IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 0206**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**ALLAN RUSSELL MCFARLANE**
Date of birth:	**24 NOVEMBER 1947**
Date of death:	**11 JANUARY 2019**
Cause of death:	**CARDIAC ARREST SECONDARY TO NEAR DROWNING**
Place of death:	**FRANKSTON HOSPITAL, 2 HASTINGS ROAD, FRANKSTON, VICTORIA 3199**

HIS HONOUR:

BACKGROUND

1. Allan Russell McFarlane was born on 24 November 1947. He was 71 years old at the time of his death. Mr McFarlane was married to Carole McFarlane for 48 and a half years, and together the couple had 43 years of experience owning or utilised boats in some capacity.

2. The first vessel Mr McFarlane owned was a small 'Carribean' fibreglass hull with a 65 horsepower **(hp)** outboard engine. Mr McFarlane used it exclusively in Port Phillip Bay around the Rye area when the weather was appropriate. The boat was primarily used for fishing. Mr McFarlane sold the vessel about 29 years ago.

3. The second boat that Mr McFarlane owned was a 'Flightcraft' Dominator speed boat with a fibreglass hull and 240hp outboard engine. Mr McFarlane exclusively used this vessel on inland waterways, with the Murray River being its predominant area of use. The boat itself was used for the purposes of water sports such as water skiing and kneeboarding. Mr McFarlane sold this vessel approximately 16 years ago.

4. Between 27 December 2018 and 1 January 2019, Mr and Mrs McFarlane hired a "little tinny" and went fishing around the Rosebud area.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr McFarlane's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and resulted, directly or indirectly, from an accident or injury.[1]

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

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[1] Section 4, definition of 'Reportable death', *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*

7. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

8. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

9. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

10. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

11. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

12. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[3] *Keown v Khan* (1999) 1 VR 69.
[4] (1938) 60 CLR 336.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

13. Mr McFarlane was visually identified by his daughter, Caroline White, on 11 January 2019. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

14. On 14 January 2019, Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Mr McFarlane's body and provided a final written report dated 27 June 2019, concluding a reasonable cause of death to be "I(a) Cardiac arrest secondary to near drowning". I accept his opinion in relation to the cause of death.

15. Toxicological analysis of ante-mortem specimens detected midazolam.[5]

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

16. On 9 January 2019, Mr and Mrs McFarlane travelled down to Rye. The couple drove separately, with Mr McFarlane towing the boat they had borrowed from their daughter, Amanda McFarlane, and her fiancé, Thayne Lilly; registration MA827 (**MA827**), and Mrs McFarlane driving their Territory. The following day the couple purchased some safety equipment from the Frankston area; being new flares and two lightweight gas filled collar type 1 personal floatation devices (**PFDs**). Mrs McFarlane advised that the couple had not used this form of PFD in the past and she had not been shown how to use it, however, recalled having tried one on either at the store or at the caravan and had later read the instructions enclosed with the PFD. Mrs McFarlane could not recall whether her husband had tried the PFD on in the store.

17. On 11 January 2019 at approximately 8.20am, Mr McFarlane launched MA827 from the Rye boat ramp. The new PDFs that the couple had purchased were in a bag and placed on the front observer seat within the boat. Neither Mr McFarlane or his wife opted to wear their PDFs; a decision that was in accordance with the provisions prescribed in the Maritime Safety Regulations 2012. Mr and Mrs McFarlane fished at three different locations after launching the boat. The vessel was not anchored; being left to drift.

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[5] Midazolam is a short acting medication that is used intravenously in intensive care patients.

18. After arriving at their third location and being there for about 20-30 minutes, Mrs McFarlane noticed that there was water at her feet. At the time, Mr McFarlane was seated or kneeling on the drivers' seat located at the front and on the starboard side of the boat, while Mrs McFarlane was seated on the rear bench seat on the port side of the boat. Mrs McFarlane notified Mr McFarlane of the situation with Mr McFarlane attempting to start the boat without success. By that time an excessive amount of water had already been taken on by the boat. In the knowledge that the boat was going to capsize and sink, the couple jumped in the water. They did not have enough time to put their PDFs on prior to abandoning the boat. On entering the water Mr McFarlane held onto the hull at the bow of the boat, while Mrs McFarlane drifted away from the boat. Mrs McFarlane said that while she was drifting, she saw a number of boats around and that despite losing sight of her husband she could still hear him calling out to her asking if she was okay.

19. At about 9.55am, a passing boat arrived and rescued the couple from the water. On retrieving Mr McFarlane, the fishermen observed that he was unconscious and frothing from the mouth. They immediately commenced cardiopulmonary resuscitation **(CPR)** and contacted emergency services. A short time later, members from Ambulance Victoria, Victoria Police and the Coast Guard were dispatched. Mr McFarlane was conveyed to the Blairgowrie Yacht Squadron Pier, some 20-30 minutes away, where ambulance paramedics took over performing CPR. Mr McFarlane was then transported to Frankston Hospital's Emergency Department before being transferred to the Intensive Care Unit. Despite medical intervention and treatment Mr McFarlane's condition continued to deteriorate with him passing away at 5.45pm.

Further investigation

<u>History of MA827 in Victorian Waters</u>

20. MA827 is a 1987 Haines Hunter Signature 1700S, 5.1 metre glass reinforced plastic vessel. It is a conventional v-shaped planning monohull, primarily designed for leisure pursuits such as water skiing. It is powered by a 1986 Mercury Mariner 135hp V6 outboard petrol engine and is designed with a low profile; having a seating configuration being front seat driver, front observer driver and rear bench seat.

21. Prior to 2009 the boat was registered in New South Wales. In 2009 the first Victorian owner purchased the boat through eBay. The purchaser had a vessel inspection conducted on his behalf where it was found to be in sound condition. The purchaser had a new bulge pump

installed in the sump. He said that he never had an issue with major water ingress into the hull, only small amounts of water pooling in the sump where the bilge pump was located.

22. In January 2010, the boat was sold. The new owner advised that he operated the vessel on Gippsland Lakes around the Paynesville area when water conditions were calm. He said that he had used the vessel on about five separate occasions and that it had only ever taken on water on one occasion as a result of him forgetting to fit once of the bungs in the stern. He advised that he was aware of the bilge pump, but only after operating the unlabelled switches on the dash whilst attempting to locate a switch to operate navigational lights and the stereo. This owner reported that when he owned the boat he had removed the rear bench seat to check oil levels and disconnect the battery on occasion and that he was unaware of the existence of the internal bung holes that led into both underdeck watertight compartments. He said that he was also unaware of the absence of bungs that should have been fitted to said bung holes.

23. In April 2018, Ms McFarlane and Mr Lilly purchased the boat. During the period of ownership, they used the vessel on two separate occasions. It was reported that the couple had used the boat for about one hour on inland waterways, being the Murray River, Echuca. On the first occasion Mr McFarlane accompanied the couple due to his experience with boats and area of operation. At the time, MA827 was found to have minor mechanical issues with the outboard engine. Subsequently, the vessel was taken to 'Boats & More', a boat mechanic, where the spark plugs were changed, and the engine tuned. No other work was required or undertaken.

24. It is reported that after each occasion of the boat's use, Mr Lilly removed the bungs whereby a small amount of water (1-2 litres) was observed to egress from the boat's underdeck compartments.

Weather on the day

25. The Bureau of Meteorology (**BOM**) provided a forecast for the Port Phillip Bay area on 11 January 2019. The forecast advised of sunny conditions with waves of less than one metre. Actual weather observations recorded wind conditions between 8.00am and 10.00am in half hour increments illustrating wind variations from 18km/h – 28km/hr from the east. These wind readings were obtained from the BOM weather site located at South Channel Island.

The Beaufort Wind Scale[6] indicates that winds between 20km/hr – 29km/hr would result in the description at sea being: 'small waves – becoming longer; fairly frequent white horses'.[7]

Shipping movements on the day

26. Enquiries made with Victorian Ports Corporation revealed that shipping movements in and around Hovell Pile, South Channel between 8.00am and 10.00am on 11 January 2019 were:

    (a) 8.03am – Spirit of Tasmania 1 – Inbound

    (b) 8.17am – OOCL Seoul – Outbound

    (c) 8.55am – NY Infinity Pacific – Inbound

    It was reported that it can be deduced that the above vessels would be responsible for producing a wake substantially greater than that of a recreational vessel.

Inspection of MA827 after the incident

27. Coast Guard of the Safety Beach Floatilla located MA827 at Blairgowrie. It was salvaged and towed to the Rye boat ramp where Water Police trailered the vessel. In order to trailer the boat, large amounts of water were bailed from within the hull. Upon being trailered MA827 was observed to have all four bungs at the aft of the vessel in place and secured. The bungs were then removed and copious amounts of water egressed from the underdeck compartments through the bung holes and also through the open area whereby engine lines were routed into the aft deck on the starboard side of the transom.

28. On 12 March 2019, in an attempt to establish a cause for the boat capsizing, Martin Jaggs, Manager Technical Services of Maritime Safety Victoria attended the Water Police Squad to commence the stability testing process. The vessel was photographed, measurements taken, and specifications noted. On 13 May 2019, Mr Jaggs re-attended the Water Police Squad to undertake testing with the assistance of colleagues, Graham Boileau-Evans, Senior Project Officer, Tom Unkles, Senior Project Officer and Wayne Rossetto, Maritime Senior Investigator.

29. All data was collated with Mr Jaggs' findings suggesting that MA827 capsized as a result of water entering the vessels hull via splashing over the transom and entering the engine cable hole in the transom/engine well and then down flooding into underdeck watertight

[6] The Beaufort Wind Scale is an empirical measure that relates to wind speed and to observed conditions at sea on or land.
[7] Bureau of Meteorology Data Document J8RE645939-2, Coronial Brief of Evidence, page 71.

compartments. Mr Jaggs reported that this was allowed to occur as the vessel has a low freeboard that is only suitable for relatively calm sea conditions.

Conclusion

30. It appears that there were a number of contributing factors that led to the capsizing of MA827:

(a) The design of the vessel makes it ideally suited to water pursuits such as water skiing. Having constant forward momentum whilst involved in towed water activities assists in water dispersing from the rear transom. Long periods of the vessel at rest would allow for water ingress through the engine cable hole located in the rear transom/engine well. On this occasion Mr McFarlane was only underway in the vessel for short periods of time and was predominately stationary while fishing.

(b) The low freeboard of the vessel, whilst it could be utilised in enclosed waters in calm conditions, it is ideally suited for use inland waterways where it is likely to be affected by bay winds and swell.

(c) On 11 January 2019, while the winds were at the lower end of the scale, it is believed they still would have been sufficient to cause a constant lapping of waves into the transom area. Add to this the favourable climatic conditions resulting in moderate to high boating traffic on the day, it can be expected that the transom would have been further exposed to water lapping in from the wakes of passing boats. The combined factors all contributed to the constant ingress of water into the boat's underdeck compartments to the point where testing suggests that the vessel had taken on in excess of 450 litres. By the time it was realised by Mr McFarlane that the boat was taking on water, capsizing was imminent, with no response being able to prevent it from occurring.

(d) While it could be said that Mr McFarlane had extensive boating experience, his familiarity with MA827 was very limited. Previously he had been on board the vessel for a total of approximately 30 minutes prior to using the boat on 11 January 2019.

(e) Mr Lilly was not in a position to educate Mr McFarlane on operation of MA827 as he himself had only spent a total of approximately one hour on the vessel. Furthermore,

this was the first boat owned by Mr Lilly, and as such, his knowledge regarding boat operation was very limited.

(f) When purchasing the boat, Mr Lilly was not aware of the presence of the bilge pump located in the sump nor was he shown by the previous owner how to operate the bilge pump. It is important to note that there is no requirement during the selling and transfer of boats that places an onus on the previous owner to divulge information pertaining to the operation of the vessel, including the operation of the bilge pump.

(g) It is expected that every licensed boat operator has a working understanding of required safety equipment essential to the type of boat they are operating together with the area of water the vessel is being operated in. Section 96 of the Marine Safety Regulations 2012 **(the regulations)** stipulates that a manual or electric bilge is required when a vessel has a covered bilge or closed underfloor compartments, other than airtight, void spaces. MA827 has closed underfloor compartments and was fitted with an electric bilge pump which is accordance with the provisions of the regulations. The bilge pump was operated via a switch located on the dashboard which was absent of any labelling. Even with sufficient labelling, had the bilge pump been operated by Mr McFarlane, it is not expected this would have prevented the vessel capsizing given the amount of water already present in the hull.

(h) There is no requirement, however, a floatation switch which would have automatically activated the bilge pump upon water entering the hull or a bilge alarm that alerted Mr McFarlane to the presence of water in the hull, would have been of great benefit in this instance.

(i) There was an absence of bungs located in the port and starboard bulkheads. The design of MA827 included port and starboard bulkheads. Bulkheads are a structural component, forming separate compartments within the hull, with the purpose of reinforcing the hull and reducing the instance of flooding into adjoining compartments of a vessel should the hull integrity become compromised. It is unknown at what point in time the bungs were removed or for what reason. It is common practice to remove bungs after a boat is removed from the water to allow water to drain from the hull. They are subsequently replaced prior to using the vessel on the next occasion. It is not uncommon that bungs are overlooked by boat operators, resulting in a sudden and quick ingress of water. This issue is usually identified whilst launching the vessel and as such is usually rectified before a life-

threatening situation arises. Vessels commonly have bung holes located at the aft of the boat which is the case with MA827. Mr Lilly was aware of the existence of these bungs. However, he was unaware of the existence of internal bung holes located within the port and starboard bulkheads. Mr Lilly's unawareness also meant that he was also oblivious to the absence of bung plugs. Had the bungs been in place, water would have been confined to the centre compartment instead of entering all three compartments. The stability of MA827 still would have been compromised and still likely to have capsized.

FINDINGS

31. Having investigated the death of Allan Russell McFarlane and having considered all of the available evidence, I am satisfied that no further investigation is required.

32. On the basis of the available evidence, I am satisfied to the requisite standard that Mr McFarlane died from a cardiac arrest after the boat he was in capsized, causing him to nearly drown. He was provided with prompt and commendable assistance from fellow fishermen and his death could not have been reasonably foreseen.

33. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Allan Russell McFarlane, born 24 November 1947;

    (b) that Allan Russell McFarlane died on 11 January 2019, at Frankston Hospital, from cardiac arrest secondary to near drowning; and

    (c) that the death occurred in the circumstances described in the paragraphs above.

COMMENT

34. Pursuant to section 67(3) of the *Coroners Act 2008,* I make the following comment:

    (a) On 20 January 2020, Mr McFarlane's family contacted the court to notify me of their intention to nominate those involved in the rescue effort for a bravery reward. I was informed that the family had met with the rescuers and have an enormous appreciation for the risk they put themselves under and the trauma they have suffered because of it. I acknowledge the efforts of each of these individuals accordingly.

(b) I commend Leading Senior Constable Clinton McGrath, Investigating Member, for a fulsome brief of evidence.

RECOMMENDATIONS

35. Pursuant to section 72(2) of the *Coroners Act 2008,* I make the following recommendations:

(a) For a number of years this Court has made recommendations with regard to prevention opportunities in boating related incidents.[8] Most recently, after the death of Graham Hill, Coroner Michelle Hodgson recommended " *...that Transport Safety Victoria consider introducing requirements that all boats be fitted with a manual or electrical pumping mechanism to all bilge areas...".*[9] I support Coroner Hodgson's recommendation and add that I concur with the Water Police Squad's advocation for all boats fitted with electrical bilge pumps in enclosed bilge areas to have automated switches or floats, or alarms if a manual bilge exists.

(b) Since 2010, the Water Police Squad has consistently campaigned for 'seaworthy' inspections at the time of registration and acquisition or transfer of vessel ownership. The absence of a vessel inspection process to Victoria tragically means that old and/or modified vessels are usually only detected as unsafe or unsuitable post incident. My fellow coroners have enduringly supported the implementation of such a system;[10] however, one is yet to be developed. For this reason, I encourage Transport Safety Victoria to explore the possibility of implementing a system of vessel inspections, akin to roadworthy inspections, to improve marine safety.

(c) Furthermore, I recommend that as part of seaworthy inspections, builders plates are retrospectively attached which determine the number of people, the conditions for which the vessel is suited and the maximum engine capacity of the vessel.

36. I convey my sincerest sympathy to Mr McFarlane's family and friends.

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

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[8] Examples: COR 2011 4499, COR 2013 2331, COR 2015 3431 and COR 2015 5121.

[9] COR 2018 0285.

[10] Examples: COR 2013 2331, COR 2017 1840 and COR 2018 0285.

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

(a) Allan McFarlane's family, senior next of kin;

(b) Transport Safety Victoria;

(c) Marine Safety Victoria;

(d) Peninsula Health;

(e) AIG Australia;

(f) Investigating Member, Victoria Police; and

(g) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 14 January 2021