Province of British Columbia

Ministry of Attorney General
B.C. CORONERS SERVICE

Case No. 92-110-0120

JUDGEMENT OF INQUIRY

Into The Death Of

FEB 1 0 1993

ASKEW	Tara-Leigh Michelle
SURNAME	GIVEN NAMES

Address: [redacted]

I, Richard J. WALTON, a Coroner in the Province of British Columbia, have inquired into the death of the above stated which was reported to me on the thirteenth day of August, 19 92 and as a result of such inquiry have determined the following facts:

Age: 10 Sex: M ☐ F ☒ Native ☐

Date of Birth: [redacted] Estimated Date of Death: 13 August, 1992

Place of Death: Nanaimo Hospital Estimated Time of Death: 11:50

Place of Injury/Illness: Nanaimo Harbour Date and Time: 13 August, 1992 - 08:10

Type of Premise: harbour Code 530

Identification Method: Visual ☒ Other:

Identification By: [redacted] grandmother, Nanaimo, B.C.

Body Released to: Mount Benson Funeral Home, Nanaimo, B.C. Date: 14 August, 1992

POST MORTEM EXAMINATION: Yes ☒ No ☐ Date: 14 August, 1992

Conducted By: John Blais LEHUQUET, pathologist, Nanaimo, B.C.

TOXICOLOGY EXAMINATION: Yes ☐ No ☒ Date:

Conducted By:

Relevant Findings:

MEDICAL CAUSE OF DEATH:

(1) Immediate Cause of Death: (a) MULTIPLE INJURIES AND DROWNING Code 001

DUE TO or as a consequence of

Antecedent Cause if any (b) SALT WATER IMMERSION Code 145

DUE TO or as a consequence of

Giving rise to the immediate cause (a) above Stating the underlying cause last. (c)

(2) Other Significant Medical Causes Contributing to Death:

BY WHAT MEANS: INJURED IN A VEHICLE WHICH FELL FROM A FERRY LOADING RAMP WHEN FERRY LEFT PREMATURELY. Code 320

Code 111

CLASSIFICATION OF THE EVENT: Natural ☐ Accidental ☐

Homicide ☒ Suicide ☐

Undetermined ☐

Dated this 18th day of January 1993

Richard Walton
Coroner

M28 2648

CIRCUMSTANCES AS A RESULT OF THE INQUIRY

Into The Death Of

SURNAME	GIVEN NAMES
ASKEW	Tara-Leigh Michelle

PART A: INCIDENT OVERVIEW

At 08:10 hours of 13 August, 1992 there was a tragic incident at the British Columbia Ferry Terminal at Departure Bay in Nanaimo. Lorraine Gail ASKEW, and her two daughters, Tara-Leigh Michelle and Dawn Nicole were accompanied by Mrs. ASKEW's husband [redacted] Mrs. ASKEW's mother [redacted] and [redacted] a young friend of the children. They were all passengers in a 1992 all wheel drive Dodge Mini Van. They were being loaded onto the upper car deck of the British Columbia Ferry Corporation Ship "Queen of New Westminster". Their vehicle was the next to last vehicle to be loaded onto the upper deck. While the van was slowly moving forward on the extremity of the loading ramp the ferry began to pull away. The front wheels of the Mini Van were so far out over the ramp that when the ferry pulled away, the front wheels of the van were left in the air and after teetering on the edge of the ramp for a few seconds, it upended, and plunged towards the water. The van landed on it's roof on the end of the lower deck of the ferry. The resulting impact of the fall to the main deck caused the roof of the van to collapse against the passengers. The van then toppled into the water. It was then swept under by turbulence from the propeller wash of the departing ferry.

A seaman on the upper car deck immediately notified the Captain, who was on the bridge at the controls. The seaman told the captain that passengers and a vehicle were in the water. At this time the ferry was already departing the dock. It was imprudent for the captain to reverse the pitch on the propellers to return back to the dock. This would have caused a reverse thrust of the propellers such that the passengers and/or vehicle would have been drawn into the propellers, preventing recovery. The captain maneuvered the ferry away from the dock and awaited further orders by standing off the dock. The Emergency Health Services Ambulance, Nanaimo Fire Department, Royal Canadian Mounted Police, Provincial Emergency Program Volunteers, Air Sea Rescue, and Canadian Coast Guard were all notified within approximately one minute of the occurrence. Most of these organizations dispatched the appropriate help to the scene of the incident. Within a very few minutes, members of the fire department, shore workers from the Ferry Corporation and Provincial Emergency Program rescue craft with divers were at the scene to render assistance. [redacted] escaped from the van, presumably by a side door as she had opened the door before the van fell. She appears to have fallen into the water parallel to the van. Apart from being submerged, and receiving some minor lacerations she was able with help to scramble to safety. [redacted] floated to the surface almost immediately. [redacted] were taken to the Nanaimo Regional Hospital for treatment. Shortly thereafter, Mr. ASKEW was brought to the surface in an unconscious condition. He regained consciousness and was taken to the hospital for treatment.

The three people who died in the incident, Lorraine Gail ASKEW, age 39, Tara-Leigh Michelle ASKEW, age 10, and Dawn Nicole ASKEW, age 13, were removed from the van with difficulty. All were transported to the hospital at various times. Treatment was provided for their injuries and the affects of submersion.

CIRCUMSTANCES AS A RESULT OF THE INQUIRY

Into The Death Of

ASKEW	Tara-Leigh Michelle
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PART B: SCENE INVESTIGATION

The police, Coroner Service, and a number of other agencies conducted investigations of the incident. An inquiry was called by the Minister responsible for the Ferry Corporation, under the direction of a Commissioner, the Honourable Nathan T. NEMETZ. The Inquiry disclosed that safety procedures laid down by various authorities and most especially by the Ferry Corporation were not followed in careful detail. The captain of the ferry, who remained on the bridge during unloading and loading procedures, had been given an "all clear" from a deck officer before the upper car deck had in fact been completely loaded. The ferry left the dock while loading was still proceeding on the upper car deck.

PART C: POST MORTEM FINDINGS

1. Lorraine Gail ASKEW sustained critical and irrecoverable injuries at the time the vehicle struck the lower deck in an upside down position. Her injuries included basal skull fracture with subarachnoid hemorrhage, among other problems. There was minimal evidence of drowning.

2. Tara-Leigh Michelle ASKEW sustained severe injuries in the fall of the van and the collapse of its roof. She had a closed head injury and cardiopulmonary findings consistent with salt water submersion.

3. Dawn Nicole ASKEW was initially treated at the Nanaimo Regional General Hospital, then transferred to British Columbia Children's Hospital, Vancouver where her condition though stable for several days, subsequently deteriorated and she died. The post mortem report included findings of diffuse alveolar damage, and early honeycomb lung. These findings are consistent with a history of near drowning.

PART D: CORONER'S FINDINGS

Lorraine Gail ASKEW, age 39 of Edson, Alberta died at approximately 10:13 a.m. of 13th August 1992 at Nanaimo, British Columbia. Tara-Leigh Michelle ASKEW, age 10, of Edson, Alberta died at 11:50 a.m. of 13th August 1992,at Nanaimo, British Columbia. Dawn Nicole ASKEW, age 13, of Edson, Alberta died at 15:29 of 18th September 1992 at Vancouver, British Columbia. All deaths are categorized as homicide. Homicide, as used by the British Columbia Coroner's Service is a neutral term and is used to classify a death that results from injuries caused directly or indirectly by the actions of another person, without imputing blame or fault to that person.

PART E: RECOMMENDATIONS

Pursuant to the British Columbia Coroner's Act, Section 3 (d) Recommendations are being forwarded to the Chief Coroner of British Columbia for distribution to the appropriate person or agency.

Dated this 18th day of January 1993

Richard J. WALTON

DK-1193

ORIGINAL TO REGIONAL CORONER

CIRCUMSTANCES AS A RESULT OF THE INQUIRY

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ASKEW	Tara-Leigh Michelle
SURNAME	GIVEN NAMES

RECOMMENDATIONS

The following recommendations which are fully supported by the British Columbia Coroner Service are taken directly from the recommendations submitted by the Honourable Nathan T. NEMETZ following his investigations.

Recommendation 1

The tower operator must communicate the clearance directly to the lower deck loading officer.

Recommendation 2

The communication outlined in Recommendation 1 must be by hard-wired telephone.

Recommendation 3

The lower deck loading officer must receive the communication of Recommendation 1 via the telephone in the main ramp operator control house.

Recommendation 4

That a single lamp be installed on the Bridge of all major vessels in the B.C. Ferry fleet. This would be a single circuit containing three key-operated switches, accessible only when ramp aprons are free and clear of the vessel. The vessel shall not leave the terminal until the lamp is illuminated.

Recommendation 5

On all major vessels, a strobe light be installed at each passenger and vehicle access point in a position where it will be visible by both the ship's crew and the ramp crew, and that at least thirty (30) seconds before departing the berth, the Master will activate the strobe lights as a warning to crews and terminal staff alike, that the vessel is about to depart.

Recommendation 6

That the Quartermaster remain at the upper passenger gangway until it is free and clear of the vessel and that he or she then report to the Master on the bridge.

Recommendation 7

That the Second Officer remain on the upper car deck apron area until such time as that apron is free and clear of the vessel and then report to the Master on the bridge.

Recommendation 8

That the decision to install video cameras at all access points, with split screen colour monitors in each wheelhouse of major vessels, be implemented forthwith and remain permanent policy.

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Recommendation 9

That the tower operator position be entitled "Tower Operator", and the corporation management, in cooperation with experienced tower operators and the Union, immediately review the workload of the position and implement changes designed to remove any responsibilities not directly concerned with traffic control and loading and clearance procedures.

Recommendation 10

That fast powered rescue boats be installed on all major vessels in the B.C. Ferry fleet.

Recommendation 11

That a regular system of frequent monitoring of clearance procedures be implemented forthwith, such system being known to employees, and being within the jurisdiction of a person with corporate wide authority.

Recommendation 12

That B.C. Ferries install a mechanical signal connected to the pin insertion mechanism of the loading ramps, clearly visible on the ramps, indicating the position of the locking pins.

Recommendation 13

That a joint task force review the scheduling and its impact upon safety, including the factors of crowded terminals and the single upper ramp bridge at Departure Bay, and report to the Directors within six months.

Recommendation 14

That the Provincial Emergency Plan Authorities convene a task force made up of the various agencies involved in waterfront emergency plans, including the major users of harbours in British Columbia, to review the question of the provision of underwater lifesaving personnel and equipment.

These recommendations are directed to:

For Action:

The B.C. Ferry Corporation,
112 Fort Street,
Victoria, B.C.,
V8V-4V2

For Information:

B.C. Ferry and Marine Workers Union,
202-990 Market Street,
Victoria, B.C.
V8T-2E9