IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 2156

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of ROBERT LITHGOW

without holding an inquest:
find that the identity of the deceased was ROBERT LITHGOW
born on 2 March 1961
and the death occurred on 19 May 2013
at the Southern Ocean off the coast of Nirranda South, Victoria 3268

from:

1 (a) UNASCERTAINED

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

Broad circumstances

1. On Saturday 18 May 2013, Robert Lithgow, Bruce Ottoway and Peter Evezard gathered at Flaxman's Hill, south east of Warrnambool, with a view to Mr Lithgow, an accredited chief instructor, instructing both Mr Ottoway and Mr Evezard in hang gliding activities. A series of events, which are not particularly pertinent to subsequent events, resulted in Mr Lithgow taking Mr Ottoway on a paragliding flight in a tandem paraglider. There is some contention as to the basis upon which Mr Lithgow and Mr Ottoway flew. The only person who can shed light on this issue is Mr Evezard. I am satisfied the proposed flight was in the nature of a joy flight. I do not accept that it was a flight where Mr Lithgow was formally instructing Mr Ottoway on paragliding. Photographs taken by Mr Evezard clearly depict Mr Lithgow as the "*pilot*" and Mr Ottoway as the "*passenger*". However, I am unable to say whether if at any time after launch Mr Lithgow permitted Mr Ottoway to "*fly*" the tandem paraglider.

2. In any event, Mr Lithgow and Mr Ottaway took off at approximately 2pm. Mr Evezard observed the paraglider in the observable vicinity for a period of time he estimated at about 30 minutes before the paraglider travelled in an easterly direction and out of his sight. At the time Mr Lithgow and Mr Ottaway took off Mr Evezard stated that the conditions were generally good. Subsequently some rain squalls came through with variable winds. Prior to losing sight of the craft Mr Evezard said he had radio contact with Mr Lithgow who advised him conditions were good and he should "*come up*".

3. After Mr Evezard lost visual contact with the paraglider rain squalls came through resulting in Mr Evezard sheltering in his car. At that time Mr Evezard observed a "*definite drop in the wind*". Mr Evezard recalls how subsequently, on a number of occasions, he unsuccessfully tried to make radio contact with Mr Lithgow.

4. Becoming somewhat concerned, Mr Evezard contacted his wife, Mandy Evezard, who in turn conveyed his concerns to Mrs Lithgow. Mrs Evezard accessed the Hang Gliding Federation Australia (HGFA) website in relation to the Flaxman's Hill launch sight and noted that the website advised there were no beach landings to the east, past the first bay, and advised flyers "*not to fly the sheer cliffs if the wind is light or likely to drop off*".

5. Mrs Evezard and Mrs Lithgow had several more telephonic contacts before becoming alarmed and contacting Rob Van Der Klooster, then president of the Hang Gliding and Paragliding Association, who was apparently listed as the HGFA contact for the Flaxman's Hill site. Mr Van Der Klooster advised the situation was such that the matter should be reported to the police. A 000 emergency call was made at 5:45pm which resulted in Victoria Police, State Emergency Services and Ambulance Victoria being notified.

6. The missing paragliders could not be located on land: it was feared they have come down in the ocean.

7. On the morning of 19 May 2013, the Victoria Police Search and Rescue Squad joined the search involving both the police Air Wing and a police Search and Rescue Vessel. In his statement, Sergeant Scott Dower of the Air Wing said shortly after becoming airborne he observed a harness/backpack floating on the surface in the ocean with what looked like a parachute underneath. The location, which was marked with smoke flares, was approximately 300 metres offshore. The aircraft remained on site until the arrival of the Water Police Vessel.

8. Shortly after 10am Water Police personnel retrieved Mr Lithgow's body, which was initially entangled in parachute strings, from the sea. Other volunteer search vessels, Coast Guard, Appollo Bay Ocean Rescue and a smaller vessel from Port Campbell Surf Living Club continued the search for the second male whose body was not located. The Air Wing Aircraft also conducted a search of the area without success.

9. The following morning, Victoria Police Search and Rescue divers attended the site, which had been marked with a buoy, and continued the search for the body of the second paraglider. The extensive search did not locate a body.

10. It was established that the body retrieved was that of Mr Lithgow. Mr Ottoway's body has not been located. However, I am entirely satisfied Mr Ottaway perished in the Southern Ocean off Nirranda South on 18 May 2013.

Report to the coroner

11. The matters were reported to the Coroner. Having considered the circumstances and having conferred with a forensic pathologist I directed an autopsy and auxiliary tests on the body of Mr Lithgow.

12. An autopsy was performed at the Victorian Institute of Forensic Medicine (VIFM) by Forensic Pathology Registrar Dr Victoria Francis supervised by the then Director of the Institute Professor Stephen Cordiner. An exhaustive autopsy, within limited due to predation of the lower torso, was conducted. Dr Francis advised she was unable to determine the precise cause of death which therefore remains "unascertained". Dr Francis commented that while drowning may have been the mechanism of death, autopsy did not disclose what caused the paraglider to enter the water. Toxicology was unremarkable with no alcohol or common drugs detected.

Concerns raised by family

13. Leaving aside media reports, where claims and counterclaims about "pilot error" by both detractors and supporters of Mr Lithgow, received quite extensive coverage both in Victoria and interstate, Mr Arron Ottaway, the son of Mr Bruce Ottaway, having received coronial documents, wrote to the Court in a letter dated 3 May 2014 in which he levelled strident criticism of Mr Lithgow and requested further investigation. Rather than endeavouring to

encapsulate his criticisms, for completeness, I include in this finding a pertinent excerpt from that letter of concerns, Mr Arron Ottaway wrote:

> *"I request further investigation into this matter with a view to;*
>
> - *Finding Rob Lithgow negligent for the crash which occurred on the 18 May 2013*
> - *Finding Rob Lithgow responsible for the death of my father on the 18 May 2013*
>
> *I also request the Coroner overview the role and operation of the Hang Gliding Federation of Australia (HGFA) and how it is managed. I believe the HGFA have been negligent in the management of its member Rob Lithgow and failed to investigate previous incidents involving Rob Lithgow."*

Mr Ottoway enumerated some 20 contentions upon which he based his criticisms, and some seven issues he suggested should be further explored.

Role of the Coroner – Relevant Law

14. In light of these comments I considered it imperative at every opportunity to refer to aspects of the law which are relevant to and impact upon my role. This is designed to assist interested parties, particularly lay parties, to understand the bases upon which I proceed. Often if strident criticism is not levelled against a party or entity a family sees as responsible for the death of their loved one, the family leaves with an unfulfilled expectation. Very often coroners are urged to find the perceived "*guilty*" party negligent; that is not the role of the coroner. In the initial and subsequent Mention/Direction hearings I advised Mr Ottoway of my views in that regard, but I consider it appropriate to reiterate the position in this formal finding.

15. In Keown v Khan[1], in my view a landmark decision, Justice Callaway, adopting a statement contained in the Broderick Committee Report[2], said:

[1] (1999) VR 69.

[2] Report of the Committee on Death Certification and Coroners (1971) (UK) (The "Broderick Report") GMND 4810.

"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame."

Again quoting the Broderick Committee (UK) Report, His Honour noted:

"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."

16. So while not laying or appropriating blame a coroner should endeavour to establish the CAUSE, or CAUSES, of a death; the distinction is fine but real. As Justice Callaway said in Keown v Khan[3]:

"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply; with even greater force, to a finding of moral responsibility or some other form of blame". (my emphasis)

Lord Lane CJ held in R v South London Coroner; exparte Thompson[4]:

"It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning blame."

17. Seeking to articulate the dichotomy between laying or apportioning blame, fault, culpability on one hand, and finding cause or contribution on the other is difficult. In Coroners Court v Susan Newton and Fairfax New Zealand[5] reference was made to Laws of New Zealand, Coroner's. At paragraph 28 under the heading of "*blame*" the following statement appears:

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[3] (1999) VR 69.

[4] (1982) 126 SJ 625

[5] (2006) NZAR 312 paragraph 28

"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause." (my emphasis).

Hardie Boys J in Louw v MacLean[6] stated:

"in order to ascertain or explain how death occurred, in the wider sense of the events that were the real cause, the implicit attribution of blame is unavoidable". (again my emphasis)

I believe it is for the coroner to establish/find the facts and for others, if they wish, to draw whatever inferences they wish.

18. I propose to refer to the limitations placed upon a coroner in relation to the coronial investigation in Harmsworth v the State Coroner[7]. Only issues sufficiently connected to the death, and circumstances of the death, can be pursued. While under the provisions of the *Coroners Act 2008* (the Act) public inquest imperatives may permit an expansion of the scope of investigation, a sufficient nexus must still exist to do so; my powers are not "*free ranging*".

19. As stated earlier, Mr Arron Ottaway levelled strident criticism of Mr Lithgow's ability, in light of previous incidents, to instruct and was highly critical of the failure of HGFA to investigate and act upon a previous incident, particularly what I will call the "*Wynne complaint*". As I have said from the outset, the fact that the precise circumstances under which the paraglider came to ditch in the sea are not known somewhat restricts the scope of my investigation. After Mr Evezard lost sight of the paraglider no one knows precisely what occurred.

20. Had I clear evidence of recklessness, or even a failure to comply with operational standards, a wider investigation of these matters would have been permissible, but no compelling evidence of such is available. The activity carries with it attendant risks and I cannot rule out

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[6] (1998) High Court of NZ (unreported 12 January 1988)

[7] (1989) VR 989.

the prospect that unexpected weather events may have precipitated the tragic accident which claimed the lives of both men.

21. As Mr Rule, for CASA, stated succinctly in his written submission of 1 November 2016:

> *"There is no evidence that Mr Lithgow was engaged in any non-compliant or unauthorised activities on the day of the incident flight. For that reason, it is submitted that no occasion arises to examine in detail the compliance history of Mr Lithgow or the manner in which he was dealt with by the HGFA."*

The regulatory regime

22. Because it is relevant to this matter I propose to address in broad terms the regulatory regime that operates in relation to paragliding, an activity which apparently came into vogue in Australia in the early eighties.

23. As the activity carries with it an element of risk it became obvious that the public interest and the risk to those directly involved meant that an "*open slather*"/laissez faire approach was inappropriate. Consequently, as with other recreational/sport aviation activities, a regulatory regime was promulgated. The regime is described as "*Self Administration*". Various organisations known as "*Recreational Aviation Administration Organisations*" (RAAOs) were established. The Self Administration Handbook[8] (the Handbook) describes the nature of the arrangement as follows:

> *"...CASA sets the regulations and then works in close cooperation with the RAAOs, to make sure the regulations are applied and enforced."*

24. Fundamentally, the regime provides exemptions from the *Civil Aviation Regulations 1988* to members of the relevant RAAO. To legally engage in the relevant activity individuals are required to be members of the appropriate organisations which are required to regulate the activity primarily to ensure that the attendant risks are minimised.

25. Paragliding comes under the umbrella of hang gliding and is administered by the RAAO, HGFA.

[8] Sport Aviation Self Administration Handbook 2010.

26. The Handbook describes incident/accident management and reporting as a key element to a safety management system to minimise the prospect of an adverse event. While it may seem obvious, key elements of risk management involve incident/accident events being reported and once reported, adequately investigated, and if considered appropriate enforced with disciplinary action, to ensure standards are met.

27. HGFA (like all RAAOs) has an operations manual which CASA, the organisation ultimately responsible for aviation safety, has approved. Like other RAAOs, HGFA has a board of management with an individual appointed by the board to fill the role of the "*accountable manager*". In the case of HGFA operations manager, the management of the activity is in accordance with the HGFA Operations Manual.

28. When one considers the quite onerous responsibilities cast upon RAAOs to manage the activities of its members, the level of commitment/competence of the "*accountable manager*" is critical.

29. Having discussed aspects of the regulatory regime generally, I turn to address matters pertinent to this investigation. I do so on the basis that as the application of the regulatory regime, in practice, may bear upon "*public health and safety*"[9]. Furthermore, section 1 (c) of the Act provides that one of the important purposes of the Act is to "*contribute to the reduction of the number of reportable deaths*".

30. Those factors, in my view, enable me to extend the scope of my role to examine, to some extent, the adequacy of HGFA's response to incidents, accidents reports and complaints. However, there is only so far I can go because, as Mr Rule submitted, there is insufficient evidence for me to conclude any regulatory oversight was a causal or contributing factor in the deaths of Messrs Lithgow and Ottaway.

31. The incident/accident reporting system utilised in the period leading to this matter was titled the Incident Reporting Information System (IRIS). In his further statement, Brett Coupland, Operations Manager HGFA, explained that IRIS followed a format which, although approved by CASA, "*did not cater well*" for recreational aviation organisations. He advised that in light of that HGFA developed, over a period of time, an online Accident/Incident Reporting System (AIRS).

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[9] See *Coroners Act 2008* section 8(f).

32. Mr Arron Ottaway, in material lodged shortly prior to the final hearing, claimed that AIRS was not significantly different to IRIS, and was, to use my term, merely a "rebadging" of the original deficient IRIS. There are similarities between the "old' and the "new systems"; that is not surprising as the AIRS system, while incorporating significant refinement, evolved from IRIS.

33. In his second further statement, Mr Coupland enumerated the details of AIRS which, to my satisfaction, demonstrate enhancements to the reporting system which should reduce the prospect of sub-optimal management of the activity into the future.

34. The deaths of Messrs Lithgow and Ottaway have thrown into sharper focus the whole issue of the reporting of incidents and accidents, the appropriate level of investigation of complaints and the oversighting and auditing by CASA of these aspects of HGFA's management of their activity under their Deed of Agreement.

35. My firm view is that although AIRS is an improvement on IRIS, it was not so much that IRIS was fundamentally significantly flawed, but it was the application, or more correctly the non-application, of the reporting/investigating requirements by former HGFA personnel that resulted in the sub-optimal investigation of the Wynne complaint. As Mr Arron Ottaway said in his final oral submission at the final hearing:

> *"...I'm satisfied that the situation is different now than it was then, and having said that, it would want to be."*

36. At the final hearing Sasha Jeffrey-Bailey, for HGFA, conceded, as I believe she had to, that the performance of at least one Operations Manager at HGFA was sub-optimal. In his submission Mr Rule accepted that former operations managers had:

> *"...not adequately discharged their duties in relation to recording and processing of complaints."*

37. I conclude those aspects of HGFA's management were indeed sub-optimal, but for the reasons stated earlier in this finding in relation to the undetermined reasons for the ditching in the sea, I cannot be comfortably satisfied they represent causal, or contributing factors in the deaths.

Exchange of material

38. During the protracted course of this investigation I have on many occasions provided material lodged by various parties to other interested parties to enable those parties to see what is being provided, and to enable each party to respond to contentions raised which may have implications for that second entity.

39. In that regard I made available to Mrs Lithgow material provided to the Court by Mr Arron Ottaway which in broad terms was highly critical of her husband. Mrs Lithgow, in a strong defence of her late husband, lodged a further statement dated 15 April 2016.

40. In that further statement Mrs Lithgow made what can only be described as an extraordinary claim which had not previously been made. Mrs Lithgow suggested Mr Bruce Ottaway had "*reasons to disappear*" and may have had a "*sinister motive…in wanting to assume a new identity*". At page 4 of her statement Mrs Lithgow made a more precise allegation stating Mr Bruce Ottaway:

> *"…may have caused the demise of my husband and assumed a new identity, having successfully convinced everyone around him of his disappearance and presumed death."*

41. One can understand Mrs Lithgow's grief following the death of her husband which obviously has deeply impacted upon her. I also suspect it is her perception that the various matters raised demonstrate some form of witch-hunt.

42. Not being aware of any evidence which would support her contention, my tentative view was that it appeared ill-founded, insensitive and likely to inflame the situation as I would be required to provide a copy of the statement to Mr Arron Ottaway for his comment. I enquired of Mrs Lithgow whether she maintained her claim, and if so what evidence she relied upon. Mrs Lithgow advised my Legal Officer she did not retreat from her allegation, relying on, as I understood it, the fact that Mr Ottaway's body was never recovered.

43. Being as sensitive as I believe I can be in the circumstances, I reject Mrs Lithgow's contention as fanciful at best, inflammatory at worst. To his credit, Mr Arron Ottaway did not respond to the claim.

44. I am totally satisfied Mr Ottaway perished at sea when the paraglider ditched in the ocean for reasons I am unable to be comfortably satisfied.

Emergency locator transmitters (ELTs)

45. I propose to address, in short narrow compass, the issue of the carriage by paragliders of Emergency Location Transmitters (ELTs). The issue was raised by Lee Ungermann of the Self Administration Sport Aviation Organisations Sector of the Office of the Director of Aviation Safety in his earlier statement to the Court dated 24 April 2015.

46. At the Mention/Directions hearing in November 2015, I sought some clarification as to the present position in relation to ELTs. Subsequently, in a further statement of 5 April 2016, Mr Ungermann expanded on the issue[10]. At the final hearing on 3 November 2016, I indicated I would formally address the issue in my Finding; I do so now.

47. In late 2011/early 2012, a New South Wales coroner recommended CASA and HGFA "*give favourable consideration*" to paragliders carrying ELTs. The recommendation was considered by the CASA Accident Investigation Review Committee. After due consideration, for a number of reasons, some of which may not have been immediately obvious, CASA did not mandate the carriage of ELTs, but in lieu, recommended hang gliders and paragliders carry Personal Location Beacons (PLB).

48. Mr Ungermann advised that in March 2015 CASA approved the following update of the Operations Manual. Paragraph 9.5.3 of the Operations Manual now reads:

> **9.5.3 Emergency Beacons**
>
> *It is recommended all pilots carry a current personal satellite GPS messenger device or a current Emergency Position Indicating Radio Beacon (EPIRB) or a current Personal Location Beacon (PLB), especially for all tandem flights, cross country flights and for any operations around or over water.*

49. While it was not mandated, but a recommendation only, I strongly support the HGFA recommendation. Participants in the activity, particularly over or near water, if only for

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[10] See pp 11-13 of that statement.

reasons of personal preservation, would be well advised to heed the recommendation; those who don't dismiss it at their own peril.

Investigation protocol

50. Deaths of individuals engaged in activities self-regulated by RAAOs, such as hang gliding, paragliding, parachuting and flying micro light aircraft, are somewhat differently investigated by coroners. While members of Victorian Police are formally the Coroner's Investigators (CI), as was the case here with Senior Constable Christopher Kelly of Warrnambool Uniform being the nominated CI, the principle investigation of the incident is undertaken by a senior member (or members) of the relevant RAAO; in this case the HGFA.

51. This is a long standing arrangement, certainly in Victoria, and as I understand it Australia wide. The rationale for the arrangement is quite simple; they are the people with the necessary expertise to undertake a proper investigation. In practice the CI and the nominated RAAO member liaise and work in conjunction with each other to provide material to the coroner to enable His or Her Honour to hopefully come to a better understanding of the circumstances surrounding the death under investigation.

52. This longstanding arrangement occurred in relation to the deaths of Mr Lithgow and Mr Ottaway. The principle HGFA investigator was Mr Rob Van Der Klooster, who was assisted with aspects of the investigation by Mr Robert Leith, Mr Jan Bennewitz and Mr Leigh Harry, all members of the HGFA.

53. It could be said that aspects of HGFA's management of Mr Lithgow were of concern to Mr Arron Ottaway; it would not be appropriate to involve the organisation in the investigation. All I say in relation to that is while HGFA members may provide information and opinion as to the circumstances surrounding the incident under the investigation, the conclusions ultimately reached as to significant matters rest solely with the coroner. In any event, I am grateful to Mr Van Der Klooster and his colleagues for their input.

54. Having examined the material provided by Messrs Leith and Bennewitz in relation to the equipment, I am satisfied equipment/apparatus failure was <u>not</u> a contributing factor in the incident.

55. The crux of Mr Van Der Klooster's report is contained in pages 56-59 of the Coronial Brief of Evidence. Mr Van Der Klooster (at page 58 of his report) commented:

> *"Whatever the reason, once below the cliff's edge in deteriorating conditions a very risky 'ocean landing' became inevitable."*

Tragically, that became the case. The precise reasons Mr Lithgow found himself in that unenviable position are matters I had hoped to establish. However, without eye witnesses to the events establishing the precise circumstances leading to the ditching is at best problematic.

56. In his report Mr Van Der Klooster provided a theory, contained in the conclusion to his report; he opined:

> *"Mr Lithgow had considerable hang gliding and paragliding experience (30+ years, 5500+ total hours and probably a thousand tandem flights in both hang gliding and paragliding), the last 15 years was mostly in simular coastal environment as he was flying in on this day. In this period he would have on many occasions experienced the effects of rain squalls on wind strength and direction which may result in a loss of lift requiring an 'out landing'*[11]*. He would have also tested many students for their supervised theory exam where the effect of rain squalls and storms are covered.*[12] *He would also have known that landing a tandem paraglider in the southern ocean, with 3-4 foot swell on this day, would be highly dangerous, especially for himself occupying the rear seat (pilot in command position).*
>
> *The last radio message from Mr Lithgow to Mr Evezard, "...conditions were good and I (Mr Evezard) should come up (to fly)... we're going to explore the ridge...", indicated that Mr Lithgow was confident and not concerned about the conditions and hints that he intended to fly toward (over) the sheer cliffs. However the variable conditions were predictable given the presence of rain squalls (as per warning HGFA Site Guide). The choice to fly away from a safe beach landing in these conditions severely increased risk if conditions were to change. The fact that no further communication occurred indicates that the situation changed rapidly and that Mr Lithgow was probably too preoccupied with remaining airborne to make any*

[11] A landing which was not the intended one.

[12] Question: Whilst flying, what would be the effect on conditions of the approach of a squall or storm? Answer: Wind speed will increase or decrease and may change direction up to 180 degrees, turbulence will become severe and rain may fall. Experienced pilots will land.

further radio communication, once committed to an ocean landing he would have had only 30 seconds to 1 min to organise a orderly exit from the harnesses for his passenger and himself.

Contributing factors

- *Rain squalls causing variations in both wind strength and wind direction*
- *The decision to fly east onto the sheer cliffs away from a reachable safe (beach) landing.*

57. Mr Van Der Klooster's hypothesis may have merit. However, in the absence of direct, compelling evidence I am not comfortably satisfied Mr Lithgow intentionally undertook a potentially dangerous course putting himself and his passenger in danger. I reiterate he may have been a victim of weather events.

Prospect of a medical event

58. It would appear that although an appropriate medical examination had been conducted, due to "*procedural deficiency*" revealed at a CASA audit, a copy of Mr Lithgow's medical certificate was not on his file. As to what may have caused or contributed to the ditching in the ocean, I observe there is no evidence to suggest the accident may have been due to Mr Lithgow having suffered a medical event compromising his ability to pilot the paraglider.

Funding

59. The principal basis for me broaching this topic is the comment by Mr Ungermann in his supplementary statement of 5 April 2016 where at paragraph 38, he wrote:

> *"CASA is satisfied that the provisions and mechanism under the Deed of Agreement in combination with the reporting requirements under the TSI Act are sufficient to address sport and recreational aviation accidents. However, it is acknowledged that these investigations may be limited due to resource constraints of both the HGFA and ATSB." (my emphasis).*

60. Having formed the view that the responsibilities cast upon RAAOs to self-regulate (subject to CASA oversight) are particularly wide and onerous, I wondered whether the resources provided enabled them to adequately carry out their responsibilities. I invited CASA to

address the issue, at least in broad terms. I wanted to seek to determine whether funding issues had compromised HGFA's ability to adequately investigate incidents/accidents and follow up complaints which may go to its regulatory responsibility to ensure, as best it can, the safety of its members.

61. At the final hearing on 3 November 2016, I again broached the issue primarily to seek to establish whether, into the future, one could be confident HGFA is able to adequately undertake its responsibilities.

62. In his final short written submission Mr Rule, for CASA, submitted:

> "*Funding*
>
> *There is nothing in the material before the coroner which would allow a finding that the HGFA is not adequately funded to perform the oversight functions required of it by CASA. Most notably, there is nothing in the HGFA's own evidence which raises any suggestion to that effect.*
>
> *Against that background, any attempt to determine with precision the extent to which the current financial resources of the HGFA are adequate would require a hearing over a number of days examining in detail the various activities undertaken by the HGFA.*
>
> *It is submitted that the known circumstances of this accident do not warrant such a far reaching enquiry.*
>
> *Other issues*
>
> *In all other respects, it is submitted that the issues properly raised by the Coroner with CASA have been addressed in clear terms in the statements of Mr Ungermann."*

I accept Mr Rule's submission on this issue.

63. I suspect that HGFA's ability to self-fund its operation is somewhat restricted due to the numbers that engage in the activity, compared, for instance, with parachuting where many thousands jump each year. I also acknowledge that funding of RAAOs, such as HGFA, are entirely matters for government. I also accept we are in times of finite resources with competing claims upon those resources. While it may appear trite, if organisations such as

HGFA are to fulfil their onerous obligations/responsibilities to <u>ensure safety of participants</u>, it is imperative they be adequately resourced.

Conclusion

64. I formally find Robert Lithgow, together with Bruce Ottaway, perished in the ocean of Nirranda South when the paraglider piloted by Mr Lithgow, in which Mr Ottoway was the passenger, ditched into the sea. While the reasons for the calamity remain undetermined, I am satisfied an adverse weather event occurred at the location at the time which may have caused or contributed to the accident.

Comments

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

65. For a variety of reasons, this matter has had a somewhat tortured course. I thank the parties for their patience. I commend my assistant, Leading Senior Constable Duncan McKenzie, who put an enormous amount of work into preparing the extensive Coronial Brief of evidence and updating it as additional materials was lodged.

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

Kate Lithgow, Senior Next of Kin;

Aaron Ottaway, Senior Next of Kin;

Sasha Jeffrey-Bailey, information recipient – solicitor for HGFA;

Sallyanne Wilkinson, information recipient – CASA; and

Senior Constable Christopher Kelly, Coroner's Investigator.

Signature:

PHILLIP BYRNE
CORONER
Date: 30 November 2016