IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 1011

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 JEFFREY COOTE

without holding an inquest:
find that the identity of the deceased was JEFFREY COOTE
born 1 September 1933
and the death occurred on 1 March 2017
at the beach outside Rye Yacht Club, 2120 Point Nepean Road, Rye, Victoria 3941
from:

1 (a) DROWNING IN A MAN WITH ISCHAEMIC HEART DISEASE

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

1. Jeffrey Coote was 83 years of age at the time of his death. He was a retired police officer and lived in Cape Schanck with his wife of 62 years, Jeanette. He had a medical history that included Type 1 diabetes mellitus, three coronary artery bypass grafts, peripheral vascular disease, hypertension and hypercholesterolaemia.

2. On the morning of 1 March 2017, Mr Coote got up and went through his normal ritual of caring for his wife, bringing her a cup of tea and breakfast and helping her around the house, until her carer arrived to assist with things that he was unable to do. As his daughter Joanne was also visiting, Mr Coote took the opportunity to have some time out, which normally consisted of either golf, bike riding or paddling his surf ski. At approximately 10:15am, Mrs Coote and Joanne left the house so as Mrs Coote could attend an appointment with a dietician at Rosebud Hospital. Mr Coote did not mention how he planned on spending his time off, but agreed to call around 11:00am to arrange a place to meet them.

3. At approximately 10:45am, Benjamin Peter and Clayton Greenbury were riding their jet skis in the ocean around Rosebud when Mr Peter saw a board in the water. As he drew closer, he realised that it was a surf ski that had flipped over and there was a male person, later identified as Mr Coote,[1] in the water attached to the surf ski by a waist strap. Mr Peter immediately came to shore and flagged down people on the beach, asking them to contact emergency services, before running to the Rye Yacht Club to seek assistance. Mr Peter then boarded Mr Greenbury's jet ski, and the two men went back out to Mr Coote and brought him to shore. Members of the public commenced cardiopulmonary resuscitation and used a defibrillator obtained from the yacht club, before ambulance paramedics arrived and took over. Mr Coote was unable to be revived and was declared deceased at 11:10am.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy upon the body of Jeffrey Coote, reviewed a post mortem computed tomography (CT) scan, medical records from Peninsula Private Hospital and South Coast Medical – Rye Clinic and referred to the Victoria Police Report of Death, Form 83. Dr Francis noted bilateral pleural effusions with full, heavy lungs and some clear frothy fluid within the airways. She also noted natural disease in the form of cardiomegaly (enlarged heart) and significant coronary artery atherosclerosis, in addition

[1] Mr Coote was tentatively identified at the scene based on a comparison with his driver's license photo. He was later formally identified visually by his wife.

to a coronary artery stent and coronary artery bypass grafts with a remote posterior left ventrical infarct. Toxicological analysis conducted on Mr Coote's post mortem blood did not detect any alcohol or commonly encountered drugs or poisons.

5. Dr Francis stated that the autopsy diagnosis of drowning can be difficult and is essentially one of exclusion as there are no specific signs. Some signs seen in classical drowning include a foam plume around the mouth (which can quickly disappear), heavy and overdistended lungs, blood stained fluid within the airways and in some cases, pleural effusions may be present. She stated that the circumstances and autopsy findings in this case were consistent with drowning.

6. Dr Francis reported that coronary artery atherosclerosis occurs when there is a build-up of cholesterol and other material in the blood vessels supplying oxygen and other nutrients to the heart. When the narrowing of the vessel becomes significant, this can cause the supplied area of heart muscled to die (myocardial infarction) or it may cause arrhythmias (disturbance in the nervous system regulating the heart beat). Both of these can result in sudden death. If there was a short time interval between the onset of the arrhythmia and death then ischaemic changes may not be identifiable at autopsy. Dr Francis ascribed the cause of Jeffrey Coote's death to drowning in a man with ischaemic heart disease.

Police investigation

7. Upon attending the scene of Mr Coote's death, police did not identify any suspicious circumstances or evidence of third party involvement. They noted that Mr Coote was wearing a long sleeved top, shorts and brown sandals, and was not wearing a personal flotation device (PFD). They were unable to locate a PFD at the scene. Mrs Coote later confirmed that her husband never wore a PFD when using the surf ski, even in the surf, and did not actually own one. When canvassing for witnesses, police identified a member of the public who had noticed a surf ski around 150 metres offshore at approximately 10:30am and viewed it through binoculars, but was unable to see a person attached to it and thought that it must have been abandoned.

8. The surf ski was assessed by Water Police investigators, who did not detect any defects or faults and determined that it was suitable for paddling in good conditions. Data obtained from the Bureau of Meteorology showed that on 1 March 2017, the temperature was between 17 and 31 degrees Celsius and there was a north east wind between seven and 10 knots. Go Pro footage obtained by police from Mr Peters showed that these conditions produced a 'glassy' effect on the water with no wave height, which were considered suitable conditions for paddling.

9. Leading Senior Constable (LSC) David Pearson was the nominated coroner's investigator.[2] At my direction, LSC Pearson conducted an investigation of the circumstances surrounding Mr Coote's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mrs Coote, Mr Peter and general practitioner Dr Miro Milanko.

10. In the course of the investigation, police learned that Mr Coote and his wife met as teenagers at the Mordialloc Life Saving Club (MLSC), where they were later made life members, and married in 1955. They had three children. Mr Coote had been involved in water activities his whole life, and up until his late 70s, competed on his surf ski in Torquay and at other destinations along the coast. He remained heavily involved with the MLSC.

11. Mrs Coote reported that her husband joined Victoria Police in 1955, and reached the rank of Detective Sergeant before retiring in the 1970s due to difficulties with his diabetes. He remained very active in retirement, continuing to enter surf ski competitions and purchasing his own surf ski in the 1990s which he continued to use until his death. Mrs Coote stated that her husband also had triple bypass surgery in 2014 at the Peninsula Private Hospital, however he recovered well and was soon back to doing physical activities including playing golf, paddling, working around the house and chopping wood. Mr Coote also walked their dog every day.

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[2] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

12. General practitioner Dr Miro Milanko of South Coast Medical – Rye reported that Mr Coote consulted him for management and treatment of his health conditions. Dr Milanko noted that at the end of February 2017, Mr Coote developed cellulitis of his right lower leg which was not responding to oral antibiotics. He advised Mr Coote to present to the emergency department of Rosebud Hospital for intravenous antibiotic treatment, however Mr Coote had not commenced treatment prior to his death. His health issues were otherwise well controlled.

13. Mrs Coote noted that while her husband was generally fit and healthy for his age, he would occasionally make unusual decisions when his insulin levels were low. On one occasion, he wanted to go on a bike ride just before dinner, or he would leave the house at random times. Upon returning, he would test his insulin levels and realise that he should not have been doing what he was doing as his insulin levels were low.

COMMENTS

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

1. This investigation highlights the importance of wearing a PFD when engaged in recreational activities on our waterway, whether boating or on human-powered vessels. Use of a PFD is particularly important during solo activities, or in remote locations, when self-rescue may be difficult and assistance not readily available.

2. Unfortunately, the failure to use PFDs has been a feature of a number of coronial investigations, including the recent cases of Ashton Meadows[3] and Nicholas Smith[4] where the additional safety benefits of the Personal Locator Beacon (PLB) or Emergency Position Indicating Radio Beacon (EPIRB) to timely notification of rescue services was identified in the event of a medical situation, distress or other emergency.

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[3] Coronial Reference Number 2014/2978.

[4] Coronial Reference Number 2016/1799.

FINDINGS

The investigation identified that Mr Coote had been involved with water activities since his early teenage years and had previously participated in surf ski competitions. Despite his medical history, he was generally of good health and was very active for his age. Mr Coote continued to ride his surf ski within Port Phillip Bay, but had an unfortunate habit of not wearing a PFD.

On the evidence before me, I am unable to determine the circumstances in which Mr Coote capsized his surf ski and ultimately drowned, however the possibility that he had a fall precipitated by a medical event, such as a myocardial infarction, or low insulin levels, and was then unable to extricate himself cannot be excluded.

I accept and adopt the medical cause of death as ascribed by Dr Francis, and find that Jeffrey Coote died of drowning in a man with ischaemic heart disease.

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

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

Mrs Jeanette Coote
Leading Senior Constable David Pearson
Transport Safety Victoria

Signature:

AUDREY JAMIESON
CORONER
Date: **19 January 2018**