IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 5779
COR 2015 631
COR 2015 644
COR 2015 1134

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, JOHN OLLE, Coroner having investigated the death of ALAN BEARDOW
without holding an inquest:
find that the identity of the deceased was ALAN BEARDOW
born on 24 July 1970
and the death occurred sometime between 10 November 2014 and 6 February 2015
at Bass Strait, off Seaspray VIC 3851

from:

1(a) UNASCERTAINED

Pursuant to Section 67(1) of the *Coroners Act 2008* (Vic), I make these findings with respect to the following circumstances:

1. Alan Beardow was born on 24 July 1970 and was 44 years old at the time of his death. He resided at Longford and is survived by his children and siblings, with whom he maintained close and loving relationships.

2. A coronial brief was provided by Victoria Police to this Court, comprising statements obtained from family, witnesses and investigating officers. I have drawn on all of this material as to the factual matters in this finding.

CIRCUMSTANCES

3. On 2 November 2014 Mr Beardow departed Sydney, bound for Melbourne, on a Jarkan 35 foot fibreglass mono hull cutter sailing vessel. Mr Beardow was travelling with his adult son, Troy Beardow, and brother Peter Greenfield. Mr Beardow and his son had no experience sailing. Mr

Greenfield had a current valid boat licence had attended a number of sailing courses over the years. He had gained a Royal Yachting Association competent crew certificate and a Royal Yachting Association Day Skipper Rating, and had also completed a Safety and Sea Survival course. Mr Greenfield stated that he was an experienced sailor who was confident in his ability to sail a yacht.[1]

4. The day prior to setting sail, Mr Beardow and Mr Greenfield spent all day conducting maintenance on the boat, including but not limited to checking all of the rigging, sails and safety gear, fixing a few small leaks in the freshwater system and tightening screws. Mr Greenfield stated that there was very little maintenance as he believed the boat to be in good condition, and he did not notice any major defects or concerns on the boat. On the day they set sail Mr Greenfield conducted a safety briefing which included where all of the safety gear was stored including the storage of life jackets, harnesses, flares etc and he discussed situations in which they would need to be worn. He informed Mr Beardow and Troy that if the weather was to become bad they were not to leave the cockpit without a life jacket or harness. Safety equipment onboard included life jackets, flares, epirb, life buoys, a six person life raft and various electronic radio equipment including a UHF and mobile phones.[2]

5. Mr Greenfield and Troy stated that over the following days Troy and Mr Beardow were 'getting very familiar on how to sail the boat' and throughout the days Mr Greensfield continually taught them how to sail and what the different items on the boat were used for.[3]

6. On 10 November 2014 they tacked West to head towards the east coast of Victoria, but found that the current was pushing the vessel back against their track. They decided to tack backwards and forwards along the coast. The sea was described as a little choppy at times but calm at other times. After a while they motored along the coastline, with just the headsail and mainsail reefed. Mr Greenfield then decided to roll the headsail up due to the wind direction and noticed that a rope attached to the roller furling drum was tangled. Mr Greenfield believed the conditions had improved and made his way toward the bow without a lifejacket or harness. Mr Greenfield could not untangle the line to the self furling head self, and asked Mr Beardow, who was in the cockpit, to assist. Mr Beardow went onto the bow without wearing a life jacket or harness. While Mr Beardow was at the bow stomping on the line in an attempt to release it,

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[1] Statement of Peter Greenfield, dated 11 November 2014, Coronial brief, 1-2.

[2] Ibid 3-4.

[3] Statement of Peter Greenfield, above n 1, 4-5; Statement of Troy Beardow, dated 18 November 2014, Coronial brief, 1-2.

Mr Greenfield observed that the conditions and swell size had changed and that the swell had increased from half a metre to one metre. Mr Greenfield decided to call Mr Beardow back due to the conditions, looked away for a split second and heard Mr Beardow scream. Mr Greenfield observed Mr Beardow over the side of the boat, being swept along the port side hanging onto the furling line. Mr Beardow was holding the line for a few seconds and then let go and attempted to hold the boarding step at the stern of the boat, but was unable to hang on. Mr Greenfield threw out a horse shoe floatation device connected to a rope, however the rope became entangled and when Mr Greenfield re-threw the device it did not make the distance to Mr Beardow. Mr Greenfield turned the vessel and Mr Beardow held onto the line, however due to the currents was pulled under the water. Mr Greenfield threw a life jacket towards Mr Beardow, which landed behind Mr Beardow. Troy then jumped into the water with a life jacket on. At this stage Mr Beardow was 'no longer struggling and appeared to have almost come to a complete stop'.[4]

7. By the time Troy reached Mr Beardow he had been in the water for approximately fifteen minutes and was face down and unconscious. Troy observed that his father's head was flopping around and could feel what he described as an 'electrical shock' coming from Mr Beardow, and could feel that Mr Beardow's heart was racing really quickly. Troy attempted to pull his father onto the vessel however eventually lost grip, and noticed that his father's heart was beating more slowly at around the time that he lost grip of him.[5]

8. Upon Troy returning to the vessel, Mr Greenfield called 'mayday' over the radio and set off a smoke flare. Mr Beardow was estimated to have gone overboard approximately 0.7 nautical miles offshore to the west of Seaspray. Three rotary and one fixed wing aircraft, a Gippsland Water Police Vessel, water police, SES and a Surf Life and Coast Guard were tasked to search the area, however Mr Beardow could not be located. At the time of the incident a strong wind warning was currently in place. South westerly winds were 25-30 knots and the west to south westerly swell was increasing from 1 to 1.5 metres offshore. The water temperature was estimated to be approximately 12 degrees.[6]

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[4] Ibid 7-8.

[5] Statement of Troy Beardow, dated 18 November 2014, Coronial brief, 4.

[6] Victoria Police Summary.

EVIDENCE IDENTIFYING THE REMAINS OF MR BEARDOW

9. On 6 February 2015 a sand shoe and the skeletal bones of a right lower leg and foot were located at the beach at Seaspray. The shoe was identified as being similar to those worn by Mr Beardow at the time he fell overboard on 10 November. A DNA comparison was undertaken at the Victorian Institute of Forensic Medicine, which confirmed with a 99.99% sibship percentage that the skeletal bones are related to Angela Brauman, Mr Beardow's sister.[7] A line search was subsequently undertaken at Seaspray Beach on 6 February, and a right hand side scapula was located. DNA also confirmed a 99.99% sibship percentage that the scapula is related to Angela Brauman. On 8 March 2015 a right adult human femur was located at Seaspray beach, 500 metres west of the Seaspray Surf Lifesaving Club. No differences were found between the DNA profiles of the femur and that of the DNA profile of the right leg/foot found on 6 February. The DNA type of Mr Beardow is expected to be produced approximately once in 100 billion in a population of randomly chosen, unrelated people.[8]

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. I acknowledge that the cause of death of Mr Beardow is unable to be ascertained. However, the evidence demonstrates that Mr Beardow was on the bow of the vessel in circumstances where he was not wearing a lifejacket and/or safety harness, at a time when a strong wind warning was currently in place. Furthermore, south westerly winds were 25-30 knots and the west to south westerly swell was increasing from 1 to 1.5 metres offshore.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations connected with this death:

1. The current Victorian regulations provide for the compulsory wearing of the required grade of personal floatation device at any time of 'heightened risk'. With the aim of minimising risk and preventing like deaths, I recommend that the definition of 'heightened risk' within the Victorian Recreational Boating Safety Handbook and *Marine Safety Regulations 2012* (Vic) be amended to reinstate the condition 'when there is significant likelihood that the vessel may capsize or be swamped by waves or the occupants of the vessel may fall

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[7] Victorian Institute of Forensic Medicine Identification Report, dated 23 February 2015.

[8] Victorian Institute of Forensic Medicine Report of Scientific Testing, dated 20 March 2015.

overboard or be forced to enter the water', as was the case at the time of this tragic incident.

2. With the aim of minimising risk and preventing like deaths, I further recommend that the definition of 'heightened risk' within the Victorian Recreational Boating Safety Handbook and *Marine Safety Regulations 2012* (Vic) be amended to include whenever a strong wind warning is current. I further recommend that the 'strong wind warning' be based on the Bureau of Meteorology's definition of a strong wind warning (25-33 knots), as opposed to the Beaufort Scale.

FINDING

10. I am satisfied, having considered all of the evidence before me, that no further investigation is required. I am satisfied that there is no evidence to suggest the involvement of any other person in this death.

11. I find that Alan Beardow died sometime between 10 November 2014 and 6 February 2015 and that the cause of his death is unascertained, in circumstances where Mr Beardow was on the bow of a vessel not wearing a lifejacket and/or safety harness and fell overboard, at a time when a strong wind warning was currently in place, south westerly winds were 25-30 knots and the west to south westerly swell was increasing from 1 to 1.5 metres offshore.

I direct that a copy of this finding be provided to the following:

The family of Alan Beardow
Investigating Member, Victoria Police;
Yachting Victoria;
Ocean Racing Club of Victoria;
Maritime Safety Victoria; and
Interested parties.

Signature:

JOHN OLLE
CORONER
20 July 2015