IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000961

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Thi Minh Tam Nguyen
Date of birth:	27 June 1958
Date of death:	20 February 2021
Cause of death:	1(a) Drowning
Place of death:	Werribee South Boat Ramp, Diggers Road, Werribee South, Victoria, 3030

INTRODUCTION

1. On 20 February 2021, Thi Minh Tam Nguyen was 62 years old when she died following a boating accident in Port Phillip Bay. At the time of her death, Ms Nguyen lived at St Albans, with her partner, Kim Lan Dao. Ms Nguyen had one daughter, Thi Tu Quen Ma (surname later changed to Dang).

2. Ms Nguyen was born in Vietnam and came to Australia as a refugee in 1990. In 1992, Ms Nguyen was able to reunite with her daughter and became an Australian citizen in May 1993. Ms Nguyen married Van Binh Dang in June 1991 however they divorced in 2008. Ms Nguyen met Mr Dao around 2010.

3. Mr Dao owned a Huntsman half-cab boat, registration TZ708, in which Mr Dao and Ms Nguyen sailed every Saturday and Sunday when the weather permitted. Mr Dao had made several modifications to TZ708, including the fitment of a Yamaha outboard motor and an electric bilge pump with a manual switch. Mr Dao modified the cabin and fitted rails to two platforms at the stern of the boat which Mr Dao states he widened.

4. Mr Dao stated that he operated boats and fished for over 30 years, in Vietnam and Australia. Ms Nguyen regularly operated the boat whilst Mr Dao went diving. She was able to swim, had diving experience, and held a Victorian Marine Licence.

THE CORONIAL INVESTIGATION

5. Ms Nguyen's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (the Act). Reportable deaths include deaths that are unexpected, unnatural, or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Nguyen's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Ms Nguyen including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

10. On 20 February 2021, Thi Minh Tam Nguyen, born 27 June 1958, was visually identified by her partner, Kim Lan Dao.

11. Identity is not in dispute and requires no further investigation.

Medical cause of death

12. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 25 February 2021 and provided a written report of his findings dated 1 March 2021 based on Victoria Police reports and post-mortem computed tomography scans conducted at VIFM

13. An autopsy was recommended to address and document natural diseases that may have contributed to Ms Nguyen's death however family members requested that one not be undertaken.

14. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

15. In the absence of a full post-mortem examination, including an autopsy, Dr Burke provided an opinion that a reasonable medical cause of death was 1(a) drowning.

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

16. I accept Dr Burke's opinion.

Circumstances in which the death occurred

17. At approximately 1.00pm on 20 February 2021, Mr Dao and Ms Nguyen launched their boat at the Werribee South Foreshore Boat Ramp and sailed to a point near Royal Australian Air Force (**RAAF**) Base Williams, Point Cook, to dive for abalone. Mr Dao stated that he had checked the weather on Google prior to leaving and thought it would be calm; he later realised that it was choppy, with waves one metre in height, however he considered that the conditions were not bad enough to abandon the trip.

18. Mr Dao and Ms Nguyen sailed to their usual spot near RAAF Base Williams where they anchored. The water was approximately three metres deep. Other vessels belonging to friends were nearby, anchored approximately five to ten metres apart.

19. Mr Dao stated that both he and Ms Nguyen wore Personal Floatation Devices (**PFD**) (lifejackets) whilst travelling to their diving spot, however when they anchored Mr Dao removed his to put on his wetsuit; Ms Nguyen removed hers to assist Mr Dao. Mr Dao sat on the starboard side of the boat whilst preparing to dive. Mr Dao stated that he noticed that it was getting rough and that the waves were getting bigger.

20. Mr Dao stated that a wave impacted the boat, causing Ms Nguyen to lose balance and fall into him; at this point they were both near the stern of the vessel. The boat leaned over, and water began entering the vessel. Mr Dao stated that he turned on the bilge pump which began working. Three large waves impacted against the boat causing more water to enter. Mr Dao stated that he could tell that the engine area of the boat was sinking.

21. Mr Dao told Ms Nguyen to jump into the water. Mr Dao jumped in the water however Ms Nguyen was still on the vessel and entered the water just as the stern sank. The boat rolled over and sank vertically, stern first, with just the bow remaining out of the water. Mr Dao stated that he was unsure whether Ms Nguyen jumped from the boat or ended up in the water after it sank.

22. Mr Dao stated that he inflated his Buoyancy Control Device and swam to Ms Nguyen who was swimming nearby; Mr Dao stated that Ms Nguyen was swimming "ok". When Mr Dao reached Ms Nguyen, she climbed onto his shoulders. Mr Dao stated that he was forced underwater but was able to use his diving regulator to breathe. Ms Nguyen told Mr Dao that she was unable to breathe so he gave her his spare regulator, but she was unable to use it and only took a few breaths before becoming overwhelmed.

23. Mr Dao requested help from the nearby vessels; Van Dau Trinh and Le Thuy took their boat (registration FN320) over to assist. In his statement, Mr Trinh noted that they were approximately 50 metres away. Mr Trinh threw a rope to Mr Dao and Ms Nguyen, pulling them closer to his boat. Mr Dao was holding Ms Nguyen up with his knees; Ms Nguyen was still conscious and told Mr Dao that she had cramps in her legs.

24. When Mr Trinh lifted Ms Nguyen into his vessel, she told him that "I can't". Mr Dao removed his diving equipment which was lifted into Mr Trinh's vessel. Le Thuy then called out to Mr Dao that Ms Nguyen had become unconscious; Mr Dao immediately climbed the ladder at the back of the boat and began breathing into Ms Nguyen's mouth. Mr Dao stated that he attempted cardiopulmonary resuscitation (**CPR**) and felt a very weak pulse at Ms Nguyen's neck. As they began to head for shore, Mr Dao stated that he thought he saw Ms Nguyen move her arms and then "breathe her last breath out". Mr Dao told Mr Trinh to drive faster.

25. Friends of Mr Dao and Ms Nguyen, Hoang Minh Cao and Trang Kim Tran, were in a nearby vessel. They went over to assist; Ms Tran called her son, requesting he call an ambulance due to her English difficulties. The 000 call was registered by the Emergency Services Telecommunications Authority as being received at 2.47pm.

26. Mr Dao stated that he continued to do CPR on Ms Nguyen whilst they sailed back to the Werribee South Foreshore Boat Ramp, taking short breaks when he was tired. They arrived at the boat ramp at approximately 3.00pm where Victoria Police members and ambulance paramedics were waiting. Mr Trinh's vessel was moved out of the water to provide a safe environment for the paramedics to work in.

27. Once the Mr Trinh's vessel was out of the water, paramedics assessed Ms Nguyen and verified her as deceased at 3.16pm.

FURTHER INVESTIGATIONS

28. On 26 March 2021, Mr Dao's vessel, TZ708, was inspected by Leading Senior Constable (**LSC**) Wayne Evans-Barker from the Victoria Police Marine Investigation Unit (**MIU**) and Martin Jaggs from Maritime Safety Victoria, and a Maritime Investigation Report was produced by Maritime Safety Victoria, dated 3 June 2021.

<u>TZ708</u>

29. TZ708 is a 4.2 metre vessel of the 'Huntsman' make built in the 1980s (the exact model and date of build is unknown) of a half cabin, enclosed deck configuration. It is constructed of fibreglass/glass reinforced plastic, powered by a Yamaha 70 horsepower outboard motor. The vessel has twin berths foreward below the foredeck accessed via a central door in a non-watertight bulkhead. The hull was found to be in an average condition consistent with a vessel of 35 to 45 years old.

30. The vessel displayed its correct Victorian registration number TZ708 on the port bow, with a reversed (but correct) registration number displayed on the starboard bow. A Transport Safety Victoria registration sticker was displayed on the port windshield with an end date of 30 January 2020. TZ708 was listed on the Department of Transport registration system as a Victorian registered vessel with a registration expiry date of 30 January 2022. A metal registration plate issued by the Marine Board of Victoria with the registration number EV280 was also displayed on the vessel, however no details for this number were able to be found. The inspection did not reveal the presence of a capacity or Australian Builders plate.

31. The deck had a sump under the transom designed to collect water from the deck where it could be pumped overboard by the vessel's 12-volt electrical submersible bilge pump. There was no automatic float switch attached to the pump requiring the pump to be manually switched on at the helm. A switch labelled "bilge pump" was located on the helm console.

32. Modifications had been made to the vessel by Mr Dao, including the installation of two platforms on the exterior of the transom, rails to assist Mr Dao to alight the vessel after diving, the Yamaha motor, fitment of an electrical bilge pump with a manual switch, and cabin modifications.

Weather on the day

33. The Bureau of Meteorology (**BOM**) provided a forecast for the Port Phillip Bay area on 20 February 2021. The forecast advised of partly cloudy conditions with waves between one and one and a half metres. Actual wind conditions recorded between 1.00pm and 3.00pm in half hour increments showed wind between 21km/hr and 24km/hr from the south, with wind gusts between 26kh/hr and 30km/hr. These wind readings were obtained from the BOM weather site located at Avalon Airport.

34. The Beaufort Wind Scale[2] indicates that winds between 20km/hr and 29 km/hr would result in the description at sea being 'small waves – becoming longer; fairly frequent white horses'.[3] Southerly winds entering Port Phillip Bay coupled with deeper water becoming shallow over the reef are likely to cause rough conditions.

Recovery of TZ708

35. Senior Constable (**S/C**) Antony Christensen and Sergeant Pisani located TZ708 approximately .6 nautical miles south of Point Cook (exact location S37º56.754, E144º45.587), with the stern still underwater and the bow sticking approximately one metre in a near vertical attitude.

36. The vessel was towed to Werribee Boat Ramp. Large amounts of water had to be bailed from the hull to allow the vessel to be trailered. Upon initial inspection, S/C Christensen noted that the vessel bungs were in place. TZ708 was then handed into the possession of Detective S/C Chris Obst of the Victoria Police MIU and taken to the Attwood storage facility to commence stability testing.

Test conclusions

37. Inspection and testing of TZ708 identified several deficiencies, including –

    a) Re-glassing of the deck by Mr Dao appeared to be in good condition until testing was conducted. Hose testing demonstrated that water from the deck could easily enter the watertight void underneath, adversely affecting the vessel's centre of gravity, causing free surface stability issues, and reducing the vessel's buoyancy.

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[2] The Beaufort Wind Scale is an empirical measure that relates to wind speed and to observe conditions at sea or on land.
[3] Bureau of Meteorology, 'Wind' *Australian Government* (accessed October 2021) (http://www.bom.gov.au/marine/knowledge-centre/reference/wind.shtml)

b) The bottom of the aft end of the keel immediately below the bungs has been severely degraded due to repeated impact and was not structurally sound. It provided a leak path for water to enter the watertight void of the vessel, further adding to free surface stability issues and reduced buoyancy.

c) The presence of lifted laminates and braded hull below the bungs indicated a lack of ongoing vessel maintenance. A thorough physical inspection of the vessel would have identified the lifted laminates, and an understanding of the need to keep the deck watertight should have identified these areas, and remedial work performed.

d) Several holes had been cut through the transom to run cables and fuel lines; some of these were not sealed. Any water entering through these holes would have ended up on deck and drain to the sump. The bilge pump in the sump should have been fastened in a properly functional upright position and fitted with a float switch for automatic operation. Furthermore, any holes through the transom should have been sealed.

e) The installation of the two platforms on the exterior the transom had the capacity to impact the ability of the vessel to return to an upright position after listing. The large cavitation plate installed by Mr Dao on the outboard motor had the capacity to cause the same effect.

Inspection and testing conclusions

38. Mr Dao reported that the vessel was loaded with a large amount of weight aft; when the incident occurred, Ms Nguyen was pitched into the starboard rear corner of the vessel. This sudden movement, plus the total mass of items, would have caused the boat to trim aft and starboard resulting in reduced freeboard on the starboard side and placing the gunwale closer to the water than normal.

39. It is probable that water entered the vessel during the voyage and when at anchor prior to the incident through the worn hull and/or the bung, resulting in a lowered freeboard aspect and stern trim, making the vessel more susceptible to taking on water over the side or transom when hit by waves. Water entering the vessel would have reduced the vessel's stability by increasing weight and centre of gravity, thereby reducing the ability of the vessel to withstand the effects of waves.

40. Leak paths from the deck to the underdeck compartment may have contributed to the incident however as the capsize was due to waves and happened quickly it is unlikely that a significant amount of water would have leaded through the deck to affect the outcome.

41. Following the incident, on 30 March 2021 a direction pursuant to Section 269 of the *Marine Safety Act 2010* (Vic) was issued to prohibit the operation of TZ708 in its current condition.

FINDINGS AND CONCLUSION

42. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[4] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

43. Having investigated the death of Thi Minh Tam Nguyen and having considered all of the available evidence, I am satisfied no further investigation is required.

44. On the basis of the available evidence, I am satisfied to the requisite standard that Ms Nguyen died from drowning after the boat she was on sank. She was provided with prompt and commendable assistance from her husband, Kim Lan Dao, as well as fellow fishermen, and her death could not have been reasonably foreseen.

45. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Thi Minh Tam Nguyen, born 27 June 1958;

    b) the death occurred on 20 February 2021 at Werribee South Boat Ramp, Diggers Road, Werribee South, Victoria, 3030, from drowning; and

    c) the death occurred in the circumstances described above.

[4] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

46. I commend Leading Senior Constable Wayne Evans-Barker for a fulsome brief of evidence pertaining to this matter.

47. I note that this Court has made several previous recommendations with regards to prevention opportunities in maritime safety incidents,[5] most recently in the matter of Allan McFarlane[6], the circumstances and recommendations of which are relevant to this case. In concurrence with the Victorian Police MIU's advocation, I made several recommendations relating to maritime safety.

48. Since 2010, the MIU 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 in Victoria tragically means that old and/or modified vessels (such as Mr Dao's) are usually only detected as unsafe or unsuitable post-incident.

49. The number of annual vessel related fatalities with common factors attributable to varying degrees of 'unseaworthiness' continues to be a preventable issue. My fellow coroners have enduringly supported the implementation of a system,[7] however one is yet to be developed.

50. I note the response received from Transport Safety Victoria dated 25 June 2021 to the matter of Mr McFarlane and I will therefore direct these recommendations to the Department of Transport for consideration and potential legislative amendment.

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[5] COR 2011 4499; COR 2011 4500; COR 2012 0298; COR 2013 2331; COR 2018 0285; COR 2019 0206.

[6] COR 2019 0206, published, [link to finding online]

[7] Examples: COR 2013 2331; COR 2017 1840 and COR 2018 0285.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

51. To the Secretary, Department of Transport, I recommend:

a) that a vehicle inspection process at the time of registration and acquisition, or transfer, of vessel ownership be developed and implemented to proactively identify deficiencies and carry out remedial work where required, akin to relevant sections in the *Road Safety (Vehicles) Interim Regulations 2020* (Vic);[8]

b) that all boats fitted with electrical bilge pumps in enclosed bilge areas have automated switches or floats, or alarms if a manual bilge pump exists; and

c) 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.

I convey my sincere condolences to Thi Minh's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Kim Lan Dao, Senior Next of Kin

Marine Safety Victoria

Transport Safety Victoria

Secretary, Department of Transport

Leading Senior Constable Wayne Evans-Barker, Victoria Police, Coroner's Investigator

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[8] Part 2.4, Part 6.5; Reg 252 - 253.

Signature:

Coroner John Olle

Date : 19 January 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.