



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 Kevin Bruce Haigh

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

- a) The identity of the deceased is Kevin Bruce Haigh;
- b) Mr Haigh died in the circumstances set out further in this finding;
- c) The cause of Mr Haigh's death was drowning; and
- d) Mr Haigh died on 5 July 2020 at Maria Island, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the investigation into Mr Haigh's death. The evidence includes:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Affidavit – Dr Andrew Reid, Forensic Pathologist;
- Forensic Science Service Tasmania – toxicological and that analytical report;
- Affidavit – Mr Adam Marmion, Intensive Care Flight Paramedic;
- Affidavit, Mrs Christine Haigh;
- Affidavit, Mr Philip Haigh;
- Affidavit, Mr Timothy Paton;
- Affidavit – Mr Steven Press;
- Affidavit – Mr Trent Wrigley;
- Affidavits (2) – Mr Ricky Lovett and attached photographs, sketch maps and extracts from marine charts;
- Affidavit – Mr Shane Blackwell;
- Affidavit – Mr Malcolm Fergusson;
- Affidavit – Mr Brian Adkins;
- Affidavit – Senior Constable Joshua Peach BM;

- Affidavit – Constable Phillip Vanderwal;
- Affidavit – Senior Constable Alistair King;
- Affidavit – Senior Constable Christopher Richardson;
- Affidavit – Craig Vermey (rank not stated), Tasmania Police;
- Affidavit – Sergeant Marcus Pearce;
- Affidavit – Sergeant Damian Bidgood;
- Affidavit – First Class Constable Angela Ghedini (and photographs);
- Affidavit – Senior Constable Eileen Langford;
- Inspection Report – Mr Scott Dobie Marine Surveyor;
- Letter - Dr Michelle Grech, Manager, Vessel Operations Australian Maritime Safety Authority; and
- Miscellaneous photographs, weather observations, maps, charts and tide tables.

Background

Kevin Bruce Haigh - known always as Bruce - was born on 17 May 1958 at Swansea in Tasmania. He lived on the east coast of Tasmania his entire life. He married his high school sweetheart, Christine, in 1980. Christine and his sons, Matthew and Scott, survive him.

Well known and respected in his local community, Mr Haigh was a keen and proficient lawn bowler.

Mr Haigh worked as a commercial rock lobster fisherman all his life, having started working for his father when he was just a boy. He worked in the Maria Island and Mercury Passage region of Tasmania's east coast.

The evidence is that he was highly experienced, careful and competent. His boat and equipment were all kept in excellent condition. Mr Haigh worked alone and had done so for many years. He was apparently unable to swim.

Mr Haigh had owned and operated the FV *Yimbala* since 1995. The FV *Yimbala* is a 14.33 m long, Huon pine constructed, after wheelhouse monohull fishing vessel. It is powered by a single 82.5 kW diesel engine.

The vessel's homeport was Triabunna. It was relevantly registered with both Marine and Safety Tasmania and the Australian Maritime Safety Authority.

It was fitted with and carried all relevant safety equipment at the time of Mr Haigh's death.

Mr Haigh had the appropriate license required to operate the vessel.

Mr Haigh's health

Mr Haigh was medicated for ulcerative colitis and high blood pressure. Neither condition prevented him from fishing or engaging in any recreational activity.

He had also received treatment for skin cancer.

In the first six months of 2020, Mr Haigh suffered two events which possibly cast light on his death. First, on 4 February 2020, he collapsed in the toilet of a hotel in Hobart. Venue aside, there is nothing to suggest that his collapse was alcohol related. He was taken by ambulance to the Royal Hobart Hospital (RHH) and admitted for observation. No specific cause for Mr Haigh's collapse was identified and it was attributed to defecation syncope.

On 31 March 2020, Mr Haigh ran FV *Yimbala* aground on Johnson's Point, north of Triabunna. He had no recollection of the incident.

Mr Haigh was subsequently reviewed by a cardiologist at the Hobart Private Hospital in April 2020. An ECG showed his ventricular size and function were normal.

Circumstances of Death

On Sunday, 5 July 2020, just before 9.00 am, Mr Haigh left his home in Orford and drove to Triabunna where the FV *Yimbala* was berthed at the wharf.

At the wharf, he baited 51 rock lobster pots, all of which were stored on the deck of the vessel. Evidence is that the FV *Yimbala* left port heading to the waters surrounding Ile Du Nord (known to some as Rabbit Island) immediately to the north of Maria Island. Mr Malcolm Fergusson, a local shipwright, who lives in Barton Avenue, Triabunna told investigators that he saw the FV *Yimbala* steaming out of Spring Bay sometime after 9.00 am.

Mr Haigh set five rock lobster pots within the area known as the Narrows, in the area between the northern tip of Maria Island and Ile Du Nord. Sometime after setting the fifth rock lobster pot Mr Haigh fell from the FV *Yimbala* into the water.

Around 1.00 pm, other fishermen working in the area checked on the FV *Yimbala* which appeared to be drifting. Upon pulling alongside, Mr Ricky Lovett, skipper of the FV *Southern Comfort* found that Mr Haigh was not on-board. Various fishermen, including Mr Lovett, Mr Press (skipper – FV *Kamarooka*) and Mr Wrigley (deckhand – FV *Kamarooka*) started to look for Mr Haigh. Authorities were notified and an air and sea search commenced.

Weather and sea conditions were, relatively speaking, benign.

At 3.25 pm crew on the Westpac Rescue Helicopter saw Mr Haigh's body floating upside down 1.5 nautical miles north-east of Ile du Nord. The *Irony*, a boat in the vicinity involved in the search, was directed to the position and Mr Haigh's body recovered. When his body was removed from the water, he was not wearing a PFD, was unconscious, unresponsive and showed no signs of life. Nonetheless Mr Timothy Paton, a crew member on board the vessel *Irony*, commenced and continued CPR on Mr Haigh until they docked at the wharf at Darlington on Maria Island, 10 or 15 minutes later. By then the rescue helicopter had landed. The crew of the helicopter included an intensive care flight paramedic, Adam Marmion, and experienced Tasmania Police rescue officer, Senior Constable Joshua Peach. While Paramedic Marmion checked for signs of life Senior Constable Peach took over CPR. Unfortunately, despite the best efforts of all involved, Mr Haigh was unable to be revived.

Investigation

Mr Haigh's body was taken to Triabunna where it was formally identified by his wife. After identification, he was taken to the RHH where Dr Andrew Reid, an experienced forensic pathologist, performed an autopsy. Dr Reid expressed the opinion, which I accept, that the cause of Mr Haigh's death was drowning. The autopsy revealed a number of characteristics associated with drowning, namely froth fluid emanating from the mouth, overinflated and overlapping lungs and frothy fluid within the upper airways.

Given the circumstances in which Mr Haigh's body was found and the opinion of Dr Reid I am satisfied that the cause of Mr Haigh's death was drowning.

Dr Reid did not find anything at autopsy of any significance. Specifically, although Mr Haigh was suffering from some coronary atherosclerosis, there was no significant stenosis, no significant myocardial fibrosis and nothing which was a physiological cause for his death.

Toxicological analysis of samples taken at autopsy was unremarkable. The only drug detected in Mr Haigh's body at the time of his death was a prescription drug used in the treatment of high blood pressure.

The FV *Yimbala* was taken to Triabunna and carefully inspected. No mechanical or other deficiencies were identified which could have caused or contributed to Mr Haigh's death.

Two Stormy Seas brand inflatable life jackets (one a yoke, the other vest) were found hanging on a rail on the inside port wall of the wheelhouse. The yoke had a Safety Alert brand PLB in the pocket. Mrs Haigh told investigators that her husband only ever wore the vest, to her knowledge, to keep warm.

An inquest?

It is clear that Mr Haigh died in the course of his employment. I am satisfied that his death was not due to natural causes. The *Coroners Act 1995* makes an inquest in such circumstances mandatory subject to section 26A of that *Act*.

Relevantly, that provision allows the senior next of kin of the deceased person to request in writing that a coroner not hold an inquest. Mrs Haigh, the senior next of kin in this case, made such a request. I was satisfied that it would not be contrary to the public interest or the interest of justice if no inquest was held and accordingly decided to dispense with an inquest. I reached this view because the investigation was so very comprehensive and the circumstances of Mr Haigh's death so obviously clear that I did not consider any benefit would be gained from the holding of an inquest.

Conclusion

I am unable to identify what caused Mr Haigh's fall from the FV *Yimbala* into the water. He may have slipped or tripped. He may have suffered some type of faintness, although there was no evidence identified at autopsy which would explain such an event.

I am satisfied that neither alcohol nor drugs played any role in his death. I am also satisfied that there are no suspicious circumstances surrounding his death and that no other person was involved in it.

Neither weather nor sea conditions caused or contributed to Mr Haigh's death.

If Mr Haigh had been wearing a PFD, and two were in the wheelhouse of his vessel, it is highly unlikely he would have drowned. The need for him to have worn a PFD, working alone as he did, was to my mind obvious.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Alistair King for his investigation and report. His report was extremely comprehensive and thorough.

I commend the efforts of Mr Haigh's colleagues – Mr Wrigley, Mr Press and Mr Lovett - for their efforts in searching for Mr Haigh. The contribution of the crew of the *Irony*, and in particular Mr Timothy Paton, are also worthy of recognition.

The circumstances of Mr Haigh's death require me to **recommend**, pursuant to Section 28 of the *Coroners Act 1995*, that all domestic commercial vessel operators, operating "single-handed" wear an appropriate PFD and carry an appropriate PLB on their person at all times when outside the wheelhouse or superstructure of the vessel. I **recommend** that the appropriate regulatory authorities give consideration to making such a requirement mandatory.

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

Dated: 4 August 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner