STATE
CORONER
VICTORIA

CORONERS REGULATIONS 1996

Form 1

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27th January, 2005
**Case No:** 1505/04

**RECORD OF INVESTIGATION INTO DEATH**

I, **LEWIS PHILLIP BYRNE**, Coroner,

**having investigated** the death of GRAHAM RICHARD PAUL with Inquest held at Coronial Services Centre, Southbank on the 22nd November, 2004
**find that** the identity of the deceased was GRAHAM RICHARD PAUL and that death occurred on 1st May, 2004 in Port Phillip Bay off Brighton from

1(a). DROWNING

in the following circumstances:

Graeme Paul drowned in Port Phillip Bay on the afternoon of 1st May 2004 when he was thrown overboard after a yachting mishap/incident off Brighton.

On behalf of Yachting Victoria the Royal Yacht Club of Victoria, Williamstown, hosted the 2004 Association Cup Regatta. A notice to competitors was issued and disseminated to participating skippers. The competition and it should not be overlooked that this was a competition, was to be sailed under Category 6 conditions. The sailing arrangements were described to me by Mr David Leroy, Race Director and Yard Manager for the Royal Yacht Club of Victoria as follows:

> "*As the Race Director I am also responsible for the drafting of the "Notice of Race" on behalf of Yachting Victoria. The document is subsequently vetted by Yachting Victoria. This document details the conditions under which the regatta is to be sailed and essentially forms a contract between the competitors and the organising authority. The document details that the races are conducted under Category 6, which means that the race is run in daylight hours, in sheltered waters, with rescue capability available. The yachts must comply with the category and carry, equipment as detailed in the Yachting Australia special regulations."*

Mr Leroy further explained that each yacht that entered the regatta must have a Safety Equipment Compliance Declaration, warranting compliance with the appropriate safety standard, lodged with its home club.

In the event, the deceased Mr Paul won the first race of the regatta sailed in the morning of 1st May 2004. The second race commenced in the early afternoon of 1st May 2004 in conditions variously described as *"squally with winds ranging from 10 knots to 27-28 knots in the squalls seas rough at about one to one and a half metres* ." (Lou Abrahams); *"choppy to rough with waves about one metre"* (Senior Constable Glenn Powell); "*sea conditions had picked up slightly from earlier and was now about one metre to a little of one metre"* (Race Director David Leroy).

Mr Leroy, who made the decision to start race two and the discretionary power to abandon the race if the safety of competitors was jeopardized, considered conditions for sailing were satisfactory . Senior Constable Powell was in agreement opining:

*"I would not describe the conditions as being dangerous or unsafe for yachting."*

In spite of the circumstances of Mr Paul's death it could not reasonably be contended conditions on Port Phillip Bay were unsuitable for sailing under Category 6 conditions even though strong wind squalls were predicted during the race.

A folder of photographs taken of competitors on the day show conditions, that would provide for exhilarating sailing.

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Mr Paul was the owner skipper of *"Adam's Den"*, an Adams design 10 metre yacht built in 1989. The Adams was designed for day sailing with a fin keel with a flush deck, three quarter fractional rig and a transon hung rudder with tiller control (to adopt the description of the yacht provided by Senior Constable Powell). Mr Paul was described as an experienced and successful yachtsman having competed in (and won) a number of Bay races. His crew were also experienced. Having completed the first three legs of the race and running before the wind with spinnaker up on the forth leg the *"Adam's Den"* with Mr Paul at the helm, was struck by a strong squall of approximately 30 knots causing the yacht to broach violently to starboard. Alan Sheers, tactician and main sail trimmer on the *"Adam's Den"* described how the vessel heeled over violently between 45-70 degrees with the spinnaker and other sails dragging in the water. Both Mr Sheers and his skipper were thrown overboard, the latter when the tiller broke as he tried to correct the course of the vessel.

Mr Sheers who was wearing a personal flotation device (PFD) and who either held onto a rope, or the side of the boat, was retrieved, but Mr Paul was left behind and was lost from sight as the yacht sailed away out of control.

The VHF radio on board the *"Adam's Den"* was inoperative at the time. The crew of the *"Adam's Den"* attempted to advise the Race Director by mobile phone of their predicament, however contact was unable to be made. Subsequently contact was made with the Royal Victorian Yacht Club who relayed the alert to the committee boat.

The Patrol Boat, Royal 5, skippered by Mr Lesleigh West responded to the alert to assist the *"Adam's Den"* although I note Mr West conceded he was not at the time aware what the precise problem was. As the patrol boat proceeded down the middle of the fleet searching for the *"Adam's Den"*,a task made more difficult by the squall which had engulfed the fleet, an urgent signal was received from Mr Lou Abraham's boat *"Another Challenge"* who had located the body of Mr Paul floating face down in the water.

An unsuccessful attempt was made by Patrol 5 to take Mr Paul aboard. His body was subsequently retrieved by the crew of *"Another Challenge"* adopting well rehearsed man overboard procedures. In spite of attempted CPR by crew members enroute to Brighton Yacht Club Mr Paul could not be revived.

The matter was reported to this office as a Reportable death. In accordance with recently established protocols the circumstances of Mr Paul's death were investigated by the Water Police and Marine Safety Victoria in conjunction. A separate report on the fatality was provided by Marine Safety (see Exhibit "K"). Paragraph one of that report describes Marine Safety's role and principle focus:

> *"... responsibility for the investigation of significant maritime incidents with specific functions to identify breaches in the Marine Act 1988 and identify deficiencies in safety systems and regulatory frameworks.*
>
> *In the context of incidents involving recreational vessels and fatality, the focus of MSV is on the lessons that can be learnt from the incident and, as appropriate, corrective action or improvements in safety systems that can be made.*
>
> *The aim of this report, therefore, is to identify the critical factors leading to the incident and fatality, examine the existing safety regimes pertinent to these factors and, as appropriate, identify potential developments in safety frameworks, systems and programs, both regulatory and non-regulatory. "*

Having regard to the fact Marine Safety Victoria is the principle maritime authority and safety regulator for Victorian waters their input is important as is that of Water Police who have historically investigated marine deaths for this office. As I have previously observed the present levels of cooperation between the two entities is welcomed by this office.

Shortly after the commencement of the coronial investigation I considered an application brought by the next of kin under Section 29 of the *Coroners Act 1985* that there be no autopsy. I was advised Mr Paul had been unwell in the week prior to his death and the forensic pathologist I consulted advised a precise cause of death could not be ascertained without full autopsy. After careful consideration I refused the application giving the following reasons:

> *"It is imperative that I determined whether the deceased suffered a cardiac episode which caused his immersion, or alternatively whether a cardiac episode (or other natural disease) impacted upon Mr. Paul's ability to deal with the emergency. I note the applicant in her application in effect concedes that the cause of death is not certain."*

In the event, post mortem examination conducted by Associate Professor David Ranson, Forensic Pathologist, confirmed death was indeed due to drowning with little evidence of *"significant natural disease of a type that might account for an individual being unable to protect themselves from their environment as a result of decreasing conscious state."* Toxicology detected nothing of significance.

I decided to take the matter to formal inquest for several reasons, one of which was an initial report from the Marine Safety Victoria Inspector which in general terms was somewhat critical of aspects of the conduct of yacht racing. I also considered it appropriate to again pursue the issue of PFD's, an issue which was then in the public forum for discussion on proposals for legislative reform.

In a memorandum to the Listing Registrar dated 6th September 2004 concerning the time to be allocated for the inquest hearing, I stated:

> *"The witness Adrian Mnew from Marine Safety Victoria at paragraph 5.10 of his report opines:*
>
> > *These factors all indicate systematic deficiencies in the administration and the management of organized yacht racing. It is recommended yachting authorities review their current approach to race organization to provide clubs, their officials and competitors with a much more structured set of requirements including associated support such as training materials, courses and accreditation.*
>
> *It may be this view will be challenged by the organizing clubs, RMYC and Yachting Victoria so one day may not be enough."*

It was therefore not surprising that at the formal public hearing, at which the family were not legally represented (but Mr Paul's daughter was in attendance), both the Royal Yacht Club of Victoria and Marine Safety Victoria were represented by Counsel, Mr James Mighell and Mr Martin Grinberg, respectively.

During the course of the hearing the report from which the excerpt was taken was withdrawn by Mr Grinberg, counsel for Marine Safety and a revised report was substituted. I suspect an accommodation may have been achieved as Mr Mnew in evidence stated he was satisfied Marine Safety would have 'input' into a mooted revision of aspects of the Rules of Racing. Furthermore, Mr Tony Mooney, whose report was tendered by Mr Mighell, indicated a significant shift in stance by Yachting Australia to the PFD issue by decreeing that from May this year on boats without guardrails (lifelines) competing in Category 5 and 6 events, all crew members will be required to wear, as a mimimum, a PFD 2 while on deck (my emphasis). I support and welcome that overdue alteration to the Rules.

I trust the apparent concession made by Marine Safety in respect of the *"systemic deficiencies"* position fosters an enhanced cooperative approach between Marine Safety and yachting, from the peak body down in respect to matters which impact upon the welfare of the yachting fraternity. I merely observe that I saw signs of a more cooperative approach in this matter.

I note in his report Senior Constable Powell recommended enhanced training procedures and suggested consideration be given that all crews sailing on yachts without safety rails (like the *"Adam's Den")* must wear some form of PFD at all times. (my emphasis).

Mr Mnew seemed to contend that often those responsible for conducting yacht racing, at least in the past, have not paid sufficient attention to risk management and accepted that as long as the competition proceeded under the International Yachting Federation's Racing Rules of Sailing adopted by the Australian Yachting Federation (the "Blue Book") then organisers considered that they had fulfilled their obligations.

In considering the issues that initially concerned Marine Safety Victoria Inspector, Adrian Mnew, the author of the report submitted on behalf of Marine Safety, I am mindful of the limits of my jurisdiction. His Honour Justice Nathan in Harmsworth v The State Coroner (1989) VR989 stated a Coroner's power to comment is not *"free ranging"*, it must be related to matters connected with the death. The power of enquiry is not a separate and distinct source enabling a coroner to enquire for the sole or dominant reason of comment or recommendation, but is incidental and subordinate and arises as a consequence of the prime function of a coroner to make the findings required by Section 19(1)(a)(b) and (c) of the *Coroners Act 1985*. There were issues raised which did not warrant my attention in this particular matter.

By way of example, it was, at least by implication, suggested Mr Paul's crew (and crews generally) were not adequately trained at man overboard procedures. In the circumstances that is somewhat academic because Mr Paul's crew was not in a position to rescue him from the water in any event as the *"Adam's Den"* was careering away down the Bay out of control due to the broken steering.

Any perceived inadequacy in the provision of a rescue facility (and I do not say there was a deficiency) is not relevant in the circumstances of Mr Paul's death, nor is the broad issue of the capacity of potential rescuers to adequately perform CPR.

Another example is the circumstances in which the Race Director can raise the Y-flag so that competitors must, as I understand it, don lifejackets (PFD's). The weather conditions prevailing on this day did not warrant the invocation of the Y-flag for a Category 6 race, so it is not appropriate for me to examine that broad issue at length.

The Rules of Sailing apparently provide the Y-flag directive can only be issued PRIOR to the commencement of a race, not during the race. So it is all or nothing; if conditions deteriorate the Race Director's only discretion is to call the race off. There may be any number of reasons why a Race Director may be reluctant to call a race off and as the subjectivity of the perceived threshold of risk raises questions it seems to me there could be a "half-way house"; that is an ability to direct the donning of PFD's during a race. That of course could only be done if there is a constant line of communication between the Race Director and all competitors. Once again I only raise this issue for consideration because there may be compelling reasons, not obvious to me, why such a situation does not presently exist.

Many of the issues of concern raised by Mr Mnew were however canvassed by the State Coroner in the Inquest into the death of Lindsay Dack. In his finding the State Coroner accepted that the yachting community had taken on board many of the lessons learnt from the Sydney to Hobart disaster and the subsequent inquest but commented:

> *"However, safety and survival also requires a constant level of pro-active work and review by regulators, yacht race officials, race managers, the broader yachting community and its representative bodies. It also requires a level of cooperative work with the regulator and other specialists in safety and risk management."*

The issue of PFD's seems to have long been a bone of contention with the yachting fraternity. As the State Coroner observed in the Dack Finding:

> *"The management of risk associated with going overboard during a yacht race should not solely rely on the skipper to assess the weather and notify all crew of the need to don a PFD (or harness and lines) It should also not depend on the assessment of an individual sailor. Passing what is a system responsibility, on to the individual sailor (like Mr Dack) is flawed safety logic and, if it persists will result in many more yachtsmen or women dying and, in some cases, further risking rescuers' lives. "*

As was the case in Dack, I have little doubt Mr Paul would have survived this mishap had he, at the time, been wearing a PFD. I was told at the inquest it was not his wont to wear a lifejacket. Apparently he did not like to wear them (per crew member Sheers). It is cruel irony that the only member of the crew who did not have a lifejacket on when the squall struck was Mr Paul, the skipper, the entity that historically has been the one responsible for taking the decision whether the crew don lifejackets.

I concur with and adopt, for the purposes of this finding, a further observation made by State Coroner Johnstone in Dack where he said:

> *"It is noted that the Marine Safety Victoria is responsible for the regulation of marine safety in this State by virtue of the Marine Act 1988 and Marine Regulations 1999. Ultimately,* ***the mandating of PFD wearing rests with Marine Safety*** *but it cannot successfully change the safety approach without the cooperation of the yachting community, in particular the AYF. Changes to Australian Standards are urgently needed (if lives are to be saved) and also require cooperation of the yachting community."*

The time has come for change. If that fact does not register with the sport (which is self regulated) the issue maybe taken out of their hands.

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Turning to the issue of communications. The Race Director, David Leroy, told me the first notice he had of a man overboard was by radio from Mr Abraham's yacht *"Another Challenge "*. If a radio message had been transmitted from *"Adam's Den"* immediately after Mr Paul went overboard, his chances of survival (subject to not wearing a lifejacket) would assuredly have been greater. As stated earlier the radio on *"Adam's Den"* was inoperative.

In this technological day and age I would have thought it imperative there exist a line of communication not only Race Director to shore, but also Race Director to all competitors and boat to boat, to ensure the safety of competitors - this again goes to the broad issue of risk management.

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An equipment failure was one of the principle factors which contributed to the death of Mr Paul. The failure of the aluminum tiller arm bracket is graphically depicted in photographs 6 - 10 in the photo folder prepared by Senior Constable Powell and Inspector Mnew which was tendered in evidence. Senior Constable Powell opined it was not a design fault that caused the aluminum rudder bracket to snap off, but general fatigue. On close examination Mr Mnew observed hairline cracks behind the broken area suggesting progressive deterioration over time. Adams 10 yachts manufactured after 1990 are fitted with stainless steel tiller brackets. Senior Constable Powell, also a sailor, made contact with all Adams' 10 owners with aluminum brackets and advised them of the potential problem. All owners have replaced, or propose to replace the aluminum fitting with one constructed of stainless steel.

It would appear the responsibility to ensure a vessel is seaworthy and equipment (such as a rudder head fitting) is serviceable rests with the owner/skipper of a boat. In light of the circumstances surrounding this death and the potential for loss of life (even multiple loss) consideration should be given to vessel survey, or some form of vessel examination and certification (even random checks) at least in relation to vessels likely to compete in rough seas. I am not sufficiently informed on this issue to make a formal recommendation, but merely raise the issue for consideration.

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There is, in my considered view, much to commend in the report provided by Marine Safety Victoria.

I concur with the contention made by Mr Mnew in the following excerpt:

> *"The RRS with YA prescriptions are very comprehensive with regard to the **racing** conduct of competitors in organized yachting events and the management of the racing aspects of the event by the regatta committee. They also contain a wealth of information in the Special Regulations regarding the requirements for structural features, boat equipment, personal equipment and qualifications etc. Whilst the **racing** rules are policed very aggressively by both competitors and regatta committees alike, the application and policing of special regulations and **safety** issues is very much left to individual skippers and crews. Similarly, the application of the ISAF Race Management Manual (RMM) by club regatta committees tends to focus more on the **racing** management aspects of events and much less on the **safety** aspects of event management.*

*In relation to safe race management, MSV would recommend a risk management approach be taken. This issue was recognized by YV which initiated the production of the YV risk management resource tool. It is recommended the application of such risk management tools be pursued by YV with affiliated clubs as aggressively as the application of racing rules currently are. With the use of such tools, clubs should feel confident to issue standard operating procedures and guidelines for race officials on how they require yachting events to be managed. Regatta committees and the volunteers, who generally run yacht racing, should be confident they are providing adequate duty of care through suitably researched, considered and applied risk management from their clubs. If the culture of clubs concentrating on minimizing liability exposure (by not actively pursing safety issues) can be changed to one of considered risk management and adequate duty of care provision, then competitors and officials in yachting events will be much better served."*

The fundamental difference in the two foci is that in the latter there is a PUBLIC INTEREST. The yachting community must recognise this fact and would be well served to accept the matters contained within the report in the spirit in which it was provided.

**CONCLUSION**

In the final analysis this was a PREVENTABLE DEATH – an experienced skipper who should have enjoyed the exhilaration of sailing on Port Phillip Bay in the prevailing conditions, tragically and unnecessarily drowned in its waters.

PHILLIP BYRNE
CORONER