IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 0748

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**ROBERT ANDREW BREWSTER**
Date of birth:	23 December 1961
Date of death:	24 February 2012
Cause of death:	Head injuries
Place of death:	The Alfred Hospital, Melbourne, Victoria

TABLE OF CONTENTS

HER HONOUR:

BACKGROUND

1. Robert Andrew Brewster (**Mr Brewster**) was a 51-year-old man who lived at Port Melbourne at the time of his death.

2. Mr Brewster was described as a loving, proud and devoted father to his two daughters, Georgia and Alexandra. Mr Brewster was in a four-year relationship with Natalie Kurban at the time of his death and was described as a wonderful friend to her two daughters. Mr Brewster remained a supportive friend to his wife, from whom he was separated.

3. Mr Brewster was a reportedly healthy man and had a routine of swimming in Port Phillip Bay between Lagoon Pier and Kerferd Road Pier at Port Melbourne three times per week in warm weather. Mr Brewster was very familiar with the area and always swam in the '*Swimming only*' zone.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Brewster's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was the result of an injury.[1]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

6. It is not the role of the Coroner to lay or apportion blame, but to establish the facts.[4] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a

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[1] Section 4 *Coroners Act 2008*
[2] Section 89(4) *Coroners Act 2008*
[3] See Preamble and s 67, *Coroners Act 2008*
[4] *Keown v Khan* (1999) 1 VR 69

consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

10. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] 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 that they caused or contributed to the death.

12. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

13. On 26 February 2012, John Brewster visually identified Mr Brewster's body as being that of his brother, Robert Andrew Brewster born 23 December 1961.

14. Identity is not in dispute and requires no further investigation.

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[5] (1938) 60 CLR 336.

Medical cause of death, pursuant to section 67(1)(b) of the Act

15. On 28 February 2012, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination of Mr Brewster's body and provided a written report, dated 24 April 2012, which concluded that Mr Brewster died of head injuries.

16. Toxicological analysis of the post mortem samples taken from Mr Brewster detected morphine, midazolam and paracetamol, consistent with his intensive care treatment following the collision.

17. I accept the cause of death proposed by Dr Lynch.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

18. At approximately 5.00pm on 24 February 2012, Mr Brewster attended the Port Melbourne beach with his daughter Georgia and her friend. They went swimming close to Lagoon Pier. Mr Brewster reportedly swam inside the '*Swimming only*' zone, toward the Kerferd Road Pier, before swimming back toward the Lagoon Pier.

19. At approximately 5.30pm, Ivan Maqi (**Mr Maqi**) was on his jetski near the Lagoon Pier with a passenger, Mohamad Mahmoud (**Mr Mahmoud**). Mr Maqi had registered the 2008 model jetski that same day, having completed an accredited recreational boat and personal watercraft assessment course on 8 February 2012 and received his Recreational Boat Licence on 9 February 2012.

20. There were many swimmers in the water that evening and a number of people fishing from the Lagoon Pier. Witnesses observed Mr Maqi to be operating his jetski up and down the foreshore area, in close proximity to the beach and the Lagoon Pier. Mr Maqi was driving the jetski within ten metres of the pier, doing spins and '*going side to side*'. Witnesses who were fishing from the pier observed Mr Maqi travel so close to the pier that he almost crossed fishing lines.

21. The area surrounding the pier was a water vessel exclusion area, with signs present in the area stating "*No Vessels*", "*No Boating Zone*" and "*Swimming Only*". Where required to operate a vessel in the area within 50 metres of the pier and 200 metres of the shore, the speed limit is 5 knots (approximately 9km/hr). Mr Maqi was reported to be travelling at speeds of approximately 50km/hr and up to approximately 70km/hr.

22. At approximately 5.50pm, Mr Maqi struck Mr Brewster in the head as Mr Brewster was swimming on the eastern side of the Lagoon Pier. Mr Maqi was seen looking back over his shoulder, talking to his passenger at the time of the collision. One witness estimated that Mr Maqi was travelling at 60-70km/hr at the time of the collision.

23. Mr Maqi, who had not realised he had struck Mr Brewster, was alerted by witnesses and returned to where Mr Brewster was floating face down and motionless in the water. Mr Mahmoud entered the water and pulled Mr Brewster over to the jetski. Mr Maqi then towed them to the shore.

24. Georgia was in the water at the time and saw that her father had been injured. She returned to the shore and ran to her doctor's rooms and asked him to go to the beach and help her father.

25. Emergency services were also called to attend. On arrival, paramedics treated Mr Brewster at the scene before transporting him to the Alfred Hospital where he was confirmed to have suffered a severe traumatic brain injury.

26. A CT scan revealed that Mr Brewster had extensive subarachnoid haemorrhage with cerebral oedema, cerebral contusions and multiple skull fractures. Mr Brewster was placed on life support, but his injuries were not survivable. He died on 26 February 2012.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

27. Mr Maqi was charged with, and pleaded guilty to, culpable driving causing death. On 22 May 2015, he was sentenced to five years' imprisonment with a non-parole period of two years and nine months. Mr Maqi's marine licence was cancelled and he was disqualified from obtaining a marine licence for a period of five years.

28. Sergeant Adrian Sinclair (**Sgt. Sinclair**) was assigned to act as the Coroner's Investigator in this matter. Sgt. Sinclair is the founding member of the Marine Investigation Unit and has been assigned to the Water Police Squad for over 10 years. Sgt. Sinclair conducted inquiries on my behalf and considered relevant marine safety improvements.

29. Sgt. Sinclair identified that safety improvements could be made in the area of Marine Licensing. He also raised concerns regarding the boat zones around the Lagoon Pier at Port Melbourne and recreational boating culture more generally.

Marine licencing in Victoria

30. Marine licence testing in Victoria does not have a practical training element. Mr Maqi had successfully completed a three-hour theoretical training course, which covered speed and distance and safety matters. During his investigations, it became apparent to Sgt. Sinclair that Mr Maqi was not sure of what constituted a '*safe*' speed and did not identify that the "*poles in the water*" delineated the boat zone from the swimming only zone.

31. In 2003, Coroner Michael Coughlan, who was investigating the death of Paul Hayes at Warrnambool, recommended that "... *all applicants for a recreational boat licence be required to undertake a practical examination and exhibit a reasonable proficiency in the operation of a boat, in addition to the existing written examination, before being issued with a licence*".[6]

32. A 2011 '*Options Paper for Marine Licencing in Victoria*' (**the Options Paper**) noted that Victoria is the only Australian jurisdiction to have a recreational boat licensing scheme with no practical skills training or assessment element or supervised, on-water vessel-operating experience.[7] The Options Paper stated:

> "*A higher standard of testing (in Victoria), such as practical training or assessing, in relation to the following competencies, could reduce the number of marine incidents in Victoria in the following ways; Training/assessment option – Training in operating high-speed watercraft, particularly PWCs (**Personal Watercraft**), and the dangers involved in operating in close proximity to others. Expected outcome – Reduce the incidence of high-speed collisions.*"

33. The Options Paper analysed incidents resulting from general boating and determined that they "*could be decreased by as much as 39%*", with marine licencing improvements, including a practical test element.

34. In 2012, Transport Safety Victoria's (**TSV**) Director (**the Director**) provided a report to the Coroners Court in the investigation into the death of Zane McLaughlin (**Zane**), which identified that the lack of skills and knowledge, including through inexperience and lack of opportunity to practice rules to prevent collisions, may have been causal factors in the boat crash which resulted in Zane's death.

35. The Director hypothesised that, "*some vessel operators may not adequately understand the requirement for and/or lack skills or knowledge about environment-scanning techniques for*

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[6] COR 2003 2529.
[7] Options Paper for Marine Licencing in Victoria for *Marine Safety Regulations 2011*, p 30.

the marine environment and therefore keeping a proper lookout. This is especially important since the environment requires 360° scanning and limited engineering controls are available in the recreational boating domain to change this requirement."

36. At a Victorian Parliamentary Inquiry into Marine Rescue Services in Victoria in 2014 (**the Parliamentary Inquiry**), the Director of Maritime Safety at TSV (**the Director**) stated:

> "*The test for the licence that boaters obtain is a knowledge test and not a competency test ... I would support a practical component to the (water) licencing regime*".

37. During the Parliamentary Inquiry, the Manager of Waterway User Safety at TSV stated:

> "*The primary problem we find with jetski users is that they are generally pretty compliant when it comes to safety equipment and those sorts of things; they are generally licenced, but where we see a greater degree of problems ... is in their operation ... in not adhering to the speed and distance rules ...*"

38. When asked directly about practical licence training, the Director replied, "*I would support a practical component to the licencing regime.*" The Director was further questioned, "*Not just for jetskis but for all boaters?*" and replied, "*For all boaters.*"

39. In a supplementary submission to the Parliamentary Inquiry, the Acting Director of Maritime Safety at TSV advised that:

> "*at the time of introduction, the marine licencing scheme sought to achieve consistency with similar schemes in other jurisdictions in Victoria by modelling the assessment on the Guidelines for Recreational Boat Operator Competencies, released by the National Marine Safety Committee in November 2000. Since that time, all other states of Australia have introduced a practical assessment of some degree into their licencing schemes.*"

40. In the Finding into the death of Zane McLaughlin,[8] then State Coroner, Judge Ian Gray, took the view that it is reasonable to infer that better training of people operating watercraft at moderate and high speeds would be likely to reduce the incidence of high-speed collisions.

41. Judge Gray commented:

> "*The failure to keep a proper lookout is a function, no doubt, of experience, immediate circumstance, possibly distraction and possibly attitude. It is fair to infer, based on ordinary human experience, that practical experience and reinforcement through training and assessment is likely to enhance the awareness and consciousness of the need to keep a proper lookout at all times ... there are powerful reasons, in my view, for concluding, as a general proposition, that a practical component to recreational boat licencing is likely to lower the overall risk of vessel operators failing to remember to keep a proper lookout or failing to take the necessary steps involved in safe vessel operation ... it is reasonable to*

[8] COR 2008 1678. The finding was delivered on 16 October 2014.

infer that it is likely to increase vessel operator consciousness, reinforce awareness of risk and thereby reduce the likelihood of accidents."

42. Judge Gray made the following recommendation:

> "*... that there be a reconsideration by relevant authorities of whether the estimated benefits of a practical component of the Victorian recreational boat licence regime continues to outweigh the costs. I recommend that such a reconsideration take into account the need to strike an appropriate balance between public safety and public cost, which may require a recalibration of the equation and a greater weighting to the public safety component of that equation.*"

43. The Parliamentary Inquiry's Final Report recommended that:

> "*the Victorian Government introduce a relevant practical component as part of the assessment process for general and restricted marine licences, and for personal watercraft endorsements.*"

44. Since 2000, the number of fatal and serious injury incidents has remained relatively constant. In 1999-2000, a period which pre-dates marine licencing in Victoria, there were 10 vessel-related fatalities. In 2013-2014, there were also 10 vessel fatalities. In 2014-2015, there were another 10 vessel fatalities. It follows that the introduction of boat licences has done little to reduce marine fatalities in Victoria.

45. In their response to Judge Gray's recommendation, dated 15 December 2014, the Secretary, Transport, Department of Transport, Planning and Local Infrastructure (**the Department**) advised that:

> *Following consultation on the draft marine safety regulations and the Licensing Options Paper the decision was made to not proceed with changes to licensing requirements. The economic assessment demonstrated that the option to require applicants for general marine licences to pass a test of competence or operational skills could not be justified based on available information. The number of deaths and injuries associated with recreational boating that could be attributed (in part or in full) to lack of competence and skill was very low. The available evidence suggested that the vast majority of incidents resulting in serious harm arise from risk taking behaviour and other human factors such as lack of attention and failure to keep a proper lookout. Requiring licence applicants to demonstrate that they possess skill or competence was thought to be unlikely to address the causes of these incidents.*
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> *However, the assessment of the proposal to introduce new endorsement requirements (towing) and to require persons to demonstrate possession of skills or competence before obtaining endorsements (personal watercraft and towing) indicated that making such changes may be justified. This is because the available evidence suggests that a large number of injuries are being sustained due to lack of skill or competence in the short period after persons start engaging in these activities. Requiring persons to pass a test of competence or skill, before being permitted to engage in these activities without supervision, is likely to be an effective way of avoiding a proportion of these incidents.*

While the Government in 2012 was not convinced of the merit in proceeding with this reform at that time it was agreed that licence endorsement requirements would be reviewed approximately three years after the commencement of the Marine Safety Regulations (1 July 2012). To set a timeframe for the review, the regulations establishing licence endorsement requirement for personal watercraft were set to expire on 21 December 2015.

The re-evaluation of licence endorsement requirements and options is proposed to commence in January 2015. The Department will recommend to the Minister for Ports, the Hon. Luke Donnellan, that the Coroner's recommendation for a practical component to marine licencing be considered in the context of that review.

46. On 22 November 2016, the Court wrote to the Department, seeking an update as to the outcome of the re-evaluation of licence endorsement requirements and the recommendation to the Minister for Ports regarding a practical component to marine licencing.

47. On 7 April 2017, the Department responded to the Court, advising that:

"The case to require practical testing for applicants for PWC endorsements was considered ... However, it was not possible to make a compelling argument in favour of this regulatory intervention. The costs would be significant and apart the circumstances surrounding Mr Brewster's death, there is not much evidence to suggest that lack of practical skills is a major contributing factor to deaths and serious injuries that have occurred on or in Victorian waters.

Since that time (late 2015), there has not been any further consideration of the case for or against incorporating practical testing into marine safety requirements. However, the Department and Transport Safety Victoria (TSV) have reconsideration of this matter on their respective draft work programs for 2017-18. TSV have commissioned further analysis of hospital admissions and emergency presentation data to support this reconsideration. A draft report has recently been received."

48. While I accept the Department's 2017 response as reflecting an honestly held view, that response did not address:

(a) the Parliamentary Inquiry's full consideration of the issue and recommendation in support of practical component to the Victorian marine licensing regime; and

(b) the 2014 Secretary of Transport's response to Judge Gray's recommendation, referred to above.

49. The fact that Victoria remains the only Australian State without a practical element to its marine licensing regime,[9] despite a Parliamentary Inquiry's recommendation to the contrary three years ago, is a concerning reflection. The financial ramifications of such a regime change should be secondary to the public health and safety considerations.

[9] TSV's supplementary submission to the Parliamentary Inquiry.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

50. I consider that the effectiveness of the Victorian marine licencing regime, and the safety of the Victorian public, could be enhanced by the introduction of a practical element. Therefore, **I RECOMMEND** that the Minister for Roads and Road Safety take the necessary steps to introduce a relevant practical component as part of the assessment process for general and restricted marine licences and for personal watercraft endorsements.

FINDINGS AND CONCLUSION

51. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Robert Andrew Brewster, born 23 December 1961;

    (b) the death occurred on 26 February 2012, at the Alfred Hospital, Melbourne, Victoria, from head injuries sustained on 24 February 2012; and

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

52. I thank Sgt. Adrian Sinclair for the extremely thorough Coronial Brief which he produced for this matter, and all of the assistance he gave to the Court in reviewing previous findings, inquiries and relevant recommendations in relation to this matter.

53. I convey my sincerest sympathy to Mr Brewster's family and friends.

54. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

    (a) John Brewster, senior next of kin.

    (b) Natalie Kurban.

    (c) The Hon. Daniel Andrews MP, Premier of Victoria.

    (d) The Hon. Luke Donnellan MP, Minister for Roads and Road Safety.

    (e) Secretary, Transport, Department of Economic Development, Jobs, Transport and Resources.

(f) Transport Safety Victoria.

(g) Sergeant Adrian Sinclair, Victoria Police, Coroner's Investigator.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 22 June 2017