IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003167

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Munif Mohammed
Delivered on:	29 October 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing date:	5 August 2024
Counsel assisting the coroner	Leading Senior Constable Clinton Smith
Keywords:	Boating Accident; Marine Incident; Drowning; Port Phillip Bay; Seaworthy Inspections; Practical Boat Licensing; Boarding Ladders

INTRODUCTION

1. On 12 June 2023, Munif Mohammed was 64 years old when he died in a marine incident on Port Phillip Bay near Portarlington. At the time, Mr Mohammed lived in Reservoir with his family.

2. Mr Mohammed was born in Veisaru, Ba, Fiji, in 1958 and was one of six children to parents Lal Mohammed Muradan and Miriam Bibi. In Fiji, Mr Mohammed was a qualified carpenter and ran his own construction company for ten years building domestic housing.

3. In 1989, Mr Mohammed moved from Fiji to Australia. His partner, Nur Munif, had already come to Australia a year earlier and they both settled in the Ballarat area. Mr Mohammed became an Australian citizen in 1991 and on 7 February 1993, Mr Mohammed and Mrs Munif married. The couple shared four children together, three sons and one daughter: Mohammed Arif, Mohammed Ashif, Aazim Mohammed Munif, and Aashna Zahara Munif. They also shared three grandchildren.

4. In the mid-nineties, Mr Mohammed and his family moved to Melbourne where he worked for the Ford Motor Company for 16 years until the closure of the factory in 2016. From 2017 onwards, Mr Mohammed worked as a dock hand at Tullamarine International Airport.

5. Mr Mohammed was an experienced fisherman and had a 20-foot vessel in Fiji which he would use to go fishing with his nephews. According to his wife, he was 'not a great swimmer' but was capable of keeping himself afloat.[1]

Medical History

6. Mr Mohammed had been managed by General Practitioner (**GP**) Dr Thair Maky of the Broadmeadows Medical Centre since May 2022. Previously he was managed by GPs at the Wells Medical Centre in Broadmeadows.[2] Mr Mohammed had a medical history of ischaemic heart disease with two stents placed in his heart. The first at the Austin Hospital in 2016 in the setting of hypertension and the second at the Northern Hospital in June 2022 due to ongoing breathlessness.[3]

[1] Statement of Nur Munif dated 21 June 2023, coronial brief pg 26.
[2] Statement of Dr Thair Maky undated, coronial brief page 36.
[3] Statement of Dr Thair Maky undated, coronial brief page 36.

7. He also had a restrictive ventilatory defect, asthma, and severe obstructive sleep apnoea.[4] From January 2020 onwards, Mr Mohammed was a patient of the Northern Health Respiratory Outpatient Clinic. During a telehealth consultation on 18 May 2023 Mr Mohammed agreed to a referral for a sleep study to consider the need for a CPAP machine to address his obstructive sleep apnoea.[5]

8. According to Dr Maky, Mr Mohammed's ongoing breathlessness did not resolve after his second cardiac stent was inserted in June 2022. He was therefore referred to Consultant Cardiologist Dr Julian Yeoh at the Austin Hospital who referred Mr Mohammed for investigations in August and September 2022. The results of these investigations were largely unremarkable. Throughout this period, Dr Yeoh considered Mr Mohammed remained clinically stable. A plan was made to review Mr Mohammed in June 2023 although the evidence suggests this did not occur.[6]

9. On 15 May 2023, Mr Mohammed presented to the Emergency Department at the Austin Hospital with troponin negative chest pain and shortness of breath.[7]

10. At the time of his death, Mr Mohammed's regular prescription medications were aspirin 100 mg daily, clopidogrel 75 mg daily, perindopril 2 mg daily, metoprolol 50 mg twice daily and rosuvastatin 40 mg daily. He was also prescribed an inhaler for his shortness of breath.

INVESTIGATION AND SOURCES OF EVIDENCE

11. This finding draws on the totality of the coronial investigation into the death of Munif Mohammed's death. That is, the initial brief of evidence compiled by Detective Leading Senior Constable Madeleine McDonald (**DLSC McDonald**) from the Victoria Police Marine Investigation Unit which includes relevant witness statements, photographs, the forensic pathologist's report and the toxicology report. At my direction additional information was obtained and the brief was reconfigured for use at inquest. This finding is also based on the evidence of those witnesses who were required to testify at inquest.

[4] Statement of Dr F.A Larry Ponnuthurai dated 21 September 2021, coronial brief pg 38.
[5] Statement of Dr F.A Larry Ponnuthurai dated 21 September 2021, coronial brief pg 39.
[6] Statement of Dr Julian Yeoh dated 3 August 2023, coronial brief 40-41.
[7] Ibid.

12. All of this material, together with the inquest transcript, will remain on the coronial file.[8] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

13. The purpose of a coronial investigation of a *reportable death*[9] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[10] Mr Mohammed's death clearly falls within the definition of "reportable death" in section 4 of the Act, satisfying both the jurisdictional nexus with the State of Victoria required by section 4(1) of the Act and section 4(2)(a) which includes (relevantly) a death that appears to have resulted, directly or indirectly, from an accident or injury.

14. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[11]

15. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[12]

16. Coroners are empowered to report to the Attorney-General in relation to a death; 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 to make recommendations to any

[8] From the commencement of the *Coroners Act 2008* (**the Act**), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[9] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[10] Section 67(1).

[11] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[12] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[13] These are effectively the vehicles by which the coroner's prevention role can be advanced.[14]

17. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[15]

IDENTITY

18. On 12 June 2023, Munif Mohammed, born 28 September 1958, was visually identified by his friend, Mohammed Khan, who signed a formal Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

20. Forensic Pathologist Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 13 June 2023 and provided a written report of her findings dated 16 June 2023.

21. Dr Ho was assisted in her report by Mr Mohammed's medical records from Austin Health, the initial police report into the death (Form 83), and the scene photos.

22. The post-mortem examination performed by Dr Ho and the computerised tomography (**CT**) scan did not show any signs of injury, including skull fractures or intracranial haemorrhage, which could have caused or contributed to death. The CT scan did show cardiac stents/calcifications and non-specific lung markings.

23. The body was weighed at 118 kilograms a measured approximately 176 cm in height representing a body mass index (**BMI**) of 38.1.[16]

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[13] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[14] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[15] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

[16] A BMI of 30 or more is considered obese.

24. Routine toxicological analysis of post-mortem samples detected the anti-hypertensive drug, metoprolol in keeping with therapeutic levels. No alcohol or any other common drugs or poisons were detected.

25. Dr Ho identified a foam plume about the mouth and washer person's type changes to the palms of the hands and soles of the feet, findings consistent with drowning. Notwithstanding, a diagnosis of drowning is one of exclusion and can be difficult to make as there are no definitive diagnostic signs of drowning. Accordingly, in cases of suspected drowning, considerable weight is placed upon the reported circumstances of the death.

26. Dr Ho provided an opinion that the medical cause of death was *1 (a) consistent with drowning in a man with ischaemic heart disease*.

27. I accept Dr Ho's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

28. On 11 June 2023, Mr Mohammed and his two sons, met with his friend, Mr Mohammed Khan at a factory in Thomastown. The factory was owned by Mr Saleem Dean, a mutual friend of Mr Mohammed and Mr Khan.

29. The men enjoyed some kava, a traditional Fijian drink, and Mr Mohammed and Mr Khan made plans to go fishing together the following day. The pair were good friends and had known each other for 10-15 years. They had previously fished together on Mr Khan's vessel on four to five occasions.[17]

30. At inquest, Mr Khan gave evidence that he checked the website, WillyWeather, for the weather and wave forecast for the following day, being 12 June 2023.[18] Mr Khan recalled that according to the WillyWeather report, there was no expectation of strong winds and waves were expected to be less than one metre. According to Mr Dean's statement, Mr Mohammed and Mr Khan checked the weather and the forecast was fine until about 3.00pm, and in any event, they planned to have returned to his factory (where Mr Khan's vessel was stored) by 2.00pm.[19]

31. At about 8.00am the following day, 12 June 2023, Mr Mohammed and Mr Khan met at Mr Dean's factory in Thomastown. They collected Mr Khan's vessel, a Sportcraft 5.3 metre

[17] Transcript pg 54.
[18] Transcript pg 56.
[19] Statement of Saleem Dean dated 21 July 2023, coronial brief pg 34.

fibreglass half cabin vessel with a single 75 HP Yamaha outboard engine (**the vessel**). At the time, the vessel was registered with Safe Transport Victoria, registered number LR 705.

32. Mr Mohammed and Mr Khan travelled to Werribee South with the vessel in tow and launched the vessel from there. They fished at a number of spots along the western side of Port Phillip Bay before they set anchor at a fishing spot near Portarlington. When they first launched the vessel into the water, Mr Mohammed was wearing his life jacket.

33. They fished in Portarlington for about half an hour.[20] At the time Mr Mohammed was positioned in the middle of the vessel fishing whereas Mr Khan was at the rear. Both men were facing the water and therefore not facing each other.

34. After fishing from this spot for about half an hour, Mr Khan heard Mr Mohammed complain that he was feeling hot. A short time later, Mr Khan heard a splash in the water. When he turned, he saw Mr Mohammed in the water on the port (left) side of the vessel. He did not witness the fall or see Mr Mohammed get into the water and assumed he had fallen.

35. Mr Khan grabbed Mr Mohammed but was unable to lift him over the port side of the vessel. He continued to try to assist Mr Mohammed, who was still in the water, to the rear (stern) of the vessel where the vessel sits lower in the water. Mr Khan told Mr Mohammed to "*pull the tag*" referring to the tag on his life jacket but Mr Mohammed said he could not as he had taken his life jacket off. [21] It did not occur to Mr Khan to throw the life jacket to Mr Mohammed while he was in the water.[22]

36. The men continued to struggle, trying to return Mr Mohammed to the safety of the vessel. He appeared unable to lift his leg so as to climb onto the engine or the vessel itself and was unable to leverage himself out of the water to safety.[23]

37. To help support Mr Mohammed, Mr Khan retrieved the line attached to the anchor (in the water) and placed it around Mr Mohammed. According to Mr Khan, prior to Mr Mohammed falling into the water the vessel was anchored from the bow (front).[24] While Mr Khan was holding Mr Mohammed with the anchor line, he braced his elbow on the rod-holder on the right-hand side of the vessel. The rod holder snapped under the pressure. As it did so, the rope around Mr Mohammed slipped off.[25]

[20] Statement of Mohammed Khan dated 12 June 2023, coronial brief pg 32.
[21] Ibid.
[22] Transcript pg 65.
[23] Transcript pg 58.
[24] Transcript pg 64.
[25] Mohammed Khan, transcript of record of interview 8 September 2023, coronial brief pg 206-207

38. Despite from Mr Khan, Mr Mohammed continued to struggle in the water. He held onto the edge of the vessel as well as to Mr Khan's hand but was unable to keep his head above the water.[26]
39. Mr Khan continued to hold Mr Mohammed's hand for about 15 minutes before they became separated.[27] Afterwards, Mr Mohammed was unable to remain above the water under his own strength and quickly went face down in the water, ceased moving and became unresponsive. His body became tangled in the fishing lines which prevented him from becoming lost at sea.
40. At 11.59am, Mr Khan called emergency services and reported the incident. Victoria Police members, Leading Senior Constables Wayne Evans-Barker (**LSC Evans-Barker**) and Geoffrey Moore (**LSC Moore**) from the Melbourne Water Police Squad responded to the call and arrived at the scene by water at 12.44pm. On their arrival, LSC Evans-Barker noted the anchor line on the vessel was secured to the bow, but it appeared to run from the bow back into the vessel and then out from the stern.[28]

41. Mr Mohammed was face down in the water a short distance from the vessel still entangled in fishing lines. LSC Evans-Barker and LSC Moore attempted to jointly lift Mr Mohammed out of the water by his jacket but were unable to do so. They attached a series of rescue lines and a rescue tube around Mr Mohammed's body in order to lift him onto the police vessel.
42. The police members did not detect any signs of life when Mr Mohammed was recovered onto the police vessel. He was taken to Portarlington Pier where Ambulance Victoria paramedics were waiting and formally verified him deceased at 1.40pm on 12 June 2023.

Location and Weather

43. The incident occurred on Port Phillip Bay approximately 1.4 nautical miles (2.75 kilometres) northeast of Portarlington at latitude 38 05.340 South, longitude 144 38.566 East. Port Phillip Bay is defined as being enclosed waters.
44. The weather forecast by the Bureau of Meteorology (**Bureau**) for Port Phillip Bay on 12 June 2023 was for northerly winds between 15 to 25 knots, reaching up to 30 knots late in the

[26] Transcript pg 62.
[27] Transcript pg 65.
[28] Statement of LSC Wayne Evans-Barker dated 22 June 2023, coronial brief pg 42.

evening. The Bureau forecasted waves at Port Phillip Bay to be around one metre, increasing to one to 1.5 metres by early evening.[29] At 10.00am on 12 June 2023, the Bureau had issued a strong wind warning for Port Phillip Bay.[30]

45. The nearest Bureau weather observation site to the incident was at Point Wilson. At 11.30am on 12 June 2023, the Point Wilson observation site recorded wind speed and gusts as follows:[31]

    i. 11.00am: northerly winds of 2 knots with gusts of up to 10 knots.

    ii. 11.30am: northerly winds of 3 knots with gusts of up to 8 knots.

    iii. 12.00pm: northerly winds of 3 knots with gusts of up to 10 knots.

46. The water temperature for Port Phillip Bay in June 2023 averaged 13 degrees Celsius. According to the National Search and Rescue Manual issued by the Australian Maritime Safety Authority, *"at 15 degrees Celsius, skin temperatures will decrease to near water temperature within 10 minutes of entry and shivering and discomfort is experienced immediately upon immersion. Dunking and submersion difficulties become increasingly distressful to the survivor."*[32]

47. In his statement included in the coronial brief, Mr Khan described conditions in the following terms – *"It wasn't too rough, not as bad some conditions we have been out in. The waves were less than half a metre and the back of the boat was pointing towards Portarlington.*[33]

48. Similarly, in oral evidence at inquest, Mr Khan estimated that when Mr Mohammed was in the water, the waves were less than half a metre.[34]

49. Prior to receiving the emergency call, LSC Evans-Barker and LSC Moore were performing patrol duties on Port Phillip Bay. LSC Evans-Barker noted that the weather had been fine but cloudy and that water was choppy with seas around 0.5 metres and standing up to approximately one metre at times.[35]

[29] Exhibit 1 coronial brief, Bureau of Meteorology Weather Forecast 12 June 2023, pg 56.
[30] Exhibit 2 coronial brief, Bureau of Meteorology Wind Warning 12 June 2023, pg 58.
[31] Exhibit 4 coronial brief, Point Wilson Weather Observations 12 June 2023, pg 62.
[32] Exhibit 19 coronial brief, National Search & Rescue Manual – February 2023 Edition, pg 241
[33] Statement of Mohammed Khan dated 12 June 2023, coronial brief pg 32.
[34] Transcript pg 59.
[35] Statement of LSC Wayne Evans-Barker dated 22 June 2023, coronial brief pg 42.

50. During transit to the incident location, LSC Moore reported that the sea was rough and reflective of the forecast, however upon arrival at the incident location, the sea was somewhat calmer than the conditions they experienced en route.[36]

Vessel LR705

51. The vessel is a Sportcraft 5.3 metre fibreglass half cabin vessel with a single 75 HP Yamaha outboard engine. The vessel has an orange hull, white cabin, and beige coloured Bimini. At the time of the incident, the vessel was registered with Safe Transport Victoria as LR705, expiring 22 January 2024.

52. At about 6.00pm on 12 June 2023, LSC Moore retrieved Mr Khan's vessel from the Portarlington Harbour and piloted the vessel to Point Richards Boat Ramp. The journey took around 30 minutes at a speed of between 7 to 8 knots. According to LSC Moore, *"The sea conditions had deteriorated by this time as there was a strong northerly creating waves up to 1 metre and due to the time of night it was completely dark. LR705 handled the conditions quite well, including being near to beam on and also having a following sea at times, two of the more dangerous conditions to be operating a vessel. I managed to stay completely dry during the journey and the vessel felt stable at all times. The steering was heavy but this is to be expected from cable steering and it felt a little underpowered by the 75 horsepower engine in comparison to what I am used to operating in my role at WPS."*[37]

53. On 16 June 2023, DLSC McDonald conducted an inspection of the vessel and its onboard safety equipment. She observed the vessel to be in an average condition with gel coating stress cracks along the transom (at the stern where the outboard engine is mounted) and on the portside bow. The keel of the vessel had significant gouges in the gel coating with bare fibreglass exposed and fibreglass patch work on the hull of the port side near mid-ships (middle of the vessel).

54. There were two batteries onboard the vessel however one was not connected and no isolator switches were located. A fuel tank was located at the starboard (right) side bow of the vessel with flexible fuel line running to the stern of the vessel. <u>The vessel had no boarding ladder and no place for a boarding ladder to be connected.</u> An engine cable opening was located lower than the edge of the wet well, resulting in a water ingress point.

[36] Statement of LSC Geoff Moore dated 16 September 2023, coronial brief pg 46.
[37] Statement of LSC Geoff Moore dated 16 September 2023, coronial brief pg 47.

55. The vessel had an unknown quantity of dirty water in the enclosed bilge area and the bung plug was difficult to remove requiring the use of pliers.[38] The bilge area of a vessel is the lowest part of the vessel's hull underneath the deck.

56. The well area in the mid of the deck had a bung plug hole but no plug, allowing water from the deck to enter the enclosed bilge area. The vessel's hull did not have an electric or manual bilge pump to remove water. The fibreglass deck was soft underfoot in the port stern quarter. The subfloor was unable to be inspected.

57. The following safety equipment was located on board:

- Two orange and two red flares, expiring December 2019 (expired)
- Two orange and two red flares, expiring December 2021 (expired)
- Two orange and two red flares, expiring December 2023
- 4.5kg fire extinguisher
- 2 kg fire extinguisher (discharged)
- 1 kg fire extinguisher (Halcon) – Outlawed under federal legislation in 1995
- Danforth anchor, chain, and rope
- Two waterproof torches
- One Menace Type 1 inflatable personal floatation device (**PFD**) (out of service, last due in September 2021)
- Bucket, no lanyard attached
- Electrical bilge pump

Vessel Stability Report

58. On 28 June 2023, stability testing of the vessel was conducted by marine surveyor, Thom Magnuson, from Maritime Survey Australia with the assistance of DLSC McDonald. The testing concluded:[39]

    - The vessel failed to meet the loss of freeboard criteria when assessed to the Australian Standard 1799.1 (Small Craft – General Requirements for Power Boats) indicating the vessel was sensitive to heel and transverse weight movements.

[38] Statement of DLSC McDonald dated 2 November 2023, coronial brief pg 52.
[39] Exhibit 13 coronial brief, Vessel Stability Report – conducted on 28 June 2023 by Marine Surveyor, Thom Magnuson, pg 148-150.

- The engine well was not watertight and had holes cut in various locations which allowed water to downflood into the vessel.

- The recessed well incorporates a drain plug in the aft bulkhead of the well. The bung was not in place at the time of the inspection, allowing water to drain into the void below the deck.

- Water on deck further reduces the vessel stability due to free surface effects, making it more prone to capsizing or rolling over. When the vessel tilts to one side, the liquid within the compartment moves to the lower side, causing the centre of gravity of the liquid to shift to that side. As a result, the overall centre of gravity of the vessel and the liquid shifts away from the vessel's original centreline. This transverse shift in the centre of gravity leads to a momentum that tends to roll the vessel further in the direction of heel.

59. On 27 July 2023, DLSC McDonald attended the Victoria Police Vehicle Impoundment Support Unit where the vessel was being stored with a Project Officer from Safe Transport Victoria.

60. As a result of this inspection and request by Victoria Police, a prohibition notice under Section 269 of the *Marine Safety Act 2010* was issued on 28 July 2023 prohibiting use or operation of the vessel until remedial work has been completed to rectify all identified issues.[40]

61. At inquest, Mr Khan gave evidence that he had not used the vessel since Mr Mohammed's death and receipt of the prohibition notice. Mr Khan testified that he planned to rid himself of the vessel as it was not worth the cost of the required repairs.

THE FOCUS OF THE INQUEST

62. Mr Mohammed's identity and the cause of his death were ultimately not controversial. The focus of the inquest was on the circumstances of Mr Mohammed's death, more specifically, whether the death was preventable and whether regulatory change is called for. The evidence will be discussed below under the following headings:

    i. Seaworthiness of Mr Khan's vessel and whether its condition contributed to Mt Mohammed's death.
    ii. The current regulatory framework for seaworthiness inspections.

[40] Exhibit 14 coronial brief, Prohibition notice dated 28 July 2023, pg 161.

iii. The need for practical marine licence testing.

iv. Whether a boarding ladder would have prevented the death and the case for mandating boarding ladders.

The seaworthiness of Mr Khan's vessel and whether its condition contributed to the death.

63. At inquest, DLSC McDonald explained that a wet well is an area at the stern of a vessel where the outboard engine is mounted. A wet well is an area which is allowed to have water enter and should have drain holes allowing any water that has come into the wet well, such as from waves over the rear, to drain out.[41]

64. On Mr Khan's vessel, there was a hole cut out of the edge of the wet well leading into the vessel with engine cabling running through it. According to DLSC McDonald, this would have acted as a water ingress point allowing water into the vessel and should have been properly sealed with a rubber boot over the engine cables. In DLSC McDonald's opinion, water entering the vessel through the water ingress point around the engine cabling would have affected the vessel's stability.[42]

65. Mr Khan advised there was never a rubber boot seal around the engine cabling on his vessel and it was like that when he purchased it. Further, he testified that when he had a new Yamaha engine installed at a shop in Preston, he assumed they would have advised him if a rubber boot seal was required for the engine cabling.[43]

66. During DLSC McDonald's examination of the vessel, a missing bung plug was also identified in the midship of the vessel.[44] The purpose of this bung hole is to allow post-cleaning drainage. According to DLSC McDonald, a missing bung plug here would allow water entering the vessel to pass through the bung hole and into the internal hull of the vessel. Again, this trapped water would result in further instability.[45]

67. Mr Khan gave evidence to the effect although there was no bung plug in the midship of the vessel, he was unaware one was required.[46]

68. DLSC McDonald also observed an unknown quantity of dirty water in the bilge of the vessel during her inspection of the vessel. Moreover, the bung plug at the stern of the vessel, which

[41] Transcript pg 16.
[42] Ibid.
[43] Transcript pg 44.
[44] Transcript pg 17.
[45] Transcript pg 18.
[46] Transcript pg 46.

allows for drainage of water in the bilge, was difficult to remove requiring the use of pliers. At inquest, DLSC McDonald opined that the dirty water and difficulty removing the stern bung plug indicated it had not been removed for some time. A buildup of water in the bilge would again adversely affect the stability of Mr Khan's vessel.[47]

69. The dirty bilge water was drained during DLSC McDonald's inspection of the vessel on 16 June 2023, but the volume was not measured. It is also unclear how much water was actually in the vessel on the date of the incident. Although she did not attend the scene on 12 June 2023, DLSC McDonald opined as follows - [48] *"there was water observed in the photographs. I didn't attend the scene on 12 June, so I can only go by what I observed in the photographs. And in the photographs taken by the crime scene officers water is visible on the back deck, which indicates that there was a significant amount of water but an unknown amount of water in the vessel."*

70. Following her inspection on 16 June 2023, the vessel was drained, washed and flushed to prevent any corrosion while in police storage. Subsequently, when stability testing was undertaken by Marine Surveyor Thom Magnuson, the vessel had no water in it[49] and as such was in better condition when tested compared to the day of the fatal incident.

71. Relevantly, the vessel still failed the loss of freeboard test. At inquest, DLSC McDonald explained that a loss of free board would affect the vessel's stability as follows[50] - *"So with the loss of freeboard…. the gap between the top of the vessel and the top of the water is less. So, yeah, more water would come in, which then causes more surface effect of – free surface effect, which then causes freeboard to be lost more, which then causes more water to come in and eventually vessels will capsize".*

72. Overall, DSLC McDonald was of the opinion that the vessel was in average to poor condition. Concerningly, DLSC McDonald added that it was "*very, very common to see these types of vessels*" on Victorian waters, and that it was not uncommon to see vessels in worse condition.[51]

73. At inquest, Mr Khan gave evidence that his regular maintenance of his vessel involved ensuring he always had two batteries, one plugged in and the other detached; checking the vessel's lights, engine oil and petrol levels; and starting the engine to ensure it runs.[52] He said

[47] Transcript pg 17.
[48] Transcript pg 19.
[49] Transcript pg 19.
[50] Transcript pg 20-21
[51] Transcript pg 22 & 24.
[52] Transcript pg 51-52.

he always checked the bung (referring to the bung at the stern of the vessel) and that it was sealed before heading out. Moreover, Mr Khan was adamant he always removed the bung plug after every time the vessel was on the water to drain any water left in the hull.[53] In response to DLSC McDonald's evidence that the stern bung plug was difficult to remove, Mr Khan testified he would use a pair of pliers to tighten the plug to make sure it was tight.[54] He suggested that the dirty bilge water came from the dust in Mr Dean's factory where he stored the vessel.[55]

The current regulatory framework for seaworthiness inspections

74. Mr Khan first registered the vessel in October 2008.[56] He recalled he was not required to get have the vessel inspected for seaworthiness or otherwise.

> *I didn't know where to go to get this roadworthy or whatever, to get it inspected. I just bought the boat and got it registered and that was it.* [57]

75. Following the inspection, vessel stability report, and resultant prohibition notice, Mr Khan stated dt inquest he was surprised to learn of all the defects of his vessel. When asked why the vessel had not been inspected by an independent assessor other than when the engine was replaced in Preston, Mr Khan indicated he would not know where he could get his vessel checked out.[58]

76. As already addressed, DLSC McDonald in her extensive experience policing Victorian waters indicated vessels in the same, or worse, condition as Mr Khan's are not uncommon. The defects with Mr Khan's vessel, although significant, were not exceedingly obvious and only apparent upon close inspection of the vessel.[59] DLSC McDonald commented:

> *"...it's very unlikely for a vessel of this type of nature to be detected before an incident. I would say close to 100 percent would be detected because it was involved in an incident. Not so much a fatality, but broken down, capsizing, swamping, um collision. Yeah, it normally - a marine incident will trigger the vessel being reviewed, and then that's how we would detect them.*[60]

[53] Transcript pg 45.
[54] Transcript pg 45.
[55] Transcript pg 46.
[56] Subsequent statement of DLSC McDonald dated 23 February 2024, coronial brief pg 265.
[57] Transcript pg 42.
[58] Transcript pg 49.
[59] Transcript pg 25.
[60] Transcript pg 24.

77. In Victoria there is no requirement that a vessel undergo or pass a seaworthiness inspection at the time it is registered. Unlike with a motor vehicle, which must pass a roadworthy each time the registration is changed in order to be registered, a vessel in Victoria can just be registered. The registration can be completed over the phone with an unknown Hull Identification Number (**HIN**) and unknown engine number.[61]

78. Regulation 27 of the *Marine Safety Regulations 2023* (Vic) (**the Marine Safety Regulations**) sets out that it is a condition of registration that the registered person of a recreational vessel must not allow the vessel to be operated if it is not fit for purpose. Relevantly in this case, regulation 27(2)(a) states that a recreational vessel is not fit for purpose if the hull of the recreation vessel is unable to maintain watertight integrity.

79. Despite condition of registration existing, there are no checks at the time of registration to ensure that a vessel adheres to the conditions of registration. DLSC McDonald expressed the opinion that a lack of seaworthy inspections at the time of registration results in '*a significant number of vessels being registered that should not be registered*', effectively as they are not fit for purpose as required.[62]

The need for practical marine licence testing

80. Applicants for a marine licence in Victoria, are required to complete an eyesight test and marine licence knowledge test consisting of 30 multiple choice questions. Unlike every other state except for South Australia, there is no requirement for any practical skills-based licence testing in Victoria.

81. DLSC McDonald advocated for the introduction of a mandatory 'on water assessment with a qualified instructor to be introduced in Victoria as a prerequisite to obtaining a marine licence'.[63] Such established programs already exist in New South Wales, Queensland, and Western Australia. She also added that skills based practical testing would, in her view, assist boaters have a greater understanding of their vessels – *"we need practical testing so that people operating the vessels have an understanding of what is required of them when it comes to seaworthiness as well."*[64]

[61] Transcript pg 26.
[62] Transcript pg 27.
[63] Transcript pg 32.
[64] Transcript pg 34.

82. In this case, Mr Khan obtained a marine licence in 2004 and at the time of the incident held a current General Marine Licence.[65] At inquest, Mr Khan confirmed he had never received any practical training on what to do in an emergency if someone were to fall in the water.[66]

Whether a boarding ladder would have prevented the death and the case for mandatory boarding ladders.

83. At inquest, Mr Khan detailed how Mr Mohammed struggled for around 15 minutes to reboard the vessel but was unable to do so. The evidence suggests Mr Mohammed unsuccessfully attempted to reboard the vessel by leveraging his leg on the outboard engine, by holding on to the wet fibreglass edge of the vessel, and by pulling on his friend's hand.

84. Mr Khan's vessel was not equipped with a boarding ladder at the time of the incident on 12 June 2023. Boarding ladders are widely available and relatively inexpensive. They are available in a variety of forms including foldable and collapsable metal varieties, or flexible rope-based ladders allowing for easy storage on smaller vessels where space may be at a premium.

85. Under the Marine Safety Regulations, there is currently no requirement for vessels to carry boarding ladders as it is not a compulsory item of equipment.[67]

86. The Australian Standard, Small craft Part 1: General requirements for power boats AS 1799.1 (2021) (**the Australian Standards**) are the current safety standards for vessels up to 15 metres in length used as recreational vessels throughout Australia. Standard 3.11.4 of the Australian Standards requires that a means of access for reboarding from the water in boats with freeboard greater than 0.3 m. If that means is a ladder, the top of the lowest step shall be at least 300 mm below the waterline when the ladder is extended.[68]

87. For obvious and logical reasons, the means of reboarding referred to in (c) above should be capable of being deployed and used without the assistance of anyone on board.

[65] Exhibit 8 coronial brief, Marine Licence Extract, pg 86.
[66] Transcript pg 70.
[67] See Schedule 3 - Safety equipment on recreational vessels & section 61, *Marine Safety Regulations 2023* (Vic).
[68] AS 1799.1, *Small craft Part 1: General requirements for power boat*, standard 3.11.4 (c)

88. When tested by Marine Surveyor Thom Magnuson, Mr Khan's vessel had an upright freeboard of 650 mm at the lowest point of the gunwale (hull edge) which lowered to 470 mm once the (excess) loss of freeboard was accounted for.[69]

89. Without a boarding ladder and at the lowest point of the gunwale, Mr Mohammed was required to lift himself 470 mm out of the water to reboard the vessel. This required a considerable level of upper body strength and cardiovascular reserves that Mr Mohammed (and potentially others) simply did not have.

90. As Standard 3.11.4 was first introduced in the now superseded 2009 version of the Australian Standards, the requirement for vessels to have a means of reboarding only applies to vessels built and sold after 2009. As Mr Khan purchased the vessel second-hand in 2008, Standard 3.11.4 did not apply. According to DLSC McDonald, it is very common to see similar vessels on Victorian waters and there are therefore many vessels currently in use to which Standard 3.11.4 does not apply unless the owner has chosen to add a boarding ladder to the safety equipment on their vessel.

STANDARD OF PROOF

91. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, having regard to the 'Briginshaw sliding scale'.[70]

92. When finding facts, a coroner has to reach a comfortable or reasonable satisfaction having regard to all of the available evidence relevant to the questions in issue in the investigation.[71] When considering whether that level of satisfaction has been achieved, regard must be had to the seriousness of the allegation; the inherent likelihood or unlikelihood of an occurrence of fact, and; the gravity of the consequences flowing from a particular finding.[72]

FINDINGS AND CONCLUSION

93. Applying the standard of proof to the available evidence regarding Mr Mohammed's death, pursuant to section 67(1) of the Act, I find that:

    i. The identity of the deceased was Munif Mohammed, born 28 September 1958.

[69] Exhibit 13 coronial brief, Vessel Stability Report – conducted on 28 June 2023 by Marine Surveyor, Thom Magnuson, pg 145.
[70] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336.*
[71] *Anderson v Blashki [1993]2 VR 89 at 96; Secretary to the Department of Health and Community Services v Gurvich [1995] 2 VR 69 at 73;*
[72] *Briginshaw v Briginshaw, op cit, at 362.*

ii. Mr Mohammed died on 12 June 2023 in the vicinity of Portarlington, Victoria 3223.

iii. The cause of Mr Mohammed's death is 'consistent with drowning in a man with ischaemic heart disease'.

iv. The death was accidental and occurred in the circumstances set out above.

v. The vessel was unseaworthy on 12 June 2023 due to a combination of factors including the water ingress point at the engine cable opening; a missing bung plug midship of the vessel; the cracks and gouges throughout the fibreglass coating; loss of freeboard; and the soft fibreglass deck at the port stern quarter.

vi. The unseaworthy condition of Mr Khan's vessel resulted in poor stability on the water and likely contributed to Mr Mohammed falling into the water.

vii. The water onboard the vessel and the unknown quantity of dirty water in the bilge, as observed by DLSC McDonald in photos captured on 12 June 2023 and during inspection on 16 June 2023 respectively, further adversely impacted the vessel's stability.

viii. The instability of the vessel contributed to Mr Mohammed falling into the water.

ix. Mr Khan made genuine and ongoing attempts to help Mr Mohammed reboard the vessel but his response to Mr Mohammed's emergent circumstances, including the failure to throw him a life jacket and the general paucity of safety equipment on the vessel speak to a lack of preparedness for an emergency on the water and poor regard to safety overall.

x. A boarding ladder, if present, would have improved the prospects of a timely rescue of Mr Mohammed by providing the best opportunity to safely reboard the vessel or, at a minimum, to enable him to hold his head above water until further help arrived.

xi. Similarly, if Mr Mohammed had been wearing his life jacket/personal flotation device when he entered the water, he would have been assisted in keeping his head above water.

xii. In that sense, Mr Mohammed's death was preventable in both scenarios.

COMMENTS

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

1. Mr Mohammed's death highlights the dangers of recreational boating which those on the water may not fully appreciate. Unlike analogous incidents on the roads, when something goes wrong on the water, help is generally not as readily available. This is compounded by the need to cope with the sea and weather conditions.

2. In some respects, the regulatory framework for boating in Victoria is not congruent with the risks to life involved in boating. Vessels can be registered to a new owner without any form of inspection or need to establish the vessel's fitness for purpose or seaworthiness, while prospective owners of vessels can obtain a Marine Licence without ever setting foot on a vessel.

3. The evidence from DLSC McDonald indicates that, like Mr Khan's vessel, significant numbers of unsafe vessels are being operated on Victorian waters, potentially by vessel operators ill-prepared to respond to emergencies.

4. The dangers of boating are well-documented in the coronial jurisdiction with several previous coronial findings calling for the introduction of seaworthy inspections[73] and practical licence testing[74] in the interests of improved public safety.

5. Since 2010, the Victoria Police Marine Investigation Unit has consistently campaigned for 'seaworthy' inspections at the time of registration and acquisition or transfer of vessel ownership. The lack of a vessel inspection process in Victoria tragically means that older and unsafe vessels, like Mr Khan's, are generally only detected following a fatal incident.

6. The absence of boarding ladders or other means of re-entering vessels has been identified as problematic in previous coronial investigations. In the investigation into the death of Jeffery Hayne[75] who similarly died after falling overboard, Coroner English (as she then was) remarked that "*it is notable that the vessel had no boarding ladder or other means for a person in the water to get onto the boat other than climbing in over the sides, which would require significant upper body strength as the freeboard was relatively high."*

7. In Mr Mohammed's case, the simple presence of a boarding ladder would have greatly reduced his risk of dying. The difference between holding on to a wet fiberglass edge raised

[73] See the investigations of Jennifer and Alexander Elliot COR 2008 1880 & COR 2008 1881; Kevin Caithness and Paul Robert Washington (COR 2011 4499 and COR 2011 4500); Damian Smith COR 2010 2010; James Sullivan COR 2012 298; Adam Pearson COR 2013 2331; Alan Mason COR 2014 6148; Imre Iles COR 2017 1840; Graham Hill COR 2016 285; Allan McFarlane COR 2019 206; Thi Nguyen COR 2021 961.
[74] See the investigations of Zane McLaughlin COR 2008 1678; Robert Brewster COR 2012 748;
[75] COR 2016 5329.

470mm out of the water compared to a ladder with specifically designed rungs for hands and feet is obvious.

RECOMMENDATIONS

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

1. I recommend that Safe Transport Victoria explores potential models for a recreational vessel seaworthy inspection and certificate regime to assess the already legislated prescribed conditions under regulation 27 of the *Marine Safety Regulations 2023* (Vic) as a means of ensuring the seaworthiness of vessels at points of registration, transfer of ownership, and after any modification of the vessel.

2. I recommend that Safe Transport Victoria considers the introduction of practical training and assessment as part of the Victorian marine licencing regime analogous to regimes already in existence in other Australian States.

3. I recommend the Minister of the Department of Transport and Planning amend the *Marine Safety Regulations 2023* (Vic) to mandate boarding ladders or other similar means of reboarding a vessel from the water in vessels with a freeboard greater than 0.3 metres, irrespective of the size of the vessel.

I convey my sincere condolences to Mr Mohammed's family for their loss.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Nur Munif, senior next of kin

Mohammed Khan

Safe Transport Victoria

Secretary of the Department of Transport and Planning

DLSC Madeleine McDonald, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date : 29 October 2024

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.