IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 6156

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	ANG
Date of birth:	[redacted]
Age:	5 years old
Date of death:	9 December 2018
Cause of death:	*Complications of Immersion and Multiple Injuries in the Setting of a Boating Incident*
Place of death:	Lake Eildon, Bonnie Doon, Victoria

CORONIAL INVESTIGATIONS

Coroners investigate reportable deaths under the authority of the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The Act sets out the matters about which a coroner must make findings. They are:

a. the identity of the deceased person;

b. the cause of their death; and

c. the circumstances in which their death occurred.[1]

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.

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.[2]

Coroner's Investigator

Coroners are assisted by members of Victoria Police to gather evidence on their behalf. In this case, **Senior Constable Christopher Obst**, Marine Investigation Unit, was assigned by Victoria Police to be the Coroner's Investigator. SC Obst compiled a comprehensive coronial brief of evidence which comprised a number of witness statements as well as other relevant documentation, including footage which recreated the movements of the boat preceding the incident.

Coroners Prevention Unit

In this case, the Victorian Coroners Prevention Unit (**CPU**)[3] was also requested to provide assistance with the investigation and specifically:

a. Any data on fatalities recorded in water vehicles being used for recreational purposes;
b. Any data on fatalities recorded in the vehicle subject of this investigation;
c. Any existing safety measures/laws applicable (specific warnings, legislation) to the activity subject of this investigation; and
d. Whether there are any prevention recommendations which may be considered appropriate regarding the circumstances of the death.

[1] Section 67(1) of the Act
[2] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.
[3] The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations.

YOUNG ANG'S CORONIAL INVESTIGATION

1. This investigation involved the death of a young boy named ANG who was born on [redacted]. He was 5 years of age when he died in a boating incident on Lake Eildon, Bonnie Doon. He was the much loved son of A and B and older brother to C and D.

2. Young ANG's family were passionate about boating and water sports and loved spending their free time at Bonnie Doon and boating on the water. His mum said, *it's what we live for.* A said that his kids had done about a *thousand hours* in their boat and ANG just loved it.

3. On the evening of 8 December 2018, ANG's mum recalled,

   Sat down with ANG 'cause I bought up all the .... Christmas catalogues from Kmart, Target and Big W and we sat together ANG and I after dinner out on the grass and we made a big collage of things that he – he wanted for Christmas.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

4. On Saturday 8 December 2018, ANG, his mother and father as well as his younger brothers travelled from Melbourne to their cabin at Bonnie Doon. They arrived at 9.30am and met A's nephew, E and his wife, F. They spent part of the day in their boat, a 2011 MB Tomcat F21, on Lake Eildon, wakeboarding, swimming and listening to music.

5. In the morning of Sunday 9 December 2018, E and F unexpectedly left Bonnie Doon. ANG's family returned to Lake Eildon to enjoy further activities in and on the water. Some of the family were swimming around the boat when they noticed a storm coming and it had started to rain. They decided to return to shore and A asked his wife to pass him his wakeboard so he could wakeboard back to the boat ramp before the storm hit.

6. As they travelled back to the boat ramp, A fell off the wakeboard a couple of times. They had a system whereby B would slow the boat to an idle and allow the wake[4] to pass prior to commencing a safe slow turn to collect him.

7. As B continued towing A back towards the boat ramp, A requested that B increase the speed from 15mph to 15.2mph. At this time, ANG and C were seated in the bow of the vessel. ANG was on the port side and C was on the starboard side. They would regularly sit in the bow of the vessel whilst it was underway.

[4] The track of waves left by a ship or other object moving through the water.

8. His father said, ANG *sat up the front, a million times. We'd always tell him not to kneel or stand or anything like that. And…he was that smart and safe in the boat…he's the most cautious out of all our kids.*

9. His mother also said, *ANG's always the most careful kid out of all three of them he was just like always looking after himself and his brothers and he doesn't ever do anything silly. He's like the most cautious little kid ever.*

10. As B was operating the boat without an observer[5], she used a combination of looking behind regularly and in the rear vision mirror to see if her husband had fallen off. ANG was noted to be seated on his knees facing forward and looking down at the water as the vessel cruised along.

11. On the final occasion B observed her husband fall off his wakeboard, she slowed the boat to an idle to allow the wake to pass under the boat. The boat was still in forward gear. At this time, she saw young ANG lose balance and fall forward over the port side bow. B immediately ran forward to look overboard (and left the boat *idling* and in gear) at which time she heard a loud thud on the underside of the boat. B returned to the helm and turned the boat off. She jumped in the water to find her son and started yelling for assistance.

12. A witness on a personal water craft collected A and took him back to the boat where he searched for ANG by repeatedly diving under the water. After about three attempts (and suffering extreme exhaustion) he located ANG underneath the boat with his personal floatation device (**PFD**) entangled in the propeller. A was eventually able to free his son from the propeller and pull him to the surface. ANG was unconscious and not breathing. It was estimated that he may have been submerged for approximately five minutes.

13. A commenced cardiopulmonary resuscitation (**CPR**) on the boat as it returned to shore.

14. Paramedics arrived quickly but attempts to revive ANG were unsuccessful and he was tragically declared deceased at 2.30pm.

IDENTITY

15. On 9 December 2018, A visually identified his son, ANG, born [redacted]

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

[5] E had acted *as the spotter the day before.* See paragraph 34.

CAUSE OF DEATH

17. Specialist forensic pathologist Dr Gregory Young practising at the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 10 December 2018 and provided a written report of his findings dated 31 December 2018.

18. Dr Young commented that one classic sign seen in immersion or drowning is a foam plume around the mouth, which was seen in this case. It is difficult to ascertain the role of the injuries sustained from the boat, given none of the individual observed injuries in themselves would have been fatal. However, he said that, given the circumstances, it is reasonable to surmise that the injuries, in combination with the immersion, led to the death. He further noted that no *unexpected* signs of trauma were seen.

19. Toxicological analysis did not identify the presence of alcohol, common drugs or poisons.

20. Dr Young provided an opinion that the medical cause of death was *Complications of Immersion and Multiple Injuries in the Setting of a Boating Incident*.

21. I accept Dr Young's opinion.

Police Investigation

22. Investigating police, including the Coroner's Investigator, arrived at the scene at around 1.25pm and immediately commenced their investigation. A preliminary breath test of B was negative for alcohol. She held a current marine licence (and had done so for about 8 years) and the boat's registration was current. She was considered very experienced in the operation of the boat (having owned it for 5 years).

23. The family were also considered to be experienced in boat and water sports including skiing and boarding. The boat itself (registration [redacted]), a 2011 F21 Tomcat sports boat manufactured by MB boats, was purpose built for water and in particular wakeboarding. The 6.4 metre fibreglass mono hull vessel was powered by a PCM Excalibur V8 engine.

24. It was noted that, whilst a storm was approaching that day, it had been calm and the weather was suited to motorised boating activities.

25. Detective Sergeant Jenelle Hardiman (**DS Hardiman)** from the Collision Reconstruction and Mechanical Investigation Unit conducted acceleration tests on the boat to determine the force

that occupants in the boat undergo as the boat is slowed and the likelihood of a child seated in the bow of the boat falling as a result of such forces.

26. DS Hardiman noted that the 'bow rider' design of the boat had provision for occupants to sit within the bow of the boat ahead of the driver, in addition to conventional seating positions.

27. She said that a passenger riding in the bow of the boat would need to lean forward more than 17 degrees to be forced forwards towards the outside of the vessel as a result of decelerating from 15.2 mph to idle. Due to the height of the back rest on the bow seat (0.28m) being above the centre of mass of a seated passenger (adult or child), even when affected by the forward g-force (gravitational force), a seated passenger should not fall from the boat. She found that within the tested conditions, a passenger seated in the bow rider cannot fall from the bow during slowing. If a child was resting or leaning on the upper hull at the front of the boat and either he or the boat was wet, this would also decrease the effect of friction resisting any acceleration.

28. DS Hardiman provided the opinion that immediately before the incident,

    It is almost certain that ANG was leaning forward onto the bow of the boat when he slipped forward as the boat slowed, he would have been leaning forward at 17 degrees or more.

29. She found no evidence that the boat was being driven inappropriately.

30. DS Hardiman said that in her opinion, *when the boat slowed, ANG was leaning forward over the bow of the boat a minimum of 17 degrees. It is likely that he was either kneeling or standing on the seat as this will increase his instability and the risk of falling as it raises his centre of mass. The higher the centre of mass and the less stable the base of the occupant, the less g force that is required for the occupant to fall from the boat during the slowing and reduced friction due to the water.*

31. She said it is not possible to know the exact g-force equivalent value applicable when young ANG fell from the boat, but during testing no peak g-force above 0.303 was experienced. This level of g-force would not result in a seated passenger falling overboard.

32. B said of her children that *they've been on that boat for thousands of hours in – in that bow every single time we go out and we didn't bump we were on flat water* and, in her record of interview, that *they were both on their knees and he must have been jumping up and down and he just lost his balance and went over.*

33. I note that young ANG was seen to have fallen forward over the bow of the vessel and this is consistent with him having been leaning over the bow when the vessel slowed for the fallen wakeboarder.

Role of observer/spotter

34. Regulation 95 of the *Marine Safety Regulations 2012 (Vic)* (**the Regulations**) requires a master of a vessel engaged in towing a person to have, in addition to the master, a person on board who is in a position to observe the person being towed; communicate with the master of the vessel. The observer must be at least 12 years old.

35. At the time of the incident, there was not an observer on the vessel. Victoria Police investigators considered that the lack of observer did not to contribute to the fatality.

Prevention Investigation

The Data

36. The CPU identified 68 deaths of people between 1 January 2000 and 31 July 2019 who were recreational boating in a powered vessel at the time of the incident. Males accounted for 64 of the deaths and ages ranged between 4 to 81 years, with one unknown. Fishing from the vessel was the most common activity undertaken by the deceased (44).

37. Two other deaths involved a ski/wakeboard vessel in addition to the death of young ANG. Neither of these involved the same make and model as that involved in ANG's death.[6]

38. There were three individuals (including ANG) who were passengers on a vessel where water skiing/wakeboarding activities were being undertaken at the time of the incident. One death occurred in similar circumstances where a person fell off the vessel at the time when the water skier/wakeboarder had fallen off and the vessel was in the process of turning around to pick them up. In this case, although the reason why the individual ended up falling off the vessel was unknown, it was believed that he stood up during the turn and lost his balance. The other death involved a collision with another vessel.

39. The CPU considered that the data did not support a review into the suitability and safety of vessels with a bow rider design.

[6] The limitation is that the make and model of the boat is not always known in the coronial finding.

Personal flotation device (PFD)

40. The CPU noted that while adults are not legislated to wear a PFD at all times on a power-driven boat between 4.8 metres and 12 metres, a PFD must be carried for each person on board the vessel. The Regulations state that children less than 10 years old are to wear a PFD at all times while on a recreational vessel. The Regulations also provide that a person who is being towed by a vessel must, at all times, wear a PFD.

41. As required, young ANG, his brothers and father were wearing PFDs at the time of the fatal incident.

Speed

42. When travelling on inland waters, a 5-knot speed limit applies to all vessels within: 50m of the water's edge (unless stated by notice), 50m of another vessel, 50m of any fixed or floating structure in or on the water, 50m of swimmers and 100m of a diver's flag buoy or vessel.

43. There are also speed limits specific to Lake Eildon.

44. There was no indication that B was speeding or that speed contributed to the fatal incident.

COMMENTS

I make the following comments connected with the death under section 67(3) of the Act:

Safety Warnings

37. The CPU noted that in January 2019, *Maritime Safety Victoria* advised in their edition of *Shipshape: Boating Safety News* of the dangers of bow riding. Although this was mainly directed at vessels that do not have seating in the bow, the publication also warned masters of bow rider vessels to ensure passengers are secure and that young children are appropriately supervised.

38. The CPU considered that *Maritime Safety Victoria* could publish a similar warning in any pamphlets or similar material they produce regarding safety in vessels. I have adopted this suggestion and intend to make such a recommendation.

45. In addition, I note that *Marine Safety Victoria* highlights important *emergency* information for recreational vessel operators who operate power boats where a *Man Overboard* occurs. In that guide, it highlights to operators that they should practice the 'man overboard' drill often, and

stop engines, where appropriate, to avoid striking the person with a turning propeller. Re-enforcing this information appears to be a valuable recommendation arising from the loss of ANG.

Installation of Hand Rails – the Family's suggestion for change

46. The family were also very keen to focus on any prevention opportunities arising from the loss of young ANG, and to help save another young life in future.

47. ANG's father told the Court about changes he had made to their boat that created a safety feature which might prevent future deaths, noting that the bow of the boat is popular for children to sit and the existence of dangers such as the boat hitting a tree stump or being affected by the wake created by another boat. The alteration included a safety hand rail that the family designed and had fitted to their boat around its bow.

48. This proposal was communicated to the MB Boats distributor but the Court was advised that there is no longer an Australian Distributor for MB Boats.

49. The Court subsequently raised the family's suggestion to the manufacturer in California for their consideration, but did not receive a response.

50. ANG's father said that MB boats are quite rare and that other more common brands like *Malibu* and *Mastercrafts* have very similar hull designs which could benefit from the family's suggestion.

51. Publication of this Finding is a means of communication to those manufacturers of this design suggestion, in circumstances where I have no power, arising from the circumstances, to make such a recommendation.

RECOMMENDATIONS

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

Maritime Safety Victoria

52. Maritime Safety Victoria consider advising boat users of the possible consequences of not being in a fully seated position on a vessel, particularly in a bow rider, in any pamphlets or similar that are provided to registered boat users.

53. Maritime Safety Victoria consider reinforcing boat users to practice man overboard procedures and, in particular, the requirement to stop engines, where appropriate to prevent injury, in any pamphlets or similar that are provided to registered boat users.

FINDINGS AND CONCLUSIONS

54. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the Deceased was ANG born [redacted];

    (b) the death occurred on 9 December 2018 at Lake Eildon, Bonnie Doon, Victoria, from *Complications of Immersion and Multiple Injuries in the Setting of a Boating Incident*; and

    (c) the death occurred in the circumstances described above and was the result of a tragic accident.

55. I convey my sincere condolences to ANG's family for their loss and acknowledge the heart-breaking circumstances in which his death occurred.

56. ANG's family were supported by the Court's Family Liaison Service throughout the coronial process and graciously provided the following words about ANG for inclusion in the finding:

    ANG was an extremely happy, well loved son to his parents, A and B and younger brothers, C and D.

    ANG's smile resembled the moonlight, sweet, kind, soft and magical. It would light up the room and a million hearts.

    ANG absolutely adored his younger brothers and cared deeply for those close to him.

    His most favourite thing to do was visit his holiday cabin and spend time with his family.

    ANG genuinely had the biggest heart and spread love, joy and kindness wherever he went.

ANG will be deeply missed but we will continue to honour and celebrate ANG's life with those closest to our hearts.

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

A and B, parents and senior next of kin

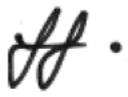
Transport Safety Victoria

MB Boats

Senior Constable Christopher Obst, Victoria Police, Coroner's Investigator

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

Signature:



SARAH GEBERT

Coroner

Date: 1 December 2021

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.