IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4499

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*
*Section 67 of the* ***Coroners Act 2008***

I, CAITLIN ENGLISH, Coroner having investigated the death of Kevin Caithness

without holding an inquest:
find that the identity of the deceased was Kevin John Caithness
born on 1 February 1971
and the death occurred on or about 30 November 2011
at the entrance to the Patterson river, Bonbeach

**from:**

1 (a) Drowning

Pursuant to section 67(2) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances**:

I have had carriage of this investigation following the retirement of Coroner Spooner in February 2014.

**Introduction**

1. Kevin Caithness was forty years old at the time of his death. He resided with his wife of 16 years, Rebecca, and their two children, in Ardeer. Mr Caithness was employed as a fork lift driver at the Toyota Plant in Altona.

2. A police investigation was conducted into the death of Mr Caithness and his friend Mr Paul Washington.

3. A coronial brief has been compiled by the Coroner's Investigator, Leading Senior Constable Glenn Powell from the Water Police. The brief is comprehensive and addresses the circumstances of death. It includes statements from Mr Caithness's wife, witnesses, police officers involved in the search and reports from experts at Transport Safety Victoria, as well as the coroner's investigator. I have also had regard to submissions by Maritime Safety Victoria and the Department of Economic Development, Jobs, Transport & Resources and

correspondence from the Water Police Squad in respect of two current coronial investigations[1]. I have relied on all this material as to the factual matters in this finding.

4. The purpose of this record of the investigation is to satisfy the legislative requirements of the *Coroners Act* 2008, section 67, namely to find, if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred.

5. The deaths of Mr Caithness and Mr Washington are a tragic loss to their families. Lessons learned from this investigation can contribute to reducing the likelihood of similar preventable deaths in the future.

**Background**

6. Mr Caithness met Paul Washington in early October 2011 at National Tiles in South Melbourne. They began chatting and Mr Washington agreed to do some plastering work at Mr Caithness' house.

7. Whilst Mr Washington was working at the house, the two men struck up a friendship. Mr Washington had recently bought a kayak and Mr Caithness decided to buy one too, so they could go fishing together.

8. Mr Caithness bought a kayak from eBay on 30 October 2011. He paid $860 for it and picked it up from Patterson Lakes.

9. Mr Caithness also bought an electric motor for the kayak. It was a white Water Snake brand and ran off a battery. Both men attached electric motors to their kayaks.

10. Mrs Caithness described Mr Caithness working on his kayak over the weekend. He also took the day off work on Monday 28 November 2011 in order to put the motor on his kayak and make preparations for the next days' fishing trip with Mr Washington.

11. Mrs Caithness described her husband as not much of a fisherman and not a good swimmer, however:

> *'...he just seemed to be hitting it off with Paul and was rolling with the idea of being a kayaker. He was adventurous and was always coming up with ideas of things he wanted to do.'*[2]

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[1] These relate to the investigation into the death of James T Sullivan COR 2012/298 by Coroner White and an email from Sergeant Adrian Sinclair, Water Police Squad, in relation to my current investigation into the death of Adam Pearson COR 2013/2331.

[2] Coronial Brief, Statement of Rebecca Caithness p 7.

**Circumstances proximate to death**

12. On 29 November 2011 Mr Caithness left the house at 6 am to meet Mr Washington and go on a fishing trip. Mrs Caithness was under the impression he was heading to Black Rock.

13. The weather forecast issued by the Bureau of Meteorology (BOM) predicted northerly winds of 20-30 knots, decreasing to 20-25 knots later in the day. The top temperature forecast was 33 C with possible late thunderstorms. Seas were 1-1.5 metres increasing to 2 metres during the morning.

14. It appears both men left the Sandringham Yacht Club in their kayaks travelling in a southerly direction with a northerly wind.

15. A text and photo was sent to Mrs Caithness at 8.05am from Mr Caithness's phone with the words 'Oooh Yeeeh'.

16. There were three confirmed sightings of the kayaks by witnesses during the day. The first was at 10.45 am when the two kayaks were seen 1.5 km off Ricketts Point travelling south. The second was at 6.30pm when two kayaks were sighted 500m offshore at Frankston North. The third sighting was between 6.30 – 8.30pm when two kayaks were sighted 1-1.5 km offshore off Patterson River, Bonbeach.

17. Attempts by family members to contact the two men during the day failed. At 8.21 pm Mrs Caithness reported them missing to Police.

18. After the two men's vehicles were located at the Sandringham Yacht Club car park, a rotary and fixed wing aircraft search commenced at 1.15 am, together with 3 vessels.

19. Bad weather and heavy rain suspended the aerial search at 4.06 am, however the vessel search continued. On daylight, 7 helicopters and one fixed wing aircraft were involved in the search together with nine vessels.

20. At approximately 6.15am on 30 November 2011, Mr Caithness's body was found washed ashore just north of the entrance to the Patterson River, Bonbeach. At 7.00am his kayak was located south of the Seaford Pier.

21. Around 7.40 am, Mr Washington's body was found 400m offshore in the water and his kayak was located ashore north of Seaford pier.

**Post mortem medical examination**

22. On 1 December 2011, Dr Paul Bedford, forensic pathologist, conducted an inspection and report on Mr Caithness' body at the Victorian Institute of Forensic Medicine. Dr Bedford noted there was circumstantial evidence of drowning and formulated this as the cause of death. I accept his opinion. The toxicology findings were non contributory.

**Detailed examination of the incident**

Trip preparation: destination details, weather forecast and clothing

23. Neither Mr Caithness nor Mr Washington advised their partners where they were departing from, where they were heading, or what time they would be back.

24. Mrs Caithness' uncertainty about what time Mr Caithness would arrive home appeared to have played a role in the timing of her call to Police.

25. The uncertainty surrounding their launch site resulted in a long delay in police commencing a search until their vehicles were located at the Sandringham Yacht Club.

26. As previously indicated, the weather forecast was fine and warm with a top temperature of 33 C. A strong wind warning was issued by the BOM with northerly winds to 30 knots decreasing later to 25 knots with a chance of a late thunderstorm with seas to 2 metres.

27. The coroner's investigator, Leading Senior Constable Powell took the view that neither man had knowledge or appreciation of the predicted weather forecast and the effect it would have on Port Philip Bay. It was his view the predicted sea conditions for the 24 hour period on 29 November 2011 were unsafe for small craft.

28. Transport Safety Victoria advises kayakers to check the weather before going out with BOM and to wear suitable clothing for the conditions.

29. When Mr Caithness and Mr Washington left Sandringham Yacht Club in their kayaks, they were dressed in shorts and T-shirts, wearing Portable Floatation Device's (PFD) Type 3. Both carried mobile phones. No other safety equipment was carried.

The vessel history

30. As previously indicated, Mr Caithness bought his kayak from eBay on 30 October 2011 for $860. He obtained his recreational boat licence on 16 November 2011 and on 28 November 2011 he registered his kayak, PC-577. Both Mr Caithness and Mr Washington registered their

kayaks as power boats, as required under the *Marine Act* 1988 (Vic)[3], as they had fitted motors.

31. Mr Washington purchased his kayak from eBay on or about 28 October 2011. He obtained his recreational boat licence on 1 November 2011 and on 25 November 2011 he registered his kayak NV-685.

32. Both Mr Caithness and Mr Washington purchased Water Snake brand electric outboard engines which were fitted to the kayaks.

33. During November 2011 both men worked on their kayaks and adapted them to fit electric motors.

34. Mr Caithness made an aluminium engine mount which was bolted through the hull to the back of the kayak. The kayak was powered by at least one 12 volt battery and steered using controls in the footwell of the kayak. The holes which were drilled through the hull near the back of the kayak to attach the motor were not internally sealed to prevent the ingress of water.

35. All alterations were made post purchase of the kayaks and neither kayak was designed to have motors fitted. Neither kayak was sea tested prior to the fishing trip.

Investigations into the vessel modification

36. A report was prepared by Mr James Nolan, Marine Surveyor, from Transport Safety Victoria for this investigation. The report examined Mr Caithness' kayak post incident. The report covers the technical aspects on Mr Caithness' kayak, an RTM K-Largo kayak. The report details the modifications made to the kayak, including the six holes cut into the polyethylene hull which had the effect of exposing the enclosed buoyant volume of the hull to the elements.

37. The attached motor was described as follows:

*'A water snake electric motor was retro-fitted to the aft end of the kayak. It is mounted on an aluminium bracket which has been bolted to the kayak. The battery and throttle cables are run forward to a battery area aft of the seating position and a throttle just forward of the seating position. ...*

*Two scupper drain[4] stoppers were fitted to the footwell scuppers. No scupper drain stoppers were fitted to the two forward and two aft well scuppers.'* [5]

[3] The *Marine Act* 1988 (Vic) is now repealed and replaced by the *Marine Safety Act* 2010 (Vic).
[4] The scuppers are effectively holes through the bottom of the kayak that allow water to drain from the deck.
[5] Report by James Nolan, dated 16/4/2012, Coronial Brief p 94.

38. The report details a stability test that was conducted on 19 January 2012 in calm conditions at the Water Police depot in Williamstown. The test showed that in calm conditions the aft well took on water through the scuppers but no water entered the buoyant volume of the hull through the cut out holes in the hull. The kayak could be normally paddled and manoeuvred.

39. When waves were simulated by rocking the kayak the well behind the seated occupant soon took on water allowing water to enter the kayak's buoyant volume through the cut out holes; *'Within 1 min 30 seconds the kayak had taken on enough water that the hole cut outs were below the waterline. This meant that even without wave action the kayak continued to take on water. The kayak continued to take on water and after 5 min 30 seconds it capsized rolling the occupant into the water. The kayak settled up-turned and partially submerged with the occupant clinging to the hull. From in the water the occupant was able to up-turn the kayak but was unable to climb back aboard because of the lack of stability due to the loss of buoyancy of the flooded hull.'*[6]

40. The report stated that once the kayak's buoyant volume was flooded, it would still provide some buoyant support to a person hanging on.

41. The report also noted the cut outs were located behind the seated position of the occupant so the occupant did not have visual sight of the kayak taking on water. Further, when the kayak was partially submerged it became difficult to tow due to the added weight of the entrapped water.

Suitability of vessel to the conditions

42. On 9 December 2011, Senior Constable Matthew Webb from the Water Police, together with Senior Constable Alister Greenwood, conducted a paddle simulation for the purposes of the coronial investigation.

43. Senior Constable Webb noted the kayaks used by Mr Caithness and Mr Washington were designed for recreational use and short distances. They were not designed for long distance paddling as they were extremely slow and cumbersome. The paddle type and blade shape indicated that an inexperienced paddler had been using it and it would be near impossible to make way on the kayaks into any headwind above 10 knots.

44. The coronial brief refers to alleged sightings of the two kayaks from witnesses around 6.30 -9 pm, off Ricketts Point, Black Rock. These sightings were discounted by the coroner's

[6] Coronial Brief, p 100.

investigator. This was on the basis that the simulated paddle testing by the experienced kayak paddlers from the Water Police Squad indicates it would have been impossible for the two men to travel from Frankston to Rickets Point between 6.30 and 9 pm on 29 November 2011, given the weather and sea conditions.

45. The coroner's investigator is of the view that the last confirmed sightings of Mr Caithness and Mr Washington was by two independent witnesses both of whom reside on the foreshore at Frankston North and Bonbeach. Both observed two kayaks between 6.30-8.30pm between 500 metres and 1.5 km offshore. They reported the kayaks making little or no progress in rough and windy conditions from the north.

**Reconstruction of the events of the evening of 29 November 2011**

46. The exact sequence of events that unfolded on the evening of 29 November 2011 will never be certain. However the evidence compiled by the coroner's investigator suggests the following scenario.

47. Sometime during the early evening off Frankston or Seaford, Mr Caithness's kayak has filled with water, entering through the unsealed engine mount holes. The kayak would have sunk to the waterline and would not have supported a person in an upright position, although it would have afforded some buoyancy.

48. The kayak had no means of being emptied. The front deck hatch[7] was also found undone at the time of recovery.

49. It appears at some point the men have tied an orange rope from the back of Mr Washington's kayak to the front of Mr Caithness' kayak. It is not known whether Mr Washington attempted to tow Mr Caithness and his kayak or whether the rope was to keep the kayaks together. At some stage the tow rope has been cut using the fishing knife attached to Mr Washington's kayak. The batteries for both kayaks appear to have been jettisoned to lighten weight, or they may have been washed overboard in the rough conditions. The electric motor attached to Mr Washington's kayak was not located. The home made outrigger was also missing. The water tight integrity of Mr Washington's kayak was compromised due to a missing front deck hatch. The electric motor was still attached to Mr Caithness' kayak when it was recovered.

[7] A deck hatch: this is a hole in the deck to get things in and out of water tight compartments. It is covered by a cover called a hatch. As kayaks sit low in the water and waves often wash over the deck, a hatch must be sealed before going afloat so that water cannot get in.

50. The coroner's investigator is of the view the two men stayed with each other as long as possible before cutting the rope between the kayaks.

51. Mr Caithness may have drowned first, as his kayak would have been the first to take on water and sink to the water line. He was also a poor swimmer.

52. Mr Washington may have remained alive for a period through the night and remained with his kayak as long as possible. This is supported by the fact the black kayak back rest was still attached to his shorts when his body was found. He was only 300-400 metres from his kayak when he was located.

53. Nearly all the property belonging to Mr Caithness and Mr Washington was found spread over a 4 km area of beach front between Seaford and Bonbeach. This supports the theory they got into trouble offshore in this area, also corroborating the witness sightings on the evening of 29 November 2011. Both paddles were located in the immediate search area indicating they kept their paddles with them for a long period.

**Safety equipment**

54. No distress calls were made and neither Mr Caithness nor Mr Washington's mobile phones were recovered.

55. Both men were wearing black coloured PFD's type 3, which provide the minimum amount of floatation to keep a person afloat.

56. The PFD's did keep the men afloat. However the water temperature that evening was 19C and there was a functional period of ten hours in emersion and a survival time frame of 15 hours.[8] A westerly storm front hit the area at 3 am on 30 November 2015, with strong winds, large seas and rain. This would have impeded paddling on a kayak and stability would have been severely affected.

57. The legislation in force at the time, the *Marine Act* 1988 (Vic)[9] required canoers and kayakers to wear PFD types 1, 2 or 3. Apart from this, no other safety equipment or distress notification items were required to be carried.

58. Mr Caithness registered his kayak as a vessel with VicRoads on 29 November 2011. Mr Washington registered his kayak as a vessel on 25 November 2011. The modification to the kayaks by attaching the motors deemed them power boats under the *Marine Act* 1988 (Vic).

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[8] Coronial Brief Statement of Leading Senior Constable Glenn Powell p 156.
[9] Marine Act 1988 (Vic) is now repealed and replaced by the Marine Safety Act 2010 (Vic).

59. The minimum safety equipment for a power boat on an enclosed waterway such as Port Phillip Bay is a PFD type 1, anchor and line, paddle, bailer with lanyard, set of flares (including two orange smoke flares and two hand held red flares) and a torch.

60. The coroner's investigator was of the view that as both men had recently obtained their boat licences and registered the kayaks in the week prior, they would have been fully aware of the safety equipment required to be carried on their kayaks by virtue of the fact that motors had been attached.

61. None of the required safety equipment was carried by either man.

**Registration and licence requirements**

62. As at November 2011, the *Marine Act* 1988 (Vic)[10] and *Marine Regulations* 2009[11] were in operation.

63. Section 8 of the *Marine Act* 1988 stated a person must not operate a vessel on State waters unless the vessel is registered under Part 2 or exempted. Registration is required for vessels fitted with means of propulsion, regardless of engine size.

64. Section 115(1) of the *Marine Act* stated that a person must not operate a general recreational vessel unless they are the holder of a licence.

65. Both Mr Caithness and Mr Washington had registered their vessels and obtained licences.

66. The Transport Safety Victoria website currently states: '*Any boat with an engine capable of being used for propulsion in Victorian waters must be registered and in a seaworthy condition.*'[12]

67. The registration process involved making an appointment with VicRoads, providing identifying details of the boat and the owner and paying the prescribed fee.

68. The current VicRoads website also details the process for 'Registering your vessel' and notes '*Your vessel must be in a seaworthy condition.*' It details the process to register a vessel as posting a completed Vessel Registration Form or attending a VicRoads Customer Service Centre. No fee is charged for an attendance. The website also notes; '*Your vessel does not need to be inspected as part of the appointment.*'

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[10] Marine Act 1988 (Vic) is now repealed and replaced by the Marine Safety Act 2010 (Vic).
[11] The current regulations are the Marine Safety Regulations 2012 (Vic).
[12] Transport Safety Victoria website accessed 17/9/2015.

69. The vessel registration forms completed by Mr Caithness and Mr Washington were obtained from Vicroads as part of the coronial investigation. Each vessel was registered as a 'canoe' with an electric outboard engine. There is no part of the Vessel Registration Form or in the Notes for Applicants on the back of the form that refers to a requirement for a vessel to be fit for purpose or seaworthy. At that time, registration requirements appear to fulfil an administrative process rather than being a qualitative evaluation of the sea worthiness of the vessel.

70. The vessel registration form has since changed and the current vessel registration form states on the second page in *Notes for applicants for the registration of recreation vessels* that 'A vessel must not be operated unless it is 'fit for purpose'. Refer to Regulation 27 of the *Marine Safety Regulations* 2012 for more details.'[13]

71. Regulation 27 states it is a condition of registration that the registered person 'does not cause or allow the recreational vessel to be operated unless it is fit for purpose.' Regulation 27(2)(a-g) details instances of when a recreational vessel is not fit for purpose, for example, Regulation 27(2)(a) states, 'a hull of the recreational vessel is unable to maintain watertight integrity'.

72. In section 23 of the *Marine Safety Act* 2008 (Vic) '*The concept of ensuring safety*' broadly covers the requirements to eliminate and reduce risk and section 31, '*Masters of recreational vessels must take reasonable care*' in Part 2.5 contains offences covering a range of scenarios related to safety matters.

**Relevant coronial recommendations**

73. In August 2010, Coroner Peter White handed down his finding in the inquest into the deaths of Jennifer and Alexander Elliot COR 2008 1880, both of whom died of injuries sustained in an explosion when the motor boat their son had purchased exploded at Pier 35 South Wharf shortly after re-fuelling.

74. Coroner White made a recommendation that '*...all non-commercial petrol powered inboard motor cruiser boats or other similar vessels be surveyed on first registration, and thereafter on each occasion that a change of ownership registration in respect of any such vessel is sought.'*

[13] Vessel registration form accessed via www.vicroads.vic.gov on 24/9/2015

75. In August 2011 a Regulatory Impact Statement by the Department of Economic Development, Jobs, Transport & Resources (the Department) on marine safety regulations considered the case for establishing a system of seaworthiness checks that could apply to all registered vessels as a result of Coroner White's recommendation. It concluded the compliance costs would likely to exceed the value of safety benefits.

76. The response to the recommendation from Transport Safety Victoria stated:

'*...analysis suggested with reasonable confidence that the costs of implementing the proposal would exceed the benefits, which in the context of that research, demonstrates that even in the most specific and well-targeted instance, there is not a reasonable expectation that there would be net benefits. In light of these findings, the Department of Transport decided not to proceed with the proposal.*'[14]

77. In early 2012, the Department recommended to the Minister for Ports that no standards be set and no system of seaworthiness checks be established. Instead, advice[15] from the Department recommended an offence be created to cause or allow a recreational vessel to be operated that is not fit for purpose.

78. Regulation 27 was the result, which came into effect on 1 July 2012 and created a condition of registration not to cause or allow a recreational vessel to be operated unless fit for purpose. Unlike other regulations under Part 2 of the *Marine Safety Regulations 2012* relating to Registration of vessels, such as regulations 16, 17, 18, 24 and 26, regulation 27 does not create an offence and no penalty is prescribed.

79. Although Coroner White's recommendation refers to '*petrol powered inboard motor cruiser boats or other similar vessel*,' if Mr Caithness and Mr Washington's modified kayaks had been surveyed at the time of registration, it is possible the impact of the modifications on their sea worthiness may have been detected.

80. In 2010, Coroner Fiona Hayes handed down her finding in her investigation into the death of Reginald Mashado. Mr Mashado died when fishing alone, the vessel he had constructed himself overturned and he was unable to right it or get back into it.

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[14] Letter from Transport Safety Victoria to Coroners Court of Victoria (CCOV) dated 29 October 2014.
[15] Letter from Department of Economic Development, Jobs, Transport & Resources

81. Coroner Hayes recommended: '... *That Transport Safety Victoria considers notification and advice to boating enthusiasts who construct their own vessel of the regulatory requirements for seaworthiness and safety equipment.*'

82. In response to this recommendation, TSV formed a multi-disciplinary working group to '*design and oversee delivery of a regulatory strategy designed to control risks associated with boating enthusiasts who design, construct and/or maintain their own vessels.*' [16]

83. TSV has advised that in mid 2012, in response to the deaths of Mr Caithness and Mr Washington, it held a workshop examining risks associated with recreational vessel owners undertaking repairs, modifications and even construction on their own vessels. TSV ran a targeted education campaign that summer called 'What floats your boat?' which '*was specifically aimed at advising recreational boaters about the risks of modifying the floatation characteristics of their vessels, as occurred in this case.*'[17]

84. TSV has advised the Coroners Court it supports the concept of a vessel inspections regime for second hand vessels but noted any mandatory inspections regime '*development and implementation in the short term would be administratively complicated and resource intensive.*'[18] The review of the now repealed *Marine Act* 1988 (Vic) examined safety issues associated with second-hand vessels and possible reform options. Stakeholder in-put indicated majority support for regulatory intervention to improve the seaworthiness of second-hand vessels.

85. The Water Police also support the introduction of a process of sea worthy inspections.[19]

**Conclusion - Contributing factors**

86. A number of factors combined to contribute to the death of Mr Caithness.

87. Firstly, there was a lack of preparation for the fishing expedition. This included not telling his wife his departure point, where he was going and what time he would be home. I note the 'Paddle safe paddle smart' brochure from Transport Safety Victoria advises to let someone know where you are going, your departure point and return time.

88. Further, it is unknown if Mr Caithness had checked the BOM site: if he did have knowledge of the weather conditions forecast, he did not appreciate how unsuitable they were for small

[16] Letter from Transport Safety Victoria to CCOV dated 6 August 2012.
[17] Letter from Transport Safety Victoria to CCOV dated 18 September 2015.
[18] Submission from Maritime Safety Victoria to CCOV regarding the investigation into the death of James Sullivan dated 6 February 2015.
[19] Email from Sergeant Adrian Sinclair, Water Police Squad to CCOV dated 26 June 2015.

craft. The top temperature forecast of 33C may have induced a false sense of security about the weather, with Mr Caithness not being aware of the forecast wind and water conditions for the day.

89. The report by James Nolan, Marine Surveyor, indicated that the modifications Mr Caithness made to his kayak impacted on its seaworthiness. In simulated wave conditions water was able to enter the kayaks's buoyant volume through the hole cut outs for the attachment of the engine mount.

90. It is unknown why, when the kayak was recovered, no scupper drain stoppers were fitted to the two forward and two aft well scuppers. The stability test showed that in calm conditions the aft well took on water through the scuppers.

91. Fourthly, Mr Caithness lacked boating experience and the evidence suggested he could not swim well.

92. Fifthly, although Mr Caithness had registered his vessel as a power boat, he did not carry the safety requirements for power boats as detailed previously.

**FINDING**

I find that Kevin Caithness died from drowning.

**COMMENTS**

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

Firstly, the coroner's investigator, Leading Senior Constable Powell, an experienced member of the Water Police Squad, now based at Bairnsdale, commented in his statement that the popularity of canoeing and kayaking on enclosed waterways such as Port Phillip and Westernport Bay has increased over the past few years. These types of vessels are readily and cheaply available on-line and through Outdoor Adventure stores. Apart from possible 'caution notes for safe operation' no training is required for their use. At present apart from having to wear a PFD 1, 2 or 3, no other safety or distress notification items are required. Transport Safety Victoria has expressed concern over the increasing number of drowning deaths involving human powered vessel occupants. Between 1 January 2000 and 31 May 2012, 12 human powered vessel occupants (in kayaks and

canoes) died due to drowning in Victoria. Prior to 2005[20], human powered vessels accounted for 8% of drowning deaths but since that date they have accounted for 33% of all occupant drownings.

Given the increase in the prevalence of canoes and kayaks use, and the lack of training or experience required to operate them, Leading Senior Constable Powell suggests operators of canoes and kayaks travelling more than 500 metres from shoreline in enclosed waters be required to carry a current set of flares and a torch, or a Personal Locating Beacon (PLB) or carry an Emergency Position Indicating Radio Beacon (EPIRB).

Secondly, all vessels age and deteriorate over time. Privately owned vessels that undergo modifications do not have to be examined or assessed for their seaworthiness. There is support for seaworthiness inspections from Transport Safety Victoria and Victoria Police. There was also support from a range of stakeholders consulted as part of the review of the *Marine Act* 1988 which led to the *Marine Safety Act* 2010. However such a scheme has not eventuated owing to assessments of the financial burden and logistical difficulties. This is notwithstanding that some aspect of seaworthiness is often a relevant and common factor of vessel fatalities.

I support the recommendation by Coroner White in Elliot COR 2008 1880 that '*...all non-commercial petrol powered inboard motor cruiser boats or other similar vessels be surveyed on first registration, and thereafter on each occasion that a change of ownership registration in respect of any such vessel is sought.*'

[20] On 1 December 2005 mandatory PFD wearing requirements for recreational boaters were introduced in Victoria, with a considerable decline in the number of drowning deaths since this date.

## RECOMMENDATIONS

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

**Recommendation 1**

I recommend that the Department of Economic Development, Jobs, Transport and Resources and Transport Safety Victoria considers reviewing and increasing the current regulatory safety requirements for operators of canoes and kayaks travelling more than 500 m from shoreline in enclosed waters by requiring them to carry either flares and a torch, or a marine radio, or a PLB or an EPIRB.

**Recommendation 2**

I recommend that Transport Safety Victoria continues to explore potential models for a non-commercial vessel seaworthy inspection and certificate regime as a means of ensuring the seaworthiness of vessels at points of registration, transfer of ownership and after any modification.

I direct that a copy of this finding be provided to the following for their information only:

Mrs Rebecca Caithness

Leading Senior Constable Glen Powell, Victoria Police

Sergeant Adrian Sinclair, Victoria Water Police

Interested parties

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

Mr Richard Bolt, Secretary, Department of Economic Development, Jobs, Transport and Resources

Mr Peter Corcoran, Director, Maritime Safety, Transport Safety Victoria

Signature:

CAITLIN ENGLISH
CORONER
Date: **9 October 2015**