QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the Cause and Circumstances surrounding the death of RICKIE JAMES MAKIN**
TITLE OF COURT:	Coroners Court of Queensland
JURISDICTION:	BRISBANE
FILE NO(s):	2020/1008
DELIVERED ON:	31 July, 2025
DELIVERED AT:	Brisbane
HEARING DATE(s):	3, 4 and 5 February, 2025
FINDINGS OF:	Donald MacKenzie, Coroner
CATCHWORDS:	Coroners: Inquest, Cause of Death: Drowning at Sea; Yacht in Heavy Seas, Adequacy of Safety Briefing; Mandated Safety Equipment; Estuarine vis-a-vis Open Sea Racing.
REPRESENTATION:	
Counsel Assisting:	Mr P. de Plater (Counsel) assisted by Ms S. Ford (Counsel)

For Wynnum Manly Sailing Club:

Mr J.J. Underwood (Counsel)
Instructed by Wotton & Kearney Lawyers

For Mr Ben Stark:

Mr C.D. Coulsen (Counsel) instructed by Kerin Lawyers

For Dr John Chippendale:

Mr S.T. Farrell (Counsel) instructed by Meridian Lawyers

For Mr & Mrs McKay:

Mr C. Pratt (Solicitor) Gilshenan & Luton

Contents

Introduction

1. Rickie James Makin, who was born on 8 February 1976, was 44 years of age when he died on Saturday, 7 March 2020.

2. He died after having fallen from a sailing yacht[1] "*Lady Helena*" into the seas of Moreton Bay at a point about two kilometres to the north-east of the northern end of the Redcliffe Peninsula. The "*Lady Helena*" was involved in a series of "*warm-up*" races for the upcoming Brisbane to Gladstone Yacht Race.

3. Mr Makin fell overboard at about 16:20 hours. At the time, he was a crew member on a 44.7 foot sailing vessel "*Lady Helena".* The prevailing winds were fairly strong, and, as described by the boat's skipper, were gusting to 25 to 30 knots[2].

4. Mr Makin was wearing neither a personal flotation device ("PFD" – "lifejacket") nor any other form of safety equipment when he fell from the yacht. Indeed, at the time Mr Makin fell from the yacht, three out of the six crew members on board "*Lady Helena*", including the skipper, were not wearing PFDs.

5. At the time of these events, there was no requirement, either by virtue of the race rules, instructions given to crew nor legislatively, for those participating in the sailing race, to wear PFDs or any other safety equipment.

6. The owner and skipper of "*Lady Helena*", Benjamin Waldemar Stark, now 75 years of age, was a highly experienced mariner. He had competed in over 20 Brisbane to Gladstone yacht races since 1992. "*Lady Helena"* is a 44.7 foot Beneteau sailing yacht which was built in May 2006. Mr Stark had purchased the yacht in mid-2015 and as at March 2020, "*Lady Helena"* was sound and seaworthy.

7. This fatal marine incident was the subject of a detailed investigation by the Burpengary Forensic Crash Unit of the Queensland Police Service ("QPS") and a comprehensive report[3] was produced. That report, inter alia, concluded that *"The cause of death was drowning which was attributed to a head injury due to the impact with the yacht boom".* The incident was also investigated by both Maritime Safety Queensland and the Australian Maritime Safety Authority, with each entity producing a report[4].

8. Accordingly, a number of questions arose from these investigations which ultimately became the issues at this Inquest:

    a. The findings required by s. 45(2) of the *Coroners Act 2003,* namely the identity of the deceased, when, where and how he died and what caused his death;

---

[1] Throughout these findings, the expressions "yacht", "boat" and "vessel" will be generally used interchangeably as will the expressions "life jacket", "personal flotation device", "PFD" and "PSD".

2 Ex B4, Statement of Benjamin Waldemar Stark para 60

[3] Ex A1
[4] Ex E2

b. the adequacy of the Formal Safety Plan and Risk Assessment and consideration of weather conditions by the Wynnum Manly Sailing Club on 7 March, 2020;

c. the adequacy of the sailing skills, formal or standard training drills, recognised competencies, rescue drills (in particular man overboard skills) and management of safety equipment on the Lady Helena on 7 March, 2020;

d. whether, given the prevailing weather conditions on Moreton Bay during the afternoon of 7 March 2020, the Wynnum Manly Sailing Club and/or the skipper of the "*Lady Helena"* ought to have abandoned participation in the yacht race that day; and

e. whether any legislative or regulatory rules are warranted to mandate:-

    i. the wearing of PSDs and/or other safety equipment during the participation in competitive yacht racing;

    ii. the wearing other items of personal safety equipment which are appropriate; and

f. whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.

9. A useful chronology of the events on 7 March 2020 is as follows:

- 0530 hrs – Mr McDonald, the Principal Race Officer and Starter for the race checked the BOM weather forecast;
- 0800 hrs – crew members of *"Lady Helena"* began arriving at the boat's berth at the Manly boat harbour to commence preparing the boat for the race;
- 1000 hrs – *"Lady Helena"* left its berth with 4 crew on board to undertake a training run in the waters near to Manly;
- 1100 hrs – *"Lady Helena"* returned to port to collect its 2 further crew members;
- 1200 hrs – Mr McDonald again checked the BOM weather forecast;
- 1300 hrs – *"Lady Helena"* arrived at a point near Mud Island and anchored for the crew to rest and have lunch;
- 1400 hrs – the start boat took up position at the start line;
- 1400 hrs – Mr McDonald again checked the BOM weather forecast;
- 1400 hrs – *"Lady Helena"* weighed anchor and headed for the race start line;
- 1445 hrs – Mr Shoesmith, on board the start boat, held a race briefing on VHF radio;

- 1450 hrs – Mr McDonald, for the final time, checked the wind speed using a handheld anemometer which recorded 20 knots gusting to 25 knots;
- 1500 hrs – Race 4 of the Kingfisher Night Series started;
- 1620 hrs – Mr McKay, on board *"Lady Helena"* took note of the time in preparation to call race control via radio to advise of the time of rounding the mark;
- 1620 hrs + 30 seconds – Mr McKay said the boat gybed and Mr Makin hit into Mrs McKay and then went over the side of the boat;
- 1631 hrs – *"Lady Helena"* makes sharp turn to starboard (according to AIS track Ex G2);
- 1659 hrs – emergency call made;
- 1711 hrs – VMR403 Coast Guard Redcliffe vessel CG 32, a 27 foot twin outboard Kevlarlat, left its base at Scarborough and proceeded at full speed in response to the emergency call;
- 1715 hrs – *"Scamp"* arrived on scene and located Mr Makin:
- 1722 hrs – Coast Guard vessel altered course and headed towards a flare which had been observed;
- 1726 hrs – Coast Guard vessel on scene near sailing vessel *"Scamp"*;
- 1730 hrs – Coast Guard vessel sighted and retrieved Mr Makin;
- 1732 hrs – Mr Makin on board Coast Guard vessel, with the vessel returning to port;
- 1745 hrs – Coast Guard vessel returned to port and was met on the dock by QAS paramedics who assisted with CPR;
- An intensive care paramedic arrived on scene and then a second intensive care paramedic arrived;
- Mr Makin was transferred into the back of an ambulance;
- Mr Makin could not be revived.

10. This Inquest had the advantage of considerable expert evidence from experienced and highly regarded mariners and sailors. In the long run, there was considerable agreement in the views expressed by the experts. This meant that the oral evidence given by all of the experts at the Inquest as well as their cross-examination was relatively short, and, largely, uncontroversial.

11. The essential elements which can be discerned from this extensive enquiry into Mr Makin's death are:-

    1. Mr Makin fell into the sea when he was not wearing a life jacket;

    2. as a consequence of distress and/or fatigue and/or injuries, Mr Makin was largely unable to assist with his own rescue; and

    3. the crew onboard the yacht from which Mr Makin fell, were unable to recover Mr Makin back onto the yacht.

12. The most important outcome of this Inquest is the Recommendations made with the assistance of the experts and legal representatives of the persons of interest in this Inquest.

The Coronial Jurisdiction

13. A coroner's powers of investigation are supported by a number of specific powers under the Act. Pursuant to s11 of the *Coroners Act 2003* (the Act), a Coroner may investigate the suspected death of a person if directed to by the State Coroner, and the State Coroner suspects that the person is dead and their death was a reportable death.

14. A coroner investigating a death has a discretionary power to order that an Inquest be held if the Coroner is satisfied it is in the public interest to hold the Inquest (s28(1)). Subject to exceptions, an Inquest must be held by the Coroners Court and in open court (s31(1)). The Coroners Court must publish a notice of the matter to be investigated, the issues to be investigated and of the date, time and place of the Inquest (s32). A coroner holding an Inquest may hold a pre-Inquest conference to decide, inter alia, what issues are to be investigated, who may appear and what witnesses will give evidence (s34). Further, a Coroner holding an Inquest has a discretionary power to order a person to attend an Inquest to give evidence as a witness (s37(4)).

15. Section 45(2) of the Act provides:

    A coroner who is investigating a death or suspected death must, if possible, find:

    a. who the deceased person is; and
    b. how the person died; and
    c. when the person died; and
    d. where the person died, and in particular whether the person died in Queensland; and
    e. what caused the person to die.

16. Further, by s46(1) of the Act a coroner may, whenever appropriate, comment on anything connected with a death investigated at an Inquest that relates to:

    a. public health or safety;
    b. the administration of justice; or
    c. ways to prevent similar deaths from happening in similar circumstances in the future.

17. After considering all of the evidence presented at the Inquest, findings must be given in relation to each of these matters to the extent that they are able to be proved. An Inquest is not a trial between opposing parties but an inquiry into the death (or suspected death). Lord Lane CJ in *R v South London Coroner; Ex parte Thompson* (1982) 126 S.J. 625 described a coronial Inquest in this way:

    > *"…an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment,*

> *there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends,"… (and) … "the function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires."*

18. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorizes a coroner to make preventative recommendations (s46) but prohibits findings being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence (s45(5)).

19. Two important observations should be made: First, whilst this Court, pursuant to Section 3 (d)(ii) of the Coroners Act (Qld) has the object of commenting on matters related to "the administration of justice", it is improper for an inferior Court created by statute, such as the Coroners Court of Queensland, which is not of higher jurisdiction in the appellant hierarchy, to review an order of a another Court of equal or superior jurisdiction such as the Supreme, District and Magistrates Courts of Queensland. Second, I must not include in any Findings any statement that a person is, or may be, (a) guilty of an offence or (b) civilly liable for something pursuant to Section 45(2) of the Act.

20. Second, Judicial officers have no right to critique or criticise a prosecutorial discretion such as whether or not to prosecute a particular charge, to enter a nolle prosequi, to proceed by way of ex officio indictment, to present particular evidence, to decide the particular charge to be laid or prosecuted and what advice is given to the Attorney-General in relation to the lodging of an appeal. In *DPP v Tutera* [2023] VSCA 188, the Victorian Court of Appeal, citing High Court of Australia authority, said:

> *"[79] It is axiomatic that decisions made in the exercise of prosecutorial discretion are not amenable to review or enquiry by the court. (see Barton v The Queen (1980) 147 CLR 75; Maxwell v The Queen (1996) 184 CLR 501 513-514). There is an important constitutional division between the executive and the judiciary with respect to the bringing, maintenance and discontinuance of criminal charges."*

21. The appropriate persons to whom such complaints about prosecuting authorities are the Commissioner of Police, Director of Public Prosecutions or the Attorney-General. Further, as a matter of good public policy, it is undesirous for a judicial or jury verdict to be reviewed by a coroner whose role is primarily a therapeutic one where the standard of proof is on the balance of probabilities and compulsive powers, not permitted in criminal jurisdiction, are available.[5] However, a coroner retains a "residual investigatory function" beyond a review of a previous court's decision within the above-mentioned constraints.[6]

[5] *Domaszewicz v State Coroner* (2004) 11 VR 237 at [81[] and *Rolfe v Territory Coroner [2023] NTCA 8 [53].*

[6] *Mirror Newspapers v Waller* (1985) 1 NSWLR 1 at [16].

22. Section 37 of the Act provides that "*the Coroners Court is not bound by the rules of evidence but may inform itself in any way it considers appropriate*". This flexibility has been explained as a consequence of being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial. However, the rules of evidence and the cornerstone of relevance should not be disregarded and in all cases the evidence relied upon must be logically or rationally probative of the fact to be determined.[7]

23. A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the Briginshaw sliding scale is applicable.[8] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[9] It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[10] This means no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As the High Court made clear in *Annetts v McCann*[11] this includes making submissions against Findings damaging to a person's reputation.

24. After considering all of the evidence presented at the Inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved.

25. An Inquest is not a trial between opposing parties but an inquiry into the death. Lord Lane CJ in *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625 described a coronial Inquest in this way:

> *… an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends," … (and) … "the function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires.*

26. The authorities are clear regarding the use of an Inquest with respect to criminal proceedings: '*…it is not the function of a coroner's inquest to provide a forum for attempts to gather evidence for pending or future criminal or civil proceedings*'.[12] Further, '*An inquest is not an investigation into criminal or civil liability. Evidence may be given which is relevant to those issues, but the coroner has to be astute to ensure that before him or her the proceedings are*

---

[7] See Evatt, J in *R v War Pensions Entitlement Appeal Tribunal; Ex parte Bott* (1933) 50 CLR 228 at 256; Lockhart J in *Pearce v Button* (1986) 65 ALR 83, at 97; *Lillywhite v Chief Executive Liquor Licensing Division* [2008] QCA 88 at [34]; Priest v West [2012] VSCA 327 at [14] (Coroners Court matter) and *Epeabaka v MIMA* (1997) 150 ALR 397 at 400.

[8] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

[9] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

[10] *Harmsworth v State Coroner* [1989] VR 989 at 994; Freckelton I., "Inquest Law" in The Inquest Handbook, Selby H., Federation Press, 1998 at p 13

[11] (1990) 65 ALJR 167 at 168

[12] *R v Poplar Coroner ex parte Thomas* [1993] QB 610 (CA), *per* Dillon LJ at 629H, cited with approval *R v Sussex Coroner, ex parte Homberg & Ors* (1994) 158 JP 357 at 372D.

properly conducted with a view to their own legitimate end'.[13] *per* Kennedy LJ, in *R (Mulholland) v HM Coroner for St Pancras* [2003] EWHC 2612 (Admin) at [17] (DC).

27. Importantly, Justice *per* Mullins J in *Atkinson v Morrow & Anor*[14] *stated:*

> '*…the Act prohibits the Coroner from framing a finding in such a way as to appear to determine any question of civil liability or as to suggest that any particular person is found guilty of any indictable or simple offence. This prohibition makes it clear that the fact-finding inquiry of the coroner should not be used for any ancillary purpose for which the coroner has no jurisdiction. The prohibition does not preclude the coroner from exploring facts for the purpose of making the findings required under [s.43(2) of] the Act which may also incidentally have a bearing on civil or criminal liability*'

The Autopsy

28. On 11 March, 2020, a full internal and external autopsy was ordered and performed examining the deceased's body to establish a cause of death. A review of the deceased's medical history, external examination of the deceased's body, CT scans and toxicological testing of the postmortem femoral blood were also undertaken.

29. A summary of the autopsy findings is:

> *"CT SCANS demonstrated a fractured right ulna (bone in the forearm). There was no discernible skull fracture.*
>
> *EXTERNAL POST-MORTEM EXAMINATION showed a man with a large laceration on the top left side of his scalp. There were various bruises on his upper limbs and torso. There was evidence of recent resuscitation efforts. Frothy fluid was present in the mouth, typical of drowning.*
>
> *INTERNAL POST-MORTEM EXAMINATION revealed three contusions on the surface of the brain. The skull itself was intact, with no fracture. There was fluid in the airways and chest cavities, in keeping with drowning.*
>
> *Several rib fractures were present, most likely due to resuscitation efforts.*
>
> *Incidentally, severe three vessel coronary atherosclerosis was identified. Though unrelated to the incident at the time of death, this natural disease process would have hastened death in the setting of head injury and drowning, so is significant.*

[13] *per* Kennedy LJ, in *R (Mulholland) v HM Coroner for St Pancras* [2003] EWHC 2612 (Admin) at [17] (DC).
[14] *At [*2005] QSC 92 at [26], citing *R v Coroner for North Humberside and Scunthorpe, ex parte Jamieson* [1995] QB 1 (CA) at 24 *per* Sir Thomas Bingham MR (judgment of the Court).

HISTOLOGICAL EXAMINATION showed non-specific changes in the lungs, consistent with drowning. Severe coronary atherosclerosis was also demonstrated.

SEROLOGICAL TESTS were non-reactive for HIV, hepatitis B and C.

TOXICOLOGICAL TESTING was performed on post-mortem samples of blood and urine. The following substances were detected in the blood:

- Temazepam (hypnotic): present at low concentration.
- Quetiapine (atypical anti-psychotic agent): present at low level.

No other drugs or alcohol were detected in the blood.

A cannabis derivative was identified in the urine, but not the blood, indicative of previous cannabis use."

30. The experienced forensic pathologist, Dr Williams, initially determined that the cause of death was:

1(a). Drowning, *due to, or as a consequence of;*
1(b). Head injury, *due to, or as a consequence of;*
1(c). Impact with yacht boom.

Other significant conditions:

2. Coronary atherosclerosis.

31. She concluded:

"In summary, this 44 year old man died suddenly and unexpectedly whilst taking part in a sailing competition in Moreton Bay. In rough conditions, the boom of the yacht struck him and he was propelled overboard. He was eventually rescued from the ocean, but could not be revived.

Autopsy examination showed signs consistent with drowning. There was also evidence of head injury, with large scalp laceration and brain contusions. This head injury was likely incapacitating and a significant factor in his death. Incidental severe coronary atherosclerosis was also present.

In my opinion, the cause of death is drowning, due to head injury, due to impact with yacht boom. Coronary atherosclerosis is a significant condition contributing to death. This is based on both the circumstances surrounding death as outlined in the Police report and post-mortem examination with associated testing."

32. Dr Williams noted as "other significant conditions" coronary atherosclerosis. That is the hardening or calcification of the arteries blocking oxygenated blood from the lungs to the heart. It was not a "cardiac event" but rather a factor inhibiting the deceased's dealing with the insult of drowning.

33. Given the state of the evidence in relation to the cause of the deceased's head injury and the circumstances of fall into the water, I asked Dr Williams for an Addendum Autopsy Report dated 19 March 2024. She responded:

> ***"****Additional information was received from the Coroner's Office, with cover letter dated 14 March 2024. This included five witness statements, provided by each of the 5 crew members onboard the Lady Helena yacht, on 7 March 2020, at the time of the incident leading to the deceased's death.*
>
> *In summary, there were no witnesses to the actual sequence of events that lead to the deceased sustaining his head injury when the yacht jibed and he struck his head on an unknown part of the yacht (not specifically the boom). Following this manoeuvre, the deceased was observed to be tangled in the lifelines on the port side, partly hanging out. He was limp and not moving, then shortly after fell into the water.*
>
> *Thereafter, rescue attempts ensued, which were ultimately unsuccessful. During these attempts, he initially regained consciousness and spoke to his crewmate, though appeared dazed and unfocussed. A laceration on the side of his head was observed to be bleeding profusely. Following an attempt to pull him back into the boat, he was noted to lose consciousness, fall into the water and float face-down.*
>
> *The description of periods of altered consciousness is consistent with concussion. In general terms, the absence of associated severe brain injury (of which there was no evidence of at post-mortem examination), one would expect him to recover from the concussion, had he not drowned.*
>
> *Based on this additional information, the cause of death is as stated below. This is slightly different to the original cause of death (issued 11/03/2020), as it is now apparent that the precise part of the yacht that the deceased struck his head on is unknown."*

34. Accordingly, the revised cause of death, which I accept and so find, is:

> 1(a). Drowning, *due to, or as a consequence of;*
> 1(b). Head injury, *due to, or as a consequence of;*
> 1(c). Impact with yacht.
>
> *Other significant conditions:*
>
> 2. Coronary atherosclerosis.

35. It seems clear from Dr Williams' supplementary Report that, although Mr Makin's described periods of altered consciousness in the water were consistent with concussion, in the absence of associated severe brain injury (of

which there was no evidence at post-mortem examination), one would have expected Mr Makin to have recovered from the concussion had he not drowned.

36. An expert toxicology report was also obtained from a Forensic Physician, Dr Jessica Page. Dated 25 September 2024[15], is highly suggestive that the traces of therapeutic or recreational substances referred to in the Toxicology Certificate of Analysis, dated 9 April 2020[16], most likely did not contribute significantly to the death or to the effects of Mr Makin's concussion.

The Inquest

37. The Inquest into the death of Rickie James Makin was held over three days on 3, 4 and 5 February 2025. There had been two Pre-Inquest Conferences. These were held on 20 May 2024 and 9 August 2024.

38. Mr Makin's death had been the subject of a detailed and thorough investigation by the Queensland Police Service, and, the police officers involved ought be commended for their comprehensive work which is apparent from not only the Form 1 Report to the coroner[17] but also the content of the extensive Brief of Evidence which, of course, was tendered at the commencement of the Inquest[18].

39. Leave to appear at the Inquest had been granted to the legal representatives of:-

- the Wynnum Manly Sailing Club;
- Mr Benjamin Stark, the owner and skipper of the sailing yacht, "*Lady Helena*";
- Dr John Chippendale, a crew member of the sailing yacht, *"Lady Helena",* and;
- Mr Glen McKay and Mrs Anne McKay, crew members of the sailing yacht, *"Lady Helena".*

40. Oral evidence was received at the Inquest from:-

1. Anthony David Shoesmith, a member of Wynnum Manly Sailing Club's race control who was present on the start boat, was the maker of a written statement[19] and was a person who was able to adopt the statement of the Principal Race Officer and starter, George McDonald[20] who had been excused from attending to give evidence on the grounds of ill health;

[15] Ex E7 Toxicology Report, Dr Jessica Page
[16] Ex A3
[17] Ex A1
[18] T 1-8, l25
[19] Ex B7 Statement of Anthony David Shoesmith
[20] Ex B6 Statement of George Moreton McDonald

2. Benjamin Waldemar Stark, the owner and skipper of the sailing yacht, "Lady Helena" and the maker of a written statement[21] and attachments[22] and a participant in a Record of Interview[23];

3. Louise Ann Stark, a crew member of the sailing yacht, "Lady Helena" and the maker of a written statement[24];

4. Glen William McKay, a crew member of the sailing yacht, "Lady Helena" and the maker of a written statement[25];

5. Anne Morag McKay, a crew member of the sailing yacht, "Lady Helena" and the maker of a written statement[26];

6. John Andrew Chippendale, a crew member of the sailing yacht, "Lady Helena" and the maker of a written statement[27];

7. Peter Andrew Kerr, the skipper of the sailing yacht, "Pagan" and the maker of various written documents and photographs[28];

8. Jack Andrew Kerr, a crew member of the sailing yacht, "Pagan" and the author/recipient of various emails[29];

9. James Glissan, the author of expert reports[30];

10. Michael James Job, the author of an expert report[31];

11. Raymond James Shaw, the author of expert reports[32];

12. Donald Buckley, the author of expert reports[33];

13. Ben Jason Callard, currently Australian Sailing head of community support and events, but formerly a regional manager of Australian Sailing and the maker of a written statement[34], and;

14. Peter Tynan Campbell-Burns, the proprietor of MarineSafe Australia Pty Ltd and the maker of a written statement together with attachments[35].

---

[21] Ex B4 Statement of Benjamin Waldemar Stark
[22] Exs B4.1 to B4.9, B4.11
[23] Ex B4.10
[24] Ex B5 Statement of Louise Ann Stark
[25] Ex B3 Statement of Glen McKay
[26] Ex B2 Statement of Anne Morag McKay
[27] Ex B1 Statement of John Andrew Chippendale
[28] Exs B63 to B63.4
[29] Ex B62
[30] Ex E6 to E6.2, Expert Report, James Glissan AM ESM KC, Supplementary Report, James Glissan AM ESM KC
[31] Ex E8, Expert Report, Michael Job MRIN
[32] Exs E5 to 5.2, Expert Report, Dr Ray Shaw
[33] Exs E4 and E4.1, Expert Report, Don Buckley, Marine Surveyor
[34] Ex B46, Statement of Ben Jason Callard
[35] Ex B65 to 65.5, Statement of Peter Tynan Campbell-Burns

Issues for the Inquest

41. The formal issues for the Inquest were:-

    a. the formal findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death;

    b. the adequacy of the Formal Safety Plan, Risk Assessment and consideration of weather conditions by the Wynnum Manly Sailing Club on 7 March, 2020;

    c. the adequacy of the sailing skills, formal or standard training drills, recognised competencies, rescue drills (in particular man overboard skills) and management of safety equipment on the Lady Helena on 7 March, 2020;

    d. whether, given the prevailing weather conditions on Moreton Bay during the afternoon of 7 March 2020, the Wynnum Manly Sailing Club and/or the skipper of the "Lady Helena" ought to have abandoned participation in the yacht race that day;

    e. whether any legislative or regulatory rules are warranted to mandate:-

        i. the wearing of PSDs and/or other safety equipment during the participation in competitive yacht racing; and,

        ii. the wearing other items of personal safety equipment which are appropriate;

    f. whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.

The evidence

42. Critically, there was little, inconsequential or no factual disputes in relation to the evidence before the Inquest. None of the legal representatives for persons given leave to have such representations criticised the following summary provided by Counsel Assisting[36]:

    "On 7 March 2020, "Lady Helena" was competing in the fourth and final race of a yacht racing series, known as the Kingfisher Night Series. According to the yacht's then owner and skipper, Mr Stark, the night series provides a great opportunity to work up the boat and the crew to participate in the Brisbane to Gladstone yacht race. The race series is undertaken on an annual basis. In 2019/2020, the four races in the night series were held on 12 October 2019, 9 November 2019, 8 February 2020 and 7 March 2020. Each race was organised by a different sailing club (Race 1 = Queensland Cruising Yacht Club; Race 2 = Royal Queensland Yacht Squadron and Race 3 = Moreton Bay Boat Cub). The

[36] Counsel Assisting Submissions paras 15 to 69

Wynnum Manly Sailing Club hosted Race 4 each year including the subject race on 7 March 2020[37]*.*

Mr Stark, who was at the time rising 73 years of age, was a highly experienced mariner. He served in the Royal Australian Navy for 20 years and began operating larger sailing yachts (35 feet and above) in 1994. Over the years, he had owned and operated several sailing yachts and, for over 25 years, had operated a yacht charter business and sailing school. He held a Master Class 5 (Sail Operations) commercial certificate of competency since 1993, and, after licencing transferred to the Commonwealth authority in 2012, he obtained a Certificate of Competency (No. QC041442) as Master <24m Near Coastal on 3 November 2017. Mr Stark has been racing in sailing dinghies since he was 16 years of age. He had competed in over 20 Brisbane to Gladstone yacht races since 1992 and he had competed in various other race series events as either skipper or crew[38]*.*

"Lady Helena" was a 44.7 foot Beneteau sailing yacht which was built in May 2006. Mr Stark had purchased the yacht in mid-2015[39]*.*

As at March 2020, "Lady Helena" was sound and seaworthy. Whilst it did not have a current Certificate of Survey, it did have a current Certificate of Operation. Mr Stark said that he thought he only required a Certificate of Operation and that this substituted for a Certificate of Survey. His view in this regard was incorrect, and, as a Domestic Commercial Vessel, "Lady Helena" also required a Certificate of Survey. Mr Stark was breached in this regard. He accepted the breach. Soon afterwards, "Lady Helena" underwent a survey. No issues were found which could be regarded as having contributed to the incident.

The master and crew of "Lady Helena" varied slightly from race to race. For Race 4 in the night series, Mr Stark was the master and there were 5 other crew members, Louise Stark, Glen McKay, Anne McKay, John Chippendale and Mr Makin. They were all experienced sailors and had often sailed together over the years.

Mr Stark said[40]*:-*

I have known all of the crew members that participate with me in the racing events for many years. They are all experienced sailors, and have sailed together often over the years. I know that I can rely on them to look after their own safety when moving around a sailing vessel because of their experience and the training they have undertaken. I have full confidence that my crew know their role while they are on board the vessel, are able to self-assess their safety in the circumstances, know what to do when tacking or jibing, know what to do in an emergency situation, and also know when they should be wearing their personal flotation device. (PFD).

The subject race was due to start at 3 p.m. and the course of the race was from a point off Mud Island, around a turning point off Castlereagh Point at Redcliffe, across Moreton Bay and then back across the bay, finishing at Mud Island.

[37] Ex B9 – Statement of Neil James Planck, para. 9
[38] Ex B4 – Statement of Benjamin Waldemar Stark
[39] Ex B4 – Statement of Benjamin Waldemar Stark
[40] Ex B4 – Statement of Benjamin Waldemar Stark para 36

On the morning of the race, "Lady Helena" was berthed at the Manly boat harbour.

According to Mr Stark, at about 10 a.m. on the day of the race, he and the crew, except for Glen and Anne McKay (who were going to join the boat later), went out in "Lady Helena" for a training run in the waters near to Manly. The training run largely involved sail drills and course plotting. They returned to Manly boat harbour at 11 a.m. to collect the McKays.

Mr Stark said that the boat arrived at a point near Mud Island at about 1 p.m. where they anchored and stopped for lunch. The crew rested and Mr Stark slept for about 30 minutes. They weighed anchor at about 2 p.m. and headed for the start line.

The wind was about 20-25 knots. The organisers moved the start line due to the wind conditions. Mr Stark said that "we" decided on a No. 2 reef in the main and No. 4 jib. He felt that this reduced sail configuration was a very conservative sail choice for racing.

According to Neil James Planck[41], an experienced sailor who has held leadership positions at the Wynnum Manly Yacht Club, having first joined the club in 1989, each club is in charge of its own race, obtains a Water Permit (in fact an Aquatic Event Authority from MSQ) as well as obtaining "Race Instructions" from the Kingfisher Night Series website. Mr Planck was the overall co-ordinator of the Kingfisher Night Series. Each club also appoints a Race Controller and RC boat which acts as the starting boat.

George Moreton McDonald[42] was the Principal Race Officer and Starter for the race. His 36 foot displacement cruiser vessel was used as the start boat. He was on board the start boat with Anthony David Shoesmith[43] and Peter Blanchard. At about 2 p.m., the start boat took up position at the start line, about 1 nautical mile to the west of Mud Island. There were 11 yachts logged to participate. "Sassy" and "Trouble and Strife" advised the start boat that they would not be racing.

Before the race, Mr McDonald checked BOM weather forecasts on 3 occasions, at 5:30 a.m., 12:00 p.m. and 2 p.m. He was aware that that the forecast was for south-easterly winds gusting up to 25-30 knots with seas at 2 to 3 metres. A strong wind warning was in place. He also checked the wind speed using a handheld anemometer several times. The last of such readings was taken at 2:50 p.m. when it recorded 20 knots gusting to 25 knots[44].

Mr McDonald said that, at 2:45 p.m., a race briefing was held by Mr Shoesmith over VHF radio. The briefing covered repositioning of the start line, the currency of the strong wind warning and the fact that the start boat would later be anchoring off St Helena Island rather than being on position on the finish line.

Mr McDonald said that the race started at 3 p.m. with the yachts "The Muse" and "Invader" withdrawing shortly after the start.

---

41 Ex B9 – Statement of Neil Planck
42 Ex B6 – Statement of George Moreton McDonald
43 Ex B7 – Statement of Anthony David Shoesmith
44 Ex B6, Statement of George Moreton McDonald paras 22, 23

From the start line near Mud Island, the competing yachts headed in a generally north-westerly direction towards a green beacon at North Reef also known as the Castlereagh Point Beacon. It was necessary for the yachts to pass around the western side of this mark and then turn to the east to sail across Moreton Bay towards Moreton Island.

Mr Stark said that after the race start, he was sailing conservatively because the conditions were gusting to 25 to 30 knots[45]*. He continued to sail conservatively on the second leg. He said that he was planning to gybe around the mark at Castlereagh Point which involved an approximately 100 degree turn to starboard. He took over the helm and was focussing on the upcoming challenging manoeuvre. He requested that two crew (instead of the usual one crew member) attend to the headsail and that two crew members attend to the mainsail. He did not nominate any particular crew member for any particular task but relied on the crew's own training*[46]*.*

There are some conflicts in the evidence as to the precise manoeuvre that was to occur and, in fact, did occur at the Castlereagh Point mark.

Perhaps some consideration of certain boat manoeuvres may assist to understand what happened.

When a sailing boat is in motion due to wind blowing on its sail(s), it is said to be on a starboard tack if the wind is blowing across the starboard (right side when facing forwards) side on the vessel in which case the boom of the vessel's mainsail would be out over or towards the port side of the vessel. Conversely, if on a port tack, the wind is blowing across the port (left side when facing forwards) side on the vessel with the boom out towards the starboard side.

A sailing vessel can change from a port tack to a starboard tack (and vice versa) in essentially one of two ways. It can "turn about" which means that the vessel turns towards the direction from which the wind is blowing such that the bow or front of the boat, at some stage, points at and passes through the direction of the wind when changing from one tack to the other. This manoeuvre is also referred to as "a granny gybe". Alternatively, the vessel can perform a "gybe" which is when the vessel turns away from the direction in which the wind is blowing such that, as the vessel turns, the wind is always blowing from the stern or back of the vessel as it changes from one tack to the other.

Traditionally, a gybe is the more powerful manoeuvre as the wind is blowing into the sails throughout the turn. "Turning about" can sometimes be problematical because, as the vessel changes direction, there is a moment or two when the vessel is pointing directly into the wind. A sailing vessel is said to "in irons" when it is pointing directly into the wind. On occasions, when a sailing vessel is in irons during a turn, instead of the vessel continuing to turn through the direction of the wind, the wind and/or sea actually push the nose of the boat back towards the direction from which it started.

On the day of the race, "Lady Helena" was on a port tack, heading in a generally north-westerly direction towards the Castlereagh Point green beacon. It was necessary to round the beacon on the beacon's western side. This meant the green beacon would have been and remained on "Lady Helena's" starboard

[45] Ex B4, Statement of Benjamin Waldemar Stark para. 60
[46] Ex B4, Statement of Benjamin Waldemar Stark paras 67, 68

side. After rounding the mark, "Lady Helena" (as mentioned above) was to turn about 100 degrees, towards the east, and head across Moreton Bay towards Moreton Island.

Its turn, at the mark, could have been achieved by "Lady Helena" in one of two ways. It could have made a 100 degree turn to starboard (its right). Having regard to the prevailing wind direction (roughly south-easterly), a turn to starboard would have been a gybe. Alternatively, once past the mark, "Lady Helena" could have turned 260 degrees to port (its left) to achieve the same result and still head off across Moreton Bay towards Moreton Island. This would have been a granny gybe. In other words, it could have achieved its required direction change by turning to the right through approximately a quarter of a circle or alternatively turned to the left through approximately three quarters of a circle.

In his statement[47], Mr Stark said that he had to gybe around the marker buoy.

In evidence[48], despite his earlier statements to the contrary, Mr Stark said that the plan was to do a granny gybe around the Castlereagh mark.

This evidence, indeed, accords with Dr Chippendale's recall. In his statement[49], Dr Chippendale said that as they approached the North Reef mark (i.e. Castlereagh Point mark), Mr Stark explained that they were going to do a granny gybe "again". Dr Chippendale explained that earlier on, when Mr McKay was at the helm, the crew had attempted a granny gybe but had "got stuck" and were "pushed back the way they came".

However, notwithstanding the planned turn, it transpires that "Lady Helena" actually gybed around the mark. This seems to be accepted by most, if not all, of the crew.

It also appears to be confirmed by the AIS track, more particularly that shown in Ex G4. This track seems to show that as "Lady Helena" approached the turning mark it took a wide sweep to its port, well past the mark. This suggests that the skipper intended to perform a granny gybe and was giving himself enough room to make the three quarters of a circle turn to the left. However, the same AIS track shows that, in fact, "Lady Helena" executed a sharp turn to the right, thus supporting the evidence that it actually performed a gybe.

The significance of this issue is that the wind and sea conditions were fairly challenging. The winds were strong and the seas were running with about a two metre swells. The conservative manoeuvre for rounding the mark would have been a granny gybe. The crew were indeed preparing for a granny gybe. What most probably occurred is that the "Lady Helena" was unsuccessful in completing its granny gybe and was pushed back in the direction from which it had started but then, either deliberately or unintentionally, executed a sudden gybe. This manoeuvre would have been significantly more violent than a granny gybe. Also, it was probably unexpected and took the crew by surprise.

The violence of the turn combined with the challenging conditions resulted in Mr Makin's falling to the deck of the vessel. It may be that he was struck by the swinging boom or its main sheet or that he simply lost his footing and fell down.

[47] Ex B4 Statement of Benjamin Waldemar Stark para. 64
[48] T1-38, l8
[49] Ex B1 Statement of John Andrew Chippendale para 24

He suffered a gash to his head which may have been caused by him being struck by a moving part of the vessel or by his striking his head on a hard object when he fell. The Police report noted that there was some blood on one of the deck winches.

In any event, after Mr Makin fell to the deck of the boat, he then fell into the sea. He was not wearing any personal floatation device (PFD) nor any harness nor was he in any other way attached to the boat.

It was accepted as common knowledge by the crew, that PFDs would be worn after sunset. According to Mrs Stark, after the start of the race, the crew had a discussion to the effect that once they rounded the mark at Redcliffe, the crew would prepare to don PFDs and have personal torches ready for the sail across the bay to the yellow special mark at the Sandhills on Moreton Island. As will be referred to below, the race rules mandated the wearing of PFDs for night sailing.

Immediately before he fell to the deck, Mr Makin was positioned towards the stern of the yacht on the starboard side in a section called the cockpit. He was positioned there in order to operate the starboard mainsail sheet (the rope used to adjust the position of the boom at the bottom of the mainsail) and its corresponding winch. Mr Stark was at the helm (or the steering position), which was located along the centre line but a little further towards the rear of the vessel. Mrs McKay was positioned to operate the port mainsail sheet and its winch. Mrs Stark was in front of Mr Makin and was positioned to operate the starboard headsail (that is the sail at the front of the yacht) sheet and its winch. Dr Chippendale was positioned to operate the port headsail sheet and its winch. Mr McKay, who had just handed over control of the yacht to Mr Stark, was in the vessel's cabin at its "nerve" centre, in preparation for using the radio to inform race control when "Lady Helena" rounded the green beacon. Mr McKay noted the time as 4:20 p.m.

None of the crew members can say that they saw Mr Makin being hit by the swinging boom. In fact, no one can say how or why Mr Makin fell to the deck.

Mr Makin was observed lying on the deck of the yacht on the port side. He then fell into the sea.

Mrs McKay said that she heard a groan and then saw that Mr Makin was no longer where she had last seen him, in the cockpit, but was laying (sic) length ways on the deck on the port side with his torso up against the stanchion. She described him as appearing unresponsive and motionless.

Mrs Stark said Mr Makin was washed through the rails and she called out "Rickie in the water and unconscious".

Dr Chippendale said that he was looking to the front towards the headsail and was adjusting the port headsail winch. He then heard a noise that made him look behind him and saw Mr Makin tangled in the "lifelines" (the yacht's side wire guardrails) with his body hanging limp out through the lifelines. A couple of seconds later, he saw Mr Makin go through the lifelines and into the water. Mr Makin was floating away from the boat face down[50]*.*

[50] Ex B1, Statement of John Andrew Chippendale para. 26

Dr Chippendale thought that he threw the aft port side life ring into the water before he himself jumped into the water from the stern port side of the boat. His PFD automatically inflated when he hit the water. He swam towards Mr Makin who then appeared to regain consciousness and lifted his head out of the water. Dr Chippendale took the life ring to Mr Makin and pulled Mr Makin partially up and over the top of the life ring. Mr Makin vomited numerous times and said he couldn't breathe properly. Dr Chippendale saw that Mr Makin was bleeding profusely from a head wound to which Dr Chippendale tried to apply pressure whilst also holding the life ring with the other hand. Dr Chippendale tried to reassure Mr Makin. He asked if Mr Makin had any allergies and Mr Makin said "No".

Dr Chippendale said that he was thrown a line which he swam to retrieve before returning to Mr Makin. There was not enough slack to tie the line onto the life ring, but he was able to do 2 turns around the life ring.

As they got closer to the boat, the man overboard strop with a clip was thrown to them but there was no location on Mr Makin for attaching the clip as Mr Makin was not wearing a PFD or harness. Mr Makin suggested clipping the strop to the life ring, so Dr Chippendale clipped it to the rope around the front edge of the life ring. Dr Chippendale put the life ring over Mr Makin's head and Mr Makin's arms were through it. He was being pulled towards the starboard side of the boat.

At this point, Dr Chippendale was exhausted and feared for his own life. He pulled himself onto the stern of "Lady Helena". He could not see Mr Makin who was at the starboard side of the boat. When he next saw Mr Makin, he had lost consciousness and was floating face down in the water. The crew asked if Dr Chippendale could go back in the water, but he had taken off his bulky life jacket, was exhausted and said that he could not go in again. Mr McKay then jumped in the water.

Mrs Stark sought to confirm that the skipper had a visual on the man overboard. The sails had been dropped and she noticed that both life rings had been deployed. She had seen Dr Chippendale in the water with one life ring. She said that on each attempt that was made for the boat to come alongside Dr Chippendale and the man overboard, waves would push them away. A heaving line was thrown to Dr Chippendale, and both Dr Chippendale and the man overboard were winched towards the boat. Ms Stark saw Mr Makin who appeared grey and ashen with glazed eyes.

Mrs Stark passed the starboard spinnaker halyard with the extender strop to Dr Chippendale who attached it to the life ring. She pulled the two men in the water towards the starboard aft quarter, with Mr McKay on the port winch. She and Mr McKay slowly started to pull Mr Makin out of the water. She tried to lift the life ring but it was too heavy. At that time, Mr Makin was holding on to the life ring. Mr Makin looked up at Mrs Stark and said "Loui, I cannot hold on". She endeavoured to reassure him. He then said "Loui, I have to go". Mr Makin then let go of the life ring and dropped back into the water. Mrs Stark did not see Mr Makin's head out of the water after that.

Mrs Stark then undid the life ring from the halyard and threw it back in the water. She also tossed over the inflatable dan buoy, but, instead of automatically inflating, it simply sank. Dr Chippendale had climbed back onto the boat and Mr McKay jumped in the water and swam towards Mr Makin. Mr McKay was

able to take hold of a line as well as hold Mr Makin. They were pulled towards the stern of the boat but the swells kept knocking them away. Mrs Stark said that she could see that Mr Makin was unresponsive.

Mrs McKay recalled that, as the boat gybed, she was hit from behind, she believes by Mr Makin as he fell across the boat. She also fell onto the side of the cockpit, hitting her forehead, arm and elbows. She did not see what caused Mr Makin to fall across the boat. She speculated that he may have been flicked by the mainsheet or lost his balance. She became aware that Dr Chippendale had jumped in the water to assist.

Mrs McKay was aware that Dr Chippendale returned to the boat and that Mr McKay jumped in the water and swam to Mr Makin. Mr McKay inflated his own PFD in an effort to keep Mr Makin's head up out of the water.

Mr McKay's recollection was that while gybing, Mr Makin, who was on the starboard mainsheet position, low side at the start of the gybe, became unbalanced and fell across the cockpit from the starboard side to the port side. He said that Mr Makin hit into Mrs McKay and then went over the side of the boat.

Mr McKay said that the boat commenced a man overboard procedure and that Dr Chippendale released the port life ring and said that he was "going in" as the recover swimmer. Mr McKay released the starboard life ring and advised the skipper of the location and the distance of the two people in the water. The sails were lowered and the engine started. He said that, after 3 or 4 attempts, they were able to pull Mr Makin and Dr Chippendale alongside the starboard stern of the boat but the crew was unable to manually lift Mr Makin on board. A recovery strop was lowered and Dr Chippendale clipped it to the life ring with Mr Makin holding on. Dr Chippendale was then assisted back on to the boat and Mr McKay proceeded to use a winch to wind in the recovery halyard attached to the life ring while Mr Makin held on to the life ring.

Mr McKay said that during the raising of the life ring, with Mr Makin holding on, Mr Makin called out that he could not hold on anymore and let go. Mr Makin then started to float away from the boat, face down. The recovery strop and halyard were blown up in the air and out of reach. Mr McKay moved to the stern of the boat, jumped in, swam to Mr Makin, inflated his (Mr McKay's) own PFD and secured Mr Makin with his head above water. Mr McKay said that Mr Makin was not showing any signs of life.

After 4 attempts of the boat getting close to them, Mr McKay was able to grab on to the stern boarding ladder while still holding Mr Makin. As Mr McKay was climbing back on to the boat, the sea conditions resulted in Mr Makin being sucked down under the stern of the boat and Mr McKay was forced to let go. Mr McKay saw Mr Makin again float away from the boat face down.

One of the ropes in the water fouled the propeller of "Lady Helena" at which time the boat lost all manoeuvring capability and was unable to continue trying to retrieve Mr Makin.

Subsequently, Mr Makin was retrieved from the water by a Volunteer Coast Guard vessel and CPR was commenced and maintained. Mr Makin was taken

back to the Coast Guard's base at Scarborough where ambulance officers and police officers attended.[51]

Mr Callard stated that Australian Sailing was an organisation affiliated to 51 sailing clubs in Queensland and 360 clubs nationally. He was able to identify what is regarded as the Racing Rules of Sailing[52]*, promulgated by World Sailing and adopted by Australian Sailing as well as Special Regulations promulgated by Australian Sailing and current as at 7 March 2020*[53]*. Affiliated clubs conducted sailing racing subject to these Rules and Regulations.*

The subject race conducted by the WMSC on 7 March 2020 was a race which fell in Category 5[54] *as defined in Section 2.01 of the Special Regulations*[55] *- "Races with limited rescue availability, in protected waters, in daylight hours or in sheltered waters at night". The particular race category had the additional feature of including the letter "N", as the race extended into hours of darkness*[56]*, and, the letter "N" indicates that "that the item is mandatory for night sailing".*

Personal equipment (including life jacket) requirements are referred to in Section 5 of the Special Regulations[57]*.*

Mr Callard was unsure of the precise procedure for rule changes by Australian Sailing but referred to the existence of a national safety committee which could make recommendations to the Board of Australian Sailing.

Mr Campbell-Burns, the long term proprietor of a company that sold and serviced life jackets, life rafts, dan buoys and all other inflatable safety equipment had, in March 2018, serviced and replaced the cylinder (carbon dioxide gas) Mr Makin's inflatable life jacket[58]*.*

It seems that neither Mr Campbell-Burns' firm nor another business which undertook similar work had serviced or certified any life jacket for Mr Makin after that date[59]*. Nothing particularly turns on this lack of annual certification.*

Mr Campbell-Burns helpfully explained the operation of inflating life jackets, both manual and automatic, and the importance of the fitting of crotch straps to life jackets. His business sold a range of inflating life jackets, varying in price from $187.00 up to $580.00, the latter being the type of life jacket used by serious off-shore sailors[60]*.*

Some life jackets contain a tether point although this is not a lifting device[61] *and some life jackets are also fitted with electronic radio beacons such as personal EPIRB's which are linked to the National rescue service in Canberra, AMSA, or AIS beacons which are linked to local craft operating on the same frequency*[62]*.*

---

[51] Submissions of Counsel Assisting paras. 71 -79
[52] Ex 9.4 World Sailing 2017 – 2020 Racing Rules of Sailing
[53] Ex F16.1, Australian Sailing, 2017-2020 Blue e-Book, Special Sailing Regulations
[54] T3-5, l30
[55] Ex F16.1, Australian Sailing, 2017-2020 Blue e-Book, Special Sailing Regulations page 13
[56] T3-5, l40 and Ex F16.1 page 6
[57] T3-6, ll1-37 and Ex F16.1 pages 73-74
[58] T3-12, ll11-17
[59] T3-13, l9
[60] T3-14 to 3-15
[61] T3-15. l43
[62] T3-16 to 3-18

Mr Campbell-Burns also gave evidence about the operation and serviceability of the dan buoy, an automatically inflating floating marker pole". [63]

The expert evidence

43. This Inquest had the advantage of considerable expert evidence from experienced and highly regarded mariners and sailors.

44. It would not do justice to the detail brought to bear by the experts to attempt to summarise their views in narrative form.

45. The expert evidence given by Messrs Glissan, Job, Shaw and Buckley has been conveniently analysed in Attachment A, together with the recommendations made by each of them on the various issues upon which they were asked to comment. Mr Glisson and Mr Job provided first class expertise and their collaboration enabled the Inquest to progress through a large volume of evidence.

46. In the long run, there was considerable agreement between the views expressed by the experts. This meant that the oral evidence given by all of the experts at the Inquest as well as their cross-examination was relatively short, and, largely, uncontroversial.

The Issues

47. As stated there were effectively six issues identified for this Inquest. The first involved the formal findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death. These are uncontroversial and will be stated in the conclusion. The remaining five, I will deal with in turn.

b. the adequacy of the Formal Safety Plan, Risk Assessment and consideration of weather conditions by the Wynnum Manly Sailing Club on 7 March, 2020;

48. In relation to this issue Counsel Assisting opined[64]:

"It seems apparent that no formal safety plan or risk assessment was undertaken and documented for this particular yacht racing event, despite a pro-forma "Risk Assessment" document being provided as Appendix 1 to the Wynnum Manly Sailing Club and Wynnum Manly Yacht Club (on water activities) Safety Management Plan (see Ex F14 and its Appendix 1 at page 27 of 29).

Whilst it seems trite to recommend the desirability of such a formal plan or assessment, sailing clubs are generally staffed by volunteers who perhaps do not have the skills, wherewithal or resources to provide the same level of

[63] T3-19, l42 to T3-20, l32"
[64] Counsel Assisting Submissions paras. 87-91

safety auditing as would be expected from say a modern industrial workplace.

Other than cancelling or abandoning the yacht race, it is unlikely that the provision of a formal documented safety plan or risk assessment would have altered the outcome for Mr Makin.

The racing rules and regulations permitted the race to proceed despite a strong wind warning. The race would have necessarily been abandoned by the same rules and regulations if gale force winds were forecast. It is commendable that Mr McDonald and Mr Shoesmith were constantly monitoring the wind speed and that the strong wind warning was mentioned during the pre-race briefing.

It is likely that the yachting community would be aghast if a recommendation was made to cancel yacht races if the wind speed exceeded 20 to 25 knots."

Wynnum Manly Sailing Club

49. Mr Underwood for the Wynnum Manly Sailing Club ("WMSC") made a number of submissions that a pre-race risk assessment was undertaken but not documented. He contended that the "evidence supports a finding that a risk assessment was not "documented" but not a finding that a risk assessment was not "undertaken". With respect, he misunderstands the point that a written or recorded risk assessment shows beyond doubt that WMSC did undertake a formal and comprehensive risk assessment so that there is evidence of it and compliance can be adjudicated. He relies on the evidence of Mr Anthony Shoesmith that following enquires regarding wind speeds, he and another official, Mr McDonald had determined *"weather conditions were not likely to further deteriorate, and that gale force conditions during the race were very unlikely to occur. … Accordingly, we considered that it was permissible and appropriate to allow the race to proceed."*[65]

50. This, in my view contradicts Mr Shoesmith's first account at paragraph [27] where he stated[66]: "*there was no formal risk assessment conducted by RC prior to the race".* Mr Shoesmith attempted to water down that contradiction by stating that formal meant *"written"* and that a risk assessment was certainly conducted by himself and Mr McDonald. Nevertheless, I agree with Mr Underwood's submission that the distinction between conducting and documenting a risk assessment is perhaps of little moment, given Counsel Assisting's fair acknowledgement that "it is unlikely that the provision of a formal documented safety plan or risk assessment would have altered the fatal outcome.

Expert Opinions

51. I readily accept the evidence of Mr Job that the radio briefing informed the competitors that a strong wind warning was in place. Since the wide adoption of the internet, competitors in sailing races have access to the same weather information as race committees and in many cases far more detailed and higher resolution information from subscription services. Mr Job opined that it was

[65] Submissions of Wynnum Manly Sailing Club paras. 8-9 p2
[66] Ex B7 - Statement of Anthony David Shoesmith, para. 27

highly unlikely that any of the competing yachts had not accessed weather forecast information prior to leaving port on the day of the race. He cited RRS Fundamental rule 3 Decision to race: 'The responsibility for a boat's decision to participate in a race or to continue racing is hers alone.' Mr Buckley opined that it was "reasonable" for the race to have proceeded, and Mr Glisson regarded himself as unqualified to offer an opinion on the matter.

52. I accept Mr Underwood's submission that the evidence does not support a finding that the race should have been cancelled or abandoned, and where no such finding is urged by Counsel Assisting, it is submitted that no such finding should be made**.**

c. the adequacy of the sailing skills, formal or standard training drills, recognised competencies, rescue drills (in particular man overboard skills) and management of safety equipment on the Lady Helena on 7 March, 2020;

53. In relation to this issue Counsel Assisting opined[67]:

> *"This issue strikes at the very knub of the crew of the yacht being unable to recover Mr Makin back onboard the yacht.*
>
> *When he was in the water, Mr Makin spoke to at least Dr Chippendale and Mrs Stark. It is self-evident that he was still alive and conscious at this time. Had he been able to be brought back onboard, it is almost certain, given Dr Williams' views, he could have survived.*
>
> *It is likely that the crew of "Lady Helena" are not alone in this respect, but, there is no evidence that they ever undertook training that closely replicated retrieving a person in the water who was unconscious.*
>
> *Much of the "man overboard" (MOB) training involves either throwing an object, such as a floating boat fender, into the water and manoeuvring the boat to retrieve it, usually with a boat hook. If a person is used in the MOB drill they would invariably be wearing a PFD and, despite attempts to simulate unconsciousness, would no doubt find it difficult to resist the temptation to provide some assistance with their own rescue.*
>
> *The suggestion that drills should include life size and perhaps weighted mannequins for MOB drills is to be commended and recommendations to improve these drills is a good one (see, in particular, the report of Mr Glissan)."*

54. Mr Coulsen for the skipper of the "*Lady Helena"*, Mr Stark, was critical of Counsel Assisting's submission that *"it is quite likely that this sudden manoeuvre took some of or most of the crew by surprise. It probable that crew were expecting to change course by means of a somewhat more conservative manoeuvre referred to as 'turning about' or 'a granny gybe'. It is possible that the gybe was unintended, and the boat was turned in this manner by a combination of the wind direction, the forces on the vessel by the wind and the state of the seas."*[68]

[67] Submissions of Counsel Assisting, paras. 94 -98
[68] Submissions on behalf of Benjamin Stark page 2

55. Mr Coulsen argued that while a granny gybe was first attempted it was unsuccessful but the opportunity to gybe the boat became possible and that he alerted his crew to course before gybing the boat. This was corroborated by Mrs Mackay. Accordingly, it is not correct to conclude that Mr Stark gybed the boat without warning or that the crew were all taken unawares.

56. I accept Mr Coulsen's submission that Counsel Assisting's observation that "*given the prevailing conditions, a safer change of course at the green beacon would have been achieved by a granny gybe rather than a gybe"* was not put to either Mr Job, Mr Glissan or Mr Buckley in those exact terms. I agree that this second submission is conjectural and I do not adopt as a criticism. However, the evidence points to a sudden unexpected "lurch" by the *"Lady Helena"* which was probably the cause of the deceased's loss of balance. That is an unremarkable observation. [69]

Dr Chippendale

57. Mr Farrell's submissions guided by Dr Chippendale on his point were very helpful and I site them verbatim[70]:

> *"Did the Lady Helena perform a Granny Gybe?*
>
> *15. Dr Chippendale's recollection is that the Lady Helena performed a "granny gybe" at the North Reef marker. In the original statements this proposition was attended with some controversy, however it is submitted that by the end of the hearing the evidence was such that the court can approach the question with some confidence.*
>
> *16. It is submitted that given the oral evidence from the crewmembers it is now tolerably clear that the Lady Helena initially attempted a granny gybe, but was unable to tack through the wind. The vessel "backed away" toward starboard and into a sudden standard gybe (whether intended or not). Somewhere in the course of this manoeuvre Mr Makin lost his footing, and fell to the port side of the cockpit, and into Anne McKay. As a result of this collision Mrs McKay sustained a broken arm, further reducing the number of crewmembers available to effectively respond to Mr Makin's recovery from the sea.*
>
> *17. That the vessel initially commenced a granny gybe is also supported by Peter Kerr, the skipper of the vessel Pagan. He stated that the Pagan rounded the Reef Point mark at 4:34 PM, beside the Lady Helena. In his statement he said that the Lady Helena had arrived a few minutes ahead of the Pagan and performed a "granny tack" (Ex B63.3, [16]).*
>
> *18. Mr Don Buckley (Exhibit E4) stated, at paragraph 4.7, that based on the course plot his opinion was that the Lady Helena was "in the middle of a "granny gybe" when the deceased lost his balance and fell". This statement acknowledges the AIS track (Ex G4) which, as noted by Counsel Assisting (at [44] of their submissions), suggests that the skipper of the vessel was manoeuvring the yacht to perform a granny gybe immediately prior to the demonstrated gybe to starboard.*

[69] Submissions on behalf of Benjamin Stark page 2
[70] Submissions on behalf of Dr John Chippendale paras 15 - 25

19. This addresses the concern raised by Mr Glissan, to the effect that if a granny gybe had been performed the accident could not have occurred as described. In fact a granny gybe was attempted, but then the turn was completed as a standard gybe. Dr Chippendale, in his evidence, confirmed that when he observed Mr Makin in the lifelines (necessarily immediately after the gybe was performed), the boom was out to port (as one would expect would be the position after the turn was completed, whichever technique was employed).

20. Mr Glissan went on to state, at page 14 of his first report, that: "The description of the movement of the boom and impact on the several crew members including the injuries to both Ms McKay and Mr Makin are more consistent with an incompletely controlled gybe [Chinese gybe] then with a tack [or granny gybe as it has been referred to by the crew]."

21. In this regard it is important to note, however, that there is no direct evidence that the boom ever made contact with Mr Makin. He may have simply lost his balance or become entangled with the sheets. His physical injuries consisted of a laceration to the superior left head, whereas if he was struck by the boom swinging from starboard to port (a path it would necessarily have had to traverse regardless of the type of gybe performed) one might think the injury would more probably be to the right side of the head assuming he was facing towards the bow.

22. Further Mrs Anne McKay's perception was that she was struck by Mr Makin's falling body, and not the boom. Notably, at [8] of her statement (Exhibit B2) Mrs McKay also expressed the view that the boom was above head height in the cockpit. To this extent the comment made on page 15 by Mr Glissan that "it is clear that … the impact that occurred, sufficient to break Mrs McKay's arm and to render Mr Makin unconscious is strongly suggestive of an uncontrolled gybe" is, of itself, not compelling.

23. Mr Job did not express a view either way. Although he did state that "placing safety considerations ahead of performance in calling for a granny gybe manoeuvre is in accordance with good seamanship in the sea state and conditions prevailing during the race" ([5.14]), no expert (including Mr Job) expressed the opinion that performing a standard gybe would be improper, and indeed there is no evidence that any other yacht performed a granny gybe at the mark. This proposition is reinforced by the fact that despite Mr Glissan forming the view that a standard gybe was the more likely manoeuvre, he did not provide any criticism of Mr Stark's decision in that regard.

24. It is submitted that Mr Stark's evidence, to the effect that he elected to complete a standard gybe once the granny gybe had failed is consistent with the other evidence. There is no basis for specific criticism of Mr Stark in this regard.

25. Further there is (it is submitted) no evidence by which the court could conclude that Mr Makin was actually struck by the boom. One can conclude, however, that he lost his balance (for whatever reason) during the course of the attempted granny gybe/subsequent standard gybe, causing him to fall across to the port side of the cockpit, and into Mrs Anne McKay. At some point during this he struck his superior left head on an unknown object."

58. Dr Chippendale was also very supportive of mandatory "man overboard" training involving a weighted mannequin or actual human being to replicate actual rescue conditions. Whilst I agree with Dr Chippendale entirely, I do not consider the rescue of the deceased was hampered by the lack of such training on the evidence before me.

59. Dr Chippendale also usefully dealt with the issue of body harness vis-à-vis tether points on a regular life jacket. In relation to this tragedy, the deceased was not wearing either, making the point moot. However, there is a clear body of thought that harnesses can impede the loading of a human body onto a vessel or cause further injury. Dr Chippendale's submissions stated[71]:

> *"31. Dr Chippendale encountered a substantial difficulty during recovery. Mr Makin was wearing a T-shirt, but no PFD. There was, accordingly, no harness point to which he could attach the strop thrown to him by Mr McKay and Mrs Stark. Mr Makin was still conscious at this time and suggested attaching the strop to the life ring, which Dr Chippendale did.*
>
> *32. It was observed by both Mr Glissan and Mr Job in their reports that one means of securing a man overboard might be by way of a bowline knot tied under a person's armpits, although neither was expressly critical of this technique not being employed in this case.*
>
> *33. It is submitted that this technique was not a reasonable expectation of Dr Chippendale in the circumstances. He faced the situation of 2-3 m seas, a disabled person who was not wearing a flotation device, and the need to control both the life ring and the line. Additionally, the line that was initially cast to Dr Chippendale had, on his evidence, very little slack, such that he could only wind it twice around the edge of the life ring. A bowline would presumably have required significantly more line. Moreover, when Dr Chippendale left to re-enter the yacht Mr Makin was still conscious, and to Dr Chippendale's knowledge was being lifted aboard the vessel by two other crewmembers.*
>
> *34. Further, as such a technique would inevitably not involve a crotch strap or similar support, insofar that Mr Makin slipped from the life ring, there is every reason to assume he would have slipped from a bowline knot also.*
>
> *35. In the premises, it is submitted that Dr Chippendale did everything which might reasonably be expected of a person in the circumstances and more.*
>
> *36. Mr Glissan ascribed the failure of the recovery to Mr Makin not wearing a PFD (which may be accepted) but also the "difficulty of lifting him aboard the ship".*
>
> *37. The issue of how to recover an unconscious person onto a yacht was the subject of conflicting evidence. The final witness, Mr Campbell Burns, expresses the view in his statement, and also in his oral evidence, that the use of the tether point on a PFD for lifting a person clear of the water would involve a risk of serious injury to that person, including (in his view) spinal injuries. He states that "to lift a person from the water, four points of connection are needed to make a safe lift". He further stated, in his oral evidence, that even a four-point harness (which he thought would be an*

[71] Submissions on behalf of Dr John Chippendale paras 31 - 40

appropriate lifting device) would not be appropriate to be worn on a racing yacht given its bulkiness and stainless steel connections.

38. The fact remains, however, that had Mr Makin been wearing a life jacket with a tether point, he could at least have been secured to the vessel, for recovery by the Coast Guard when it arrived. Moreover, even allowing for the risk of injury identified by Mr Campbell Burns, insofar that such an injury would be preferable to death, at least that option would be available.

39. Notably, no other witness, including Mr Glissan (whose expertise in terms of maritime rescue is unimpeachable) suggested any such limitation. The substantial weight of the evidence was that a PFD with attachment or "tether" points would have facilitated the effective recovery of Mr Makin back on board the yacht.

40. In any event, what can be stated with confidence is that had Mr Makin been wearing a PFD, his death would likely have been avoided."

60. I adopt Dr Chippendale's submissions.

d. whether, given the prevailing weather conditions on Moreton Bay during the afternoon of 7 March 2020, the Wynnum Manly Sailing Club and/or the skipper of the "*Lady Helena*" ought to have abandoned participation in the yacht race that day;

61. This issue was covered under issue b. above.

e. whether any legislative or regulatory rules are warranted to mandate:-

i. the wearing of PFDs and/or other safety equipment during the participation in competitive yacht racing; and,

ii. the wearing other items of personal safety equipment which are appropriate;

62. Counsel assisting made the following submissions[72]:

"There was no rule, regulation nor legislative instrument that mandated the wearing of PFDs at the time Mr Makin fell from the yacht.

Mr Stark was of the view that this could and should be left to the individual crew member to make the decision whether or not to wear a PFD and times when they were not required by the rules or legislatively to do so.

With respect, it is submitted that this attitude is inconsistent with modern approaches to safety.

Those who oppose the mandatory wearing of life jackets would argue that it hampers movement, is uncomfortable and/or that automatic inflation might cause life jackets to unexpectedly inflate if splashed with water. The same opponents would also probably argue that sailing is a dangerous pastime and that participants should be willing to accept the risks involved.

[72] Submissions of Counsel Assisting, paras 100 -116

One wonders whether the same arguments were advanced prior to the mandatory wearing of seat belts in motor vehicles or helmets on motor cycles – activities that similarly carry the risk of death or serious injury.

The simple fact is that had Mr Makin been wearing the very life jacket that he had on board the yacht and was intending to don after the yacht rounded the mark at Castlereagh Point, 10 minutes earlier, he would probably be alive today.

Yacht racing is a pastime that involves some risk to health and safety of its participants. Various fittings on boats are heavy and move quickly and sometimes unexpectedly. Boats, in any kind of weather, can be unpredictable. Crew in sailing races are busy and often focussed on tasks at hand without necessarily paying close attention to what else might be happening around them. As already mentioned, the gybe at the Castlereagh Point mark was probably sudden and unexpected.

If yacht races are undertaken at night, crews are required to wear PFDs, irrespective of the conditions, and yet no complaint or resistance to that requirement is evident.

There seems no sensible reason why, if PFDs are necessary and are worn at night, then, the same ought not apply during the day.

Without hesitation, it is submitted that your Honour would make a recommendation that PFDs be worn at all times during yacht races.

Whilst not binding on Australian Sailing, we submit that, an additional recommendation open to your Honour, is to the effect that its National Safety Committee recommend to the Board, that the Special Regulations be changed so as to require the mandatory wearing of life jackets during all competitive yacht racing.

Such a change could be achieved by deleting paragraphs (g), (h), (i) and (j) in Regulation 5.01.1, adding to the end of paragraph (k) in Regulation 5.01.1 the words "except briefly while changing or adjusting clothing or personal equipment" and making paragraph (k) applicable to Categories 1 2 3 4 5 6 7.

The relevant Queensland legislative instrument which pertains to the wearing of life jackets during boating activities is the Transport Operations (Marine Safety) Regulation 2016.

Section 24 requires ships to be equipped with one required lifejacket for each individual onboard but only mandates the wearing of those lifejackets by children, in open areas of the ship, or when crossing a coastal bar.

Whilst expressions like "smooth waters", "partially smooth waters", "beyond partially smooth waters', "open area (for a ship)", "aquatic events" and "sailing ship" are defined and/or used throughout the Regulation, there are no specific provisions relating to the wearing of lifejackets during competitive sailing events.

Certain aquatic activities are dealt with individually by the Regulation. For example, in relation to waterskiing, Section 199 mandates that a skier must

wear a lifejacket (of a nominated standard) unless participating in a specified skiing event or it is impractical or unsafe to do so.

Accordingly, it is further submitted that a recommendation for amendment to the Regulation is appropriate. To this end, the Regulation ought be amended to, first, include provisions regarding "competitive sailing events", and, secondly, require the wearing of a lifejacket, level 150 or above, by all onboard while in "open areas" of the "sailing ship" during participation in competitive sailing events unless it is impractical or unsafe for the individual onboard to wear such a lifejacket."

63. Counsel Assisting also added[73]:

"92. the Race Control boat could have displayed Flag Y, which would have required all competitors to wear personal floatation devices except briefly while changing or adjusting clothing or personal equipment.

93. It does not seem that it occurred to Race Control on this occasion to invoke the provisions of Rule 40."

Wynnum Manly Sailing Club

64. WMSC submitted openly that the evidence at this Inquest does not support a finding that in was incumbent on the club's Race Control should have required participants to wear PFD's. Mr Underwood noted Counsel Assisting "submits that Race Control "could" have recommended the wearing of PFDs, but not that they "should" have done". That cautious submission was appropriate in his submission. He submitted that the wind and sea state forecasts suggested that the conditions would abate and it was a fundamental Rule 1.2 of the Racing Rules of Sailing (RRS)stating that "Each competitor is individually responsible for wearing a PFD adequate for the conditions".

65 Further, Fundamental Rules 3.1 and 3.3 of the RRS state that, by participating in the race, each competitor agreed to accept the rules and each person in charge of a racing boat agreed to ensure that all competitors were aware of their responsibilities under the rules. Special regulation 5.01(h) of the Australian Sailing Special Regulations(SSR) "highly recommend" the wearing of PFDs by people participating category 5 races when "the true wind speed is 25 knots or above" and the fact that the skippers of the boats involved in the race were all "experienced skippers".

66. Mr Underwood noted that Mr Shoesmith gave evidence that his personal view was that "wearing PFDs should be mandatory when on deck when racing in forecast of prevailing winds of 25 knots or above, regardless of the race *category designation*" but he did not feel it was appropriate for him to have imposed his personal opinion on all competitors. His evidence was that: "when on deck between the hours of sunset and sunrise, and also if the yacht did not have compliant lifelines".

67. Mr Underwood quite correctly noted that in hindsight, it may have been preferrable for Mr Shoesmith to have imposed his personal view on all competitors in the race, but that is beside the point. Even if Race Control had recommended or suggested that PFDs be worn throughout the race, it does not

[73] Submissions on Counsel Assisting, Para 92 - 93

follow that the outcome for Mr Makin would have been different. He may have decided to take up the recommendation; he may have not. I agree that the window of hindsight is the clearest window of all, but this Inquest is looking for mechanisms to prevent death - not attribute blame.

68. No doubt anxious to disestablish WMSC's contribution to this tragedy, Mr Underwood noted:

    (i) Mr.Stark, made it the responsibility of the individual to decide whether to wear a life jacket.

    (ii) All crew members of the Lady Helena had at some time attended the SSSC course and as a result it can be assumed that they would have been aware of the advantages of wearing a life Jacket.

    (iii) Three of the crew chose to wear life jackets during the race and three did not.

    (iv) It was Mr. Makin's' own choice not to wear a life jacket on the day he fell overboard.

    (v) Mr Glissan KC opined that Mr Makin should have been directed to wear a PFD, but that the direction should have come from the skipper of Lady Helena, not Race Control.

    (vi) While the Race Control "could" have recommended the wearing of PFDs, the expert evidence demonstrated that the responsibility for wearing PFDs in fact lay elsewhere.

69. I do not criticise WMSC's interpretation of the mandatory wearing of lifejackets on the day of this death. However, my view is that legislative change is necessary.

Mr Stark

70. Mr Coulsen, for Mr Stark similarly submitted that the wearing of lifejackets is always at the end of the day a matter of personal responsibility and personal safety. He noted that the point was well made by each Mr Peter Kerr and Mr Jack Kerr, each with wide experience in different boat types, in that the type of boat and the nature of the sea state influence their own decision making rather than a single wind limit.

71. He submitted that is accepted that encouraging personal responsibility through regulation is fraught, but one size may not fit all. Equally, caution should be exercised equating the circumstances of recreation undertaken voluntarily with an attendant assumption of risk to that of a workplace.

72. Whilst I accept Mr Coulsen's argument generally, I am of the view that this death would more probably not have occurred if the deceased was wearing a life jacket particularly a PFD with attachment or "tether" points.

f. whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.

73. There were no particular submissions in relation to this "blanket" issue. However, WMSC submitted the following[74]:

> *"(c) Recommendations*
>
> *26. WMSC respectfully supports a recommendation that relevant rules or regulations be amended to provide:*
>
> *All participants in competitive sailing be required to wear PFDs:*
>
> *(a) Whenever wind speeds exceed 25kns; and*
> *(b) At all times between sunset and sunrise, regardless of wind speed.*
>
> *27. WMSC has adopted this rule in all races hosted by it."*

74. Mr Coulsen for Mr Stark made the following general submission[75]:

> *" Lastly, as to Australian Sailing, no time or effort should be wasted making recommendations, as the evidence of Mr Callard demonstrated that Australian Sailing, in the last 11 years had never implemented a recommendation of a Coroner, while the evidence of Mr Shaw appeared to be catalogue of reasons why the committee of which is the chairman would not act on any recommendation."*

Conclusions

75. I make the following factual determinations: -

1. On 7 March 2020, "*Lady Helena*", a 44.7-foot sailing yacht was competing in the fourth and final race of a yacht racing series, known as the Kingfisher Night Series.

2. The subject yacht race was organised and hosted by the Wynnum Manly Sailing Club, which hosted the fourth race of the series each year.

3. The crew of *"Lady Helena"* comprised Benjamin Stark, as owner and skipper, and five other crew members namely, Louise Stark, Glen McKay, Anne McKay, John Chippendale and Mr Makin, all of whom were experienced sailors and had often sailed together over the years.

4. The subject race was due to start at 3p.m. and the course of the race was from a point off Mud Island, around a turning point about two kilometres to the north-east of the northern end of the Redcliffe Peninsula, across Moreton Bay to a point near the Sandhills on Moreton Island and then back across the bay, finishing at Mud Island.

5. The weather forecast for the time of the race was for south-easterly winds gusting up to 25-30 knots with seas at 2 to 3 metres, with a strong wind warning in place.

[74] Submissions on behalf of Wynnum Manly Sailing Club para 26
[75] Submissions on behalf of Benjamin Stark page 3

6. The WMSC appointed a Race Controller and Race Control boat which acted as the starting boat, with George McDonald as the Principal Race Officer and Starter for the race onboard his 36-foot displacement cruiser vessel which was used as the start boat. Anthony Shoesmith and Peter Blanchard were also on the start boat.

7. At 14:45 hours Mr Shoesmith provided a race briefing via VHF radio which covered re-positioning of both the start and finish lines of the race as well as the currency of a strong wind warning.

8. At 14:50 hours Mr McDonald checked the wind speed using a handheld anemometer and recorded winds of 20 knots gusting to 25 knots.

9. The race was conducted in accordance with the Kingfisher Interclub Night Series Notice of Race & Sailing Regulations[76] and Australian Sailing's Racing Rules of Sailing and Special Regulations.

10. The WMSC had in place a generic Safety Management Plan[77], although no specific safety management plan was developed and published for this specific event.

11. No rule, regulation or legislative instrument required those sailing on board vessels in the race to wear PFDs (lifejackets) during the daylight hours of the subject yacht race. The Special Regulations 1.01.4(a), 2.01.6 and 5.01.1(k) only mandated the wearing of lifejackets complying with AS4758-2015 (minimum Level 100) or AS1512-1996 Type 1 (not less than 100N) or an equivalent or more stringent overseas standard for night sailing.

12. Despite all crew of "*Lady Helena*" having their own personal lifejackets onboard the vessel, from the start of the race until Mr Makin fell into the waters of Moreton Bay, only Glen McKay, Anne McKay and John Chippendale were wearing their lifejackets.

13. Race Control had not suggested nor insisted that those competing in the yacht race ought to wear their lifejackets before sunset.

14. Mr Stark, as skipper of "*Lady Helena"* had not suggested nor insisted that his crew ought to wear their lifejackets before sunset.

15. From the start line near Mud Island, "*Lady Helena*", together with the other yachts competing in the race, headed in a generally north-westerly direction towards a green beacon at North Reef also known as the Castlereagh Point Beacon.

16. As "*Lady Helena*" approached the beacon, Mr Stark was at the helm.

17. In the vicinity of the beacon, and at about 1631 hrs, "*Lady Helena*" changed course from a port tack to a starboard tack by means of a sharp turn, known in sailing jargon as a gybe.

[76] Ex 9.2 and F15
[77] Ex F14 Wynnum Manly Yacht Club, Safety Management Plan (On water activities) WMSC, WMYC 2020

18. It is likely that this sudden manoeuvre took some or most of the crew by surprise. It is possible that the crew were expecting to change course by means of a somewhat more conservative manoeuvre referred to as "*turning about"* or "*a granny gybe".* It is quite possible that the gybe was unintended, and the boat was turned in this manner by a combination of the wind direction, the forces on the vessel by the wind and the state of the seas. All of this is conjecture but more importantly unremarkable in the sense of the dynamics yacht racing in heavy winds and seas.

19. Given the prevailing conditions, a safer change of course at the green beacon might have been achieved by a granny gybe rather than a gybe. However, I do not consider the helmsmanship of Mr Stark to be in error or reckless.

20. When *"Lady Helena"* gybed at the green beacon, Mr Makin who was positioned towards the stern of the yacht on the starboard side in a section called the cockpit and where he was operating the starboard mainsail sheet and its corresponding winch, lost his footing and fell to the deck of the yacht.

21. As none of the crew can say why Mr Makin fell, it is unclear whether he was struck by the swinging boom or the main sheet or whether he might have slipped and fell, striking his head on a hard surface of the yacht such as the deck or a winch. What is clear is that after Mr Makin fell to the deck he was suffering from a significant wound to his head.

22. After Mr Makin fell to the deck, he then fell from the yacht and into the waters of Moreton Bay.

23. When Mr Makin fell into the water, he was not wearing any PFD nor any harness nor was he in any other way tethered to the boat.

24. Heroically, after Mr Makin fell into water, Dr Chippendale, who was wearing a PFD, jumped into the water, whereupon his PFD inflated, and he swam to Mr Makin.

25. The yacht's two life rings were thrown into the water.

26. The yacht's sails were lowered, and its engine was started.

27. Dr Chippendale swam towards Mr Makin with one of life rings and pulled Mr Makin partially up and over the top of the life ring.

28. A line or halyard was thrown to Dr Chippendale, and he swam to retrieve and then returned to Mr Makin.

29. There was not enough slack in the line to tie it onto the life ring, however, he was able to do two turns of the line around the life ring.

30. Three or four attempts were made by the crew on the yacht to pull Mr Makin and Dr Chippendale alongside the starboard stern of the boat, but the crew was unable to manually lift Mr Makin on board.

31. A recovery strop was lowered and Mr Makin, himself, suggested to Dr Chippendale that he clip the recovery strop to the life ring which Dr Chippendale did as well as putting the life ring over Mr Makin's head with Mr Makin's arms through it.

32. Mr McKay, assisted by Mrs McKay who had herself suffered a fractured arm, proceeded to use a winch to wind in the recovery strop attached to the life ring while Mr Makin held on to the life ring.

33. Mr McKay, Mrs McKay and Mrs Stark were unable to pull Mr Makin up on the starboard side of the yacht.

34. Dr Chippendale, exhausted and fearing for his own life, was assisted back on to the stern of the yacht.

35. Mr Makin was heard to say that he was unable to continue holding on to the life ring and he slipped out of it and fell back into the water in what appeared to be in an unconscious state.

36. The life ring was untied from the strop and thrown back into the water.

37. The self-inflating dan buoy, was also thrown in the water, but instead of automatically inflating, it simply sank. (This is a concern but not a sole cause of this death.)

38. Heroically, Mr McKay then jumped from the stern of the boat into the sea and swam to Mr Makin. Mr McKay inflated his own PFD and secured Mr Makin with his head above water, however, Mr Makin was not showing any signs of life.

39. After further attempts of the yacht getting close to them, Mr McKay was able to grab on to the stern boarding ladder while still holding Mr Makin. As Mr McKay was climbing back on to the boat, the sea conditions resulted in Mr Makin being sucked down under the stern of the boat and Mr McKay was forced to let go. Mr McKay saw Mr Makin again float away from the boat face down.

40. One of the ropes in the water fouled the propeller of *"Lady Helena"* at which time the vessel lost all manoeuvring capability and was unable to continue trying to retrieve Mr Makin.

41. A Mayday call was made from "*Lady Helena"* at 1659 hrs.

42. At 1711 hrs, VMR403 Coast Guard Redcliffe vessel CG 32, a 27-foot twin outboard Kevlarlat, left its base at Scarborough and proceeded at full speed in response to the emergency call.

43. At 1730 hrs, the Coast Guard vessel sighted and retrieved Mr Makin.

44. At 1745 hrs, the Coast Guard vessel returned to port and was met on the dock by QAS paramedics who assisted with CPR.

45. An intensive care paramedic arrived on scene and then a second intensive care paramedic arrived.

46. Mr Makin was transferred into the back of an ambulance.

47. Mr Makin could not be revived.

s45 Coroners Act (Qld) Formal Findings

76. Findings required by *s.45 Coroners Act* (Qld):

(a) Identity of the deceased – Mr Rickie James MAKIN

(b) How the deceased died - Drowning following a man overboard incident during a yacht race on Moreton Bay where he fell overboard without a life jacket or other safety equipment in heavy seas at dusk.

(c) Place of death - Moreton Bay, Brisbane He died after falling from a sailing yacht, *"Lady Helena"* and into the seas of Moreton Bay at a point about 2 kilometres to the north-east of the northern end of the Redcliffe Peninsula. At the time, he was a crew member on the sailing yacht which was then competing in a sailing race.

(d) Date of Death - Saturday, 7 March, 2020 4:30 p.m.

(e) Cause of Death -
1(a). Drowning
1(b). Head injury,
1(c). Impact with yacht.

Other significant conditions:

2. Coronary atherosclerosis.

Recommendations

1. **That the *Transport Operations (Marine Safety) Regulation 2016* be amended to include the mandatory wearing of a lifejacket level 150 or above with fitted rescue tether points on a vessel engaged in competitive yacht racing activities unless it is for momentary adjustment or impractical or unsafe for the individual onboard to wear such a lifejacket.**

77. Both principal experts assisting this Inquest, Mr Glissan and Mr Job concluded that it was uncontroversial that the deceased's failure to wear a life jacket *"was highly likely to be a contributing in his not surviving when he fell overboard."* The inability of a halyard to be attached to the body of the deceased in lieu of a life ring was another significant factor. They disagreed as to how draconian laws should be in ensuring the wearing of lifejackets with tether points in high seas during yacht races. In the ten years prior to this tragedy there were 12 marine incidents requiring the attendance of emergency services during yacht racing. Mr Makin's death was the only fatality. There appears to be no data regarding whether the injured were wearing lifejackets.

78. I am clearly of the view that yacht racing is a dangerous sport and the wearing of lifejackets at all times should be mandated by law when not sailing in areas

of smooth waters. I agree that Mr Job's recommendations do not go far enough. The current regime of individual responsibility for wearing lifejackets is insufficient.

79. The relevant Queensland legislative instrument which pertains to the wearing of life jackets during boating activities is the *Transport Operations (Marine Safety) Regulation 2016*. Section 24 requires vessels to be equipped with one required lifejacket for each individual onboard but only mandates the wearing of those lifejackets by children, in open areas of the ship, or when crossing a coastal bar.

80. Whilst expressions like "smooth waters", "partially smooth waters", "beyond partially smooth waters', "open area (for a ship)", "aquatic events" and "sailing ship" are defined and/or used throughout the Regulation, there are no specific provisions relating to the wearing of lifejackets during competitive sailing events.

81. Accordingly, I make a recommendation to amend *Transport Operations (Marine Safety) Regulation 2016*.

82. The Regulation ought be amended to, firstly, include provisions regarding "competitive sailing events", and, secondly, require the wearing of a lifejacket, level 150 or above, by all onboard while the "racing yacht" during participation in competitive sailing events unless it is impractical or unsafe for the individual onboard to wear such a lifejacket.

83. It would not be binding on Australian Sailing, but an additional recommendation I make is that its National Safety Committee recommend to the Board that the Special Regulations be changed so as to require the mandatory wearing of life jackets during all competitive yacht racing.

2. That Australian Sailing direct its members, member stakeholders and affiliates that it is the responsibility of the skipper of a racing yacht to ensure, in Queensland, that wearing a lifejacket of level 150 or above with fitted rescue tether points on a vessel engaged in competitive yacht racing activities is mandatory, unless it is for momentary adjustment, impractical or unsafe for the individual onboard to wear a lifejacket.

84. This is to assist in ensuring that the responsibility for the mandatory wearing of lifejackets is also with the skipper of a racing yacht as well as personal responsibility.

3. That Australian Sailing direct its members, member stakeholders and affiliates that it is the responsibility of the skipper of a racing yacht to ensure, in Queensland, regular Man Overboard Drills be undertaken using a life-sized and weighted mannequin or actual human volunteer to ensure authentic skill development and practice.

85. This is to assist in limiting a repeat of the background ancillary failures which exacerbated the recovery of the deceased: Dan Buoy failure, line entanglement leading to engine failure, winch damage, loss of halyard, damage to starboard stanchions, inability to secure life ring, delays in radio emergency call and absence of a man overboard drill manifest.

4. That Dr John Chippendale, Mr Glen McKay and Ms Anne McKay each be nominated for a bravery decoration for their roles in the attempted

rescue of the deceased, to the Honours and Awards Secretariat, the Council of the Order of Australia before whom recommendations are made to the Governor-General.

86. The efforts of Dr Chippendale and Mr Glen McKay entering rough sea in an attempt to rescue the deceased to the point of their near exhaustion and with the assistance of Ms Anne McKay, herself badly injured, onboard clearly warrant nomination for a bravery medal.

87. I wish to acknowledge the friends and family of the deceased and express my condolences on behalf of the coroners Court of Queensland.

88. I close the Inquest and Investigation.

Donald MacKenzie
Coroner
BRISBANE

31 July, 2025.

ATTACHMENT "A" – MAKIN INQUEST – Analysis of the Expert Evidence

ISSUE: Existence of yacht race safety plan and pre-safety race outline (Disagree)	
James Glissan	**Michael Job**
There is no clarity as to which documents were in force on the day.[1]	In March 2020 there was no specific Safety Management plan for the Kingfisher Bay series, each club being guided by their own Safety Management System/plan when conducting their own race.[2] WMSC hosted the race and used their SMP (Ex F14).

ISSUE: Adequacy of on-board safety equipment (Disagree)	
James Glissan	**Michael Job**
…there appears to be an adequate VHF/DCN radio and navaids including waypoint and MOB recording capacity on the vessel but all were located below decks and not readily accessible in an emergency. The availability of a	The AMSA inspector Mr T. R. Davis stated in his report 'The vessel met all the requirements of a class 2C charter vessel and is still meeting the requirements of the national law.'

[1] Pg 5.
[2] Pg 12, 2.20.

secondary MFD at the helm station would have enabled more rapid response by VMR.[3]	It is my view that the Lady Helena far exceeded the safety equipment requirements of the Kingfisher Bay NOR. It is my view that as a vessel inspected and certified as a commercial charter vessel and a sail training vessel, in addition to YA Category 5N compliance, the Lady Helena would have been among the best, if not the best, equipped and prepared yacht in the race.[4]
It is common practice and sound seamanship in modern times for that adage to be supplemented by the use of safety harnesses and 'jacklines' to prevent accidental loss of crew overboard in addition to the wearing of life jackets. This is particularly the case during periods of heavy weather. No jackline or similar safety equipment was available on the Lady Helena. While not mandated by survey or otherwise, as is set out below jacklines provide security, do not interfere with comfort or mobility and do so at relatively low cost. [5]	

[3] First report, p 9.
[4] Pgs 17 – 18.
[5] First report, p 9.

ATTACHMENT "A" – MAKIN INQUEST – Analysis of the Expert Evidence

ISSUE: Whether the vessel was fit for purpose (Agree)	
James Glissan	**Michael Job**
The "Lady Helena" was adequately found and nothing in the material suggests that either the yacht itself or any of its standing or running rigging contributed to the incident.[6]	It is my view that the Lady Helena was in all ways fit for purpose for the sea state and conditions experienced during Race 4 of the Kingfisher Bay series.[7]

ISSUE: Adequacy of MOB training and procedures (Disagree)	
James Glissan	**Michael Job**
At 28-9 a MOB procedure is set out in the SMS and at 41 a risk register assesses the level of risk associated with MOB. It is clear the procedure was not followed on the 7 March in a number of respects. No lifting equipment was deployed, nor it seems was any available and as noted above the MOB function on the MFD was not activated. No radio communication	Mr Glissan states that 'No lifting equipment was deployed, nor it seems was any available'. In his witness statement Mr Stark states that an attempt was made to lift Mr Makin onboard using a line tied to the life ring led to one of the winches in the cockpit. From the evidence in the crews' statements, the issue was not the lack of lifting arrangements, but Mr Makin slipping out from the life ring they were attempting to use to hold him.

[6] First report, p 9. See also: addendum report, [17].
[7] Pg 18, 4.11.

was made until a significant period of time had elapsed. All these form part of a standard set of MOB protocols. They were not followed on the evening of 7 March 2020. This failure argues that the training procedures on the vessel were inadequate or insufficiently practiced.[8]	It should be noted that every yacht has halyards leading to a powerful winch and this makes for an effective and easily accessible crane or lifting arrangement.[9]
	Broadly speaking there are 3 parts to any MOB recovery. (a) The immediate action the skipper must take to stop the boat and return to the casualty and stop the vessel alongside them. (b) Making contact with the casualty and lifting them aboard. (c) The immediate care of the casualty and arrangements to get them ashore.[10] The actions taken by the crew of the Lady Helena in attempting to rescue Mr Makin broadly followed the best practice for a MOB response aboard a sailing yacht.[11] According to Mr Stark and other crew member's statements, upon Mr Makin entering the water, the alarm was raised, the crew advised to spot the casualty, the engine started, life rings deployed and the sails lowered. Mr Makin was kept in visual sight and the Lady Helena returned alongside Mr Makin in a short time interval. It is my view that the decision to lower both

[8] First report, p 10.
[9] Pg 42, 28.8.
[10] Pg 19, 4.11.
[11] Pg 21, 4.21.

	the headsail and mainsail was a prudent one to assist with manoeuvrability in the prevailing sea state and conditions. [12] In my experience there is no 'one size fits all solution' to recovering a person back on board a sailing yacht of this size.[13] The variables are many including: the size of the boat and its freeboard (the distance between the water level and the deck), the strength of the crew, the equipment available and the sea state. [14]
What is clear from the events leading up to the death of Mr Makin is that such training as was provided did not permit effective response to the emergency that developed. In the circumstances of the emergency and the lack of clarity about the training this is not surprising. In addition to Mr Makin, who washed overboard either unconscious or semi-conscious, the ships log [Tab 16] reveals that the balance of the crew was compromised by the time AVCGA arrived and took the vessel in tow Ann McKay had suffered a fractured arm requiring surgery, Glen McKay hypothermia treated in hospital, John Chippendale exhaustion and Louise Stark bruising. The vessel itself also suffered significant damage.[15]	

[12] Pg 21, 4.22.
[13] Pg 22, 4.31.
[14] Pg 22, 4.32.
[15] First report, p 11.

The MOB crew training and procedures adopted by Mr Stark and recorded in the material provided to the investigating police were standard drills designed to create a system or protocol for responding to a situation where a crewman has gone overboard. Those drills are commonly conducted in benign conditions and as described do not involve either a human to be recovered or even a mannequin. The recovery of a lifering or fender does not involve the unmanageable frame or mass of a human being in the water, nor replicate the difficulties encountered in restoring a person to the vessel. As such they offer a very superficial approach to the problems encountered in a MOB event. Proper training involving the use of a weighted mannequin is recommended if the drills are to be of any real practical effect...[16]	It is my experience that few racing crews practice MOB drills regularly. It is my experience that the common practice has been for both recreational yacht race crews *and* RYA instructors to only practice/teach the first part of an MOB (As explained in 4.11(a) of this report), with the drill finishing with the fender being lifted out with a boat hook. The crew had previously practiced a method of lifting the casualty using a life ring and a halyard (a line that is used to hoist sails). Despite the attempt being unsuccessful, the crew of the Lady Helena had planned and trained for this situation and had used the equipment and resources available to them at that time.[17] The initial actions of controlling the vessel, staying in visual contact with the casualty and returning to the casualty in a timely manner appear to have been well practiced and executed. [18] In summary I form the view that the training and MOB drills undertaken by the crew of the Lady Helena were in keeping with the principles of good seamanship. It is my view that this training would have been the equal off or more robust than any of the other recreational yachts competing in the race, and in this regard the crew of the Lady Helena were more prepared for this eventuality than most crews competing in yacht racing at this level, despite it being unsuccessful on this occasion.[19]

[16] First report, p 12. See also: Addendum report, [20] – [21], and [23].
[17] Pg 22, 4.33.
[18] Pg 22, 4.36.
[19] Pg 22, 4.34.

ATTACHMENT "A" – MAKIN INQUEST – Analysis of the Expert Evidence

ISSUE: Whether a granny manoeuvre was performed (Disagree)	
James Glissan	**Michael Job**
A preliminary observation must be made in relation to this question: it is in the writer's opinion not at all certain that such a manoeuvre was performed. The evidence from the crew, helmsman and master of the vessel is inconsistent, with some members, as discussed below, suggesting that the actual events involved a standard gybe. If this is correct, the events suggest that that gybe was not carried out in a safe manner. The resultant uncontrolled movement of the boom is consistent with the injuries sustained by the crew. On the material available to me it is not possible to resolve the conflict in the evidence.[20] If a granny gybe was performed the accident could not have occurred as described.[21]	

[20] First report, p 12.
[21] First report, p 13.

An essential feature of safely gybing a yacht, in all but the lightest of conditions, is to manage the boom by bringing it in [trimming the mainsheet] in order to restrict or limit the arc over which it will travel. This reduces both the possible distance and the speed of motion should control be lost at the moment of transfer of force from one side to the other of the sail and the resultant force produced is minimized. It is clear that this did not occur and the impact that occurred, sufficient to break Mrs McKay's arm and to render Mr Makin unconscious is strongly suggestive of an uncontrolled gybe, with an extended boom, rather than a tack/granny gybe. The subsequent loss of the control lines, mainsheet and halyard is also consistent with an uncontrolled gybe. It follows from the preceding discussion that a properly executed 'granny gybe' would have been the safer manoeuvre for changing tack in the circumstances that obtained. [22]	A granny gybe also causes the yacht to stop heading in the desired direction as it is performed, and so is not conducive to winning races. It is a conservative action usually. based on safety considerations. I have done it many times myself when racing in strong winds. [23] In his witness statement John Chippendale states that the crew of the Lady Helena had performed a granny gybe in practice before the start of the race and once during it, before performing it at the North reef turning mark.[24] It is my view that placing safety considerations ahead of performance in calling for a granny gybe manoeuvre is in accordance with good seamanship in the sea state and conditions prevailing during the race. [25]

ISSUE: Legislative changes – safety equipment

[22] First report, p 13.
[23] Pgs 23 – 24, 5.12.
[24] Pg 24, 5.13.
[25] Pg 24, 5.14.

ATTACHMENT "A" – MAKIN INQUEST – Analysis of the Expert Evidence

James Glissan	Michael Job	Dr Ray Shaw
The Transport Operations (Marine Safety) Act 1994 (Qld) [TOMSA] provides a framework for marine safety in relation to ships that are in any way associated with QLD. There is a question whether that provision as presently drafted is wide enough to permit the course suggested, but an amendment is open.[26] It is perfectly true that it is not possible to attempt to eliminate all of the factors. However better seamanship training is capable of minimising those risks and with the assistance of AMSA rules and guidelines and a more rigorous approach to training in methods of recovery of MOB Better outcomes may be expected.	The Special regulations dictate the safety equipment (including life jackets) that must be carried on board and in some instances when the wearing of life jackets is mandatory.[28] These special safety regulations are created and reviewed by the AS national safety committee. Members of this committee are all highly experienced yacht racers with a specific knowledge and understanding of the risks associated with the sport.[29] Australian Sailing has in place a national safety auditing scheme to ensure compliance with the special regulations. Auditors are trained and annually appointed to conduct these audits. [30] It is my view and recommendation to the coroner that **any further changes to the enforcement of wearing of life jackets/and or other safety equipment during yacht races should be made, implemented and promoted by the peak body**	There is no question that state boating authorities should highly recommend the wearing of lifejackets during such times of heightened risk and that should be sufficient for areas considered smooth or partially smooth waters as defined in the Queensland regulations. For boats in yacht races venturing further off-shore, the Australian Sailing Special Regulations mandate the wearing of lifejackets when alone on deck, when the wind speed is 25 knots or more and during times of restricted visibility (including nighttime). Of course, irrespective of any regulatory requirements, the judgement of the vessel skipper and the preferences of individual crew members must be respected at other times. In summary, the Australian Sailing regulations regarding the wearing of lifejackets during yacht races are deemed appropriate but **further review of the Queensland regulations**

[26] First report, p 17.
[28] Pg 25, 6.13.
[29] Pg 25, 6.14.
[30] Pg 25, 6.15.

Moreover in the modern world and with the advent of modern and non-intrusive PFDs there is in my view simply no excuse for leaving the determination of whether or not to employ those devices to the discretion of the crew or the skipper of the vessel. The recent events in the 2024 Sydney Hobart race where 2 lives were lost and one MOB was recovered in very difficult circumstances highlight the need for a more rigorous approach to the issues of safety in yacht racing.[27]	**of the sport, rather than specific regulation of the sport by AMSA or state maritime authorities**.[31] Any attempt to eliminate all of these factors by legislation would be a nearly imposable endeavour, or at the very least impose such draconian conditions on the recreational pursuit of yacht racing as to either severely impact participation or cause it to cease completely.[32]	**more generally regarding the conditions under which the wearing of lifejackets for non-racing yachts should be recommended or required should be undertaken**.[33] The lifejacket requirements for racing yachts meets or exceeds that currently required by the Queensland Boating Regulations and is considered adequate. [34]
	PFD enforcement *JG recommends that Australian Sailing take the lead.*	**PFD enforcement** *RS recommends the onus be placed on Maritime Safety QLD* Compared to other states, while these requirements are certainly appropriate, they are quite limited. Most other states invoke the concept of "heightened risk" to define a more comprehensive set of circumstances when life

[27] Addendum report, pp 1 – 2.
[31] Pg 25, 6.16. NB: JG disagrees with this statement in his addendum report at [24], which states: *I believe we have now reached a point where the use of lifejackets ought be mandated and enforced by Maritime authorities, including AMSA at a national level. The approach of relying on the sporting authority clearly has not been successful.*
[32] Pg 43.
[33] Pg 2.
[34] Pg 2.

		jackets should be worn. It is recommended that the Maritime Safety Queensland review the existing requirements for wearing life jackets and harmonise to the other states as appropriate. The regulations governing yacht racing in Australia have to cover a very wide range of crafts (dinghies, keel boats, kite boards), sailing environments (ocean (open and sheltered), bays, lakes, rivers etc.) and Australia Sailing (AS) has to keep in mind this wide diversity in developing the safety framework that governs these events. Additionally, local clubs are better positioned to make more well-informed decisions to suit their individual sailing environments. The current AS regulations set the minimum requirement for wearing life jackets and clubs are empowered to supplement those requirements as appropriate. Finally, individual boat skippers make decisions to participate based on their boat and crew. This approach to sharing the responsibility for managing safety between AS setting the high level framework, clubs adapting it to their local environment and then finally boat skippers and crews making decisions for their

		boat is key to raising the overall level of safety awareness within the sport.[35]
		Other equipment For racing yachts, invariably covered by the Australian Sailing Special Regulations, the safety equipment required to be carried significantly exceeds what is currently required by Queensland law for all sea state regimes and is considered fit for purpose. Additionally, these requirements are under constant review to incorporate lessons learned from incidents and emerging technologies.[36]

ISSUE: Whether public recommendations about safety equipment should be made **(Agree)**

[35] Addendum report, p 2.
[36] Pg 2.

ATTACHMENT "A" – MAKIN INQUEST – Analysis of the Expert Evidence

James Glissan	Michael Job	Ray Shaw
PFDs[37] A recommendation that in all circumstances of offshore yacht racing at a minimum PFD's should be worn would in my opinion be appropriate. This should be required and be unrelated to weather conditions or to the time of day or night. <u>Special regulations – reg 5.01(h)</u> Agree with MJ's proposals, but they should ne enshrined in regulation or legislation.	**PFDs**[38] It is uncontroversial to state that this is highly likely to be a key contributing factor in him not surviving when he fell overboard.[39] It is my view that the risk of a similar tragedy can be lessened by taking the decision to wear life jackets in certain conditions out of the hands of the skipper and crew and enshrine them in the special regulations and/or the sailing instructions. <u>Special regulations – reg 5.01(h)</u> It would be my recommendation that the special regulations be amended to compel competitors to wear lifejackets by amending special regulation 5.01 (h) from 'Strongly recommended' to 'Shall' and be extended to all categories of races. I would further recommend that special regulation 501 (h) (ii) be amended to 'when a	**PFDs**[40] Again, this is the minimum requirement, and clubs are best placed to make a determination to increase these requirements to suit their individual fleets, geographical location and weather situation. As MJ points out, there is provision within the Racing Rules of Sailing (Rules 40.1 and 40.2) to allow race management to require the wearing of life jackets by flying International Code flag Y. In Victoria, sailing on Port Phillip, this is routine practice whenever a strong wind warning has been issued by the Bureau of Meteorology. However, talking to an international race officer in Brisbane, while she was certainly aware of this option, she felt it was not generally well-known or used locally so this is certainly an opportunity for AS to better educate race officials through its regular communication channels.

[37] First report, p 18.
[38] Pgs 25 – 27.
[39] Pg 43.
[40] Addendum report, p 2.

RRS rules [7.11] – [7.19] of MJ's report highlights the ineffectiveness of these rules	strong wind warning issued by the BOM is in place AND if a strong wind warning is not in place but the true mean wind speed is 25 knots or above'. RRS rules RRS Rule 40.1 and 40.2 allow the race committee to compel competitors to wear life jackets when, in their view, wind and sea conditions make it prudent to do so. It is my experience that many competitors and race officials are unaware of the existence of this rule and many competitors would be unaware of the meaning of code flag Y. I would strongly recommend that Australian Sailing communicate with all race officers and clubs reminding them of this rule and that the clubs communicate with their members advising them of the existence of this rule. I would strongly recommend that Australian Sailing ask race officers in this communication to consider the use of this rule for keelboat races if conditions require it, and that they be guided by special regulation 5.01 (h) in deciding whether to implement rule 40.1. I would further recommend that Australian	

	Sailing also use this proposed communication to race officers, race committees, clubs and competitors to remind them of RRS 37. RRS 37 reads - SEARCH AND RESCUE INSTRUCTIONS When the race committee displays flag V with one sound, all boats and official and support vessels shall, if possible, monitor the race committee communication channel for search and rescue instructions.	
Other PPE[41] - Personal locator beacon - Jacklines or jackstays		
Specific recommendations[42] 1. That xxx consult with its members to introduce mandatory wearing of lifejackets etc etc 2. That xxx collaborate with manufacturers, and its member stakeholders, in		

[41] First report, pp 19 – 21.
[42] First report, pp 20 – 21.

giving consideration to the development of ... technical specifications for crew, and to give consideration to revising Yachting Australia's rules accordingly. 3. That xxx collaborate with manufacturers, and its member stakeholders, in giving consideration to the development of Personal Flotation Device technical specifications for yachting competition .... so as to maximise crew safety compatibly with the performance requirements of the sport, and to give consideration to revising Yachting Australia's rules accordingly. 4. That YA give consideration to introducing into their rules and procedures a requirement that race scrutineers or PRO's ensure that all PPE to be worn by crew are a secure and close		

fit (snug), and are secure and correctly adjusted.		

ISSUE: Whether the organisers of competitive yacht races should be required to prepare, document and adhere to formal Safety Management Plans and/or undertake and document formal risk assessments (Agree)		
James Glissan	**Michael Job**	**Dr Ray Shaw**
Yes.[43]	Yes.[44]	<u>Addendum report</u>[45] AS already strongly advocates clubs prepare Safety Management Plans and provides training and templates to clubs to help them in this process. It is also common practice, as was the case in the Kingfisher Series, for the local Port or Marine Safety Regulators, to require such a plan as a condition of issuing a race permit. <u>First report</u>[46] I note that the Wynnum Manly Yacht Club had in place a responsible Safety Management Plan. While Australian Sailing cannot mandate

[43] First report, p 21.
[44] Pg 27, 9.1.
[45] Pg 3.
[46] Pg 4.

		these activities, by constantly stressing the need for these programs through presentations and regular safety focussed newsletters, the safety profile within the Australian yacht club community continues to increase. Invariably, any organisation conducting boating events, including yacht races, are captured under the provisions of the prevailing Occupation Health and Safety Regulations and having in place a formal risk assessment and safety management plan, as recommended and promoted by Australian Sailing, is an important step towards ensuring compliance and should be required.

ISSUE: Whether formal or standardised training drills, including recognised competencies, should be undertaken and documented with respect to rescue drills, and, in particular man overboard drills. **(Disagree)**

ATTACHMENT "A" – MAKIN INQUEST – Analysis of the Expert Evidence

James Glissan	Michael Job	Dr Ray Shaw
Safety and survival course Agrees with MJ[47]	**Safety and survival course** In response to the coroner's findings from the inquest to the 1998 Sydney to Hobart yacht race, Australian Sailing developed and implemented a Safety and Sea Survival course. While invaluable to any yachtsperson, its syllabus is primarily concerned with emergency situations in offshore situations and includes life raft drills, abandoning ship, offshore communication and offshore search and rescue, among other topics. I would recommend that Australian Sailing consider the creation of a similar course designed for the requirements of inshore racing.[48] The MOB component should include practical demonstrations of MOB techniques, recovery and lifting the casualty back on board and immediate care of the casualty.[49]	**Safety and survival course** *Disagrees with MJ* <u>First report</u> The current training requirements for racing yachts, as laid out in the Special Regulations, are considered appropriate.[50] <u>Addendum report</u>[51] The existing Safety and Sea Survival Course is well developed, readily available in all states and covers a wide variety of safety-related material, including dealing with MOB situations, and is applicable to in-shore and off-shore sailing. While it does include many practical in-water activities, it does not include MOB practice. However, it is common practice for clubs to require annual certification that MOB crew training has been completed and clubs often provide an actual mannequin to make the exercise more representative of a real-life situation. This is an opportunity for AS to further promote this

[47] Addendum report, [27].
[48] Pg 28.
[49] Pg 29, 10.14.
[50] Pg 4.
[51] Pg 3.

		practice nationally but the current training offerings are considered adequate. MJ correctly identifies the challenge of lifting an MOB out of the water onto a yacht. There are many techniques that can be used and need to be tailored to a specific yacht design and its crew. What works for one yacht may well be impractical on another. This can only be worked out by actual practice on the water.
Competencies/qualifications Offering recognition by qualification as 'racing crew', 'leading crew' etc with associated competencies would assist organizers, skippers and crew to be confident of the abilities of competing yachts to operate safely and minimize the risk of serious injury and death. Moreover the 'ticket' would assist the crew if seeking to join another yacht and could be managed at little cost by the clubs and associations in the same way as the yachtmaster ticket is offered	No comment	No comment

at present.[52]		

ISSUE: Decision to proceed with the race (Disagree)		
Don Buckley	**James Glissan**	**Michael Job**
The weather conditions the fleet experienced were at the very upper end of scale for safety and comfort with actual wind measurements of up to 35knots at the time of the incident.[53] The decision by the race committee to start the race under an official "strong wind warning", which was forecasted for some time. That said **conditions at the 3pm start time were reasonable**, and as forecasted	I am not concerned to express an opinion on the propriety of the committee starting the race in the conditions surrounding the event, nor do I regard myself as qualified to do so. I have **no comments** on that part of Mr Job's report.[55] The conditions were … conducive to significant risk and heightened danger of sailing and navigating even in enclosed or partially smooth waters.[56]	A Gale warning was not in place so in my view it **was reasonable to start the race**.[57]

[52] First report, p 22.
[53] Pg 6, 4.10.

with stronger winds expected as the race progressed.[54]		

ISSUE: Whether dedicated safety boats (for night series) should be introduced		
Don Buckley	**James Glissan**	**Michael Job**
Nil comment.	Nil comment.	While the argument can be made that a rescue boat on hand at the time Mr Makin fell may have assisted in his rescue, this would assume that the vessel was near the Lady Helena at the time. It is my view that a dedicated rescue boat would place an additional burden on the organizing club with no guarantee it would have been in a position to assist.[58]

ISSUE: PFD responsibility (Disagree)	
Michael Job	**James Glissan**

[55] Addendum report, [16].
[56] First report, pg 4.
[57] Pg 30, 13.1. See also: Pgs 8 – 10.
[54] Pg 7, 5.1.
[58] Pg 31.

Both the WMSC safety management plan and the standing orders from the skipper of the lady Helena Mr stark made it the responsibility of the individual to decide whether to wear a life jacket. All crew members of the lady Helena had it sometime attended the SSC of course and as a result it can be assumed that they would have been aware of the advantage of wearing a life jacket. Three of the crew chose to wear life jackets during the race and three didn't. It was Mr Makin's own choice not to wear a life jacket on the day he fell overboard.[59]	I am strongly of the opinion that that ought never to have been the case. It was the responsibility of the skipper on the ordinary application of WHS laws to ensure the safety of the crew. Similarly it was the duty of the race organisers to operate a SWMS that ensured that same level of safety. In my opinion both were in breach of that duty.[60]

ISSUE: Should crew have been directed to wear PFDs **(Agree)**		
Don Buckley	**James Glissan**	**Michael Job**

[59] Pg 44.
[60] Addendum report, p 2.

Given the wind conditions and reduced crew numbers, there would be a heightened sense of the need for safety and crew co-ordination. This factor makes it difficult to understand why 2 of the 6 crewmembers were not wearing their lifejackets at start time and that the deceased did not have his on at any time. Generally it is accepted that the wearing of lifejackets is firstly a. personal choice and then in most cases a rule and the responsibility of the master of the vessel for all crew to wear lifejackets and other safety gear after dark. Given it was approaching dusk and there was a long windward leg ahead	Yes.[63]	Given the conditions on the day it is my view that it would have been prudent for the skipper Mr Stark to have directed the crew to wear lifejackets.[64]

[63] See first report, pg 8.
[64] Pg 31.

it would have been usual for all crewmembers to be given opportunity to be appropriately dressed and equipped before rounding the next mark. This would have been an opportunity to put on a lifejacket.[61] **Major contributor to the incident** The decision by some crewmembers to not wear a lifejacket.[62]		

ISSUE: Timing of alarm and mayday call	
James Glissan	**Michael Job**
Delay in mayday call The MayDay call was not made for a considerable time [approximately 20 minutes] after the incident and no MOB waypoint was entered on the system at any time. This added to the delay in activating the AVCGA vessel and in the time taken for the Coast Guard to locate the Lady Helena and the MOB.[65]	**Should alarm have been raised earlier?** Yes, However the evidence shows that the crew were fulling engaged in retrieving Mr. Makin themselves and it may not have occurred to do this at first.[66] **Delay in mayday call** All crew (including those that entered the water to assist) were

[61] Pg 6, 4.8.
[62] Pg 7, 5.2.
[65] First report, p 9.

	concentrating all efforts of retrieving Mr Makin from the water.[67] From the information in the brief of evidence the exact time the Mayday call was made is not clear, however the weight of evidence points to it being broadcast at or about 5:00pm. This was 28 minutes after Mr Makin entered the water (at 4:32pm). From the crew members' witness statements I form the view that during this 28-minute period the remaining uninjured crew members of the Lady Helena were entirely focused and concentrated on retrieving Mr Makin from the water. John Chippendale states this in his evidence.[68] While in hindsight it can be speculated that an earlier Mayday call *may have* resulted in a different outcome for the deceased, this would be conjecture given the head injury to Mr Makin, the witnesses' evidence of the short interval between him falling overboard and him becoming unresponsive or unconscious and the time it took for the Coast Guard vessel to reach the scene once they departed their base.[69]

ISSUE: Should Race Control have abandoned the race after MOB	
James Glissan	**Michael Job**
Yes.	Yes.

[66] Pg 31, 16.1.
[67] Pg 32, 17.5.
[68] Pg 34.
[69] Pg 35, 19.2.

RQYS's safety management plan…identifies circumstances in which races are to be abandoned under the control of the principal race officer [PRO] as 'Level 3 heavy wind and big seas', and 'level 4 very strong wind and big seas'. It appears that either description was applicable to the circumstances in which the incident under consideration occurred.[70]	Section 17- 'Emergency Action Plan' contained in the WMSC Safety Management plan states 'In the event of a critical situation, all racing is abandoned and competitors advised by radio to return to harbour unless they are active in providing assistance'. It is unclear whether the race was formally abandoned as all competitors except one abandoned racing after the MOB incident. The yacht Matrix completed the course. It is unknown from the evidence if Matrix was awarded an official finishing time in the race results. However, the abandonment or otherwise of the race had no impact on Mr. Makins death.[71]

Further recommendations suggested by the experts

Suggested by Michael Job[72]

1. Formal SMPs

   That Australian Sailing consider compelling affiliated sailing clubs to create formal Safety Management Plans.

2. Amendments to reg 5.01(h)
   - That Australian Sailing consider amending special regulation 5.01(h) from 'highly recommended' to 'shall' wear life jackets in the conditions set out in that point for category 4,5, 6 and 7 events.
   - That Australian Sailing consider the addition of 'when a strong wind warning or higher is in place' to the conditions set out in in special regulation 5.01 (h).

[70] First report, p 6.
[71] Pg 35.
[72] Pgs 39 – 40.

3. Communication between Australian Safety and race officers/clubs
    - That Australian sailing communicate with all race officers and clubs to remind them of the existence of RRS rules 40.1 and 40.2 and encourage them consider its application for keelboats and multihulls events. Rule 40 gives race committees the discretion to require all competitors to wear life jackets if weather conditions deem it appropriate.
    - That Australian sailing communicate with all race officers and clubs to remind them of the existence of RRS 37: Search and rescue instructions.

4. Safety course
   That Australian Sailing consider the implementation of a one-day SSSC style course for those who compete in events category 4 and below. This could take the form of a one-day practical course covering safety equipment carried aboard yachts racing in these categories, with a particular focus on life jackets (types, correct fitting and appropriate use), practical MOB drills including retrieval of the casualty from the water and use of the Mayday call.

5. Mandatory lifting equipment
   The special regulations compel boats to carry life rings and danbuoys for use in a MOB situation but are silent in regards to arrangements or equipment for lifting casualties back on board. There has been much development of systems and equipment by industry in this area and are readily commercially available. I recommend that the Australian sailing consider tasking the relevant safety committee to investigate available equipment and consideration be given to adopting these into the special regulations as either mandatory or highly recommended as the committee see fit.

Suggested by Mr Buckley[73]

1. Race management

[73] Addendum report, p 5.

Clear National, State or Regional standards or recommendations are needed to assist the race management and participants, determine if a race should be cancelled or postponed. Note the huge range of weather, sea and geographic conditions would have need to be allowed for.

This lends weight to the concept that the decision be left to the local race committee or organiser not a national regulator such as AMSA.

2. PFDs
   Clear definitions and instructions regarding the wearing of lifejackets and type of lifejacket to be used.

   *This matter could be addressed by Australian Sailing (**AS**) who already have a broad understanding of the range of vessels, conditions and circumstances.*
3. Racing category structure
   Assessment of the current racing category structure as outlined by **AS** and based on the International Yacht Racing Rules and Regulations which are managed by World Sailing (**WS**).

   These long established governing bodies and the various global affiliates are in the best position to assess the risks and necessary solutions and outcomes.

4. Training standards
   Assessment of the current training standards and requirements for the various levels of yacht racing participation.

   As noted in the reports, the range of participation in organised and recreational sailing is very broad, both nationally and internationally.

   The current structure for the management of organised yacht racing by a World authority (WS) directing National authorities (AS) who in turn work with State & National agencies and regulators, Safety and Rescue agencies, although cumbersome does go a long way providing a workable management framework.

   That said, incidents such as the death of Mr Makin, highlights areas where ongoing work needs to be done, such as

- *Safety Education and training of Race management and participants*
- *Adoption of better standards and rules for wearing user friendly, wearable lifejackets and buoyancy vests.*