IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000372

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Terry John Chandler
Date of birth:	20 January 1979
Date of death:	20 January 2021
Cause of death:	1(a) Drowning
Place of death:	McLoughlins Beach-Seaspray Coastal Reserve, Woodside, Victoria, 3874

INTRODUCTION

1. Terry John Chandler was 42 years old at the time of his death and worked as a farmhand in Nambrok. Mr Chandler lived in a farmhouse with his de-facto partner of 11 years, Rhiannon Bruce and their daughter Jade Chandler and Noah Chircop, Ms Bruce's son from her previous relationship.

2. In the early hours of 20 January 2021, Mr Chandler was found deceased in the water of Jack Smith Lake State Game Reserve, Woodside, after setting out to sail his boat the night before.

3. Mr Chandler did not regularly attend healthcare practitioners and there was limited documentation of his exact health condition. As far as his family were aware, Mr Chandler typically visited the local clinics for common ailments.

4. Mr Chandler owned a 3.7 metres Clark boat of open tiller steer aluminium build[1] which he partially acquired in December 2020. It was equipped with a 15 horsepower, 2-stroke Mercury outboard motor.

5. According to Noah, Mr Chandler was a good swimmer [2] but had not had much boating experience. In Ms Bruce's statement said of her partner: *"Terry* [Mr Chandler] *had not done any boating since we have been together but he has told me about launching boats and going boating before".*

THE CORONIAL INVESTIGATION

6. Mr Chandler'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.

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

[1] Colloquially known as "tinny" or "tinnie".
[2] Coronial Brief of Evidence (**CB**), interview transcript of Noah Chircop.

8. 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.

9. Victoria Police assigned Leading Senior Constable Glenn Mackenzie[3] (LSC Mackenzie) to be the Coroner's Investigator for the investigation of Mr Chandler 's death. LSC Mackenzie conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist and investigating officers – and submitted a coronial brief of evidence.

10. As part of my investigation, the Coroners Prevention Unit[4] (**CPU**) was requested to examine possible prevention opportunities in this with a view to making recommendations if appropriate.

11. This finding draws on the totality of the coronial investigation into the death of Terry John Chandler including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

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

The beach

12. Jack Smith Lake State Game Reserve[6] is a lagoon that adjoins McLoughlins Beach-Seaspray Coastal Reserve, also known as Jack Smith Beach[7]. Jack Smith Beach is accessible via a short sand track.

[3] LSC MacKenzie is a member of the Water Police and holds several marine operation qualifications.

[4] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[5] 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.

[6] Including Jack Smith Lake as part of the reserve.

[7] Investigators and witnesses have referred to the beach adjacent to Jack Smith Reserve as Jack Smith Beach.

Circumstances in which the death occurred

13. On the afternoon of 17 January 2021, the Chandler family set out from Nambrok to camp at the reserve. They were also joined by Ms Bruce's nephew, Allan Bruce.

14. The plan for the Chandler's family was to stay at the campsite until 21 January 2020 to celebrate Mr Chandler's birthday before he returned to work from his leave. Mr Chandler brought his boat along on the trip, intending to use it for fishing on the lake.

15. According to Ms Bruce, the Chandler family had been to the reserve area on approximately 10 to 15 times throughout the year of 2020. Mr Chandler had not, however, taken it to Jack Smith Beach until this trip.

16. The Chandler family stayed in their camps relaxing and had *"a good time messing around"*. Mr Chandler was happy and keen to get out on to the water but Ms Bruce recalled the weather conditions for the first three days of their stay was *"was windy and the surf was too big"*.

17. On the morning of 19 January 2021, Mr Chandler was seen drinking alcohol since 10.00am. Ms Bruce said *"he usually would drink more on his holidays than he usually drinks* [sic]*"*. He was seen to have consumed approximately *"half a bottle"* of his one litre double-distilled homebrew whiskey and stopped at 12.00pm.

18. At approximately 10.00pm, Ms Bruce recalled *"it was the first time it had been calm enough since [they] got there"*. She then proceeded to fish near the shore at McLoughlins Beach and Mr Chandler was seen getting his boat ready for fishing.

19. Although the winds had calmed down, Ms Bruce believed *"the surf was too big"*. Concerned for their safety, Ms Bruce asked Mr Chandler not to go boating with Alan and Noah. Mr Chandler dismissed Ms Bruce's concern and told Allan and Noah that he *"had been out in worse conditions"*.

20. On 20 January 2021, at approximately 12.15am, Mr Chandler towed the boat to the shore of Jack Smith Beach with the assistance of Allan and Noah. He intended to deploy the fish baits to fish for sharks and return to the shore with the fishing rod.

21. At approximately 12.30am, they launched the boat and motored to approximately 200 metres off the shore.

22. While Mr Chandler was deploying the bait, a swell struck the boat and it capsized, ejecting all three of them into the water. All three of them were wearing a Type 1 Personal Floating Device[8] (**PFD**) at the time of the capsize, Mr Chandler was wearing a Watersnake inflatable PFD.

23. Mr Chandler and Noah swam back to the boat and grabbed hold the submerged boat for support. Allan swam to the shore instead.

24. Shortly after, another wave hit the boat, turning the upturned boat the right way up. Mr Chandler and Noah were again thrown into the water. This time they manage to swim and climbed back into the boat. Mr Chandler then called out to Noah to restart the engine but he was unable to do so.

25. Mr Chandler then jumped into the water and took the bow line intending to swim the vessel back to the shore. At that time, Noah observed Mr Chandler was swimming with one hand at that time. He recounted that Mr Chandler *"was trying to kick and he was just…like he's been getting real bad chest pains* [sic]*"*.

26. While Mr Chandler was swimming and pulling the boat back to the shore, the boat was again hit by a large swell, ejecting Noah into the water. The boat was almost immediately consumed by waves and capsized. Noah lost sight of Mr Chandler and the boat and swam back the shore.

27. At approximately 1.09am, Allan swam back to the shore and contacted emergency services upon returning to the campsite. Noah arrived back on the shore shortly after Allan.

28. Victoria Police from the Sale station and Rescue Coordination Centre (**RCC**) were notified. Police Air and Water Police were tasked to attend the advised location.

29. Police arrived at approximately 2.10am followed by Ambulance Victoria paramedics and a police helicopter at 2.52am.

30. Police immediately commenced a land search and located the boat at approximately 400 metres southwest of the launched location.

[8] Which is colloquially known known as lifejacket. Type 1 Personal Floating Device (**PFD**) which is also level 100 and over, is a lifejacket that provides high level of buoyancy and keeps the wearer in a safe floating position. It is made in high visibility colours with reflective patches.

31. At 3.02am, Mr Chandler was located approximately 250 metres off the shore. He was faced up at the water in his inflated PFD, unresponsive. Mr Chandler was later recovered from the water by members of Police Air Wing and conveyed to ambulance paramedics at 3.55am.

32. Upon examination by ambulance paramedics, Mr Chandler displayed no signs of life and was deceased.

Identity of the deceased

33. On 20 January 2021, Terry John Chandler, born 20 January 1979, was visually identified by his de-facto partner, Rhiannon Bruce.

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

Medical cause of death

35. On 28 January 2021, Forensic Pathologist Registrar Dr Joanne Chi Yik Ho from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy[9] on the body of Terry John Chandler. Dr Ho also reviewed a computed tomography (**CT**) scan and referred to the Victoria Police Report of Death (Form 83), VFIM preliminary examination form, VFIM contact log, Victoria Police scene photographs and medical notes from Latrobe Regional Hospital. Dr Ho provided a written report of her findings dated 10 May 2021.

36. The post-mortem examination revealed features of immersion and drowning. The post-mortem CT scan revealed fluid within the ethmoid sinuses, bilateral pleural effusions and watery fluid within the stomach and heavily inflated lungs.

37. There was no post-mortem evidence of any injuries which may have caused or contributed to death.

38. Toxicological analysis of post-mortem samples identified the presence of ethanol of 0.06 g/100mL (alcohol) and delta-9-tetrahydrocannabinol[10].

39. With reference to Mr Chandler's toxicology results, Dr Ho noted that the level of ethanol might cause a level of relaxation, decreased alertness and coordination, and might have

[9] Under the supervision of Dr Joanne Glengarry, Forensic Pathologist from the VFIM.

[10] Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis (marijuana). The strength of cannabis usually varies from 2-4% but can exceed 10%. It is normally inhaled through cigarettes smoked in a similar fashion to tobacco or inhaled through a water pipe or bong. It can also be consumed orally through food products, such as cookies.

impaired his rational judgement and motor coordination, leading him to drown after entering the water.

40. Furthermore, Dr Ho also noted the medical episode of chest pain experienced by Mr Chandler prior to his death. Dr Ho commented that while there was evidence of mild coronary artery atherosclerosis, mild vessel disease and compensatory myocardial disease, these diseases were unlikely to have caused or contributed to his chest pain.

41. In considering Mr Chandler's previous medical records, his young age and the circumstances of the medical episode described, Dr Ho posited the possibility of a medical condition of cardiac channelopathy[11].

42. Dr Ho commented that the diagnosis of drowning is based on a constellation of nonspecific autopsy findings with weight given to the circumstances.

43. Based on the available evidence and her autopsy findings, Dr Ho ascribed the medical cause of death to 1 (a) drowning.

WATER POLICE INVESTIGATIONS

Vessel inspection

44. Water Police inspected the recovered vessel and observed the engine became malfunctioned due to seawater ingestion. The boat was modified with welds in the upper corners of the transom and additional reinforcement on the transom and engine mount. It is in seaworthy condition and the buoyancy is positive.

45. The engine was mounted to the vessel via screw style clamps. The safety lanyard was fitted to the engine and attached to the engine's cut-off switch. LSC Mackenzie noted the lanyard was still connected to the engine, indicating it was not attached to the operator when the engine was still running during the course of capsize. In normal operation, the lanyard is attached to the operator to allow the operator to disable the engine if the operator has fallen overboard or was unable to control the vessel.

[11] Cardiac channelopathies such as long QT syndrome, catecholaminergic polymorphous ventricular tachycardia and Brugada syndrome have been implicated with some cardiac arrhythmias. Some people can have little or no symptoms, others may have lighted-headedness, heart palpitations, weakness or blurred vision. Many of these conditions are potentially genetically inherited,

46. Although the boat was equipped with safety equipment in the way of a search light, Emergency Position Indicating Radio Beacon (**EPIRB**), oars and an anchor, there was absence of an electrical power system. The boat was also not fitted with a bilge pump or navigation lights for night-time operation.

Weather and sea conditions

47. Bureau of Meteorology data indicates that on 19 January 2021 there were south-west to west-south-west winds of 15 to 20 knots throughout most of the day, decreasing to 5 to 6 knots at approximately 10.00pm swinging to the north-west direction. The average sea surface temperature was between 19 and 20 degrees Celsius.

48. LSC Mackenzie explained that the decreasing wind knots would *"quite quickly reduce the sea state making it appear calmer…however not substantially reduce the residual swell"*.[12]

49. LSC Mackenzie commented that:

> *"While the sea conditions appeared somewhat calmer than the previous days there was still residual swell. The small vessel could handle the swell while slowly making way with the bow pointing directly at breaking waves. However, once Terry had placed his baits and turned the vessel to come back to shore the dynamic change substantially. Once caught by a breaking wave the vessel did not have the power to outrun a shore break. Ideally the vessel would need to be place on the back of a wave to safely come to shore. This can be difficult to time and would take experience with the conditions and the vessel, of which Terry had neither"*.[13]

Marine Licence

50. During the course of his investigation, LSC Mackenzie's learned that Mr Chandler did not hold a current Victorian marine licence.

51. In Victoria, marine licences are required by any individual who intends to operate a recreational vessel in Victorian waters. General marine licences[14] are available by application from VicRoads to individuals who are at least 16 years old.[15] Individual who wishes to obtain a Victorian marine licence must self-study the Victorian Recreational Boating Safety Handbook in preparation for the marine licence knowledge test or holds an interstate licence

[12] CB, police summary
[13] CB, police summary.
[14] Or restricted marine licence for individuals between 12 and 16 years old.
[15] *Marine Safety Act 2010* (Vic), section 53.

that has not expired for more than five years or a valid Certificate of Competency or a valid Certificate of Attainment.[16]

52. Pursuant to section 46 of the *Marine Safety Act 2010* (Vic), it is an offence for an individual to have command or be in charge of a registered recreational vessel without a marine licence, which highlights the importance of an individual operating a recreational vessel having the required competency to pursue recreational maritime activities.

LSC Mackenzie's opinion and suggestion

53. In light of Mr Chandler's toxicology report, LSC Mackenzie provided the following opinion in relation Mr Chandler's death:

"…a combination of issues lead to Terry's [Mr Chandler] *death. Inexperience and intoxication……Terry did not hold any form of marine licence or certification indicating his experience. If any, Terry's experience was minimal…[and] had also been consuming alcohol and cannabis impairing his decision-making ability and cognitive function. Compound this was an overwhelming desire to use the boat for it's intended purpose and following the rollover, a desire to salvage the vessel* [sic].[17]"

54. Additionally, LSC Mackenzie noted that the left side of Mr Chandler's PFD remained uninflated. Despite that, LSC Mackenzie commented that Mr Chandler's PFD *"offered at least some buoyancy. Had [he] not focused on salvaging the boat but rather stayed with it or swam to the shore, it is possible he would have survived the incident"*.[18]

55. Having considered all the circumstances surrounding Mr Chandler's death, LSC Mackenzie stated that he had no further recommendations for me other than to raise the awareness of the general public on the continuous servicing of PFDs.

CPU REVIEW

56. While it is difficult to speculate whether better training and education in recreational boating may have assisted Mr Chandler, it is at least certain that a holder of a marine licence is

[16] See further at VicRoads website, https://www.vicroads.vic.gov.au/licences/licence-and-permit-types/marine-licence.
[17] CB, police summary.
[18] Ibid.

competent in the ways that they are aware of the safe operating practice and relevant marine safety laws.[19]

57. The CPU acknowledged LSC Mackenzie's opinion and found that Mr Chandler did not understand his safety risks. His understanding was also impaired by the use of alcohol and illicit substance prior to launching his boat at night and in challenging conditions.

58. The CPU concluded that it found no evidence to suggest that Mr Chandler's death could have been prevented and that a potential rescue was assisted in any way by the presence of an EPIRB.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

59. The death of Mr Chandler highlights the reality of inherent risks associated with recreational boating. His personal factors combined with the weather and sea conditions, was evidently the least ideal for one to go fishing.

60. Mr Chandler was relatively inexperienced in recreational boating and operating his boat. He did not understand the risks to his safety and his passengers and made the decision to launch and operate his vessel under the influence of alcohol and illicit substance. It was also likely that his decision-making capacity was compromised by the influence of alcohol.

61. Whilst it is not possible to say Mr Chandler would have survived if his PFD was fully functional, it is apparent that his chance of survival would have been enhanced. But for the chance of Allan and Noah wearing a functional PFD, this incident might well have been three fatalities rather than one.

62. I acknowledge that the prevention opportunities to be pursued in the circumstances such Mr Chandler's tragic incident are rather fundamental to the awareness of conducting regular professional service on PFDs.

63. I also acknowledge and commend the efforts of Transport Safety Victoria to raise awareness among boaters through the "Prepare to Survive: Know the Five" campaign. The five steps

[19] *Marine Safety Act,* section 45 - Purpose of licensing.

provide that boater should *"know the weather, practise getting back on, carry a distress beacon, lock in a buddy plan [and] wear a lifejacket"*.

64. In fulfillment of my prevention role in enhancing public health and safety, I find that further attention to the five steps advice is warranted to ensure the public are made aware of these basic but essential advice. Consequently, I have made recommendation accordingly.

RECOMMENDATIONS

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

1. In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria highlight and disseminate the circumstances in which Mr Chandler drowned in its upcoming educational materials and safety promotional campaign.

2. In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria produce and disseminate awareness campaign such as the "Life Jacket Label-Read It" campaign[20] as advanced by the National Safe Boating Council of the United States.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Terry John Chandler, born 20 January 1979;

   b) the death occurred on 20 January 2021 at McLoughlins Beach-Seaspray Coastal Reserve, Woodside, Victoria, 3874; and

   c) I accept and adopt the medical cause of death ascribed by Dr Joanne Chi Yik Ho and I find that Terry John Chandler died from drowning while fishing and in circumstances where he was under the influence of alcohol and illicit substance.

I convey my sincere condolences to Mr Chandler's family for their loss.

[20] https://safeboatingcampaign.com/news/life-jacket-label-read-it/. The campaign highlighted the importance to check life jacket every year to make sure "it still floats you, has no rips or tears, and fits you well".

Pursuant to section 73(1B) of the Act, I order that this Finding to be published on the Coroners Court of Victoria website in accordance with the rules.

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

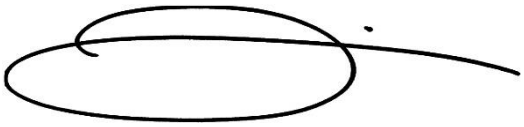
Rhiannon Bruce

Leading Senior Constable Glenn Mackenzie, Coroner's Investigator, Victoria Police

Life Saving Victoria

Transport Safety Victoria, Maritime Safety Division

Signature:



AUDREY JAMIESON

CORONER

Date: 12 July 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.