IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001498

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:	Peter Boyle
Date of birth:	8 June 1960
Date of death:	19 March 2022
Cause of death:	1(a) DROWNING
Place of death:	McMillan Strait, Paynesville, Victoria, 3880
Keywords:	Boat; boating incident; drowning; Paynesville; Parkinson's disease; personal flotation device; repair to vessel; Safe Transport Victoria

INTRODUCTION

1. On 19 March 2022, Peter Boyle was 61 years old when he drowned in the McMillian Straits in Paynesville, Victoria.

2. At the time of his death, Peter had lived in Paynesville for three years with his wife, Leanne Boyle.

3. Peter had 45 years of sailing experience and owned at yacht named 'Matilda' which he had purchased approximately three years before his death. The Matilda was a 9m Lidgard fibreglass fixed keel yacht which has a small inboard engine which drives the propellor through a hull shaft. Peter berthed the Matilda at his home in the canals in Paynesville.

4. In 2007, Peter was diagnosed with Parkinson's disease. In 2012, Peter underwent deep brain stimulation surgery which improved the symptoms of the disease, although with the passage of time he began to develop problems with his balance. Peter was prescribed three medications to manage his condition by his neurologist, Professor Dominic Thyagarajan.

5. In August 2021, Professor Thyagarajan referred Peter to physiotherapy to target his balance and voice problems. These issues forced him to give up work in 2018. However, Professor Thyagarajan noted that this did not interfere with his activities on the water which included windsurfing and yachting. Leanne described Peter as a fair swimmer, however, his ability was hampered by his condition.

6. Peter was not known to suffer from any mental health issues or concerns or other serious health conditions.

THE CORONIAL INVESTIGATION

7. Peter'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.

8. 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.

9. 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.

10. Victoria Police assigned Senior Constable Tara Manson to be the Coroner's Investigator for the investigation of Peter's death. Senior Constable Manson 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.

11. This finding draws on the totality of the coronial investigation into the death of Peter Boyle 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

12. On 19 March 2022, Peter Boyle, born 8 June 1960, was visually identified by his wife, Leanne Boyle.

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

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

14. Specialist Forensic Pathologist, Dr Gregory Young from the Victorian Institute of Forensic Medicine, conducted an external examination on 21 March 2022 and provided a written report of his findings dated 11 April 2022.

15. The post-mortem examination did not reveal any unexpected signs of trauma. There was wrinkling of the pads of the fingers and toes was seen, in keeping with the history of immersion.

16. The post-mortem CT scan showed patchy increased lung markings and minor fluid in the maxillary sinuses.

[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.

17. Dr Young stated that a post-mortem diagnosis of drowning can be difficult and is essentially one of exclusion, as there are no specific signs. In absence of an internal examination, one may see a froth plume around the nose and mouth which can disappear quickly. In this case, Dr Young confirmed that the circumstances are consistent with drowning.

18. Toxicological analysis of post-mortem samples identified the presence of Amantadine which is used for the treatment of Parkinson's disease and the prophylaxis of influenza A.

19. Dr Young provided an opinion that the medical cause of death was *drowning*.

20. I accept Dr Young's opinion as to the cause of death.

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

21. At approximately 12:00pm on 18 March 2022, Peter met his crew member, Mr Robert Scholes at the Gippsland Lakes Yacht Club in Paynesville. They boarded the 'Matilda' and began preparation for the Ancient Mariners event which was held at the yacht club every Friday.

22. The pair had met two weeks earlier and Peter asked Robert to assist with being a forward hand on the Matilda on that day. Robert is an electrical engineer and had been sailing boats all of his life.

23. Robert and Peter encountered issues with changing the sails and had a delayed start time of around 12:30pm. They set sail and headed in a northerly direction up McMillian Straits, passing the Paynesville Ferry. Robert recalled that they were travelling at approximately 2 knots.

24. The weather on that afternoon was clear with a southerly breeze of 6 knots. The air temperature was 21 degrees Celsius, and the water temperature was approximately 18 degrees Celsius.

25. Robert stated that he was on the bow of the Matilda adjusting the jib sail. Peter was positioned in the cockpit at the stern. As Robert finished adjusting the jib and started to make his way towards the stern to raise the main sail, he noticed that Peter was not at the controls, but in the water.

26. Peter only had underwear on and said something about the sheet (the line attached to the sail). Robert stated that it appeared the main sail had become entangled in the propellor, and Peter jumped into the water on his own accord to free it.

27. Peter then dived under the Matilda, which continued to drift in a northerly direction. He became separated from the Matilda with no means to climb back onto the boat. At this point in time, Peter was approximately 50 metres from the Matilda and Robert threw a horseshoe shaped foam life ring towards him. The ring had no weight to it and was made of a light foam material. It did not land anywhere near Peter and continued to float way from Peter on top of the water.

28. The distance between the Matilda and Peter continued to grow. Robert had no means to turn the Matilda around as it had minimal steering, due to the line being entangled in the propellor. Robert recalled that Peter was approximately 50 metres away. Robert stated that *Peter… didn't take into account the drifting velocity difference between the yacht and himself.*

29. At approximately 1:28pm, Robert lost sight of Peter and called for assistance over the UHF radio and was able to reach the Gippsland Lakes Yacht Club who were monitoring channel 77. Robert notified them of the incident and that the Matilda was berthed *200 metres south east of Raymond Island Ferry*. This was around 150 metres from where Peter had gone overboard in the McMillian Straits. The Gippsland Lakes Yacht Club contacted the Gippsland Water Police.

Search and rescue response

30. At approximately 2:00pm the Gippsland Water Police office in Paynesville activated the Paynesville Coast Guard and Police Airwing and assumed coordination of the search response.

31. A datum point buoy was released in the water at Peter's estimated last known location. A thorough air and water search was conducted over the course of the afternoon. A land search was also conducted by around the shoreline of the McMillian Straits. The horseshoe shaped ring that was thrown to Peter was located by a land-based unit washed up on the shoreline.

32. At 2:30pm, Gippsland Water Police boarded and secured the Matilda. Police reported that the Matilda was unremarkable and observed to be mechanically powered by an inboard diesel engine via a gearbox and propeller.

33. Police observed Peter's clothing in the cockpit area of the Matilda, along with a personal inflation device (**PFD**) which was split open at the top with the inflation bladder partially hanging out. A black and white line was located tied to the starboard side railing with the other end in the water. Police attempted to pull the line from the water, however, it was entangled under the Matilda.

34. At approximately 6:00pm, the Matilda was towed to a police berth for further investigation. Police continued to conduct a search of the McMillian Straits with a vessel side scan sonar until 9:00pm when the search was called off to resume the following morning.

35. At approximately 8:00am on 19 March 2022, Victoria Police Search and Rescue Squad divers arrived and commenced an underwater search from Peter's last known location. They were supported by the police airwing in a rotary wing aircraft.

36. The Matilda was inspected to determine the exact nature of the rope entanglement and to ensure that Peter had not become entangled underneath the vessel. A rope was observed to be tied to a railing of the starboard side of the boat and tangled with something on the underside of the vessel. It was determined that approximately 3 metres of rope had been tangled in the drive shaft of the yacht propellor and was not readily able to be freed.

37. At approximately 1:00pm, the Melbourne Water Police Underwater Security Team (**UST**) arrived at McMillian Straits with a vessel fitted with specialised underwater side scan sonar equipment.

38. At approximately 4:50pm, the UST crew observed a scanned image they believed to be a human body whilst their vessel was in a location approximately 80 metres from Peter's last known location. Search and Rescue Squad divers recovered Peter's body a short time later.

39. It is the opinion of the Coroner's Investigator that Peter's death was the result of several miscalculations made at the time of the incident, including Peter's compromised swimming ability, misjudging the drift of the Matilda and not wearing a life jacket or being tied to the Matilda as he entered the water.

40. I accept their opinion as to the contributing factors to Peter's death and I am satisfied that a comprehensive investigation has been undertaken.

FURTHER INVESTIGATIONS

41. In investigating the circumstances surrounding Peter's death, Senior Constable Manson identified two issues which relate to the use of lifejackets by mariners who have an impaired swimming ability and whether the use of manually inflatable (or pull tab) life jackets should be restricted for people who suffer from physically disability or have an impaired swimming ability.

42. In considering this issue, I wrote to and consulted with Safe Transport Victoria (**ST Vic**). I have included a summary of the information provided by ST Vic below.

Education resources

43. At present, ST Vic produce and circulate advice on their website and through sailing clubs about the range of lifejackets that are available to suit the many types of water activities. ST Vic do not currently provide any guidance on the most appropriate type of lifejacket to be used by an individual with a physical disability or limited swimming capacity.

44. ST Vic have acknowledged the role that the organisation has in facilitating safe outcomes for people of all abilities and supports the principles of the proposed *Disability Inclusion Bill*[2] set to be introduced into Parliament in 2023 and will continue to investigate whether they can provide specific guidance aimed at persons with disability as part of their water safety program.

PFDs

45. ST Vic confirmed that there are a number of resources which are available to mariners regarding the requirement to carry an appropriate size and type of lifejacket for each person on board a vessel. However, ST Vic do not produce any specific guidance as to the best type of lifejacket for individuals with disabilities or those that are otherwise restricted in their ability to swim. ST Vic have confirmed that they intend to revisit its approach to the production of this type of material.

46. ST Vic have also undertaken to investigate whether it can produce guidance material about the appropriate lifejacket to be worn in different circumstances by people restricted in their ability to activate a manual lifejacket. Notwithstanding this, I do acknowledge that automatic inflatable lifejackets can present a hazard for boaters in some circumstances, particularly if activated in close quarters or near the edge of a vessel.

Undertaking repairs to vessels

47. ST Vic have confirmed that at present there are no regulations or guidelines in place which require or recommend that individuals be tethered to a vessel before entering the water to undertake repairs. However, ST Vic have confirmed that they will continue to engage with sailing clubs and other recreational boating clubs to ensure that boaters are aware of the

[2] https://engage.vic.gov.au/disability-act.

importance of being tethered or tied to a vessel while undertaking maintenance below the waterline.

48. Whilst I am not critical of the work being done by ST Vic to inform mariners of water safety issues relating to the use of lifejackets, undertaking repairs on vessels and more broadly, the organisation has acknowledged that there is a need to revisit the current policies and procedures in place for distributing that information to mariners who are not engaged with sailing or recreational boating club or those who regularly check the St Vic website.

49. ST Vic have advised that they would be supportive of a recommendation to review their current policies and procedures for distribution educational material to mariners on water safety related issues, including use of lifejackets and undertaking repairs on vessels.

FINDINGS AND CONCLUSION

50. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Peter Boyle, born 8 June 1960;

    b) the death occurred on 19 March 2022 at McMillan Strait, Paynesville, Victoria, 3880, from *drowning*; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

51. Having regard to the circumstances of Peter's death, and the information provided by ST Vic, I recommend that:

(i) ST Vic consider reviewing the current information and safety material provided to mariners to ensure that it includes:

    a. information about the requirement to conduct an annual service and test of inflatable lifejackets to ensure that they are functional. The material should include a step-by-step guide as to how to conduct a check and service of the lifejacket if it is to be done by the owner or information about third-party contractors who provide this service;

b. information about the availability of automatic inflating life jackets which may be a preferable option for people who have a disability or restriction of movement - such a life jacket would automatically inflate if the person entered the water; and

c. guidance to mariners about the precautions they should take to protect themselves if they need to enter the water to conduct repair works (for example to clear a line that has become tangled in the propellor) including but not limited to, anchoring the boat if possible, tethering themselves to the vessel before entering the water, advising and briefing other crew members before entering the water.

(ii) ST Vic consider providing this information with the annual renewal of the registration of a vessel to ensure that boat owners read and understand this information. Consideration should be given by ST Vic to the feasibility of developing an online test to be completed prior to renewal of registration.

52. I confirm that recommendations (i)(a) and (ii) above have been directed to ST Vic in the coronial investigation into the death of Trevor Mckie (COR 2020 004384) in which I considered similar issues relating to the annual servicing and testing of inflatable life jackets and the distribution of relevant information and safety material to mariners.

I convey my sincere condolences to Peter'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:

Leanne Boyle, Senior Next of Kin

Senior Constable Tara Manson, Coroner's Investigator

Safe Transport Victoria

Signature:

JUDGE JOHN CAIN
STATE CORONER

Date: 5 June 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.