



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 2002

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Andrew Francis Powell
Date of birth:	11 March 1987
Date of death:	21 April 2019
Cause of death:	1(a) Drowning
Place of death:	Rutledge Creek Bay, Port Campbell, Victoria

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INTRODUCTION

1. On 21 April 2019, Andrew Francis Powell was 32 years old when he died while performing a volunteer lifesaving operation in rough waters. At the time of his death, Mr Powell lived at Cooriemungle with his partner.

THE CORONIAL INVESTIGATION

2. Mr Powell's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.
3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Powell's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
6. This finding draws on the totality of the coronial investigation into Mr Powell's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.¹

¹ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

7. On 21 April 2019, Andrew Francis Powell, born 11 March 1987, was visually identified by his mother, Valeria Powell.
8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Forensic Pathologist, Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (VIFM), conducted an inspection on 22 April 2019 and provided a written report of her findings dated 30 April 2019.
10. The post-mortem examination revealed a right-sided occipital fracture with pneumocranium and fourth ventricle and interventricular haemorrhage, increased lung markings in keeping with drowning, lacerations around the right side of the head and neck, and bruising of the right arm.
11. Dr Glengarry concluded that drowning represented the final mechanism in the setting of adverse environmental conditions, namely rough seas and capsizing with concurrent head injuries.
12. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.
13. Dr Glengarry provided an opinion that the medical cause of death was "*1(a) Drowning*".
14. I accept Dr Glengarry's opinion.

Circumstances in which the death occurred

15. Mr Powell, affectionately known to loved ones as 'Andy', grew up on the family farm in Cooriemungle with four older siblings. In adulthood, he followed in his father's footsteps and continued working on the family farm. And like his father, Mr Powell was also an active volunteer in his community, becoming a member of the Port Campbell Surf Life Saving Club and State Emergency Service.

16. At the time of his death, Mr Powell and his partner were looking forward to the birth of their first child. Mr Powell was described as loyal, selfless, loving, honourable, and committed.
17. The Powell family lovingly provided the following description of Andrew and his father, which fittingly encapsulates the determination of the heroic actions they went on to display on 21 April 2019:²

The key to both Andy and Ross' lives was nothing less than character, rectitude, dignity, a sense of what is right, being responsible and decorous. They were the type of people that would always do the right thing, even if nobody was watching.

Ross and Andy's lives were enriched by the contribution they made to society. And our community was so much richer for the their contribution.

The beach

18. Sherbrook Beach is located approximately 7.5 kilometres east of Port Campbell. It is known to be rough with strong rips. Posted signs variously warned against swimming due to strong currents and large waves.³

The vessel

19. The Port Campbell Surf Life Saving Club owned and operated an offshore rescue boat known as the 'Pelican'. Life Saving Victoria allocated it the call sign of 'Western 21'.
20. Manufactured in approximately 1982, it had was a 5.85 metre rigid hull inflatable hull constructed of fibreglass with an inflatable pontoon. It was fitted with twin 70 horsepower Yamaha 4-stroke outboard engines and weighed approximately 1.16 tonne.
21. The Port Campbell Surf Life Saving Club purchased the vessel in approximately 1988. The Yamaha engines were fitted in 2014 and were last serviced in November 2016.
22. In 2018, a Kenwood NX-5700 mobile radio kit with separate speaker inside the console was installed on the Pelican.⁴

² Coronial Brief (CB) 89.

³ CB 1550-1552, 1569-1570.

⁴ CB 2002-2016.

The events of 21 April 2019

23. On the morning of 21 April 2019, two tourists visited Sherbrook River. Abhinash Balachandran Pillai, from Singapore, was with his friend, Sanjay Bhaskar, who lived in Australia at the time. They parked in the Thunder Cave and Broken Head car park and walked down the track to the mouth of the Sherbrook River, passing multiple warning signs along the way.⁵
24. At this time, the Sherbrook River entrance was silted over and there was no water flow between the river and the ocean.
25. Mr Bhaskar intended to take a dip in the ocean and then the river. While he described himself as a good swimmer, his only intention on this occasion was to wade into waist-high water. He stood on the beach for a while and watched the waves and determined that they did not appear dangerous.⁶ Conversely, Mr Balachandran Pillai described the waves as *“pretty high. The wave heights were maybe more than two metres high.”*⁷
26. Mr Bhaskar stated that he stood in the water for about five minutes. The water then quickly became deeper, and waves began crashing over him. He tried to swim back to shore but the waves kept pushing him our further to sea.⁸
27. Sometime after entering the water, Mr Bhaskar began signalling to Mr Balachandran Pillai, who was still on the beach. He initially thought he was asking him to take a photo. It eventually became clear that Mr Bhaskar was in fact signalling for help and was being swept away from the beach. He was eventually swept up to 100 metres offshore and unable to return to the beach. He was pushed toward the cliff face and began swallowing seawater.⁹
28. At 10.34am, Mr Balachandran Pillai telephoned emergency services for assistance. This call was hampered by communication difficulties and Mr Balachandran Pillai not knowing the location. Passers-by assisted with determining the exact location, but it was only after some minutes that it was made clear that a person was in the water and needed rescuing.¹⁰

⁵ CB 76.

⁶ CB 66.

⁷ CB 76.

⁸ CB 67.

⁹ CB 67, 76.

¹⁰ CB 77.

The weather and sea conditions

29. The weather forecast for 21 April 2021 was cloudy with a high chance of showers and a chance of an afternoon thunderstorm. Winds were forecast to be northwest to north-easterly 25 to 35 kilometres per hour, tending west to north-westerly 15 to 25 kilometres per hour in the middle of the day, then turning south-westerly 15 to 20 kilometres per hour in the afternoon. The daytime maximum temperature was forecast to be in the low 20s.¹¹
30. The coastal waters forecast was north to north-easterly winds 15 to 20 knots tending north-westerly during the morning, then shifting south-westerly from the west during the afternoon. Forecast seas were one to two metres, decreasing to one to one and a half metres in the morning. Swell was south-westerly two to three metres, increasing to three to four metres during the morning.¹²
31. Phillip Younis, an experienced member of the Port Campbell Life Saving Club and a local community member with an intimate knowledge of the coastline, later stated to police that on the morning of 21 April 2019, he observed a rising and powerful swell.¹³ He said it was an “ugly looking” and a “messy sort of thing”. It was a solid westerly ground swell on the rise.¹⁴

The responders

32. At 10.42am, a multi-agency emergency response was activated with Victoria Police (in the Warrnambool Police Service Area), the State Emergency Service, and the Country Fire Authority being alerted. Given that some of the agency volunteers were members of more than one organisation, word of the emergency quickly spread around town and Parks Victoria and the Port Campbell Life Saving Club were subsequently alerted informally.
33. Phillip Younis, Port Campbell Country Fire Association Captain and Life Member of the Port Campbell Surf Lifesaving Club, was finishing a job attending a fire incident when he received alerts on his State Emergency Service and Country Fire Authority pagers.¹⁵ He immediately

¹¹ CB 962.

¹² CB 970.

¹³ Detective Senior Constable Kane Treloar described the sea state as “*significant, with the swell coming almost directly onshore to Sherbrook beach*” and estimated the swell would have been two metres and there was significant form: CB 249. Simon Illingworth, member of the Port Campbell Fire Authority, stated the waves were over 15 feet: CB 306. David McKenzie, Port Campbell Surf Lifesaving Club member, described the swell as enormous with broken water everywhere: CB 333.

¹⁴ CB 1868, 1871.

¹⁵ CB 329.

made his way to the Life Saving Club. At this time, Ross and Andrew Powell were also heading to the Life Saving Club to launch the Pelican.

34. At approximately 11.05am, the Victoria Police Rescue Co-Ordination Centre was notified of the incident and commenced co-ordination of the response. The Rescue Co-Ordination Centre is located at the Water Police Squad office in Williamstown and designed for coordination of marine rescues. Initially there were communication difficulties with units on scene but by 11.10am, they had made contact with a police unit on the scene.¹⁶
35. At about the same time, the Port Campbell Life Saving Club tower had also commenced radio communication with Life Saving Victoria (based in Melbourne) and advised that the Pelican would be deployed in response to the incident.¹⁷

The attempted rescue

36. At 11.08am, the Pelican crew conducted a radio check with the Port Campbell Life Saving Club tower. The Pelican was launched.¹⁸
37. At 11.10am, the Pelican, operated by Mr Younis, left the pier, and headed out of Port Campbell Bay. Ross and Andrew Powell were the other crew members. Mr Younis later stated to police that he observed to Ross and Andrew Powell that the water was nasty, and they had to be careful.¹⁹
38. As part of the response, cliff-top co-ordinators were deployed via road to the land side to assess conditions at the scene for the purpose of providing briefings regarding conditions to the Pelican via Life Saving Victoria communications. The first briefing from the cliff-top co-ordinators *en route* was at 11.16am, informed the tower of “*really big surf, quite rough*”.²⁰
39. However, the cliff co-ordinators did not head directly to the cliff top. They initially diverted to Sherbrook Beach to assist in an immediate rescue attempt. One of the co-ordinators subsequently commenced paddling on a board to Mr Bhaskar but aborted the attempt due the conditions and inability to bring Mr Bhaskar back to shore. He returned to the beach.²¹

¹⁶ CB 423-424.

¹⁷ CB 159, 217, 1207.

¹⁸ CB 159, 229, 1207, 1898; Exhibit 31.

¹⁹ CB 1875-1876.

²⁰ CB Exhibit 31.

²¹ CB 182, 188.

40. At 11.17am, the Rescue Co-Ordination Centre updated Life Saving Victoria communications as follows:²²

The male is in the water, on the western side of the river entrance. It sounds like he is closer to the cliff faces though, and he is getting hit with two-metre swell and he can't get out of there. I don't know if the vessel will be able to get in that close. We've got two air units en-route.

41. At 11.18am, the Pelican arrived on the ocean side of Sherbrooke Beach out the back of the surf break and reported a huge swell, which would make entry difficult.²³ The Pelican conducted a couple of parallel runs to the beach and swell direction to assess the ability to proceed further inshore.²⁴

42. Ross Powell, who was providing communication from the Pelican provided a situation report to Life Saving Victoria Communications noting, "*Huge seas here ...*". Hearing only the tail end of the report from the Victoria Police Rescue Co-Ordination Centre, Ross Powell asked for a situation report from Life Saving Victoria and was told:²⁵

Po, it appears that there is a male in the water on the western side of the river mouth entrance, we've been told the sea is quite dangerous in there and he is trapped on the little beach to the west side of the river mouth and at this point may be too dangerous for the boat to get in there.

43. Ross Powell acknowledged the message and replied that they were assessing the conditions but agreed the seas were "*really big*".²⁶

44. At 11.19am, Life Saving Victoria communications confirmed that the Pelican crew understood there was Victoria Police air support on the way, to which Ross Powell replied, "*Roger that*", but it appears he was unaware of how far away it was or where it was coming from.²⁷ Mr Younis later stated to police that they may not have proceeded had the crew been aware the arrival of a helicopter was in fact imminent.²⁸

²² CB Exhibit 31.

²³ CB 160, 1207.

²⁴ CB 1876, 1953-1955.

²⁵ CB Exhibit 31.

²⁶ CB Exhibit 31.

²⁷ CB 1877, 1922-1923.

²⁸ CB 1922-1923.

45. Mr Younis later stated to police that when he heard chatter on the radio, he attempted to back off a couple of times to make communication easier, but Ross Powell told him to keep going and confirmed he could hear communications.²⁹ It is evident that Mr Younis was unable to hear exactly what was being communicated over the radio.³⁰
46. At 11.21am, Mr Younis manoeuvred the Pelican inside the outer breaking waves into an area close to the inner break in an attempt to locate Mr Bhaskar. Mr Younis noted it was a unanimous decision to move closer for a look and he would not have proceeded if one of the crew felt uncomfortable doing so.³¹
47. Mr Younis later stated to police that when they went in there was someone on the eastern side waving, someone on the beach waving and when they got in and started running parallel, Mr Powell had said, *“This is – this is weird ... I think we need to get out of here, I don't like it”*. He said, *“... we can't see anything and there is different signals coming from the beach and we need to get in touch with ... our clifftop to find out exactly what's going on.”* He further stated that he said to Mr Powell that he would do a ‘loop’ and then stop to use the radio as they could not hear anything on the radio. They decided that they needed to go out the back of the waves and shut the engines down to listen to the radio.³²
48. At 11.22am, Mr Younis navigated the Pelican over a breaking wave launching off the back and continued out to sea.³³ However, the swell was building, including along the previously safe passage they had used to enter.

Capsize of the Pelican

49. Mr Younis then attempted to navigate the next wave, which had already commenced breaking, by motoring directly into the wave but it appeared the Pelican had suffered a catastrophic fault. Mr Younis stated:³⁴

Andy yelled out, “Outside motor’s not – stopped”. So I pulled the outside motor throttles back to neutral, hit the starter, as we do, and give it to her again and still no power.

²⁹ CB 1875-1876, 1900.

³⁰ CB 1921.

³¹ CB 1933-1934.

³² CB 1877-1878, 1955-1956, 1975, 1987.

³³ CB 1956-1957.

³⁴ CB 1879-1880.

Then I looked down and [the dial] for the outside motor was blank.

And I sorta – I've got the key off or something so, "Are the keys on?" "Yes, the keys are on." How I pulled the – we have a lanyard here that's got the autostop.

"Is that out?" And, "No, no everything's right". Tried again. Nothin'. Looked up and this bloody was – with one motor you've got ... bugger all. You've got less than ... It's not like half. It's less than ... well less than a third.

You've only got enough to sort of move and I thought, "Well, we're gunna have to take it nose on. If I turn now, I'm gunna – it's gunna hit us sideways for sure". I didn't have enough time to turn around and, you know, catch it up the bum.

So I just – and Po's saying – Po's like, "Go, go, go, go go." So I just give it with the one motor.

Unfortunately with the way it broke on the bow of the boat ... and exploded us to, you know, God knows where.

50. The wave subsequently consumed the Pelican and capsized it, bow over stern.
51. At approximately 11.26am, the crew were all ejected from the vessel.³⁵ Mr Younis subsequently surfaced and observed both Ross and Andrew Powell motionless and face down in the water. At no stage did Rose and Andrew Powell show any signs of regaining consciousness in the water. Mr Younis had suffered a fractured and dislocated pelvis in the incident and was unable to assist them.³⁶

Retrieval of survivors and the deceased

52. A short time later, the Ambulance Victoria Helicopter Emergency Service (**HEMS 4**) arrived over the overturned Pelican.³⁷ An attempt was made to winch down to either Ross or Andrew Powell, but large waves meant the attempt was aborted. The sea was described as heaving, surging, and breaking white water estimated to be greater than 10 feet high. Any attempt to locate and winch any person in the water would be very difficult.³⁸

³⁵ CB 1208, 1227.

³⁶ CB 1881, 1887-1888, 1964, 1977-1978.

³⁷ CB 1235.

³⁸ CB 411.

53. Mr Younis was swept to a point located between Sherbrooke River and Rutledge Creek, and in and out of cave in the cliffs.³⁹ The HEMS 4 was eventually able to winch him, and he was lifted to Sherbrooke Beach where he was attended to by paramedics and eventually airlifted to hospital.⁴⁰
54. The Pelican drifted into a cove off Sherbrooke Beach and Mr Bhaskar was able to grab hold of an attached line. A Parks Victoria officer on the clifftop threw him a life jacket, which Mr Bhaskar eventually grabbed.
55. After dropping off Mr Younis, HEMS 4 headed toward Mr Bhaskar who, by this stage, had been in the water for more than one hour and 20 minutes. At approximately 11.50am, he was winched out of the water and dropped off to paramedics, who transported him to hospital. Mr Bhaskar received superficial injuries in the incident.⁴¹
56. Throughout these two rescues, Ross and Andrew Powell remained motionless in the water and eventually drifted around the point and into a cove at Rutledge Creek, which is the west side of Sherbrooke River. HEMS 4 hovered over them and dropped dye markers to mark their location in anticipation of the Victoria Police helicopter (**POLAIR**) arriving.⁴²
57. At approximately 1.00pm, POLAIR winched Ross Powell to the top of the cliff where emergency services were positioned. He had sustained a laceration to his head and was deceased. Although he was no longer wearing a Personal Flotation Device (life jacket), he had been wearing one whilst he was on the Pelican. It appeared his Personal Flotation Device had become loose in the conditions.
58. Almost an hour later, POLAIR later winched Andrew Powell to the top of the cliff. He also had a large laceration to his head and was bleeding from his ears and nose and was also deceased. He was still wearing his Personal Flotation Device, which had not been deployed.

Criminal charges

59. Leading Senior Constable Obst has informed me that no criminal charges have been pursued.⁴³

³⁹ CB 1883-1885.

⁴⁰ CB 411, 414.

⁴¹ CB 69, 411.

⁴² CB 411, 416.

⁴³ Email from Leading Senior Constable Chris Obst, 15 June 2020.

INVESTIGATION INTO CONTRIBUTING FACTORS AND PREVENTION OPPORTUNITIES

Life Saving Victoria Critical Incident Review

60. Part of my investigation has been informed by a Critical Incident Review conducted by Life Saving Victoria.⁴⁴ This report was commissioned by Life Saving Victoria and the Port Campbell Surf Lifesaving Club and conducted by three independent reviewers. In addition to a review of the events of 21 April 2019, the scope included a review of equipment and training, operational management, and the processes and systems in place at the time. An objective of the outcome was to identify changes required to equipment, training, and process. The reviewers subsequently made 32 recommendations covering the following areas:
- (a) training, qualifications, and compliance;
 - (b) vessel licensing, audits, maintenance, and trials;
 - (c) safety aids/equipment for crew members
 - (d) the maintenance of a marine rescue service in the area and consideration of requirements for future responses;
 - (e) operation procedures and interaction between agencies;
 - (f) command hierarchy and information dissemination and information recording during rescues; and
 - (g) planning for future rescues.
61. I note that an objective in section 7 of the *Coroners Act 2008* is for the Court to avoid unnecessary duplication of inquiries and investigations. I also note that Life Saving Victoria commissioned a report from three subject-matter experts in this area, and their investigation has been particularly thorough with sound recommendations made. Given this, I do not intend to repeat the findings or recommendations of the Critical Incident Review. Rather, I have attached the recommendations from that report to my finding (Appendix 1) and will limit my finding to the prevention opportunities not identified or traversed by Critical Incident Review.

⁴⁴ Life Saving Victoria, Critical Incident Review, Rescue Operation Sherbrook River, Port Campbell 21 April 2019, July 2019.

I note that as of 24 March 2021,⁴⁵ 22 recommendations had been accepted and implemented, seven were in progress,⁴⁶ two had been declined,⁴⁷ and one was ‘to be announced’.⁴⁸

Coroner’s Investigator

62. Leading Senior Constable Christopher Obst, Coroner’s Investigator, also prepared a particularly detailed coronial brief capturing the events of 21 April 2019 and the various factors that may have contributed to the incident. His expertise and thoroughness have greatly assisted my investigation.
63. Leading Senior Constable Obst has also suggested a number of recommendations to prevent deaths from occurring in similar circumstances, including:
- (a) review of signage in the area;
 - (b) availability of rescue aids on the clifftop;
 - (c) consideration of helmets for rescue crew to reduce the risk of head injury and provide for adequate radio communications (also recommendations made by the Critical Incident Review);
 - (d) a review of current Victorian search and rescue vessels and their suitability for their role (the safety issue raised here is largely addressed by several recommendations made by the Critical Incident Review which recommend oversight by Life Saving Victoria and the development of a Safety Management System for all marine rescue vessels);
 - (e) seaworthiness inspections of vessels (also addressed by the Critical Incident Review, however addressed in terms of maintenance and sea trials);

⁴⁵ I also obtained a statement from Detective Senior Constable Kane Treloar, Director of Lifesaving Services at Life Saving Victoria, dated 24 June 2021, which provided a further update of the implementation of the recommendations made by the Critical Incident Review.

⁴⁶ Of the recommendations in progress, six were awaiting the delivery of a coronial finding but some work had been undertaken in anticipation. The remaining recommendation referred to Port Campbell Life Saving Club engaging with Victoria Police and other agencies to plan for the Easter period, when the area receives an influx of tourists. As the Life Saving Club had withdrawn their Marine Search and Rescue Service, this was not implemented. However, Life Saving Victoria maintains a strong relationship with the Victoria Police Water Police Squad and meets regularly with their management.

⁴⁷ According to an update from Life Saving Victoria on 24 March 2021 and the statement from Detective Senior Constable Treloar, the two declined recommendations appear to be wholly due to the Port Campbell Surf Live Saving Club withdrawing a Marine Search and Rescue service, but there was a view to re-establish a service at some point.

⁴⁸ This recommendation referred to the review panel reconvening after the delivery of a coronial finding.

- (f) clear delineation of roles when volunteers are members of more than one responding agency; and
- (g) implementation of improved interagency communication methods.

Signage warning of dangers

- 64. While there was signage present warning of the dangers of swimming, the victim and the person who initiated the emergency service response were both persons who had English as their second language.
- 65. Leading Senior Constable Obst suggested consideration could be given to a review of signage in identified hazardous beach areas along the Victorian coastline to explore a standard size and multilingual format. This type of strategy could be further extended to develop Australian customs information announcements and arrival card processes to acknowledge the dangers of swimming at beaches and education regarding swimming between the flags.
- 66. I intend to make a recommendation for signage that is specifically targeted to the tourist population who visit this area.

Availability of rescue aids

- 67. Leading Senior Constable Obst also noted that the circumstances of this incident included the fact that several emergency services and civilian witnesses were present and observing as it unfolded, however were powerless to provide any assistance due to the topography causing difficult access and the treacherous ocean conditions. A Parks Victoria officer arrived on scene with a personal flotation device after a significant time had passed and was able to deploy it over the edge of the cliff. Mr Bhaskar was able to reach the personal floatation device, and this almost certainly extended his timeframe of survival.⁴⁹
- 68. Leading Senior Constable Obst suggested life rings or rescue devices around cliffs at identified treacherous beaches could be considered for installation to provide timely rescue options to increase timeframes of survival. I intend to make a recommendation along these lines.

⁴⁹ Senior Sergeant Mark O'Rourke, Water Police Squad, agreed that the personal flotation device undoubtedly assisted in saving Mr Bashkar's life: Statement from Senior Sergeant Mark O'Rourke, dated 4 August 2021.

Clear delineation of roles and rescue co-ordination

69. As noted above, Mr Younis was alerted to the rescue emergency as a member of the State Emergency Service and the Country Fire Authority. It is assumed the Powells were alerted in the same way or via word of mouth that was quickly travelling about town. Various multi-agency volunteers subsequently made their way to the Life Saving Club to initiate a rescue response and subsequently self-deployed. This occurred before the Rescue Co-Ordination Centre even knew about the emergency.
70. Leading Senior Constable Obst noted there were difficulties for the various agency managers when considering notification processes and tasking. In his discussions with me, he noted that the benefit of having a control agency in control is that a Marine Coordinator has time to conduct a risk assessment, consider who should respond, and formulate a plan.
71. Leading Senior Constable Obst recommended the implementation of more robust system to identify and confirm specific roles when responders to a critical incident are aligned to more than one agency.
72. This recommendation has similarly been made by the Critical Incident Review, which recommended that Life Saving Victoria meet with other emergency service organisations to review tasking arrangements and conduct annual pre-season briefings.
73. As part of my investigation, I obtained a statement from Senior Sergeant Mark O'Rourke of the Victoria Police Water Police Squad⁵⁰ regarding multiagency co-ordination and communication between the control agency and the Marine Coordinator and the response agency, and how command and control is effected by the control agency when the response agency is making decisions 'on the ground'. In reviewing the events of 21 April 2019, Senior Sergeant Mark O'Rourke considered that task dispatch and response unit decision-making as the most significant issues.

The control agency

74. Senior Sergeant O'Rourke considered that the deployment of a winch-capable helicopter is, and should always be, the first consideration for a Marine Coordinator in a marine search and rescue incident in heavy surf conditions such as at Port Campbell. It provides the most time efficient and safest rescue option.

⁵⁰ Statement from Senior Sergeant Mark O'Rourke, dated 4 August 2021.

75. He explained that Victoria Police is the control agency for marine search and rescue arrangements in Victoria. The Water Police Squad provide the specialist coordination and response to marine search and rescue incidents in Victorian waterways, including coastal and inland waterways.
76. Victorian waterways are aligned with the local Police Service Areas, which will take responsibility for the marine search and rescue task and the Water Police Squad will take charge of the marine search and rescue on water response.
77. Senior Sergeant O'Rourke noted that the Water Police Squad coordinate and respond to approximately 1400 to 1500 marine search and rescue incidents per year, which are all coordinated from the Rescue Co-ordination Centre in Williamstown.
78. Victoria Police relies heavily on volunteer units to be able to provide a marine search and rescue and there are 30 registered volunteer units with over 800 members spread across coastal and inland waterways. These units are utilised on a daily basis and are considered the backbone of marine search and rescue in Victoria. The majority of marine search and rescue incidents coordinated by the Water Police Squad involve recreational vessels and response units are Water Police, Coast Guard, or Volunteer Marine Rescue units.

Task dispatch

79. Senior Sergeant O'Rourke explained that the initiation of the task in this matter was via 000. This resulted in the dispatch of the job to the Warrnambool Police Service Area, State Emergency Service, and Country Fire Authority at 10:42am.
80. The Rescue Co-ordination Centre was not notified until approximately 11:05am by which stage the crew of the Pelican was in the process of deploying. By the time the Marine Coordinator had a clear picture of conditions and potential response, the Pelican crew had deployed.
81. Senior Sergeant O'Rourke noted that given the time critical nature of the job and the fact that marine search and rescue expertise sits within the Rescue Co-ordination Centre, the Rescue Co-ordination Centre notification should occur to ensure the most efficient and safe response possible. This enables the task to be triaged and risk assessed at the earliest opportunity.
82. He explained that in order address this issue in the short term, the Water Police Squad has worked closely with Police Communications, which now have a direct link into the Rescue

Co-ordination Centre. All incoming jobs are monitored by a Police Communications Liaison Officer. If the job requires a marine search and rescue response, the Rescue Co-ordination Centre is contacted immediately.

83. He also noted that marine search and rescue jobs will have a specific code that will initiate notification of the Rescue Co-ordination Centre. This will avoid agencies that have no marine search and rescue response (as occurred in this instance with the Country Fire Authority and State Emergency Service) being notified and will enable earlier interaction between the Rescue Co-ordination Centre and responding agencies to ensure assessment of conditions/ risk assessment and formulation of a response plan.
84. Emergency Management Victoria are working with the Water Police Squad on a longer-term option. The Supplementary Alerting System will enable direct alerting of volunteer units via the Rescue Co-ordination Centre. Senior Sergeant O'Rourke explained that this would mean any marine search and rescue being tasked directly to the Rescue Co-ordination Centre. The Marine Coordinator will then decide who is tasked to the job. He noted that this will ensure the Marine Coordinator risk-assesses the task prior to tasking responders. This will avoid the scenario where volunteer units are tasked prior to being triaged by the Rescue Co-ordination Centre as occurred in this case.

Response agency decision-making

85. Senior Sergeant O'Rourke noted that marine search and rescue response arrangements and who is the Control Agency can get confusing. It becomes further blurred when a Life Saving Victoria volunteer is made aware of an incident through his or her work as a volunteer with another agency, not through the normal communication chain. An additional aspect is the fact that Life Saving Victoria members regularly 'self-deploy' (and they governed by specific standard operating procedures). In addition, when faced with a time critical incident, the obligation to respond can override the need for risk assessment and adherence to policy or governing arrangements.
86. He noted it was imperative that response unit crew understand marine search and rescue arrangements and the requirement to be tasked by the Control Agency prior to deployment. It is apparent that the response in this matter was complicated by the fact responders were volunteers for multiple agencies.
87. He explained that in order to address this issue, responding agencies must ensure that their members understand marine search and rescue arrangements and where their organisation fits

in these arrangements, as well as the alignment of dynamic decision making and risk assessments with those of the control agency.

88. Senior Sergeant O'Rourke noted that Emergency Management Victoria now provide leadership training to all registered volunteer units. The training covers state and national marine search and rescue arrangements, control agencies, principles of Incident Command Control System, risk assessment, and dynamic decision making. He considered this course covered the identified issues.
89. Finally, Senior Sergeant O'Rourke stated that the Water Police Squad will continue to work closely with Emergency Management Victoria to ensure that the risks involved with 'time and condition' critical incidents and dynamic marine search and rescue leadership are front of mind for responding volunteer units via continued training and marine search and rescue exercises. He was confident that these measures will minimise the likelihood of a similar incident occurring in the future. Given the substantial work already undertaken to address this issue, I do not propose to make a recommendation.

Barriers affecting effective interagency communication

90. While the Port Campbell Life Saving Club had direct communication between Life Saving Victoria,⁵¹ there were clear communication breakdown issues between them and the other agencies which affected the provision and receipt of point-in-time situation reports across the emergency network and effected the co-ordination of assets. There appears to have been an attempt to manage this by diverting some interagency communication to informal telephone calls, which has meant these calls have not been captured in relevant communication logs.⁵²
91. Mr Younis stated that while he was aware that air assistance was on the way, he was unaware of all the other radio communications from the Rescue Co-Ordination Centre and Life Saving Victoria communications, which conveyed the updated location of Mr Bhaskar, the current risks and dangers, and a direction to assess. Without these communications and further input from all the crew members, his ability to make a full risk assessment was limited.
92. Statements from Port Campbell Surf Lifesaving Club volunteers also refer to gaps in communications between the club tower, Life Saving Victoria Communications, and other responding agencies. While the club tower had direct communication with Life Saving

⁵¹ The Water Police (Marine 900) linked into the radio channel that was transmitting communications to the Port Campbell Life Saving Club and Life Saving Victoria and could receive and transmit messages on the frequency: CB Exhibit 31.

⁵² For example, see CB 158, 218, 268, 289.

Victoria Communications, they were unable to hear transmissions from the HEMS helicopter and other units. Marina Deppeler, volunteer at the Port Campbell Lifesaving Club, noted it was difficult to keep track of communications. When they requested an update from Life Saving Victoria, they could hear the request for information but could not hear the reply and would need to wait for Life Saving Victoria to relay the information.⁵³

93. It was reported, “*There was quite a lot of dead time on our radio ...*”, and after the Pelican had been upturned, there was uncertainty as to how many patients were in the water or their status. Communications with the Lifesaving Club tower slowed as Life Saving Victoria communicated directly with Water Police and the HEMS helicopter.⁵⁴
94. Leading Senior Constable Obst also noted that the Rescue Co-Ordination Centre did not have the ability to communicate directly with all responding emergency services due to differing communication networks. This caused issues with determining the operations of the HEMS helicopter crew and the receipt of situation reports.
95. He noted that this issue had been previously identified and as a result the Emergency Management Victoria Marine Search and Rescue Office had developed the Operational Communications Project Plan to support interagency operational channels for direct contact between responding search and rescue agencies and the Rescue Co-Ordination Centre. The objective of this project was to improve the process from dispatch through to tasking and monitoring incidents. It is also anticipated that this would allow more timely allocation of resources by reducing dispatch and human error, as well as improving operational communications.
96. Leading Senior Constable Obst provided me with an update regarding this project in July 2021.⁵⁵ He noted that an interagency operation channel had been in place for the last 18 months. The channels are set aside at Police Communications and are available upon request. Once approved, the relevant agency can access the channel using their own compatible radios. He noted that interagency communications had been used in a recent flood event in the Gippsland region and it had reportedly worked quite well.
97. Given the Emergency Management Victoria has already identified this issue and the interagency operation channel has been implemented, I do not propose to make a

⁵³ CB 217-218.

⁵⁴ CB 159-161, 217-218, 223.

⁵⁵ Email from leading Senior Constable Christ Obst, dated 12 July 2021.

recommendation. However, I suggest that Emergency Management Victoria continue to review interagency communications so that any weaknesses or limitations that may arise in future can be promptly identified and addressed.

Whether the Pelican suffered a mechanical fault

98. While the Critical Incident Review did not have the benefit of the police report capturing the mechanical inspection of the Pelican, my investigation did.
99. The Pelican was recovered on the morning of 22 April 2019. It was missing its inflatable pontoon, console, seat, and all auxiliaries. The Victoria Police Search and Rescue Squad removed the outboard engines.
100. The two Yamaha 70 horsepower four-stroke engines were later examined by Yamaha Motor Australia under the observation of Victoria Police. Due to damage, electronic diagnostics were unable to be performed. However, physical examination allowed the Yamaha representative to conclude that both engines were not running at the time they were submerged. This could have been a direct result of the emergency kill switch being dislodged when the operator was ejected from the vessel. The engines could have also cut out when they were inverted whilst capsizing, which could have created fuel starvation. Due to damage, further evidence of mechanical failure could not be determined.⁵⁶
101. Leading Senior Constable Obst concluded that the Pelican likely suffered mechanical failure after negotiating the first wave. It was most likely that an electrical failure was the cause of what Mr Younis described as a blank gauge on the outside motor. Had the motor stalled with circuitry in contact with the battery terminal, the gauge should have still had a display. If the kill switch had been pulled, both gauges should have had a blank display.
102. Regarding the engine stalling, Mr Younis stated to police:⁵⁷

... is not uncommon. ... You know, they do stall ... sometimes going over a wave.

You don't wanna go with full power on ... otherwise your – you know, you could launch or ...

⁵⁶ CB 153.

⁵⁷ CB 1888-1891. Also see CB 1969, 1972-1973.

So you do back off and just let it sort of come under ... sometimes if you back off too much and the boat gets a bit of momentum backwards, that may mean a backwards can stall the motor with the – pressure coming up the exhaust.

And if you haven't got enough revs on ... with the pressure coming up the exhaust can stall the motor ...

...

But it – I stalled for whatever reason. I don't know whether it was because of back pressure or I had the ... whatever, it stalled ...

103. Mechanical failure would have resulted in a significant reduction in forward propulsion and an inability to change course or power through the second breaking wave.
104. I also note that Mr Younis recalled that he felt a “*bit of a stutter*” in one of the motors during the initial stages of the journey. He was unsure of which one but thought it was the outside motor and believed it was due to fuel starvation, but it came right once they started going.⁵⁸ This was apparently after some recent maintenance or the installation of new radio equipment, and it was unclear whether a sea trial or check had been conducted after this.
105. Yamaha Motor Australia recommend the outboard engines should be serviced every 12 months or 100 hours (whichever comes first) as per the manufacturer's recommendations.⁵⁹ The last record of service for the Pelican's outboard engines was on 1 November 2016,⁶⁰ which is outside of the manufacturers' guidelines for maintenance. It is unclear whether this was the last service or merely a reflection that servicing records for the Pelican were not kept.⁶¹ However, Scott McKenzie, President of the Port Campbell Surf Lifesaving Club, stated the Pelican was serviced annually at Yamaha.⁶²
106. There is no evidence that the Pelican was not fit for service, and I am satisfied that any mechanical failure may have been incidental to the operation of the vessel rather than due to poor maintenance. I note that the Critical Incident Review has made several recommendations regarding vessel safety, including the implementation of a Safety Management System, the

⁵⁸ CB 1902-1904.

⁵⁹ CB 1741-1742.

⁶⁰ CB 873.

⁶¹ CB 181.

⁶² CB 172.

keeping of maintenance records, and conducting sea trials after repairs have been undertaken. I note that these recommendations have been accepted.

FINDINGS AND CONCLUSION

107. Pursuant to section 67(1) of the Act I make the following findings:

- (a) the identity of the deceased was Andrew Francis Powell, born 11 March 1987;
- (b) the death occurred on 21 April 2019 at Rutledge Creek Bay, Port Campbell, Victoria, from drowning; and
- (c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

108. Despite warning signs, Mr Bhaskar, like many others who visit this country, entered the water. While Australian-born beach users have the dangers and risks of swimming in unpatrolled beaches continually drilled into them from a young age, many tourists or new arrivals have no such knowledge or appreciation of how treacherous our waters can be. They subsequently not only risk their own lives when entering the water, but they risk the lives of their rescuers.

109. In my *Finding Into the Death of Amanda Bourke Without Inquest*⁶³ I discussed inadequate signage warning of risks of swimming at The Cutting at Tower Hill. The Cutting was a beach that locals knew was dangerous but to which tourists were attracted because it was quiet, and the waters appeared relatively calm. While I was satisfied that there was inadequate signage in the area, I cited research that suggests signs warning of danger are not always effective:

... from an aquatic safety signage application perspective, warning recognition and recall rates are generally less than 50 per cent.⁶⁴ Life Saving Victoria therefore recommends multiple risk treatments and prevention programs be utilised in conjunction with safety signage strategies in order to increase awareness, interpretation, and behavioural compliance of signs.

110. However, I was satisfied in that case, as I am satisfied in this case, that given the hidden dangers of this beach, it is paramount that there is adequate signage warning of dangers in the

⁶³ Published 20 November 2020.

⁶⁴ See Bernadette Matthews et al. 'Warning signs at beaches: Do they work?' (2014) 62 *Safety Science* 312.

area. Given the area is a well-known tourist attraction, particularly for international tourists, I am satisfied that adequate signage in this case is required in multiple prominent locations with clear pictorial warnings, advice in languages other than English, *and* an emergency marker (code) to quote to emergency services if their attendance is required.

111. Finally, I acknowledge the impact of this tragedy on the Port Campbell community and responding emergency personnel. There were many people involved in the initial rescue of Mr Bhaskar and the subsequent rescue of Mr Younis and Ross and Andrew Powell after the Pelican overturned. I commend each of the volunteers and responding emergency personnel for their heroic actions on this tragic day.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. I commend Life Saving Victoria for conducting an independent and thorough review of the events of 21 April 2019. I strongly support all of the recommendations made and I recommend **Life Saving Victoria** take immediate action to complete the implementation of *all* of the recommendations made in the Critical Incident Review Report, dated July 2019. To that end, Life Saving Victoria's response to this recommendation pursuant to section 72(3) of the *Coroners Act 2008* should provide an update regarding the implementation of the 32 individual recommendations made in the Critical Incident Review Report.
2. I recommend **Parks Victoria** work with Life Saving Victoria to develop adequate signage warning of risks of swimming along the Port Campbell coastline. Particular consideration should be paid to size, location, audience, and the provision of information in languages other than English. Signs should also provide unique emergency location markers or codes to quote to emergency services in the event emergency services are required.
3. I recommend **Parks Victoria** consider providing rescue/ flotation aids along non-patrolled areas of the Port Campbell coastline so that they can be deployed while patients await the assistance of a Marine Search and Rescue service.

I convey my sincere condolences to the Powell family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Amber Griffiths, senior next of kin

Port Campbell Surf Life Saving Club Inc

Life Saving Victoria

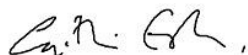
Parks Victoria

Transport Safety Victoria

Emergency Management Victoria

Leading Senior Constable Christopher Obst, Victoria Police, Coroner's Investigator

Signature:



Caitlin English, Deputy State Coroner

Date: 04 April 2022



NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.

1. RECOMMENDATIONS

As a result of our investigation and findings, the Review Panel makes the following recommendations:

1. Operational Readiness Inspections by an 'approved' person from LSV are introduced to provide oversight, guidance and management of Marine Rescue operations and assistance in developing an approved Safety Management System and to provide uniformity and consistency in training and operations leading to improved outcomes in interoperability between all services and external agencies.
2. All relevant state and federal legislation and marine rescue vessel licencing requirements are identified to ensure that state and national SLSA policies remain contemporary and that SLSA policies do not contradict legislation or government policies.
3. An audit be conducted to ensure that all operators including skippers, drivers and crewpersons of marine rescue vessels are appropriately licenced and proficient to operate those vessels.
4. Skippers and Drivers of larger marine rescue vessels receive nationally recognised training and are qualified with MAR20318 - Certificate Of Operations (Coxswains Grade 1 Near Coastal) and MARSS00008 Shipboard Safety Skill Set.
5. A Safety Management System be implemented for all marine rescue vessels and these are routinely audited by the operator and an appropriately qualified and experienced Life Saving Victoria officer.
6. Maintenance records are kept at the location where the Marine Rescue Vessel is based and they are kept as part of the Safety Management System. These records are to include servicing schedules, service and maintenance undertaken and processes for reporting faults.
7. The Safety Management System should include the requirement to conduct sea trials on the vessel after any scheduled maintenance or repairs have been undertaken. Those sea trials are to be completed before the vessel is returned to operations.
8. Each crew person on a marine rescue vessel which operates in remote locations or has to travel more than two nautical miles from their home base carry a Personal Location Beacon.
9. Life Saving Victoria, in consultation with other stakeholders, investigate and implement suitable lifejackets for the operators of marine rescue vessels. These lifejackets are to ensure the wearer is able to operate the vessel satisfactorily and meets the requirements of the Australian Maritime Safety Authority and various Australian Standards. In the event of an emergency should they enter the water, the wearer remains afloat with their head above water should they lose consciousness.

10. Life Saving Victoria, in consultation with other stakeholders, investigate and implement suitable lifejackets for those members acting as a rescue crew officer or rescue swimmer on board a marine rescue vessel. These jackets are to ensure the wearer is able to perform rescue operations satisfactorily, but the wearer remains afloat with their head above water should they lose consciousness.
11. In conjunction with Recommendations 9 and 10, any investigations should include the wearing of wetsuits of different types and thicknesses and the effect they have on the buoyancy.
12. Manual or auto inflating PFD's / Lifejackets (of any type) should not be worn on any type of marine rescue vessel that operates in wave zones where there is a possibility that persons may be thrown from the vessels or the vessels capsize and whereby the persons may be injured, incapacitated or unconscious and not able to activate a manually inflated PFD.
13. Life Saving Victoria review similar vessels and consider minimising potential head strike.
14. Life Saving Victoria, in consultation with other stakeholders, investigate and implement suitable head protection for the operators of marine rescue vessels that might also provide for adequate radio communications.
15. A marine rescue service be maintained at Port Campbell SLSC for marine rescue operations in the coastal region.
16. Port Campbell SLSC and Life Saving Victoria appoint a multi-agency working group to develop the next generation of a marine rescue service in the region. This working group should consider all available resources including vessels, aircraft (i.e. remotely piloted aircraft), communications, technology and inter-agency operability.
17. Life Saving Victoria should review operating documentation and training records of similar vessels in light of this report.
18. Life Saving Victoria meet with other Emergency Service Organisations and review tasking arrangements (including at a local level). This protocol is formalised into a Standard Operating Procedure and implemented. Consideration should be given to completing this prior to the commencement of the lifesaving season and that the new SOP is discussed at any pre-season internal workshops, conferences, etc.
19. Life Saving Victoria conduct annual pre-season briefings with Emergency Service Organisations. This briefing should include seasonal weather forecasts, service capabilities, communications systems and tasking arrangements.
20. Life Saving Victoria Standard Operating Procedure "5.04 – Search and Rescue Operations" should be reviewed to confirm its validity or be amended to ensure that it remains contemporary and achievable. SOP 5.04 should be distributed and discussed in pre-season briefings.

21. Life Saving Victoria Standard Operating Procedure “5.04 – Search and Rescue Operations”, should be provided to Emergency Service Organisations and ensure they are cognisant of the tasking arrangements for LSV resources.
22. An up-to-date version of the LSV Standard Operating Procedures should be maintained in each surf lifesaving club, service facility and the LSV Communications Centre.
23. The Life Saving Victoria Standard Operating Procedures be reviewed, particularly those dealing with lifesaving and rescue operations, so that an increased emphasis on risk assessments is achieved through all stages of a rescue operation.
24. Life Saving Victoria ensures that appropriate agency command is in place for all rescue operations, and are coordinating with the designated Control Agency.
25. LSV agency commanders must maintain full situational awareness to support decision making.
26. During rescue activities the Estimated Time of Arrival (ETA) should be provided and sought for all key resource movements.
27. Communication and decision logs should be maintained by all key roles during a rescue. These logs should include entries for all forms of communication (including radio, data/pager and telephone)
28. Any Response or Action Plan, including a SMEAC plan is to include a risk assessment process that is reviewed regularly through the rescue operation.
29. The Port Campbell Surf Life Saving Club engage with Victoria Police and other agencies to conduct a briefing and planning session including coastal rescue considerations prior to the Easter holiday period (and any other period where it is deemed appropriate.)
30. Surf lifesaving clubs and support operations regularly participate in local and regional multi-agency planning sessions and search and rescue exercises.
31. Life Saving Victoria consider nominating Phillip Younis, Ross Powell, Andrew Powell and Ben Matthews for bravery recognition through the SLSA system and the Australian Honours and Awards.
32. The Review Panel is reconvened once any external investigation is complete and / or the Coroner has realised his findings with the intention to review this version of the Report and provide an updated version in light of any new information. It is further recommended that consideration be given to have one or more Panel members present during any Inquest to support this process.