IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000796

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Robert Wayne Edwards
Date of birth:	20 July 1958
Date of death:	11 February 2020
Cause of death:	1(a) INJURIES SUSTAINED IN A BOAT COLLISION
Place of death:	Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	Boat, boat accident, vessel, Gippsland Lakes, Marine Safety Act, Marine Safety Regulations, Regulations for the Prevention of Collisions at Sea

INTRODUCTION

1. On 11 February 2020, Robert Wayne Edwards (**Mr Edwards**) died as a result of injuries sustained when the vessel he was operating, collided with another vessel in waters adjacent to Butlers Point on the Gippsland Lakes in Victoria.

2. At the time of his death, Mr Edwards was 61 years old. Mr Edwards had lived in the Paynesville area for approximately 30 years. He held a current Victorian Marine Licence and was an experienced boat operator.

3. Mr Edwards is survived by his son, William Robert Edwards, his mother, Catherine Edwards and sister, Cathy Johnson.

THE CORONIAL INVESTIGATION

4. Mr Edwards's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. 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.

6. 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.

7. Victoria Police assigned Detective Leading Senior Constable Christopher Obst (**DLSC Obst**) to be the Coroner's Investigator for the investigation of Mr Edwards's death. DLSC Obst 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.

8. The coronial brief of evidence also included a report prepared by Senior Constable Brett Gardner from the Collision Reconstruction Mechanical Investigation unit who conducted a detailed examination of both vessels, an analysis prepared by Senior Sergeant Andrew Sinclair

of GPS data from Mr Edwards vessel which tracked the path of that vessel pre and post collision, and a report from Mr Nayland Aldridge who is a Senior Maritime Investigations Officer employed by Transport for NSW.

9. This finding draws on the totality of the coronial investigation into the death of Mr Edwards Wayne Edwards 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.[1]

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

10. On 11 February 2020, Mr Robert Wayne Edwards, born 20 July 1958, was visually identified by his son William Edwards.

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

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

12. Forensic Pathologist, Dr Joanne Glengarry from the Victorian Institute of Forensic Medicine, conducted an examination on 13 February 2020 and provided a written report of her findings dated 17 February 2020.

13. The post-mortem examination showed complex depressed right temporal skull fractures and a right acute subdural haemorrhage with midline shift. There were right posterior and lateral rib fractures with extensive subcutaneous emphysema, a right sided hemopneumothorax and a left sided Pneumothorax. There were no limb or spinal fractures.

14. Toxicological analysis of ante-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.

15. Dr Glengarry provided an opinion that the medical cause of death was:

1 (a) INJURIES SUSTAINED IN A BOAT COLLISION.

[1] 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.

16. I accept Dr Glengarry's opinion as to the cause of death.

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

17. At 9.00am on Tuesday 11 February 2020, Mr Edwards arrived at the Esplanade boat ramp and launched a 5.4 m Haines Signature ski boat powered by a 200 hp outboard engine. This vessel was owned by Mr Mark Chatwoood who had identified a fault with the engine (not running smoothly) that he had asked Mr Jayson Smith from 'All Power Marine' to investigate and rectify. Mr Smith had subcontracted this job to Mr Edwards who was regarded as a capable and competent person to undertake this job. Mr Edwards needed to conduct an on-water test of the vessel to identify the fault so he could complete repairs.

18. The weather was recorded as being fine. The visibility was good, it was slightly overcast, with no fog and a light wind of less than 10 knots (20 kms/hr).[2]

19. At approximately 10.30am, Mr Mathan Malchi (**Mr Malchi**) and Anthony Neilson (**Mr Nielson**) arrived at the Dawson Cove boat ramp to launch Mr Malchi's vessel, a 5.3 m Cruise Craft Reef Finder powered by a 115 horsepower outboard motor. This vessel is a half cabin style boat with a tinted Perspex windscreen. Mr Nielson had planned a fishing trip on Lake Victoria. Mr Malchi held a current Victorian Marine Licence and this was the first time that Mr Nielson had been on the water with Mr Malchi.

20. Mr Malchi and Mr Nielson left Dawson Cove boat ramp heading in a northerly direction on the west side of a spit that leads to Butlers Point. Mr Malchi was driving the boat. There is a port hand navigation pile located north of Butler Point (**the pile**), that vessels are required to leave to starboard (right) before turning to the east and then north to travel to Lake Victoria.

21. As Mr Malchi approached the pile, he accelerated and states that he was travelling at a speed between 26 and 30 kms/hr.[3] As he was increasing speed, he was turning the boat to starboard following the channel round Butlers Point. Mr Malchi was seated in the driver's position and looking through the tinted Perspex windscreen.

22. Both Mr Malchi and Mr Nielson state that as they came around Butlers Point and were accelerating, they observed Mr Edwards' vessel travelling in a westerly direction almost head

[2] CB at p 499, Bureau of Meteorology.
[3] CB at p 566, Transcript of Digital Video Recorded Interview with Mr Malchi.

on to their course. They also observed that Mr Edwards' vessel was travelling at speed. Neither was able to estimate the speed of the approaching vessel.

23. The vessels collided a short distance north of Butlers Point.[4] Mr Malchi's vessel impacted Mr Edwards' vessel at the driver's seat on the Starboard side. The bow of Mr Malchi's vessel impacted at the 'tow hook' area of the bow (the hook under the bow that is used to secure the vessel to the trailer), rode up on the gunwale (the top edge of the hell of vessel) of Mr Edwards vessel, before rolling slightly to port and sliding back into the water.[5] The impact caused significant damage to Mr Edwards' vessel, crushing the starboard side of the fibreglass boat from the top of the gunwale to a short distance above the waterline.

24. Both Mr Nielson and Mr Malchi state that the time between first seeing Mr Edwards' vessel to impact was very short, Mr Malchi says 10 to 15 seconds[6], Mr Nielson says 20 seconds.[7] The available evidence suggests that Mr Malchi did not take evasive action[8] or reduce speed in the seconds before impact. In his recorded interview with police, Mr Malchi states '*I didn't change speed*'.[9]

25. Immediately after impact, the two vessels drifted apart, and Mr Malchi quickly manoeuvred his vessel towards Mr Edwards' vessel and rafted his vessel next to it. Initially they were unable to see Mr Edwards in the boat and feared that he may be in the water. After closer examination, Mr Edwards was located in the boat, covered by debris.

26. Mr Nielson and Mr Malchi did not board Mr Edwards' vessel to render assistance as they were concerned that additional weight on board may sink the boat, as the damage extended too close to the water line. In any event, both men had injuries, Mr Nielson a dislocated shoulder and Mr Malchi a head knock. These injuries would have made it very difficult for them to render assistance.

27. Mr Malchi contacted emergency services. Police arrived at 11.25am and towed Mr Edwards' vessel to Sunset Cove Boat Ramp. At the ramp they were met by paramedics who extracted Mr Edwards from the vessel and arranged for him to be airlifted to the Alfred Hospital. Mr Edwards passed away later that evening from injuries sustained in the collision.

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[4] CB at p 120, Report of Adrian Sinclair.
[5] CB at p 102, Report of Adrian Sinclair.
[6] CB at p 563, Transcript of Digital Video Recorded Interview with Mr Malchi.
[7] CB at p 36, Statement of Anthony Nielsen.
[8] CBat p 110, Report of Adrian Sinclair.
[9] CB at p 566, Transcript of Digital Video Recorded Interview with Mr Malchi.

FURTHER INVESTIGATIONS

28. The police investigation focused on the period immediately prior to the collision, to understand the path of each vessel, the speed that they were travelling and whether evasive action was or should have been taken to avoid the collision.

29. Senior Sergeant Adrian Sinclair of Victoria Police provided a report which includes a detailed examination of the data that was downloaded from the GPS in Mr Malchi's vessel. This evidence provided a clear picture of the course of the vessel in the time immediately prior to the collision. It shows the vessel leaving the boat ramp travelling in a northerly direction to the point where the vessel is directly west of Butler Point and then begin to change course to the east in an arc to the point of collision at a position north of Butlers Point.[10]

30. The analysis of GPS data indicated that no evasive action was taken by Mr Malchi immediately before impact, it is only after the collision that there is a noticeable change in the heading of his vessel. This is consistent with the statements of both Mr Malchi and Mr Nielson.

31. Senior Sergeant Adrian Sinclair concluded that Mr Malchi's vessel was travelling fast enough for its bow to rise higher out of the water: *either plowing through the water under acceleration or having reached planing speed*'. The first point of impact for Mr Malchi's vessel was in the vicinity of its tow hook. It then penetrated Mr Edwards' vessel on the starboard side, then pitched up and ramped on the top of Mr Edwards', depressing it underneath Mr Malchi's vessel. The path of engagement of Mr Malchi's vessel was over the masters (driver) seat of Mr Edwards' vessel'.[11]

32. The GPS data does not include information about the speed the vessel was travelling. The information about speed came from Mr Malchi's statement, where he states that he believed the engine was running at between 2500 and 3000 revolutions per minute (**RPM**) at the time of the collision[12]. He also states that he was monitoring his Tachometer prior to the collision.

33. To determine the likely speed of the vessel, DLSC Obst requested that Detective Sergeant Dr Janelle Hardiman of the Victoria Police Marine Investigation Unit conduct on-water tests on Mr Malchi's vessel to determine the likely speed corresponding to particular RPM's. This

[10] CB at p 102, Report of Senior Sergeant Adrian Sinclair.
[11] Ibid.
[12] CB at p 566, Transcript of Digital Video Recorded Interview with Mr Malchi

testing was conducted at Williamstown by Dr Hardiman and showed that at 2500 RPM the average speed would be 15.6 km/h and at 3000 rpm the average speed would be 21.5 km/h.[13]

34. SC Brett Gardner of the Victoria Police Collision Reconstruction Mechanical Investigation Unit also conducted a thorough examination of both vessels. When he examined Mr Malchi's vessel the examination did not reveal any issues that may have contributed to the collision. In relation to Mr Edwards's vessel, he did not identify any issues that may have contributed to the collision other than the battery isolating switch being in the off position. He states:

> '*…with the battery isolation switch in the off position the vessel will not run. If the engine is running and the isolation switch was turned to the off position, the engine will stop immediately. The witness markings on the isolation switch are consistent with the switch being in the off position when it was impacted*'.[14]

35. This conclusion is inconsistent with other evidence that suggests that both vessels were underway at the time of the collision.

36. In light of this inconsistency, Victoria Police arranged for Senior Maritime Investigation Officer, Mr Nayland Aldridge from Transport Safety for NSW, to examine both vessels, review the brief of evidence and consider whether Mr Edwards' vessel was underway at the time of the collision.

37. Mr Aldridge concluded that '*at the time of the collision both vessels were travelling at similar speeds, either planning or in a transition attitude*'.[15] This is based on his assessment of the damage to both vessels. Mr Aldridge opined:

> '*…. the damage to the Haines (Mr Edwards vessel) although massive, is not as extensive as would be expected if that vessel were not making way. The relative lack of penetration into the Haines indicates that both vessels were moving at reasonably similar speeds*'.[16]

38. The police investigation also considered whether either or both vessels were in breach of the *Regulations for the Prevention of Collisions at Sea* (**COLREGs**) or the *Marine Safety*

[13] CB at p 131, statement of Dr Jenell Hardiman.
[14] CB at p 127, Report of Senior Constable Brett Gardner, Collision Reconstruction Mechanical Investigation Unit.
[15] CB at p 189, Report of Nayland Aldridge, Senior Maritime Investigation Officer from Transport Safety for NSW.
[16] CB at p 189, Report of Nayland Aldridge, Senior Maritime Investigation Officer from Transport Safety for NSW.

Regulations (2012) (**MS Regulations**). The COLREGs are internationally agreed rules that apply to all vessels operating upon the high seas and all waters connected therewith, including inland waterways connected to the open sea. The COLREGs can be modified by local laws where appropriate.

39. The COLREGs Rules relevant to this investigation are:

- Rule 5: Every vessel shall at all times maintain a proper lookout by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and the risk of collision.

- Rule 9(a): A vessel proceeding along the course of a narrow channel or fairway shall keep as close to the outer limit of the channel or fairway which lies on her starboard side as is safe and practicable. In Victoria this has been modified by Regulation 111(1) of the MS Regulations. Regulation 111(1) states that a master of a vessel underway in a channel or fairway must ensure that the vessel keeps to the right of the centre of the channel or fairway.

- Rule 9(f): A vessel nearing a bend or an area of a narrow channel or fairway where other vessels may be obscured by an intervening obstruction shall navigate with particular alertness and caution and shall sound the appropriate signal prescribed in Rule 34(e).[17]

40. There are also Rules that deal with situation involving 'head on' collisions and Vessels 'crossing the path of another'.[18] However, those Rules are not relevant in the circumstances of this incident.

41. Based on my review of all the available evidence, I have concluded that:

- Mr Edwards' vessel was underway and not stopped as suggested by SC Brett Gardner and that both vessels were traveling at similar speeds. This is based on the opinion of Mr Nayland Aldridge.[19]

[17] International Maritime Organisation – International Regulations for Preventing Collisions at Sea.
[18] International Maritime Organisation – International Regulations for Preventing Collisions at Sea.
[19] CB at p 189, Report of Nayland Aldridge, Senior Maritime Investigation Officer from Transport Safety for NSW.

- GPS data/evidence is consistent with both vessels being close to Butlers Point at the time of collision.

- Rule 9 of the COLREGs and Regulation 111(1) of the MS Regulations apply in this situation – Mr Edwards's vessel was on the port side of the channel, and he was required to be on the starboard side of the channel, and thus created the risk of collision.

- The risk of collision may have existed prior to the time Mr Malchi commenced turning to starboard near Butlers Point and if so, then at that point, Mr Malchi was required to keep clear of Mr Edwards's vessel.

- When the vessels first sighted each other, the drivers had an obligation to move to starboard to avoid the collision. It is noted that Mr Malchi was doing this in any event as he was following the natural course of the waterway.

- There is some evidence that Mr Edwards may have moved to port immediately prior to the collision.[20] However, this change in course should have been to starboard as required by Rule 9 of the COLREGs and Regulation 111(1) of the MS Regulations.

- The evidence supports the view that Mr Malchi only saw Mr Edwards' boat 10 to 15 seconds prior (Mr Nielson states 20 seconds) to impact which would suggest that he was not keeping a proper look out in accordance with Rule 5. There is evidence that he was looking at the Tachometer and may have been transitioning the vessel to plane position and his view could have been obstructed by the bow of the boat.

  There is no evidence of the observations that Mr Edwards made.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr Robert Wayne Edwards, born 20 July 1958;

    b) the death occurred on 11 February 2020 at Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from INJURIES SUSTAINED IN A BOAT COLLISION; and

[20] CB at p 152.

c) the death occurred in the circumstances described above.

43. Having considered all the evidence, I am satisfied that the failure to keep proper look out as required by Rule 5 of the COLREGs was the cause of this collision resulting in the death of Mr Edwards.

COMMENTS

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

44. On 5 December 2021, summary charges were issued against Mr Malchi for Dangerous Operation (*Marine Safety Act 2010* (Vic) section 87), Contravene Collision Regulations (*Marine Safety Regulations 2012* (Vic), section 109) and Exceed 5 knots within 50 meters of another vessel (*Marine Safety Act* 2010 (Vic), Notice cl2(c)). These matters were heard in the Bairnsdale Magistrates Court on 13 October 2021, Mr Malchi pleaded guilty to the Dangerous Operation (*Marine Safety Act 2010* (Vic) section 87) charge and was fined $3000 and his Marine Licence was cancelled for a period of 6 months.

45. In investigating possible criminal offences arising from this incident, Victoria Police formed the view that there is a gap in the current legislative framework that results in summary charges being the only available option in a case like this.

46. Victoria Police suggest that the 2009 amendment to the *Crimes Act 1958* (Vic) (**Crimes Act**) which saw vessel operation inserted into the 'Culpable Driving' provisions, has created a gap in the current legislative framework where conduct that is reckless or negligent, but does not meet the high criminal standard, can only be addressed by summary charges. It is suggested by Victoria Police that conduct that breaches the COLREGs and leads to death or serious injury, warrant an indictable offence not the lower-level summary offence.

47. In considering this issue, I wrote to Safe Transport Victoria and asked if they supported the introduction of a new offence into the *Marine Safety Act 2010* (Vic) (**MS Act**), of operating a vessel in contravention of the COLREGs, or operating a vessel that is unsafe causing death or serious injury. This would be an indictable offence and would apply where one or more vessel operators may have contributed to the death or serious injury and does not require proof that the accused solely or substantially caused the death or serious injury.

48. Safe Transport Victoria have advised that they would be supportive of the introduction of such an offence but consider that it should be included in the Crimes Act as opposed to the MS Act.

Whether the new offence sits in the Crimes Act or the MS Act is a matter for the Victorian government should they considered it appropriate to introduce the new offence and not something that I need to comment on.

49. As both Victoria Police and Safe Transport Victoria agree that the proposal has merit, I will recommend that the Minister for Transport Safety give consideration to this proposal.

RECOMMENDATIONS

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

    (i) That the Minister for Fishing and Boating consider the introduction of a new indictable offence to cover situations where the operator of a vessel breaches the COLREGs or operates a vessel in a manner that is unsafe and causes serious injury or death. The new offence would apply where more than one vessel operator may have contributed to the death or serious injury and would not require the prosecution to prove that the accused solely or substantially caused the death or serious injury.

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

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:

William Edwards, Senior Next of Kin

Minister for Fishing and Boating

The Chief Commissioner Victoria Police

Chief Executive Officer of Safe Transport Victoria

Senior Constable Chris Obst, Coroner's Investigator

Signature:

JUDGE JOHN CAIN
STATE CORONER
Date: 15 December 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.