IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001241

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Michael John Hanratty
Date of birth:	20 September 1960
Date of death:	8 March 2021
Cause of death:	1(a) Drowning
Place of death:	McLoughlins Beach, Victoria, 3874

INTRODUCTION

1. Michael John Hanratty was 60 years old at the time of his death and lived alone in Nambrok. Mr Hanratty was occasionally visited by his partner, Judith Sinclair, and he occasionally stayed with her in Traralgon.

2. Mr Hanratty suffered no significant health issues apart from high blood pressure.[1] He was a smoker and social drinker.[2]

3. Mr Hanratty was a keen fisherman and experienced boatsman. He held a current Victorian marine licence and owned a 5.4 metres fibreglass half-cabin recreational boat[3], registration number BH790.

4. In the time Mr Hanratty had owned the boat, he had taken it out many times in the water off McLoughlins Beach with his son, Liam Hanratty. He was described as a very safety conscious person and was very conscientious about maintaining his vessel.

5. On 8 March 2021, while fishing in a boat off McLoughlins Beach with Ms Sinclair, the boat capsized. Mr Hanratty drowned and died as a result. Ms Sinclair was rescued by a recreational fishing boat nearby.

THE CORONIAL INVESTIGATION

6. Mr Hanratty'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.

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

---

[1] Coronial Brief of Evidence (**CB**), medical records of Michael Hanratty.
[2] CB, statement of Judith Sinclair.
[3] A type of motorised vessel. It was fitted a "Mariner" 75 horsepower motor.

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

9. Victoria Police assigned Senior Constable Hollie Jackman (SC Jackman) to be the Coroner's Investigator for the investigation of Mr Hanratty's death. SC Jackman conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. As part of the coronial investigation, advice was sought from the Coroners Prevention Unit (**CPU**[4]) in examining possible prevention opportunities in this matter with a view to making recommendations if appropriate.

11. This finding draws on the totality of the coronial investigation into the death of Michael John Hanratty 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. McLoughlins Beach settlement is situated on the Eastern shore of Victoria, enclosed to the south by the westernmost edge of the Ninety Mile Beach. To the southwest of McLoughlins Beach lies St Margaret Island and Manns Beach.

13. The entrance to the offshore water of McLoughlins Beach is through crossing a nearby ocean bar[6] ("the bar").

---

[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] The *Marine Safety Regulation 2012* (Vic) (**MSR**) defines an ocean bar as an area in state waters comprising a ridge of sand or gravel near or slightly above the surface of the water that: is located near or at the entrance to the sea from a bay, inlet, river or other waterway; extends across the mouth of that bay, inlet, river or waterway or parallel to the shore; and is permanent or occurs from time to time. This includes all waters within 500 metres of the ridge/bar.

14. Two posted signs located at the boat ramp cautioned and warned the risk of entering the bar due to *"strong currents at the entrance"* and *"severe sea conditions existing on the shallow bar outside entrance"*.[7] One of the posted signs cautioned boaters to wear a lifejacket.

Weather and sea conditions

15. The weather forecast for 8 March 2021 did not issue any weather warning for the Gippsland area.

Circumstances in which the death occurred

16. On the night of 7 March 2021, Mr Hanratty and Ms Sinclair were planning to go fishing the next day morning off McLoughlins Beach. They planned *"to leave early in the morning, spend a couple of hours fishing offshore and then come in and fish inside when the tide [is] good* [sic]*"*. Mr Hanratty told Ms Sinclair that the "best time" to return from the bar would be around 11.00am.

17. On the morning of 8 March 2021, Mr Hanratty checked the forecast on Willy Weather, which he always did before boating. Ms Sinclair recalled the weather was great. They drove the boat to the McLoughlins Beach boat ramp and arrived at approximately 7.00am.

18. At the boat ramp, Mr Hanratty and Ms Sinclair were encountered by a couple, Christian and Sharon Hughes, who were also planning to go fishing offshore. They discussed the "safest passage" to get out to the open waters through the bar at Manns Beach.

19. Mr Hughes believed that Mr Hanratty's boat was "too small" to safely get through the bar at McLoughlins Beach. Mr Hughes advised them to follow his boat by motoring along the coastline to the bar at Manns Beach, and they agreed.

20. As they were approaching the bar, Mr Hanratty and Ms Sinclair put on their respective personal floating device (**PFD**). They subsequently removed their PFDs, as soon as they went passed the bar and spent some time drift fishing in the offshore waters between McLoughlins Beach and Manns Beach.

[7] CB, police summary.

21. At approximately 11.15am, Ms Sinclair noted that *"it was time"* to head back to the launch point. Mr Hanratty motored his boat by following a "track line" on his global positioning system (**GPS**) device, which he believed was the same route[8] Mr Hughes had taken them.

22. However, it eventually became clear that the route was not the one Mr Hughes had taken them. Mr Hanratty proceeded to motor towards the bar[9] regardless. Ms Sinclair put her PFD back on, but Mr Hanratty did not.

23. As they were crossing the bar, the boat became stranded because of the low tide. Mr Hanratty managed to free his boat and eventually motored it to deeper water. The plan at the time was *"to wait and follow for another boat to come along"* so they could follow another boat back to the launch point.[10]

24. At approximately 12.30pm, Daniel Rand was boating in the same area with his friends, Mark Levy, Elaine Watkins and Brad Simmon. Mr Rand recalled *"the wind was picking up and the tide was choppy"* which he decided "*to head in as the bar is a bit iffy* [sic]*"* at that time.

25. Mr Rand sighted Mr Hanratty's boat "hanging outside the entrance" of the bar when he was approaching the entrance of McLoughlins Beach.[11] At around the same time, Mr Hanratty and Ms Sinclair sighted Mr Rand's boat from afar and Mr Hanratty quickly motored his boat towards Mr Rand's direction.

26. Ms Sinclair recalled as they *"started to follow them [Mr Rand's and his friends] ...[she] felt a wave come from the left side"*. The boat then lost control and capsized, ejecting them into the water.

27. When Mr Rand looked out for Mr Hanratty's boat again, he saw the boat had capsized. He quickly motored his boat towards Mr Hanratty's direction to render assistance.[12] Ms Sinclair was rescued from the water and appeared conscious, but Mr Hanratty was unable to be located. Mr Rand later made a "Mayday" call on his marine radio.

28. After motoring for approximately 300 meters, Mr Rand sighted Mr Hanratty floating face down in the water.[13] Mr Hanratty was unconscious and vomiting when taken on board. Ms

[8] Towards the sandbar near Manns Beach.
[9] Near McLoughlins Beach.
[10] CB, statement of Judith Sinclair.
[11] CB, statement of Daniel Rand.
[12] Ibid.
[13] Ibid.

Watkins immediately commenced cardiopulmonary resuscitation (**CPR**) on the boat as Mr Rand motored back to the shore.

29. At approximately 1.00pm, Mr Rand and his passengers arrived at the boat ramp. An off-duty nurse took over CPR attempts until ambulance paramedics arrived at the scene.

30. At approximately 1.30pm, ambulance paramedics arrived and examined Mr Hanratty. No further attempts of CPR were made as it was apparent that he was deceased.

31. The boat was subsequently located by members of Gippsland Water Police approximately 300 metres away from the entrance.[14] The boat was turned upside down and its propellers were protruding from the water, and eventually recovered the next day morning at high tide.

Identity of the deceased

32. On 8 March 2021, Michael John Hanratty, born 20 September 1960, was visually identified by his partner, Judith Sinclair.

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

Medical cause of death

34. On 9 March 2021, Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on the body of Michael John Hanratty. Dr Bedford also referred to a post-mortem computed tomography (**CT**) scan and reviewed the Victoria Police Report of Death (Form 83). Dr Bedford provided a written report of his findings dated 10 March 2021.

35. Dr Bedford commented that the circumstances surrounding Mr Hanratty's death were consistent with a boat related drowning.

36. Toxicological analysis of post-mortem samples identified the presence of diltiazem[15].

37. On the basis of available evidence before him, Dr Bedford ascribed the medical cause of death to 1 (a) drowning.

WATER POLICE INVESTIGATION

---

[14] CB, police summary.
[15] Diltiazem is a calcium channel blocker indicated for angina pectoris, hypertension and arrhythmias.

Vessel inspection

38. A member of Gippsland Water Police, Leading Senior Constable Graham Shoobert (LSC Shoobert) later inspected the recovered vessel. The hull was intact with no structural fault. The ignition key was in the "on" position. The kill switch lanyard was not connected to the kill switch and the kill switch was in the "run" position.

39. From his inspection and various witness statements, LSC Shoobert concluded that the vessel appeared seaworthy before it capsized.[16] He was unable to attribute any mechanical or structural fault that might have led to the vessel capsized.

40. Though police recovered only one PFD, it was Ms Sinclair's evidence that Mr Hanratty had all the necessary safety equipment onboard, including a fire extinguisher and a registered emergency position indicating radio beacon (**EPIRB**).

Cause of the vessel capsize

41. LSC Shoobert noted the risk of the sandbar in the offshore waters of McLoughlins Beach and explained that:

    "McLoughlins Bar is a sand bar that is prone to movement that makes this bar very dangerous. The bar on this day was very shallow with no natural channel that is present. The entrance to the bar moves and times it is difficult to see where the safest point to cross".[17]

42. Wayne Crawford, an experienced boater and a local community member with an intimate knowledge of the McLoughlins Beach area, stated that:

    "Every time you navigate the McLoughlins Beach bar you should treat it as the first time you have been out there…the day the boat capsized and the person [Mr Hanratty] died was a relatively good day…but it does not surprise me that someone died coming through that ocean bar".[18]

43. Mr Crawford also stated that *"in my opinion, the boat capsized because he [Mr Hanratty] was in the wrong spot"*.[19]

---

[16] CB, statement of Leading Senior Constable Graham Shoobert.
[17] Ibid.
[18] CB, statement of Wayne Crawford.
[19] Ibid.

Personal Floating Devices

44. When Mr Hanratty went into the water, he was not wearing a PFD. Nor was he wearing a PFD when he was attempting to cross the bar, despite a Type 1 PFD[20] being available on board.

45. Regulation 101 of the *Maritime Safety Regulations 2012* (Vic) (**MSR**) required a Type 1 PDF to be worn by a person on a recreational vessel of more than 4.8 metres but not more than 12 metres in length[21] when the vessel is on coastal waters and underway[22]; and during a "time of heightened risk". A time of heightened risk includes times when a vessel is crossing or attempting to cross an ocean bar or operating within a designated hazardous area[23].

46. Mr Hanratty was required to wear a PFD as per the MSR because his vessel was 5.4 metres long, was underway in coastal waters and he was boating in a time of "heightened risk".

SC Jackman's recommendation

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

48. The similarity of those circumstances was that small vessels had been launched or operated in an inshore coastal location such as surf zones or sandbars that are less than two nautical miles. These boats capsized due to exceeding boat conditions or were due to operator incapability. SC Jackman commented that this is a trend that was not seen in the previous years.

49. At the boat ramp, SC Jackman also noted that the signages located at the car park area *"are small and…not lit up when it is dark"*.

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

---

[20] Personal floating device Type 1, 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.
[21] Schedule 4, Table D, Item 1, Column 2 and 3 of the Regulations.
[22] *Maritime Safety Regulations*, Regulation 101(1)(a).
[23] *Maritime Safety Regulations*, Regulation 101(4), which is one of the applicable specific circumstances stipulated by sub-regulation (2)(b) of Regulation 101. See also Victorian Recreational Boating Handbook dated May 2021, page 34.
[24] These accidents are reported to the Coroners Court of Victoria. These matters are Terry Chandler COR 2021 372 and David Coulter COR 2021 452.

(i) limiting the existing maritime laws on the delineation of coastal water, to mandate vessels in coastal inshore waters to also be required to carry all necessary safety equipment; and

(ii) develop adequate signages in the boat ramp area, particularly more prominent and illuminating signages

CPU REVIEW

51. I sought the advice of the CPU in examining the merit and feasibility of SC Jackman's recommendations. In doing so, the CPU reviewed Mr Hanratty's matter in conjunction with two other reportable incidents brought to my attention.[25]

52. The CPU found the recommendation of changing the delineation of coastal water would have made no appreciable difference to the outcome for Mr Hanratty. Of greater significance, the circumstances surrounding Mr Hanratty's death draw particular focus on the wearing of a PFD, as opposed to the means available to him or Ms Sinclair 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 Hanratty's.

53. 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[26], and as a result, relevant provisions of maritime law were subjected to review.

54. Although SC Jackman did not put forward further reasonings for her second recommendation, the CPU found it was likely that SC Jackman put forward this recommendation because the signages were not noticeable. When Mr Hanratty and Ms Sinclair arrived at the boat ramp in the morning on 8 March 2021, it was still dark. It was likely that without sufficient lighting around, the surrounding visibility was low.

55. However, noting that Mr Hanratty had initially put on his PFD when crossing the sandbar, it was likely that Mr Hanratty did heed the warnings on the signages. Evidently, his subsequent failure to put his PFD back on when returning to the launch point, contributed to his death.

---

[25] See paragraph 47.

[26] 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".

56. The CPU also noted that actions to replace the existing signages with larger and brighter signages are underway and, as such, no further preventative action on this specific issue is required.

57. The CPU concluded that there was no evidence to suggest that Mr Hanratty's death could have been prevented by the presence of safety equipment such as an EPIRB and could be in any way assisted a rescue.

58. Mr Hanratty held a valid marine licence and was obviously a conscientious boat owner, meaning he had the required safety knowledge to go on recreational boating. He also had all the safety equipment on board on 8 March 2021.

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, especially in locations that entail heightened risk. All persons operating a vessel should have the required knowledge and capacity to do so.

60. Mr Hanratty enjoyed spending time with his son and partner fishing, doing something he loved. He had been on boats multiple times over the years without incident. The events of 8 March 2021 were entirely unexpected.

61. When the boat capsized, Mr Hanratty was not wearing a PFD. The available evidence illustrates that Mr Hanratty removed his PFD after he and Ms Sinclair crossed the sandbar in their outbound leg. Unfortunately, while attempting to again cross the bar on his return leg and when the wave struck the boat, the short time frame meant he had limited opportunity to put on his PFD before he was immersed.

62. Whilst it is not possible to say he would have survived, it is apparent that the wearing of a PFD would have enhanced his chance of survival. But for the chance of Ms Sinclair wearing a PFD, this incident might well have been two fatalities rather than one.

63. I acknowledge that the prevention opportunities to be pursued in the circumstances such Mr Hanratty's tragic incident are rather fundamental to the awareness of wearing a PFD when boating in a time of heightened risk.

64. 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 caution boaters 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. With the aim of promoting public health and safety and preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria highlight and disseminate the circumstances in which Mr Hanratty drowned in their upcoming educational materials and safety promotional campaign.

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 Michael John Hanratty, born 20 September 1960;

   b) the death occurred on 8 March 2021 at McLoughlins Beach, McLoughlins Beach, Victoria, 3874;

   c) I accept and adopt the medical cause of death ascribed by Dr Paul Bedford and I find that Michael John Hanratty died from drowning when his boat capsized while attempting to re-enter McLoughlins Beach across a sandbar.

   d) AND I further find that Michael John Hanratty was not wearing a Personal Floating Device in a time of heightened risk, as required by law.

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

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:

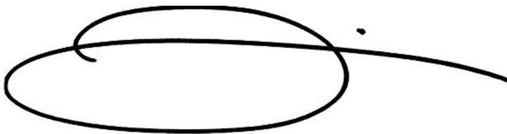
Damien Hanratty

Senior Constable Hollie Jackman, 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.