IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000452

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	David Andrew Coulter
Date of birth:	24 March 1962
Date of death:	23 January 2021
Cause of death:	1(a) Drowning
Place of death:	Anglesea, Victoria, 3230

INTRODUCTION

1. David Andrew Coulter was 58 years old at the time of his death and lived with his wife, Kate Coulter, in Lancefield. He is also survived by his three children from a previous marriage.

2. Mr Coulter worked as a flower farmer and enjoyed fishing and boating in his leisure time. According to Mrs Coulter, he was an experienced fisherman and a strong swimmer.

3. The evidence indicates that Mr Coulter was in relatively good health, except for health issues of calcified tendons and carpal tunnel.[1]

4. On 23 January 2021, while fishing in a boat off Anglesea with his friend, Geoffrey Bowell, the boat capsized. Mr Bowell was able to swim back to shore, but Mr Coulter drowned.

THE CORONIAL INVESTIGATION

5. Mr Coulter'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.

6. 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.

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

8. Victoria Police assigned Senior Constable Jessica Lang[2] (SC Lang) to be the Coroner's Investigator for the investigation of Mr Coulter's death. SC Lang 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.

[1] Coronial Brief of Evidence (**CB**), Statement of Kate Coulter.
[2] SC Lang was also a member of the Water Police squad at the time of this coronial investigation.

9. As part of the coronial investigation, advice was sought from the Coroners Prevention Unit (**CPU**[3]) in examining possible prevention opportunities in this matter with a view to making recommendations if appropriate.

10. This finding draws on the totality of the coronial investigation into the death of David Andrew Coulter, 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.[4]

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

The boat

11. Mr Bowell owned the boat. Manufactured in approximately 2003, it is a 4.2 metres Stacer aluminium boat. It is fitted with a 30 horsepower Yamaha hand tiller engine with a maximum loading capacity if 360 kilograms.

The beach

12. O'Donohues Beach formed part of the Queenscliff Coastal Reserve and is located approximately 1.1 kilometres southwest of Point Roadknight.

Weather and sea conditions

13. The weather forecast for 23 January 2021 was partly cloudy. Winds were forecast to be south-easterly with a 10 knots variability during the afternoon. Forecast seas were below 1 metre. Swell was south-westerly 1.5 to 2.0 metres, increasing to 2 to 3 metres in the west.

Circumstances in which the death occurred

14. It was Mr Coulter's routine to spend his weekend in Anglesea maintaining the house and sometimes going fishing with Mr Bowell on Mr Bowell's Stacer ("the boat"). Mr Bowell is

[3] 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.

[4] 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.

also an experienced fisherman and boater. He described himself as having *"done a lot sailing…also a lot of diving and surfing"*.[5]

15. On the Saturday morning of 23 January 2021, Mr Bowell went to pick Mr Coulter up from his holiday house in Anglesea. They drove to the Point Roadknight boat ramp with the boat and launched the boat at approximately 10.30 am. Both of them were wearing an inflatable style Type 1 personal floating device[6] (**PFD**).

16. Once the boat was in the water, Mr Coulter motored the boat passed the point and headed southeast, approximately five miles off the shore. Mr Bowell recalled they *"motored out as far as we both [felt] comfortable"*.[7] Mr Coulter then stopped the engine and began drift fishing.

17. At approximately 2.00pm, after drift fishing for some time catching some fish, they decided to motor to the offshore water of O'Donohues Beach[8], attempting to catch some whiting.
18. It is still unclear how far they went offshore, but Mr Bowell estimated that he and Mr Coulter stopped again at approximately 100 metres from the breaking waves. Mr Bowell recalled that they "surveyed" for their position and stated, *"we felt we were ok [at] where we were"*.[9]
19. At that time, an off-duty member of Anglesea Surf Lifesaving Club (**ASLC**), Owen Solly, who was checking for the surf at the 12th Avenue lookout, sighted the boat. Mr Solley recalled the boat was *"pretty close to the waves…they were drifting in towards to the shore, closer and closer* [sic]*"*.[10]

20. Mr Bowell proceeded to deploy an anchor and fishing lines into the water from the bow and Mr Coulter was sitting at the stern. Before Mr Bowell was able to tie the anchor rope, he saw large waves approaching them. The boat was then struck by *"a very large wave"* and got *"carried over"*.[11]

21. Shortly after, Mr Bowell saw another "very large" wave approaching them. The wave struck the boat again, causing it to lift upright in the water and the boat was brought back down as the wave broke.

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[5] CB, Statement of Geoffrey Bowell.
[6] Type 1 PFD, which is also level 100 and over, is a lifejacket that provides a high level of buoyancy and keeps the wearer in a safe floating position. It is made in high visibility colours with reflective patches.
[7] CB, Statement of Geoffrey Bowell.
[8] Which is southwest of Point RoadKnight beach
[9] CB, Statement of Geoffrey Bowell.
[10] CB, Statement of Owen Solly.
[11] CB, Statement of Geoffrey Bowell.

22. Mr Bowell asked Mr Coulter to start the engine, which he did. Mr Coulter then steered the boat with its stern into another approaching wave. The wave continued to lift the boat, "*tipping the boat backwards over itself"* and ejected both of them into the water.[12]

23. Almost immediately, they were pulled under the water by swells. Mr Bowell estimated he was under the water for about 15 to 20 seconds before he was able to break free and resurfaced.

24. When Mr Bowell resurfaced[13], he saw Mr Coulter not too far away in the water. He then called out to Mr Coulter telling him to inflate his lifejacket. Mr Coulter nodded in agreement but got pulled under the water again by another swell before he could inflate his lifejacket.[14]

25. Mr Bowell was also pulled under the water shortly after Mr Coulter. He immediately inflated his lifejacket and was able to resurface when his lifejacket became inflated. Mr Bowell lost sight of Mr Coulter when he resurfaced.

26. Mr Bowell began to swim back to shore and eventually made it back to O'Donohues Beach. Several people came to the immediate assistance of Mr Bowell when he was approaching the shore.

27. Shortly after, Mr Bowell saw his capsized boat being brought back by the wave towards the shore but did not see any signs of Mr Coulter. Further search and rescue efforts for Mr Coulter were already underway.

The search and rescue

28. Upon seeing the boat capsizing, Mr Solly immediately notified his mother, Mrs Solly. She then informed two on-duty members of the ALSC, Edward MacKay and Sebastian Top, who were patrolling at the Point Roadknight Beach.

29. Mr MacKay and Mr Top drove their respective personal watercraft (**PWC**) to O'Donohues Beach and started searching along the shore. Almost immediately, Mr Top spotted an overturned boat lying on the rocks off O'Donohues Beach but did not see Mr Coulter near the boat from a distance on their PWCs.

30. They beached their PWCs and gathered information from witnesses on the beach. Mr Solly also arrived at O'Donohues Beach and joined in the search.

[12] CB, Statement of Geoffrey Bowell.
[13] It is unclear from the evidence whether Mr Coulter resurfaced before Mr Bowell.
[14] CB, Statement of Geoffrey Bowell.

31. At approximately 2.20pm, Mr Top located Mr Coulter floating face down against the rock in the water. Mr Top pulled Mr Coulter out from the water with the assistance of Mr Solly. Mr Coulter was unconscious, and Mr Top immediately commenced cardiopulmonary resuscitation (**CPR**) on him.

32. At approximately 2.28pm, ambulance paramedics arrived and took over CPR. Mr Coulter was unable to be revived and was declared deceased shortly after.

Identity of the deceased

33. On 23 January 2020, David Andrew Coulter, born 24 March 1962, was visually identified by his friend, Geoffrey Bowell.

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

Medical cause of death

35. On 25 January 2021, Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on the body of David Andrew Coulter. Dr Beer also referred to a post-mortem computed tomography (**CT**) scan and reviewed the Victoria Police Report of Death (Form 83). Dr Beer provided a written report of his findings dated 27 January 2021.

36. The post-mortem examination revealed findings in keeping with Mr Coulter's clinical history.

37. The post-mortem CT scan revealed a small level of fluid in the right sinus.

38. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) and delta-9-tetrahydrocannabinol[15] (cannabis).

39. On the basis of available before him, Dr Beer ascribed the medical cause of death to death was 1 (a) drowning.

WATER POLICE INVESTIGATION

Vessel inspection

[15] 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.

40. Following the incident, Mr Bowell's boat was recovered by Water Police the next day during low tides and was sent to Maritime Safety Victoria (**MSV**) for a comprehensive inspection.

41. MSV provided a detailed report, concluding that the boat was in a sound mechanical, structural and electrical condition at the time of the incident and equipped with operative safety equipment.[16] The report also highlighted that *"the quantity of fishing line wrapped around the propeller appeared sufficient to seize and stall a 30 Horsepower engine"*.[17]

Personal Floating Device

42. Both Mr Coulter and Mr Bowell were wearing inflatable PFD at the time of the capsize. As part of the investigation, both PFD were inspected that by VicLab.

43. The inspection revealed that Mr Coulter's PFD was not activated during the course of the capsize. His PFD was manufactured in September 2009 and had no records of professional service.[18] The testing did not identify any faulty issues that would have resulted in the PFD not inflating as required.[19] On the evidence, it was likely that Mr Coulter had insufficient time to activate his PFD.

44. It was fortunate that Mr Bowell's PFD was activated and operated correctly. It was manufactured in August 2017 and has not been professionally serviced since its purchase.[20]

Marine Licence

45. During the course of her investigation, SC Lang learned that Mr Coulter did not hold a current marine licence. The available evidence also failed to disclose what previous boating education or training Mr Coulter had.

46. In Victoria, marine licences are required by any individual who intends to operate a recreational vessel in Victorian waters. General marine licences[21] are available by application from VicRoads to individuals who are at least 16 years old.[22] Individuals who wishes to obtain a Victorian marine licence must self-study the Victorian Recreational Boating Safety Handbook in preparation for marine licence knowledge test or holds an interstate licence that

[16] CB, Exhibit 6 – Maritime Investigatio Report by Maritime Safety Victoria.
[17] Ibid.
[18] CB, Exhibit 8 - VicLab Test Report.
[19] Ibid.
[20] CB, Exhibit 7 - VicLab Test Report.

[21] Or restricted marine licence for individuals between 12 and 16 years old.
[22] Section 53 of *Marine Safety Act 2010* (Vic).

has not expired for more than five years or a valid Certificate of Competency or a valid Certificate of Attainment.[23]

47. 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. This highlights the importance of an individual operating a recreational vessel having the required competency to pursue recreational maritime activities.

SC Lang's recommendations

48. During the course of SC Lang's investigation, she noted Mr Coulter's incident was one of three recreational boating accidents that had occurred in 2021[24] and appeared to have occurred in similar circumstances.

49. The similarities in these circumstances were that small vessels had been launched or operated an inshore coastal location such as surf zones or ocean bars that are less than two nautical miles.[25] These boats capsized due to exceeding boat conditions or were due to operator incapability. SC Lang commented that this is a trend that was not seen in the previous years.

50. SC Lang suggested several two recommendations to prevent deaths from occurring in similar circumstances:

    (i) expanding the definition of an "unsafe vessel" and a vessel that is "fit for purpose" under the *Marine Safety Act 2010* (Vic) (**MSA**) and *Marine Safety Regulation 2012* (Vic) (**MSR**) to include a recreational vessel must only be used in the area or conditions for it is designed and intended; and

    (ii) limiting the existing maritime laws on the delineation of coastal water so as to mandate vessels in coastal inshore waters to also be required to carry all necessary safety equipment.

[23] See further at VicRoads website, https://www.vicroads.vic.gov.au/licences/licence-and-permit-types/marine-licence.
[24] These accidents are reported to the Coroners Court of Victoria. These matters are Terry Chandler COR 2021 372 and Michael Hanratty COR 2021 1241.
[25] CB, police summary.

CPU REVIEW

51. I sought the advice of the CPU in examining the merit and feasibility of SC Lang's recommendations. In doing so, the CPU reviewed Mr Coulter's matter in conjunction with two other reportable incidents brought to my attention.[26]

52. The CPU found that in contrast to the available definition of an unsafe vessel in the MSA and the criteria of a recreational vessel that is not fit for purpose in the MSR, SC Lang's recommendation is somewhat vague.

53. The CPU commented that it is very subjective to definitely establish whether a vessel is suited for a particular area or a particular set of conditions. Thus, making the expansion of the definition and criteria difficult.

54. While it is difficult to speculate whether better training and education in recreational boating may have assisted Mr Coulter, it is at least certain that a holder of a marine licence is competent in the ways that a boater is aware of safe operating practice and relevant marine safety laws.[27]

55. In this regard, the CPU noted that whether a vessel was suited to the prevailing conditions, inexperience or unlicensed boater is at higher risk of harm than experienced or licensed boaters due to the lack of required safety knowledge to attain a marine licence.

56. The CPU found the recommendation of changing the delineation of coastal water would have made no appreciable difference to the outcome for Mr Coulter. There was no evidence to suggest that Mr Coulter's death could have been prevented or that a rescue could be in anyway assisted with the presence of safety equipment such as an EPIRB.

57. The circumstances surrounding Mr Coulter's death draw particular focus on the timing of usage of a PFD, as opposed to the means available to him or Mr Bowell to raise the alarm when the boat capsized. Therefore, this recommendation does not have any meaningful preventative value for boaters in the circumstances such as Mr Coulter.

[26] See paragraph 48.
[27] Section 45 of *Marine Safety Act 2010* (Vic), Purpose of licensing.

58. I am aware this issue was also raised in another Victorian coronial investigation by my colleague, Coroner Leveasque Peterson in the Finding into death of Ehren Clement Hyde[28], and as a result, relevant provisions of maritime law were subjected to review.

COMMENTS

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

59. Recreational boating is an integral part of the lifestyle of many Victorians. Whether it is for fishing or the pleasure of sailing, all persons operating a vessel or persons onboard should be aware of the incidental risks of undertaking such activities. All persons operating a vessel should have the required knowledge and capacity to do so.

60. Mr Coulter enjoyed spending time with Mr Bowell fishing, doing something he loved. He had been on the same boat multiple times over the years without incident. The events of 23 January 2021 were entirely unexpected.

61. The death of Mr Coulter highlights the reality of inherent risks associated with recreational boating. It was also evident from Mr Solly's evidence that Mr Coulter and Mr Bowell would know what they agreed upon. He observed them motoring the boat to a location of risky condition despite feeling "comfortable". Although Mr Coulter was wearing a PFD, unfortunately, the available evidence indicates that he had limited opportunity to inflate his PFD before he was immersed.

62. Whilst it is not possible to say Mr Coulter would have survived if his PFD was inflated, it is apparent that his chance of survival would have been enhanced. But for the chance of Mr Bowell wearing an inflated PFD, this incident might well have been two fatalities rather than one.

63. I commend SC Lang's effort in putting forward prevention-focussed recommendations for my consideration. I acknowledge that the prevention opportunities to be pursued in the circumstances such Mr Coulter's tragic incident are rather fundamental to the awareness of conducting regular professional service on PFDs.

[28] COR 2019 2848, available on the website of the Coroners Court of Victoria. Coroner Peterson recommends that "Transport Safety Victoria liaise with the Department of Economic Development, Jobs, Transport and Resources to explore the possibility and feasibility of legislative amendment to require EPIRBs or PLBs to be carried by the operators of recreational vessels (regardless of the classification of waterway or distance offshore) in high risk situations, including when operating alone".

64. I also acknowledge and commend the efforts of Transport Safety Victoria raise awareness among boaters through the "Prepare to Survive: Know the Five" campaign. The five steps provide that boater should *"know the weather, practise getting back on, carry a distress beacon, lock in a buddy plan [and] wear a lifejacket"*.

65. 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 Coulter 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[29] 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 David Andrew Coulter, born 24 March 1962;

   b. the death occurred on 23 January 2021 at Anglesea, Victoria, 3230; and

   c. I accept and adopt the medical cause of death ascribed by Dr Brian Beer and David Andrew Coulter died from drowning in the circumstances where Geoffrey Bowell's boat capsized whilst fishing with Geoffrey Bowell in the offshore water of O'Donohues Beach.

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

[29] 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 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:

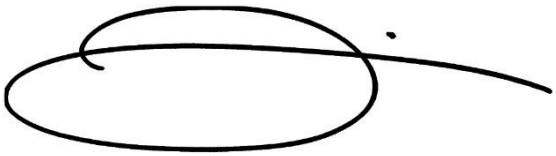
Kate Coulter

Senior Constable Jessica Lang, 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.