

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004666

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

*Amended pursuant to s77 of the Coroners Act 2008 on 3 July 2024 by order of State Coroner Judge John Cain.

Findings of: Judge John Cain, State Coroner

Deceased: Giovanni Castillo Garbanzos

Date of birth: 31 May 1982

Date of death: 2 September 2021

Cause of death: 1(a) Lost at sea presumed drowned

Place of death: Eastern Bass Strait approximately 20 nautical miles (40km) East of Flinders Island, Tasmania

Keywords: Drowning, fishing boat, AMSA, personal flotation device; Marine Safety (Domestic Commercial Vessel) National Law Act 2012

* The finding has been amended to correct the name of the vessel to the Lady Miriam

INTRODUCTION

1. On 2 September 2021 at approximately 7.50 pm, Giovanni Castillo Garbanzos (**Mr Garbanzos**) was struck by a large wave whilst working on the open deck of commercial fishing vessel the Lady Miriam and was swept off the working deck into the sea. Despite considerable efforts by the skipper and crew of the Lady Miriam, Mr Garbanzos was unable to be recovered and he is presumed to have drowned.
2. At the time of his death, Mr Garbanzos was 39 years of age. He was born and grew up in the Philippines and came to Australia to work in the fishing industry. At the time of his death, he was living in the caravan park at Lakes Entrance, Victoria.
3. Mr Garbanzos was described by his colleague as a hardworking, honest and good person.

THE CORONIAL INVESTIGATION

4. Mr Garbanzos' death was reported to the Tasmanian Coroner as the death occurred in Tasmanian waters. Due to the home port of the Lady Mirium being Lakes Entrance in Victoria, Mr Garbanzos residing in Victoria, and the restrictions imposed by the COVID-19 pandemic it was agreed that I would take carriage of the investigation.
5. As Mr Garbanzos resided in Victoria and therefore his death fell within the definition of a reportable death pursuant to the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
8. Victoria Police assigned Detective Senior Constable Madeline McDonald (**DSC McDonald**) to be the Coroner's Investigator for the investigation into the death of Mr Garbanzos . DSC

McDonald conducted inquiries on my behalf, including taking statements from witnesses – such as family, the crew members of the Lady Miriam, investigating officers – and submitted a coronial brief of evidence. The Australian Marine Safety Authority (AMSA)¹ were also involved in the investigation as they are the National Regulator for marine safety. Their investigation focused on the Lady Miriam compliance with regulations and requirements.

9. This finding draws on the totality of the coronial investigation into the death of Mr Garbanzos including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.²

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

10. The evidence supports the conclusion that Mr Giovanni Castillo Garbanzos, born 31 May 1982, was the person washed off the deck of the Lady Miriam on 2 September 2021.
11. Identity is not in dispute and requires no further investigation.

Medical cause of death

12. As noted above, the evidence supports the conclusion that Mr Garbanzos was the person washed off the deck of the Lady Miriam on 2 September 2021. Following the incident, his body was not recovered, and as such post-mortem examination was not completed.
13. Notwithstanding the absence of a post-mortem examination, having reviewed all of the evidence on the court file, I am satisfied that an appropriate medical cause of death is *lost at sea presumed drowned*.

Circumstances in which the death occurred

14. At approximately 9.30pm on 1 September 2021, the Lady Miriam had completed refuelling and provisioning. The Lady Miriam departed its home port of Lakes Entrance Victoria and headed to

¹ AMSA is a Commonwealth statutory authority established by the Australian Maritime Safety Authority Act 1990 with the functions of regulating maritime safety, marine environment protection and pollution response, and maritime and aviation search and rescue in Australia.

² Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

the fishing grounds east of Flinders Island, near Babel Island. On board the Lady Miriam were the Master and Engineer, Mr Moises Cyrus Penana (**Mr Penana**) and crew Mr Renan Manao (**Mr Manao**), Mr Siegfredo Torrecampo (**Mr Torrecampo**) and Mr Garbanzos. The Lady Miriam travelled overnight arriving at the fishing grounds at 3.00pm on 2 September 2021. Mr Manao reported the weather as wind strength 20 to 30 knots with 2 metre swells. In a telephone call between the owner of the Lady Miriam, Mr Antonio Guarnaccia (**Mr Guarnaccia**) and Mr Penana, Mr Penana described the weather as “shitty”³

15. The nets were released on arrival and once on the bottom, the Lady Miriam commenced steaming south at 3 knots. The nets were towed for 4 hours. At 7.23pm, the Lady Miriam reduced its speed to 1 knot and the nets were winched back onto the working deck. The nets contained approximately 100kg of fish (a disappointing haul) and Mr Penana advised that he wanted to release the nets again. The Lady Miriam was drifting at this time. The crew continued to sort fish and prepare for the second release of the nets.
16. Mr Garbanzos was standing on the starboard stern quarter of the vessel shovelling fish. He was facing towards the stern of the vessel. The stern of the vessel, where the nets are released and retrieved, is completely open to the sea with no guard rail or fence installed to make the area secure. As the crew were preparing for the second release of the net, Mr Penana was slowly manoeuvring the Lady Miriam into the best position to release the net. At the time the net is to be released, the stern of the boat needs to be clear of obstructions so the net can run freely into the ocean. Without warning a larger wave approximately 2 to 3 metres high struck the starboard side of the vessel and washed over the working deck. The force of the wave took Mr Garbanzos by surprise and washed Mr Garbanzos off the deck through the open stern where the nets are released and retrieved. One of the crew yelled a warning of the approaching wave but Mr Garbanzos did not have time to brace himself against the force of the wave.
17. Mr Garbanzos was wearing wet weather gear – rubber overalls a jacket and gum boots. The wet weather gear is quite heavy and would have made swimming quite difficult. The weight of the evidence supports the conclusion that he was not wearing a Personal Flotation Device (**PFD**) or buoyancy vest nor did he have a strobe light or personal locator beacon (**PLB**) with him.
18. Mr Manao immediately yelled ‘man overboard’ and Mr Penana who had just started to make way in preparation for releasing the nets stopped the Lady Miriam. Although it was dark, Mr Garbanzos was visible to the crew approximately 30 metres from the stern of the vessel. The

³ Statement of Antonia Guarnaccia, p63.

working deck lights are quite powerful and project light beyond the stern of the vessel. The crew could hear Mr Garbanzos cries for help and Mr Penana reversed the Lady Miriam to get closer to Mr Garbanzos so that he could be thrown a life ring. The Lady Miriam got within 6 metres of Mr Garbanzos. Three attempts were made to get a life ring to Mr Garbanzos. On the first two attempts the life ring landed too far away from him to grab, and the third attempt landed in the water within reach of Mr Garbanzos, however he was unable to grab the life ring as it appeared to the crew that it was being battered by the waves. Shortly after this last attempt the crew, they lost sight of Mr Garbanzos in the waves.⁴

19. The Lady Miriam transmitted a 'Pan Pan' distress message at 8.00pm which was received by Tas Maritime Radio. The operator at Tas Maritime notified AMSA and the Joint Rescue Co-ordination Centre (JRCC) took control of search dispatching an aircraft to the area to search for Mr Garbanzos. Medical advice was sought by the JRCC and the opinion of the medical expert was that there was no reasonable prospect of Mr Garbanzos surviving past 1.00am on 3 September 2021.⁵
20. The Lady Miriam continued to search for Mr Garbanzos for some hours eventually abandoning the search and heading to Babel Island where they anchored and were later directed by police to return to Lakes Entrance. The Lady Miriam arrived at Lakes Entrance on 4 September 2021.
21. Various search and rescue aircraft co-ordinated by AMSA searched the area without finding any trace of Mr Garbanzos. The search effort continued until 2.08pm on 3 September 2021 when it was abandoned. Despite the best efforts of the Master and crew of the Lady Miriam and other search and rescue resources, no trace of Mr Garbanzos was found.

The weather at the time of the incident

22. The Bureau of Meteorology (BOM) issued a forecast for the area east of Flinders Island on 1 September 2021. This forecast included a strong wind warning for 2 September 2021 with winds Northerly 15-25 knots reaching 30 knots during the day with swell 1.5-2.0 metres increasing to 2.0-3.0 metres around midday. The forecast for the following day was for Northerly winds, 20-30 knots shifting west south-west in the late morning.⁶
23. The weather station readings recorded by BOM within the forecast area are consistent with the forecast wind. BOM do not have any monitoring equipment to measure the sea state however

⁴ Statement of Dominigo Fial at CB, p54 and Statement of Renan Garay Monao at CB, p52.

⁵ Summary of Incident at CB, p2.

⁶ BOM forecast at CB, p128-129

Tasmania police reported that the sea state was up to 3 metres, consistent with the BOM forecast.⁷ The sea temperature at the time was 12-13 degrees Celsius.

The Lady Miriam

24. The Lady Miriam is owned by T& D Pguarnaccia Pty Ltd and Hunt Morey Pty Ltd. The vessel was in survey and held all relevant certificates and authorisations. The companies have owned and operated the Lady Miriam for 21 years and although they have come to the attention of the regulators from time to time, the issues identified would generally be described as minor or low-level compliance issues.
25. Following the initial investigation of the Lady Miriam by members of the Marine Investigation Unit of Victoria Police, Marine Safety Inspector Matthew Wardley from AMSA completed an inspection of the Lady Miriam and provided a written report of his findings from the inspection (**AMSA report**). The ASMA report identified 22 deficiencies with the Lady Miriam, as follows:
- Stern ramp protective arrangement missing,
 - Centre deck fish hold hatch securing device missing,
 - Port deck fish hold hatch closing device defective,
 - Deck wheelhouse watertight door closing device defective,
 - Deck engine room door closing device defective,
 - Bathroom light fitting cover missing,
 - Port engine room fan inlet vent blocked and cover defective,
 - Engine room wiring along deck head cable tray not safely secured,
 - Engine room wire in deck head cable tray has exposed end,
 - Engine room hoses and electrical wires have evidence of leaked hydraulic fluid,
 - Engine room high level bilge alarm defective,
 - Battery charger in galley defective,
 - Life jacket stowage not marked correctly,
 - Life jacket vessel identification missing,
 - Winch aft of wheelhouse machinery guard missing,
 - Anchor windlass missing, anchor not available to be dropped immediately,
 - Bilge pump manifold in engine room not marked,
 - Safe means of rapid rescue for persons overboard not located on board,

⁷ Ibid

- Satellite phone not working,
- Winch control stations do not have clear vision of deck area, and
- AIS Class B [TX/TR] not fitted.

26. The outcome of that investigation was that AMSA charged the owner of the vessel, T GUARNACCIA PTY LTD ABN 98061114289 (formerly known as T & DP GUARNACCIA PTY LTD) under section 13(4) of the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (Cth) (**MSNL Act**) for contravention of the general safety duty and section 12(1) of the MSNL Act which imposes duties on owners of Domestic Commercial Vessels to ensure safety of vessels, marine safety equipment and operations. The prosecution was heard in the Bairnsdale Magistrates Court on 30 May 2023. The company was convicted and fined \$30,000 and ordered to pay court costs of \$87.20 and \$198.00. No other prosecution of the company has been commenced.
27. I am obliged to avoid unnecessary duplication of inquiries and investigations under section 7 of the Act. Having reviewed all of the material on the court file, I am satisfied that no further investigation of the circumstances of Mr Garbanzos' death is required. However, there are three matters arising from the inspection of the Lady Miriam that I will comment on later in this finding.

FINDINGS AND CONCLUSION

28. On the balance of probabilities, I find that Mr Garbanzos died on 2 September 2021 approximately 20 nautical miles east of Flinders Island after being washed from the working deck of the Lady Miriam into the sea by a large wave.
29. Pursuant to section 67(1) of the Act, I make the following findings:
- a) the identity of the deceased was Garbanzos Castillo Garbanzos, born 31 May 1982;
 - b) the death occurred on or about 2 September 2020 in the waters of Bass Strait approximately 20 nautical miles (40km) East of Flinders Island, from an unascertained cause and that Mr Garbanzos was lost at sea and presumed to have drowned; and
 - c) the death occurred in the circumstances described above.

30. The absence of Mr Garbanzos' body is consistent with the hypothesis that after he was washed from the deck of the Lady Miriam and the crew lost sight of him in the water that the combination of waves, current and tides carried his body away.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Stern ramp protective net or barricade

31. As referred to above, in undertaking an inspection of the Lady Miriam, AMSA identified a number of deficiencies with the vessel including that the stern ramp protective barrier was missing. In the latest version of the Safety Management System Version 2 (SMS-v2) there is reference to the requirement that the stern ramp protective barrier be in place at all times other than when launching or retrieving the nets. There is no doubt that this measure would make the working deck safer. However, notwithstanding this, I am satisfied that at the time that Mr Garbanzos was washed from the working deck, the barrier would have been removed as the nets were about to be released and it is not possible to release the nets while the barrier is in place.

Wearing of PFDs and PLBs by the Lady Miriam crew

32. On the night that Mr Garbanzos was washed off the deck of the Lady Miriam, the evidence supports the conclusion that he was not wearing a PFD or any type of flotation device. He was wearing wet weather gear - gum boots, waterproof trousers and jacket. It was dark and the water temperature was between 12 - 13 degrees.
33. The medical advice was that he was unlikely to survive beyond 1.00am on 3 September 2021, that is no more than 5 hours in the water. The evidence of other crew members that Mr Garbanzos appeared unable to grab the life ring even though it was only a short distance from him, adds weight to the conclusion that only a very quick retrieval from the sea was going to save his life. If he could have been located within a short period after entering the water, it may still have been possible to save him. Without a PFD to keep him afloat and a light to indicate his location in the dark or some type of GPS tracking device it is difficult to see how any rescue effort was going to be successful. I am satisfied that Mr Garbanzos' best chance of survival was a PFD with a light and PLB. Unfortunately, he had none of these items when he was washed overboard.

34. The Safety Management System Version 1 (SMS v1) that was in operation at the time of this incident is unclear on when a PFD should be worn by the crew. The SMS v1 in Appendix A page 4 under the heading of 'Person Overboard' states 'Lifejacket to be worn'⁸ with no additional explanation is provided. In Appendix E of the SMS v1 under the heading 'Person Overboard Drill' it states:

'People working in exposed situations where there is a risk of falling into the water are required to wear safety belt lifelines PFD's or lifejackets. Outside of the handrails, lifejackets are mandatory'.⁹

35. Various statements from the crew of the Lady Miriam provide some insight into the operational approach taken to wearing life jackets on the Lady Miriam.

36. Namely, Mr Dominigo Fial stated that:

'At the time of the incident on 2 September 2021, I was not wearing a life jacket during the fishing operations. My understanding of the safety management systems is that we are required to wear life jackets when working on the deck in the bad weather. The safety briefing covers wearing life jackets but at the time of the incident no one was wearing a life jacket. We were all wearing wet gear, it is very hard to have the life jacket on top. The life jackets are readily available and there are lots on board. We all have one, and there are extras. I haven't been involved in any salvage operations on this vessel and I haven't had to do any work outside of the railings.'¹⁰

Giovanni [Mr Garbanzos] was wearing complete wet gear, he had rubber overalls, a jacket and gum boots on. I am not sure if he was wearing a small life jacket but previously, he had been wearing one in the bad weather. The small one is like a collar type; we don't wear the big ones as they are heavy and not good for working'.¹¹

37. In addition, Mr Manao stated that:

⁸ SMS Appendix A at CB, p485.

⁹ SMS Appendix E at CB, p490.

¹⁰ Statement of Dominigo Fial at CB, p58.

¹¹ Statement of Dominigo Fial at CB, p56.

*‘When we are working the deck, we normally wear sea boots and Stormline wet weather pants and jacket. No one on this night was wearing any type of floatation which is normal for us’.*¹²

38. Similarly, Mr Penana stated that:

*‘We have life jacket on the boat, but we only wear them in really rough weather. All of us make the decision when we use life jackets. Giovanni was not wearing a life jacket on this trip because it wasn't really that rough’.*¹³

39. These statements are hard to reconcile with the Lady Miriam’s SMS v1. Further, if lifejackets are not worn, after sunset, in winds of 20 - 30 knots with wave height of 2 - 3 metres in an area of Bass Strait on the edge of the continual shelf where the water temperature is 12 - 13 degrees, I am left wondering what the trigger for wearing a life jacket on the Lady Miriam would be?

40. Following this incident, the owners of the Lady Miriam directed that SMS v1 be reviewed and updated. In the updated version of the Safety Management (SMS v2) standard operating procedure, Appendix D under the heading of ‘Shooting and Hauling of Nets’ the first item listed is ‘Prepare and wear PFD’s in rough weather 15 knots of wind and above’.¹⁴ This is a welcome amendment as it makes it clear when a PFD is to be worn by reference to a single criteria of wind strength. I do not have any information about whether this is being embraced by the crew of the Lady Miriam and I can only hope that it is.

41. I note that in 2021, AMSA sought industry feedback on mandating wearing of lifejackets for all commercial fishing boat or for particular categories of boats either by size, when on deck or operating with reduced crew. AMSA provided the following information by way of update to some of the regulations:

'Lifejacket wear

The Marine Safety (Domestic Commercial Vessel) National Law Act 2012 (National Law Act) imposes general safety duties on a range of persons with a connection to domestic commercial vessels (DCVs), including DCV owners. Section 12 of the National Law Act requires DCV owners to implement and

¹² Statement of Renan Manao at CB, p52.

¹³ Coronial Brief, statement of Moises Penana, p47.

¹⁴ Coronial Brief, p956.

maintain a safety management system (SMS) as part of their general safety duties.

An SMS is a documented and practiced approach to managing safety and includes elements such as safe operating procedures, appropriate crewing arrangements and emergency procedures. A risk assessment is a central component of an SMS and DCV owners are required under Marine Order 504 (Certificates of operation and operation requirements—national law) 2018 (MO504) to develop the risk assessment in consultation with the master and crew, document it and update it when appropriate.

AMSA recently revised MO504 to strengthen lifejacket wear requirements. Since 1 August 2023, DCV owners are explicitly required to address lifejacket wear requirements in their SMS's risk assessment and written procedures.

The recent changes to MO504 follow extensive industry consultation on lifejacket wear requirements for DCVs and represent a risk-based and proportionate approach to person overboard and drowning hazards.

AMSA has a dedicated webpage on the lifejacket wear changes that includes guidance for DCV owners when undertaking their SMS's risk assessment. AMSA's lifejacket wear webpage can be accessed here: [Lifejacket wearing \(amsa.gov.au\)](https://www.amsa.gov.au/lifejacket-wearing).

Beacons

AMSA introduced new laws in January 2021 requiring the carriage of float-free emergency position-indicating radio beacons (EPIRBs) on certain types of DCVs.

Float-free EPIRBs are buoyant and float to the surface of the water with the aerial pointing vertically and transmitting a distress signal.

These changes were in response to incidents in which DCVs sank quickly and the master and crew were not able to deploy their non float-free EPIRBs in

time. More information on these changes can be found here: Distress beacons (amsa.gov.au).¹⁵

42. In February 2024, I held a meeting with representatives from AMSA. Following that meeting, in March 2024, AMSA provided a statement to the Court outlining the work that had been done by AMSA since the time of this incident. In that statement AMSA confirmed, the changes made to the National Law that came into effect on 1 August 2023, and the industry consultation that had been undertaken to gather feedback on mandatory life jacket wearing from the industry.¹⁶ AMSA also confirmed the ‘risk based, data driven and proportionate approach’¹⁷ taken to their regulatory role.
43. The statement also provides information about recently completed education campaigns and a focused inspection campaign (**FIC**) conducted from 1 October 2023 to 30 November 2023 and provided an example of a partnership with industry bodies to improve lifejacket wearing and overall safety culture.
44. AMSA also provided information about safety awareness work that has been done with the Seafood Industry in Queensland in fishing areas north of Mooloolaba. There is no indication if these collaborative efforts are going to extend to southern Australian waters.
45. In conclusion AMSA state:

*‘The existing regulatory settings, when combined with industry outreach activities, represent a risk-based and proportionate approach to person overboard and drowning prevention. AMSA is planning more education and industry engagement activities to continue to promote the benefits of lifejacket wear. AMSA will also continue to monitor compliance with the strengthened lifejacket wear requirements and other metrics, including incident data, to determine if further changes are needed’*¹⁸

46. I commend AMSA for introducing these changes that require those connected with a Domestic Commercial Vessel to implement and maintain a SMS as part of their general safety duties and

¹⁵ Email from AMSA to Court dated 22 January 2024.

¹⁶ Statement from AMSA dated March 2024 at p2.

¹⁷ Ibid p3.

¹⁸ Ibid p4.

their efforts to work collaboratively with the seafood industry. I am nevertheless left with the impression based on comments made by the crew of the Lady Miriam that the practicalities of wearing older style PFDs that are considered cumbersome and uncomfortable to wear when working on the deck of a commercial fishing boat means that crew may be reluctant to wear PFDs in all but the most extreme conditions. PFDs of this older style, do not have lights attached to them or PLBs.

47. In February 2003, a report was compiled by Maria Batchelor and Lyndal Bugeja from the Coroner's Court of Victoria titled 'Commercial Vessel Fatalities in Victoria, 1991-2001'.¹⁹ The aim of this report was to identify fatal incidents on commercial vessels in Victoria, between 1991 and 2001. Coronial investigations of the identified fatal incidents were examined in order to highlight potential improvement to safety equipment and procedures, in particular the use of PFDs. The authors of the report as part of their work considered design and comfort of PFDs for the commercial fishing industry.

48. They recommended that for fishing vessels:

'That appropriate bodies (i.e. State Boating Council, Marine Safety Victoria etc) in collaboration with the commercial fishing industry consider ways of encouraging the design, manufacture and marketing of affordable, comfortable personal flotation devices (PFDs) (in accordance with Australian Standard 1512/88 or amendment to the standard) with the intention of increasing their use. It may also be necessary to trial various currently available PFDs (e.g. Stormy Seas brand) to determine their suitability and acceptability to the commercial fishing industry for a range of fishing vessel tasks. It also may be necessary to encourage training in how to correctly wear and fit PFDs'.²⁰

49. I have been unable to ascertain whether any steps were taken to implement this recommendation. It is as relevant now as it was in 2003. If there was available a fit for purpose PFD that was comfortable to wear, was integrated into the wet weather gear or designed to be complementary to wet weather gear worn by crew on commercial fishing boats that incorporated a strobe light and PLB then crews on commercial fishing boats may be more willing to wear it as part of their standard equipment in all condition. This would mean that if a crew member was washed off the

¹⁹ Batchelor and Bugeja Report February 2003.

²⁰ Ibid.

deck the chances of recovery and survival would be greatly improved. If such a PFD had been available to and worn by Mr Garbanzos, then it is possible that he could have been located and retrieved from the ocean and his death may have been prevented.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

- (i) AMSA (consistent with the recommendation in the Batchelor and Bugeja report February 2003) lead, in collaboration with the seafood industry and the manufacturers of PFDs:
 - a review of existing PFDs currently available in the market to determine suitability for use by commercial fisherman;
 - if existing PFDs are found not suitable for use by commercial fisherman encourage and work with the manufacturers of PFDs to design a suitable PFD that would be acceptable to commercial fishermen and compatible with the appropriate Australian Standard; and
 - engage with the Australia New Zealand Safe Boating Education Group and other industry stakeholders to raise awareness of and support for this work.

I convey my sincere condolences to Mr Garbanzos' family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Lara Firmanes, Senior Next of Kin

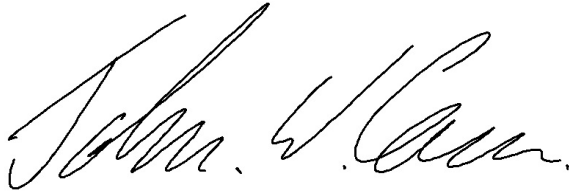
AMSA

WorkSafe

Detective Senior Constable, Madeleine McDonald, Coroner's Investigator

State Coroner Tasmania

Signature:



Judge John Cain

State Coroner

Date: 3 July 2024

NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
