IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5253

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**MARK JORDAN-HILL**
Date of birth:	21 November 1969
Date of death:	5 November 2016
Cause of death:	Drowning
Place of death:	Approximately 500 metres off Whites Beach, Torquay, Victoria

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HER HONOUR:

BACKGROUND

1. Mark Jordan-Hill (**Mr Jordan-Hill**) was a 46-year-old man who lived at Winchelsea with his wife, two children, and niece and nephew at the time of his death.

2. Mr Jordan-Hill was self-employed as a fencing contractor and farmer. He was in good physical health and did not suffer from any known medical issues at the time of his death.

3. Mr Jordan-Hill took up paddling approximately three years before his death. His sons and nephew decided to compete in the Lorne Anaconda Adventure Race as a team and needed a paddler. Mr Jordan-Hill received lessons from Tim Altman (**Mr Altman**) and purchased a ski from him.

4. Mr Jordan-Hill subsequently competed in various ocean paddling events and was a confident paddler. He was a member of the West Coast Paddlers Facebook group, which is used by local people in the Surf Coast area of Victoria to meet for informal paddles at various locations.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Jordan-Hill's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was both unexpected and not from natural causes.[1]

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

7. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

8. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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[1] Section 4 *Coroners Act 2008*
[2] Section 89(4) *Coroners Act 2008*
[3] *Keown v Khan* (1999) 1 VR 69

9. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

10. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

11. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

12. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] 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 that they caused or contributed to the death.

13. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

14. On 7 January 2016, Shane Jordan-Hill identified the Deceased to be Mark Jordan-Hill, born 21 November 1969.

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[4] (1938) 60 CLR 336

15. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

16. On 9 November 2016, Dr Michael Burke (**Dr Burke**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Jordan-Hill's body. Dr Burke provided a written report, dated 23 November 2016, which concluded that Mr Jordan-Hill died from *"Drowning."*

17. Dr Burke commented that the post-mortem examination should no evidence of any injury or any natural disease process which would have contributed to or led to death.

18. Toxicological analysis of post mortem specimens taken from Mr Jordan-Hill were negative for common drugs or poisons.

19. I accept the cause of death proposed by Dr Burke.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

20. On 4 November 2016, Mr Jordan-Hill made contact with Mr Altman, who was also a member of the West Coast Paddlers Facebook group. Mr Altman had organised a paddle to take place on 5 November 2016, from Point Roadknight in Anglesea to Fisherman's Beach in Torquay. The approximate distance of this paddle was 11 nautical miles. Due to the predicted weather, which was forecasted winds of 25 to 30 knots and a solid swell, the proposed paddle was only suitable for experienced paddlers. Mr Jordan-Hill organised to meet Mr Altman on the morning of 5 November 2016 at Point Danger in Torquay to survey the conditions.

21. At 7.00am on 5 November 2016, Mr Jordan-Hill met Mr Altman at Point Danger. They subsequently drove their vehicles to Fisherman's Beach, which was their final destination. They left Mr Jordan-Hill's vehicle at the final destination and travelled back to Point Roadknight in Mr Altman's vehicle with both ocean skis.

22. At approximately 8.00am, Mr Altman and Mr Jordan-Hill launched their skis at Point Roadknight. Mr Jordan-Hill left first so that Mr Altman could check that his co-paddler could handle the conditions.

23. According to the coronial brief prepared by Coroner's Investigator, Leading Senior Constable Jarrod Roberts, they paddled to an area off Red Rock at Anglesea, which is

approximately 3.5 nautical miles from Point Roadknight. This was approximately a third of the way through the paddle. Mr Jordan-Hill told Mr Altman that he was feeling relaxed despite the choppy and windy conditions. Mr Altman passed Mr Jordan-Hill and continued on to Fisherman's Beach.

24. According to the coronial brief, Mr Jordan-Hill fell into the water somewhere between Point Danger and Fisherman's Beach. His leg rope detached from the ski, which was washed away.

25. At 9.54am, Mr Jordan-Hill used his mobile telephone, which was in a waterproof bag around his neck, to call Mr Altman for assistance. At this time, Mr Altman was back on shore. Mr Jordan-Hill informed him that he had come out of his ski approximately 500 metres from Bombora's Café, which is at the top end of the boat ramp at Fisherman's Beach. At this time, Mr Altman was with Peter Currie (**Mr Currie**) at Fisherman's Beach. Mr Altman ran to his vehicle and changed into a wetsuit before borrowing a Surf Life Saving Spec ski from Mr Currie to look for Mr Jordan-Hill. Mr Altman told his friend, Nikki McMillan (**Ms McMillan**), to contact emergency services if he did not return within 30 minutes. Mr Altman searched for approximately 45 minutes before returning to shore.

26. Mr Jordan-Hill made three further calls to Mr Altman. During the final call, at 10.14am, Mr Jordan-Hill left a voice message in which he can be heard to be slurring his words.

27. At 10.15am, Mr Currie telephoned Scott Tannahill (**Mr Tannahill**) from the Torquay Surf Life Saving Club and requested an Inflatable Rescue Boat to assist with the search. However, the boat could not be launched due to the conditions. Mr Currie subsequently attended the Torquay Rescue building, but was unable to locate a direct number for Torquay Marine Rescue before his mobile telephone battery went flat.

28. At approximately, 10.20am, Mr Tannahill arrived at Fisherman's Beach to assist with the search. At 10.27am, he contacted emergency services. At approximately 10.30am, Ms McMillan contacted Surf Life Saving Communications to report the incident. The Victoria Police Air Wing was immediately tasked and an Air Ambulance was dispatched.

29. At 11.08am, Senior Constable Tracey Van Looy called Mr Jordan-Hill. The call was answered and lasted for 53 seconds, however, only the sound of gushing water could be heard. At 11.09am, Mr Jordan-Hill telephoned his friend, David Kininmonth. Similarly, only gushing water could be heard.

30. At approximately 11.20am, the Police Air Wing arrived overhead at the scene. Almost immediately, the Police Air Wing observed Mr Jordan-Hill face down in the water. He was between 100 and 400 metres from shore. The Police Air Wing dropped an orange smoke signal and directed Torquay Marine Rescue to the area, where they were able to recover Mr Jordan-Hill.

31. Once on shore, members from Torquay Marine Rescue commenced cardiopulmonary resuscitation before ambulance paramedics arrived. Although paramedics continued resuscitation attempts upon arrival, they were unable to revive Mr Jordan-Hill.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

The weather conditions on the day of the accident

32. According to the coronial brief, the weather conditions on 5 November 2016 in the Torquay area were overcast with strong winds. Between the times of 7.00am and 11.00am, the wind gusted between 20 and 35 knots and the air temperature ranged between nine and 14 degrees. The water temperature was between 14 and 16 degrees. The swell was from the South West and was one of the largest of the year. Offshore waves were in the three to four metre range. Large waves were breaking completely across the area between Point Danger and the area known as the Gap, which only occurs a few days a year. Fisherman's Beach lies between Point Danger and the Gap, which meant the paddlers would have been challenged in avoiding the breaking waves.

33. According to Mr Altman, he discussed the safest route with Mr Jordan-Hill upon arriving at Point Roadknight. They determined the only threat of danger was the swell coming around from Point Danger and they both agreed to take a *"conservative line,"* which was high and wide off Point Danger to avoid the white water. According to Mr Altman, he had seen Mr Jordan-Hill paddle in similar conditions and his skill level meant he was capable of completing the proposed paddle.

34. According to Mr Currie, who is also an experienced paddler, the area in which Mr Altman and Mr Jordan-Hill paddled could be quite dangerous at low tide with a large swell. Mr Currie states that although the wind conditions were excellent, there was a low tide at 10.00am and he was relieved that he did not do the paddle from Point Roadknight that day. Mr Altman and Mr Jordan-Hill checked the conditions at 7.00am from Point Danger, which was three hours before the low tide. When he spoke to Mr Altman on the water in Zeally Bay, Mr Altman told him that he had to *"pick his way in."* Mr Currie expressed surprise

when he was informed that Mr Jordan-Hill was paddling with Mr Altman, as he thought it would have been a challenging paddle for him.

35. According to Andrew Kay (**Mr Kay**), member of the Torquay Marine Rescue, the conditions were poor. The winds were 30 to 35 knots and the waves were from six to seven feet. Mr Kay states that the conditions were terrible for a kayaker.

Equipment used by Mr Jordan-Hill

36. According to the coronial brief, Mr Jordan-Hill used a Stellar Racer ocean ski, which was in excellent condition. This model of ski is aimed at the intermediate paddler and is designed to paddle in open water and catch unbroken waves (it is not designed to catch broken waves). Mr Jordan-Hill also wore a Mocke Racer personal flotation device, used a leg rope attached to the ski and carried a mobile telephone and an emergency distress flare.

37. The leg rope used by Mr Jordan-Hill is not fitted as a standard feature on this ski model. He used a XM power clip model, which is designed to be used with stand-up paddle boards. The attachment on this leg rope is designed with a 'breakaway' clip attached to the user's lower leg. This is a feature that allows the operator to pull a small release pin and the leg rope will detach to avoid the operator being pulled under the water with their board in large waves or other hazardous conditions. The leg rope is not designed to be used on an ocean ski.

38. When he was found, Mr Jordan-Hill had the leg section of the leg rope attached to himself and the breakaway clip was still in place, but the cord connecting him to the ski had been detached.

Delay in contacting emergency services

39. I note that the first contact to emergency services was 33 minutes after Mr Jordan-Hill's initial call for assistance. When the Police Air Wing responded, they located Mr Jordan-Hill almost immediately once overhead at the scene. He was recovered minutes later.

40. A more timely notification to emergency services, or the activation of a Personal Locator Beacon or an Emergency Position Indicating Radio Beacon (which transmits a distress signal to satellites in order to alert relevant authorities to the existence of an emergency), may have led to Mr Jordan-Hill spending less time in the water and a timelier search and rescue operation.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

41. I recommend that the Department of Economic Development, Jobs, Transport and Resources consider reviewing current regulatory safety requirements for operators of human-powered recreational vessels by requiring operators to carry and/or fix Emergency Position Indicating Radio Beacons and/or Personal Locator Beacons (preferably those with GPS capability) onto their Personal Flotation Devices (with no limitations as to distance from the coast). This has the potential to significantly increase the timeliness of notifications to emergency services, and any subsequent search and rescue operation.

FINDINGS AND CONCLUSION

42. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Mark Jordan-Hill, born 21 November 1969;

    (b) the death occurred on 5 November 2016, approximately 500 metres off Whites Beach, Torquay, Victoria, from drowning; and

    (c) the death occurred in the circumstances described above.

43. I convey my sincerest sympathy to Mr Jordan-Hill's family.

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

    (a) Philippa Jordan-Hill, senior next of kin;

    (b) Transport Safety Victoria;

    (c) Department of Economic Development, Jobs, Transport and Resources; and

    (d) Leading Senior Constable Jarrod Roberts, Victoria Police, Coroner's Investigator.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 8 January 2018.