18 July 2022

Nancy Carbone
Coroner's Registrar
Coroner's Support Services
Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3006

Dear Ms Carbone,

Investigation into the deaths of Ross Powell (COR 2019 002001) and Andrew Powell (COR 2019 002002).

Please find below Life Saving Victoria's (LSV's) response to the recommendation directed to our organisation outlined in Deputy State Coroner Caitlyn English's Finding without inquest into the death of and Ross Powell (Court Reference: COR 2019 002001) and Andrew Powell (COR 2019 002002).

Recommendation 1:
"…I recommend Life Saving Victoria take immediate action to complete the implementation of all of the recommendations made in the Critical Incident Review Report, dated July 2019. To that end, Life Saving Victoria's response to this recommendation pursuant to section 72(3) of the Coroners Act 2008 should provide an update regarding the implementation of the 32 individual recommendations made in the Critical Incident Review Report."

Response:

The Coroner's recommendation is being implemented in line with LSVs scope and areas of responsibility, and where practicable.

In the Critical Incident Review Report, the reviewers made 32 recommendations. Since February 2020, LSV has been actioning these recommendations, together with relevant life saving clubs and other relevant bodies (including Emergency Management Victoria (EMV) and Water Police) in order to improve marine search and rescue services across the state.

I am pleased to advise that significant progress has been made in actioning the individual recommendations. Of the 32 recommendations 24 have been implemented, 3 are nearing completion, 2 had an alternative solution/approach implemented, and 3 could not be implemented.

Regarding the 24 recommendations that have already been implemented, evidence for the implementation is incorporated in various documentation including:

- Standard operating procedures,
- training programs and related documentation,
- induction packages,
- quality assurance and other reports,
- international standards and vessel survey,

- standard maritime structures and frameworks,
- national equipment list,
- communication logs, online databases and registers, and
- minutes, standing agenda and calendar items and letters, circulars or other correspondence.

Further detail regarding the eight recommendations that had either an alternative implemented, are yet to be implemented, or were unable to be implemented is provided below.

Recommendations 8, 31 and 32 are currently being implemented, with details as follows:

- Recommendation 8 *"Each crew person on a VMR [Volunteer Marine Rescue] vessel which operates in remote locations or has to travel more than two nautical miles from their home base carry a PLB [Personal Locator Beacon]"* is due to be completed in full by December 2022. To date the LSV Safety Management System has been updated to require a PLB be worn by the skipper and crew. This is in addition to the EPIRB (Emergency Position Indicating Radio Beacon) carried on the vessel. All units have been supplied with a PLB for the skipper and crew. The current policy states that PLBs are recommended to be worn. The next policy update in December 2022 will mandate the requirement for PLB use in all MSAR operations

- Recommendation 31 *"LSV consider nominating Phillip Younis, Ross Powell, Andrew Powell and Ben Matthews for bravery recognition through the SLSA system and the Australian Honours and Awards"* is being implemented. To date SLSA honours awards were completed and received and the Australian honours applications are in process.

- Recommendation 32 "*The review panel is reconvened once any external investigation is complete and / or the Coroner has released findings with the intention to review this version of the report and provide an updated version…"* is being implemented. The process to reconvene the review panel is underway and scheduled for completion by the end of August 2022 (subject to panel availability).

Alternative solutions/approaches to two recommendations were made for the reasons outlined below:

- Recommendation 4 *"Skippers and drivers of larger VMR vessels receive nationally recognised training and are qualified with MAR20318 – Certificate of Operations (Coxswains Grade 1) and MARSS00008 Shipboard Safety Skill Set".* Different training than that specified has been provided (EMV MSAR training package – delivered by EMV Marine Search and Rescue [MSAR]). Noting that this training is a higher level than that recommended. Additionally all current skippers have had their qualifications 'grandfathered' to meet the standard as per the requirements of domestic commercial vessel national law exemption 24. This is as per the declaration provided by the local unit. All new skippers are trained to meet the above standard and records are verified by LSV's subject matter expert.

- Recommendation 29 *"The Port Campbell SLSC engage with Victoria Police and other agencies to conduct a briefing and planning session including coastal rescue considerations prior to the Easter Holiday Period (and any other time as deemed appropriate)."* This recommendation was no longer relevant to the Port Campbell Surf Life Saving Club (PCSLSC) MSAR service because the club made the decision to withdraw this service and advised LSV and EMV in writing of this decision. However,

LSV recognises that PCSLSC already has a strong relationship with local emergency services in regard to ongoing briefing and planning considerations for their seasonal activity, and the club has continued to expand on this with Local Municipal Emergency Management Planning Committees and Regional Emergency Management Planning Committees where practicable.

Finally, the following three recommendations could not be implemented, for reasons outlined below:

- Recommendation 12 "*Manual or auto inflating PFDs / lifejackets (of any type) should not be worn on any type of VMR vessel that operates in wave zones where there is a possibility that persons may be thrown from the vessels or the vessels capsize and whereby the persons may be injured, incapacitated or unconscious and not able to activate a manually inflated PFD*" could not be implemented because this recommendation does not comply with the relevant national and state legislation. LSV lifejacket requirements are outlined in LSV SOP 9.03 which is compliant with International Maritime Organisation and Safety of Life at Sea standards.

- Recommendations 15 and 16 regarding the PCSLSC VMR service could not be implemented due to the discontinuation of the PCSLSC MSAR service.

LSV's mission is to prevent aquatic related death and injury in all Victorian communities, and our vision that all Victorians will learn water safety, swimming and resuscitation, and be provided with safe aquatic environments and venues; and it is incidents like this that compel us to do everything within our power to partner, innovate, educate and work with our communities to improve water safety outcomes for everyone.

We acknowledge the continued grief of all affected by this tragic incident, particularly Ross and Andy's families, friends, fellow club members, community and colleagues, as well as those of their fellow crewperson Phillip Younis, who was critically injured during the operation.

The safety of our people is our highest priority, and we thank both the Deputy State Coroner and the panel of independent reviewers for their expertise and care in ensuring we identify, define and improve on the lessons learnt from this tragic incident, so that our members can continue to safely undertake their pivotal role of saving lives.

If you or any of your team have any questions in relation to the above, please do not hesitate to contact Liam Krige, General Manager Lifesaving Services, by phone 03 9676 6991 or email: liam.krige@lsv.com.au.

Yours sincerely,

Catherine Greaves
CEO Life Saving Victoria