FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 142/08

Inquest into the Death of DALE GRAHAM RUSS

Delivered On:	10th June 2010
Delivered At:	Hearing Room, Coroners Court of Victoria, Level 1, 436 Lonsdale Street, MELBOURNE 3000
Hearing Dates:	21st April 2010
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	The Russ family, in person.
	Leading Senior Constable Greig McFarlane, State Coroners Assistants Unit, assisting the coroner.

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 142/08

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: RUSS
First name: DALE
Address: 6 Bayley Close, Heathmont, Victoria 3135

AND having held an inquest in relation to this death on 21st April 2010

at the Coroners Court of Victoria at Melbourne, sitting in the County Court at Melbourne,

find that the identity of the deceased was DALE GRAHAM RUSS born on 11th September, 1981,

and death occurred on the 9th January, 2008,

at the Austin Hospital, Studley Road, Heidelberg, Victoria 3084,

from: 1(a) UPPER CERVICAL SPINAL CORD INJURY

in the following circumstances:

BACKGROUND & PERSONAL CIRCUMSTANCES

1. Dale Graham Russ was the twenty-six year old son of Karen and Graham Russ and the brother of Tiffany and Michelle. Mr Russ left school in Year 10 to undertake an apprenticeship as a fitter and turner. He enjoyed good health and lead a fit and active lifestyle and became engaged to be married in 2005. When this relationship ended in 2006, Mr Russ returned home to live with his parents in Heathmont. The relationship ending was a mutual decision and he appeared to be under no particular emotional stress. He continued to enjoy an active social life, often staying with his sister Michelle in St Kilda after going out on the weekends.

NEW YEAR'S EVE 2007-8

2. New Year's Eve 2007 started at the family home where Dale, his girlfriend Kelly Cayzer and his sister Michelle attended a family party for their grandfather's 80th birthday. Dale did not drink at the party as they had plans to drive to St Kilda later. At about 7:00pm Dale, Kelly and Michelle drove first to St Kilda, then to a friend's house in Kew where Mr Russ had about six cans of Boubon & Cola, according to his sister. At about 1:00am they returned to Michelle's apartment in St Kilda. Shortly after arriving at the apartment they walked to a nightclub in Fitzroy Street, St Kilda where they stayed for about an hour and a half. According to Michelle, Dale had about two glasses of a rum mixer, before they returned to her apartment to sleep.

NEW YEAR'S DAY

3. At about midday the next day, Dale, Kelly, Michelle, and her boyfriend Aaron had breakfast in St Kilda, after which Dale and Kelly went to the beach near Brooks Jetty, Marine Parade, St Kilda, arriving at about 2:00pm. There was a lot of pedestrian traffic on the jetty at the time. Dale was in a good mood and optimistic about the year ahead. He told Kelly that he wanted to jump off the jetty, and she cautioned him saying "You don't know how deep it is". Kelly stated that she assumed it was deep owing to the dark colour of the water. Dale handed her his towel, thongs and hat before diving into the water head first with his arms by his side.

4. Kelly lost sight of Dale for a short time before seeing him about half a metre below the surface face down, bobbing up and down, with blood in the water around his head. In response to Kelly's cry for help, two unknown males jumped into the water to help Dale and turned him face up. Kelly jumped into the water and found it was only chest height at the point where Dale had dived in. Dale was conscious but could not speak and indicated that he was having trouble breathing. Emergency services were called.

MEDICAL ASSESSMENT & TREATMENT

5. Ambulance officers arrived shortly thereafter and stabilised Dale before taking him to the Alfred Hospital where he required immediate intubation and mechanical ventilation. A CT scan revealed a spinal cord injury (type III fracture of the dens (C2) with retropulsion and dissection of the right vertebral artery. On 2 January 2008, Dale was transferred to the Austin Hospital, Intensive Care Unit (ICU), where Mr Doug Brown, Director of the Victorian Spinal Cord Service, was the Consultant responsible for his care. Mr Neil Roberts, Vascular Surgeon, also reviewed Dale and advised that no intervention for vertebral artery dissection was appropriate. Investigations at the Austin Hospital confirmed his dire prognosis.

6. On 3 January 2008, Dale was advised that there was no prospect of neurological recovery, and that he would need permanent mechanical ventilation and institutional care. The following day, a surgical tracheostomy was performed by Mr Simon Knight, Thoracic Surgeon, to increase Dale's comfort and allow him to communicate verbally via a Passy Muir valve. This allowed him to speak to his family and to make his wishes known.

7. On 7 January 2008, Dale's condition was stable. A trial of breathing without mechanical ventilation was conducted and no spontaneous ventilatory movement was demonstrated. Dale indicated that he did not want to continue with mechanical ventilation and wanted to be allowed to die. He was assessed twice by psychiatrists who found him to be mentally competent to have full decision making capacity. He indicated to them, and also to medical staff and his family, repeatedly, consistently and rationally that he was not prepared to accept the quality of life which would be associated with permanent total ventilator dependence, and the need for totally dependent institutional care.

8. On 9 January 2008, Dale was told that medical staff would accede to his wish for ventilator withdrawal under sedation. He said he understood and expressed his thanks. He was sedated and when unresponsive at 3:15pm, mechanical ventilation was withdrawn. He was pronounced deceased at 3:25pm.

CAUSE OF DEATH

9. There was no autopsy as I allowed the family's objection to autopsy pursuant to *section 29 of the Coroners Act 1985*. However, Forensic Pathologist Dr Katherine White from the Victorian Institute of Forensic Medicine (VIFM) reviewed the circumstances as reported by the police, the medical deposition and medical records from the Austin Hospital, postmortem whole body CT scanning and advised that it would be reasonable to attribute death to *"upper cervical spinal cord injury"*.

10. Toxicological analysis was undertaken at VIFM of antemortem samples taken some 24 hours after the diving incident, at 1:45pm on 2 January 2008, on Dale's admission to the Austin Hospital. The results revealed no ethanol (alcohol) or commonly encountered drugs or poisons, apart from Morphine at 0.1mg/L and a trace of Propofol, both consistent with therapeutic use.

INVESTIGATION OF CIRCUMSTANCES - ADEQUACY OF SIGNAGE

11. The circumstances surrounding Dale's death were investigated by Constable Stuart Chettle from St Kilda Police Station who provided the coronial/inquest brief. There was no

contention around Dale Russ' identity, the cause date and place of his death and most of the circumstances. Ascertaining these facts is the primary purpose of a coronial investigation.[1]

12. In the statements of Const Chettle and A/g Sen Sgt Wursthorn, and again in the covering memorandum of A/g Sen Sgt Barney Wursthorn, attention was drawn to signage on the jetty which was described as poor, and to the need to highlight to the public (again) the dangers of diving into water of unknown depth. The issue of the adequacy of signage and the broader issue of public safety, became the main focus of the coronial investigation of this death, especially of the inquest proper. These issues are relevant to the coroner's obligation to comment and/or make recommendations on any matter connected with the death, including public health and safety or the administration of justice, commonly referred to as the coroner's broader "prevention" role.[2]

13. In order to better appreciate these issues, I attended a view at Brooks Jetty in May 2009, with my assistant Leading Senior Constable Greig McFarlane, A/g Sen Sgt Wursthorn and Mr Graeme William Davis, Chief Ranger, Port Phillip/Westernport, for Parks Victoria, which is responsible for maintenance of the jetty (seaward from the concrete stormwater sewer[3]) and for signage. At the inquest, photographs were produced of the signage as at 1st January 2008, as it was during the view in May 2009 after some upgrading, and at it is currently, after further upgrades.

14. It is necessary to have some appreciation of the nature of the jetty to appreciate the impact of the signage. The following description from Constable Chettle's statement[4] is sufficient for present purposes -

> *"From the boardwalk, prior to the waterline, a concrete landing leads out to the timber walkway. There is a double column steel pole barrier either side of the walkway, the southern side of the barrier stops a short distance out from the waters edge. The northern side barrier continues to the end of the jetty. As the jetty changes direction north [it is an L shape overall] the barrier continues on the beach side of the jetty ... [at a height of] approximately 1.5 metres high, estimated from my own height...[On 22nd October 2008] Measurements were taken toward the end of the jetty, the approximate location ... where the deceased dived into the water. The height from the water to the walkway was measured as 1.8 metres. The depth of the water that time was 2 metres. These measurements can be taken as a guide to conditions on 1st January 2008 as conditions obviously vary due to the time of day and year."*

---

1 As the inquest took place on 21 April 2010, the provisions of the *Coroners Act 2008* apply. That Act provides (relevantly) that a coroner investigating a death must find, if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred if there is a public interest in so doing (*see sections 67(1) & (2)*).

2 See the preamble and purposes of the *Coroners Act 2008*, especially *section1(c)* which came into operation on the 1st November 2009 and applies to this inquest.

3 The foreshore and the jetty up to an including the concrete stormwater sewer falls within the jurisdiction of the City of Port Phillip which was not involved in the inquest.

4 Exhibit "B", dated 8th December 2008.

15. As at the 1st January 2008, there were only two relevant signs on the jetty, both of the pictogram variety. The first a "no diving" sign situated at the start of the wooden walkway on a post above the barrier or handrail, the second a "no jumping, no diving from structure" sign with associated pictograms situated at the end of the jetty at the butt of the L-shape, well above eye level. Photographic evidence provided by the Russ family would suggest that as at 1st January 2008, both signs but especially the second "dual" pictogram had been defaced by vandals making the safety message more obscure. Mr Davis testified that the signs were still legible and that the graffiti was cleaned off within a few days of New Year's Day 2008.[5]

16. By the time of the view conducted in May 2009, signage on the jetty had been upgraded. Both signs remained in the same locations as before with the no diving pictogram, but with the wording changed to read "shallow water no diving no jumping". In addition, on the outward leg of the jetty, three small triangular "shallow water" signs with the no diving pictogram were installed/screwed into the edge of the jetty, so as to be visible to those walking by and also to anyone standing ready to dive or jump off the edge.

17. Mr Davis explained in evidence that these improvements were *"as a result of recognition that we saw a need to do something better at Brook's Jetty as a consequence of Mr Russ' accident. We weren't in a position then to finalise the nature of signage across all our piers and jetties so we chose to put that interim signage in until there had been agreement to the port wide description of signs on all piers and jetties."*[6] In earlier evidence, Mr Davis explained that as at January 2008, VicParks were in the midst of a total review of signage in Port Phillip and Westernport Bays, required by the amendments to the Port Services Act which imposed an obligation to prepare safety and environment management plans. VicParks were half way through the risk analysis process which would lead to new signage across all structures and new aquatic risk signage.[7]

18. The review was completed in late 2009 and the Brook's Jetty signage upgraded yet again as a result of that review on or about 24 February 2010. At the commencement of the wooden walkway there is a sign welcoming people to Brooks Jetty and highlighting the two most significant hazards in Parks Victoria's assessment, namely "shallow water" and "submerged obstacles" by means of two yellow diamond shaped signs with appropriate pictograms. Notably, the shallow water pictogram shows a diver striking his head on the surface, midway through a diving motion. There is also a series of thirteen signs placed on the edging or capping, at the feet of those using the jetty. These are placed in groups and warn of submerged obstacles, shallow water, no diving, no jumping and no swimming.[8]

---

5 Transcript page 26.
6 Transcript page 27.
7 Transcript page26.
8 See transcript pages 30,31 and following for a description of these.

FINDING

19. Whilst it is clear that Dale did not heed the signage in place on 1 January 2008, it is not clear whether he did not see the signs at all, did not understand the nature of their warning or intentionally disregarded them. In any event, I find the signage in place as at 1 January 2008 was inadequate, both as to number and placement of signs, and that it insufficiently conveyed the dangers of diving, as opposed to the unlawfulness or undesirability of the activity.

OTHER SAFETY ISSUES

20. The Russ family raised a number of broader safety concerns they saw as arising out of the circumstances surrounding Dales' death. While I think it is appropriate to note their concerns here, for completeness, I am obliged to restrict my comments and/or recommendations to matters of public health and safety which are connected with Dale's death, and not at large.

20.1 They noted that on the day the beach was full of litter including used syringes, and that Dale chose to dive in off the jetty to access the water without walking on the foreshore. There is no evidence before me which would support a coronial finding that this was his motivation in diving off the jetty and therefore contributed to his death. I will, however, provide a copy of this finding to the City of Port Phillip for their information and any remedial action they consider appropriate in this regard.

20.2 Mr Graham Russ queried the need for the jetty altogether. As a boating enthusiast he noted that there were no depth markers or tidal warning, no feasible use of the jetty for boating due to its height from the water and lack of a landing, and sandbarring all around the jetty. Mr Davis gave evidence about the historical nature of the jetty and strong local support for its continuation as a promenade. It is beyond my scope to comment on this issue beyond noting that it was not the existence of the jetty but its inappropriate use as a diving platform which lead to Dale's death, and noting the obvious need for decision-makers to balance a range of interests including public safety concerns in deciding the future of historical infrastructure.

20.3 The absence of a barrier or handrail on the southern and seaward edges of the jetty was also cited as a safety concern. Based in large part on my view of the jetty, and quite incidental to the investigation of Dale's death, a second handrail would clearly improve safety for those using the jetty properly as a promenade, but would not impede anyone intent of diving in disregard of the improved signage. Both Mr Davis and A/g Sen Sgt Wursthorn gave evidence of their own observations of people, especially the young, using handrails and even roofs of structures adjacent to water, as jumping or diving platforms.

20.4 The Russ family were aware of another incident twelve months earlier in which a man in his twenties sustained injuries entering the water from the jetty and was left a quadraplegic. They asked how many others had suffered a similar fate? As was apparent from evidence at the inquest, statistics about incidents occurring at Brooks Jetty may be held by a number of authorities[9] and are difficult to bring together so as to gain an accurate picture of the scope of the problem.

21. RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

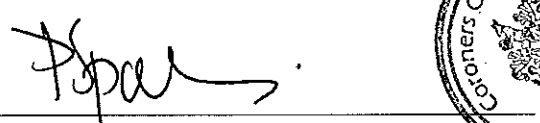
1. Whilst I recognise that signage can only go so far in protecting people by highlighting dangers, and that its usefulness is limited by people's preparedness to heed the messages it conveys, the continued absence of signage at the end Brooks Jetty poses a danger to public safety. I recommend that Parks Victoria considers further upgrades to the signage by additional signs at eye level at the furtherest end of Brooks Jetty.

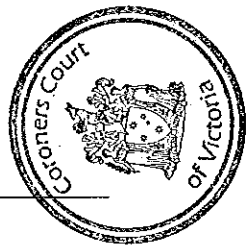
2. I also recommend that Parks Victoria considers the usefulness of a public education campaign to highlight the dangers posed by shallow water and submerged objects, particularly when jumping and diving from jetties, such campaign to be targeted both as to when it should take place and to those most at risk, which on the basis of the evidence before me is children and young adults.

DISTRIBUTION OF FINDING

The Russ Family
Victoria Police c/o the investigator Constable Stuart Chettle, St Kilda Police
Parks Victoria
City of Port Phillip
Life Saving Victoria
Secretary, Department of Justice re "Play It Safe By The Water" campaign.

Signature:





PARESA ANTONIADIS SPANOS
CORONER
Date: 10th June, 2010

9 For example the local Life Saving Club, Metropolitan Ambulance Service, the Emergency Departments of Public Hospitals, Victoria Police, Parks Victoria to name a few. Some of these are unlikely to be concerned with and therefore unlikely to reliably record the precise location where the incident occurred.