

5 September 2016

Our ref: DOC/16/303435 Your ref: COR 2013 002331

Lidia Lo Giusto
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Lo Giusto

INVESTIGATION INTO THE DEATH OF ADAM J PEARSON CASE NUMBER – COR 2013 002331

On behalf of Transport Safety Victoria's (**TSV's**) Maritime Safety branch, I write in response to your letter of 27 June 2016 and the Coroner's findings without inquest following the investigation into the death of Adam J Pearson, and the recommendation below.

1. I recommend that Transport Safety Victoria continues to explore potential models for noncommercial vessel seaworthy inspection and certificate regime as a means of ensuring the seaworthiness of vessels at points of registration, transfer of ownership and after any modification of the vessel.

Response:

TSV supports this recommendation in principle. As previously advised in correspondence to the Court dated 11 January 2016, in relation to the deaths of Kevin Caithness and Paul Washington, TSV is developing a policy paper focussing on seaworthiness inspections for recreational vessels as part of the registration process which will be put to the Victorian Government for their consideration. It is expected that this project may take some time given the complexity of the task.

In relation to this particular case, TSV inspected Mr Pearson's vessel after it was recovered and formed the view that the vessel was not in fact unseaworthy and would likely have passed a seaworthiness or fit for purpose check before and after the incident. The throttle and steering friction controls had been adjusted within the manufacturer's tolerances to enable the vessel to keep operating in a straight line without a hand on the tiller and the kill switch had been disabled using an override switch, which is typically provided on this type of motor. The ability to adjust and set these controls is built into the engine by the manufacturer and had not been modified in any way by a third party.

As noted in the Coroner's investigation report, a number of decisions made by the operator were contributing factors to this incident and its outcome, including the decision — $\,$

- not to wear a personal flotation device (PFD), despite operating alone in heightened risk conditions;
- to adjust the throttle and steering friction controls to enable the vessel to keep operating in a straight line;
- to disconnect the vessel's kill switch;
- not to connect himself to the kill switch by way of a lanyard;
- · not to inform anyone of his exact location and the exact time he was expected home; and
- not to ensure, prior to voyage, that he had the capacity to raise an alarm.

As noted in TSV's previous correspondence to the Court in relation to the death of Ashton Meadows dated 25 May 2016 (your ref: COR 2014 002978), TSV has identified low lifejacket wearing rates and a



poor understanding of heightened risk as serious issues affecting the safety of recreational vessel operators. TSV has been addressing these issues through educational programs and targeted enforcement activities.

TSV has produced new educational material (a quick reference guide 'Skipper's Manual' and a brochure 'You're the Skipper – You're Responsible') to provide practical guidance to recreational vessel operators about 'heightened risk', lifejacket wearing and raising the alarm. This information has been placed on TSV's website and distributed through normal channels (like the boat show). Additionally the brochure has been directly mailed out to all registered recreational boaters (as part of their registration renewal). TSV's boating safety education officers provide the resource directly to boaters as part of their one-on-one discussions with boaters at boat ramps.

If you require any further information, please contact Jane Wright, Policy Adviser, on (03) 9655 1022.

Yours sincerely

PETER CORCORAN

Director, Maritime Safety