IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2478

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Jacqui Hawkins
Deceased:	Desmond John Watson
Date of birth:	16 May 1952
Date of death:	27 May 2017
Cause of death:	I(a) Neck trauma and severe ischaemic heart disease in the setting of immersion
Place of death:	Gunnamatta Beach, Fingal, Victoria, 3939

BACKGROUND

1. Desmond John Watson was 65 years old at the time of his death and lived in Armstrong Creek with his wife, Anne Watson. Mr Watson was an experienced kneeboarder and was very capable in the water. He enjoyed attending kneeboarding club events and was described as a great friend to many people.

2. Mr Watson had a medical history of hypertension, cervical vertebral fusion (C5-7) anterior approach in 2013, renal calculus and right dorsal thoracic spine pain.

3. Mr Watson's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008*.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability[1].

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Watson's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

6. In writing this Finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

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

Identity of the deceased

7. Mr Watson was visually identified by his brother in law, Tim Ryan, on 27 May 2017. Identity was not in issue and required no further investigation.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

Medical cause of death

8. On 30 May 2017, Dr Essa Saeedi, Forensic Pathology Trainee under the supervision of Dr Sarah Parsons, Forensic Pathologist, at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Mr Watson and reviewed the Form 83 Victoria Police Report of Death, medical records from Surf Coast Medical Centre, and the post mortem computed tomography (CT) scan.

9. The autopsy revealed extensive ischaemic heart disease, haemorrhage involving the posterior neck muscles, the atlanto-occipital membrane, and the extradural aspect of the cervical spinal cord. Three blunt force fractures to the face and anterior rib fractures were also observed.

10. Dr Saeedi noted that coronary artery disease is caused by narrowing of the blood vessels that supply the heart with blood and oxygen. This usually occurs because of the accumulation of cholesterol within the walls of these vessels. As a result, the heart does not receive the required oxygen and nutrients, which can lead to myocardial infarction and/or a fatal arrhythmia. Mr Watson had several risk factors for developing ischaemic heart disease, which included hypertension and his age.

11. The neck injury may have resulted in hyperextension or hyper-flexion of the neck, which leads to death suddenly by impeding onto vital structures at that level that include the cardiorespiratory centres of the lower brain stem, or by causing paralysis of the diaphragm that impedes breathing.

12. Dr Saeedi considered possible reasons for Mr Watson's fall from the board. Firstly, he could have had a cardiac arrhythmia that caused a fall, which led to the neck injury. Secondly, he may have sustained the neck injury and lost consciousness and drowned, or thirdly, a combination of both.

13. Toxicological analysis of post mortem blood did not detect the presence of alcohol, common drugs or poisons.

14. Dr Saeedi provided an opinion that the medical cause of death was 1(a) NECK TRAUMA AND SEVERE ISCHAEMIC HEART DISEASE IN THE SETTING OF IMMERSION.

15. I have advised the Registrar of Births, Deaths and Marriages of the amended cause of death, which comprises the insertion of the word 'disease'.

Circumstances in which the death occurred

16. On the morning of 27 May 2017, Mr Watson attended Rye back beach to compete in the 2017 Victorian State Kneeboard Titles. A permit to hold the competition had been obtained from Parks Victoria, and a trained, remote area first aid officer (one of the judges), was in attendance. The waves at Rye back beach were not breaking well enough, and a decision was made to relocate the competition to Gunnamatta Beach.

17. At Gunnamatta Beach, there was a northerly wind of approximately 20-25 km/h, the waves were approximately four to six feet high with a left-hand break to the east, and a right-hand break to the west. There was a visible rip running out to sea along the 'lefthander'. The tide was coming in, but the event was expected to finish before the tide turned and potentially change conditions. The competition was set up on the viewing platform of the 'First Car Park', which is approximately 30 metres from where the event trailer was parked.

18. The event began at about 8.30am. All of the surfers were to compete in the first round, with the first and second placegetters progressing to the open final, and the third and fourth placegetters progressed to the B grade final. Each heat lasted approximately 20 minutes. None of the competitors complained about the conditions.

19. Mr Watson placed third in the first round and progressed to the B Grade Final. The competitors were all surfing the right-hand break, and the conditions had not altered since 8.30am. One of the competitors stated that there were two breaks that could be surfed. One break was to the south east, and was larger with better waves, but was riskier. A smaller, but safer break was available to the north east. Mr Watson opted for the former. He was described as looking very confident and comfortable in the conditions. The conditions were described by Tim Ryan, Mr Watson's brother-in-law as challenging but not dangerous.

20. About 10 minutes before the conclusion of the B Grade Final, Mr Watson caught a powerful wave and was seen over towards the channel, to the east of the judging tower. His board was seen to fly vertically up in the air before a wave closed over it. After the wave had subsided, his board floated to the surface. Mr Watson then rose to the top of the water, face down, and began to be swept towards the rip and back out again. The judges observed Mr Watson and at first, they thought that he might have been adjusting his leg rope. However, when he did not get up, the competition horn was sounded, the flags dropped, and an ambulance was requested. Dave Rosenbrook, one of the judges, used hand signals to other competitors in the water to retrieve Mr Watson. Another judge, Aaron Weeks, marshalled surfers on the beach to paddle out to Mr Watson. It was decided not to use a rescue board because there was too much white

water to duck-dive the board through, however by this point, seven experienced surfers went out to assist with the rescue.

21. When the first group of surfers reached Mr Watson, cardio pulmonary resuscitation (CPR) was attempted in the water while providing air via breaths. More surfers paddled up, and one attempted chest compressions in a 'bear hug' type fashion. However, the heavy conditions and the surfer's boards hampered their efforts. Accordingly, a decision was made to get Mr Watson to shore as soon as possible, and he was placed on a board and paddled towards the shore. During this time Mr Watson was hit by a wave and fell into the water. His location was unknown for a short period until he resurfaced. Mr Watson was placed on the board again and transported to shore. Estimates varied in relation to the length of time that it took to bring Mr Watson to shore, however it appears that it took a significant amount of time.

22. When Mr Watson reached the shore, he was not breathing and was unconscious. An injury to his nose was observed. Attempts were made to remove water from his airways and CPR was continued by a bystander and Victoria Police while Ambulance Victoria administered other treatment. Despite all best efforts, Mr Watson could not be revived.

Coronial investigation

23. Victoria Police immediately commenced a coronial investigation.

24. Kneeboard Surfing Victoria (KSV) provided a generic Risk Management Plan dated 10 December 2016. After control measures were put in place, minor injury in the surf was assessed as being unlikely. Similarly, the likelihood of major injury in the surf was assessed as a rare occurrence.

25. A Risk Assessment for Events by Surfing Victoria was also provided as part of the coronial brief. The likelihood of a competitor sustaining an injury from a board was assessed as being at a rate of one incident per year. The risk of a competitor (or staff member or member of the public) needing to be rescued from the water was assessed as unlikely. It concluded that it was only plausible that an incident might happen over a five to ten-year period.

26. Robert Andronaco, Risk and Spatial Analyst Specialist for Life Saving Victoria provided a report and suggested that a suite of options could be considered in the context of a risk management plan for Gunnamatta Beach. These included establishing a working group to facilitate the development and implementation of a risk management plan. It was also suggested that proactive measures could be put in place, such as reconfiguration of the carpark, which would divert traffic to an area adjacent to the lifesaving facility.

27. A report about Gunnamatta Beach was obtained from Life Saving Victoria (LSV). It had been drafted in response to the death of James Lin on 24 January 2016 (COR 2016 0350), which was investigated by Coroner Rosemary Carlin. LSV found that Gunnamatta Beach is an extremely dangerous beach, and over the past eight seasons, accounted for approximately 16% of all rescues across Victoria. The beach is characterised by pronounced changes in depth, which signifies the presence of large sandbars accompanied by adjacent troughs. Rips often form between the bars in the troughs. The presence of reefs also dictate the behaviour of rips and provide additional drop offs.

28. Coroner Carlin made two recommendations to LSV, the first of which was that Victoria Police liaise with LSV, local life saving clubs and other stakeholders for the purposes of establishing the Mornington Peninsula Surf Safety Working Group (MPSSWG). That recommendation was implemented, and the MPSSWG held its first meeting at Gunnamatta SLSC on 28 February 2018.

29. The second recommendation made by Coroner Carlin was that the surf safety working group give specific consideration to changes suggested by the President of the Gunnamatta SLSC. That recommendation was implemented, with Gunnamatta SLSC's suggested changes being tabled at the first meeting of the MPSSWG meeting for consideration and discussion.

30. Having considered the evidence I am satisfied that no further investigation is required.

FINDINGS

31. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

32. I find that:

    (a) the identity of the deceased was Desmond John Watson born 16 May 1952; and

    (b) Mr Watson died on 27 May 2017 from 1(a) *Neck trauma and severe ischaemic heart disease in the setting of immersion*;

    (c) in the circumstances described above.

33. I find that Mr Watson was an experienced kneeboarder and according to Mr Ryan competent in difficult water conditions. Based on the medical investigations by Dr Saeedi I am unable to determine whether Mr Watson had a heart attack or whether he was hit by his board or a combination of both.

34. I acknowledge the heroic efforts of the competitors and lifesavers at Gunnamatta Beach on the day in trying to perform CPR in the water, in extremely difficult conditions and in an attempt to get Mr Watson back to shore safely.

35. I wish to express my sincere condolences to Mr Watson's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

COMMENT

36. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comment:

> I note the Kneeboard Surfing Victoria's risk assessment was a generic assessment dated 10 December 2016. Whilst risk assessments are an excellent tool to assist organisers/administrators with the running of an event, conditions on each day of an event are never the same and can suddenly change. To ensure the safety of competitors a risk assessment should be conducted before each day of an event and I have made a recommendation to support this comment.

RECOMMENDATION

37. Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations:

> To KNEEBOARD SURFING VICTORIA – To ensure the safety of competitors at a Kneeboard Surfing Victoria Event, I recommend that Kneeboard Surfing Victoria should conduct a risk assessment prior to the commencement of each day before an event to take into consideration the location, weather, wind and surf conditions, and any other relevant conditions on the day of an event.

PUBLICATION

38. I direct that this recommendation be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

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

The family of Mr Watson;

Mr Jim Brown
President
Kneeboard Surfing Victoria
5 Hollydene Court
COWES VIC 3922

Mr Paul James
Life Saving Victoria
200 The Boulevard
PORT MELBOURNE VIC 3207

Mr Geoff Goullet
President of Gunnamatta Surf Life Saving Club
Truemans Road
FINGAL VIC 3939

Registrar of Births, Deaths and Marriages; and

Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 15 May 2019