

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2009 / 4832

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

I, JOHN OLLE, Coroner having investigated the death of APOSTOLOS KATELAS

without holding an inquest:

find that the identity of the deceased was APOSTOLOS (PAUL) KATELAS

born on 6 August 1968

and the death occurred on 10 October 2009

at Port Phillip Bay, Melbourne

from:

1 (a) DROWNING

Pursuant to section 67(2) of the *Coroners Act 2008*, I make findings with respect to the following circumstances:

1. Mr Apostolos Katelas was aged 41 years at the time of his death. He lived at 18 Maureen Close, Cranbourne East.
2. The coronial brief compiled by Leading Senior Constable Reynolds is comprehensive and fully addressed the circumstances of death. I have also been assisted by the family and further documentation from LSC Reynolds that focussed on potential preventative measures. In addition, I referred the material to the Coroners Prevention Unit (CPU)¹.
3. The deaths of Mr Katelas and Mr Emmanouel are a tragic loss for their families. It is hoped that lessons can be learned from the investigation, which can reduce the likelihood of similar preventable death in the future.

¹ The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

Circumstances

4. On Friday 9 October 2009 at approximately 6.30pm, Apostolos (Paul) Katelas launched his 1985 model 5.2 metre-long Haines Hunter 520 SLC vessel from Kananook Creek boat ramp in Frankston. Accompanying Mr Katelas was his close friend Georgios Emmanouel, aged 71 years.
5. On this night, wind speed was measured at 15km/h gusting up to 26km/h and waves were described as being 1-1.5 metres in height. Sunset occurred at 7.31pm. The Bureau of Meteorology recorded the maximum air temperature on this day as 16.7 degrees Celsius and the minimum temperature on 10 October as 8.7 degrees Celsius.
6. At approximately 7.55pm, Mr Katelas made a mobile telephone call to the Australian Volunteer Coast Guard. During this conversation he reportedly stated that his vessel was taking on water and that he was positioned '4 Ks off Frankston' before the signal cut out. A second telephone call was made where Mr Katelas stated that he was taking on water faster than he could bail out. No further details were obtained from him as the phone signal again cut out. The Coast Guard member immediately notified a Coast Guard vessel and then the Melbourne Water Police.
7. At approximately 8.15pm an Australian Volunteer Coast Guard vessel attended the general vicinity of 4km off Frankston. An extensive search for the vessel was initiated and continued throughout the night and into 10 October 2009.
8. On the morning of 10 October 2009, Mr Katelas was located in the water by rescue authorities. A short time later Mr Emmanouel was located. On 12 November 2009, water police located their vessel on the seabed, approximately five nautical miles offshore between Frankston and Seaford.

Post Mortem Medical Examination

9. On 13 October 2009, Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination on the body of Georgios Emmanouel.
10. Dr Baker found the cause of death to be drowning.

Detailed examination of the incident

Mr Katelas

11. The available evidence indicates that Mr Katelas was a keen fisherman and regular boater who occasionally fished in Port Phillip Bay. He had owned several boats previously and as a hobby, would do these boats up to sell and then upgrade. He was described as a cautious and responsible boater. Mr Katelas would typically undertake maintenance on the vessels himself.

The vessel history

12. Mr Katelas had purchased the vessel on 12 May 2009 from David Fent of Bluefin Marine Power Boats in Seaford. Mr Fent had originally purchased this vessel through eBay. Prior to selling the vessel to Mr Katelas, Mr Fent undertook various repairs on the vessel and fitted new items.²
13. Mr Katelas experienced problems with the vessel on several occasions in the months prior to his death. These issues, and the subsequent maintenance performed, were described in various witness statements.³ The main issues seemed to relate to engine loss of power and amounts of water being removed from the hull after each fishing trip. Mr Katelas had applied silicon around the stern bung plug housings to prevent water entry. The last fishing trip made prior to the vessel sinking was on 3 October 2009 in Western Port Bay. A friend accompanying Mr Katelas recalled that no water exited the stern bungs after being on the water for several hours. Issues with the engine losing power however were still apparent.⁴

Investigations into vessel sinking

14. The water police squad conducted an extensive investigation into the incident, including a re-enactment of the vessel sinking.
15. The ignition was found in the off-position and the gear lever in neutral. The anchor was located in the cabin area of the vessel and not in the anchor well. Investigators were unable to determine at what point the anchor was raised.

² Refer to original and supplementary statements of Mr Fent which detail the repairs performed and new items fitted.

³ Refer to statements of John Frantzis, Allen Swain and Sean Gleeson.

⁴ Refer to statement of John Frantzis.

16. An oval aperture was cut quite low in the engine well to allow for cable steering at the time of manufacture. The cable steering had since been removed. This aperture had hydraulic steering hoses and fuel line through it and was not sealed. Any water that passed through this hole entered directly into the bilge area, through the bait wells, and inside the hull of the vessel.
17. No issues were found with the integrity of the hull. While on a trailer, the hull was filled with water via the aperture in the engine well. After sitting for approximately one hour, no water was seen to exit the vessel from anywhere on the hull except slightly from the port side stern bung plug.
18. A controlled simulated sinking of the vessel was performed by the Water Police. Video footage of this simulation was provided to the Coroner. This revealed that:
 - Both men were standing at the stern of the vessel which would have caused the transom and engine well to sit closer to the water surface. This weight, combined with wave action, allowed for water to enter through the oval aperture.
 - Water was seen to wash into the engine well and through the aperture. Water then entered the bilge section which was hidden from view by false cupboard floors and equipment at the stern of the vessel. Water then filled the bilge section, overlapped over the fuel tank, and then travelled under the flooring into the live bait wells, down the unplugged bung housings and into the hull. This in turn made the vessel heavier at the stern and made the transom sit lower into the water. Water then flowed faster into the aperture due to the increased weight, until completely submerged.
 - The two men would have likely been unaware of the water penetrating the vessel until it began to flood the floor.

Safety equipment

19. The following equipment was recovered:
 - Five Type 1 Personal Flotation Devices (PFDs).
 - Two boxes of unused orange and red flare kits (both expired in March and May 2008).
 - One fully charged fire extinguisher.

- A 27 megahertz (MHz) radio was fitted on the dash of the vessel with the face missing. It is believed to have not been working at the time of the incident.
 - A GME AM/FM radio was fitted.
 - A Lowrance brand M52 GPS/sounder was also fitted to the dash.
20. The vessel did not have a compass, a bilge pump, or an Emergency Position Indicating Radio Beacon (EPIRB). The *Marine Regulations 1999* applicable at the time of the incident did not require this vessel operating in Port Phillip Bay (designated as “enclosed” waters) to have these items. The current regulations also do not require these items to be carried.

Raising the alarm

21. There were no reported sightings of flares in the region. Two boxes of unused flares (both expired) were on board the vessel upon recovery. The vessel did not require a marine radio or an EPIRB on board because it was operating in Port Phillip Bay, which is designated as “enclosed waters”. While a 27 MHz marine radio was fitted to the vessel, it is not believed to have been working at the time.
22. Telephone records showed that Mr Katelas had contacted the Telstra Directory at least five times to obtain the telephone number of the Australian Volunteer Coast Guard. At no point did he dial triple zero. While conversing with the Coast Guard, his mobile signal dropped out. Mr Katelas is believed to have given a location of four kilometres off Frankston.
23. The Australian Volunteer Coast Guard did not have telephone recording facilities and the mobile telephone call made by Mr Katelas could not be retrieved to verify the details relayed. The few details relayed formed the basis of subsequent search attempts by rescue authorities including the Coast Guard and water police.

Personal Floatation Devices

24. Despite several Type 1 PFDs being available on board, neither man was wearing a PFD at the time of being located. The *Marine Regulations 1999* required a PFD to be worn by an adult on a vessel of this size only during a “time of heightened risk”. A time of heightened risk includes times where there is a significant likelihood that the vessel may capsize or be swamped by waves, or the occupants may fall overboard or be forced to enter the water. Arguably, PFDs should have been worn when water ingress was detected. S/C Reynolds

suggested that a lack of training and safety knowledge may have meant that neither occupant was aware of the emergency they were facing.

Investigations initiated by the Katelas family

25. A vessel inspection was undertaken by marine surveyor Bruce Dart from Maritek Pty Ltd on behalf of Mr Katelas' family, with the objective to establish the root cause of the vessel sinking.
26. The condition of the hull was eliminated as a cause of the sinking. Mr Dart identified that a stern bung plug did not sit correctly because silicon had been used to seal the bung plug housing (consistent with a previous report that Mr Katelas had applied silicon in September 2009 following advice from Mr Fent). He also identified the aperture in the transom well had a rubber boot present but not for the purposes of sealing.
27. Mr Dart concluded that water slowly leaked into the vessel via the defective stern bung plug (possibly up to 120 litres over a period of four hours). This caused the vessel to sit on an angle due to the water on board. Water then entered via the open aperture in addition to the bung, causing it to rapidly sink.
28. Jim Kerin, experienced in the design, build and repair of vessels, also inspected the vessel on behalf of the family of Mr Katelas. His findings were similar to that of S/C Reynolds in that a cause of the vessel sinking was water entering the vessel via the unsealed oval aperture. He further stated that the absence of a bilge pump was a contributing factor. Mr Kerin asserted that a flat battery was another contributing factor to the incident because the GPS/sounder was non-operational, hence the misreporting of the vessel's position. Several reasons as to why this occurred were proposed. He noted that had the battery been in a marine box or had a cover or the terminals greased the battery would not short circuit from water spray via the aperture.

Supplementary investigations following Mention Hearings

29. I requested Senior Constable Reynolds to comment on the findings of Mr Dart's report. Senior Constable Reynolds acknowledged that the incorrectly seated stern bung plug did not assist in the watertight integrity of the vessel. However, he noted that when the vessel was placed in the water for an hour as part of the simulation to test the plugs, water did ingress into the hull. However, the amount was minimal and in the time period, this was deemed to

be a contributing factor rather than the underlying cause. The vessel was in the water for no more than two hours on the night of the incident.

30. A supplementary statement was sought from Mr Fent to address specific concerns raised by the family in relation to the condition of the vessel when sold. Mr Fent stated that the vessel was not sold with any electrical devices however Mr Katelas later purchased and fitted a 27 MHz marine radio, a GME brand AM/FM radio and a Lowrance brand GPS/sounder to the vessel.
31. Mr Fent could not recall whether drain plugs were in the bait wells at the time Mr Katelas purchased the vessel. He did recall that the bait wells were originally pink in colour when he sold the vessel to Mr Katelas and noticed that they had been repainted white when shown a photo of the vessel after the sinking.
32. With respect to the oval aperture in the engine well Mr Fent stated:

“I do not believe the vessel had nor had any hydraulic lines entering or coming out of the vessel at the time of sale. The vessel would have had a standard steering cable mounted coming through the side of the engine well which goes to the tilt tube of the outboard motor. It is connected to the motor direct through the motors tilt tube as standard. The rubber boot is used for the steering cable to come through.”
33. Further:

“At no time or stage did we modify or repair any sections of the Outboard motor well and associated area/s. The rubber stopper/grommet hole where the steering cable exits the vessel to the outboard is a factory made hole.”
34. Mr Fent was unable to advise on the possible alterations or modifications to the vessel that may have been completed after the vessel had been handed over to Mr Katelas.

Recreational vessel occupant drowning deaths in Victoria

35. The Coroners Prevention Unit advised that between 1 January 2000 and 31 December 2011, 71 recreational vessel occupants died due to drowning in Victoria.⁵ These deaths resulted from 59 separate incidents; more than one occupant died as a result of the incident on 10 occasions. Six fatal incidents remain under investigation by a coroner.

⁵ Case search and analysis methodology summarised in Section 5 of this report.

36. There was a notable decrease in the number of deaths from 2005 consistent with the introduction of mandatory personal flotation device wearing requirements in Victoria on 1 December 2005.
37. Among the 23 incidents occurring in enclosed waters, 70% (n=16) occurred in Port Phillip Bay. Where distance from shore was specified (n=17 of 23), four incidents occurred offshore (i.e. more than two nautical miles from shore) and all four occurred in Port Phillip Bay. These vessels included a yacht and three motorised boats.
38. Where known, vessels most commonly capsized (37%) or victims had fallen or were thrown overboard (25%).
39. These findings reflect those of Bugeja (2003) through an examination of all recreational vessel drownings in Victoria between 1999 and 2002. Bugeja (2003) found that the deceased most often had entered the water suddenly and unexpectedly with occupants afforded little if any time to prepare themselves. This was frequently as a result of a capsized (50%) or man overboard scenario (17%).
40. Among the 68 deaths where PFD wearing status was known, 19 victims (28%) were wearing a PFD prior to their death.
41. In 60% (n=34) of the total incidents the alarm had not been raised by an occupant of the vessel. Where the alarm was raised via the vessel on which the deceased had been an occupant, it was most commonly through another occupant having swum to shore (n=11). Where the alarm had been raised through means other than the occupants of the vessel, it was most commonly through family or friends who had reported the vessel overdue (n=14), or through occupants of another vessel who had witnessed the incident or located the deceased/vessel (n=10).
42. In 37% (n=22) of the total incidents the vessel was being operated by a person who was alone at the time. This proportion varied by vessel type; 64% (n=7) of human-powered vessels were operated alone and just 28% (n=11) among motorised boats. Of those operating alone, just one vessel operator raised the alarm.

Recommendations of LSC Reynolds

43. Upon request, LSC Reynolds put forward several prevention-focussed recommendations for my consideration. These recommendations addressed:
- The incorporation of a practical component to the boat operators' licensing system in Victoria, similar to the Western Australian model;
 - Expansion of the safety equipment required on board powered recreational vessels, including:
 - Emergency Position Indicating Radio Beacons (EPIRBs) (preferably with GPS interface) for all recreational vessels operating in both coastal and enclosed waters;
 - 27MHz marine radios for all recreational vessels in all waters.
 - Manual or electric bilge pumps for all vessels capable of mechanical propulsion; and
 - Compulsory marine battery covers for all vessels;
 - Permanent telephone recording facilities for the Australian Volunteer Coast Guard-Victoria; and
 - The introduction of a system for pre-purchase surveys of vessels.
44. I sought the assistance of the Coroners Prevention Unit (CPU) in examining the merit and feasibility of the above recommendations. In doing so, the CPU obtained advice from a number of key agencies including the Maritime Safety Division of Transport Safety Victoria, the Australian Volunteer Coast Guard, and the Australian Maritime Safety Authority (AMSA). I am most appreciative of the assistance provided by each of these organisations.
45. I am aware that marine safety legislation in Victoria was recently subject to extensive review and some of the key issues raised in this coronial investigation were previously considered by the Department of Transport.

Safety equipment

46. The *Regulatory Impact Statement for Marine Safety Regulations 2011* and associated Technical Papers stated that the Department of Transport could not find a case to justify introducing additional mandatory safety equipment (including EPIRBs, marine radios and bilge pumps) for vessels operating in Victorian waters beyond the current requirements.

Transport Safety Victoria advised the Court that they will continue to encourage boaters to go beyond the minimum regulatory requirements and to equip their vessels with additional safety equipment. Such advice is crucial; if a decision has been made not to strengthen the safety equipment requirements, certainly boaters should be encouraged to go beyond the minimum.

47. With respect to batter covers, Transport Safety Victoria advised that they do go some way to mitigate the risk of batteries becoming wet and inoperable, and there must be a method of ventilation. However, they may also potentially increase the likelihood for vessel owners to not pay sufficient attention to the condition of the battery itself.

Raising the alarm: EPIRBs and marine radios

48. The deaths of these men have drawn a particular focus on the means currently available to recreational boaters to raise the alarm in the event of an emergency in a vast waterway like Port Phillip Bay.
49. Flares and smoke signals are currently the only mandated safety equipment capable of raising the alarm for a vessel operating in these “enclosed waters”. EPIRBs and marine radios are required only by vessels venturing more than two nautical miles from shore in “coastal waters”.
50. While Mr Katelas had fitted a 27MHz marine radio to his vessel, the available evidence indicates that it had not been working. Although he possessed a mobile phone, it is deemed a weaker form of communication and susceptible to issues such as signal loss and water damage.
51. Unlike a mobile phone, a marine radio enables the alarm to be broadcast to more than one recipient. EPIRBs, particularly those with a GPS interface, are capable of both raising the alarm and verifying the location of a vessel in distress. The distress call is initially received by AMSA. Those with GPS functionality can locate a person or vessel to within 120m while those without have an accuracy locator of around 5km. A GPS-enabled device facilitates a much timelier rescue.
52. I have been alerted to a finding handed down in February 2012 by Western Australian State Coroner Alastair Hope who considered the issue of lifting an exemption for EPIRBs in a particular coastal area off the WA mainland. With respect to inadvertent EPIRB activations, an AMSA representative advised the inquest that the response costs are minimal as most

cases are resolved through a telephone call to the registered EPIRB owner. In his finding, State Coroner Hope acknowledged that if the exemption zone was lifted many more vessel owners would incur the additional cost of purchasing an EPIRB. State Coroner Hope however concluded that it was time to revisit the issue, particularly given that the cost of EPIRBs has significantly decreased over time.

53. Whilst Port Phillip Bay is a different environment, the same practical implications are relevant. The cost to boaters and rescue authorities and the ultimate necessity for such a regulation needs to be heavily considered. AMSA has advised the Court that they do support the use of EPIRBs in Port Phillip Bay, but emphasised that they should only be used in circumstances of “grave and imminent danger” and only after alternative means of communication, such as a marine radio, has been attempted.
54. The Coroners Prevention Unit has advised that since mandatory PFD wearing requirements were introduced in Victoria on 1 December 2005, a significant reduction in recreational vessel occupant drowning deaths has been seen. However, eight occupants died from drowning in Port Phillip Bay, representing 42% of all such deaths in Victoria in this same period. At least three of these incidents in Port Phillip Bay occurred more than two nautical miles from shore (including the current matter). In two of these, the boat occupant was wearing a Type 1 PFD. In her finding handed down in 2009 relating to one such incident, Victorian Coroner Stella Stuthridge highlighted the importance of an EPIRB:
- EPIRBs are a vital search and rescue tool and have demonstrated their usefulness on many occasions. The wearing of an EPIRB can make the difference between a successful outcome and failure.
 - It is clear from the circumstances in this case, and in others investigated by the Coroners Court, that EPIRBs are a vital piece of equipment and should be considered as essential by all boating enthusiasts.⁶
55. EPIRBs and marine radios would undoubtedly be of value to boaters heading into Port Phillip Bay where the environment may present risks not dissimilar to offshore waters. Whether these devices, (particularly EPIRBs) should become mandatory in such waters is a matter I feel requires further investigation by the relevant authorities. The decreasing purchasing cost for boaters, the valuable assistance provided to search and rescue

⁶ Victorian coroner’s reference no. 4693/07.

authorities, and the real potential to save lives are critical issues for consideration. Past fatalities certainly demonstrate that wearing a PFD alone is not sufficient, particularly in remote areas; the alarm must also be effectively raised and the location of the vessel determined in order to facilitate a timely rescue.

Mobile telephone calls and dialling “000”

56. Prior to reaching the Australian Volunteer Coast Guard, Mr Katelas had phoned the Telstra Directory at least five times to ascertain their telephone number. There was uncertainty as to whether Mr Katelas had stated “kilometres” or “nautical miles” and the brief conversation could not be retrieved because the Coast Guard did not have permanent telecommunication recording facilities at the time. The Australian Volunteer Coast Guard of Victoria has since advised the Coroners Court that recording facilities were installed by Telstra at their exchange facility in March 2011 to enable incoming telephone calls to be recorded.
57. While mobile phones are not the most reliable form of communication, Transport Safety Victoria advised that in a marine emergency where mobile phone reception is available, boaters should dial triple zero in the first instance. This simple but vital message should be well communicated to boaters.

Boater education: practical licensing and ongoing education

58. Unlike the majority of recreational vessel drowning deaths in Victoria, where sudden and unexpected water entry occurred through a capsizing or person overboard scenario, Mr Katelas and Mr Emmanouel had time available to take action. It is not enough to simply carry safety equipment; its value ultimately relies on a boater making use of it in the event of an emergency.
59. Mr Katelas was described as a passionate fisherman and a responsible, confident and competent boater who had bought and sold boats in the past. The failure to make use of the available safety equipment (flares and PFDs) suggests that the two men were overwhelmed by the emergency that confronted them and their ability to take effective action was severely compromised as a result.
60. In August 2011, the Department of Transport released the *Options Paper for Marine Licensing in Victoria*. This paper noted that human factors contributed to the majority of serious marine incidents in Victoria. The boat operator licensing system is intended to instil critical knowledge and skills among new boaters to ultimately reduce the extent to which

human factors contribute to marine incidents. However as Transport Safety Victoria noted, any changes made to the licensing system will ultimately affect new boaters only; there must also be strategies in place to educate existing licence holders. There is also the possibility that such knowledge may be forgotten over time.

61. Other Australian jurisdictions have already incorporated a practical skills component into their licensing process, with Western Australia's "Recreational Skippers Ticket" model considered the most comprehensive.
62. The options paper also noted that based on hours of exposure, a recreational vessel was approximately 3.89 times more likely to be involved in a fatality than a road vehicle.⁷ A conclusion was reached that an improvement to Victoria's current licensing scheme is necessary:
 - As discussed, the Victorian licence scheme when objectively assessed did not produce competent operators compared with those from another licensing scheme. The recommended option is to improve operator competency and provide a significant increase in the safety of boating activities. This is the option which requires the new applicant to pass an improved knowledge test and successfully demonstrate skills and competency by completing a practical assessment. This option has a negative benefit cost ratio in the range of 0.6 – 0.7.
 - The option is seen as the best way to improve competency, albeit at a cost, to meet the intent of the national *Guidelines for Recreational Boat Operator Competencies*, ensure consistency with other Australian jurisdictions and improve confidence in the Victorian licensing scheme.⁸
63. The available evidence did not disclose what previous education or training these two men. While it is difficult to speculate whether better training and education in emergency preparation may have assisted Mr Katelas and Mr Emmanouel, there certainly appears to be merit in introducing a practical component to the boat operator licensing system in Victoria for the benefit of new boaters. A Victorian Coroner has previously recommended that recreational boat licence applicants be required to undertake a practical examination and

⁷ Refer to page 178 of the Discussion Paper, Options for Marine Licensing in Victoria.

⁸ Refer to page 54-55 of the Discussion Paper, Options for Marine Licensing in Victoria.

exhibit a reasonable proficiency in the operation of a boat before being issued with a licence.⁹

Pre-purchase vessel safety checks

64. The introduction of vessel safety standards and a system for periodic vessel safety inspections was considered by the Department of Transport throughout the review of the marine safety regulatory framework. These issues were also the subject of recommendations by Coroner Peter White following an inquest into two deaths resulting from a recreational vessel explosion in 2008.¹⁰ The Department of Transport concluded that the costs associated with establishing recreational vessel standards and a system of periodic safety or seaworthy checks would outweigh the estimated safety benefits. Moreover, a system for recreational vessel standards was considered to be best placed at a national level.
65. Transport Safety Victoria noted that once a vessel has been purchased, an owner may modify the vessel or neglect ongoing maintenance. It is Transport Safety Victoria's view that ongoing maintenance of a vessel will have the greatest impact on boating safety.

Personal Flotation Devices

66. PFDs are a vital piece of safety equipment for boaters. Unfortunately, their value, like most safety equipment, ultimately relies on the individual boater to make the decision to use it. Unlike many other drowning deaths seen where sudden and unexpected water entry occurs, providing little or no opportunity for the occupant to prepare themselves, Mr Katelas and Mr Emmanouel did in fact have time to put on their available PFD.
67. Their vessel measured 5.2 metres in length and as such, a PFD was only required to be worn during a defined "time of heightened risk". Yet neither man put on a PFD when faced with the reality that their vessel was sinking, which arguably was indeed a time of heightened risk.¹¹ The non-use of available PFDs is a persistent issue seen by Victorian Coroners and a common contributing factor among recreational boating fatalities.

⁹ Victorian case number 2529/03

¹⁰ Refer to Coroner White's finding into the deaths of Alexander and Jenifer Elliott handed down in August 2010 (cases 20081880, 20081881). Copies are available on the Coroners Court of Victoria website: <http://www.coronerscourt.vic.gov.au/home/case+findings/>

¹¹ For the purposes of reg.232A under the Marine Regulations 1999, a "time of heightened risk" includes:

(e) when there is a significant likelihood that—

(i) the vessel may capsize or be swamped by waves; or

Comments

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

68. The tragic deaths of Mr Katelas and Mr Emmanouel highlight the reality of the inherent risks associated with recreational boating. It is evident that a combination of factors led to this fatal outcome. The totality of evidence has revealed:
- The oval aperture in the engine well, originally designed to allow for cable steering which had since been removed and replaced with hydraulic steering, was positioned low in the engine well and was unsealed which allowed for water ingress. The available evidence supports the conclusion that the modification was made at some point after Mr Fent had sold the vessel to Mr Katelas.
 - With the two men fishing at the stern of the vessel the engine well sat closer to the water surface. This weight, combined with wave action, allowed for water to enter through the oval aperture which eventually travelled under the flooring into the live bait wells without the men realising. The drain plugs were missing from the bait well housings which compromised the reserve buoyancy of the vessel and permitted the water to directly enter and fill the hull.
 - Whilst a stern bung plug may not have been adequately positioned due to the silicon used around the housing, testing by the water police squad identified only a minimal amount of water ingress in the period of one hour. This correlates with reports of Mr Frantzis who had been out on the vessel on 3 October 2009 for several hours and observed no water to exit the hull.
 - Upon realising their vessel was indeed sinking, the alarm was not effectively raised with emergency services. The 27MHz marine radio fitted by Mr Katelas does not appear to have been working properly. Mr Katelas did not dial triple zero using his mobile phone but instead called the Telstra directory multiple times to reach the Australian Volunteer Coast Guard. The mobile phone signal was poor and their location was unable to be verified. None of the available flares were activated.
 - Finally, neither man wore the available Type 1 PFDs to minimise their risk of drowning upon entering the water.

(ii) the occupants of the vessel may fall overboard or be forced to enter the water.

69. I wish to offer my sincere condolences to the family of both Mr Katelas and Mr Emmanouel. If anything, this tragedy should hopefully serve as a vital lesson to all boating enthusiasts that boating is a high-risk activity, things may go wrong quickly and unexpectedly, and the fate of the occupants may ultimately lie in their level of emergency preparedness.

Recommendations

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

1. Part of my role as a coroner is to investigate a death not only for the purpose of determining the cause and circumstances surrounding the death, but also to contribute where possible to reducing the number of future deaths and promoting public health and safety. A coronial investigation provides the unique opportunity to evaluate what appropriate safeguards are (or should be) in place to minimise the likelihood of such a tragedy from occurring again.

Pursuant to section 72(2) of the **Coroners Act 2008**, I recommend that the Maritime Safety Division of Transport Safety Victoria:

1. Research the use of marine radios and EPIRBs in Port Phillip Bay and other designated enclosed waters to explore the merit and feasibility of mandating these devices. This research could include, for example, determining current usage rates among recreational vessels, and the public's view towards a potential requirement to carry these items in certain recreational vessels.
2. Continue to undertake boating education campaigns addressing:
 - a. The importance of going beyond the minimum safety equipment requirements when operating vessels in Victorian waters. In particular, boaters should be encouraged to carry marine radios and EPIRBs when venturing into enclosed waters such as Port Phillip Bay.
 - b. The fundamental steps to take in the event of a marine emergency, including the need to wear a personal flotation device (PFD) and to raise the alarm through whatever means available.
 - c. If using a mobile telephone to raise the alarm, the importance of dialling triple zero in the first instance.

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

Ms Christine Simper, Next of kin

Leading Senior Constable Jason Reynolds, Water Police Squad Investigating Member

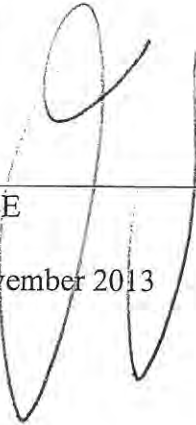
Director, Maritime Safety - Transport Safety Victoria

Interested parties

Australian Volunteer Coast Guard Association

Emergency Response Division, Australian Maritime Safety Authority

Signature:



JOHN OLLE
CORONER

Date: 1 November 2013

