IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005337

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Harold Lester Clayton
Date of birth:	7 February 1955
Date of death:	24 September 2023
Cause of death:	1(a) Effects of carbon monoxide
Place of death:	Cameron's Bight, Sorrento, Victoria 3943
Keywords:	Boating accident, seaworthy inspections, carbon monoxide alarm,

INTRODUCTION

1. On 24 September 2023, Harold Lester Clayton was 68 years old when he was found deceased on his boat (**the *Waimana*)** where it was moored in Cameron's Bight in Sorrento, Victoria.

2. Harold is survived by his partner, Trish, and his four children. He also had a close relationship with his son-in-law, Matthew.

3. Harold was a boilermaker by trade but was also described by family and friends as a clever engineer, who was very competent in mechanical repair. His friend John, an experienced electrical engineer, described him as "*one of the handiest guys I have ever met*". Harold was a strong and active man who liked to keep busy, keeping several boats of varying disrepair that he was working on.

4. When he was younger, Harold broke his nose and had an impaired sense of a smell as a result, with his daughter, Jessica, describing it as "*nearly non-existent*". Aside from a minor blood pressure issue 18 months earlier, Harold had no significant health conditions, nor any history of mental ill health that his family were aware of.

5. On 24 September 2023, at about 4.00pm, Matthew came to collect Harold from the *Waimana*, with Harold having spent the day doing work on it, when Matthew tragically found Harold deceased.

THE CORONIAL INVESTIGATION

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

7. 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.

8. 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.

9. Victoria Police assigned Detective Leading Senior Constable (**DLSC**) Madeleine McDonald to be the Coronial Investigator for the investigation of Harold's death. DLSC McDonald 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.

10. This finding draws on the totality of the coronial investigation into the death of Harold Lester Clayton. 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

11. On 24 September 2023, Harold Lester Clayton, born 7 February 1955, was visually identified by his son-in-law, Matthew Taylor.

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

Medical cause of death

13. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an examination on 26 September 2023 and provided a written report of her findings dated 31 October 2023.

14. Examination of the post-mortem CT scan showed bilateral renal cysts and slight cardiac hypertrophy. There were no head injuries.

15. Overnight toxicology showed a carbon monoxide level of 55.7 per cent, which Dr Baber noted is considered a fatal level. No other common drugs or poisons were detected.

16. Dr Baber provided an opinion that the medical cause of death was *effects of carbon monoxide*.

17. I accept Dr Baber's opinion.

[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.

Circumstances in which the death occurred

18. On 24 September 2023, at about 9.10am, Matthew drove Harold out to Cameron's Bight via jet ski, to drop Harold off on the *Waimana*. Harold planned to spend the day working on changing the batteries to start the main engines and the fuel pump. They organised for Matthew to return between 4.00pm and 6.00pm to collect Harold.

19. At about 12.30pm, Harold called Matthew and had a brief conversation, during which it was confirmed Matthew would pick Harold up that afternoon.

20. At about 4.00pm, Matthew returned to the *Waimana* on his jet ski and observed that the boat's generator was running. Upon entering the cabin, Matthew saw Harold on the floor of the engine bay, in a sitting position but slumped forward, with the top half of his body horizontal to the floor.

21. Harold did not respond to physical or verbal cues, and Matthew observed there was no pulse and that Harold had "*gone yellowy/white and just looked lifeless*". Matthew called triple zero and attempted to turn the generator off but could not locate it.

22. Road ambulance paramedics were first to arrive to the scene but were unable to reach the *Waimana* as it was moored about 500 to 800 metres from the pier. At 5.54pm, the Helicopter Emergency Medical Service arrived, and dropped an intensive care paramedic to the boat at about 6.15pm. The paramedic observed that Harold was warm to touch but unresponsive, and that there was a notable gas smell in the area where Harold was located.

23. Harold was confirmed to be deceased at 6.21pm.

24. At 7.13pm, the Water Police Squad and the Southern Peninsula Rescue Squad coordinated to tow and dock the *Waimana* at the Sorrento boat ramp.

25. At about 8.06pm, Fire Rescue Victoria members boarded the *Waimana* and assessed carbon monoxide levels reaching up to 1800 parts per million. Efforts were made to turn off all possible sources of carbom monoxide and ventilate the vessel, with a satisfactory reduction in readings reached at about 9.30pm.

26. On 24 October 2023, the *Waimana* sank following a large storm. The boat was recovered by the insurance company and was assessed to have sunk due to taking on too much water from the storm. There is no evidence to suggest that the sinking of the *Waimana* was suspicious.

FURTHER INVESTIGATIONS

27. On 25 September 2023, Harold's boat, the *Waimana,* JV362, was inspected by Detective Sergeant (**DS**) Brett Colley from the Victoria Police Marine Investigation Unit (**MIU**) and a report was produced dated 12 February 2024.

28. DS Colley identified the boat to be a Riviera Flybridge 38, manufactured in 1990. Due to the age of the boat, DS Colley was unable to obtain sufficient information to perform an exemplar comparison. However, he otherwise observed no identifiable damage to the boat, although noted that it was in poor condition and was unkept. There were two loose batteries, tools and an alcohol container in the engine compartment where Harold was located.

29. The weather conditions on 24 September 2023 were calm to moderate winds from the north-west with mild air temperature and good visibility.

30. DS Colley concluded that:

    a) Harold was in the confined engine compartment of the vessel whilst conducting a mechanical modification on the engine batteries with the aft mounted generator running to supply power.

    b) It is most likely that the fumes emitted by the operation of the generator caused the confined engine compartment to be inundated with a toxic level of carbon monoxide, ultimately causing Harold's death.

31. DS Colley found no evidence that there had been any contribution from the operation of the vessel underway, prevailing weather conditions, sea state, or any other person.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Harold Lester Clayton, born 7 February 1955;

    b) the death occurred on 24 September 2023 at Cameron's Bight, Bay Trail, Sorrento, Victoria, 3943, from 1(a) *effects of carbon monoxide*; and

    c) the death occurred in the circumstances described above.

COMMENTS

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

Seaworthy inspections

33. Since 2010, the MIU has consistently advocated for 'seaworthy' inspections at the time of registration, acquisition, or transfer of vessel ownership, including periodic inspections for older vessels where doubt exists as to the condition of the vessel. The implementation of mandatory inspections has been supported by several recommendations that have previously been made by coroners of this Court in relation to maritime safety incidents.

34. In connection to the passing of Thi Minh Tam Nguyen in 2021, Coroner John Olle made the following recommendation to the Secretary to the Department of Transport (**the Department**):

> "*a vessel 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).*"

35. In response, the Department advised that his Honour's recommendation would be considered in a review already on foot of the relevant legislation, the *Marine Safety Regulations 2012*.

36. Following the review, the Department explained in its Statement of Reasons that, due to significant costs to the industry, the Department would "*need to be confident that the additional costs are outweighed by any potential improvement in the seaworthiness of the recreational vessel fleet in Victoria*". It was concluded that the current fit for purpose conditions of registration were adequate for the purpose of assessing seaworthiness of vessels.

37. The *Marine Safety Regulations 2023* subsequently came into effect on 11 June 2023 and do not include a provision for mandatory seaworthy inspections.

38. Registration and use of recreational vessels that are later found to be unseaworthy following an accident remains an ongoing issue. Deputy State Coroner Paresa Spanos most recently made a further recommendation regarding the seaworthy inspection process in December 2024. I have reiterated her Honour's recommendation below.

Carbon monoxide alarms

39. There has been previous advocacy for mandatory gas detectors to be installed on all recreational vessels. In 2021, in relation to a death where an LPG leak was identified on the vessel, Coroner McGregor directed a recommendation to the Department and to Marine Safety Victoria that legislation be developed for a mandatory gas detecting system on any recreational vessel with an LPG system on board in an enclosed area.

40. The Department and Safe Transport Victoria advised in their responses that the responsible regulator for gas safety systems is Energy Safe Victoria who administer the *Gas Safety Act 1997*. The Department further advised that any recommendations in relation to gas safety should be considered as part of the regulatory scheme under that legislation.

41. The relevant Australia Standard, AS 1799.1, which relates to general requirements for power boats, provides that a gas detector should be installed on vessels in cooking or heating areas. However, in its current form, it is not a mandatory standard, nor is it required that the alarm is installed in engine bays.

42. It is apparent that preventable deaths continue to occur in similar situations to Harold's, and I therefore make the following recommendations in line with these comments.

RECOMMENDATIONS

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

(i) To the Safe Transport Victoria, I recommend that potential models are explored 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.

(ii) To Energy Safe Victoria, I recommend that legislation be developed under the *Gas Safety Act 1997* to mandate the installation of a gas detecting system on vessels in a position to alert occupants of high levels of carbon monoxide and other toxic gases and that it coordinates with Standards Australia to amend AS 1799.1 (2021, Small craft, Part 1: General requirements for power boats) in accordance with this legislation.

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

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

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the place of death to the following: "Cameron's Bight, Bay Trail, Sorrento, Victoria, 3943".

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

Patricia Beer, Senior Next of Kin

Travis McKay, Safe Transport Victoria

Leanne Hughson, Energy Safe Victoria

Detective Leading Senior Constable Madeleine McDonald, Coronial Investigator

Signature:

Judge John Cain
State Coroner
Date: 7 April 2025

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.