STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ian Baker
Hearing dates:	**29,30,31 March 2017**
Date of findings:	**19 June 2017**
Place of findings:	State Coroners Court, Glebe
Findings of:	Deputy State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Power boat racing Water ski racing High speed on water racing Speed restrictions Emergency equipment Aquatic licences
File number:	2014/331002
Representation:	Counsel Assisting the Coroner, **Mr Adam Casselden SC** instructed by Jessica Wardle of the Crown Solicitor's Office; Ski Racing Australia, **Ms Catherine Gleeson;** Roads and Maritime Service**, Mr Michael Spartalis.**
Findings:	The *Coroners Act* in s81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of **Ian Baker.** **Name of deceased**: Ian Baker **Place of death**: Hawkesbury River, Ebenezer, NSW **Date of death**: 8 November 2014 **Manner and cause of death**: Ian Baker died from multiple injuries when he struck the water after the boat he was a passenger in lost control during a high speed water ski race.

Recommendations:	**Recommendations in relation to Ski Racing Australia** 1) That Ski Racing Australia give consideration to introducing speed restrictions in the unlimited and super class categories. 2) That Ski Racing Australia give consideration to introducing a requirement that all vessels competing in a Ski Racing Australia sanctioned event carry spinal boards, neck braces and defibrillators and that the driver, observer and skier/s are adequately trained and/or certified in the use of spinal boards, neck braces and defibrillators. 3) That Ski Racing Australia give consideration to using a device, such as a net of an appropriate depth, cage or some other suitable device, when sweeping aquatic courses for Ski Racing Australia sanctioned events, to collect debris that may be submerged or partly submerged beneath the water surface. 4) The Ski Racing Australia, through its affiliate NSW Water Ski Federation, give consideration to having additional paramedics stationed on water at appropriate intervals during the Bridge to Bridge Water Ski Classic. **Recommendations in relation to RMS** 1) That the Roads and Maritime Service ("RMS") give consideration to ensuring that licensees of RMS issued aquatic licences for any Bridge to Bridge Water Ski Classic comply with the conditions of the aquatic licence including by undertaking adequate checks to confirm that the licensee is satisfying the aquatic licence conditions. 2) That the RMS consult with Ski Racing Australia and other relevant stakeholders to determine whether it is desirable or necessary for a speed restriction to be a condition of an aquatic licence for any Bridge to Bridge Water Ski Classic.

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The Coroners Act in s81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Ian Baker.

Introduction

1. The death of Ian Baker was the tragic outcome of an accident during the Bridge to Bridge Water Ski Classic, a high speed water skiing race, on 8 November 2014. Ian Baker was the designated "observer" on the boat known as 'The Ringmaster'.

2. Ian Baker was the husband of Joanne and the father of Jessica, Jordan, Jenna and Jasmine. He was 45 years of age. I offer Ian's family and friends my sincere condolences for their sad loss.

The Inquest

3. Section 81 of the Coroners Act 2009 requires a coroner presiding over an inquest to confirm that the death occurred and make findings as to:-

- the identity of the deceased;
- the date and place of the death; and
- the manner and cause of the death.

4. Under s. 82 of the Act a coroner may make such recommendations considered necessary or desirable in relation to any matter connected with the death, including in relation to public health and safety.

5. There is no controversy in this case as to identity, date or place of death. I am able to find that Ian Baker died on 8 November 2014 at approximately 11.35am at Ebenezer following a power boating accident on the Hawkesbury River as part of the Bridge to Bridge Water Ski Classic.

6. The real issues in this Inquest relate to the manner and cause of Ian's death and in particular what caused 'The Ringmaster' to lose control and crash and whether I consider it necessary or desirable to make any recommendations in relation to any matter connected with Ian Baker's death.

The evidence

Race day

7. On the day of Ian's death he was a member of an experienced four-person water ski racing team. Daniel McMahon was the owner and driver of the 'The Ringmaster'. Ian Baker was the observer. Mr McMahon and Ian Baker had competed together for over eight years. They were both very experienced in their chosen roles. The two skiers being towed behind the boat were Steven Berry and Codie Rigg. Mr Berry and Mr Rigg were experienced water skiers.

8. ‘The Ringmaster’ was a Bullet Boat custom made to Mr McMahon’s requirements. It was built by Paul Tuesley and fitted out by Troy Wood. The boat was relatively new at the time of the incident, having first been tested following fit out on 3 October 2014. Mr McMahon complained of heavy steering when he decelerated the boat on this occasion. After several more instances of the steering being tested and fixed, Mr McMahon believed that the steering was in perfect working order on and from 10 October 2014.

9. The boat was serviced in Bendigo by Nankervis Marine prior to the Hawkesbury Bridge to Bridge which involved, amongst other things, a mechanical inspection and water testing.

10. On 8 November 2014, ‘The Ringmaster’ team was competing in the ‘Hawkesbury Hotshots Shootout’ event in the Superclass category. Mr McMahon performed standard pre-race inspections and preparations of the boat and was satisfied that it was in perfect racing condition.

The race

11. ‘The Ringmaster’ commenced racing at 11:27am. The water conditions were described by the witnesses as good. Mr McMahon gave evidence that the boat was travelling well at the start of the race.

12. The team were travelling along a straight section of the river, before making a right hand turn at 187km/hr. Mr McMahon in his evidence stated that there was no indication or warning that the boat was in trouble. He remembers setting up for a corner by having the boat just off centre of the river, and the next thing he remembers was hitting the water head first.

The fatal incident

13. At the time of the incident various data was recorded by the RaceSafe H20 and MoTec units which were fitted on board ‘The Ringmaster’. The data recorded by the MoTec unit indicated that ‘The Ringmaster’ was travelling at approximately 187km/hr and experienced an abnormal g-force at the time of the incident.

14. Ian Baker and Mr McMahon were both thrown from the boat. Mr McMahon ended up in a bush on the river bank very close to the water. Ian Baker was found floating face down in the water. Ian Baker was immediately moved onto a spinal board by his teammates and moved onto the river bank were CPR was commenced.

15. Codie Rigg, Daniel McMahon and Ben Gully, a skier from the ‘Sapphire’, commenced chest compressions. Within 2 minutes a paramedic had arrived with an Automated External Defibrillator (“AED”). On the water paramedics, Brett Nicholson and Ryan Dennis, arrived very shortly thereafter, noting that effective CPR was being provided. Paramedic Nicholson checked for a pulse, however could not locate one. He attached the AED to Ian, however the machine showed “no shock” and advised to continue with CPR. NSW Ambulance Intensive Care paramedic, Warwick Holland arrived a short time later. Paramedic Holland noted that Ian’s body was starting to go blue and that he had two black eyes, his pupils

were dilated and unresponsive, and he had a possible spinal fracture; his injuries were consistent with a rapid deceleration. There were no other signs of life, and Paramedic Holland pronounced Ian Baker life extinct at 12:20pm. Dr Clifton, pathologist, was of the opinion that Ian's pattern of injuries would have resulted in instantaneous death.[1]

What caused 'The Ringmaster' to lose control and crash?

16. On inspection of the boat following the incident, Sergeant Curtis observed that there was damage to the skeg of the boat and several large pieces of metal were missing, indicating, in his opinion, that it had hit something. Troy Wood (marine mechanic) also inspected the boat at the site of the incident and observed damage, in his opinion, consistent with the boat impacting with a submerged object. During the Inquest Mr McMahon, Mr Rigg and Mr Berry were each shown, for the first time, photographs of the damage to the skeg. Each of them were of the opinion that the damage to the skeg was consistent with the boat hitting a hard object. Mr Rigg was a boat builder who had previously observed similar impact damage to skegs.

17. No signs of damage were noted by Mr McMahon prior to the race. Prior to the boat being retrieved from the water Senior Constable Hall observed that the boat remained in the water in an upright position with the bow of the boat pointing to the sky. Senior Constable Sutton, who was with Senior Constable Hall, observed the bow to be approximately 1.5 metres out of the water. The boat was 6.6 metres long and weighed about 1500kg. The river depth ranged from 11 metres in the centre of the river to 2.5 metres when closer to the western bank of the river. We do not know whether the skeg was resting on the riverbed before it was retrieved as no depth scan was carried out in the immediate area where the boat was retrieved nor have any of the NSW Police divers made any comment on that matter.

18. Several visual "sweeps" of the river were performed by crews in the days leading up to the Bridge to Bridge event and also on the morning of the event. Shortly before and following the incident none of the occupants of 'The Ringmaster' observed any debris that may have caused the incident. A scan by NSW Police Divers following the incident did not find any debris or obstructions which the boat may have struck. No mechanical defect was identified as a possible cause of the incident.

19. Kristie Middleton, former CEO of Ski Racing Australia thought, as a possible cause of the incident that 'The Ringmaster' may have had a "blow out", which is where the propeller leaves the water, causing the vessel to turn sharply against the direction of the propeller. Messrs McMahon, Berry and Riggs gave clear and compelling evidence that this did not occur. I accept their evidence on this matter.

[1] Exhibit 1, Vol 1, Tab 3, Autopsy Report of Dr Leah Clifton

Expert evidence

20. Mr Nayland Aldridge, marine investigator, was of the opinion that the boat became uncontrolled due to the extremely high speed it was travelling at causing the boat to become hydro-dynamically unstable. His opinion was based on damage patterns visible on inspection, MoTec data and the principles of inertia. Mr Aldridge concluded that the following events occurred at some stage during the incident:

(a) The bow area of the boat entered the water causing "bow steer";
(b) The left (port) chine dug in suddenly preventing the boat from sliding through the water;
(c) The propeller torque took control of the boat causing the stern to move rapidly to the left (port).

21. In examination during the inquest, Mr Aldridge held to his opinion that the boat did not collide with an object causing it to lose control and crash. In his opinion, if a collision had occurred with an object the skeg would have been damaged equally on both sides and the damage observed would have been far more significant. Mr Aldridge was of the opinion that the damage to the skeg may have been caused by the skeg resting/bobbing on a rock or the riverbed after the incident and before its retrieval. He said the boat was sitting in the river in a bow up position for a number of hours in shallow water before it was then dragged towards shore and this could therefore account for the damage to the skeg.

22. Professor Yeomans, metallurgist, was of the opinion that the fracture of the bottom edge of the skeg was caused by a single high energy impact collision with a submerged or partly submerged object in the water with 'The Ringmaster' during forward motion. In his opinion damage to the surface of the skeg was isolated to the bottom left (port) side resulting in failure of the skeg through its thickness towards the right (starboard) side. The fracture is angled at about 45 degrees upwards towards the right and has produced a rough and granular appearance typical of cast aluminium alloys such as the skeg.

23. In examination at the inquest, Professor Yeomans agreed that you would expect to see damage on both sides of the skeg if it had hit an object face on. Therefore, he believes that this collision was more of a "glancing impact on one side only".

24. In relation to the suggestion that the damage to the skeg may have been caused by the skeg resting for some time on a rock or the riverbed, Professor Yeomans thought this was possible but in his opinion it was not probable. He did not think there would be enough energy to cause the type of damage observed to the skeg.

25. Professor Yeomans also noted that the damage was to the leading face of the skeg and that if the damage was caused by the boat being dragged across a concrete surface you would expect the damage to be lower down.

26. Each of the views expressed by the respective expert witnesses was compelling and was supported by objective evidence, be it the data recorded by the MoTec

unit or the damage visible in photographs of 'The Ringmaster', including to the skeg. I am not able to prefer one expert witness over the other as each opinion was equally plausible based on the available evidence. Accordingly, I cannot find, on the balance of probabilities what caused 'The Ringmaster' to lose control and crash.

Issues:

Did speed contribute to Ian's death?

27. Speed contributed to Ian's death. 'The Ringmaster' was travelling at a speed of 187 km/hr at the time of the incident. The boat could not have become hydro-dynamically unstable, whether as a result of speed alone or by impact with an object, unless it was travelling at an excessive speed. Further, as the pathologist has stated, the multiple injuries sustained by Ian Baker are consistent with blunt force trauma sustained in a high speed boating collision.

Were there appropriate systems, procedures and governance in place to ensure the safety of participants in the Bridge to Bridge Water Ski Classic?

28. Given the inherent risks involved in water ski racing, the systems, procedures and governance to ensure the safety of participants in place at the time of Ian's death, were, in large measure, appropriate. As acknowledged in evidence by a number of witnesses further safety improvements could be made to the sport. Those areas of improvement, which are supported by the evidence, are identified in the recommendations I make below. It was a striking feature of this inquest that a number of witnesses involved in the sport identified that speed was a concern and that they would like to see speed restrictions introduced.[2]

29. I have considered the submissions on behalf of the RMS regarding the proposed recommendations that are directed to them and their further response to Counsel Assisting's submissions in reply which were filed on 16 June 2017. Following my consideration of Counsel Assisting's submissions in response, the relevant sections of the Marine Safety Act 1998 (NSW) and the Marine Safety Regulations 2016 (NSW) and the relevant evidence of Mr Hunter, General Manager, Boating Operations, NSW Maritime Division of RMS, and Mr Brown, Manager Operations RMS for Hawkesbury/Broken Bay, I do not consider there is any impediment to making these recommendations.

[2] Evidence given at inquest by Daniel McMahon; Codie Rigg; Steven Berry; Janice Thurgar

30. The first recommendation directed to the RMS requires it to give consideration to ensuring compliance with conditions for Bridge to Bridge Water Ski Classic aquatic licences including by undertaking adequate checks to ensure compliance. The recommendation requires the RMS "give consideration" and perform what they would consider to be "adequate checks". Accordingly I do not accept that this fetters the RMS' discretion. Indeed Mr Hunter and Mr Brown in their evidence accepted that RMS staff at an event could and do perform checks to ensure that conditions in an aquatic licence were satisfied.

31. The second recommendation directed to the RMS requires the RMS to consult with SRA and other relevant stakeholders to determine whether it was collectively thought desirable or necessary for a speed restriction to be a condition of the aquatic licence for the Bridge to Bridge Water Ski Classic. RMS submits in their further response to Counsel Assisting's submissions in reply that other conditions may achieve the same outcome of reducing speeds. I consider that a recommendation requiring consultation with SRA and other relevant stakeholders would allow the RMS to consider other conditions that may achieve the same outcome. I do not consider there is any impediment to making this recommendation.

32. In closing, I would like to thank the officer in charge of the investigation, Senior Constable Jennifer Ross for her thorough investigation and preparation of the brief.

33. I would like to thank my counsel assisting, Mr Adam Casselden SC and his instructing solicitor, Jessica Wardle from the Crown Solicitor's Office for their excellent work in assisting me before, during and after this inquest.

34. Finally, I offer my sincere condolences to Ian's wife, Joanne and his four daughters. Joanne spoke so beautifully about Ian Baker when she said "*Ski racing was one of Ian's passions and tragically it took him from us. However his biggest passion was his family".*

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The identity of the deceased was Ian Baker.

Date of death

Ian Baker died on 8 November 2014.

Place of death

He died at the Hawkesbury River, Ebenezer, NSW.

Manner and cause of death

Ian Baker died from multiple injuries when he struck the water when the boat he was a passenger in lost control during a high speed water ski race.

Recommendations

Recommendations in relation to Ski Racing Australia

1) That Ski Racing Australia give consideration to introducing speed restrictions in the unlimited and super class categories.

2) That Ski Racing Australia give consideration to introducing a requirement that all vessels competing in a Ski Racing Australia sanctioned event carry spinal boards, neck braces and defibrillators and that the driver, observer and skier/s are adequately trained and/or certified in the use of spinal boards, neck braces and defibrillators.

3) That Ski Racing Australia give consideration to using a device, such as a net of an appropriate depth, cage or some other suitable device, when sweeping aquatic courses for Ski Racing Australia sanctioned events, to collect debris that may be submerged or partly submerged beneath the water surface.

4) That Ski Racing Australia, through its affiliate, NSW Water Ski Federation, give consideration to having additional paramedics stationed on water at appropriate intervals during the Bridge to Bridge Water Ski Classic.

Recommendations in relation to RMS

1) That the Roads and Maritime Service (“RMS”) give consideration to ensuring that licensees of RMS issued aquatic licenses for any Bridge to Bridge Water Ski Classic comply with the conditions of the aquatic license including by undertaking adequate checks to confirm that the licensee is satisfying the aquatic license conditions.

2) That the RMS consult with Ski Racing Australia and other relevant stakeholders to determine whether it is desirable or necessary for a speed restriction to be a condition of an aquatic license for any Bridge to Bridge Water Ski Classic.

I close this inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner
Date: 19 June 2017