IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 3431

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of PAUL MERVYN GENDRE

without holding an inquest:

find that the identity of the deceased was PAUL MERVYN GENDRE

born 1 November 1953

and the death occurred between 6 and 11 July 2015

at Horsefall Road, Lake Dartmouth, Dartmouth Victoria 3701

from:

1 (a) CIRCUMSTANCES CONSISTENT WITH DROWNING IN A MAN WITH ISCHAEMIC HEART DISEASE

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Paul Mervyn Gendre was 61 years of age at the time of his death. He was a chef and lived in Camberwell with his wife Wendy. Together they had three daughters and a number of grandchildren. Mr Gendre's medical history included dyslipidaemia, a motor vehicle accident requiring a plate in his left occiput, and previous deep venous thrombosis and pulmonary embolism. Mr Gendre's current medication included telmisartan for hypertension.

2. At approximately 12.30pm on 6 July 2015, Mr Gendre set off alone in his 4.82m Coleman Ram-x scanoe[1] from the shore of Lake Dartmouth, intending to camp in a remote location

[1] A scanoe is a canoe with a square transom.

approximately 10km away from the Dartmouth boat ramp. The scanoe was fitted with a four horsepower petrol outboard motor and was loaded with enough equipment and food for five to seven days of camping.

3. At approximately 12 noon on 11 July 2015, Mr Gendre was located by passing fishermen lying face down, partially submerged at the edge of Lake Dartmouth, holding onto a yellow dry bag[2] with his left hand. He was opposite the entrance to the Larsen Creek, approximately 10km from the main boat ramp. It was apparent that there were no signs of life. Mr Gendre's scanoe was sighted in the distance, approximately 1.5km away. The fishermen alerted people on a nearby boat who came with them to assist. The fishermen then returned to shore and drove to the Dartmouth Hotel to contact emergency services.

4. Police attended and were assisted by fisheries officers from the Department of Economic Development, Jobs, Transport and Resources,[3] and staff from Goulburn Murray Water and the State Emergency Services (SES). Mr Gendre's body was recovered and returned to the Dartmouth boat ramp. Ambulance paramedics arrived and declared Mr Gendre to be deceased at 3.12pm on 11 July 2015.

INVESTIGATIONS

Forensic Pathology investigation

5. Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a full post mortem examination upon the body of Mr Gendre, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Baber observed a slightly enlarged heart with hypertrophied lateral left ventricular wall and approximately 70% stenosis of all three major coronary arteries.

6. Toxicological analysis of post mortem blood detected alcohol at a concentration of 0.23g/100mL.[4] It was noted that a blood alcohol concentration in excess of 0.15g/mL can cause considerable depression of the central nervous system affecting cognition and capable of

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[2] A 'dry bag' is commonly used by canoeists to keep their belongings dry.

[3] I note that this department was then known as the Department of Primary Industries.

[4] This compares with the 0.05g per 100ml being the legal limit for blood alcohol concentration for fully licensed car drivers.

producing adverse behavioural changes. Dr Baber opined that the high blood alcohol level may have contributed to the circumstances surrounding Mr Gendre's death.

7. Dr Baber ascribed the cause of Mr Gendre's death to drowning in a man with ischaemic heart disease.

Police investigation

8. At the time that Mr Gendre's body was recovered from the water, police noted that he was not wearing a personal floatation device. Police searched Mr Gendre's pockets and located his wallet – containing a Victorian Driver's Licence, mobile phone and a set of vehicle keys. The mobile phone contained photographs of the lake and scanoe. Fisheries Officers located Mr Gendre's scanoe untethered and upturned on the opposite side of the lake from where he was found. There were no visible holes or damage to the scanoe; the outboard motor was still in the half open throttle position with no fuel in its tank.

9. Leading Senior Constable (LSC) Jonathon Anderson, the nominated coroner's investigator,[5] conducted an investigation of the circumstances surrounding Mr Gendre's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by members of Mr Gendre's family and a number of witnesses. A report prepared by Marine Surveyor Erik Eriksson for Maritime Safety Victoria was also included in the brief.

10. Wendy Gendre described her husband as family-oriented, calm and stable. She said Mr Gendre's state of mind was in the best place it had been in years; he was content with his personal and work life. Mrs Gendre noted he had high blood pressure and believed he was a strong swimmer, however his current fitness level was moderate. Mr Gendre smoked daily, but only at work.

11. The Gendre family had owned a Coleman Scanoe with an outboard motor for approximately 26 years. LSC Simon McCormick of the Water Police Squad stated that the scanoe was constructed of a hard plastic type material, and designed to be fitted with a motor. It had a square transom with a timber engine mounting block. Marine Surveyor Erik Eriksson reported that the vessel was made from moulded polyethylene and had a light aluminium tube frame.

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[5] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

12. Mrs Gendre said her husband was a very competent boatman with a lifetime of experience in the use of boats of all different sizes and in different conditions. Family member Ros Silverwood agreed that Mr Gendre was not just a part time water person; it was a huge part of his life. He was a very competent seaman and strong swimmer. Over the past 42 years, Mr Gendre had been boating on Lake Dartmouth about 10 to 12 times. The July 2015 trip was the third time he had taken the scanoe to the lake.

13. Mrs Gendre knew her husband held a book about obtaining a boating licence in the house, but noted that when they had a big boat, a licence was not required in Victoria. She added that Mr Gendre owned lifejackets, but it was not usual practice for him to wear one. Detective Sergeant Graeme Simpfendorfer noted that no registration numbers were observed on the scanoe. In his summary contained in the coronial brief, LSC Anderson noted the absence of a Victorian Recreational Boating Licence or registration of the scanoe.[6] LSC Anderson suggested that while neither would have guaranteed Mr Gendre's safety, the educational process involved with the boating licence may have encouraged effective decision making processes regarding alcohol consumption, life jackets and cold water immersion.

14. Mrs Gendre last saw her husband at approximately 3.00pm on Sunday 5 July 2015. He was in good spirits and was excited to be going trout fishing, planning to be away until at least 9 or 10 July 2015 – depending on the quality of the fishing. Mr Gendre told his wife he planned to park his car at the Dartmouth boat ramp and 'scanoe' his way to camp at the Eustace Creek camping ground. It was Mrs Gendre's understanding that her husband was meeting a work colleague, Damon who was going to travel separately in his own 'tinny' to get to the campsite. At 9.27am on 6 July 2015, Mr Gendre called his wife and said he was purchasing bread in Wodonga and that Damon was about 25 minutes behind him. Police spoke to Damon on 12 July 2015 and he advised he had told Mr Gendre he would only come fishing if he got his work done, and would only possibly get there for one day. He did not meet Mr Gendre on 6 July 2015 or arrive to Lake Dartmouth at a later date.

15. A witness who was in the vicinity of Lake Dartmouth on 6 July 2015 stated that the weather was really cold, over cast and a bit windy. The water was a bit choppy. LSC Neville Barrow stated that the weather during the week preceding 11 July 2015 was one of the worst recorded

[6] The investigation identified that due to the four horsepower outboard motor fitted to the scanoe, Mr Gendre was required to register the scanoe with Maritime Safety Victoria and to obtain a recreational boating licence.

in the Lake Dartmouth area for some time. On 11 July 2015, Fisheries Officers measured the water temperature at Lake Dartmouth to be 10°C.

16. Another witness saw Mr Gendre loading his scanoe with camping equipment on 6 July 2015 and said it seemed a strange activity for the middle of winter. A separate bystander noted that Mr Gendre's scanoe looked top heavy with all the equipment loaded and thought it appeared unstable and 'an accident waiting to happen'. LSC Neville Barrow opined that Mr Gendre's scanoe would have been dangerously overloaded. However, Mr Erikkson reported that the manufacturer of the scanoe declared a total load capacity of 740 pounds or 336kg, and noted evidence revealed the scanoe had a total load of approximately 246kg at the time of the incident. Mr Erikkson confirmed that it appeared the scanoe was not overloaded in terms of weight, but items aboard it were relatively bulky, resulting in a high centre of gravity and less stability. Mr Erikkson suggested the bulky items were generally an inappropriate choice for a solo camping expedition involving a scanoe, and the loading condition could have been greatly improved by choosing more compact camping equipment.

17. Edward Wright was fishing on the western end of Lake Dartmouth on 9 July 2015 and stated that he and his friend saw a dark coloured canoe at approximately 3.30pm. Mr Wright's friend looked through binoculars and noticed a rope at the front of the canoe, which appeared to be tied to a log.

18. Mr Eriksson found that Mr Gendre's scanoe appeared to be intact and in reasonable condition; there were no leaks apparent during testing. He noted that at the time of the incident, the scanoe's engine was likely to have been either running at full throttle, or had run out of fuel, as the throttle mechanism was seized in the full fuel position. He opined that the engine either continued to run until it ran out of fuel, or had run out of fuel and in the process of retrieving the spare fuel, Mr Gendre had fallen overboard.

19. LSC Barrow stated that on 12 July 2015, a car fridge was found on the bank of Lake Dartmouth, south east from where Mr Gendre's body was located. The fridge was possibly owned by Mr Gendre and contained unopened food items. If this was so, LSC Barrow believed it suggested Mr Gendre had not made it to his camping spot at Eustace Creek, possibly coming into difficulty on 6 July 2015 shortly after launching from the boat ramp.

20. LSC Anderson reported that Mr Gendre's mobile telephone indicated it was last used on 6 July 2015 at 1.12pm. There were several photographs taken of the Lake Dartmouth boat ramp, the loaded scanoe and photographs of the scanoe on the water.

21. Within the summary of the coronial brief, LSC Anderson noted that signage relating to safety requirements at most Victorian inland and coastal waterways' boat launching facilities is either convoluted, non-existent or wrongfully located. Specifically, LSC Anderson observed that the safety equipment requirement signage at Lake Dartmouth is convoluted and located approximately 500m from the ramp. He opined that signage should be simplified and there should be an onus upon the Waterway Managers to adjust signs relative to water levels and launching locations. In addition, LSC Anderson suggested that consideration should be given to corflute signage[7] located at ramps, stating words to the effect of 'Cold Water Kills – Always Wear Your Lifejacket'.

Coroners Prevention Unit investigation

22. Following receipt of the coronial brief, I asked the Coroners Prevention Unit (CPU)[8] to provide information relating to the frequency of boating deaths in Victoria and to source examples of improved signage that could be implemented at locations including Lake Dartmouth.

23. The CPU identified that 17 deaths occurred in Victoria involving the operation of human powered vessels – canoes and kayaks – between 1 January 2000 and 31 May 2016. Five of these deaths occurred in circumstances where the deceased set out alone; ten occurred where the deceased was not wearing a life jacket; and six occurred in circumstances where the deceased was either alcohol or drug affected.

24. Life Saving Victoria (LSV) and Maritime Safety Victoria (MSV) were contacted and it emerged that the agencies have previously raised concerns regarding human powered vessels and aquatic safety signage.

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[7] Corflute is a trade name for a double-sided material, with a corrugated layer in between, made of plastic rather than paperboard so that it is relatively weather-proof.

[8] 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

25. Rob Andronaco, Risk and Geographic Information System Development Manager at LSV, advised that a new Australian Standard (AS/NZS 2416) exists for aquatic safety signage, but no standard signage exists for warning of the dangers of cold water immersion. Mr Andronaco added that sign placement can be contentious and that the standard[9] states 'the siting of water safety signs and multiple signs should allow hazards to be recognised and appropriate avoiding action to be taken by users'. Mr Andronaco noted that the distance of the safety signage, located at the commencement of the road near the car park, from the Dartmouth boat ramp may have been too far from the departure point to have any influence on behaviour or judgment. He added that in general, common problems with signage include poor placement; use of symbols without any prior testing on associated recognition and recall rates; not using symbols but using text instead; putting too much content on the sign; deciding on sign context based on a 'best guess' rather than based on a structured risk assessment process.

26. Mr Andronaco advised that it was problematic boat users may fail to comply with regulations due to the remoteness of Lake Dartmouth. He said that it is not the signage itself which is the major impetus behind behavioural change; it is the fear of consequences. Mr Andronaco opined that if people are not fearful of injury or drowning risk, and there is little chance of regulatory enforcement, then compliance is going to be low regardless of what is signposted. However, he did note that given the small local community, any enforcement would be likely to spread by word of mouth. Mr Andronaco suggested there has become an overreliance on signage, but did not deny its effectiveness if used appropriately and in conjunction with other risk treatment options.

27. Lisa Faldon, Manager of Operational Standards at MSV noted that a study was currently underway regarding boating safety signage, including the extent to which people actually read signs. Ms Faldon advised that initial findings indicated people generally do not read a sign unless they are new to an area. She added that another issue with kayakers and signs, was that generally they can launch in innumerable places, so may not even see a sign. Further research was underway looking at the behaviour of kayakers, including their understanding of risks, and from where they obtain safety information.

28. Ms Falson noted there is generally a poor understanding about the requirement to register a kayak once a motor of any size is attached. She opined that registration itself would not have

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[9] See: AS/NZS 2416.3:2010 Clause 4.2.1.

improved Mr Gendre's understanding of safety issues; but it would have triggered the requirement for a boat licence. Ms Falson believed that if Mr Gendre had completed a course and obtained his licence, he would have been sufficiently informed about his responsibilities for safety equipment (including personal floatation device) and other issues such as speed and distance rules. She noted an absence of emphasis on cold water emersion issues. However, Ms Falson acknowledged that there would be no guarantee Mr Gendre would have met these responsibilities.

Further investigation

29. The Court sought a statement from General Practitioner Dr John Addis at Canterbury Medical Clinic regarding his treatment of Mr Gendre. By way of facsimile dated 7 September 2016, Dr Addis advised the Court that he had last seen Mr Gendre on 25 November 2014. Mr Gendre's health issues related largely to his cigarette smoking, which ceased in 2013, with comorbid dyslipidaemia and casual hypertension. He had no mental health issues while under the care of Dr Addis.

FINDINGS

The exact circumstances surrounding Mr Gendre's death remain unclear at the completion of my investigation. It is possible that Mr Gendre suffered from either a medical event or was affected by alcohol, lost balance and fell into the water, succumbing to hypothermia and subsequently drowning. The weight of the evidence – including the photographs in Mr Gendre's mobile phone and the location of the car refrigerator with unopened produce – suggest the critical incident most likely occurred on 6 July 2015.

A number of safety issues appear to have contributed to Mr Gendre's death, including the absence of a personal floatation device; an elevated blood alcohol level; and boating alone. Incidental breaches of regulations, including an unregistered scanoe and the lack of a recreational boating licence also reflect a lack of safety related education on Mr Gendre's part and should appropriately be included as possible contributing factors.

I acknowledge the concerns raised in relation to the location of safety signage at Lake Dartmouth, and the lack of reference to the dangers of cold water immersion. I also note that in these circumstances Mr Gendre may have been less likely to read any signage given his significant experience and history of boating in the area.

On the evidence available to me, it appears that Mr Gendre died in circumstances that were preventable. By taking his scanoe to a relatively remote area, loading it with bulky items, travelling with no life jacket or personal floatation device, apparently consuming alcohol, and failing to obtain a Recreational Boating Licence and associated education, Mr Gendre was exposed to considerable risk of injury.

I accept and adopt the medical cause of death as identified by Dr Yeliena Baber and find that Paul Mervyn Gendre, a man with ischaemic heart disease, died from drowning.

RECOMMENDATION

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

1. With the aim of reducing the risk of harms and preventing like deaths through the provision of appropriate information about the risks associated with boating and associated water activities, **I recommend** that Goulburn Murray Water erect additional safety signage adjacent or proximate to the boat ramp at Lake Dartmouth.

Pursuant to section 73(1A) of the Coroners Act 2008, I order that this Finding be published on the internet.

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

Mrs Wendy Gendre
The Hon. John Eren MP, the Victorian Minister for Sport
Life Saving Victoria
Maritime Safety Victoria
Mr Neil Brennan, Interim Managing Director, Goulburn Murray Water
Ms Elizabeth Muhlebach, Transport Safety Victoria
Dr John Addis, General Practitioner
Leading Senior Constable Jonathan Anderson

Signature:

AUDREY JAMIESON
CORONER
Date: **16 September 2016**