FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 1473/09

In the Coroners Court of Victoria at Melbourne

I, Kim M. W. Parkinson, Coroner

having investigated the death of:

Details of deceased:

Surname: ROLTON
First name: DARYL
Address: 12 WRIGHT COURT, WODONGA, VICTORIA, 3690

without holding an inquest:

find that the identity of the deceased was DARYL MARK ROLTON
and death occurred on 7th February, 2009
at Albury Base Hospital, Albury, New South Wales 2640

from
1a. ASPHYXIA DUE TO DROWNING

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Mr Daryl Rolton was a 27 year old man, born 23 August 1981. He resided at 12 Wright Court, Wodonga with his sister, Ms Anne Marie Rolton and her children.

2. Senior Constable Chris Grimmett of Victoria Police at Wodonga provided an extensive brief to the Coroner setting out police investigations into the death. I have drawn on this material as to the factual matters in this finding.

3. Mr Rolton was diagnosed with an intellectual disability and was in receipt of services delivered by the Department of Human Services. He had a long history of alcohol addiction and was undertaking community based sentencing dispositions under the supervision of Department of Corrections Victoria. He had a number of supervisory orders outstanding and had been assessed for services to assist him with his alcoholism and his intellectual disability, in the context of his offending behaviour.

4. On 6 and 7 February, 2009 Mr Rolton had been drinking alcohol until the early hours of the morning with a friend, Ms Melissa Bryan. Ms Bryan reported that they had consumed significant amounts of alcohol before falling asleep. At approximately 6am on 7 February, Mr Rolton woke and began to drink more alcohol. At approximately 5pm Ms Bryan, Ms Peggy Ferguson and Mr Rolton took three children in their care to the Wodonga Creek, a tributary of the Murray River, for a swim. The day had been very hot, reaching 44.8 centigrade. They attended at a popular swimming spot known as the Stock Route Bridge, Wodonga Creek. Mr Rolton had been drinking all day and continued drinking on the way to and after arrival at the swimming spot.

5. Witnesses report that Mr Rolton was apparently under the influence of alcohol when he arrived. Witnesses stated that they observed him in an intoxicated state and that he was seen to be stumbling and falling into the water. He entered the water near the bridge and stood near a bridge pylon where he continued skylarking.

6. Ms Bryan reports that she attempted to discourage him from entering the water and tried to talk him into returning to the shore. She watched him stumble in the water, saw him sway and then shortly afterwards he disappeared under the water and did not resurface. This is consistent with the observations of other witnesses.

7. Ms Rolton raised the alarm and police and a number of people already at the site commenced to look for Mr Rolton, including a group of young men. One of their number, Mr Mark Bell entered the river and located Mr Rolton submerged approximately 50 metres downstream from where he had last been seen. He rescued him from the water, commencing resuscitation efforts as he took him to shore. By the time Mr Rolton was brought to the surface he had been submerged for between 7 to 15 minutes. Police continued resuscitation at the shore. Paramedics attended and obtained a cardiac output. Mr Rolton was transported to Albury Base hospital.

8. An Autopsy was performed by Dr Douglas Oxbrow who reported that the cause of death was asphyxia, by drowning with alcohol intoxication a contributing factor. The toxicology analysis of ante-mortem blood samples identified a blood alcohol level of 0.209g/100mL. This is an amount in excess of four times the prescribed legal limit for driving a motor vehicle and suggests a significant level of intoxication.

9. Mr Rolton was reportedly a strong and confident swimmer. Whilst flowing waterways, such as rivers and creeks are often subject to strong currents, undertow, irregular footing and snags, the area is a popular swimming hole utilised by families and save for the usual requirements for precaution in any open flowing water area, does not appear on the evidence before me to be unusually difficult or dangerous water.

10. It is unclear how Mr Rolton came to get into difficulty in the water, whether by loss of footing, cramp or otherwise, however he entered the water in an intoxicated state. I am satisfied that it may reasonably be concluded that his consumption of alcohol and level of intoxication contributed to his inability to respond to the difficulty and to prevent himself drowning.

11. Police report no suspicious circumstances. I am satisfied on the evidence before me that there are no matters which require further investigation. I am satisfied that Daryl Rolton died on 7 February 2009 as a result of asphyxia by accidental drowning in circumstances where he was alcohol affected.

COMMENTS:

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

1. The consumption of alcohol in any quantity prior to swimming and particularly in excess, as in this case, is a dangerous activity. This fact has been well publicised by life-saving organisations and public health authorities over many years and in many forms of media. It is difficult to understand why people do not take notice of this most basic of safety messages.

2. Despite extensive campaigns in the past, it is apparent that there remains a requirement for this message to be continually publicised and perhaps with greater emphasis on country and regional areas.

3. Information obtained from Life Saving Victoria[1] by the Coroners Prevention Unit records that between July 2000 and June 2009 there were 108 drowning deaths in inland waterways in Victoria. This figure represents 33% of drowning deaths in Victoria. Alcohol was detected in 30% of those drownings. Most alcohol related drowning deaths involved males (82%).

[1] Life Saving Victoria is a body established in 2002 at the initiative of The Royal Life Saving Society Australia Victoria Branch and Surf Life Saving Victoria.

4. Included in the total 108 deaths were 56 drowning deaths in rivers, that is, almost half of inland waterway deaths were in rivers or their tributaries as in this case. Alcohol was detected in 21 of the deaths and no alcohol detected in 23 cases, that is almost half of drowning deaths in rivers. Alcohol continues to be a significant contributing factor to death by drowning in inland waterways and particularly rivers.

5. Life saving organisations are highly respected and are regarded as effective communicators of water safety messages. To that end consideration might be given by State and Local Governments to the provision of additional funding to life saving organisations to continue to promote public safety messages focused upon the danger of alcohol related drowning in country and regional areas.

RECOMMENDATIONS:

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

1. I recommend that State and Local Government provide funding to life saving organisations, to enable them to continue to promote public safety messages as to the danger of alcohol related drowning, specifically in country and regional areas.

2. I direct that a copy of this finding be provided to the Minister for Local Government Victoria, the Municipal Association of Victoria and Life Saving Victoria and to the New South Wales Coroner at Albury.

Signature:

Kim M. W. Parkinson
Coroner
Date: 4 May 2010

Court Reference: 1473 / 09

FORM 1

Rule 21

AFFIDAVIT OF SERVICE

Section 55(2)(a) of the ***Coroners Act 2008***

In the matter of the investigation/inquest into the death of Daryl Rolton

I, Christianne Borovec of 1/436 Lonsdale Street, Melbourne VIC 3000 in the State of Victoria make oath and say that—

1. At 11:30am ON 25 June 2010 at 1/436 Lonsdale Street, Melbourne VIC 3000, I served Minister Richard Wynne (GPO Box 2392 Melbourne Vic 3001 Australia) with the following document(s):
   a) Finding into Death without Inquest of Daryl Rolton by Coroner Parkinson dated 4 May 2010

2. The method of service was by Registered Post.

3. True copies of the documents served are attached.

SWORN/DECLARED by the deponent

At Melbourne

On : 25/6/10

Before me: Registra