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

Ian Graham Thompson

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Ian Graham Thompson with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

23 October and 14 December 2017 at Hobart in Tasmania

Representation

Counsel Assisting the Coroner: Mr S Nicholson

Counsel for Tassal Operations Pty Ltd: Mr N Sweeney and Ms S Masters

Introduction

1. Mr Ian Thompson died as a result of injuries sustained in a workplace accident on a vessel, the Efishent, in the waters of Great Taylors Bay, near Bruny Island on 3 December 2013.

2. The *Coroners Act* 1995 (the '*Act*') provides that a death is reportable to the coroner if, *inter alia*, the death is one of a person that occurred in Tasmania, and that death is "unexpected, unnatural or violent" (see section 3).

3. Section 19 of the *Act* creates an obligation upon any person who becomes aware of what is suspected to be a reportable death to report that fact to the coroner.

4. The circumstances of Mr Thompson's death were such that, pursuant to section 19 of the *Act*, the fact of his death was reported to the Coronial Division of the Magistrates Court of Tasmania. This was so because his death was properly regarded as, at the very least, unexpected.

5. Section 24 (1) (ea) of the *Coroners Act* 1995 makes the holding of an inquest mandatory where a death occurs at a person's place of work or as a result of an accident or injury that occurred at a person's place of work. Inquest is defined in the *Act* as a public hearing. Section 24 (1) (ea) contains an exception with respect to death by natural causes, which has no applicability to this case. Section 24 (1) (ea) is also subject to section 26A of the *Act*. Mr Thompson's senior next of kin, his widow Melinda, did not request that no inquest be held.

6. Accordingly an inquest was held in October and December of 2017. It was preceded by a case management conference as well as an inspection of the *Efishent*.

The Scope of the Investigation

7. Section 28 (1) of the *Coroners Act* 1995 deals with the ambit of any coronial investigation. Relevantly that section provides:

"(1) A coroner investigating a death must find, if possible –

(a) the identity of the deceased; and

(b) how death occurred; and

(c) the cause of death; and

(d) when and where death occurred; and

(e) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1999*."*

8. The provision requires the making of various findings, but without apportioning legal or moral blame for the death (see *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7). A coroner is required to make findings of fact from which conclusions may be drawn by others (see *Keown v Khan* [1998] VSC 297; [1999] 1 VR 69, Calloway JA at 75 – 76). The coroner neither punishes nor awards compensation – that is for other proceedings in other courts, if appropriate.

9. One matter that the *Act* requires a finding to be made about is how death occurred (section 28 (1) (b)). It is well settled that this phrase involves the application of the ordinary concepts of legal causation (see *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506). Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the death so as to discharge the obligation imposed by section 28 (1) (b) upon the coroner.

10. In addition to being required to make findings pursuant to section 28 (1) of the *Act* a coroner is empowered, in appropriate cases, to make "recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate" (section 28 (2)) and to "comment on any matter connected with the death including public health or safety or the administration of justice" (section 28 (3)). Any recommendation or comment must be connected to the death, the subject of the enquiry (see *Harmsworth v The State Coroner* [1989] VR 989).

Findings of Fact

11. The circumstances of Mr Thompson's death were not at all in dispute. On the basis of the evidence at the inquest I make the following findings of fact. At the time of his death on 3 December 2013 Mr Thompson was employed by Tassal as a fish farm hand. He had worked for that company for approximately 2 years before his death. Mr Thompson had spent virtually his whole working life on the water. He was a competent,

experienced and safe worker, highly regarded by those with whom he worked.

12. Mr Thompson was 45 years of age having been born on 27 September 1968. He was married to Melinda and the father of two children, Lachlan and Brooke. The family lived at Surges Bay.

13. At about 7.00am on 3 December 2013 Mr Thompson set out on the *Efishent* with his colleague Mr Jeremy Hickey. Prior to setting out Mr Hickey and Mr Thompson completed the normal safety checks. They delivered some oxygen packs (for diving purposes) to another boat, and then went to Hawker's Wharf to drop off a net. They then returned to Dover where at about 8.00am the men picked up Mr Grant Purdon, the regional manager for Marine operations at Tassal. Mr Thompson was skipper of the vessel on the day.

14. The weather in the area was calm and, I am satisfied, played no role in Mr Thompson's death.

15. The three men then proceeded to the Tassal Marine farm lease north of Butler's Beach on Bruny Island and east of Partridge Island in the waters of Great Bay. Their purpose was to move lease boundary markers. Each marker was attached to a concrete mooring block. Each block weighing 3.5 tonnes was attached to a length of chain and fitted to a length of rope. The evidence was that the rope was 40mm 3 strand SuperTEC marine rope with a breaking strength of 29,600 kg. The rope was in turn attached to a floating marker buoy.

16. The evidence was that the men checked the position of each marker buoy using a GPS. All three were wearing PFDs and safety helmets. The first marker was dropped in place by the crew of the *Efishent*. The second was found to be in the correct position and hence not moved. The third marker was moved to the correct position without incident.

17. The vessel was steered by Mr Thompson into position to move the fourth marker buoy. Mr Hickey described in his evidence, in detail, the procedure adopted to move the marker buoy. He said it was common operation and involved the use of the capstan, a large winch installed towards the stern of the *Efishent*, to lift the block off the seabed. The *Efishent*'s capstan is situated immediately in front of the wheelhouse. It had, at the relevant time, an exclusion zone clearly marked in yellow paint on the deck. Mr Hickey described the operation in the following way:

> *"One person is stationed next to the capstan on the starboard (right) side. This person watches for knots in the rope and moves the knot around so it does not get jammed in the other part of the rope that is winding around the capstan. If the rope gets jammed it stops the capstan from operating. Knots are commonly in the rope as they are a marker for the buoys. The person next to the capstan may signal for the speed of the capstan to be changed (e.g. speed up or slowed down, stopped or put into reverse). This person also coils the rope on the deck once it has passed through the capstan.*
>
> *The person at the front of the vessel operates the lever which controls the speed at which the capstan turns. The person is in a position to watch the block as it rises and observe the capstan and the person who was standing next to the capstan.*
>
> *The Efishent requires at least two people to operate: the skipper and deckhand. It is equipped with a crane that sits on the front port (left) side. The lever to operate the capstan is on the front right."*

18. The evidence was that Mr Hickey wound the rope on the capstan between five and six times. Mr Thompson was positioned on the left of the capstan (outside the clearly marked exclusion zone). Mr Purdon was at the bow of the *Efishent* operating the lever which controlled the speed and direction of the capstan. It is apparent that the men experienced difficulty in ensuring that the rope gripped correctly. Mr Hickey attempted to make the rope grip

by pulling on it, something he said had worked in the past. However, pulling on the rope did not work on this occasion.

19. Mr Thompson told Mr Hickey to switch places with him. He re-did five loops of the rope around the capstan. He then stepped back out of the exclusion zone away from the capstan. Mr Thompson then signalled to Mr Purdon to start the capstan again, which he did. Mr Hickey described the rope as gripping this time. However, there were knots in the rope. Apparently this was not an uncommon occurrence. To prevent a knot from jamming the rope, a crewmember must move the loop so that lays above the section of rope that is coming up from the water. The capstan was not stopped as Mr Hickey undertook this action. The decision not to stop the capstan was not unreasonable in the circumstances given the very low revolutions at which it was being operated.

20. Mr Hickey described the knot coming to the top of the capstan and pinching a portion of the rope. He said that this is usually fixed by pulling on the rope to pull it out from where it has “pinched”. On this occasion Mr Purdon stopped the capstan to enable Mr Thompson to attempt to pull the rope out from the pinch. Mr Thompson attempted to do so was unable to pull the rope clear.

21. Mr Thompson apparently said he would try tying off the “excess” rope on a bollard located at the bottom right of the capstan. Mr Hickey said the idea was to pull the knot through from where it was jammed; an activity that he described as having been undertaken on hundreds of occasions, it is inferred, without incident.

22. Mr Hickey described what happened next as follows:

> *“Ian signalled to Grant to start the capstan, which he did. I was watching the capstan. I saw the rope fling off the capstan. I looked at Ian. He was laying back near where the stairs go to the wheelhouse.*

His eyes were "jittering" and the side of his head was caved in. his jaw appeared to be out of place."

23. Mr Hickey was uncertain as to which part of the rope hit Mr Thompson. He thought that the rope around the bollard was still attached but could not be certain.

24. Mr Purdon and Mr Hickey saw that Mr Thompson was terribly injured. They called for urgent assistance and commenced first-aid. Mr Thompson was rushed by another boat to a waiting ambulance at Dover. From there he was airlifted to Hobart but was pronounced deceased at the Royal Hobart Hospital.

Forensic pathology evidence

25. After formal identification an autopsy was carried out upon Mr Thompson's body by forensic pathologist, Dr Donald McGillivray Ritchey. Dr Ritchey expressed the opinion that the cause of Mr Thompson's death was blunt trauma of the head. The autopsy revealed severe injuries of the right frontal scalp that overlay a depressed skull fracture along with extensive calvarian and basal skull fractures. Dr Ritchey said the injury to the underlying brain was so severe that it caused brain swelling and secondary injury to his brain stem which resulted in death. I accept Dr Ritchey's opinion.

26. Samples taken at autopsy were subsequently analysed toxicologically at the laboratory of the Forensic Science Service Tasmania. That toxicological analysis revealed the presence of cannabis in Mr Thompson's blood. No alcohol or other drugs of significance were identified as having been present in those samples. I am satisfied on the basis of the evidence at the inquest that the presence of cannabis in Mr Thompson's body did not contribute to the happening of the accident which caused his death.

The Investigation

27. An investigation was immediately commenced in relation to Mr Thompson's death under the *Coroners Act*. In addition to that investigation Worksafe Tasmania carried out an investigation as to the circumstances of Mr Thompson's death. The principal Worksafe investigator gave evidence at the inquest and the whole investigation file was tendered as evidence.

28. Relevantly, the Worksafe investigation determined that Mr Thompson, Mr Purdon and Mr Hickey were all appropriately qualified to carry out the roles that they were performing on the day of Mr Thompson's death. The evidence from Worksafe was that Mr Thompson was the holder of current Master 5 /Skipper 3 and marine engine driver grade 3 licenses, all issued by Marine and Safety Tasmania. The Master 5 /Skipper 3 License contained a number of endorsements dealing with:
    - use and maintenance of deck machinery installed on the vessel;
    - the use of simplified stability information to maintain the stability of the vessel; and
    - seamanship skills and techniques including the use of ropes, rigging gear and cranes.

29. The Worksafe investigation also demonstrated that Mr Thompson had over 15 years' experience in the aquaculture industry and had been formally inducted into the Tassal site on 13 September 2012. That induction covered the outlining of specific hazards on the site and instruction in safe operating procedures for those hazards. The induction specifically covered the use of capstans.

30. In addition, the evidence was that Mr Thompson had been "signed off" as having been instructed in, and having an appropriate understanding of, the following employer policies, procedures and inductions:
    - Occupational Health and Safety policy;
    - WHS hazard identification and risk policy;

- Hazard Management Policy;
- Escalation of Risk Policy;
- The vessel *Efishent* induction (including the operation of on-board machinery) - conducted by Mr Purdon;
- Hazard Reporting; and
- The Tassal policy dealing with plant and machinery hazards.

31. I am satisfied on the basis of the material contained in the Worksafe investigation file that Tassal had in place, at the relevant time, a comprehensive safety management system. That system addressed appropriately the hazards and risks associated with, *inter alia*, capstan use.

32. I am satisfied on the basis of the material obtained in the Worksafe investigation that Tassal utilised at all relevant times internal and external training regimes to ensure its staff, including relevantly Mr Thompson (and Mr Purdon and Mr Hickey), were competent to operate all equipment relevant to their role.

33. The capstan was thoroughly examined by police, Worksafe Tasmania and an independent consultant engaged by Tassal. I am satisfied, on the basis of the evidence from those sources, that there were no faults at the relevant time with the capstan itself nor with the manner in which it was operated. It was mechanically sound and the installation of any guard would, in my view, have been both impracticable and unnecessary.

34. I note that the evidence at the inquest was that there was no record of an incident causing a fatality or serious injury of the type that caused Mr Thompson's death having occurred anywhere in Australia at any time in the past. The evidence was that all recorded injuries related to capstan use resulted from the operator becoming entangled in rope. All investigations suggest that the incident which caused Mr Thompson's death was unique.

35. The Worksafe Inspector who investigated Mr Thompson's death, and gave evidence at the inquest, Ms Beechey, acknowledged in her evidence that it

was impracticable to “fit a traditional fixed guard to a capstan”. She gave evidence as to the possibility of alternatives that might be investigated to prevent similar incidents occurring in the future. Those alternatives she suggested included:

- replacement of capstans with hydraulic winches that can be effectively guarded, particularly when commissioning new plant or vessels;
- investigating options for shielding or guarding to prevent operators being struck by broken rope or loops in rope (the suggestion being a ‘cow horn’ style guard);
- the investigation of alternative designs of capstans, particularly increasing the size of the lip at the top to ensure wraps of rope cannot fly off the top of the capstan (the obvious difficulty with this proposal being the hindering of the physical task of wrapping rope around the capstan by the positioning of the large lip); and
- consideration of alternative rope options such as high strength options such as ‘Dyneema’.

36. I am satisfied in this instance, however, that Tassal has eliminated entirely any risk associated with the carrying out of the operation of moving blocks in which Mr Thompson was engaged when he was fatally injured. This has been done, so the evidence indicated, by removing altogether the need for any employee to be on the deck of the vessel and manually handle blocks or any other items previously moved by the capstan. In these circumstances I do not consider a need to make any recommendations or comments.

37. The evidence as a whole satisfies me that the death of Mr Thompson was a tragic accident. I am satisfied that it was both unforeseen and unforeseeable.

Formal findings

38. I am obliged by section 28 of the *Act* to make a number of formal findings. Those findings are as follows:
    a) the identity of the deceased was Ian Graham Thompson;
    b) Mr Thompson died in the circumstances outlined earlier in this finding;
    c) the cause of Mr Thompson's death was blunt trauma of the head sustained by him when he was hit by an industrial fishing rope; and
    d) Mr Thompson died at the Royal Hobart Hospital on 3 December 2013.

Recommendations and comments

39. For the reasons indicated above I do not consider it necessary or appropriate to make any recommendations or comments pursuant to section 28 of the *Coroners Act* 1995.

40. I express my appreciation to the assistance afforded by counsel who appeared at the inquest.

41. I also express my appreciation for the comprehensive investigation carried out by Worksafe Tasmania and Constable Wolf of Tasmania Police.

42. I wish to express my sincere condolences to the family and loved ones of Mr Ian Thompson on their loss.

Dated: 16 February 2018 at Hobart in Tasmania

Simon Cooper
Coroner