety of the diver and is essentially silent with respect to the safety of the deckhand.

75. In contrast, the Abalone Industry Committee of Victoria has developed and promulgated a simple sample safety management system. The system was tendered at the inquest.[25] Counsel assisting submits that the Victorian model has much to commend. I agree. At its most basic the Victorian system is a simply understood formal written safety management system easily applied throughout the abalone industry. The implementation of such a system would help avoid dangerous informality and proceeding on untested assumptions.

76. Evidence at the inquest was that commercial vessels are regulated by the Australian Maritime Safety Authority (AMSA). That organisation is based in Canberra. Amongst other things it has responsibility for regulating whether commercial vessels meet survey requirements. A

[25] see exhibit C 32

national system in this regard is in place.[26] That system came into place on 1 July 2013. Before then the seaworthiness of commercial vessels was regulated at a state and territory level. In Tasmania that was done by Marine and Safety Tasmania (MAST). It is beyond the remit of these findings to comment upon whether safety at sea has been improved as a consequence of a centralisation of marine safety regulatory compliance oversight.

77. However it is appropriate in my view to look at a particular aspect of regulation in the context of Mr Russell's death. As I have already mentioned the dinghy did not require an independent survey. The rationale seems to be that the dinghy operates as an extension of the mothership which must be in survey. The fallacy of such an approach, or so it seems to me, is that it equates the dinghy with other pieces of equipment such as flares, EPIRBs and the like. The tender dinghy is much more than a piece of equipment. Experienced maritime surveyor Mr Brancher said that because the dinghies operate independently of the mothership he considered that they should be treated as individual vessels and equipped (and surveyed) accordingly. I agree with Mr Brancher's contention. In this instance whilst I accept that the dinghy was seaworthy, and very well equipped in terms of safety equipment, it was operating independently of the *Breaksea*. I accept counsel assisting's submission that it is appropriate to comment about the desirability of a tender dinghy being independently surveyed, even though the dinghy not being independently surveyed did not cause or contribute to Mr Russell's death.

[26] see Marine Safety (Domestic Commercial Vessel) National Law Act 2012 (Cth) and Marine Safety (Domestic Commercial Vessel National Law Application) Act 2013 (Tas)

Formal Findings

78. On the basis of the evidence at the inquest I make the following findings pursuant to section 28(1) of the *Act*:

    a. The identity of the deceased is Allan Geoffrey Russell.

    b. Mr Russell's death was the result of him entering the water likely at the same time but possibly preceding the capsize of the tender dinghy.

    c. The cause of Mr Russell's death was drowning.

    d. Mr Russell died between 1.00pm and 3.00pm on 14 April 2015 in the waters south of Red Point, Louisa Bay, Tasmania.

Comments and Recommendations

79. In accordance with s 28(2), I **recommend** that:

    a. The Tasmanian Abalone Council Ltd and WorkSafe Tasmania review the Tasmanian Abalone Industry Code of Practice and consider amendments in line with the system developed by the Abalone Industry Committee of Victoria that address the engagement and qualifications of deckhands, the wearing of lifejackets and the condition of vessels off which diving occurs (i.e. tender vessels such as the dinghy).

    b. The Australian Maritime Safety Authority review the survey requirements for tender vessels, noting that such vessels at times operate with considerable independence and autonomy.

80. In accordance with s 28(2), I **comment** that it is critical for all persons spending time on the water to wear a correctly fitted and serviced lifejacket at all times.

Conclusion

81. I extend my thanks to counsel who appeared at the inquest, Mr Hallett and Mr Thompson, for their assistance.

82. I formally acknowledge the contribution of Mr Bryan Denny and Mr Larry Coulson, crew of the *Montunui*, to the search for Mr Russell.

83. In conclusion I extend my condolences to the family, loved ones and friends of Allan Geoffrey ‘Joe’ Russell on their loss.

Dated 10 May 2019 at Hobart in Tasmania

Simon Cooper
Coroner