



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 001107

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	NM
Date of birth:	13 March 2013
Date of death:	25 January 2026
Cause of death:	Drowning
Place of death:	No 4. Beach, Venus Bay, Victoria
Keywords:	Missing person – suspected death – drowning – adult supervision

INTRODUCTION

1. On 25 January 2026, NM was 12 years old when he went missing on the beach at Venus Bay. At the time of his disappearance, NM lived with his family in a suburb in the northwest of Melbourne.
2. NM is warmly remembered as an intelligent, helpful and happy boy who is deeply mourned by his family.

BACKGROUND

3. NM was diagnosed with mild autism when he was two years old. NM's mother reported that her son's diagnosis did not impact on any aspect of his daily activities. She also advised that he had no mental health issues.
4. In 2017, NM began swimming lessons. He stopped due to the restrictions associated with the Covid-19 pandemic and did not resume lessons when pools reopened. NM liked to swim and his mother took him to the pool regularly. She reported that he was not an "*overly athletic swimmer, but he was able to swim by himself without floaties or a life vest*".
5. NM enjoyed going to the beach, and the family had been to Venus Bay multiple times. His family reported that he was always supervised by an adult when he was in the water. Further, they stated that he would not go deeper than chest-height and never wandered off by himself.

CORONIAL INVESTIGATION

6. NM'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. Under section 3 of the Act, death includes a suspected death.
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 an officer to be the Coronial Investigator for the investigation of NM's death. The Coronial 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.
10. This finding draws on the totality of the coronial investigation into NM's death. While 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
11. The coronial investigation of a suspected death differs significantly from most other coronial investigations which commence with discovery of a deceased person's body or remains. The focus in those cases is on identification of the body or remains, a forensic pathologist's examination, and advice to the coroner about the medical cause of death and, where possible, the circumstances in which the death occurred.
12. Absent a body or remains, the coronial investigation focuses on the last sighting of the person suspected to be deceased, any subsequent contact with family or the authorities, and evidence of proof of life since death. In such cases, the coronial investigation must first endeavour to establish, on the balance of probabilities, whether the person suspected to be deceased, is deceased.

CIRCUMSTANCES OF DISAPPEARANCE

13. On 25 January 2026, NM and his parents drove to Venus Bay to go swimming and collect pipis. They arrived at Venus Bay Access No. 4 Beach (**No. 4 Beach**) at around 11:00am.
14. No. 4 Beach is an unpatrolled beach. There is a sign at the entry point which indicates hazards including high surf, strong currents and drop off, and advises that the nearest patrolled beach is at No. 1 Beach. There is also public rescue equipment available near the entry point.

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.

15. When NM and his family arrived, No. 4 Beach had a steadily rising tide moving towards a high-water peak, creating shifting surf conditions. The weather was warm, and waves were large with a big swell and white water, as well as rip currents in the water. The beach was also busy with several hundred beachgoers in the immediate area.
16. Once they arrived at the beach, NM's father dropped NM and his mother off while he went to find a carpark. NM and his mother set up a beach tent and started collecting pipis along the shoreline while they waited for the father to meet them. As NM's mother went back to their beach tent to put her shoes away, NM went into the water up to approximately knee height. She remained standing on the shore watching him. NM ordinarily wore glasses but did not wear them while swimming.
17. NM's father arrived at the beach tent around 11:20am and told his wife that he would watch their son while he swam. NM's mother then walked towards No.5 Beach to collect pipis. NM's father stayed at the water's edge to keep an eye on NM, who was only a few meters away from him.
18. NM's father needed some water, so he asked NM to come back to the shore. At this point, NM was in knee-deep water with some other children nearby. NM's father later told his wife that he told NM he needed to get a drink and to come out of the water, and NM gave him a thumbs up in response and began walking towards the shore. Their beach tent was not far from the shoreline but was approximately 70 metres from where NM was swimming, as he had gradually drifted over towards No. 3 Beach while he was swimming. NM's father recalled that he returned to the place where his son had been swimming after around five minutes.
19. When NM's father returned to the water, he could not see his son. He thought that he may have gone to play with other children and looked up and down the beach but could not find him. He then searched the shoreline and after 30 minutes, he found his wife near No.5 Beach.
20. NM's father asked his wife if she had seen their son. She said she had not, and NM's father explained that he had returned to the beach tent for some water but then lost sight of NM and had been looking for him for the last 30 minutes. NM's parents continued looking for their son. They searched up and down the beach for another 30 minutes but could not find him.
21. NM's mother then called her other son (who had remained at home) and explained what had happened. He told her to contact Victoria Police and explained the process to her as she spoke Vietnamese and her English was limited. At around 12.45pm, NM's mother contacted

- emergency services with the assistance of other Vietnamese beachgoers and explained that NM was missing. She provided a description of what NM had been wearing, being a navy-blue rash vest with dark blue shorts. NM's family continued to search for him while waiting for services to arrive.
22. Victoria Police initiated a multi-agency search operation for NM, also involving Life Saving Victoria (LSV) and the State Emergency Service (SES). Together, they conducted an extensive land, sea and air search.
 23. At 1.15pm, SES and LSV members commenced a line search along the beach. There were two metre swells and breaking waves which made conditions difficult. SES members conducted land searches for NM, and helicopters were also deployed to assist in the search. Police divers also entered the water at No.4 Beach to assist with the search. The search continued until 6:00pm, when it was ended for the day due to poor visibility, with a plan to begin again in the morning.
 24. Later that evening, a medical advisor to Victoria Police provided an expert opinion that given NM's height, weight, swimming ability and the temperature of the water, he was unlikely to have been able to survive in the water beyond 10.30pm that evening.
 25. On 26 January 2026, the search continued with inflatable rescue boats, divers and aerial support. Sharks were observed swimming in the water which impacted search efforts, as well as poor conditions later in the day.
 26. On 27 January 2026, LSV, SES and Victoria Police continued to conduct a combination of aerial, land and water searches. At around 1:30pm, there was a reported sighting of an item of clothing near Point Smythe at the water's edge, approximately five kilometres from where NM went missing. A pair of underpants were subsequently recovered from the water, which NM's parents confirmed had belonged to him. LSV jet skis then entered the water around this area, and a pair of torn dark blue shorts were recovered from the water, about 20 metres offshore and directly in line with the position of the underpants. NM's parents also confirmed the shorts appeared to belong to their son. Despite ongoing searches, NM could not be found.
 27. On 28 January 2026, SES members conducted a line search at low tide along beach and rocks in the adjacent Inverloch area. A Victoria Police helicopter and divers were also involved in the search, but there was no sign of NM.
 28. The search for NM was suspended indefinitely on 29 January 2026.

FINDINGS AND CONCLUSION

29. I am satisfied that NM drowned at No 4. Beach at Venus Bay on 25 January 2026. It is likely that he got into difficulty in the challenging conditions and his swimming ability was not sufficient to enable him to manage the conditions and return safely to shore.
30. Pursuant to section 67(1) of the Act, I make the following findings:
- a) the identity of the deceased was NM, born 13 March 2013;
 - b) the death occurred on 25 January 2026 at Venus Bay No. 4, Venus Bay, Victoria from drowning; and
 - c) the death occurred in the circumstances described above.
31. It is acknowledged that the fact that NM's body has not been recovered is very distressing for his family.

I convey my sincerest sympathy to NM's family for their loss.

COMMENTS

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

Supervision

32. NM's death was a tragedy which has devastated his family.² His death highlights the risks to swimmers at Victoria's ocean beaches. Swimmers (and where relevant their carers) need to carefully and consciously assess their ability to manage the variable conditions at surf beaches before deciding to enter the water. Those who are not confident and sufficiently competent in the water to manage the potential hazards should approach Victoria's ocean beaches with caution and swim at patrolled beaches. The communication of this message is particularly important as we head towards another summer where residents and visitors to Victoria will be visiting its beaches and waterways to enjoy the recreational activities they have to offer.

² NM's parents advised police that they intended to make donations to Victoria Police, SES and LSV from his tuition fund in gratitude for their efforts in searching for their son.

33. NM's death also highlights the importance of adult supervision of children who are swimming at Victorian beaches. On its website, LSV warns that "*Children must be actively supervised whenever they are in, on, or near water. Stay within arm's reach of young children and maintain constant visual contact. Put phones and other distractions away*".³ Children (particularly those with limited swimming ability) can lose their footing in rough conditions even in shallow water, and can become submerged quickly and without a splash or other sound.
34. These comments are not made by way of criticism of NM's parents who have suffered a devastating tragedy. They are deserving of sympathy and not judgment. They are provided as a salutary warning to all caregivers of children to prevent further tragedies at our beaches.

Culturally and linguistically diverse (CALD) communities

35. Surf Life Saving Australia (SLSA) developed an online platform and mobile App called Beachsafe.⁴ It is freely available in over 100 languages and provides safety information on all beaches within Australia, including when they are patrolled and any potential safety considerations at each location. Additionally, Beachsafe provides a range of other safety tips and information, including beach safety information videos in a number of different languages that were developed for populations or groups determined to be at a high risk of drowning.
36. The conditions at the beaches at Venus Bay are often hazardous. The Beachsafe entry for Venus Bay states that it is "*A potentially hazardous beach usually with high waves and strong rips, so stay on the inner bar and in the patrol area between the flags. There is an average on 23 rescues each year, indicating the level of hazard*". Its designated "General Hazard Rating" is 7/10 (Highly hazardous).
37. In its *Aquatic Injury Prevention Agenda 2026-27*, LSV identified the following relevant water safety issues associated with high-risk populations, including multicultural communities:
- a) Lack of water safety messaging and programs which are accessible and appropriately tailored for those from CALD backgrounds;
 - b) Lack of understanding or preparedness for open waterway conditions and dangers, particularly rip currents or strong currents;

³ <https://lsv.com.au/what-we-do/staying-water-safe>.

⁴ <https://beachsafe.org.au>.

- c) Lack of swimming ability (adults; parents/caregivers);
 - d) Swimming outside the red and yellow flags at patrolled beaches, or swimming at unpatrolled beaches; and
 - e) Not reading aquatic safety signs and supervising others while not having adequate water safety skills or knowledge themselves.
38. The Royal Life Saving Society- Australia, LSV and SLISA are well aware of the ongoing water safety risks to multicultural communities. They have conducted significant research and produced a series of publicly available communication materials for multicultural communities explaining the dangers of multiple aquatic environments and risk factors. These have been translated into a number of languages.⁵ They also deliver a number of practical and theoretical education programs to a wide variety of groups, including newly arrived refugees, asylum seekers, migrants and international students.
39. The Australian Water Safety Council has also developed the Australian Water Safety Strategy 2030 in furtherance of its commitment to improving water safety in Australia, which includes a focus on multicultural communities
40. Further, LSV's *Aquatic Injury Prevention Agenda 2026-27* contained the following recommendations relevant to multicultural communities:
- a) Promote multi-sector partnerships (eg aquatic organisations, migrant settlement services, universities, sports clubs, cultural groups) to raise awareness of drowning risks among migrant communities;
 - b) Advocate for embedding beach safety education within English-language learning systems to reach multicultural communities;
 - c) Use culturally tailored messaging to emphasise swimming as a life skill and which can lead to participation in other aquatic activities, acknowledging barriers related to cost and cultural norms;
 - d) Build programs for migrants that leverage social networks and peer participation, enabling them to attend with family, community groups or friends to increase comfort and motivation;
 - e) Use campaigns to counter beach behaviours driven by social proof, emphasising that “others in the water” does not equal safety;

⁵ <https://www.royallifesaving.com.au/stay-safe-active/communities/multicultural-communities/resources-by-language>.

- f) Provide accessible educational materials in multiple languages and through migrant-relevant channels (community magazines, faith-based groups, WhatsApp/WeChat networks, consulates, universities); and
- g) Investigate how signage terms can be revised in English to improve translatability (eg replacing “shore dump” with clearer terms such as ‘crashing waves’).

41. I endorse the recommendations made by LSV and other water safety bodies which are targeted towards preventing drowning deaths, including with a focus on multicultural communities.

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.

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to “*I(a) Drowning*”.

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

NM’s mother, Senior Next of Kin

Life Saving Victoria

Kidsafe

Leading Senior Constable Rohan Michael, Coronial Investigator

Signature:



Coroner David Ryan

Date: 21 October 2026

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.
