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

Trevor John Tolputt

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Record of Investigation into Death (With Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, have investigated the death of Trevor John Tolputt with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

27, 28 and 30 November 2018 and 13 December 2018

Representation

Counsel Assisting the Coroner: J Shapiro

Counsel for the State: P Turner

Counsel for Mr Stephen Sanderson: A Vince

Counsel for Eco-Geo International Pty Ltd: D Zeeman

Introduction

Mr Trevor Tolputt died on 14 July 2016 as a result of succumbing to hypothermia whilst walking alone in freezing, snowy conditions on the Overland Track in Tasmania.

The Overland Track is a 65 kilometre walk through the Cradle Mountain – Lake St Clair National Park, part of the Tasmanian Wilderness World Heritage Area. Most walkers will complete the walk within six days, staying in designated huts and associated tent sites along the way. The walk has a national and international reputation as one of the great wilderness walks. About 9,000 walkers embark on the Overland Track every year. It is physically challenging and walkers may face rapidly changing weather conditions.

On the section of the track at which he was found deceased, Mr Tolputt was very close to the shelter of Narcissus Hut. At that stage he had been walking for six days in extremely challenging conditions. Narcissus Hut marks the end of the walk for the majority of walkers, who then use a ferry service from that point to travel along Lake St Clair to the visitor centre complex - a journey taking about 40 minutes. From the Lake St Clair visitor centre complex, walkers arrange their own collection or transport from the area.

Whilst Mr Tolputt died before 8.30pm on 14 July, a rescue was not commenced until about 8.00am the following morning, 15 July. This is despite the fact that, at between about 6.00pm and 7.00pm on 14 July, a walker on the track who had reached Narcissus Hut and who had passed Mr Tolputt, reported to a staff member of the privately operated ferry using the hut radio, that Mr Tolputt was likely in a position of serious risk, having not yet made it to the hut. That information was not passed on by the ferry operator to Parks and Wildlife Service (PWS) staff or police until the following morning.

Complicating the issues regarding communication of Mr Tolputt's potentially perilous situation was an unplanned power outage in the Lake St Clair area covering the visitor centre complex. This commenced on the morning of 13 July and lasted until the afternoon of 15 July. As a result of the outage, mobile and landlines were non-operational. Apart from the two-way radio between Narcissus Hut and the visitor centre complex used for ferry bookings, there were no other modes of communication. The PWS radio system was also inoperative due to snow on the towers.

The complex at Lake St Clair comprises a visitor centre operated by PWS and associated PWS infrastructure such as rangers' cabins, together with a private business operation conducted by Eco-Geo International Pty Ltd (EGI) operating a retail shop and restaurant, cabin accommodation and campground facilities and scenic boat tours, water taxi and boat hire service. In this finding, I will refer to all of the infrastructure in this location - the PWS visitor centre manned by PWS employees during business hours, other PWS buildings and the EGI operation as the "visitor centre complex".

EGI employs between 12 and 40 people in the Lake St Clair Lodge operation, depending upon seasonal demand, and occupies the premises under a lease with the Crown, managed by PWS. In this finding, I will refer generically to this operation as Lake St Clair Lodge (LSCL). The water taxi operation is serviced by one vessel, the "Ida Clair". I will refer to this service transporting walkers from Narcissus Hut to the visitor centre as the "ferry service".

It was apparent from the evidence at inquest that the services provided by LSCL play a critical part in the Overland Track experience provided by the Tasmanian government through PWS, although, as will be discussed, the relationship between the two was somewhat problematic and not conducive to effective communication.

The main issues explored by this inquest were:

1. The time and circumstances surrounding Mr Tolputt's death;
2. The non-reporting to PWS and/or police of Mr Tolputt's overdue status on 14 July, the likely Police Search and Rescue response if it had been reported and whether his life could have been saved with timely reporting and action;
3. The preparedness, in terms of experience, clothing and equipment of Mr Tolputt to safely undertake the walk in winter conditions and alone;

4. Deficits in communications between LSCL and PWS relating to Mr Tolputt being reported missing, and whether any deficit in communication contributed to death; associated with this issue was the relationship between LSCL and PWS;
5. Appropriate procedures for LSCL and PWS upon a walker being reported missing and overdue, including notification of police; and
6. The appropriateness of the implementation by PWS of further safety measures regarding walking the track in winter, including enhancement of the “Walker Safety Checklist” and other warnings, imposition of requirements (or stronger promotion of) the carrying of a satellite phone or EPIRB, extension of the summer booking system to winter months, additional staffing for PWS on the track or visitor centres, and more prominent track markings.

This inquest was held against the background of other deaths having occurred on the Overland Track and, notably in 2014, the death of Chinese national Kang Jin, an ill prepared walker who died of hypothermia. After this death, and in response to coronial recommendations, PWS implemented significant measures to enhance walker safety. These measures included enhanced messaging to emphasise that walkers may encounter extremely difficult conditions, additional controls upon walkers at the commencement of the walk in the booking season, and the introduction of foreign language buttons on the PWS Overland Track website.

The evidence in this investigation comprised affidavits relating to identification of Mr Tolputt, autopsy findings, toxicological findings, evidence from family members and eyewitnesses, PWS employees, LSCL employees, EGI director, police officers involved in the search and subsequent investigation, and employees of Tas Networks. The evidence also comprised a report of a survivability expert. Documentary evidence was tendered, including PWS and LSCL policies and procedures, PWS walker safety material, weather information, maps, information concerning gear and equipment. Oral evidence at inquest was received from 13 witnesses relating to both the circumstances of Mr Tolputt’s death and the safety and procedural issues the subject of this inquest.

Background

Trevor John Tolputt was born in England on 19 October 1960. He was the fourth child of Reginald Tolputt and Evelyn Tolputt. In 1966 Mr Tolputt and his family relocated to Australia. Mr Tolputt has two children from two previous relationships. They are Lucas Tolputt, born 1983 and Lauren Tolputt, born 1992. In 1993 Mr Tolputt commenced a long-term relationship with Brigid Reynolds. He and Ms Reynolds moved from Tasmania to Queensland in 1996 and remained living in Queensland. Mr Tolputt was employed as a call centre operator. Mr Tolputt enjoyed playing golf, watching sports on television and walking to maintain his health and fitness.

The evidence indicates that, for much of his adult life, Mr Tolputt consumed quantities of alcohol and smoked cigarettes. However, about three years before his death, he changed

his lifestyle significantly by ceasing consumption of alcohol, giving up smoking and increasing his fitness. He took up hiking/bushwalking in the year before his death. Mr Tolputt suffered from hypothyroidism which he successfully managed with medication. Apart from that condition, he was in good health. He was of lean build, weighing approximately 72kg and was 186cm in height.

In October 2015 Mr Tolputt successfully walked the Overland Track as part of a group tour with Tasmanian Expeditions. It appears that he intended to walk the South Coast Track in November 2016, also with Tasmanian Expeditions, as he attended his general practitioner on 15 March 2016 for a medical certificate. His general practitioner, Dr Jennifer Thorne, completed the relevant medical certificate advising that his fitness level to walk over rough ground with a day pack for 8 to 10 hours with only short stops was excellent.

Circumstances Surrounding Mr Tolputt's Death

In May 2016 Mr Tolputt decided that he would travel to Tasmania to walk in the Walls of Jerusalem National Park. To prepare for the walk he purchased new walking gear and equipment and tested it on a walk in Queensland.

In her affidavit for the investigation, Ms Reynolds stated that before his trip, Mr Tolputt decided that, due to recent flooding, he would walk the Overland Track for a second time instead of the Walls of Jerusalem track. Ms Reynolds stated that Mr Tolputt was happy with the gear that he had purchased and felt well prepared for the Overland Track. He used his checklist from his previous Tasmanian Expeditions walk as a reference for his packing. As will be further discussed in this finding, Mr Tolputt's walking gear was not adequate for winter conditions on the Overland Track.

The evidence regarding Mr Tolputt's movements on the walk were described in affidavit evidence of witnesses who encountered him on the track and their oral evidence at inquest. The evidence regarding the communication by persons concerning Mr Tolputt not arriving and official reporting was also explored in detail at inquest. There was little dispute as to the evidence of significance. I will set out, in accordance with the evidence, the findings regarding the circumstances surrounding his death and reporting of him as missing, dealing with the credibility of the evidence where necessary.

On 7 July 2016 Mr Tolputt flew from Queensland to Launceston and met with his daughter Lauren Tolputt ("Lauren"). I note that Lauren, in her affidavit for the investigation, mistakenly indicated that she collected her father on 8 July and is also mistaken by one day in regards to her recounting of further dates.

In her affidavit for the investigation, Lauren said that her father was obsessive with most things and that he would have done significant research into bushwalking. He took pleasure in showing her the things in his pack. Lauren said that he appeared well prepared, although she discussed with him the fact that he did not have an EPIRB. Mr Tolputt said that he might look in to hiring or buying one the following day when he collected some supplies. The evidence from Mr Tolputt's records indicate that on 8 July 2016 he purchased food and fuel for his walk.

At 5.00pm on 8 July 2016 Ms Reynolds spoke with Mr Tolputt on the telephone and he indicated no concerns about the walk.

The following morning, 9 July 2016, Lauren picked up Mr Tolputt early from his accommodation with the aim of reaching Cradle Mountain at about 7.30am. Lauren dropped Mr Tolputt off at Ronny Creek, being the point from which the Overland Track officially commences. Mr Tolputt checked his equipment and signed the hiking register before commencing the walk. I note that Lauren, in her affidavit, indicates that this occurred on 10 July, however, I am satisfied from the extract of the Walker Log Book that Mr Tolputt commenced the walk on 9 July. On the Walker Registration, he noted his intended walk finish date as being 14 July.

Mr Tolputt walked to Waterfall Valley Hut for the purpose of sleeping the night. There he met Mr David Crothers, an experienced bushwalker who had walked the Overland Track on six occasions in both summer and winter seasons. Mr Crothers provided an affidavit for the investigation and gave evidence at inquest. In his evidence, Mr Crothers said that he had expected to hit bad weather on this trip and his group was advised at the Rangers Hut before the trip that there would be snow. He said that, at Waterfall Valley Hut the temperature was about 0°C outside and the thermometer in the hut showed 4°C. He noted that, in the hut, Mr Tolputt was dressed in a t-shirt, shorts and a pair of "croc" shoes. He stated that Mr Tolputt was very slim and did not appear to carry any body fat.

The following morning, 10 July 2016, Mr Tolputt set out for the day's walk. Mr Crothers described Mr Tolputt as dressed in wet weather gear, wearing an Akubra style hat, gloves and a lightweight walking pole. When Mr Crothers said to Mr Tolputt that he would see him at the next hut, being Windermere Hut, Mr Tolputt stated that he intended to skip that hut and walk through to Pelion Hut.

Mr Tolputt reached Pelion Hut that same day, 10 July, and stayed in that hut for the night.

On the following evening, being 11 July 2016, Mr Crothers again saw Mr Tolputt, who told him that he was staying his second night at Pelion Hut as he had attempted to climb Mount Oakleigh but had had to turn back due to bad weather.

The following morning, 12 July, Mr Tolputt left Pelion Hut alone. Mr Crothers' group arrived at the destination, Kia Ora Hut, just on dusk. Mr Crothers noticed that Mr Tolputt was there dressed in a t-shirt, shorts and crocs. Mr Crothers stated that the heater inside the hut was not working and it had started to snow heavily. The evidence indicates that this was the start of the significant worsening of the weather.

The following morning, 13 July, Mr Crothers said that they all (including Mr Tolputt) had breakfast and packed. Mr Crothers did not see Mr Tolputt leave the hut as he left before Mr Crothers' group. However, Mr Crothers indicated that Mr Tolputt returned 10 minutes later, stating that he had forgotten his water. Mr Crothers observed Mr Tolputt leave again only to return 20 minutes later, stating that he was unable to find the track and would walk with the Crothers group as there was "safety in numbers". Mr Crothers gave a detailed description in his evidence of the conditions facing the walkers leaving from Kia Ora Hut and provided photographs taken of the snow conditions starting out from that hut. He said that the water

taps at the hut were frozen. He stated that the track was hard to find due to the depth of snow and also because the snow was weighing down branches and disguising the track. The walkers had to dig into the snow with their sticks to try and find something resembling a track. He said that the snow was about knee depth. The photographs indicate that Mr Crothers at one point was waist deep in snow.

Nevertheless, Mr Crothers' group and Mr Tolputt, together, pressed on to the next destination, Windy Ridge. Although parts of the track were visible, Mr Crothers reviewed the decision to continue on several occasions. In evidence, Mr Crothers said it took the group 10 hours to do the usual 5 hour walk to Windy Ridge Hut. Once it became dark, the group donned headlamps. Mr Tolputt's lamp failed and so he borrowed one from Mr Crothers. As the group proceeded over Du Cane Gap in the dark, it was windy and snowing heavily. Upon arriving in the Windy Ridge area at about 9.00pm, they lost the track to the Windy Ridge Hut. The group made numerous attempts to find the hut but failed. Mr Crothers indicated that they should camp in tents until dawn as, by this time, it was about 10.30pm. In relation to this period, Mr Crothers states in his affidavit:

"We backtracked about 10 minutes to a bridged creek to ensure we had a water supply and a safety perspective as we were lost.

Trevor wanted to walk on, however we set up camp. Trevor had his own tent and I asked him if he had his own food, which he replied he had plenty. We prepared food and settled down for the night.

We knew from experience and the map that we were close to the hut. At dawn Trevor and Neil went looking for the track again backtracking until they found markers that led to our campsite and the clearing that we had reached the night before. Trevor and Neil found the hut after about an hour.

We packed up our campsite, the conditions were still very difficult with deep snow and a cold wind. Standing about in our tracking gear, produced the early stages of hypothermia as it was very cold.

At this time Trevor said goodbye as he wanted to push through and meet his daughter at Lake St Clair. We talk to him about the need to rest, get warm, dry clothes and food, however he was adamant to continue, and headed off.

We spent the next two days at Windy Ridge drying our gear and recuperating.

My observations of Trevor were that he was fit and fast on the track, however, he had limited clothing suitable for the prevailing conditions. His timeframe to complete the track in my opinion also didn't allow for holding up whilst bad weather past (sic)."

In his evidence at inquest, Mr Crothers stated that his group had high quality Gore-Tex walking gear and had planned the walk very carefully. Mr Crothers, who was walking with his son, said that he would not have taken his (adult) son if his son only had the gear carried by Mr Tolputt. In particular, he noted that Mr Tolputt had no beanie to keep his head warm. He gave evidence that Mr Tolputt was adamant in his desire to keep walking from Windy Ridge

Hut even when, as a last resort, Mr Crothers tried to bring him into the hut for breakfast. Mr Crothers said that the track markers suffice under normal conditions and he said the weather was unusual to hide the markers and have snow laden trees covering the track.

On the morning of 14 July, despite the attempts by Mr Crothers and his group to persuade Mr Tolputt to stay at Windy Ridge Hut, including advice that walking in a group was a safer option than by himself, Mr Tolputt left alone to head towards Narcissus Hut. Mr Crothers had no further contact with him after this point.

At about 4.15pm on 14 July Mr Tolputt encountered walkers Mr Simon Cubbin and Angela Roberts, walking with their 11-year-old son, on the Overland Track past the junction with Pine Valley Track.

Mr Cubbin swore an affidavit in the investigation and gave evidence at the inquest. He travelled to Tasmania from New South Wales to visit Pine Valley and the Labyrinth just off the Overland track. He is a walker with around 30 years' experience and has walked the full length of the Overland Track on three occasions. He said in his affidavit that his group were well-prepared to walk at this time of the year being fully aware of the extreme weather conditions that might occur.

Mr Cubbin provided evidence that on Tuesday 12 July the weather on the track turned bad whilst they were at Pine Valley Hut. He stated that on Thursday 14 July they set off from Pine Valley Hut at about 11.00am to join the Overland Track to head south to Narcissus. He stated in his affidavit: *"the track was tough due to the bad weather and debris on the track. There was heavy snow, swollen creeks and parts of the track were submerged. We left Pine Valley around 11.00am and what should have taken us three hours to walk took us around 5.75 hours."*

Mr Cubbin gave evidence that the walking was stressful due to concern about his 11-year-old son and the possibility of suffering hypothermia in the conditions. He gave evidence that they had to break track and found themselves often going into water. He said that he could see footsteps in the snow heading towards Narcissus Hut. He stated that the footsteps had a decreasing stride length and he followed those footsteps for approximately 2 kilometres from the turn off from Pine Valley before meeting Mr Tolputt (not known to him then) approximately 1.2 kilometres from Narcissus Hut and about 500 metres to the north of the "swing bridge" (being a suspension bridge over the Narcissus River).

Mr Cubbin stated in his affidavit sworn on 15 July 2016 that Mr Tolputt was walking alone and looking tired. When Mr Cubbin asked if he was okay, Mr Tolputt replied that he was okay but it was hard going. Mr Tolputt asked about the distance to the next hut to which Mr Cubbin replied that they were 10 to 20 minutes north of the bridge and another 10 to 20 minutes to the hut after the bridge. Mr Cubbin described Mr Tolputt as seeming lucid and was offering information freely without having trouble with his speech. He was not shivering. Mr Cubbin stated in his affidavit that he did not feel Mr Tolputt was in immediate danger and simply appeared tired due to the tough conditions. He observed Mr Tolputt to be wearing an Akubra hat which he believed was "crazy". He gave evidence that he was familiar with the first stages of hypothermia and he did not see that Mr Tolputt was suffering hypothermia.

In his evidence at inquest, Mr Cubbin said that there would normally be a camaraderie between walkers when meeting in such adverse circumstances. However, Mr Cubbin indicated this was not the case when meeting Mr Tolputt. Mr Tolputt did not accept Mr Cubbin's offer of chocolate or to walk with Mr Cubbin's group. Mr Tolputt said that he would walk behind Mr Cubbin's group. Mr Cubbin said at inquest that his son was suffering hypothermia and he needed to ensure that he took him to the hut so that he could recover. Therefore, Mr Cubbin, his partner and his son continued successfully onto Narcissus Hut. He stated, however, that in ordinary conditions the walk would have taken 20 minutes but instead took 45 minutes. Mr Tolputt did not arrive as expected.

In his affidavit, Mr Cubbin stated as follows:

"We arrived around 4.45pm and had set up camp by 6.00pm. We organised warmth and food. I was worried about the male [Mr Tolputt] so I located the back to base radio and made contact with a staff member from the lodge called Brett. I arranged to call Brett back if the male showed up. I intended to go back to locate the male however my gear was wet and it wasn't safe for me to go alone. I notified Brett at 7.00pm that I couldn't go back. Brett agreed that we should stay put and told me he had notified the Parks service and there was a 48-hour window before they would commence a search."

Mr Brett Jones, who was the Ferry Master employed by EGI at LSCL, was the employee referred to in the above passage. Mr Jones warned against Mr Cubbin searching for Mr Tolputt due to the water over the track and the tea tree possibly causing a cover of darkness. In his evidence at inquest, Mr Cubbin emphasised the danger to which he would be exposed if he attempted to search for Mr Tolputt. He stated that he and his wife seriously considered searching but ultimately he believed he may easily walk off track, become waist deep in water or snow and die. Mr Cubbin placed an illuminated torch outside the hut so that if Mr Tolputt was nearby he would be able to locate the hut.

It was unusual, on the evidence, that Mr Cubbin was able to speak to Mr Jones because at that time the radio for LSCL is usually not manned, its existence being solely for scheduled ferry transport during the day.

Mr Cubbin and his family stayed at the hut overnight. In evidence, Mr Cubbin stated that he did not sleep due to concern about Mr Tolputt and said that at one stage he attempted to walk 100 metres along the track in an effort to locate him but turned back due to conditions being too challenging.

Mr Jones stated in his affidavit that he received radio contact with Mr Cubbin at 8.00am the next morning, during which conversation Mr Cubbin told Mr Jones that the man had not made it to the hut overnight and he was gearing up to go and look in the area where he had last seen him.

At about 8.45am Mr Cubbin and his family headed out to look for Mr Tolputt with a rescue kit. Between 7 and 15 minutes later, Mr Cubbin located Mr Tolputt to the side of the track, lying in what he described to be an awkward position. He was laying in running water and appeared deceased.

I will discuss later in this finding the evidence regarding the response from PWS and staff of LSCL and the communication between the two as it pertained to Mr Tolputt's rescue. However, presently, it is relevant to set out the undisputed evidence. It is also to be noted that the mobile phone reception on the Overland Track is poor to non-existent. Further, the complete power outage in the area (as set out above) meant that the only form of communication outbound from Narcissus Hut was by the two-way radio operated by LSCL for the purpose of scheduling ferry transport. There was also no other way to communicate outbound from the visitor centre complex with the exception of a satellite phone, if available, or travelling a distance away from that area to secure telephone reception.

At 8.40am Mr Jones approached the PWS ranger in charge, Mr Daniel Ferguson, likely between the visitor centre complex and the reception of LSCL. The distance between these two points is a matter of metres. Mr Jones informed him of the information radioed by Mr Cubbin the previous evening regarding the missing walker. Mr Jones and Mr Ferguson, with other personnel, decided to travel from LSCL on the "Ida Clair" to try and locate Mr Tolputt. They took with them a satellite phone that Mr Ferguson had only discovered when he was gathering necessary equipment to travel up the lake. In evidence, Mr Ferguson said that he charged that phone, which was likely left by the Overland Track staff. Whilst on the trip, and prior to reaching Echo Point, Mr Jones received a radio call from Mr Cubbin stating that he had located Mr Tolputt.

Upon arrival at Narcissus Hut in the boat, they were met by Mr Cubbin who took them to Mr Tolputt at his original location. Mr Ferguson checked Mr Tolputt and was unable to detect a pulse or any other signs of life.

At 10.15am Mr Ferguson called the Police Search and Rescue radio room on the satellite phone and notified them of the death of a bushwalker. Arrangements were made for helicopter retrieval.

At 12.50pm the Police Search and Rescue helicopter, with five personnel on board, arrived at Mr Tolputt's location. He was transported to the Hobart mortuary.

A coronial investigation commenced with a forensic examination of the scene by specialised officers of Tasmania Police.

On 18 July Dr Donald Ritchey, forensic pathologist, performed an autopsy upon Mr Tolputt. Dr Ritchey had regard to the police report of death outlining the weather conditions on the track at the time of Mr Tolputt's death and subsequent results of toxicological testing of a sample of Mr Tolputt's blood. Dr Ritchey observed that Mr Tolputt had bruises of both knees that extended onto his left shin. He also noted moderate natural disease, evidenced by a mildly enlarged heart with moderate atherosclerotic coronary vascular disease that appeared stable. He noted the presence of emphysema, a lung disease caused by Mr Tolputt's prior smoking habit. Dr Ritchey concluded that Mr Tolputt died of hypothermia. He stated in his conclusion of the report:

"Hypothermia occurs when the core body temperature drops below 35°C and the body's usual compensatory mechanisms fail to generate sufficient heat to keep the body warm. Often individuals who are hypothermic can become delirious and engage

in 'burrowing behaviour', crawling on their hands and knees and often sustaining superficial injuries in the process. Additionally, there were superficial stress ulcers in the lining of the stomach (Wischnewsky's ulcers), a non-specific finding, but one often seen in individuals who die of hypothermia."

I accept the evidence of Dr Ritchey and find that Mr Tolputt died of hypothermia as a result of environmental cold exposure.

Mr Tolputt's Time of Death

Mr Tolputt was last seen alive by Mr Cubbin at approximately 4.15pm on 14 July 2016, a distance of approximately 1.2 kilometres north of the Narcissus Hut. Whilst Mr Tolputt did not present to Mr Cubbin as hypothermic, I find that Mr Tolputt was, in fact, significantly hypothermic at that time. In this regard, the inquest received an expert report from Dr Paul Luckin, who was engaged to provide an opinion on how long Mr Tolputt might have survived after that point under the prevailing conditions. Dr Luckin is an experienced specialist anaesthetist and expert on the question of survivability. Dr Luckin has been involved in Rescue as a paramedic since 1974 and Search and Rescue as a doctor since 1982.

In his report, Dr Luckin had regard to the evidence in the investigation, including evidence of the wind and temperature conditions, Mr Tolputt's physical characteristics, Mr Tolputt's walking clothes and gear and reports of his behaviour and conversation on the track. Regarding these matters, Dr Luckin concluded that the cold conditions, his low body weight and inadequate clothing would have contributed to the onset of hypothermia in Mr Tolputt. It is appropriate to set out the essence of Dr Luckin's conclusion regarding Mr Tolputt's progression to hypothermia and death. He states as follows:

"Mr Cubbin states that when his group found Tolputt walking by himself, at 16.15 on the 14 July 2016, he looked tired. He notes that Tolputt was stopped on the track.

When Cubbin greeted Tolputt "his response seemed odd, in that he didn't seem pleased or surprised to see us." "...he simply looked at us and said something along the lines of 'It is tough going. I'm simply exhausted'. Trevor looked like he had just completed a marathon and I became slightly [sic] about his demeanour". [In the context of what Cubbin was saying, I suspect the missing word would have been 'concerned'.]

It seems that Cubbin was concerned enough about Tolputt's condition to ask if he was OK, if he had walked the track before, to offer him some chocolate, and to ask if Tolputt would like to walk with Cubbin's group.

Tolputt refused the offer to walk with Cubbins but said he would walk behind.

Given Tolputt's earlier statements that it was tough going and he was simply exhausted, the weather conditions, the time of day and the approaching darkness, this was not the response of a person thinking normally.

[Sunset that day was at 1702 (Bureau of Meteorology, historical data for Lake St Clair.) Given the rain it would have been getting fairly dark by 1615 hrs.]

Despite the statement that Tolputt seemed lucid, answered logically, and had no trouble with his speech, the detailed description of his tracks in the snow and his behaviour makes me believe that he was by this stage already suffering the effects of severe hypothermia.

The observation that Tolputt was not shivering does not clarify his core temperature. Shivering generally starts at a core temperature of about 35°C, and generally stops by about 33°C, but this varies from individual to individual, and from time to time within the same individual. A few individuals do not shiver at all. I think it most probable that Mr Tolputt's core temperature was below the temperature at which he had stopped shivering.

It is also possible that Mr Tolputt did not shiver because his skeletal muscles were so cold that peripheral nerve function was severely impaired.

Mr Tolputt was at this stage in deep snow, wet, exposed to windchill, in failing light, and losing heat energy rapidly. He was generating little heat from voluntary muscle movement, and none from shivering. His core temperature would have fallen rapidly.

Mr Tolputt would have become more and more lethargic, less able to think clearly, to understand his situation, or to take steps to improve his chance of survival.

Const James' photographs show Tolputt's hat resting partly on his head, between his head and rucksack. His body is in a semi-lateral resting position, with his legs out straight and his arms folded across his chest. His left hand appears to be holding a fold of material above his right elbow. The entire posture suggests to me that he did not fall into this position, but that as he became too lethargic to continue he lay down in this position. In either case, once lying in water within a few degrees of freezing his core temperature would have dropped very rapidly, and he would have lost consciousness within a very short period of time.

The question then arises as to whether his airway was obstructed in this position, resulting in rapid hypoxia (low blood oxygen level) and imminent death, or whether he became progressively more hypothermic but was potentially resuscitatable. Resuscitation would require trained personnel, appropriate transport, a suitable location close by, and equipment and facilities to conduct prolonged rewarming and resuscitation."

In his report, Dr Luckin concluded by forming the view that from the time Mr Tolputt was last seen alive there was no reasonable prospect that he would have survived for longer than a few hours. He stated that he would estimate his maximum survival time at approximately 4 hours. In his oral evidence at inquest, upon questioning, he said that it was more likely that Mr Tolputt would have survived only for 2 hours. This being the case, his death was more likely to have occurred by about 6.30pm, although it is possible that he may have survived until 8.30pm.

Dr Luckin was an impressive witness at inquest. He carefully explained the above conclusions. His high degree of medical and associated knowledge in the area of survivability was apparent. I accept his opinion without hesitation.

Dr Luckin commented in evidence that, if Mr Tolputt had walked with Mr Cubbin's group, there was a good chance that he would have survived, by effectively being coaxed to the hut. He further commented that if Mr Cubbin had chosen to search for Mr Tolputt after

having reached the hut he himself may well have succumbed to hypothermia and died. Dr Luckin gave evidence that the final stage of hypothermia involves reduced blood flow to the brain and that the process of death is not unpleasant.

I therefore find that Mr Tolputt died before 8.30pm but more likely on or before 6.30pm on 14 July 2016. As will be apparent from the following discussion, even if police Search and Rescue had been alerted and a rescue attempt activated that evening, personnel could not have reached Mr Tolputt by the time he had died.

In this regard, I have received evidence from experienced member of Tasmania Police Search and Rescue (SAR), Sergeant Damian Bidgood. Sergeant Bidgood reviewed the circumstances surrounding Mr Cubbin's report that Mr Tolputt had not reached Narcissus Hut by 7.00pm. He stated in his affidavit that, if weather permitted, SAR would have immediately activated a helicopter search. However, he reviewed the aviation weather data for the time in question which indicated that the helicopter response would most likely not have been possible. He gave evidence that the alternative response, being a land and water based rescue involving Marine and Rescue officers driving to the visitor centre complex and then launching a boat to travel along the lake, would take in the vicinity of six hours. I accept the evidence of Sergeant Bidgood and find that in the prevailing weather conditions a helicopter rescue would not have been activated. If a land and water rescue had been activated, those officers involved would not have been able to reach Mr Tolputt before he died.

The Reporting of Mr Tolputt as an Overdue Walker

At 3.00pm on 14 July, Lauren arrived at Lake St Clair. She went to the visitor centre complex where she had arranged to pick up her father at the conclusion of his walk.

At 3.30pm Lauren asked Mr Russell Scott, PWS visitor services officer, at the visitor centre if he had seen Mr Tolputt. He advised he had not seen or heard from him but that he suggested he was slowed due to weather conditions. All the evidence indicates that the conversation between Mr Scott and Lauren was brief and casual, with Mr Scott directing Lauren to the LSCL reception, only across the corridor within the complex, to check their ferry manifest. Lauren spoke with the ferry master, Mr Brett Jones, at the Lodge and enquired if he had seen Mr Tolputt. He advised her that no-one had booked the ferry that afternoon and that she should speak with PWS. She replied that she had already spoken to PWS staff (being Mr Scott).

Lauren stated in her evidence that staff at the restaurant tried to contact Narcissus Hut about 3-4 times on the radio while they waited at the Lodge.

Mr Scott saw Lauren again at 4.00pm. He stated in his affidavit that Lauren informed him that Mr Tolputt was not at Narcissus Hut or on the ferry manifest. He suggested that Mr Tolputt could be waiting for the weather to ease in another hut and was likely a day behind in his schedule. Mr Scott suggested that she stay at LSCL due to the roads being affected by snow.

Between 4.30pm and 5.00pm, after being present at the complex for a total period of about 1.5 to 2 hours, Lauren and her partner decided to drive back to Launceston and return the following day.

At about the same time, after Lauren had left for Launceston, Mr Scott spoke to Mr Ferguson, who happened to be delivering a generator to Mr Scott's staff residence, in regards to the discussions he had had with Lauren. From both the evidence of Mr Scott and Mr Ferguson, it is apparent that the substance of the conversation at this time was that both believed that, due to the extreme weather conditions, Mr Tolputt had been delayed and was sheltering in a hut or his tent somewhere on the track. Mr Ferguson did not refer to the discussion with Mr Scott in his affidavit sworn in December 2016 but did so in his second affidavit of April 2018 and his evidence at inquest. In that latter affidavit, he stated that they discussed Mt Tolputt's equipment and experience, as relayed by Mr Scott. I cannot confidently determine the content of this discussion, and it is likely affected by unintentional reconstruction. In this regard, Lauren gave evidence that she had no recollection of speaking to Mr Scott about her father's gear or experience. She was a credible and coherent witness. No documents or notes were generated by Mr Scott at the time of Lauren's attendance regarding her father's failure to arrive, nor by Mr Ferguson. In fact, Mr Ferguson's comprehensively completed Visitor Incident and Hazard Report Form dated 16 July 2016 made no mention of any conversation with Mr Scott about Mr Tolputt, let alone an analysis of his risk after considering his gear and experience. I find that any conversation that occurred was only a basic recounting of the fact that Mr Tolputt had not arrived.

In any event, it is clear that neither man believed that Mr Tolputt was likely to be in danger and that the weather conditions meant that he was delayed from his intended schedule but safe. Both were also of the view that, given the conditions, there was not much more they could do. Specifically, Mr Ferguson stated in his affidavit that *"it was not plausible for us to launch our boat due to the time of day and weather forecast. Doing so would have meant putting staff and resources at unnecessary risk."* Again, I am not convinced that this degree of consideration occurred. It was not in the incident report. Certainly, Mr Ferguson's evidence at inquest was that there was no thought by him that police needed to be notified at that stage or that Mr Tolputt may be in danger. Mr Ferguson stated in his affidavit that he made a mental note to catch up with Lauren when she returned the next day to determine if she could add any further information to what they knew. Again, this may be unintentionally reconstructed as a result of the subsequent knowledge gained.

Unfortunately there was conflicting evidence about the exact timing of the communication between Mr Cubbin and Mr Jones and also whether there were one or two radio calls by Mr Cubbin. On balance of the evidence, I am satisfied that it was about 6.00- 6.30pm that Mr Cubbin radioed Mr Jones from Narcissus Hut regarding the possibility of Mr Tolputt being in trouble. Further, I am satisfied that there was a second radio call by Mr Cubbin which occurred at about 7-7.30pm.

At about 7.30pm Mr Jones spoke to his manager, Stephen Sanderson. As Marine and Maintenance Manager, Mr Sanderson had responsibility for running the ferry service and maintenance of the cabins. Mr Jones asked Mr Sanderson what the procedure was in this situation. He told Mr Sanderson that Lauren had already spoken to PWS that afternoon. In

his affidavit, Mr Jones stated *"I spoke with my manager, Steve Sanderson, who was with us at the Lodge. I asked what the procedure was and told him that the man's daughter had already spoken to Parks that afternoon. He said if Parks were aware then we would be on standby if they required us. I stayed by the radio until about 10:30 PM but didn't hear back from Simon (Cubbin)"*.

However, in his evidence at inquest Mr Jones gave evidence that Mr Sanderson replied that there were "no procedures". Mr Sanderson, in his affidavit for the investigation sworn in May 2018 (by which time he was working for another company in the area) stated that he wanted to organise a search party but was reluctant to take the Ida Clair, being the only means of commencing the search, due to a perceived prohibition on its use by LSCL management. His affidavit contained a number of grievances relating to the company which were expressed assertively. Mr Sanderson's court evidence was somewhat different, indicating he did not seriously consider a rescue and did not think the worst for Mr Tolputt nor consider it a real emergency, stating that he was not aware of the weather conditions outside the immediate area. He said that it was his belief that Mr Tolputt would turn up.

In his affidavit Mr Sanderson stated *"we never contacted Daniel Ferguson as the PWS office was closed. I have Daniel's after hours number but the power was out and I couldn't call him. To be honest we never really thought outside the idea of conducting our own search and rescue operation"*.

At this point I observe, in accordance with maps and oral evidence, that the proximity of LSCL (where Mr Sanderson was situated) to the ranger's house where Mr Ferguson was present was between 100-500 metres. The evidence indicates that the distance could have been walked (and likely driven). Mr Nic Deka, PWS Regional Manager Northwest, gave evidence that he did not believe that weather conditions would ever prevent LSCL staff walking to the rangers' premises. I accept his evidence. Mr Sanderson gave evidence that, notwithstanding the proximity between the two, he did not know where, in the complex of PWS residences, Mr Ferguson was present. The map indicated that there was a clusters of about 7 such residences that would have been relatively easy to reach and find Mr Ferguson. The evidence from Mr Scott and Mr Sanderson also indicates that, whilst the weather was poor, they would have been able to drive outside the complex to a point several kilometres along the road where telephone reception could be gained.

As will be discussed, Mr Sanderson gave evidence that the relationship between LSCL employees and PWS staff was extremely poor. He said, in fact, that there was no relationship with PWS and that he would not speak to Mr Ferguson, even during an emergency, giving evidence that he would prefer to drive to the police station or seek help through other means. As will be discussed, Mr Jones gave evidence at inquest that he was not allowed to communicate with PWS staff, except as authorised by LSCL management. His evidence was more moderate than Mr Sanderson's in terms of his description of the relationship between LSCL staff and PWS staff. Both Mr Sanderson and Mr Jones, however, gave credible evidence that there were no procedures or induction training as to how to respond to reports such as that made by Mr Cubbin relating to concern for walkers.

In summary, and piecing together affidavits and oral evidence, I find that at about 7-7.30pm Mr Jones and Mr Sanderson discussed the concerns relayed by Mr Cubbin for Mr Tolputt. I find that Mr Jones relayed to Mr Sanderson that Mr Cubbin had passed a walker who had not reached Narcissus Hut and who was not booked on the ferry as he was due to walk around the lake to complete the walk. Mr Jones conveyed to Mr Sanderson that PWS was aware of the report because Mr Jones knew from the earlier involvement that Lauren had spoken to PWS. However, by this time a further 4 to 5 hours had elapsed.

Mr Sanderson did not know that the time of the report to PWS was much earlier and when there was good reason to think that Mr Tolputt would not be in danger. I also find that PWS was not aware of the later, concerning information regarding Mr Tolputt reported by Mr Cubbin. I find that although Mr Sanderson and Mr Jones may have had a brief discussion regarding deploying the vessel, the *Ida Clair*, that proposal was not pursued. The proposal to further notify PWS to ensure it had received the new information was not contemplated and a report to police (having to be made by driving along the road to gain reception) was also not contemplated. It was, however, decided that Mr Jones would remain available for the night if required to assist.

Mr Sanderson remained by the radio that evening, with Mr Jones and other staff, until 10.30pm but did not receive any further transmissions from Narcissus Hut. No further action was taken or reports made that evening.

At 8.30am on 15 July, Mr Jones spoke to Mr Cubbin again on the radio. Mr Cubbin informed him that Mr Tolputt had not made it to the hut overnight and that Mr Cubbin was readying himself to go out and attempt to locate him. As previously discussed, at 8.40 am Mr Jones informed Mr Ferguson and the search for Mr Tolputt commenced.

Ms Helen Dillon is, and was at relevant times, a director of EGI, and who was responsible for LSCL operations. She is a resident of Western Australia. Ms Dillon provided affidavit and oral evidence at inquest. The evidence indicated that, whilst she spent little time on site, she was the person to whom the managers on-site reported.

Ms Dillon was not advised on the evening of 14 July by Mr Sanderson or any other LSCL staff about the potential plight of Mr Tolputt following Mr Cubbin's report. However, early the following morning Mr Sanderson drove out from the visitor centre complex to a point along the road to obtain mobile telephone reception and then sent text messages to Ms Dillon relating to the power outage and the consequences to LSCL. Those text messages, which were part of the evidence at inquest, did not mention the concerns relating to Mr Tolputt or Mr Cubbin's report. Mr Sanderson had not been advised at that stage that Mr Tolputt was deceased.

After sending these initial text messages and returning to the visitor centre complex, Mr Sanderson learned of Mr Tolputt's death. Upon receipt of this news, Mr Sanderson again drove along the road and sent further texts to Ms Dillon advising that he had been notified of the death of a walker. He indicated in the messages that he had knowledge that a walker had not arrived at Narcissus Hut the previous evening and he stayed back with other staff to man the radio. He told Ms Dillon that he had hoped that the walker had stayed at Windy

Ridge. In his affidavit, however, he stated that he thought Mr Tolputt might have walked on to Echo Point. I observe that both scenarios were plainly not viable options. Mr Tolputt could only have safely walked to Narcissus Hut. I accept that he may not have been told the exact location of Mr Tolputt but such speculation understandably reflects his feeling of responsibility for the matter.

Analysis of Issues Raised by this Inquest

I have, above, made factual findings regarding the time and circumstances surrounding Mr Tolputt's death, as well as factual findings regarding the reporting (and non-reporting) of Mr Tolputt's overdue status and, subsequently, failure to arrive at Narcissus Hut. I have also concluded, for the reasons discussed above, that Mr Tolputt's life could not have been saved even if there had been timely reporting of his apparently perilous situation.

I now deal under separate headings with the remaining issues.

Adequacy of Mr Tolputt's clothing, equipment and experience to undertake the Overland Track in winter

A number of witnesses with extensive relevant experience, including Dr Luckin and Sergeant Bidgood, gave evidence that, in their opinion, the clothing worn by Mr Tolputt was inadequate for the conditions that he faced on 14 July.

Dr Luckin said that Mr Tolputt's rain jacket, in particular, was not adequate. The jacket was not seam-sealed which meant that small holes in the fabric caused by the stitching at the seams allowed water to penetrate the jacket. Therefore, while the material of the jacket was waterproof, the jacket could only be described as "water-resistant" as water could penetrate the seams of the jacket. In addition, the jacket was not made of a breathable fabric, such as Gore-Tex (or a similar product sold under a different brand name). Consequently, any moisture on the inside of the jacket, such as perspiration, would be trapped and would not pass through the jacket and evaporate. In summary, Mr Tolputt was wearing a jacket which would not have properly kept him dry in the conditions he faced and may have contributed to the development of hypothermia.

Dr Luckin further stated that Mr Tolputt did not possess a beanie or warm gloves. His evidence was that a large amount of heat is lost from the head and Mr Tolputt's Akubra hat was not adequate to prevent hypothermia. I accept his evidence in this regard. I am unable to determine the reasons why Mr Tolputt chose to wear such a hat rather than a warm beanie. In my view this indicates that, whilst his level of fitness was good, he lacked experience of equipping himself for such conditions.

The PWS Walker Safety Checklist and presentation by walkers at the Visitor Centres

The Walker Safety Checklist ("the Checklist") contains a list and description of clothing and gear required for the Overland Track and is published by PWS on its website and promulgated generally to walkers as a guide to clothing, gear and equipment required for the

walk. The Checklist was updated in response to comments and recommendations made in the coronial finding relating to the death of Kang Jin at Cradle Mountain in 2014.

During the summer booking season, it is a PWS requirement that the Checklist and associated documentation be filled out and signed by walkers. The document requires walkers to acknowledge the risks of walking the Overland Track and particularly the risk of extreme weather. It also requires walkers to confirm that they are carrying the minimum level of gear, as published by PWS, to complete the walk safely. Walkers who are booked to walk in the summer season must present their signed documentation to staff at the visitor centre at Cradle Mountain before commencing the walk. PWS staff speak there with walkers about their walking experience, their equipment, the dangers on the walk, the weather forecast and provide other relevant advice. The requirement that walkers go to the visitor centre during the summer months ensures that PWS staff physically see all walkers before they commence the walk. I note that safety messages in the visitor centre were also enhanced by PWS in response to the prior coronial recommendations.

However, Mr Tolputt did not present at the visitor centre at the start of his walk, as he was not required to do so in the non-booking winter season. Instead, he chose to be driven directly to the start of the track at Ronny Creek. He therefore lost an opportunity to discuss weather conditions and the adequacy of his gear and equipment with PWS staff. There is also no evidence that he was seen by any ranger prior to commencing the walk. This is not intended as criticism of PWS. There was no obligation upon PWS to position rangers at the start of the track at Ronny Creek. The evidence was also that there are few rangers on the track in winter and walkers are, in fact, unlikely to encounter rangers during their walk.

Comparing the clothing worn by Mr Tolputt to the Checklist reveals that Mr Tolputt did not have a fully waterproof jacket, a beanie or warm gloves. He did, however, have a relatively good quality waterproof and breathable over-pants, which are currently not an essential requirement of the checklist.

Dr Luckin suggested that the Checklist should be enhanced by including a requirement that walkers carry a waterproof and breathable jacket similar to a Gore-Tex branded jacket and also waterproof and breathable over-pants. Whilst Dr Luckin also suggested updating the document to make it clear that a warm beanie was essential, in my view that requirement is already sufficiently clear.

Therefore, while the consensus of opinion was that Mr Tolputt's clothing was inadequate for the conditions on 13 and 14 July 2016 it was not so inadequate as to drastically fall foul of the requirements of the Checklist.

PWS ought to be commended for the improvements it has made in recent times to the Checklist. It is nevertheless appropriate that PWS update the Checklist to ensure that the list of clothing is adequate for the conditions that can occur on the Overland Track in winter and, in particular, consider the inclusion in the Checklist of a requirement that walkers carry a good quality waterproof jacket and over-pants, which are seam-sealed and made of a

breathable fabric, such as, or similar to, material branded as "Gore-Tex." Counsel for PWS, Mr Turner, in final submissions, stated that PWS was prepared to consider such amendments, which should remain standard and applicable to all seasons given that severe weather conditions can occur at any time during the year.

I have made the recommendation set out below.

Communication capabilities at Lake St Clair and on the Overland Track, particularly during extreme weather and in times of power outage

The power outage in the area, affecting the community of Derwent Bridge (including the visitor centre complex) occurred between 13 July 2016 at 8.19am and 15 July 2016 at 2.48pm. As stated in an affidavit for the inquest, Mr Edward Jaeger, employed as the Engineering Group Leader, explained the nature of the fault as a recloser operating in response to a fault on the network which did not automatically restore power, an indication of an issue that was not transient but which required a crew to attend to identify the cause.

Mr Jaeger explained that this weather event was one of the more extreme events the network has experienced in recent times. An accompanying spreadsheet of power outages for the area corroborated this evidence, indicating that most outages were resolved within several hours. The power outage in question, being over multiple days, was exceptional.

I note that the fault was not reported until 15 July, which reporting may possibly have been the obligation of Telstra. However, the evidence of Tas Networks was that that organisation would not have sent a crew to the area for remedial work until this time, in any event, due to the extreme conditions and the multitude of other reported faults around the state.

There was also evidence from Tas Networks relating to the potential connection between the power outage and the failure of mobile phone service in the area, perhaps relating to the failure of power supply to the local Optus tower. Certainly, I accept that there was no mobile telephone service for the relevant period on the evidence at inquest. It appears to be related to the power outage but the inquest did not further explore this complex issue.

Power outages affect the ability to run all PWS field office and visitor centre communication equipment. In normal operating conditions, the generators will support a computer, the server, office telephones, radios, heating and lighting.

In 2016, PWS purchased three generators to provide a backup power source and ensure the visitor centre complex, field office and waste water treatment plant were all self-sufficient in terms of power supply. The generators were operational on 14 July, however, their effectiveness was reduced to heating and lighting only as other communication service infrastructure elsewhere in the area was not operational. PWS radios were also inoperable due to heavy snow covering radio communication aerials.

In response to the communications issues raised by Mr Tolputt's death, two satellite phones were purchased for PWS at the visitor centre and, more recently, satellite Internet and Wi-Fi

have been obtained. This development is important. PWS staff in the visitor centre complex must have the ability to maintain communication in a total power/ communications outage.

Ultimately, the inquest did not explore the issue of possible improvements in power infrastructure to the area. Again the connection between this issue and Mr Tolputt's death was not strong, given that there was an ability to make contact with police about his situation on the night in question, even if it meant travelling a little distance to obtain mobile reception.

Evidence from Mr Deka indicated that mobile telephone service along the length of the whole Overland Track is unreliable even when power is fully operational. I am satisfied that it is not appropriate in this inquest to inquire into the issue of enhancing mobile telephone service across the length of the track for the purpose of walker safety. There is no sufficient connection between this issue and Mr Tolputt's death and, further, the lack of service is a matter of which walkers should be aware of and accept as part of their wilderness experience.

Reporting procedures by PWS and LSCL regarding overdue or missing walkers

In 2016, at the time of Mr Tolputt's death, PWS had in place a "Lost or Missing Walker/Visitor" policy. Both that policy, and the current updated version of that policy (similar but with a little more detail) requires PWS to contact Tasmania Police when a walker is reported as lost or missing.

The policy requires the person to whom the report is made to obtain sufficient details to complete the "Incident Response Report Form", to check the walker registration books in relation to the walker's intentions, to contact Tasmania Police on the listed numbers and to commence a communication log of all correspondence relating to the incident.

The inquest examined in some detail the obligation of Mr Russell Scott, upon receiving the information from Lauren in the afternoon of 14 July, to report that information to police. Mr Scott did not complete the form, nor report Lauren's attendance to police. He is a long-term PWS staff member. There was no evidence given by him or other PWS employees as to why that report was not completed and why he did not complete a communications log. It would have been most helpful in ascertaining the facts surrounding the passing on of Lauren's report and any subsequent conversation with Mr Ferguson. If a walker is "lost" or "missing", an ordinary reading of the policy required a police report and did not provide for any discretion in taking that action. In fairness to Mr Scott, the policy is not specified to relate to "overdue" walkers as opposed to "lost" or "missing" walkers. It therefore appears to be a matter of individual judgment, taking into account time periods and circumstances, as to when a reported overdue walker may be deemed lost or missing so as to invoke the policy requirements. Like Mr Scott and Mr Ferguson, Mr Deka gave evidence that Lauren's report was not sufficiently concerning to justify contacting police.

The evidence of both Mr Scott and Mr Ferguson was that, in practice, PWS employees only report walkers as overdue or missing when they have sufficient information to conclude that the situation, in their view, warrants intervention by police. Sergeant Bidgood, in his initial

affidavit, indicated that, as a SAR officer, he would prefer to be notified or be given a “heads up” at the earliest possible opportunity. In his evidence at inquest, however, he accepted that police do not necessarily wish to be notified in every single case where, for example, a day walker on an easy track with mobile phone reception may be reported as slightly overdue. Certainly, Sergeant Bidgood maintained at inquest that PWS should provide all information to SAR as early as possible because SAR is the lead agency responsible for deciding upon, coordinating and actioning a search for a missing or overdue walker. He said that the earlier the notification is made to SAR the better prepared and more effective the response is likely to be. He stated that if Lauren’s report was passed on by Mr Scott directly to SAR, a search would not have been initiated at that earlier stage, although the report would not have been unwelcome. I accept his evidence. That report may have caused SAR, for example, to consider potential availability of suitable air and marine rescue resources over the following days.

Therefore, while the non-reporting to police of Lauren’s earlier report by PWS did not contribute to Mr Tolputt’s death, it is nevertheless appropriate to make some further comment about this issue and possible improvements.

Mr Deka gave evidence that many PWS employees are very experienced. For example Mr Ferguson gave evidence that he had over ten years’ experience as a park ranger. There will, however, be situations where less experienced PWS employees receive information relating to a potentially overdue or missing walker.

I accept the submission of counsel assisting, Mr Shapiro, that PWS policies should ensure consistency in reporting a walker as overdue or missing. Whether a report is made to police in a specific instance should not depend on the subjective experience and judgment of the particular PWS employee receiving the report as such a system does not enhance public safety. As submitted by Mr Shapiro, the contrary opinions expressed by Mr Ferguson and Mr Deka as to whether a report to the police should have been made by Mr Ferguson in the morning of 15 July, prior to departure on the lake, demonstrates that very experienced PWS employees can have different views about when police should be notified.

In my view, the evidence justifies a finding that a “pro-reporting” policy should be adopted by PWS in respect of missing or overdue walkers. While representatives of Tasmania Police stated during a meeting with PWS representatives in August 2018 that, in their experience, the timing of notifications from PWS was appropriate as it stands, the minutes of that meeting also state that police “*stressed that if PWS staff are in doubt as to whether to notify or not, then err on the side of caution.*” On balance, the available evidence does not indicate that SAR would be inconvenienced or overburdened with a slightly higher level of reporting from PWS.

It is unavoidable that PWS employees will need to make a decision as to whether police should be contacted in any particular instance of a walker being reported overdue or missing. There is real force in Mr Shapiro’s submission that relevant PWS policies should more actively encourage the reporting of overdue or missing walkers and embrace the

concept that SAR prefers to receive the notification at an early time. This will mean that police will likely be contacted more regularly than occurs currently and potentially when little information is available. However, this will allow appropriate preliminary risk assessment to be conducted by SAR. The policy should reflect these realities so that PWS employees are not discouraged from contacting police when detailed information may be unavailable, although the policy should continue to instruct PWS employees to gather as much information as possible. The policy should also be clear that PWS staff need to complete the written requirements of the policy on every occasion when a walker is reported simply as overdue, rather than lost or missing. Again, the evidence allows me to conclude that PWS do not receive a large number of reports of missing walkers and therefore documentation of reports would not be a significant imposition.

There was some evidence about the possibility of PWS developing an urgency assessment tool to guide PWS employees as to the optimal timing of reporting an overdue walker. This may be appropriate, although staff will require training as to its use and to some degree such a tool replicates that used by SAR as the lead agency in any rescue response. I am hesitant to make a positive recommendation as to implementing such a tool without PWS further investigating its merits. However, I acknowledge that any process that encourages increased reporting to police may need to make exceptions for those reports where the risk of danger to the walker is negligible (being applicable to other walks rather than the Overland Track).

In relation to LSCL procedures, Ms Dillon stated in her affidavit that the policy to be adopted by LSCL staff was to contact PWS or police in the event of an emergency, and that her staff knew of that policy. Ms Dillon's evidence was not convincing as it did not demonstrate knowledge of staff training and procedures at the LSCL operation. Perhaps that was due to her remoteness to the issues on site, being a resident in Western Australia. The evidence was that Ms Dillon did not manage staff but there were on-site staff managers for the operation, including her father and stepmother. In particular, it appeared that her stepmother, Minda Dillon, was the manager to whom Mr Sanderson and Mr Jones reported. Ms Dillon, through her counsel, did not apply to have her give evidence at inquest and therefore the managerial structure on site was somewhat lacking in details.

Ms Dillon was not aware of written policies or whether the staff had training in those policies. I accept the evidence of Mr Jones and Mr Sanderson that neither were aware of any policies and, in fact, Mr Jones stated that the fact that a walker is "late" is not something that would normally be passed on to PWS. I find that at the time of Mr Tolputt's death there was no policy communicated to Mr Jones and Mr Sanderson by their employer, EGI, regarding proper action upon receiving a report of an overdue or missing walker. I find that, in fact, EGI had no such policy.

The evidence was that, within one week of their employment, LSCL staff were required to undergo a one hour induction instigated by PWS and using induction procedures devised by PWS. These induction procedures, produced in a written document, did not substantively deal with reports regarding procedures in the event of a walker being reported missing or overdue. The only reference to this in the document was that "*PWS staff can be contacted in the event of a walker being reported missing.*" I note that the induction documentation was

not given to LSCL staff but was solely used for a guide for presenters at the induction. There were also no refreshers for staff following up this initial induction. The lack of procedures and ongoing training regarding walker safety is the joint responsibility of both LSCL and PWS. The inadequacies in these matters pertaining to LSCL staff reflect particularly poorly on EGI as their employer.

As the employer of the LSCL staff, EGI should work cooperatively with PWS on an ongoing basis, taking initiatives where appropriate, to develop a clear, workable and unambiguous set of written procedures relating to relevant duties and issues, including walker safety. It is not the responsibility of PWS alone to do so.

Mr Deka gave evidence that the induction procedures are in the process of being reviewed generally to ensure uniformity of information between PWS and LSCL staff. There was evidence that in late 2018 PWS and EGI met with a view to enhancing those procedures to take into account the matters raised by this inquest.

The induction procedures and information, when completed, will be converted into a reference document to be provided to LSCL staff on arrival before being formally inducted by PWS. The document will contain procedures for the assessing and notifying of reports of overdue walkers. As discussed above, those procedures should require reporting by LSCL staff to PWS, ideally at any time of day, and encourage reporting by both organisations to police.

In relation to after-hours availability of PWS staff, Mr Deka stated that PWS staff located in field centres (such as the visitor centre complex) should be able to be contacted after visitor centre hours for emergencies. He indicated that PWS intends to investigate the introduction of an availability system at Lake St Clair and Cradle Mountain as soon as possible, noting that this will require consultation with staff and the Tasmanian Public Service Union. Given the high numbers of walkers, tourists and visitors in these two centres, this proposal would seem necessary. If PWS staff members were available (and known to be available) after business hours for communication of important information, then Mr Sanderson may have felt more able to convey the information immediately after its receipt.

I have made recommendations below in respect of the reporting of overdue walkers by PWS and LSCL.

Communications between LSCL and PWS

It should be clear from my findings above that Mr Sanderson should have notified PWS of Mr Cubbin's report immediately after it was communicated to him by Mr Jones. Mr Jones, a new employee of LSCL, took sufficient action by notifying Mr Sanderson, his direct manager. He gave evidence that it did not enter his mind to contact PWS, indicating poor instruction and training on the part of his employer. I have no doubt that PWS, if notified, would have contacted police. It is also clear from the above discussion that the failure by Mr Sanderson to notify PWS (and therefore police) made no difference to the unfortunate fate of Mr Tolputt.

It appears that the reasons for Mr Sanderson's failure to notify PWS were as follows:

- (a) The gravity of the emergency was not well appreciated by Mr Sanderson at the time or, if it was, he felt he lacked options for progressing the matter;
- (b) There was a lack of emergency response training provided to him by EGI;
- (c) The cultural problems that existed between PWS and LSCL created a perceived disunity between staff of both organisations at the visitor centre complex that made potential co-operation less effective than it ought to be; such disunity was a factor in Mr Sanderson not attempting to locate Mr Ferguson and provide him with Mr Cubbin's information;
- (d) There were deficiencies in the systems of work between PWS and LSCL;
- (e) There was likely a dilution of the information reported by Mr Cubbin to Mr Jones (such as Mr Tolputt's exact position on the track when he was last seen); and
- (f) The lack of telephone reception at the time.

Although I accept that Mr Sanderson considered utilising the "Ida Clair" that evening, I also fully accept that it was not his responsibility to conduct any rescue. Indeed, serious harm may have come to him in that event. It is fortunate that he did not use the vessel and endanger himself. Even if he had departed after his discussion with Mr Jones, he would not have been able to save Mr Tolputt.

Mr Sanderson and Mr Jones both gave evidence that they had been specifically directed by EGI (Ms Dillon) not to communicate with PWS employees. Whilst this evidence might be difficult to accept given the obvious need for mutual communication to run the tourist operation at Lake St Clair, I find that in a general sense this direction was given or an expectation created. In evidence, Ms Dillon stated that she could not understand why Mr Sanderson and Mr Jones would both give this evidence. Nevertheless, she did admit that there was an adversarial attitude between EGI and PWS. This is corroborated by the evidence of Mr Ferguson who had been told that the LSCL employees had been directed not to speak with him. He gave evidence that there had been significant disputes between him personally and the owners or managers of LSCL. He stated that the genesis of this tension was the earlier building works associated with the expansion of the Lodge that Mr Ferguson believed were not being completed in accordance with relevant permits. It appears that Mr Ferguson was most assertive in vocalising his concerns to EGI, and perhaps others, at the time. It seems that animosity and poor communication continued after the building works were complete.

In his affidavit and evidence at inquest, Mr Sanderson also articulated various criticisms of his working conditions and of the LSCL operation generally. These included a lack of decision-making autonomy, high staff turnover, poor staff accommodation and food, lack of procedures and mismanagement of the ferry service. Although Mr Sanderson was a reasonably credible witness on the issues central to the inquest, it is not appropriate to make findings regarding this evidence. Suffice it to say that the evidence at inquest does not give me confidence that LSCL and staff were well-managed by EGI at the relevant time, nor encouraged to develop a cooperative working relationship with PWS.

Under the lease between the Minister (for PWS) and EGI, it is the obligation of EGI to operate the business of LSCL to the standards set out in the lease agreement and the protocol that is annexed to the lease. The inquest did not inquire into the manner in which EGI may or may not have complied with their obligations under the lease in respect of matters raised by this inquest. It was the view of Mr Deka, however, that the terms of the lease did not allow PWS to address particular non-performance issues relating to LSCL and to hold it accountable. He indicated that it was not the lease that PWS wished to have. In evidence, he said that it was a poorly written document with no properly defined performance standards and inadequate provision as to remedial actions for PWS. He stated that in the absence of goodwill between the two parties there could be no adequate enforcement of standards.

There may be force in Mr Deka's evidence, but I note that the protocol meetings provided for by the lease are, at least, a vehicle to regulate the relationships between LSCL and PWS and to make informed joint decisions regarding mutual operations and obligations. The stated objective of the protocol meetings is to both identify and resolve any visitor service, operational or lease management issues that may arise, thereby ensuring the visitor has a quality experience. The protocol provides that both PWS and LSCL will meet, as a minimum, monthly during the peak season and bi-monthly during the off-peak season, with more frequent meetings arranged upon agreement of both parties. The meetings are to include the lessee (or delegate), senior ranger (or delegate) and senior Commercial Visitor Services officer (or delegate).

As previously discussed, I find that at the time of Mr Tolputt's death, there was a culture of poor communication between the staff on the ground of the two organisations regarding day-to-day issues. As submitted by Mr Vince, counsel for Mr Sanderson, this necessarily militated against efficient and effective responses to emergency situations. Mr Deka gave evidence that the relationship between PWS as land manager and Ms Dillon as the effective lessee, has long been a difficult one and remains so. I fully accept his evidence. He was an articulate, knowledgeable and helpful witness in all respects. He said that communication between staff of the two organisations at the visitor centre complex has improved and no such difficulties now exist as they did at the time of Mr Tolputt's death. Again, I accept that the situation has improved. It is most unfortunate that these issues, potentially affecting safety of walkers and visitors, developed and became entrenched. Whilst the relationship issues at higher management level remain unresolved, the greater the potential for a less than ideal relationship between staff.

I note that the protocol imposes a requirement that the Senior Ranger is to ensure that *"PWS and the lessee work cooperatively to present high-quality Park experience for visitors."* And that *"there is good communication between PWS operational staff and the lessee to ensure the visitor experience is enhanced by the two operations, rather than the site being divided."* When the lease was drafted in 2010, the parties therefore were aware of the importance of cooperation and good communication. It does not appear, at the time of Mr Tolputt's death,

that these components of the protocol were satisfied. However, they provide the mechanism to regulate future relations. I have made the recommendation below.

Desirability of extending the “booking system” year round and walker presentation at the visitor centre

Currently, the booking season operates from 1 October to 31 May and was introduced to control the number of walkers on the track. This control prevents degradation of the environment and enhancement of the walker’s experience. While the booking system was not introduced as a result of safety concerns, it resulted in additional rangers being on the track and those rangers carrying communication equipment, including satellite phones, which may be used in an emergency. Rangers walk the track in the winter non-booking season far less frequently and generally only in response to particular issues, for example if repairs are required at one of the huts. There is no evidence in this case that, if additional rangers were on the track, they would have encountered Mr Tolputt, let alone see him at the point when he was in trouble. Even in the booking season, a walker may encounter a ranger infrequently.

Dr Andrew Davey, president of Bushwalking Tasmania, gave evidence at inquest. He was a most experienced walker and knowledgeable about relevant issues. He stated that BT opposed any extension of the booking system. He said that the imposition of a booking system would interfere with the right to free and unimpeded access to the Tasmanian wilderness and would not increase walker safety. He made the point, quite correctly, that walkers accept the risks associated with bushwalking, must be self-reliant and that there is no right to the presence of a ranger on the track. He said that walking on the Overland Track in winter involves short days, cold weather (likely frost and snow) with no guarantee of a place in any hut. Further, a snow-covered track may be hard to find, harder to negotiate and very exhausting.

In the winter non-booking season, approximately 600-700 walkers walk the Overland Track and complete the walkers’ registration books. Mr Dekka estimated that there could be as many as an additional 300 walkers who walk the track without completing the registration books at the start or end of the walk. Mr Dekka gave evidence that, since the introduction of the booking system, there has been an increase of walkers during the winter months. He stated that there is information on the internet promoting the walk as a safe undertaking during the winter months when payment of the booking fee is not required. This type of information may well encourage more walkers who do not appreciate the need to properly prepare for the walk.

Nevertheless, the evidence does not support a recommendation that the booking system be extended on the grounds of walker safety. Mr Dekka gave evidence, and it is obvious, that people walk the track because it is a challenging wilderness experience and accept that they must be prepared for changeable weather conditions, including the extremely cold conditions of winter. Mr Dekka pointed out, also, that an extension of the booking system may convey a perception of a higher level of safety than actually exists, particularly in winter conditions.

A more assertive promotion by PWS of the desirability of winter walkers voluntarily attending at the visitor centre at the start of the walk, either at Cradle Mountain or Lake St Clair, may be warranted. This would ensure that walkers were physically seen by a PWS employee, received relevant weather and equipment advice and have complied with the Walker Safety Checklist. This could be done without a fee or booking system. I note that PWS has received advice that visitor centre staff do not have the legal power to prevent walkers that they believe are ill equipped from embarking on the walk. If such power was deemed appropriate legislative amendments would be required.

It is possible that, if he had attended the visitor centre, Mr Tolputt may have been told to plan for delays due to bad weather, particularly given the weather forecast. If that was communicated to Lauren the deceased may not have felt compelled to continue walking on the 14 July. He may also have been encouraged to purchase other items, such as a warm beanie. I have made the recommendation set out below.

Staffing levels and resources for PWS in relation to safety on the Overland Track

As discussed, extra staffing on track will not prevent situations such as that of Mr Tolputt's death. However, exploration of further staffing at both the PWS and LSCL visitor centres are a matter that PWS may explore in light of the recommendations below.

The adequacy of track markings in winter when the track is covered in snow

The track was obscured by snow in parts during Mr Tolputt's walk, and the evidence indicates that he deviated from the track at times before returning to it. However, this fact did not in any immediate way contribute to his death. Mr Deka stated that he considered that the track was very good and markers clear in most conditions. The conditions faced by Mr Tolputt were exceptionally poor. Mr Deka described the existing track and markers as striking the correct balance between walker safety on the one hand and preservation of the natural beauty of the landscape on the other. I accept Mr Deka's evidence that the existing markers are adequate and make no further comment or recommendation in this regard.

Should walkers be discouraged from walking the Overland Track alone in winter?

The evidence indicates that the Overland Track walk in winter is for experienced, well-equipped walkers. In my view, walkers who are not experienced or not well-equipped should be discouraged from walking the track alone in winter. Bushwalking Tasmania submits that an able, well-equipped companion or two is likely the closest to being able to guarantee safety in winter conditions where there is a higher probability of severe weather and less margin for error generally. Accidents can occur at any time and a person who is alone may not be able to raise the alarm. In winter conditions, hypothermia will quickly follow. PWS messaging already communicates the dangers of walking alone. It may wish to consider, based upon further consideration of walker statistics, whether stronger messaging is needed in this regard.

Should it be a requirement, or more strongly encouraged that walkers in winter carry communications equipment?

There was evidence at inquest that PWS cannot legally compel a walker to carry communications equipment, however the messaging from PWS available on their website urges walkers to consider carrying a personal locator beacon (PLB). There was also evidence that walkers can hire an EPIRB or PLB from Service Tasmania shops and also from the Cradle Mountain Visitor Centre. In this case it seems very unlikely that if Mr Tolputt had been carrying a PLB he would have triggered it at a time that could have resulted in him being saved. Dr Luckin's opinion was that Mr Tolputt was already suffering the effects of severe hypothermia when he met Mr Cubbin. The fact that Mr Tolputt did not accept an offer of assistance from Mr Cubbin leads me to conclude that it is very unlikely that he would have triggered a PLB. Even if a PLB had been triggered at that time or later the evidence is that Mr Tolputt could not have been rescued as the rescue helicopter could not fly in the weather conditions. Given my findings, this is not an appropriate case to recommend a change to the current messaging around walkers carrying communication equipment.

Conclusion

The evidence establishes that PWS has taken commendable steps over the last several years to address issues of walker safety, both generally and in respect of the Overland Track. It is apparent that PWS has carefully considered its safety strategy and has reached an appropriate balance between providing information, guidance and regulation on the one hand and allowing walkers to engage freely in the activity. I have made some recommendations connected to issues arising on this inquest, although in making them, I emphasise that the actions of other persons did not contribute to Mr Tolputt's death in any way.

In succumbing to hypothermia and death on the Overland Track, Mr Tolputt, tragically, brought about his own demise by a series of poor decisions - to walk alone with inadequate clothing and equipment, to fail to plan for delays, to try and press on in extreme conditions instead of remaining at Windy Ridge to recover, and finally, to reject the assistance offered by other walkers that would likely have seen him safe.

The activity itself is one attendant with risks, which are significantly higher in winter. The prime principle remains that walkers must be completely self-reliant and responsible for their own safety. Persons contemplating walking the Overland Track need to understand the demands of the walk, to be physically and psychologically prepared and to have appropriate clothing and equipment. The demands of walking the track in winter are particularly onerous.

Findings Required by s28(1) of the Coroners Act 1995

- (a) The identity of the deceased is Trevor John Tolputt;
- (b) Mr Tolputt's death occurred in the circumstances set out in this finding;
- (c) The cause of death was hypothermia; and
- (d) Mr Tolputt died on 14 July 2016 on the Overland Track at Lake St Clair.

Recommendations

1. I **recommend** that PWS review the Walker Safety Checklist to ensure that the list of clothing is adequate for the conditions that can occur on the Overland Track in winter and, in particular, consider the inclusion in the Checklist of a requirement that walkers carry a waterproof jacket and over-pants, which are seam-sealed and made of a breathable fabric, such as, or similar to, material branded as “Gore-Tex.”
2. I **recommend** that PWS produce a video concerning the development and prevention of hypothermia whilst walking; and further, produce and disseminate any further pertinent information for walkers regarding safety considerations of walking in winter on the Overland Track.
3. I **recommend** that PWS develops and implements a strategy to strongly encourage all walkers to present at either the Cradle Mountain or Lake St Clair visitor centres prior to commencing the Overland Track in the non-booking season.
4. I **recommend** that PWS, in consultation with police as appropriate, update its Lost or Missing Walker Policy to reflect that it applies to reported “overdue” as well as lost or missing walkers, and to develop guidelines to ensure that PWS staff notify Tasmania Police at an early stage of a report received of an overdue or missing walker; and that PWS provide ongoing training to staff in the new guidelines.
5. I **recommend** that PWS investigate and implement after-hours availability of PWS staff at Lake St Clair and Cradle Mountain visitor centres.
6. I **recommend** that PWS and LSCL, jointly, conduct a staff induction procedure concerning the role and requirements of each organisation (as updated) in respect of overdue or missing walkers; that such documentation be provided to the staff; that the induction be repeated on an annual basis; and that PWS and LSCL consider separating the induction procedures in respect of safety matters from other matters of staff induction.
7. I **recommend** that the Senior Ranger (PWS) devise and implement a strategy to ensure full compliance with the protocol in the lease requiring effective communication between PWS operational staff and LSCL staff.
8. I **recommend** that EGI nominates a suitable LSCL staff member, whose responsibility is to ensure ongoing and effective communication and cooperation with PWS in the visitor centre complex, particularly in respect of issues of walker safety; and that such nominee is responsible for implementation of mutual strategies and procedures.

I am grateful for the work of Mr Shapiro, counsel assisting, and also for the most thorough preparation and assistance provided by Senior Constable Jessica Haight, coroner’s

associate. I also appreciate the assistance provided by the other counsel involved in this inquest.

I convey my sympathy to Mr Tolputt's family and loved ones.

Dated: 21 May 2019 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner