IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4500

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 Paul Washington

without holding an inquest:
find that the identity of the deceased was Paul Robert Washington
born on 19 March 1975
and the death occurred on or about 30 November 2011
at 100 metres off Seaford beach

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

Introduction

1. Paul Washington was 36 years old at the time of his death. He was living with his de facto partner, Adrianna Gusman in Elwood. They had been together for over 12 months. Mr Washington had his own business and worked as a tiler.

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

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 Washington's partner, 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 (Vic)*, 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 Washington and Mr Caithness 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 Washington met Kevin Caithness 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 bought a kayak from eBay in early September 2011, and Mr Caithness decided to buy one too, so they could go fishing together.

8. After Mr Caithness had bought his kayak 30 October 2011, the two planned a kayaking trip together.

9. Both men attached electric motors to their kayaks.

10. Ms Gusman indicated Mr Washington was a keen fisherman but nearly all his fishing had been land based. She described him as a good swimmer with a fishing obsession.

Circumstances proximate to death

11. On 29 November 2011 Mr Washington left the house at approximately 6.15 am to go fishing on his kayak.

12. He did not mention where he was going kayaking. As he usually goes fishing at Black Rock, Ms Gusman assumed he had headed down there.

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

[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.

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. 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.

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

17. After the two men's vehicles were located at the Sandringham Yacht Club car park, a rotary and fixed wing aircraft search commenced on 30 November 2011 at 1.15 am, together with 3 vessels.

18. 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.

19. Around 7.40 am, on 30 November 2011, Mr Washington's body was found 400m offshore in the water and his kayak was located ashore north of Seaford pier.

20. Earlier, at approximately 6.15am, 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.

Post mortem medical examination

21. On 1 December 2011, Dr Paul Bedford, forensic pathologist, conducted an inspection and report on Mr Washington's 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 as to the cause of death. The toxicology results were non contributory.

Detailed examination of the incident

Trip preparation: destination details, weather forecast and clothing

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

23. Mrs Caithness's uncertainty about when Mr Caithness would arrive home appeared to play a role in the timing of her call to Police.

24. Ms Gusman did not know when Mr Washington was due home. She stated:

    '*I tried him numerous times on his mobile during the day, the first time being around 4 pm. The last time I tried was around 10 pm. Every time that I called his phone would go straight to his message bank service.*'[2]

25. The uncertainty surrounding their launch site resulted in a long delay in commencing a search until their vehicles were located at the Sandringham Yacht Club car park which determined their starting point.

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 men 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 Washington and Mr Caithness left Sandringham Yacht Club in their kayaks, they were dressed in shorts and T-shirts, wearing portable floatation devices, type 3. Both carried mobile phones. No other safety equipment was carried.

The vessel history

30. As previously indicated, Mr Washington purchased his kayak from eBay on or about 28 October 2011. It was a Nigbo Beilun brand. He obtained his recreational boat licence on 1 November 2011 and on 25 November 2011 he registered his kayak NV-685. Both Mr

[2] Coronial brief Statement of Adriana Gusman p. 9.

Washington and Mr Caithness registered their kayaks as power boats, as required under the *Marine Act* 1988 (Vic)[3] as they had fitted motors.

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

32. Mr Washington purchased a Water Snake brand electric motor to be attached to the kayak for extra propulsion.

33. Mr Washington fitted the engine to the right side of his kayak. It was bolted onto an aluminium bracket made by Mr Caithness. The engine was powered by two 12 volt batteries mounted behind the seating position and the kayak was steered using a tiller attachment.

34. Mr Washington had retro-fitted a foam filled PVC pipe outrigger to give him extra stability when underway. He also put some foam filling inside the hull of his kayak.

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. The report examined Mr Washington's kayak post incident. The report covers the technical aspects of Mr Washington's kayak, a recreational kayak intended for use in smooth waters or surf zones near the shore.

37. The report details the modifications made to the kayak. A motor support bracket had been attached on the starboard side by bolts through the skin of the kayak. A buoyant pontoon had been added to the kayak on the right side to support the weight of the trolling motor. Where penetrations had been made through the skin of the kayak, a product of expandable foam had been inserted to ensure the watertight integrity of the kayak. The pontoon was made out of a PVC tube with a cut down plastic bottle fitted at the forward end to reduce drag in the water. The PVC tube pontoon was filled with expandable foam to ensure the buoyancy of the outrigger was maintained. The pontoon was attached to the kayak via U-bolts onto some pieces of timber that were bolted through the skin of the kayak.[4]

38. On 19 January 2012, a stability test was conducted in calm conditions at the Water Police depot in Williamstown. The kayak was buoyant and had no water ingress while all inspection ports were fitted.

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[3] The *Marine Act* 1988 (Vic) is now repealed and replaced by the *Marine Safety Act* 2010 (Vic).

[4] Coronial Brief, Report by James Nolan dated 14/4/2012, Transport Safety Victoria p 86.

39. When the kayak was recovered from the beach at Seaford, the outrigger arrangement had been separated from the kayak. The kayak would have been unbalanced if the pontoon arrangement left the kayak with the electric motor still attached.

40. The presence of the outrigger on the starboard side severely interfered with the ability to stroke evenly with the paddle on both sides of the kayak. During trials it was evident that the kayak was very hard to paddle in a straight line in calm conditions as the stroke on the starboard side was limited to about one quarter of the length of the stroke on the port side.

41. The kayak was found at Seaford with an inspection port missing from the forward hatch opening and some sand inside the buoyant space of the kayak. The report found this indicated at some point there was a loss of watertight integrity of the kayak, however until that happened, the kayak would have supported the weight on board. [5]

42. The report also found that after the inspection port was removed, the kayak quickly took water and had no inherent buoyancy fitted to remain afloat. The pontoon contained the only substantial amount of foam buoyancy and this was separated from the kayak at some point.

43. An orange rope attached to the back end of the kayak had been cut by a fishing knife attached by a cable tie to the side of the kayak.

Suitability of vessel to the conditions

44. 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.

45. Senior Constable Webb noted the kayaks used by Mr Washington and Mr Caithness 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.

46. 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 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

[5] Coronial Brief, Report by James Nolan dated 14/4/2012, Transport Safety Victoria, p 89.

men to travel from Frankston to Rickets Point between 6.30 pm and 9 pm on 29 November 2011, given the weather and sea conditions.

47. The coroner's investigator is of the view that the last confirmed sightings of Mr Washington and Mr Caithness 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

48. 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.

49. Sometime during the early evening off Frankston or Seaford, Mr Caithness's kayak has filled with water due to 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.

50. The kayak had no means of being emptied. The front deck hatch[6] was also found undone at the time of recovery.

51. 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. It is unknown when this has occurred.

52. The electric motor was still attached to Mr Caithness' kayak when it was recovered.

53. 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.

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[6] 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.

54. 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.

55. 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.

56. Nearly all the property belonging to Mr Washington and Mr Caithness 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

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

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

59. 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.[7] A westerly storm front hit the area at 3 am on 30 November 2011, with strong winds, large seas and rain. This would have impeded paddling on a kayak and stability would have been severely affected.

60. The legislation in force at the time, the *Marine Act* 1988 (Vic)[8] 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.

61. Mr Washington registered his kayak as a vessel on 25 November 2011. Mr Caithness registered his kayak as a vessel with VicRoads on 29 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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[7] Coronial Brief Statement of Leading Senior Constable Glenn Powell p 156.
[8] Marine Act 1988 (Vic) is now repealed and replaced by the Marine Safety Act 2010 (Vic).

62. 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.

63. 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.

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

Registration and licence requirements

65. As at November 2011, the *Marine Act* 1988 (Vic)[9] and *Marine Regulations* 2009[10] were in operation.

66. 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.

67. 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.

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

69. 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.*'[11]

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

71. 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 Vic Roads 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.*'

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

72. The vessel registration forms completed by Mr Washington and Mr Caithness 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.

73. 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.'[12]

74. 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.' Regulations 27(2)(a) to 27(2)(g) detail instances of when a recreational vessel is not fit for purpose, for example 27(2)(a) states; when 'a hull of the recreational vessel is unable to maintain watertight integrity'.

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

Relevant coronial recommendations

76. 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.

77. 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.*'

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

78. 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.

79. In the response to the recommendation, 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.*'[13]

80. 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[14] from the Department recommended an offence be created to cause or allow a recreational vessel to be operated that is not fit for purpose.

81. 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.

82. 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.

83. 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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[13] Letter from Transport Safety Victoria to Coroners Court of Victoria (CCOV) dated 29 October 2014.

[14] Letter from Department of Economic Development, Jobs, Transport & Resources.

84. 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.*'

85. 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.' [15]

86. 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.*'[16]

87. TSV has advised the Coroners Court that 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.*'[17] 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.

88. The Water Police also support the introduction of a process of sea worthy inspections.[18]

Conclusion - Contributing factors

89. A number of factors combined to contribute to the death of Mr Washington.

90. Firstly, there was a lack of preparation for the fishing expedition. This included not telling his partner 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.

91. Further, it is unknown if Mr Washington 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

[15] Letter from Transport Safety Victoria to CCOV dated 6 August 2012.
[16] Letter from Transport Safety Victoria to CCOV dated 18 September 2015.
[17] Submission from Maritime Safety Victoria to CCOV regarding the investigation into the death of James Sullivan dated 6 February 2015.
[18] 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 Washington not being aware of the forecast wind and water conditions for the day.

92. The report by James Nolan, Marine Surveyor, indicated that the modifications Mr Washington made to his kayak impacted on the ability to stroke evenly with the paddle on both sides of the kayak. Although the kayak was buoyant and had no water ingress while all inspection ports were fitted, the kayak was found with an inspection port missing from the forward hatch opening and some sand inside the buoyant space of the kayak. This indicated at some point there was a loss of watertight integrity of the kayak Further, the outrigger arrangement had been separated and the kayak would have been unbalanced if the pontoon arrangement left the kayak with the electric motor still attached.

93. Fourthly, although Mr Washington was a good swimmer, he lacked boating experience and all his fishing experience was land based.

94. Fifthly, although Mr Washington 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 Paul Washington 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[19], 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.*'

[19] 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:

Ms Adriana Gusman

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**