



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Andrew Amos Grey

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

- (a) The identity of the deceased is Andrew Amos Grey;
- (b) Mr Grey died in the circumstances set out below;
- (c) The cause of Mr Grey's death was drowning;
- (d) Mr Grey died on 29 December 2014 at Burns Bay, St Helens in Tasmania;
and
- (e) Mr Grey was born in Launceston on 3 April 1969 and was aged 45; he was married and a builder at the date of his death.

Background:

Andrew Amos Grey was born in Launceston on 3 April 1969, the son of Peter and Anne Grey. He was the youngest of four children having two sisters and one brother. Mr Grey grew up, was educated and lived his whole life at Campbell Town.

Mr Grey and his wife Sheree met while they were both still at school and commenced a relationship in 1990, marrying in 1995. They had two children together, James and William.

After leaving school Mr Grey completed a pre-vocational course at TAFE and then completed successfully an apprenticeship. Self-evidently, he was a hard worker and a valued employee. From 1997 he worked with the Northern Midlands Council as a builder and later as a driver.

Mrs Grey reports that aside from high blood pressure and high cholesterol her husband's health was good and he suffered no serious illness or accident during his life.

Reportedly, Mr Grey loved fishing and had been using boats for many years, particularly in the St Helens and Swansea areas. The evidence is that he was a competent boat handler.

Circumstances Surrounding the Death:

On Monday 29 December 2014 the Grey family were holidaying at Mrs Grey's father's home in Steiglitz, near St Helens on the East Coast of Tasmania. At about 7.30am Mr Grey launched his white aluminium 5.2 m runabout "Salt On" from the boat ramp at Steiglitz. With him were his sons, along with a friend of the boys, Jarrod Lewis (aged 15 years). It was their intention to check some recreational lobster pots that the family had set the previous day in Skeleton Bay (roughly halfway between Middle and Burns Bays).

Mr Grey was wearing an 'XL' sized yellow Stormy Seas brand inflatable PFD. William was in an 'L' sized red Stormy Seas brand inflatable PFD, and James and Jarrod were in solid foam PFDs.

William Grey said in his affidavit made under the *Coroners Act* 1995 that on this occasion the boat was launched at the Steiglitz boat ramp although the majority of the time they launched at the Burns Bay ramp, outside the St Helens bar way. William went on to say that he had been over the bar at least 20 times with his father. James confirmed this was so.

William drove the boat through Georges Bay to the bar way where Mr Grey took over the controls. William described the boat as being nearly all the way through the bar way when "Salt On" was hit by a big wave that crashed over the bow and smashed the boat's windscreen. The runabout was then hit by the next wave causing it to capsize. The boys and Mr Grey were thrown into the water in an area where waves were breaking.

James was initially trapped under the overturned boat. He was wearing a foam PFD and the buoyancy of the vest prevented him from swimming down, under and away from the overturned boat to the surface. He had to take his PFD off so he could escape from under the boat. When he surfaced he had no PFD as a result.

Mr Grey's PFD was seen by the boys to inflate. William was unable to inflate his PFD. William and James clung to Jarrod as he was wearing a PFD that had buoyancy. The three boys were close to Mr Grey. All four started swimming towards the rock wall nearby at Blanche Beach to get out of the breaking waves. A catamaran yacht was nearby travelling through the bar way. The skipper of the catamaran stopped the boat and the boys started to swim towards it. This was the last any of the boys saw of Mr Grey. He was seen to be swimming towards Blanche Beach.

The crew of the catamaran - the "Aurora" - saw debris and noticed the boys in the water. They immediately sent a Pan-Pan distress message by radio which was picked up by the operator at St Helens volunteer marine rescue. The message was broadcast at 8.10am. The volunteer marine rescue operator, Mr Danny Andrews, immediately contacted Tasmania Police radio dispatch services to advise of the incident.

Meanwhile, a member of the public, Mr Steven de Bruyn, who was not far away in his boat "Ski" with his father Peter de Bruyn and his 11-year-old nephew Jak Oxford, heard the radio message and went to the yacht *Aurora*. He was told by the crew of the *Aurora* of the situation and it was indicated to him where in the water the three

boys were. Despite the rough conditions, with waves at least a metre high, Mr de Bruyn took his boat into the area of the breaking waves and managed to get the three boys aboard. He was told by them that Mr Grey was still in the water and so went further into the bay to search for him.

Shortly after he did so his boat was struck by a large wave (described as being about six feet in size). The wave broke over the stern of the boat. It knocked both Jarrod and William back into the water. Fortunately Mr Steven de Bruyn and his crew were able to rescue the boys again. He made a decision to get the boys back to shore; a decision which was the correct decision in the circumstances.

Mr Steven de Bruyn had the presence of mind to keep the PFDs being worn by William and Jarrod. He gave them later to investigating police. He also plotted on a GPS where he had picked up the boys on both occasions. He gave that information to Tasmania Police as well.

As the boys were being rescued, local police, who were at the Burns Bay boat ramp conducting inspections, were advised by another member of the public, Mr Greg Quinn, of the emergency. Senior Sergeant Bidgood was taken by Mr Greg Quinn in his boat across the bay towards the *Aurora*. Having been made aware of the rescue of the boys and that Mr Grey was still unaccounted for, Senior Sergeant Bidgood commenced to coordinate the search of the area. Other recreational vessels converged on the area to help.

Roughly 20 minutes after the search commenced two members of the public, Mr Paul Hicks and Mr Gary Andjelkovic, who were assisting in the search in Paul Hicks' boat, saw Mr Grey floating face down just outside the breaking waves. They pulled him aboard. They saw Mr Grey was unconscious and his visible skin blue in colour. Mucus was noticed at his mouth. Both men, familiar with the operation of Stormy Seas jackets, did not observe any irregularities in relation to either the shape or inflation of the jacket. It was noted to be inflated at the front as well as the rear. They deflated the jacket with a knife so that CPR could be commenced. Another member of the public, Mr Ricky Hill, was nearby in his boat. He jumped aboard Mr Paul Hicks' boat to assist with CPR. Mr Ricky Hill is also experienced in the use and operation of Stormy Seas PFDs. He later told investigating police that he noticed the jacket was more inflated on one side than the other.

Very shortly after, Senior Sergeant Bidgood was able to get aboard Mr Paul Hicks' boat to assist with CPR. When he did so he noticed that the PFD being worn by Mr Grey was already deflated but was shown where it had been cut with a knife. His estimate, and I accept it, was that Mr Grey was in the water for at least 20 minutes after capsized before he was located, pulled aboard Mr Paul Hicks' boat, and CPR commenced. CPR was continued until the boat was driven to shore onto a trailer. Ambulance Tasmania personnel arrived at approximately 9.00am. CPR was continued for a short period of time by a paramedic but it was apparent that Mr Grey was beyond help and CPR was ceased at 9.05am and no other attempts to revive him were made.

Mr Grey's body was conveyed by mortuary ambulance to the mortuary at the Royal Hobart Hospital. After formal identification an autopsy was carried out by forensic pathologist, Dr Donald McGillivray Ritchey. Dr Ritchey's opinion as to the cause of Mr Grey's death was that it was consistent with drowning. He did note that other

possible significant contributing factors were contusions of the scalp and forehead as well as atherosclerotic and probable hypertensive cardiovascular disease and obesity. I am satisfied that the most likely cause of Mr Grey's death was drowning.

Samples taken at autopsy from Mr Grey's body were subsequently analysed at the laboratory of Forensic Science Service Tasmania. No alcohol or drugs of any significance were identified as being present in those samples. The drug Metoprolol, which is used in the treatment of hypertension and angina, was identified as being present but there is no particular significance that attaches to that fact in the context of this case and is explicable in terms of Mr Grey's diagnosed high blood pressure.

The coronial investigation focused upon both the seaworthiness of the boat and more specifically the PFD worn by Mr Grey. The PFD worn by William was also looked at carefully because it did not inflate.

The boat was inspected by Mr Peter Keyes who is a qualified shipwright with roughly 50 years' experience and a marine surveyor with 22 years' experience in that role. Mr Keyes expressed the opinion, which I accept, that the boat appeared to have been in a seaworthy condition prior to the incident which claimed Mr Grey's life. I am satisfied that there was nothing about the boat which caused or contributed to Mr Grey's death.

Tests were carried out by Senior Sergeant Bidgood and Mr Keyes in relation to the PFD worn by Mr Grey at the time of his death. The test was recorded by video and the video was made available to me to view. Significantly, it is plainly apparent that on all occasions when laying forward the PFD failed to right Senior Sergeant Bidgood (who was wearing it) and lift his face from the water.

The PFD was examined by a representative of Stormy Seas (the manufacturer) in the presence of Senior Sergeant Bidgood and Mr Peter Keyes. That examination revealed that because the PFD had not been serviced, press studs (almost certainly corroded) came loose. Senior Sergeant Bidgood said in an affidavit, and I accept, that the press studs in the PFD popped every time he inflated it and that whilst the bladder remained in or near its correct position on every occasion, it failed to right him or lift his face from the water.

It is apparent from the photographs, as well as the video taken of the examination, that the air bladder in the PFD worn by Mr Grey was out of place. An examination of the PFD worn by Mr Grey found that it was in poor condition with an extremely poor service history. As to service history the records kept by the manufacturer indicated that the jacket was last serviced on 25 October 2011 (three years and two months prior to the incident). It was 16 years old, having been purchased on 9 February 1999. The manufacturer recommends that the product has a shelf life of 10 years and when used recreationally it should be serviced every two years (commercial use mandates service every 12 months).

Additionally, it is noted that given the age of the PFD, it is no longer compliant with the applicable contemporary Australian Standard. That standard has been significantly changed. Formerly Australian Standard AS 1512 applied. That standard was replaced by Australian Standard AS 4758.1 in 2010.

The change in the standards led to a number of important improvements. First, the minimum buoyancy increased from 100 N to 150 N. Second, the previous standard had resulted in a more upright floating position rather than one reclined backwards as the new standard requires. Third, PFDs manufactured to comply with AS 4758.1 are sold with automatic inflation fitted, which will cause the jacket to inflate every time it is submerged.

Similar issues with respect to the age and service history of the PFD worn by William were identified. It had not been serviced for 10 years prior to the incident and an examination of it found that the orange whistle chord with which the PFD is fitted was wrapped around the CO2 cartridge which prevented inflation. In addition, the air bladder had a hole, so even if it was able to inflate it would not have remained inflated. The issue of entanglement of the activation mechanism would obviously have been identified if the PFD had been serviced.

I am satisfied that Mr Grey's death was at least contributed to by the fact he was wearing an out-dated PFD, which did not comply with the current applicable Australian Standard and had not been serviced in accordance with manufacturer's recommendations.

Comments and Recommendations:

Section 28 (2) and (3) of the Act provide as follows:

“(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.”

In this case I am satisfied it is appropriate to **recommend** pursuant to section 28(2) of the Act as follows:

- No person should wear a PFD that does not comply with AS 4758.1; and
- All inflatable PFDs must be serviced in accordance with manufacturer's recommendations.

I **comment** pursuant to section 28(3) of the Act that in my view the bravery demonstrated by Mr Steven de Bruyn and Mr Peter de Bruyn in effecting the rescue of James Grey, William Grey and Jarrod Lewis is worthy of particular recognition.

I also commend the other members of the public and police who participated in efforts to rescue and resuscitate Mr Andrew Grey.

In concluding, I convey my sincere condolences to the family of Mr Grey on their very sad loss.

Dated: 27 June 2016 at Hobart in the State of Tasmania.

Simon Cooper
Coroner