



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION



---

## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Craig Alan Cowen

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

- a) The identity of the deceased is Craig Alan Cowen;
- b) Mr Cowen died in the circumstances set out below;
- c) The cause of death is drowning; and
- d) Mr Cowen died on 27 March 2017 at Dover, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Cowen's death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; and forensic evidence.

Mr Cowen was born on 26 January 1966 and was aged 51 years at his death. He was married to his wife, Debbie Lee Cowen. There are two children of the marriage, Kane Cowen and Dwayne Cowen. Mr Cowen was a boilermaker and welder by trade. Mr and Mrs Cowen established the firm Dover Engineering, where Mr Cowen worked at the time of his death.

Mr Cowen had no significant medical issues. The evidence indicates that he consumed cigarettes, alcohol and cannabis on a regular basis.

In the late afternoon of 27 March 2017 Mr Cowen and his son, Dwayne, had been working on Mr Cowen's boat at the Dover wharf. Paul Delaney and Jason Gould, who were also at the wharf, came onto the boat and the group commenced consuming alcohol. John Careless was also present at the wharf with his father as well as some others.

When it became dark, Dwayne left to go home. Subsequently, the group including Mr Cowen, Mr Delaney, Mr Gould and Mr Careless were drinking alcohol on Mr Delaney's vessel, the *Teiva*. The members of the group became very intoxicated.

At about 10.00pm Mr Cowen decided to leave Mr Delaney's vessel. As he went to step from the vessel to the wharf, he slipped and fell into the water between the vessel and the wharf. Mr Careless helped Mr Cowen back up onto the wharf. It appeared that Mr Cowen was not injured. It seems that the remainder of the group either returned to Mr

Delaney's vessel or were simply standing on the wharf, but their exact movements are unclear. Mr Delaney and Mr Careless provided affidavits for the investigation but due to their state of intoxication affecting their recall, parts of their account lacked detail.

In any event, after about 10 to 20 minutes, both Mr Careless and Mr Delaney noticed that Mr Cowen was not with them. Assuming that he had walked off the wharf to leave, they searched for him. Having no success, they also checked the vessels and then used a dinghy to search for him.

At approximately 11.20pm Mr Careless observed Mr Cowen in the water between the wharf and the vessel *Julie Rose*, a vessel they had been also accessing. Mr Careless and Mr Delaney pulled him from the water onto the vessel and commenced CPR. An ambulance was called. Ambulance officers attended and continued CPR.

Police officers initially arrived on the scene at about 11.45pm, at which point ambulance officers were still attempting to resuscitate Mr Cowen. He was declared to be deceased at 12.05am on 28 March. However, I am satisfied that he was already deceased before midnight.

Police obtained relevant details of persons within the area while a scene was established for examination. These people were intoxicated and emotional.

In particular the accounts of Mr Careless and Mr Delaney were obtained by the officers, with both accounts of events consistent, even though both were significantly under the influence of alcohol.

The attending police officers then organised for the attendance of CIB and forensic officers to assist in the investigation. The attending CIB and forensic officers attended shortly thereafter to complete an investigation of the scene. They observed no suspicious circumstances and, on a preliminary basis, assessed that Mr Cowen drowned accidentally as a result of a fall whilst intoxicated. They noted that Mr Cowen had a number of injuries to his scalp consistent with falling from the wharf or boat and colliding with the wharf timbers or the boat at the water level approximately 2 metres below. Located on his head near his injuries were some shell particles likely to have come from the shell fish from the timber at water level.

On 28 March 2017 an autopsy was conducted by State Forensic Pathologist, Dr Christopher Lawrence at the Royal Hobart Hospital. Autopsy revealed a superficial injury to the left side of the head, which appeared consistent with contacting shell-like objects. There was no apparent deep head injury.

Toxicological testing indicated that Mr Cowen's blood alcohol level was very high, between 0.260g/100ml and 0.340g/100ml. Cannabis was also detected which, in the opinion of Dr Lawrence, would have increased the effects of alcohol intoxication.

Dr Lawrence noted that Mr Cowen's lungs were over-expanded, consistent with drowning. He therefore formed the opinion that Mr Cowen died of drowning in a state of acute alcohol intoxication. I accept his opinion.

Upon all of the evidence, I find that Mr Cowen fell accidentally into the water at the wharf and drowned. His inability to recover and extract himself was caused by excessive alcohol levels, combined with the central nervous system effects of THC, which appeared to have been ingested some time before death. There is insufficient evidence to indicate that any impact to the deceased's head during the second fall contributed to his death.

Mr Cowen was located in the water directly next to where his vehicle was parked on the wharf. It is most likely on the evidence that Mr Cowen walked from the *Teiva* in the direction of his car to leave the wharf. While attempting to get to his car which was parked on the wharf, he fell between the *Julie Rose* and the wharf, at the point directly opposite his car door. This conclusion is reached primarily due to Mr Cowen being found underneath the wharf at this very point. Due to the containing structure of the wharf, it is unlikely that he moved from where he fell into the water. Alternatively, it is possible, but less likely, that he may have been present on the *Julie Rose* and was trying to cross from that vessel to the wharf or back to the vessel. No gangways were present and the footing and distances were treacherous.

I am satisfied that there were no suspicious circumstances. Unfortunately, no other person saw Mr Cowen's fall into the water nor noticed his absence until he was unable to be revived. The intoxication of the other members of the group likely contributed to this lack of awareness.

### **Comments and Recommendations**

Mr Cowen's most unfortunate death represents a scenario that coroners continue to encounter, being the consumption of alcohol to excess on and around water and vessels. High levels of intoxication impair judgement, coordination and responsiveness and impact severely upon the ability to recover from a fall into water.

I extend my appreciation to investigating officer Senior Constable Michael Balmer for his investigation and report.

The circumstances of Mr Craig Cowen's death are not such as to require me to make recommendations pursuant to Section 28 of the *Coroners Act 1995*.

I convey my sincere condolences to the family and loved ones of Mr Cowen.

**Dated:** 4 February 2019 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**  
Coroner