IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 005123

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**GEOFFREY STUART McINNES**
Date of birth:	1 November 1943
Date of death:	9 October 2015
Cause of death:	1(a) DROWNING CONTRIBUTING FACTOR: ISCHAEMIC HEART DISEASE
Place of death:	Warrnambool, Victoria

HER HONOUR:

Background

1. Geoffrey Stuart McInnes was born on 1 November 1943. He was 78 years old when he died from drowning on 9 October 2015 while fishing in a boat off Warrnambool with his friend Ronald Edgar ('Ed') Kolody.

2. Mr McInnes lived in Warrnambool with his wife Lois McInnes. At the time of his death, Mr Ronald 'Ed' Kolody and his wife Beverly Kolody were staying with the McInneses. Mr McInnes and Mr Kolody both drowned in the boating accident.[1]

3. Mr McInnes had a history of heart problems. He had previously undergone coronary artery bypass graft surgery, and suffered from triple vessel coronary artery disease and a narrowed carotid artery. He was being medicated and monitored for high cholesterol.

The coronial investigation

4. Mr McInnes's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

5. The role of a coroner is to 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.[2]

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

7. 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

[1] Finding into the death of Ronald Edgar 'Ed' Kolody COR 2015 005121.
[2] 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 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.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr McInnes's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

9. 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.

10. 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

11. Mr McInnes was visually identified by his wife Lois McInnes on 9 October 2015. Identity was not in issue and required no further investigation.

Medical cause of death

12. On 13 October 2015, Dr Yeliena Barber, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of Geoffrey McInnes, after reviewing a post mortem CT scan. The autopsy revealed evidence of immersion including multiple superficial injuries, bilateral pleural effusions, heavy and congested lungs. There were also signs of heart disease including triple coronary artery bypass graft and a remote posterior left ventricular wall infarction.

13. Toxicological analysis of post mortem specimens taken from Mr McInnes detected therapeutic amounts of fluoxetine (an antidepressant medication) and salicylic acid (aspirin).

14. After reviewing toxicology results, Dr Barber completed a report, dated 24 December 2015 2015, in which she formulated the cause of death as '1(a) drowning' with the contributory factor of ischaemic heart disease. I accept Dr Barber's opinion as to the medical cause of death.

Circumstances in which the death occurred

15. Mr McInnes and Mr Kolody were both experienced fishermen. In his statement Mr McInnes's son Nigel McInnes said *'Dad had always been fishing for as long [as] I can remember'*.

16. Mr Kolody and Mr McInnes planned to go fishing for parrotfish together on the morning of 9 October 2015 off Warrnambool. Mr McInnes normally fished for parrotfish near La Bella Reef, south of Warrnambool breakwater.

17. At approximately 5.10am that morning, Mr McInnes checked the forecast, which he always did before boating.[3] At approximately 8.45am, he and Mr Kolody towed Ms McInnes's 5.6 metre cuddy cabin boat[4] to the Warrnambool boat ramp, launched the boat and motored to a reef system about five hundred metres south of the breakwater to commence drift fishing.

18. At approximately 9.57am witnesses noticed Mr McInnes' capsized boat drifting near the reef. They could not see any people on or near the boat. Search and rescue personnel were called and a full-scale search and rescue response was commenced.

19. Mr McInnes and Mr Kolody were recovered from the water, deceased. Neither man was wearing a personal flotation device (**PFD**).

Marine Safety Victoria vessel inspection

20. Water Police inspected the recovered vessel and observed significant damage to the port and starboard quarters. The outboard motor propeller was free spinning and a broken gear lever on the forward controller indicated it was in neutral gear. The ignition key was in the controller in the 'off' position. The vessel was equipped with safety equipment in the way of several PFDs and an emergency position indicating radio beacon.

21. A mechanical inspection of the vessel conducted by Marine Safety Victoria (**MSV**) revealed that notwithstanding its age, the engine was in a 'fair to good' overall condition and was well-maintained. The only fault identified was an overfilled fuel tank which may have restricted fuel flow to the outboard prohibiting it from starting.

22. The vessel surveyor who conducted the inspection stated:

[3] See statement of Nigel McInnes (10 October 2015) p 2; first statement of Lois McInnes (10 October 2015) p 3.
[4] A type of motorised vessel.

In this case, it appears that the fuel tank was overfilled and when the excess fuel has collected in the vent it may have caused a restriction in fuel flow to the engine ... If there is a restriction in the vent line, the amount of fuel flowing to the engine will be restricted ... In all other aspects the motor appeared likely to have been in a fully functioning condition with no other causes of failure.

Weather and sea conditions

23. Coast weather observations for Warrnambool that day indicated light wind statistics of less than ten knots in an east south easterly direction. Sea conditions were forecast to be waves less than 1 metre, increasing to 1 metre around midday. Although the forecast was reasonable, in reality the sea swell conditions were significant at two to three metres in height.

24. Near the reef systems where Mr Kolody and Mr McInnes were fishing is a navigation channel called the 'South West Passage'. The conditions in this passage are referred to locally as the *'mad minute'* because in heavy southerly sea swell conditions, swells that hit the Warrnambool breakwater bounce back and revert seaward, which creates large standing waves and turbulent tidal surges in the reef area.

25. According to Mr McInnes's friend Kenneth Bott, he and Mr McInnes would often go fishing near La Bella Reef for parrotfish:

This was our usual parrotfish spot ... I usually keep my distance from La Bella Reef, at least twenty metres of water depth. When there is a swell around the reef, I usually stay further out and drift around the area for them with the motor off so we don't scare the fish or waste fuel. When it is a heavy swell, it gets really stirry between the reef and the breakwater. It is really bad and it gets called the washing machine'.

26. Local Coast Guard skipper and commercial rock lobster fisherman Michael Astbury stated:

Inside the channel where a lot of reformed waves bounce back, the turbulent water creates a lot of surge and current and waves standing up ... It just wasn't feasible for people to be fishing in this area as it was dangerous at that time. Had the vessel been seaward of the first breakers, where I presume he was first, in those conditions [on the day] around those reef systems not to be ideal. As the day got on, the swell kept building throughout the day as

the sea conditions kept changing. I have worked this particular area for thirty years ... Had the swell have gone from moderate to heavy, I wouldn't have competently been able to skipper the boat into that area.

27. Volunteer Coast Guard Skipper Steve Tippett stated:

Sea conditions that day on the La Bella Reef I would describe as treacherous. There was a large swell running over the reef and with the low tide the reef was exposed. It is not an area that any person should have been on that day as it was too dangerous.

28. The Warrnambool Surf Living Saving club secretary Justin Houlihan stated:

On most days there is some form of waves moving over the reefs. When big swells are present, it may be spectacular to look at but is not a place boating where boating should happen. On calm days, there is movement in the channels but it is totally dependent on the wind. There is a lot of bull kelp floating around which may get caught up in motors. There are also hidden reefs where propellers might get hit if a boat came down too far on a wave. The whole area should be a no boat zone due to the reef, the waves, the wave reflection, the kelp and the unpredictability of the water movement through the channels. I think this is quite a dangerous area, when adding swell this can be treacherous.

Personal flotation devices (PFDs)

29. Section 101 of the *Marine Safety Regulations 2012* (Vic) (**the Regulations**) provides:

PFD to be worn on certain recreational vessels and hire and drive vessels during time of heightened risk

1. A person who is on an open area of a recreational vessel or a hire and drive vessel of a type listed in Column 2 of Table D in Schedule 4 must wear a personal flotation device if a type specified in Column 3 of the Table opposite that type of vessel if—
   (a) the vessel is on coastal waters and underway; and
   (b) the specified circumstances apply.

...

2. For the purposes of subregulations (1), (2) and (3), the applicable specified circumstances are—

(a) The vessel is crossing or attempting to cross an ocean bar or operating within a designated hazardous area; or

(b) The vessel is being operated by a person who is the only person on board the vessel; or

(c) The vessel is being operated during the period commencing one hour after sunset and ending one hour before sunrise; or

(d) The vessel is disabled; or

(e) The vessel is a yacht and no safety barriers, lifelines, rails, safety harnesses or jacklines are in use; or

(f) The vessel is being operated during a period of restricted visibility; or

(g) The vessel is operating in an area where a warning, that is current, of the following kind has been issued by the Bureau of Metereology—

(i) A gale warning;

(ii) A storm force wind warning;

(iii) A hurricane force wind warning;

(iv) A severe thunderstorm warning;

(v) A severe weather warning.

29. Schedule 4, Table D, Column 2 of the Regulations specifies a *'Powerboat more than 4.8 metres but not more than 12 metres in length'*. The PFD required for coastal water on such a vessel is a PFD Type 1. This device is defined in Schedule 1 Part 2 according to compliance with particular regulatory standards set out in that provision.

30. Neither Mr Kolody nor Mr McInnes was wearing a PFD despite the fact they were poor swimmers and Mr McInnes had a cardiac condition. They were not required to do so under the Regulations because they were in a vessel greater than 4.8 metres but not more than 12 metres in length (their boat was 5.6 metres long), they were underway in coastal waters, and they were not boating in a time of 'heightened risk'.

31. Whilst it is not possible to say they would have survived, obviously Mr Kolody and Mr McInnes' chance of survival would have been enhanced by the wearing of PFDs.

Findings

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

(a) the identity of the deceased was Geoffrey Stuart McInnes, born 1 November 1943;

(b) Mr McInnes died on 9 October 2015, at Warrnambool, Victoria, from drowning in a setting of ischaemic heart disease; 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 in connection with the death:

1. In fulfilment of my prevention role I asked the Coroners Prevention Unit (**CPU**) to examine possible prevention opportunities in this case with a view to making recommendations if appropriate. In this regard the Coroner's Investigator, who was a member of the Water Police Squad, proposed three possible strategies to lessen the chance of a repeat occurrence, namely: better identification of the hazardous reef, periodic vessel seaworthy inspections and expanding PFD laws. The CPU sought advice from Maritime Safety Victoria (MSV), a branch of Transport Safety Victoria, in relation to these proposals.

Identification of a hazardous reef

2. The reef was south of the Warrnambool boat ramp and although a boating safety information sign at the ramp indicated a hazardous rocky area there were no buoys or cardinal marks on the water. There was also a light at the end of the breakwater to alert night time mariners.

3. MSV advised, and I accept, that due to the extensive reef areas throughout the Victorian coastline it would not be feasible to place cardinal marks extensively along the coastline. However MSV indicated it would be prepared to review safety markings where reefs do exist to assess their adequacy, and possibly to implement further buoyage and educational information about hazardous areas.

Vessel inspections to ensure seaworthiness

4. The Coroner's Investigator suggested a system of periodic seaworthiness inspections for all vessels, but especially older vessels, by qualified surveyors. Although the evidence does not indicate that the age of the vessel contributed to its capsize and the subsequent deaths of Mr

Kolody and Mr McInnes, the Coroner's Investigator noted that older vessels in apparently good condition may suffer minor mechanical or electrical issues with catastrophic consequences.

5. On 1 July 2012 the *Marine Safety Act 2010* introduced the new concept of 'master' of a vessel as a person who has command or is in charge of a recreational vessel. The master of a vessel is required to hold a marine licence to operate a powered recreational vessel and has obligations under the Act to register the vessel and the requirement to maintain and operate a safe vessel. The Act defines an unsafe vessel as one which because of its condition and the absence of any item of required marine safety equipment may endanger a person.

6. The Act imposes a new concept of safety duties on masters and operators of vessels which in part require that they take reasonable care of themselves and others who may be affected by their actions. The Act defines the concept of ensuring safety as a duty imposed to eliminate risks to safety so far as reasonably practicable and to determine that duty regard must be given to what a person knows or ought to reasonably know about the hazard or risk and ways to eliminate or reduce the hazard or risk. The Act requires that masters and operators of vessels do not wilfully or recklessly put the safety of another person at risk.

7. Further, the Regulations impose conditions for vessel registration and provide that a vessel is not fit for purpose if the hull is unable to maintain watertight integrity and the steering system does not control the vessel. There is provision in Schedule 2 of the Act for the Regulations to make provision for the Safety Director to be notified of any alterations or damage to registered recreational vessels. The Act imposes penalties for contravention of any its provisions.

8. In the light of this statutory regime the CPU did not consider a recommendation as to continuing vessel inspection was necessary. I agree.

Expanding PFD laws

9. Both MSV and the Coroner's Investigator favoured expansion of the existing PFD laws. MSV noted that the definition of 'heightened risk' is not well understood by boaters and nor are they equipped to conduct risk assessments. Instead they tend to abide by what they perceive to be the minimum statutory requirements.

Recommendations

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

1. If it has not already done so, Maritime Safety Victoria should conduct a systematic review of existing safety markings of Victorian coastal reefs to assess their adequacy and where necessary to provide additional signage and cardinal markers.

2. The legislation regulating the use of PFDs should be reviewed, in particular as to the adequacy of the definition of 'heightened risk' and whether it should include boating in coastal reef areas and adverse weather or water conditions other than the ones currently specified.

3. Maritime Safety Victoria produce and disseminate educational information about the dangers of coastal reefs and the advisability of wearing PFDs at all times, particularly given the unpredictability of weather and water conditions.

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 McInnes's family.

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

Lois McInnes, Senior Next of Kin

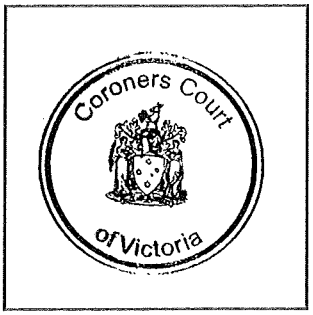
Mr Peter Corcoran, Director Marine Safety, Marine Safety Victoria

Fisheries Victorian

The Honourable Luke Donellan MP, Minister for Ports

Senior Constable Patrick Yeung, Coroner's Investigator, Victoria Police

Signature:



ROSEMARY CARLIN
CORONER
Date: 7 June 2017