IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 0295

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of DANIEL MICHAEL MILES

without holding an inquest:
find that the identity of the deceased was DANIEL MICHAEL MILES
born 2 April 1988
and the death occurred on 18 January 2015
at Cape Bridgewater, Victoria 3305
from:

1 (a) DROWNING

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Daniel Michael Miles was 26 years of age at the time of his death. He lived in Mount Gambier in South Australia.

2. At approximately 4.00pm on 18 January 2015, Mr Miles was washed off the rocks and into the ocean at Cape Bridgewater. He had been planning to fish with his friend, Justin Green, north of the Blowholes car park in the Discovery Bay Marine National Park. Mr Green called emergency services and an air, land and sea search was conducted over the next two days.

3. At approximately 3.00pm on 20 January 2015, Mr Miles' body was located by a Police Search and Rescue Squad diver in approximately 16 metres of water in a small rock cave nearby.

INVESTIGATIONS

Forensic Pathology investigation

4. Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a full post mortem examination upon the body of Mr Miles, reviewed a post mortem CT scan and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Lee observed generalised pulmonary oedema, bilateral pleural effusions and haemorrhage within the mastoid sinuses. There were no findings that were inconsistent with drowning. Dr Lee also observed that coronary atherosclerosis, although mild, was significant for a 26 year old man.

5. Toxicological analysis of post mortem blood detected alcohol and delta-9-tetrahydrocannabinol.[1]

6. Dr Lee opined that while cardiac disease and/or drugs may have played a role in the circumstances surrounding Mr Miles' death, they were not causal. Dr Lee ascribed the cause of Mr Miles' death to drowning.

Police investigation

7. The circumstances of Mr Miles' death have been the subject of investigation by Victoria Police on my behalf. The police investigation did not identify evidence of third party involvement. Police obtained statements from Mr Miles' friend Justin Green and a passing jogger.

8. In the course of their investigation, police learned that Mr Miles and Mr Green had left Mount Gambier at approximately 1.00pm on 18 January 2015, to go fishing at Cape Bridgewater.

9. When they arrived at the Blowholes car park, they had looked at the blowholes first, and then retrieved their fishing gear from the car. Mr Miles had a fishing rod, and a bag of bait. Mr Green had his fishing rod and a tackle box. At approximately 3.45pm they had set off in a northerly direction, walking along the track which follows the coastline.

10. Mr Green stated that the weather at the time was warm and sunny; the wind was blowing but not excessively. The seas at the time were rough, about eight to 10 foot waves. The passing jogger similarly reported that it was windy at the time and that the waves were smashing against the rocks and coming up the cliff side.

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[1] Delta-9-tetrahydrocannabinol is the active component of cannabis.

11. Mr Miles and Mr Green came across an outcrop and a set of stairs. They left the track which follows the coastline and climbed over a wire fence and down a steep track. They decided to fish from a rock platform approximately 30 metres down the cliff face. Mr Miles went down the track first and was about five metres in front of Mr Green. When Mr Green reached the spot where they had planned to fish, he put his tackle box down. Mr Miles had walked further down the rocks and was heading towards two larger puddles on a lower level. Mr Green started to follow him when a large set of waves came in. Mr Green took three steps backwards and was covered by the wave, losing sight of Mr Miles. About two seconds later, he saw Mr Miles in the surf, about 50 metres from the rock, floating in a northerly direction. He had his arms in the air and was calling out 'Justin'. Mr Miles disappeared at one stage but came back to the surface. Mr Green called emergency services and could still see Mr Miles bobbing up and down in the surf. When he got off the phone, Mr Miles had disappeared. Mr Green went back to the track and spoke to a passing jogger.

12. Mr Green reported that he and Mr Miles had consumed no alcohol that day, but Mr Miles was possibly hung over from the night before.

Coroners Prevention Unit investigation

13. The Coroners Prevention Unit (CPU),[2] also investigated the circumstances of Mr Miles' death on my behalf, in particular in relation to the prevalence of deaths related to rock fishing.

14. It was identified that between 1 July 2000 and 31 January 2016, 15 other deaths had occurred in Victoria in the context of rock fishing. None of the people who died had been wearing life jackets at the time of immersion into the water.

15. The Life Saving Victoria 2013/2014 Annual Report included observational studies that disclosed none of those who were rock fishing, observed as part of the report, had been wearing lifejackets.

16. It was noted that a '[D]on't put your life on the line' safety campaign by Life Saving Victoria had been included in the Fisheries Victoria 2016 Recreational Fishing Guide. The rock fishing

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

safety advice specified advice including 'never fish alone…'; 'wear a personal flotation device and carry safety gear and a first-aid kit'; 'wear appropriate footwear with non-slip soles'; and 'seek out local advice on your intended fishing spot-tidal behaviour and accessibility'. Life Saving Victoria confirmed that their campaign had translated into little or no uptake of life jacket use by those undertaking rock fishing.

17. It was also identified that the New South Wales (NSW) government had recently proposed new legislation that would make wearing life jackets whilst rock fishing mandatory. ABC news reported on 2 July 2015,[3] that the NSW Deputy Coroner Carmel Forbes had noted that life jackets should be mandatory and that the cost of the proposed measure would be 'far outweighed by the saving of lives and subsequent reduction of social and financial costs associated with the loss of lives in rock fishing'.

18. On 7 February 2016, ABC news reported that the NSW government had pointed to 37 rock-fishing related deaths in the state over the past four years.[4] The article also noted that there would be a 12 month grace period before the laws were brought in, and that the law would be difficult to police.

Further investigation

19. I also sought a statement from Parks Victoria in relation to the suitability of the area at Cape Bridgewater for rock fishing. Bernadette Hoare, Acting Area Chief Ranger, Glenelg Area and Portland for Parks Victoria, provided a statement to the Court dated 28 October 2015.

20. Ms Hoare noted that Parks Victoria has no designated tracks to the water's edge in this area, and that the coastal cliffs in the vicinity are the highest in Victoria. Rock fishing can be performed in this area, but due to very large and dangerous waves reaching the shore, signage asks people to stay away from cliff edges. Ms Hoare stated that Discovery Bay Beach, Whites Beach and Shelley Beach are the most suitable places in the area to fish. There are smaller rock faces in these areas, other than the steep cliffs between Shelley Beach and Discovery Bay. Ms Hoare advised the Court that since Mr Miles' death, further signage has been placed at the Blowholes Car Park, Whites Beach and along the cliff edge, stating 'Rock Fishing is Highly Dangerous'.

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[3] See: <http://www.abc.net.au/news/2015-07-02/deputy-coroner-wants-rock-fisherman-life-jacket-laws/6590418>

[4] See: <http://www.abc.net.au/news/2016-02-07/nsw-government-to-force-rock-fishers-to-wear-lifejackets/7146854>

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. I acknowledge and endorse the comments and recommendations made by Coroner Heather Spooner in the Findings following the Inquest into the deaths of Theam Chheng,[5] Shida Li,[6] and Liangwei Wang,[7] delivered on 20 April 2011. Her Honour noted inter alia that '[A]ppropriate signage is essential and the revised Safety Management Plan for Rock Fishing has highlighted several key safety factors for all those rock fishes who wish to participate in this extremely high risk sport. Foremost among them is wearing a personal floatation device, educating Culturally and Linguistically and Diverse communities, overcoming difficulties and delays in communicating with emergency services and locating and responding to rock fishing emergencies that occur in regional and/or remote locations.'

2. Coroner Spooner recommended that 'the Safe Management Plan for Rock Fishing be adopted by those agencies who participated in the safety management process including; Parks Victoria, Fisheries Victoria, Life Saving Victoria, VRFish, Australian National Sportfishing Association Limited (ANSA) and the Bass Coast Shire Council.'

3. I note that the responses to Coroner Spooner's recommendations, particularly in relation to the wearing of Personal Floatation Devices (PFDs), were mixed. Parks Victoria responded that it was 'pleased that the use of PFDs has been highlighted as a priority in the comments and recommendations... Parks Victoria continues to strongly support the use of PFDs by all rock fishers as an effective strategy to reduce rock fishing fatalities'. In addition, Life Saving Victoria wrote that it had 'identified that wearing a PFD should be a prominent communication focus in all public awareness messaging and as such will continue to communicate wearing of PFDs in all media and resources as a safety priority.'

4. In contrast, the Victorian Branch of ANSA responded that it did not believe that mandating the use of PFDs is appropriate for rock fishers. This stance was because the organisation believed: PFD Type 1s have a warning printed on them to the effect that their effectiveness is considerably reduced in rough or breaking seas and surf; the design of the PFD may have serious consequences for a rock fisher washed into the sea and PFDs with inherent built-in

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[5] COR 2009 3741

[6] COR 2009 5959

[7] COR 2009 6036

buoyancy may be more effective in a rock platform environment when compared to inflatable types that provide less protection from buffeting against rocks with the added risk of rupture; PFDs may give the wearer a false sense of security leading to fishing sessions best left for another day; the cost for some fishers will be an issue inevitably leading to ignoring any mandatory requirement to use PFDs.

5. On balance, I am persuaded that the use of PFDs would be a sound strategy to tackle the continuing problem of too many deaths occurring from rock fishing. Arguments against the use of PFDs; such as the difficulties of enforcing the uptake, some PFDs are more effective than others in rough swells, and the idea that they might convey a false sense of security, are somewhat meagre in the face of consistent deaths.

6. In this context, and in light of the fact that Life Saving Victoria's 2013/2014 Annual Report suggested there has been little to no uptake of life jacket usage by people who participate in rock fishing, a strong preventative approach, such as that slated for adoption in NSW, is justified.

RECOMMENDATIONS

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

1. With the aim of preventing like deaths and encouraging a consistent national legislative framework, I recommend that the Hon. John Eren MP, the Victorian Minister for Sport, consider implementing laws in Victoria that mandate the use of Personal Floatation Devices while rock fishing.

FINDINGS

On the evidence available to me, it appears that Mr Miles died in circumstances that were preventable. By rock fishing on a relatively inaccessible outcrop, in a remote area, with rough swells, and with no life jacket, Mr Miles was exposed to considerable risk of injury.

I accept and adopt the medical cause of death as identified by Dr Jacqueline Lee and find that Daniel Michael Miles died from drowning.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Mr Peter Miles

The Hon. John Eren MP, the Victorian Minister for Sport

Parks Victoria

Life Saving Victoria

Australian National Sportfishing Association Limited (Victorian Branch)

First Constable Nathan Cashion

Signature:

AUDREY JAMIESON

CORONER

Date: **22 April 2016**