

CITATION: *Inquest into the death of Daniel Thomas Bradshaw*  
[2018] NTLC 005

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

FILE NO: D0005/2017

DELIVERED ON: 8 February 2018

DELIVERED AT: Darwin

HEARING DATE(s): 11, 12 December 2017

FINDING OF: Judge Greg Cavanagh

**CATCHWORDS:** **Death of deckhand, dangerous access  
and egress from vessel, no gangway,  
regulatory response to death**

**REPRESENTATION:**

Counsel Assisting: Kelvin Currie  
Counsel for AMSA: Martin Hanson  
Counsel for the Master: Peter Bellach

Judgment category classification: B  
Judgement ID number: [2018] NTLC 005  
Number of paragraphs: 77  
Number of pages: 23

IN THE CORONERS COURT  
AT DARWIN IN THE NORTHERN  
TERRITORY OF AUSTRALIA

No. D0005/2017

In the matter of an Inquest into the death of  
**DANIEL THOMAS BRADSHAW**  
**ON 8 JANUARY 2017**  
**AT BARGE EXPRESS**  
**25 MURAMATS ROAD, HUDSON CREEK**

**FINDINGS**

Judge Greg Cavanagh

**Introduction**

1. Daniel Thomas Bradshaw (Dan) was born 16 February 1979 in Subiaco, Western Australia to Patricia and James Bradshaw. He had one older brother, James.
2. While working in Darwin in the year 2000 he met Tanya Louth. They became engaged in 2002 and had two children.
3. He worked on boats. His working life included skippering a boat in Darwin for many years and working as a marine engineer at Hay Point Wharf Construction Project in Queensland.
4. When work ended at Hay Point, employment was difficult to find. He and Tanya sold their house and she stayed in Queensland with the children. He got a job with Barge Express in Darwin primarily due to one of his workmates from Hay Point recommending him for the position.
5. Barge Express operated four barges that serviced communities across the top end of the Northern Territory and into Western Australia. He commenced work on 25 May 2016 as a deckhand. His qualifications at that stage

included Master V, MED II, Senior First Aid Certificate, Elements of Ship Board Safety, Safety Training, Marine Engine Driver 2 (NC) and Licence to Perform High Risk Work.

6. He worked a month on and a month off. On the month off he either lived with his brother in Western Australia or went to Queensland to visit his children. He was planning on going to Queensland on his next month off. During the “on” month he lived on the Sammy Express, the barge on which he worked. The Sammy Express had four crew. The skipper, an engineer and two deckhands.
7. The Barge Express premises is at East Arm. The address of the premises is in Muramats Road and has a frontage onto what is commonly referred to as Hudson Creek. Barge access to Hudson Creek is very much dependent upon the tide. At low tide the water recedes leaving the barges sitting on the mud.
8. The wharf area is made up of concrete walls with large tyres hanging on the walls. There are two walls, known as the West and East walls. Between them there is a canal that leads to a ramp where the barges load and unload. It is called “the slot” or “the landing”. The East wall has a permanent gangway. The West wall does not.
9. When in Darwin the Sammy Express would generally tie up to a larger barge on the eastern wall or it would be in the slot. If tied to a barge on the East wall, getting on and off the barge was over the other barge to the gangway on the Eastern wall. When in the slot access was gained by the front door being lowered and walking off the barge onto the ramp.
10. The Sammy Express returned from a run to Port Keats at about 4.00am on Saturday morning, the 7<sup>th</sup> January 2017, and dropped anchor at Catalina Island just off East Arm. The trip had taken longer than usual as the seas had been rough. None of the crew had been able to sleep during the trip. They caught a few hours’ sleep after dropping anchor.

11. Later that morning, with the tide on the way in, they undertook the half hour run to the premises of Barge Express. Dan piloted the barge. The skipper and engineer were impressed with his skills. They arrived at 10.58am. The tide at that time was 4.9 metres. It reached high tide at 12.47pm (5.44m).
12. Already at the Barge Express premises were the other three barges. One was in the slot and the other two were at the East wall. One against the wall and the other tied up alongside. The one against the wall was not operational at that time. The skipper said that he had been told he could tie up at the West wall.
13. It was anticipated that the barge in the slot would leave on the tide at 2.00pm and the Sammy Express would take its place. Two members of another crew helped tie the Sammy Express to the wall. There was, at that stage, no thought of anyone getting on or off as they only planned to be there for about three hours.
14. However, the barge in the slot did not leave as expected. At about 3.30pm the engineer, Craig, and the two deckhands, Dan and Ashley, left the Sammy Express to go into Darwin. They left by stepping from the “bridge wing” onto the wall. I was told that at that time the height of the tide meant the bridge wing railing was almost level with the wall. They climbed onto the railing using a ladder (running between the bridge wing and the fly bridge) as support to hold onto and stepped across. At that time the tide was still above 4 metres.



Photo 1 Showing the railing and ladder used for support while stepping from the barge to the wall.



Photo 2 showing the railing and ladder in the distance.

15. As the tide dropped however, that was not able to be done, and access and egress were gained by stepping onto a tyre on the wall and using the chains that held the tyre to get up and onto the wall.



Photo 3 showing the bridge wing, tyre and chains and the distance to the top of the wall

16. No one on the boat considered it necessary to put in place a gangway. That was despite the Safety Management Manual stating:

“When the ship is safely alongside, a gangway must be rigged in order to secure safe access to the ship. The gangway must be rigged with rail, safety net and appropriate lighting.”
17. The purpose of leaving the boat was to have a drink at a hotel, and to drop Ashley at the Cullen Bay ferry so he could go home for the night. Dan also wished to buy a couple of XXXX longneck beers. They took a work vehicle and drove to the Frontier Hotel in Darwin where they each had a few beers.
18. Just prior to 5.00pm Dan and Craig dropped Ashley at the Cullen Bay Jetty and then headed back to Barge Express.
19. There was a “no drinking” policy on the barges. However, in the yard was a shed used by the crews for drinking. Dan stayed at the shed to drink the two XXXX longneck stubbies.
20. Craig went back to the barge. On the way he picked up a piece of rope and fashioned it into a means to assist in getting over the edge of the wall. He looped the rope around a bollard on the top of the wall and tied knots at regular intervals down the two lengths of the rope to make it easier to lower himself over the wall and down to the tyre. He left it in place for Dan to use when he was ready to board (the rope can be seen in the picture above). The time was about 6.45pm and the tide was at 3.45 metres.
21. A crew member from another barge, Dean, was going to get some KFC for his crew at about 7.00pm. He had known Dan at Hay Point. He described Dan as a “fun loving, humorous guy, always with a clever wit and a smile on his face”. Dan asked him to get a some longneck beers while he was out.
22. That night at about 10.00pm the barge in the slot and the other operational barge left on the tide. Dean was on one of those barges. As he was leaving he spoke to Dan at the shed. He suggested that Dan go to bed. Dan replied:

“what am I going to do there?” Dean said he did not consider Dan to be drunk and did not see him drinking.

23. The skipper cooked pizza that night and left some out for when Dan returned to the barge. The next morning the pizza was eaten and the plate was in the position where Dan sat. Also on the table was Dan’s portable phone recharger and cord.



Photo 4 of galley showing plate at position where Dan sat and portable phone charger and cord

24. Daniel sent a number of text messages throughout the night to a friend. She was working a night shift. The last of those texts was sent from his phone at 5.45am (8 January 2017). The subject matter was a potential road trip in a couple of months’ time. Her reply was sent at 6.34am. That reply was not read by Dan.
25. At 7.35am Ashley was returning to the boat. He climbed from the top of the wharf down to the tyre and turned to see a reflective shirt in the water below

him, between the wall and the barge. He looked more closely and realised it was Dan floating face down in the water. At that time the water was only about 30 centimetres deep.

26. The deckhand raised the alarm and went to get a ladder. Craig put on his boots and climbed down to assist Dan while Ashley went to get a stretcher and life jacket.
27. Craig turned Daniel over in the water. On checking he found no pulse and Daniel was not breathing. He had prune type skin on his hands. His body was lifeless and “all floppy” and he had froth in his mouth. It was obvious that he had been deceased for some time.
28. Ashley climbed down and together with Craig put Dan’s body on the stretcher and the life jacket under his head to keep it above water. They then waited for the ambulance and police.
29. A yard worker had contacted emergency services at 7.37am. The ambulance arrived at 7.50am closely followed by the fire brigade and police. The Police conducted records of interview with the crew that morning.
30. An autopsy conducted by Forensic Pathologist, Dr John Rutherford determined that Daniel drowned. Injuries observed were as follows:
  - “a. A small (0.5cm) abrasion on the outer aspect of the right eyebrow surrounded by reddened bruising (1.8 x 1.3cm);
  - b. Superficial abrasion (1.8 x 0.8cm) on the posterior vermilion border of the left lower lip;
  - c. An abraded bruise (3 x 2.5cm) over the mid-portion of the right iliac crest in the mid-axillary line;
  - d. A fresh pink bruise (1.8 x 1.5cm) on the mid-portion of the ulnar aspect of the right forearm;
  - e. An abraded bruise (1.7 x 0.9cm) on the dorsum of the upper quarter of the extensor aspect of the right forearm;

- f. An abrasion (approximately 0.9 x 0.7cm) over the middle knuckle of the right little finger;
- g. An abrasion (0.3cm) over the middle knuckle of the right ring finger;
- h. Fractures of the right 2<sup>nd</sup> and 9<sup>th</sup> ribs anteriorly, the right 4<sup>th</sup> and 5<sup>th</sup> ribs laterally and the right 2<sup>nd</sup> to 10<sup>th</sup> ribs dorsally;
- i. Dislocation of the right 4<sup>th</sup> costovertebral joint;
- j. Transverse fracture through the 2<sup>nd</sup> thoracic vertebra; and
- k. A straight laceration on the back of the upper part of the neck extending horizontally (that is, approximately at right angles to the long axis of the neck) and centred a little to the left of the midline.

31. In the opinion of Dr Rutherford the fractured ribs and thoracic vertebra were consistent with a heavy fall from a height:

“the heaviness of the fall being reflected in the damage to the rear aspects of the ribs on the right side of the body ... it would seem likely that he fell heavily onto a hard surface immediately prior to being immersed. The clear white foamy material exuding from his mouth indicates that he was still alive and taking breaths underwater, drowning representing the terminal event.”

32. The laceration to the back of his head was in the opinion of Dr Rutherford due to a sharp edge rather than blunt trauma. The laceration travelled in an upward manner through the flesh to the skull.
33. The only sharp edge proximate to the location of his body likely to have been responsible for the laceration was the edge of the grated tread on the bridge wing.



Photo 5 showing edge of protruding bridge wing

34. Below were the hard (albeit rounded) surfaces of the gunwales.

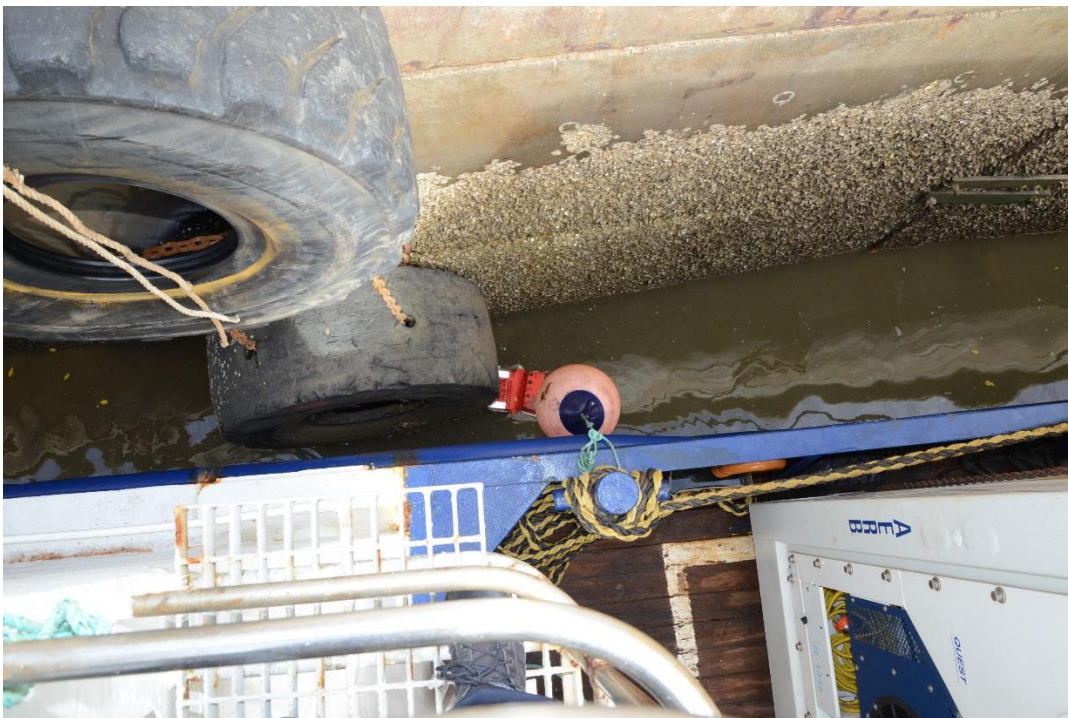


Photo 6 showing gunwale below bridge wing

35. On the top of the Wall were Dan's mobile phone and cap.



Photo 7 showing Dan's cap and mobile phone on the top of the wall (the stain under the phone is rust and the tile nearby is fixed).

36. Craig gave evidence that when climbing from the barge to the wall it was natural to throw ones cap and phone to the top of the wall. He said, "So going from the vessel to the – to shore, that would be a pretty guaranteed scenario."
37. It is likely that Dan was climbing from the barge at or about 6.00am in the morning. He jumped from the barge bridge wing onto the tyre and threw his hat and phone onto the wall. However, either in completing that manoeuvre or shortly after he lost his grip on the rope or wall and fell back.
38. As he fell he hit the back of his neck at the base of his skull on the protruding end of the bridge wing grated tread and then fell (right side first) heavily on the gunwale below before falling face down into the water.

39. The Forensic Pathologist was of the opinion that he may well have been rendered unconscious by the strike to the back of the neck. The low level of the water at the time (about 30 centimetres) would indicate that was probable.
40. The fact that his body was found in the water below the place where the crew climbed on and off the barge at low tide, the laceration to the back of Dan's neck (likely caused by the bridge wing protrusion) and the presence of the hat and phone on top of the wall make it most likely that Dan was getting off the barge and negotiating the climb to the top of the wall when he fell. Why he was doing so at about 6.00am when he was due to start work at 7.30am is less certain.
41. Toxicology indicated that at the time of his death his blood alcohol level was 0.28%. The Manager of Barge Express gave evidence that he found 14 longneck beer bottles at the shed the following day. Two were XXXX Gold longneck stubbies and the other 12 were said to be "Melbourne heavy longneck stubbies". He was of the opinion that the other crews would not have been drinking that evening as they were leaving on the tide at about 10.00pm that night.

## **REGULATORY AUTHORITIES**

### **NT WorkSafe**

42. NT WorkSafe attended the following day (9 January 2017). The business of Barge Express is run by Conlon Murphy Pty Ltd. NT WorkSafe served an improvement notice on the company that day requiring the company to undertake a "risk assessment and implement control measures to ensure workers and others have safe access/egress to Barge Express marine vessels".

43. At the time of the inquest NT WorkSafe said they had identified a number of “potential breaches” of the *Work Health and Safety (National Uniform Legislation) Act and Regulations*.
44. On 29 January 2018 NT WorkSafe issued a press release stating that Barge Express and the Master of the vessel had been charged with breaches of the *Work Health and Safety (National Uniform Legislation) Act*.

## **AMSA**

45. On 25 May 2017 Sri Srinivas, the Principal Marine Safety Officer with the NT Department of Infrastructure, Planning and Logistics (and delegate of AMSA) submitted to the Australian Maritime Safety Authority (AMSA) breach reports recommending prosecutions against the Owner and Master of the barge.
46. The breaches were suggested to be sections 13(2) and 18(4) of the Schedule to the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012*. Section 13(2) is in the following terms:

“(2) A person commits an offence if:

- (a) the person does an act or omits to do an act; and
- (b) the act or omission contravenes section 12(1); and
- (c) the person is reckless as to whether the act or omission is a risk to the safety of a person or the domestic commercial vessel concerned.”

47. Section 12(1) & (2) state:

“(1) An owner of a domestic commercial vessel must, so far as reasonably practicable, ensure the safety of:

- (a) the vessel; and
- (b) marine safety equipment that relates to the vessel;  
and

(c) the operation of the vessel.

(2) Without limiting *subsection* (1), an owner of a domestic commercial vessel contravenes that *subsection* if:

- (a) the owner does not provide or maintain the vessel so that the vessel is, so far as reasonably practicable, safe; or
- (b) the owner does not implement and maintain a safety management system that ensures that the vessel and the operations of the vessel are, so far as reasonably practicable, safe; or
- (c) the owner does not provide, so far as reasonably practicable, such information, instruction, training or supervision to people on board the vessel as is necessary to ensure their safety.”

48. I was told by Mr Brian Hemming, the National Operations Manager for Regions at AMSA, that it was the view of AMSA that there were “insufficient grounds to refer the matter to the Commonwealth Department of Public Prosecutions”. He said in his statement of 1 December 2017:

“In AMSA’s view there is no evidence to show that the owner of the vessel Sammy Express exhibited a significant degree of criminality, or that Mr Bradshaw’s death was attributable to the arrangements for access to the Sammy Express.”

49. The fact that Dan’s body was found below the bridge wing and tyre used to access the wall and barge, the fact that his hat and phone were on the wall, and the fact that climbing from the vessel to the wall was clearly dangerous, did not appear to sway Mr Hemmings view that the death was a coincidence rather than connected to the unsafe access and egress to and from the vessel.
50. However, the laceration on the back of Dan’s neck is unlikely to have been caused in any other way than falling backward from the tyre while climbing to or from the wall. The presence of the hat and the phone could be indicators of climbing up or down the wall but most indicative of climbing

up. Given those facts, the suggestion that his death was not connected to the unsafe access or egress is in my view ludicrous.

51. Section 18(4) is in the following terms:

“(4) A person commits an offence if:

(a) the person does an act or omits to do an act; and

(b) the act or omission contravenes section 16(1) or 17(1) or (2).

Penalty: 60 penalty units.

(5) An offence against *subsection* (4) is an offence of strict liability.”

52. The terms of section 16 are similar to section 12, excepting that they relate to the Master instead of the Owner. Section 17 requires the Master to take reasonable care of the safety of other persons and not unreasonably put the safety of others at risk.

53. For the same reasons noted at paragraph 47 above, AMSA did not take any action in relation to that recommendation.

54. I was told by the Master of the vessel that there was another gangway in the yard, but it was too short and not a compliant gangway. He said,

“Yes, I haven't seen a compliant gangway in the yard as long as I've worked there, that has – that follows that SMS requirement. I've never seen a boarding catch net under any gangway.”<sup>1</sup>

55. A deckhand stated:

“If we tied up on the Eastern wall we used the big gangway, but it used to go down to the deck, and that was pretty unsafe too.”<sup>2</sup>

56. Mr Hemming said that AMSA,

---

<sup>1</sup> Transcript p 27

<sup>2</sup> Transcript p 12

“separately decided that the safety management system (SMS) in force for the Sammy Express ... did not ensure that the vessel and the operations of the vessel were, so far as reasonably practical, safe. In particular, neither SMS made explicit provision for a safe means of access to and from the vessel where such access is affected by the rise and fall of the tide (as was the case at the time of Mr Bradshaw).”

57. Accordingly, on 7 November 2017 (10 months after the death), AMSA provided to Conlon Murphy Pty Ltd (T/A Barge Express), a Direction Notice:

- “1. The safety management system (SMS) ...be altered to ensure there are arrangements in place for the safe access to and from its vessels when alongside/berthed that account for the rise and fall of the tide.
2. The master and crew ... are given proper training and instruction to enable each master and crew member to implement and comply with each SMS.”

58. That was a curious direction, given the evidence that the SMS was unable to be complied with at the Barge Express premises. There were simply no gangways with netting. Lighting was considered an issue and the only gangway other than the permanent gangway on the East wall was too short.

59. The date for compliance with the Notice of Direction was 27 November 2017. On 30 November 2017 the Manager of Barge Express sent an email. The subject was, “Gangway Bow Door Access and Egress”. The email stated:

“For all staff to adhere to immediately.

Procedure SMM 4.011 will be amended to reflect and distributed.

1. All staff are prohibited to access or egress a vessel once it is safely moored, if no compliant gangway or bow door arrangement is in place. No Gangway/bow door arrangement – No Access/Egress.

Please amend current JHA’s to reflect.”

60. The following day in response to that email, the Manager of Compliance at AMSA wrote:

“I am satisfied that you have now taken the steps specified in Direction Notice (D100165). I will close the notice off.

As discussed I’ll also ensure that someone from the Vessel Ops team contacts you.”

61. There was no evidence provided to AMSA that Barge Express knew what a “compliant gangway or bow door arrangement” entailed. There was no evidence that there was a compliant gangway available. There was no evidence of what the training indicated. There was no evidence of any training at all.
62. When asked why the Notice would be closed before the SMS had been changed and without any evidence of proper training and instruction, Mr Hemming said:

“It's not the perfect practice but it is the accepted practice where a lot of notices issued on behalf of AMSA or by AMSA are done in either through self-declaration or voluntarily giving us information that they had actually done what was required.”<sup>3</sup>

“Again, it's depending on the nature and specifics of the notice itself. Again, the manager of compliance is the one that's made the decision to lift the notice. I admit that it could have made reference to what training the company intended to do and that may have been part of the discussions had with them verbally that I am unaware of.”<sup>4</sup>

63. Mr Hemming listed four main considerations in determining whether to prosecute a breach:

- Exhibits a significant degree of criminality or disregard;
- Was sufficiently serious that the Commonwealth and the community would expect it to be dealt with by prosecution;

---

<sup>3</sup> Transcript p 72

<sup>4</sup> Transcript p 74

- Resulted in significant or real harm; and
- Warrants a prosecution so as to deter future behaviour.

64. The following questions were asked:

**“Counsel Assisting:** Do you think ... having persons climb on and off vessels without gangways is something that prosecution might deter?

**Mr Hemming:** I think, ultimately, but we have a strong belief that we’ve got to start at the bottom and get this cultural change. And I’ve seen many incidents around the country where the means by which embarking and disembarking vessels is significantly inadequate. It's compounded, I know, by the tidal influence in Darwin; but we’ve also seen marginal improvements in some areas, many voluntary, many from us actually working with operators to improve those conditions. And that’s what we applied here, in terms of a directions notice that asked that this be done.<sup>5</sup>

**Counsel Assisting:** Yesterday we heard from the Master of the vessel. He said there had never been compliance in that regard with the gangway provision and there still wasn't. Do you have a different view to that?

**Mr Hemming:** No, I don't have a different view to it and it comes down to what resources are available to address that particular incidence as well as what priorities are applied in terms of what are the most significant safety issues we deal with in a domestic commercial vessel fleet across the country.

**Counsel Assisting:** What you're saying is that gangway safety is one of the lower or lesser priorities?

**Mr Hemming:** I wouldn't say it's a lesser - it is a lesser priority. What I am saying also there are other significant safety influences that take priority

---

<sup>5</sup> Transcript p 66

over that - for example the wearing of life jackets has significant priority. The application and development of relevant SMSs to address the behaviour and change of culture over time has a significant influence on our approach, as examples.

**Counsel Assisting:** Is what you are saying there are so many non-compliances in relation to the domestic commercial vessels that it's a very long list?

**Mr Hemming:** Without being controversial, yes it is. We have a significant generational, cultural change ahead of us and in some cases we need to take small steps, in other cases, you know, over time we need to use the full extent of the suite of tools available to us to influence that change.”

65. The lawyer for AMSA went further and suggested that there was no offence committed due to a strict reading of the wording of Marine Order 23 (applicable because of the “grandfathering clauses”). I invited AMSA to expand on that suggestion in further written submissions. However, they did not expand that point and I am assuming AMSA realised that Marine Order 23 does not and cannot modify the requirements to have a safe means of access and egress.
66. The following photograph was tended during the inquest.

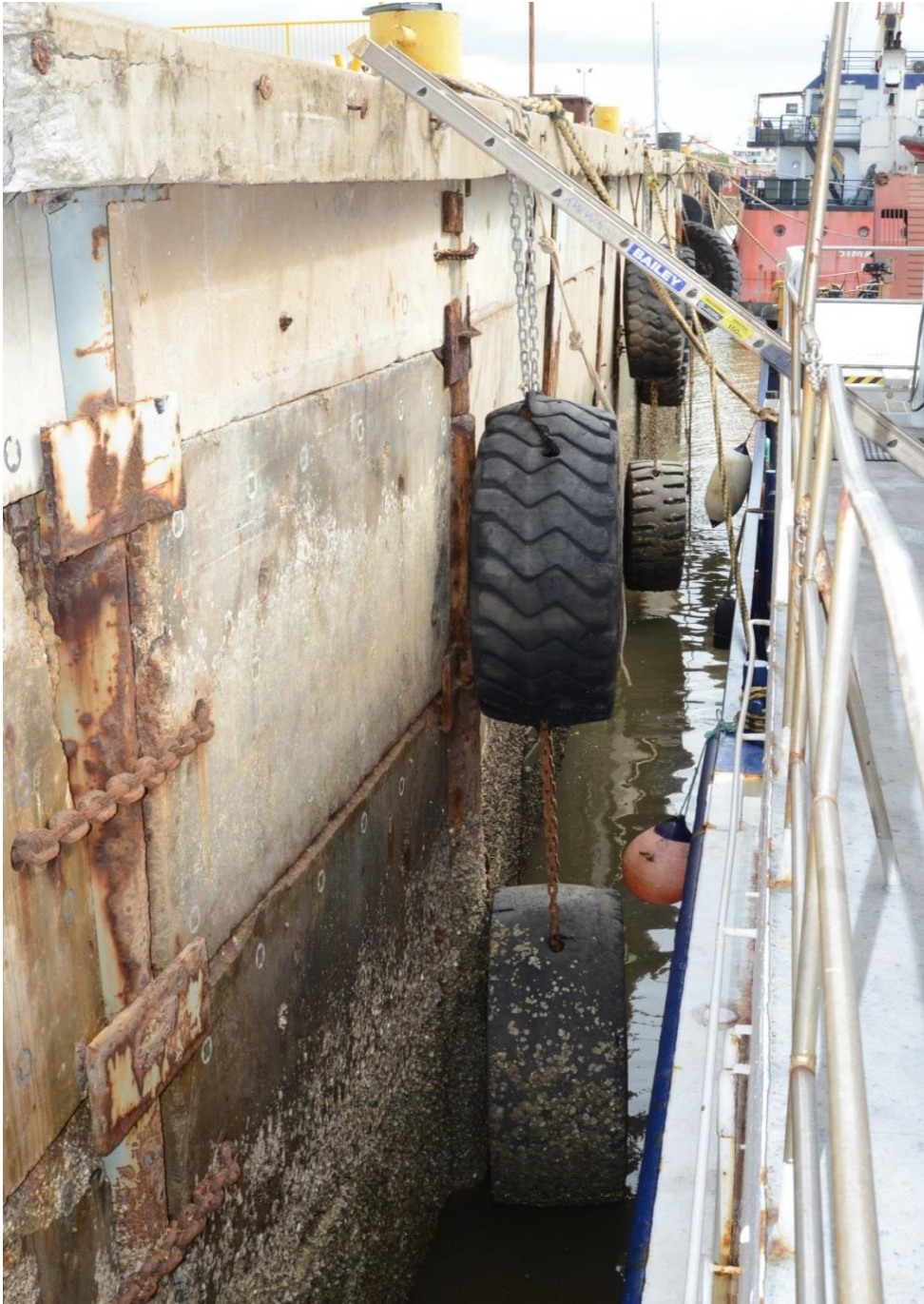


Photo 8 - Exhibit 5 depicting the means of access (minus the ladder)

67. The ladder in the photograph was put in that position after the death to allow access for the police officers undertaking the forensic analysis on the vessel. Why no gangway was used is likely because there was no suitable gangway.

68. I asked both the manager of Barge Express and Mr Hemming whether what that photo depicted was a safe means of access. They both agreed that it was not.

69. I specifically asked Mr Hemming these questions.

**“Coroner:** You see, I had the crew who I understand to be middle-aged men effectively telling me that they would hop from the deck onto the tyre, pull themselves up and over to the wharf by the chain and with the rope - do you understand?

**Mr Hemming:** Yes, I've seen very similar structures of egress and access to vessels around the country.

**Coroner:** Well, not only is that method shown by that photograph unsafe, surely it's dangerous as well isn't it?

**Mr Hemming:** I would agree that it does appear to be dangerous.”

## **Formal Findings**

70. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

- (i) The identity of the deceased was Daniel Thomas Bradshaw born on 16 February 1979 at Subiaco, Western Australia.
- (ii) The time of death was between 5.45am and 7.37am on 8 January 2017. The place of death was Barge Express, Muramats Road, Hudson Creek in the Northern Territory.
- (iii) The cause of death was drowning.
- (iv) The particulars required to register the death:
  - 1. The deceased was Daniel Thomas Bradshaw.
  - 2. The deceased was not of Aboriginal descent.

3. The deceased was employed as a deckhand at the time of his death.
4. The death was reported to the Coroner by Police.
5. The cause of death was confirmed by Dr John Rutherford.
6. The deceased's mother was Patricia Bradshaw (nee Masters, now Baird) and his father was James Montgomery Bradshaw.

71. Section 34(2) of the *Act* operates to extend my function as follows:

“A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.”

72. Additionally, I may make a report pursuant to section 35(3):

“(3) A coroner may report to the Commissioner of Police and the Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that an offence may have been committed in connection with a death or disaster investigated by the coroner.”

## **Comment**

73. As I noted in the course of the inquest, access to a land based workplace in the form depicted in the photographs above would not be tolerated. If such access were detected it would be required to be corrected immediately. If there was a death resulting from such access one might expect a significant regulatory response.

74. This death illustrates the vast difference between the levels of safety existing for those that work on domestic commercial vessels and those that work on land. It also illustrates the differing expectations of the regulators.

75. There should not be such differences. I was told that change in the industry will be “generational”. However, if that means that this generation of workers are exposed to risks that legally should not exist, it is not good enough.
76. Where there is a death resulting from unsafe practices the community is entitled to expect that the unsafe practices be denounced in the strongest possible terms. This is the second such inquest relating to a domestic commercial vessel, in the Northern Territory in the last 18 months, where the regulatory authorities appear to be either slow or unwilling to denounce unsafe practices. In the first death (*Inquest into the death of Ryan Harry Donoghue [2016] NTLC 009*), no action at all had been taken two and a half years after the death by any regulatory authority.
77. As at the date of the inquest there was no evidence to suggest that any mode of access or egress to and from the barges was compliant or safe.

Dated this 8th day of February 2018.

---

GREG CAVANAGH  
TERRITORY CORONER