IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002270

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Geunhee Park
Date of birth:	28 June 1989
Date of death:	5 May 2019
Cause of death:	1(a) Head injury
Place of death:	Port Phillip Bay, Frankston, Victoria, 3199
Keywords:	Port Phillip Bay, spear fishing, boating, recreational vessel, Canadian Bay, Maritime Safety Act,

INTRODUCTION

1. On 5 May 2019, Geunhee Park (**Geunhee**) was 29 years old when he died due to injuries sustained in a diving incident in Port Phillip Bay, Frankston. At the time of his death, Geunhee lived at Unit 2 of 17 Lithgow Avenue, Blackburn.

2. Geunhee was born in South Korea and moved to Australia in 2017 on a bridging visa after marrying his partner, Katie Taylor. He had completed an open water and advanced SCUBA course in the Philippines and was an advanced swimmer. In 2018, Geunhee developed an interest in spearfishing and began to fish on a frequent basis.[1]

THE CORONIAL INVESTIGATION

3. Geunhee'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.

4. 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.

5. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Geunhee's death. The Coroner's Investigator 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.

[1] Coronial brief, statement of Katie Taylor dated 27 May 2019, page 99.

7. This finding draws on the totality of the coronial investigation into the death of Geunhee Park 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.[2]

8. In considering the issues associated with this finding, I have been mindful of Geunhee's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

Arrival at the site

9. On 5 May 2019, Geunhee met his friend, Sayoon Hong (**Sayoon**), at Earimil Drive in Mount Eliza to go spear fishing. The duo changed into their diving equipment, with Geunhee wearing a long-sleeve black wetsuit, mask, and weight belt. He also carried a spear gun and a safety buoy. Geunhee and Sayoon walked to the beach and inflated their buoys. Sayoon stated both buoys had a safety flag attached that would sit approximately 40cm above the buoy.[3] [4]

10. The two fishermen swum out to a position southwest of Canadian Bay[5] and approximately 400 metres from the shoreline, reaching a yellow isolated danger warning pole which was secured in the water. They then swum approximately 30 metres east of the pole. Sayoon stated that they did not swim any further westward into the bay than the yellow pole.[6]

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[2] 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.

[3] Coronial brief, statement of Sayoon Hong dated 5 May 2019, page 39.

[4] An examination conducted by Victoria Police investigators on 7 August 2019 indicated that Geunhee's bouy did not have a safety flag attached. Photographic evidence provided within the Coronial Brief indicates that it is likely that Geunhee's buoy, an "Ocean Hunter" branded device, did not have a flag attached (Coronial brief, pages 214-223). Given the circumstances surrounding the collision, it is not necessary to resolve this discrepancy.

[5] Coronial brief, GPS imaging, page 68.

[6] Coronial brief, statement of Sayoon Hong dated 5 May 2019, page 39.

11. Sayoon and Geunhee began fishing, diving approximately six metres under the surface looking for fish before resurfacing. Sayoon stated that Geunhee was approximately 20 metres north of his position and that, at the time of the incident, the water was calm, there was no swell or wind, and the waves were gentle. Sayoon stated that their safety buoys were clearly visible on the surface of the water.[7]

The incident

12. After approximately one and a half hours of diving, Sayoon heard a boat motor approaching their position. Sayoon surfaced and observed a white boat (later established to be the **Serendipitous**[8] skippered by Nicholas Mouat) pass close to him before it stopped approximately 20 metres south of his position. Sayoon gestured and called out to the operator of the Serendipitous who waved back and continued towards Mornington.[9]

13. Occupants on a nearby boat driven by William Classon (**William**) stated that they observed the Serendipitous approach the divers from the north/northwest direction at a speed of approximately 10 knots and pass between the diver's buoys, with one of the buoys appearing to be in the boat's wake as it left the area. Leendert Vanderwal (**Leendert**), a passenger on William's boat, stated that it appeared as though the operator of the Serendipitous did not appear to be looking where he was going at the time he passed between the buoys.[10]

14. After the Serendipitious left the area, Sayoon stated that he swum back down to the seabed and waited for fish to appear but noticed Geunhee lying nearby motionless with a large injury to his head and face. Sayoon immediately swum to Geunhee's location and lifted him to the surface, eventually managing to summon the attention of William in his nearby vessel for assistance.[11]

15. William motored over to Sayoon's location and assisted him in lifting Geunhee onto his vessel. William noted that Geunhee appeared to have a serious head injury and contacted 000, arranging to meet emergency services at the Frankston Pier whilst his friends and Sayoon attempted to perform first aid on Geunhee.[12]

[7] Coronial brief, statement of Sayoon Hong dated 5 May 2019, pages 39-40.
[8] A 575 Haines Signature half-cabin vessel approximately six metres in length with a single outboard motor.
[9] Coronial brief, statement of Sayoon Hong dated 5 May 2019, pages 40-41.
[10] Coronial brief, statement of William Classon dated 5 May 2019, page 51; statement of Leendert Vanderwal dated 8 May 2019, page 58; statement of Kelvin Bertacchini dated 7 May 2019, page 64.
[11] Coronial brief, statement of Sayoon Hong dated 5 May 2019, page 41.
[12] Coronial brief, statement of William Classon dated 5 May 2019, page 52.

16. Geunhee was transported back to Frankston Pier by the boat with Sayoon performing cardiopulmonary resuscitation during the trip which took approximately 15 minutes. On arrival, Ambulance Victoria paramedics continued resuscitation efforts however they were unsuccessful and Geunhee was verified as deceased at approximately 2.00pm.[13]

Post-collision investigation

17. On 6 May 2019 at 9.44am, Nicholas Mouat (**Nicholas**) contacted Frankston Police Station after seeing a news segment about the incident and realising he had been in the area where the divers had been swimming.[14] Nicholas was later arrested by Victoria Police members in relation to the matter and was conveyed to Mordialloc Police Station (**MPS**). The Serendipitous was seized by police members and transported to MPS.[15]

18. On 6 May 2019, Nicholas was interviewed by police members in relation to the incident that claimed Geunhee's life. During the interview, Nicholas stated that he had been searching for fish in the area in his vessel, the Serendipitous, and that he was concentrating on his sounding device at the time of the incident.[16] At the time of the incident, Nicholas held a valid General Marine Licence issued in accordance with the *Marine Safety Act 2010*.[17]

19. During the interview, Nicholas stated that he was travelling at approximately five knots and did not see the divers or their orange buoys until he passed the isolated danger pole.[18] Nicholas also stated that he did not feel or notice the impact with Geunhee and continued in a southerly direction to find more fish.[19]

20. Following the Victoria Police investigation, Nicholas was charged with several offences and pled guilty to one – 'Drive in Manner Dangerous Causing Death'. On 19 September 2022, he was ordered to serve a Community Corrections Order, perform 600 hours of unpaid community work, and pay a fine of $10,000.[20] Nicholas' vessel and related property were also forfeited, and his marine licence cancelled for six months.

[13] Coronial brief, statement of Sayoon Hong dated 5 May 2019, page 41; statement of William Classon dated 5 May 2019, page 53; statement of Acting Sergeant Steve Wisniewski dated 4 June 2019, page 103.
[14] Coronial brief, statement of Senior Constable Madeleine McDonald dated 31 October 2019, pages 115-117.
[15] Coronial brief, statement of Senior Constable Madeleine McDonald dated 31 October 2019, pages 115-117.
[16] Sounding is the use of a sonar device to identify fish under the surface of the water.
[17] Coronial brief, exhibit 55.
[18] Coronial brief, record of interview dated 6 May 2019, pages 289-294.
[19] Coronial brief, record of interview dated 6 May 2019, pages 297, 301.
[20] Coronial brief, record of orders made dated 19 September 2022, page 462-463.

Identity of the deceased

21. On 6 May 2019, Geunhee Park, born 28 June 1989, was visually identified by his partner, Katie Taylor.

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

Medical cause of death

23. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy/examination on 8 May 2019 and provided a written report of his findings dated 30 May 2019.

24. The post-mortem examination revealed a sharp force injury to the left parietal region with associated significant traumatic injuries, consistent with the history given.

25. In deference to the family's wishes, the coronial investigation proceeded without autopsy.

26. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

27. Dr Lynch provided an opinion that the medical cause of death was from a 1 (a) head injury.

28. I accept Dr Lynch's opinion.

FINDINGS AND CONCLUSION

29. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[21] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

[21] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

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

    a) the identity of the deceased was Geunhee Park, born 28 June 1989;

    b) the death occurred on 05 May 2019 at Port Phillip Bay, Frankston, Victoria, 3199, from a *head injury*; and

    c) the death occurred in the circumstances described above.

31. Having considered the circumstances, and on the balance of probabilities, I am satisfied that Geunhee died after being struck in the head by a propeller blade from the Serendipitous. I am further satisfied that a significant contributing factor to this event was Nicholas' failure to observe maritime safety laws regarding minimum maintaining safe distances from divers and keeping a proper watchout as he traversed the area in his vessel.

COMMENTS AND RECOMMENDATIONS

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

Breaches of the COLREGS

32. In 2008, a fatal vessel collision occurred at Lake Eildon in which Casey Hardman tragically lost her life.[22] The incident highlighted the presence of reckless and negligent factors in the manner in which the vessel was being operated. In December 2009, the *Crimes Act 1958* (**the Crimes Act**) was amended to include vessel operation under the same provision as 'Culpable and Dangerous Driving Cause Death or Serious Injury'.[23]

33. Since Ms Hardman's death, there have been other fatal vessel collisions where reckless or negligence to the criminal standard were not evident, however gross breaches of the 'Convention on the international regulations for prevention collisions at sea'[24] (**COLREGS**) were found to be substantial contributory factors.[25]

[22] COR 2008 005821 (unpublished).
[23] *Crimes Act 1958*, section 318; section 317B.
[24] *Convention on the international regulations for prevention collisions at sea,* 1977, *United Nations Treaties Series*, vol. 1050, No. 15824 (available from https://treaties.un.org/doc/publication/unts/volume%201050/volume-1050-i-15824-english.pdf).
[25] COR 2008 001678; COR 2013 00190.

34. Whilst the COLREGS are the cornerstone of safety and operating rules for maritime vessels, and that contravention of these involve some level of reckless or negligent action, a breach of these rules remains a minor offence, with relatively trivial penalties available to judicial officers to punish offenders.[26]

35. At present, a legal void exists when death or serious injury is not caused by the speed or manner a vessel was operated, but rather by disregard for the COLREGs. In the matter in question, Nicholas was travelling at a low speed and was not affected by drugs or alcohol. Rather, a significant contributing factor to Guenhee's death was a breach of Rule 5 of the COLREGs – failure to maintain a proper look out.

36. The gap between offences and penalties available under the Crimes Act and the *Maritime Safety Act 2010* (**the Maritime Act**) leaves prosecutors and judicial officers limited scope for appropriate offences and penalties when individuals such as Geunhee are killed or seriously injured in these circumstances.

37. I note the advice from the Coroner's Investigator, Detective Senior Constable (**DSC**) Madeline McDonald, in this matter that, fatal incidents notwithstanding, approximately 65 per cent of serious injury collisions at sea involve an obvious breach of the COLREGs but no serious offence can be applied unless disproportionately high speed, "hoon-type manoevers", or drugs or alcohol consumption are evident.[27]

38. In the matter of the death of Robert Edwards[28] State Coroner John Cain noted the discrepancy between maritime incidents that do not meet the high criminal standard and presently available offences and penalties under the Crimes Act and Maritime Act.

39. In that matter, His Honour recommended the introduction of an indictable offence 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.[29] A response from the Minister has yet to be received to this recommendation.

[26] As of 2023, the penalty for breaching the COLREGs in a recreational vessel is 20 penalty units (*Maritime Safety Regulations 2012*, regulation 109). For comparison purposes, an individual who forgets to renew their recreational vessel's registration receives a similar penalty.
[27] Coronial brief, summary, page 18.
[28] COR 2020 000796.
[29] COR 2020 000796, [45]-[50].

40. Under section 52B of the New South Wales *Crimes Act 1900*, a person is guilty of the offence of "dangerous navigation" if they cause the death or grievous bodily harm of another if they navigate a vessel:

    a) Under the influence of alcohol or drugs; or

    b) At a dangerous speed; or

    c) In a dangerous manner.

41. It is likely that the introduction of a similar offence to section 52B above would "close the gap" between instances where breaches of the COLREGs are found to be significant contributing factors to the serious injury or death of another person but the prosecution is unable to make out the high criminal standard necessary to prosecute.

42. Therefore, pursuant to section 72(2) of the Act, I make the following recommendation:

    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.

Definition of 'recreational'

43. During the Nicholas' plea hearing, the matter was compared to road-related vehicle incidents to determine the level of risk to the public. It is difficult, however, to compare vessel and vehicle incidents due to numerous factors including the weather, environment, and sea conditions. As noted by DSC McDonald, the marine environment is a three-dimensional space, with traffic liable to approach from all directions with very limited warning signs or directional prompts, unlike roads. This may even include submerged objects (including SCUBA divers and spear fishers).

44. Whilst the responsibilities of 'commercial' vessel operators are highly regulated and observed, individuals operating 'recreational' vessels are not subject to the same rules. The word 'recreational' implies a sport or fun activity with a different level of responsibility by those taking part. The culture of boating, and the way others perceive it, is influenced by the language attributed to it.

45. The references to marine incidents being 'recreational' fuels the underlying tone that death and serious injuries are mere misadventures. By extension, it may be seen that a 'recreational' vessel operator should not be seen as being as responsible as the driver of a motor vehicle or another other form of transport for serious incidents.

46. In the matter of the death of Zane McLaughlin,[30] Transport Safety Victoria (**TSV**) made submissions on 23 August 2012 in which they noted, amongst other things, that:

> …recreational boaters approach the task of operating a vessel from the perspective that the activity is recreational and meant to be enjoyable. This frame of mind may lead to a lessened expectation of hazards and risks, potentially contributing to relaxing the task of operators to look out for or identify hazards.[31]

47. The 'recreational' term attached to privately owned vessels is not commensurate with other vehicles and drivers. Vehicles are not classified as recreational cars, recreational four-wheel drives, recreational buses, or recreational trucks. The only exceptions may be trail bikes that have a limited 'recreational' registration permitting a person to ride only on dirt roads, generally on trail bike tracks, and the 'recreational' pilot certificate which limits a pilot to hobby type aircraft and where they can fly, akin to the trail bike rule, however the same rules applicable to all other forms of flying apply.

48. There continues to be an attitude that a higher degree of risk for 'recreational' activities, such as boating, is acceptable despite amendments to the Crimes Act noted at [31] above. The acceptance of this risk has led to serious maritime incidents being written off as accidents and misadventures, despite available offences under the Maritime Act and Crimes Act. It is however an important prevention initiative to create a regulatory environment which reinforces a proper culture of responsibility amongst those that operate such craft, concomitant with broader community expectations in relation to other vehicle use.

[30] COR 2008 1678.
[31] Coronial brief, Appendix H, page 622.

49. In the matter of the death of Courtney Keast,[32] Deputy State Coroner Iain West (as he then was) noted this exact issue,[33] recommended the term "recreational vessel" be amended to read "vessel" so as "to lessen the implied notion that operation is akin to a hobby with lesser standards of responsibility that those faced by road users".

50. His Honour further noted that it may be appropriate to use the term "private vessel" to create a distinction from "commercial vessels" if need be.[34]

51. It is imperative that those who operate vessels in the maritime environment understand and have due regard for the inherent dangers associated with such an activity. Whether a 'recreational' or 'commercial' venture, the dangers of operating a maritime craft cannot be understated. Therefore, and pursuant to section 72(2) of the Act, I make the following recommendation:

    I recommend the Minister for Fishing and Boating and Safe Transport Victoria review the term 'recreational vessel' amd amended in relevant legislation and publications to 'vessel'. It may be appropriate to use the term 'private vessel' to create a distinction from 'commercial vessels' if need be.

52. Finally, I wish to acknowledge and commend the hard work and fulsome brief provided by Detective Senior Constable Madeleine McDonald in this matter.

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

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

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[32] COR 2014 0190.
[33] His Honour also recommended the introduction of the indicatable offence of "operate a vessel in (a) contravention of the [COLREGs], or (b) that is an Unsafe Vessel causing death or serious injury" be created, mirroring recommendation one above.
[34] COR 2014 0190, [26](c).

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

Katie Taylor, Senior Next of Kin

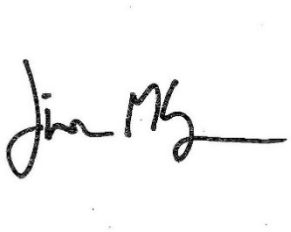
Sonya Kilkenny, Minster for Fishing and Boating

Chief Commissioner Shane Patton APM, Victoria Police

Tammy O'Connor, Chief Executive of Safe Transport Victoria

Detective Senior Constable Madeleine McDonald, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date: 17 April 2023

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.