IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0285

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*
*Section 67 of the Coroners Act 2008*

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| Findings of: | **MICHELLE HODGSON, CORONER** |
| Deceased: | **GRAHAM HILL** |
| Date of birth: | 22 May 1966 |
| Date of death: | 18 January 2018 |
| Cause of death: | 1(a) DROWNING |
| Place of death: | Port Phillip Bay, Frankston, Victoria |

**HER HONOUR:**

## Background

1. Graham Hill was born on 22 May 1966. He was 51 years old when he drowned on 18 January 2018.

2. Mr Hill lived in Bayswater. He is the father of Joel and Melissa.

3. At the time of his death, Mr Hill was in a relationship with Felicity Wilson.

4. Mr Hill was described as an experienced sailor who had sailed in small boats in and around Port Phillip Bay. At the time of his death, he held a recreational boat licence.

5. In December 2017, Mr Hill bought a Haines Hunter Model 580 SLF centre console (**the boat**) from his friend, Charles Sherpes. The boat was approximately 22 years old. At the time of purchase, the boat was in a good condition. Mr Sherpes had had a new fuel tank fitted and some cosmetic work done. Upon buying the boat, Mr Hill undertook further cosmetic repairs.

6. The boat carried all the required safety equipment, including marine flares and fire extinguisher. Life jackets (PFD type 1) were on board and stored in the centre console cupboard under the helm.

## The coronial investigation

7. Mr Hill's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not

9. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Hill's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

12. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

13. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

**Identity of the deceased**

14. Mr Hill was identified by his fingerprints. Identity was not in issue and required no further investigation.

**Medical cause of death**

15. On 19 January 2018, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mr Hill and reviewed a post mortem computed tomography (CT) scan.

16. Toxicological analysis of post mortem specimens taken from Mr Hill identified citalopram[2] and methylamphetamine.[3]

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make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Citalopram is an antidepressant.

[3] Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as 'speed' or 'ice'.

17. After reviewing toxicology results, Dr Young completed a report, dated 9 February 2018, in which he formulated the cause of death as "*1(a) Drowning*". I accept Dr Young's opinion as to the medical cause of death.

**Circumstances in which the death occurred**

18. On the morning of 18 January 2018, Mr Hill and Ms Wilson set out to go fishing. They launched at Patterson River, Carrum, at approximately 2.45am.

19. On this day, the weather at Frankston was clear. There was a northerly wind of approximately 20 to 30 kilometres per hour. The sea surface temperature was approximately 22 degrees Celsius. It was a warm summer morning and ideal sea conditions for small boating on Port Phillip Bay.

20. The couple travelled to a fishing spot off Carrum, anchored, and fished for a short time before moving to another spot towards Frankston.

21. Between 6.00am and 6.30am, the couple headed back to the boat ramp.

22. After approximately 30 minutes, Ms Wilson, who was seated at the rear of the boat, noticed water covering the floor of the rear of the boat. She informed Mr Hill, who replied that it was usual for a little water to be on the floor. Ms Wilson noted, *"When we were fishing, water used to come in the back a little bit and got out again. But this time it didn't."*

23. Ms Wilson told Mr Hill there was a lot of water.

24. Mr Hill subsequently stopped the boat and turned the engine off. As soon as he stopped, water began to flood into the boat. Mr Hill and Ms Wilson immediately began to bucket the water out.

25. After a short time and seeing that the buckets were not making a difference, Mr Hill instructed Ms Wilson to get the life jackets. As Ms Wilson attempted to get the life jackets from the centre console, the boat capsized and the couple were thrown into the water.

26. The couple managed to hold onto the boat's siderail and the anchor line for approximately 30 to 40 minutes. They became increasingly cold in the water.

27. Mr Hill assisted Ms Wilson to partially climb out of the water and onto the upturned bow of the hull. Mr Hill remained in the water.

28. Mr Hill eventually grew tired and let go of the boat. A short time later, Ms Wilson observed her partner floating face down. She was unable to assist him.

29. Approximately 20 minutes later, a passer-by stopped to assist. Mr Hill was retrieved from the water and dragged onto the passing vessel, at which time he was administered cardiopulmonary resuscitation, however he was unable to be resuscitated. Ms Wilson was also assisted onto the vessel. Emergency services were contacted and met the rescue vessel at St Kilda Marina.

***Maritime Safety Victoria inspection***

30. Martin Jaggs, Manager, Maritime Technical Services, Maritime Safety Victoria, subsequently inspected the boat and provided a report dated 20 May 2018.

31. Mr Jaggs reported that if the boat was loaded as it probably was on the day (that is, with two persons), it had sufficient freeboard and was in a good enough condition to be operated safely.

32. The boat was configured as a sealed deck vessel with drainage scuppers,[4] which were above the external waterline when tested on the water. However, the deck was not sealed and had drainage paths leading directly to the bilge via the wet well and fuel tank compartments, which allowed water to collect in the bilge.

33. Mr Jaggs also identified that the boat's scuppers were not able to be closed:

> *Once the vessel has approximately 200-240 litres of water in the bilge, loaded as she was and with the scuppers not being able to seal closed, the vessel will eventually take sufficient water on board through the downflooding points to lead to a loss of stability. This will be sufficient to ensure that the vessel will capsize unless additional flooding water can be prevented from entering and/or water on board can be removed.*

[4] The boat had scuppers port and starboard fitted with flaps. These flaps were fitted with a metal loop, which should be fitted with a line leading through the scupper directly into the vessel. This allows it to be pulled closed from the inside. The inspection found the line ran out through the scupper enabling it to be pulled open but prevented it from sealing closed to stop water entering the boat.

*There are a number of leak paths which prevent the 'sealed deck' from working correctly and preventing water drainage to the bilge.*

34. Mr Jaggs noted that in order to capsize, at least 200-240 litres of water must have entered the bilge through one of the following mechanisms prior to, and/or during, the voyage:

    (a) water must have collected on the deck and drained to the bilge during the voyage via spray or rain or through the scuppers due to rough conditions; and/or

    (b) water must have collected on the deck and drained to the bilge during previous voyages and the bungs have not been removed to drain the water between voyages; and/or

    (c) water must have collected on the deck and drained to the bilge whilst the boat was stored and the bungs have not been removed to drain the water between voyages.

35. Mr Jaggs noted that no bilge pump was fitted to the boat.

***Victoria Police investigation***

36. Leading Senior Constable David Glasser, Coroner's Investigator, noted that once Mr Hill stopped the boat, water began to flood the boat, presumably from the open scuppers at the rear of the boat. At this time, the scuppers would have been below the waterline due to the increase of weight of water on board the vessel. This extra water was presumably in the bilge area and below the deck. Once the boat stopped, additional water was taken onboard.

37. Leading Senior Constable Glasser opined that bailing out the water with buckets was of no use. The scuppers were unable to be closed shut from inside the boat.

38. He was unable to conclude whether the water below the deck was present prior to launching the boat. There were various leak points at which water could enter the bilge area. He noted that there were no mechanical or electrical bilge pumping mechanisms on board. Water could only be removed from the boat's bilge by re-trailering and opening the bung ports. However, the bung plugs were secured with Teflon tape, which created a water-tight seal. Once he removed the plugs, a lot of water came out.

39. Leading Senior Constable Glasser therefore concluded that the causes of the capsize were:

(a) there was no bilge pump mechanism. Once water was in the bilge, it was impossible to get out when the boat was out at sea;

(b) inability to close the scuppers from the inside. Once below the waterline, it was impossible to stop water flowing in; and

(c) the weight of the boat. Once the bilge filled with approximately 240 litres of water, combined with the above factors, sinking was inevitable.

**Findings**

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Graham Hill, born 22 May 1966;

(b) Mr Hill died on 18 January 2018 at Port Phillip Bay, Frankston, Victoria, from drowning; and

(c) the death occurred in the circumstances described above.

**Comments**

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

1. Leading Senior Constable Glasser helpfully informed me that the Victoria Water Police Squad has advocated for the introduction of a regulatory regime of seaworthiness inspections for a number of years. He suggested such inspections could be conducted at the time of registration, acquisition or transfer of vessel ownership, as well as periodic inspections for older vessels.

2. I agree with Leading Senior Constable Glasser's assertion that the absence of a vessel inspection process in Victoria means that defects in vessels are usually only detected post incident. Although the *Marine Safety Act 2010* (Vic) and *Marine Safety regulations 2010* (Vic) regulates a registration and safety framework, the absence of a physical inspection process means that unsafe or unsuitable vessels remain unchecked and undetectable.

3. Leading Senior Constable Glasser directed me to a number of other coronial findings that have dealt with vessel unseaworthiness. This Court has previously made recommendations

for the introduction of an inspection regime – the most recent being that of Coroner English in *Finding into Death Without Inquest of Adam James Vincent Pearson*.[5] After that finding was handed down, Transport Safety Victoria notified the Court that they supported the recommendation in principle and was developing a policy paper focussing on seaworthiness inspections for recreational vessels as part of the registration process.

4. Despite multiple recommendations for the introduction of a vessel inspection regime in previous findings of this Court, preventable deaths attributable to vessel unseaworthiness continue to occur. I therefore add my support for the introduction of a system of vessel inspections, similar to roadworthy inspections, to improve marine safety in Victoria.

5. I also support Transport Safety Victoria's ongoing education campaign regarding the importance of wearing lifejackets when using recreational vessels. Had Mr Hill been wearing a lifejacket, his death may have been prevented.

**Recommendations**

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. I recommend Transport Safety Victoria consider introducing requirements that:

   (a) all boats be fitted with a manual or electrical pumping mechanism to all bilge areas; and

   (b) when scuppers are fitted to a vessel, ensure that scuppers can be closed shut from within the vessel when they are fitted to a vessel.

2. I support Coroner English's recommendation that Transport Safety Victoria continue to explore potential models for a non-commercial vessel seaworthy inspection and certificate regime as a means to ensuring the seaworthiness of vessels at points of registration, transfer of ownership, and after a modification of the vessel.

[5] COR 2013 2331.

**Publication**

Given that I have made recommendations, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

I convey my sincere condolences to Mr Hill's family.

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

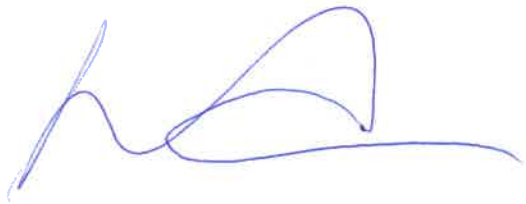
Susan Hill, Senior Next of Kin

Transport Safety Victoria

Eastern Health

Leading Senior Constable David Glasser, Coroner's Investigator, Victoria Police

Signature:




**MICHELLE HODGSON**
**CORONER**
Date: 4 December 2018.