IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 0190

FINDING INTO DEATH WITHOUT INQUEST

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

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of Courtney Faith KEAST

without holding an inquest:

find that the identity of the deceased was Courtney Faith KEAST

born on 1 January 2002

and the death occurred on 12 January 2014

at The Royal Children's Hospital, 50 Flemington Road Parkville, 3052 Victoria

from:

1 (a) HEAD INJURY

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Courtney Keast was a 12-year-old student who resided in Kyneton. She was the daughter of Ms Jodie Keast and Mr Brad Keast. The Keast family were friends with Mr Brian Matthews and Mrs Nadene Matthews.
2. Mr Matthews owned a ski boat, a 2002 Classique Contarge which he frequently took out on open water. On 10 January 2014, Mr Matthews decided to go for a water ski with his 14 year old son Jack and two of Jack's friends, Mason Mackay and Cooper Matricardi. Also on board was Mr John Mancini with his son Tristan as well as Courtney.
3. Mr Matthews towed the boat from Kyneton to Lake Eppalock where it was launched from Kirrang Point on the western side of the lake. The weather was fine with light winds and conditions for boating and skiing were very good with many other vessels using the waterway.
4. Mr Michael Smith was also operating his boat that day, a 1988 Gilflite Integra. Mr Smith was on board the boat with his children, Tori and Kyle, as well as his nieces Shannae and Ashleigh, and nephews Jye and Trent.
5. At about 7.20pm, both Mr Matthews and Mr Smith were driving their vessels in the stretch of water between Mountain Duck Point and Lamandra Cove in the central part of Lake Eppalock. Mr Matthews was towing Mr Mancini and Cooper who were wakeboarding

behind his boat with Courtney sitting in the back left seat. Mr Smith was towing Kyle who was waterskiing behind his boat.

6. Both vessels were heading in a direction from the east to the west. The natural curve of the lake meant that vessels travelling from the east to the west made a slow right hand turn towards the north-west as they travel around the shore line between Mountain Duck Point and Lamandra Cove and head towards a stretch of water called Ja Ja Wong Passage.

7. The distance between Mountain Duck Point and Lamandra Cove is about 250 metres at the narrowest point, depending on the water level, making it a traffic choke point before opening up to wider bodies of water.

8. This particular area of Lake Eppalock has an unrestricted speed zone according to the Vessel Operating and Zoning Rules (VOZR), however, general speed limits of 5 knots (9km/h) within 50 metres of the shore and other vessels still apply.

9. The application of the VOZR meant that only the middle section of the waterway was available for waterskiing or higher speed activities, where two vessels could pass more than 50 metres from each other, whilst travelling above 9km/h and maintain at least 50 metres from the shore. In reality however, vessels would transit through this narrow area at high speed in disregard or ignorance of these rules.

10. As both vessels travelled in a westward direction, they went between Mountain Duck Point and Lamandra Cove. Mr Matthews was on the southern side of Mr Smith meaning Mr Matthews was closest to the Lamandra Cove shore and Mr Smith was closer to Mountain Duck Point. Mr Matthews was travelling in a westerly direction along the natural curve of the waterway and had been weaving as he travelled.

11. Both vessels were travelling b/w 20-25 knots (37 to 46km/h) which was normal for skiing activities. Mr Matthews continued travelling and turned right. Unfortunately, he did not observe Mr Smith's boat and collided into the left hand side of his boat. As a result, Mr Smith's boat rode up on top of Mr Matthew's boat before sliding back into the water. Courtney was struck in the head by the underside of Mr Smith's boat as it rode over the top of her. She became unconscious and was bleeding. Mr Mancini and Cooper swam to Mr Matthew's boat and climbed in just as Kyle swan to Mr Smith's boat and climbed in. Mr Matthews attended to Courtney whilst Jack manoeuvred the boat away from the shore. They asked Mr Smith to follow them and drove back to Kirrang Point arriving at approximately 7.27pm. Emergency services were contacted and Courtney was subsequently airlifted to the Royal Children's Hospital.

12. Courtney was admitted with bilateral temporoparietal skull fractures, widespread brain contusions, haemorrhagic contusions of the midbrain, cerebral oedema and penumocephalus. There was marked raised intracranial pressure and she was taken to theatre and then the intensive care unit for management.

13. At 7am on 11 January 2014, Courtney was returned to theatre for bilateral extensive craniectomies but her intracranial pressure continued to rise. A repeat CT scan on 11 January 2014 showed worsening contusions and cerebral oedema. After discussion with her family, a decision was made to withdraw active treatment due to the catastrophic nature of the injury.

14. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine performed an external examination of Courtney and provided a written report of his findings. Post mortem examination confirmed large craniectomies and showed a fractured base of skull and fracture mandible. There was markedly swollen brain with left

posterior cerebral artery infarction. The external examination was consistent with the clinical history. Toxicological analysis revealed the presence of morphine, midazolam, thiopentone and phenytoin.

15. Mr Smith was interviewed by police and explained he was travelling at approximately 20 knots whilst towing Kyle. Shannae was acting as the water ski observer (thus facing backwards). Mr Smith estimated that he was about 70 metres from the southern shore (Lamandra Cove) side and did not see Mr Matthew's boat at all before the collision. Mr Matthews also indicated he did not see Mr Smith's boat until the last moment when it was too late to take evasive action.

16. On 14 January 2014, Mr Smith participated in a re-enactment with investigators. His speed and track line were recorded by way of GPS and measurements were taken on his position. The result showed that Mr Smith was moving at about 25 knots and travelled on a line practically halfway between Mountain Duck Point and Lamandra Cove. He was approximately 130 metres from the southern shore.

17. Mr Matthew's declined to participate in the re-enactment and in his statement indicated he believed he was about 80 metres off the shore although Cooper and Mr Mancini place him considerably closer. What can be concluded is that Mr Matthews was somewhere between the shore and Mr Smith's left hand side. The geographical area created a natural narrow point but there was still sufficient room for each vessel to operate more than 50 metres away had Mr Matthews and Mr Smith seen each other.

18. Investigators concluded that regardless of whether Mr Matthews had turned right in front of Mr Smith, or was travelling in a straight line with Mr. Smith on a perpendicular course to his right, Mr Matthews was required to give way to Mr Smith based on the Prevention of Collision Conventions (COLREGS). The circumstances of the case including consideration of the geographical area and the narrowing of the waterway still allowed Mr Matthews to do something else other than cross ahead of Mr Smith such as not turn to his right, stop or slow down and go behind the other vessel. Sun glare and excessive speed were deemed not to be factors in the incident. Both vessels were inspected by an expert examiner from the Victoria Police Forensic Services Centre and the conclusion reached by the examiner was consistent with the explanations given by Mr Matthews and Mr Smith.

19. Mr Matthews was charged with one count of contravening the prevention of collision convention pursuant to Rule 109 of the *Marine Safety Regulations 2012* (Vic). He pleaded guilty to the charge on 2 October 2014 and was fined $1000 without conviction. That concluded the criminal aspect of the investigation.

20. I find that the cause of death of Courtney Keast was head injury.

COMMENTS

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

21. During the course of investigation, investigators concluded that the existing 50 metre rule when operating over 5 knots is insufficient for towing activities and inland waterways. Additionally, it became evident during the course of police interviews that Mr Matthews and Mr Smith were unsure about the rules and their obligations regarding distances between vessels and speed limits. Both operators were longstanding and experienced licence holders and regular waterway users but the base knowledge required to pass a boat licence test was not evident.

22. Sergeant Adrian Sinclair concluded that that licence compliance is not the issue but rather the education process to obtain the licence does not impart the requisite knowledge needed to safely operate a vessel. Furthermore, the testing process does not identify deficiencies in knowledge that need to be addressed before a license can be issued.

23. Sergeant Sinclair also raised concerns regarding the COLREGS which are the underpinning set of rules that boat operation is based on. These rules apply equally to commercial and 'recreational' vessels. The use of the term 'recreational' attached to privately owned vessels and operators is not commensurate with other vehicles and drivers. In general, a vehicle is a vehicle and the responsibilities, dangers and risks associated with driving a vehicle are well understood. This is still not the case with private vessel operators in part due to labelling their operation 'recreational,' thus ensuring a cultural spin-off.

24. Breaching the COLREGS remains relatively trivial and is only a minor regulatory offence for the 'recreational' boat operator. Consequences for the commercial boat operator are much more serious and Sergeant Sinclair is of the opinion that there is little deterrent value in breaching the COLREGS despite the fact that any breach that does materialise in a collision will have catastrophic consequences. Most fatal collisions involve an obvious breach of the COLREGS but no serious offence can be applied, unless the normal road-based concepts of high speed or dangerous manner are evident or there is a gross departure from standards of behaviour or duty of care.

25. In 2009, the *Crimes Act 1958* (Vic) was amended to include vessel operations under the same provision as Culpable and Dangerous Driving Causing Death. However this case highlights the gap that continues to remain in marine legislation when death or injury is not caused by the speed of a vessel or the manner in which it was operated by a person failing to have proper control due to alcohol, drugs or distractions. In these cases, it is the careless disregard for the COLREGS or marine safety that cause the death, but no serious legal consequences apply.

RECOMMENDATIONS

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

26. I adopt the following recommendations made by Sergeant Sinclair regarding changes to be made to ensure safety and liability for boating vessels;
    a. Review of the Vessel Operating and Zoning Rules regarding speed and distance rules for towing activities with particular consideration of;
        i. Narrow and confined waterways
        ii. Human factors and task liability on vessel operators
        iii. Vessel dynamics and ability (or inability) to decelerate or alter course
    b. More stringent boat license training including a component regarding estimating distance over water, followed by a practical assessment to test foundation knowledge and effectiveness of the learning. It should be emphasised that in the last 10 years, there have been numerous fatal vessel incidents where fully licensed boat operators have shown complete ignorance of the rules or safe vessel handling. The call for improved license training and testing has been subject of numerous Victoria Police recommendations but no real improvement has been seen.

c. The term 'recreational vessel' be removed in the relevant legislation and publications and simply leave it as 'vessel' to lessen the implied notion that boat operation is akin to a hobby with lesser standards of responsibility than those faced by road users. An alternative may be to use the term 'private vessel' to create a distinction from a 'commercial vessel' if need be.

d. An indictable offence of "operate a vessel in (a) contravention of the Prevention of Collisions Convention, or (b) that is an Unsafe Vessel causing death or serious injury' be created within the *Marine Safety Act 2010* (Vic). This proposed offence should fit within Part 3.5, Division 2 of the Act.

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

Mrs Jodie Keast

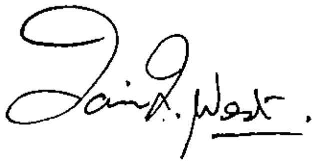
First Constable Christine Sykes, Melbourne North Police Station

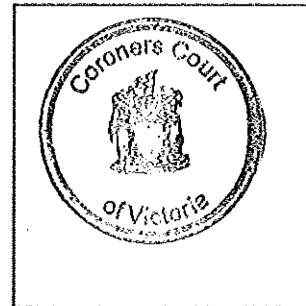
Sergeant Adrian Sinclair, Marine Investigation Unit

The Director, Transport Safety Victoria

Law Institute of Victoria

Signature:





IAIN WEST
DEPUTY STATE CORONER
Date: **3 May 2015**