IN THE CORONERS COURT
OF VICTORIA
AT WARRNAMBOOL

Court Reference: COR 2012 005004

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, Mr Jonathan G Klestadt, Coroner, having investigated the death of Robert J Ward

without holding an inquest:
find that the identity of the deceased was Robert J Ward
born on 24 October 1947
and the death occurred 25 November 2012
at East Beach PORT FAIRY 3284 VIC
from:

1a Consistent With Drowning

Pursuant to section 67(2) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances**:

On the afternoon of Saturday the 25th of November 2012 what should have been a pleasant days fishing turned in to a tragedy claiming the lives of Robert and Kaye Ward. At the time of their deaths Robert Ward was 65 years old, and Kaye Ward was a few days short of her 61st birthday. Both were suffering from a variety of medical conditions, which compromised their mobility and fitness.

On the 25th of November Mr. and Mrs. Ward had come to Port Fairy with Mrs. Ward's 43 year old son from a previous marriage, Mr. Brian Clarke. The three lived at the same address in Warrnambool and were joint owners of their fishing boat.

The weather on Sunday the 25th of November was fine, with a moderate south to south easterly wind. The breeze increased in strength during the day from about 10 knots, to up to 20 knots later in the afternoon. The area in which the deceased and Mr. Clarke were fishing was partially sheltered by the easternmost end of Griffiths Island but during the later part of the afternoon the swell and wind waves would have increased to the stage that the conditions would have been at the upper limit for their boat.

The boat in which the deceased and their son were fishing from was a 4.5 metre Delta Craft open "runabout" with an enclosed foredeck and a windscreen. Although no positive evidence of its' age is available it appears to have been manufactured in the 1970's or early 1980's. It had been bought in June or July 2012 from JV Marine in Melbourne and was properly registered and fitted out. While

some technical deficiencies in the boat and it's equipment were noted in the report by Transport Safety Victoria dated 22nd March 2013 it is clear that none of these contributed to the incident leading to the death of Mr. and Mrs. Ward.

After driving from Warrnambool to Port Fairy the boat was launched in the Moyne River boat ramp sometime around 1.00pm. The 3 occupants donned their inflatable Personal Flotation Devices (PFD's) and Mr. Ward, who was the only licensed boat operator, drove the boat out of the river and into the area known as Belfast Bay. They travelled east towards Warrnambool for about 500 metres before stopping the motor and setting their lines. To slow the rate of drift and position the boat beam-on to the waves, small drogues or sea anchors were set fore and aft.

After drifting and fishing for about 45 minutes it was seen that they had drifted to the north towards the beach to a point where they were getting too close to the breaking waves near the shore. The boat's motor was started without incident, the sea anchors were retrieved, and they motored out into deeper water, where they again stopped the motor, deployed the sea anchors, and began fishing.

After another 45 minutes or so Mr. Clarke observed that they were again in shallower water and approaching the northern shoreline, and so it was decided to move further out to sea. However, when they attempted to start the motor it would not fire. It was apparent that the boat's battery was still charged, but no power was getting through to actuate the starting solenoid, which activates the starter motor. The motor had come with the boat and was a Suzuki 65 horsepower unit of indeterminate age. It had previously operated without incident, but on examination after the incident it was discovered that the main cable supplying power from the battery to the starter solenoid had corroded to the point that no electrical connection existed.

When it was clear that they were not able to start the motor Mr. Clarke deployed the boats principal anchor in an effort to stop the boat drifting into the breaking waves. The anchor was a 1.8 kilogram "Danforth" style sand anchor. Although it had an anchor rode of adequate size and length, the anchor itself was approximately half the 4 kilogram weight of the recommended anchor for the size of boat.

Mr. Clarke and Mr. Ward attempted to attract the attention of others by using the boat's radio to call for help. The radio was a 27 megahertz (Mhz), two way radio, of a type that was once commonly used by recreational fisherman. It has a limited range and power, and has been gradually superseded by the more powerful VHF (Very High Frequency) radios. While the 27 Mhz radio is of some use it is not commonly monitored by shore based services. No response was elicited from these radio calls.

A vessel was seen leaving the mouth of the Moyne river, approximately 1 nautical mile to the south of the boat, and a small surf lifesaving rescue boat was also noticed to south west. Attempts were made to attract their attention by waving the boat's paddle in the air, and by letting off a red hand held flare and an orange smoke flare. Although each operated properly they were apparently not noticed by anyone on the other vessels or onshore.

It was becoming clear that the bow anchor was not holding the boat stationary, but was dragging along the bottom causing the boat to drift further towards the breaking waves and surf on the northern shore of Belfast Bay. All occupants inflated their PFD's and Mr. Clarke entered the water in an attempt to reach the shore and get help for his mother and Mr. Ward. It seems the boat was at this stage about 350 to 400 metres from the shore and close to the line of breaking waves. It was recognised that neither Mr. or Mrs. Ward were fit enough to attempt to reach the shore in the water.

Mr. Clarke was shocked by the cold temperature of the water and was only able to "dog paddle" for a short time before being forced to turn on his back and kick his legs. A large part of the problem was that his PFD rode up over his shoulders and he had to use his arms to hold it down and stop it slipping over his head.

When Mr. Clarke reached the beach he was very fatigued and turned to see that the boat was still upright with his mother and Mr. Ward still aboard with their PFD's on. The boat was still just outside the line of the breaking waves.

Mr. Clarke ran along the beach towards the west where he encountered two people and enlisted their aid. After a short while a mobile phone call was made to 000. The call was logged at 3.08 pm.

Meanwhile the boat had entered the breakers and capsized. Mr. and Mrs. Ward either jumped or were thrown from the boat into the water. Neither survived their time in the water, and their bodies were cast onto the beach within a few minutes. Although rescuscitation efforts were made by Mr. Clarke, lifesavers, and paramedics, neither was able to be revived. In each case it was determine that no autopsy should be performed but upon inspection, a pathologist from the Victorian Institute of Forensic Medicine found that the deaths of Mr. and Mrs. Ward was consistent with drowning.

It should be noted that both deceased were located with their PFD's still attached to their bodies and inflated, however the device was not in place around their neck and head. A similar difficulty referred to above, was noted by Mr. Clarke.

The wearing of PFD's in certain small craft was made mandatory in Victoria in the 1990's. Many sailors and motorboat users wear an inflatable "shawl" style PFD to comply with this law because they are easier and less cumbersome to wear in the confines of a small boat. In this case, each of the three occupants of the boat was wearing a commonly available and approved inflatable Type 1 PFD. I am aware from my own experience and from anecdotal evidence that these PFD's have a significant design flaw.

In the absence of a means of preventing the inflated PFD from riding up on the body of the wearer, due, naturally, to its' buoyancy, a considerable effort is required by the wearer to stop from slipping out and through the device. This usually means placing ones arms over the top of the inflated chamber and using the arms to bear at least part of the body's weight. The straps securing the device laterally around the body will not perform this function unless they are unreasonably tight. The effect of this flaw is that a person in the water relying on the PFD for support cannot use their arms for any other purpose, such as swimming, holding onto others, or attempting to raise himself or herself onto another boat or platform.

High-end PFD manufacturers and professional mariners recognise that, to be effective, an inflatable PFD must be fitted with a means to stop the device riding up. The most effective way to do this is a "crutch strap", or straps. These straps pass from the front of the device, under the wearers groin, and secure to the back. A properly designed and adjusted crutch strap only marginally increased the discomfort level and cumbersomeness of these devices but is vital for their proper deployment.

I note also that the anchor on the boat owned by the deceased and Mr. Clarke was inadequate for the size of the boat and the conditions which existed on the afternoon of the 25th November 2012. Whilst there are standards for equipment that is required by law to be present aboard a boat, an anchor is a most fundamental piece of emergency gear. Any attempt to reduce the size of an anchor to save money or weight is ill conceived.

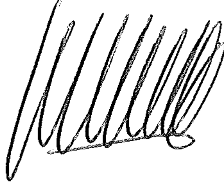
The tragic death of Mr. and Mrs. Ward is a reminder to all of us who enjoy spending time on the water that the sea demands our respect. Constant vigilance is required to ensure that circumstances do not contrive to place us, and those who are our responsibility, in a situation where a life could be lost. The provision of adequate equipment and the maintenance of that equipment is a basic requirement for the safe operation of any vessel at sea.

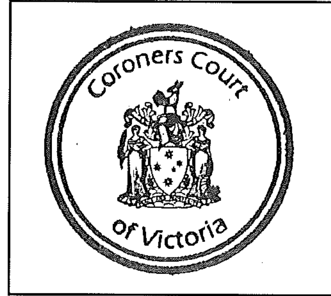
RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

I recommend that the Transport Safety Victoria consider seeking a modification to the Australian Standard for Type 1 inflatable PFD's to require that a crutch strap be a part of the design of these devices.

Signature:





Mr Jonathan G Klestadt

Date: 21/11/2013