IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5638
COR 2018 0135
COR 2018 0569
COR 2018 0641
COR 2018 6486
COR 2019 1061
COR 2019 4142

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Yik Sua Hong
Date of birth:	1 December 1938
Date of death:	On or after 29 October 2017
Cause of death:	1(a) Unascertained
Place of death:	Rye Back Beach – Number 16, Rye, Victoria

HER HONOUR:

Background

1. Yik Sua Hong was born on 1 December 1938. He was 78 years old when he died on or after 29 October 2017 from an unascertained cause of death, presumably after being swept out to sea.

2. Mr Hong was born in Cambodia. He and his wife, Nang Keo Tia, moved to Australia in 1979 and welcomed seven children into their family. At the time of his death, Mr Hong and his wife lived in Wantirna.

3. Mr Hong was a keen fisherman and would frequent Rye Back Beach with family and friends to fish off the rocks. His favourite fishing location was Beach Number 16. Here, there is a rock known as Dragon's Head. Mr Hong would usually continue past this rock to the west and fish off a rocky ledge at low tide. This was his regular fishing spot for over 15 years.

4. Mr Hong's medical history included mild hypertension, which was controlled with medication, and impaired glucose intolerance. He was otherwise in good health.

The coronial investigation

5. Mr Hong's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. Coroners independently investigate reportable deaths to find, 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. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

7. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

[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.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Coroner Rosemary Carlin initially had carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Hong's death. The Coroner's Investigator investigated the matter on Coroner Carlin's behalf and submitted a coronial brief of evidence.

10. The investigation was then transferred to Coroner Michelle Hodgson whilst Coroner Carlin was on long service leave. After reviewing the evidence, Coroner Hodgson requested the Coroners Prevention Unit[2] (**CPU**) to provide advice regarding deaths that have occurred in similar circumstances in order to determine whether any measures could be implemented to prevent further deaths.

11. In the interim, the coronial investigation was transferred to me. After considering all the material obtained during the coronial investigation, including the advice from the CPU (detailed below), I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

12. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Circumstances in which the death occurred

13. On the morning of 29 October 2017, Mr Hong intended to go fishing at Beach Number 16 at Rye. He had previously arranged to fish with friends, but they had cancelled due to family commitments.

14. At approximately 9.00am, he informed his wife he was going to fish at his regular spot at low tide, which was 12.00pm. It was normal practice for Mr Hong to return home approximately four hours after low tide. He thereafter left home and drove to the beach in his vehicle.

[2] The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

15. At approximately 9.30am, a surfer observed an elderly male of Asian appearance walking along the sand to Dragon's Head and either wearing or carrying something that was coloured red. He subsequently observed the male fishing near Dragon's Head, standing on the rocky ledge. The surfer left the water at 10.30am but continued to watch the man fishing and observed that as the waves crashed over the rocky platform the water would rush around his legs to approximately knee height.

16. The surfer also observed another fisherman near Dragon's Head and later observed a swimmer get caught in a rip, which took him 100 metres off shore. He paddled to the swimmer and warned him that it was too dangerous to swim. At this time, he noticed that the Asian male was still fishing on the rocks.

17. When the surfer left the water, he walked back up the stairs and stood at the top for approximately 10 minutes watching the beach. He noted the Asian male and other fisherman were still fishing. I note that the identity of the 'Asian man' has never been confirmed to be Mr Hong.

18. At approximately 7.30pm, Mr Hong's wife telephoned their son, Kevin, and reported that Mr Hong had not returned from fishing. Kevin and others drove to the beach. They found Mr Hong's vehicle in the carpark at the Number 16 carpark on Tasman Drive, Rye, and contacted emergency services. At this time, it was high tide and Kevin was unable to reach the platform at which his father usually fished.

19. Victoria Police members and further family members arrived at the beach at 10.30pm and conducted a search of the beach. The Police Air Wing also assisted the search until weather conditions interrupted the search. Mr Hong was subsequently reported as a missing person.

20. The search continued the next morning and involved police members, the Police Air Wing, State Emergency Service members, and Mr Hong's family members.

21. The search continued for a number of days during which some items belonging to Mr Hong were found on the beach.

22. Over the following months, a number of human remains were later found in and about the area that Mr Hong was known to fish:

(a) on 7 November 2017, a lower left leg and foot in a dive boot was found by passers-by at Gunnamatta Back Beach (file COR 2017 5638);

(b) on 7 January 2018, a right femur was found by passers-by on a rocky platform at Gunnamatta Back Beach (file COR 2018 0135);

(c) on 4 February 2018, a right second rib was located by Mr Hong's family members along the rocky shoreline from the point where the first remains were located heading towards Flinders (file COR 2018 0569);

(d) on 8 February 2018, a left femur was found by police divers in the water in a small off-shore channel near the location at which the first two sets of remains were found (file COR 2018 0641);

(e) between 6 April and 24 December 2018, Mr Hong's family found eight bone fragments (from the sacrum, vertebrae, right third rib, right fourth rib, clavicle, left rib (two fragments), and metacarpal) at Fingal Back Beach (file COR 2018 6486);

(f) between 1 January and 26 February 2019, Mr Hong's family found six bone fragments (from the right tibia, right clavicle, a mid-thoracic vertebra, proximal hand phalange, right radius, and rib fragment) at Gunnamatta Ocean Beach (file COR 2019 1061); and

(g) on 4 August 2019, Mr Hong's family handed in another three bones (right incomplete os coxae, right fibula, right patella), also found at Fingal Back Beach, to Victoria Police (file COR 2019 4142).

Identity of the deceased

23. Each of the remains listed above were identified as belonging to Mr Hong via circumstantial evidence, DNA comparison, and/or anthropological means. Identity was not in issue and required no further investigation.

Medical cause of death

24. Dr Paul Bedford, Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy of the leg and foot found in the dive boot and did not identify any significant inflicted injury. Dr Bedford formulated the cause of death as *"1(a) Unascertained"*.

25. The leg and foot in the dive booth and each of the bones were examined by Dr Soren Blau, Senior Forensic Anthropologist, or Dr Samantha Rowbotham, Forensic Anthropologist, at the Victorian Institute of Forensic Medicine. Their examinations did not identify any apparent evidence of skeletal trauma, pathology, or anomalies.

26. The circumstantial evidence satisfies me that Mr Hong died on or after 29 October 2017. His cause of death is unknown. It is likely he drowned after being swept out to sea.

27. I am satisfied that no further investigation is required.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Yik Sua Hong, born 1 December 1938;

(b) Mr Hong died on or after 29 October 2017 at Rye Back Beach – Number 16, Rye, Victoria, from an unascertained cause; and

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

Comments

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

Signage at Beach Number 16, Rye

1. On 10 April 2018, Leading Senior Constable Wayne Pattison, Coroner's Investigator, photographed the signage at the carpark at Beach Number 16 (entry is via Tasman Drive).

2. The Parks Victoria signage at the entrance to the carpark warns of strong currents, slippery rocks, high surf, and submerged rocks. It also indicates that there are no life-saving services in the immediate vicinity. The Parks Victoria signage at the first and second walkways to the beach warn of strong currents, deep water, slippery rocks, high surf, submerged rocks, drop off, and no life-saving services.

3. I am satisfied that the signage, which warns beachgoers of the inherent risk of the beach, is adequate in the area and that anyone entering the beach from the carpark, as it appears Mr Hong did, would have visibility of these signs.

Rock-fishing deaths within Victoria – themes

4. Coroner Hodgson requested the CPU to conduct research regarding deaths that occurred in similar circumstances, particularly among the Asian community which appeared to be over-represented in statistics, and to determine whether any measures could be taken to help prevent such deaths.

5. The CPU identified eight persons, including Mr Hong, who had died whilst rock fishing in the period 2008 to 2018 in Victoria.

6. The CPU's research was somewhat limited due to nationality or ethnic background not being routinely recorded in coronial documentation. As such, the CPU was only able to definitively confirm that six of the eight rock fishing deaths between 2008 and 2018 were individuals who were born overseas. The six individuals were of an Asian background, being either from China or Cambodia, which included Mr Hong.

7. The CPU therefore concluded that the comparatively high representation of individuals who were either born overseas and/or had an Asian background and died whilst rock fishing was hugely in excess of their representation in Victorian drowning deaths as a whole.

8. I note that this anomaly has been identified by other organisations who have also expressed concern about drowning among members of immigrant communities in Victoria. Life Saving Victoria (**LSV**), in their Victorian Drowning Report for 2017/18, referring to Culturally and Linguistically Diverse (**CALD**) communities rather than specific immigrant communities, stated that:

> *This year 14 (35%) individuals that drowned were reported as being from culturally and linguistically diverse (CALD) communities. This is a 73% increase when compared to the 10-year average* ***(8 per year from 2007/08 to 2016/17).***
>
> *Of those individuals where country of birth was recorded 27 drowning victims (20%) also had the number of years they had been living in Australia reported. Of those 27 individuals the median length of time living in Australia was six years.*

In the past decade 21% of drowning deaths were of individuals known to have been from CALD communities. Of those, the majority were males (84%), and aged 25-44 years (46%) followed by 15-24 years (25%). Incidents typically occurred in open waterways; with 44% at beaches and 20% in rivers/creeks/streams. The most common activity prior to the drowning incident was swimming/wading (45%), including attempting a rescue of a family member or friend. The other common activity was fishing (18%), which included rock fishing, fishing from a boat or diving for abalone.[3] [Emphasis added]

9. LSV's Victorian Drowning Report for 2018/19 records a slight increase as follows:

This year 10 (18%) individuals that drowned were reported as being from culturally and linguistically diverse (CALD) communities. This is one more than the 10-year average of nine. Due to limitations with country of birth data collected, data has also been analysed over the previous 10-year period from 2008/09-2017/18. On average, 23% of drowning deaths were of individuals known to have been born overseas (with 57% unknown country of birth).[4]

10. Again, the majority were males (86%) and the most common age group was 25 to 44 years (46%) and the most common activity prior to coastal drowning incidents was swimming (46%), followed by fishing (35%).

11. Encouragingly, the LSV has indicated at 22,000 people from the CALD community took part in LSV programs in 2018/19, which signified a 60% increase compared to the five-year average (2013/14 to 2017/2018).[5]

Previous coronial findings regarding rock-fishing

12. In order to identify common themes amongst the rock-fishing deaths identified above and previous coronial recommendations and comments, I reviewed the findings related to their deaths. Four of the seven coronial findings contained recommendations and comments, and one included coronial comments only.

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[3] Life Saving Victoria, *Victorian Drowning Report 2017/18*, 11, 2018, available at https://lsv.com.au/research/victorian-drowning-reports/.
[4] Life Saving Victoria, *Victorian Drowning Report 2018/19*, 14, 2019, available at https://lsv.com.au/research/victorian-drowning-reports/.
[5] Life Saving Victoria, *Victorian Drowning Report 2018/19*, 7, 2019, available at https://lsv.com.au/research/victorian-drowning-reports/

13. The most notable finding involved the 2009 deaths of three individuals died whilst rock-fishing. These were Theam Chheng,[6] Shida Li,[7] and Liangwei Wang,[8] and their deaths all occurred in a five-month period between August and December 2009 (with the deaths of Shida Li and Liangwei Wang occurring only five days apart). All three deaths also involved individuals who were either born overseas and/or had an Asian background. In light of these connections, Coroner Heather Spooner decided to investigate the cases concurrently.

14. Coroner Spooner identified that there were several commonalities between these cases, including the fact that none of these three individuals were wearing a life jacket or buoyancy aid at the time of their death, or took adequate safety measures or equipment for rock fishing.

15. Prompted by these deaths, Coroner Spooner issued a media release on 8 January 2010 urging people to use caution whilst rock fishing, including suggestions as to how it might be done more safely (e.g. fishing in a group, wearing a life jacket/buoyancy aid, wearing suitable non-slip footwear).

16. Coroner Spooner also directed the CPU to prepare information regarding the three deaths and coordinate Rock Fishing Safety Management meetings, which Her Honour convened on 14 April and 20 July 2010 and involved several key agencies. These meetings led to the creation of a new Safety Management Plan for Rock Fishing, which was hoped would guide future preventive strategies surrounding rock fishers.

17. On 20 April 2011, Coroner Spooner made comments and a recommendation across all three of these coronial findings, as follows:

> *The three deaths of rock fishers in 2009 were entirely preventable. They have once again highlighted the particular vulnerability of CALD communities, who are grossly over represented in rock fisher fatalities.*
>
> *Appropriate signage is essential, and the revised Safety Management Plan for Rock Fishing has highlighted several key safety factors for all those rock fishers who wish to participate in this extremely high-risk sport. Foremost among them is wearing a personal flotation device (PFD), educating CALD communities, overcoming*

[6] Finding into death with Inquest regarding Theam Heng Chheng COR 2009 3741, delivered on 20 April 2011.
[7] Finding into death with Inquest regarding Shida Li COR 2009 5959, delivered on 20 April 2011.
[8] Finding into death with Inquest regarding Liangwei Wang COR 2009 6036, delivered on 20 April 2011.

difficulties and delays in communicating with emergency services and locating and responding to rock fishing emergencies that occur in regional and/or remote locations.

I recommend that the Safety 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 (LSV), VRFish, Australian National Sportfishing Association Limited (ANSA) and the Bass Coast Shire Council.

18. The responses to Coroner Spooner's recommendations in relation to these cases, particularly in relation to the wearing of Personal Flotation Devices (**PFDs**), were mixed. Parks Victoria responded that they strongly supported the use of PFDs by all rock fishers to reduce the number of fatalities. Similarly, LSV responded 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. However, the Victorian Branch of Australian National Sportfishing Association Limited responded that it did not believe that mandating the use of PFDs is appropriate for rock fishers because:

(a) PFD Type 1s have a warning printed on them to the effect that their effectiveness is considerably reduced in rough or breaking seas or surf;

(b) the design of the PFD may have serious consequences for a rock fisher washed into the sea and PFDs with inherent built-in buoyancy may be more effective in a rock platform environment when compared to inflatable types that provide less buffeting against rocks with the added risk of rupture;

(c) PFDs may give the wearer a false sense of security leading to fishing sessions best left for another day; and

(d) the cost for some fishers will be an issue inevitably leading to ignoring any mandatory requirement to use PFDs.

19. ANSA instead recommended educating fishers about sea and weather conditions and how to swim to safety if they happen to be swept out to sea.

20. In 2015, Coroner Spooner delivered a finding regarding Shu Dong Zhang[9] who was a 55-year-old Chinese citizen who had come from Beijing to Victoria to visit his daughter and son-in-law. On the morning of 13 March 2012, Mr Zhang and others went fishing off the rocks at Punch Bowl Beach in San Remo. Here, he caught a fish but as he started to reel it in, his fishing line became tangled. He climbed down the face of the rocks closest to the ocean to untangle the lines and was struck by a large wave that knocked him off his feet and into the ocean. He was unable to make it back to shore and was eventually retrieved from the ocean by helicopter in an unresponsive state.

21. In her finding, Coroner Spooner commended LSV for progressing the various initiatives outlined in the Victorian Safety Management Plan for Rock Fishing to raise awareness of the risks and to strengthen the evidence base on drowning prevention strategies. She noted that a formal evaluation of the initiatives was desirable to measure the impact on the frequency of immersions and drownings.

22. In 2015, Daniel Miles,[10] a 26-year-old man, went to Cape Bridgewater with his friend intending to fish from the rocks there. The pair had decided to fish in the area of the Blowholes car park in the Discovery Bay Marine National Park. They climbed over a wire fence and down a steep track, having decided to fish from a rock platform approximately 30 metres down the cliff face, however Mr Miles headed down to a lower level. A large set of waves came in and washed Mr Miles about 50 metres away in the surf. His body was later found by a Search and Rescue Squad diver in a small rock cave nearby, in approximately 16 metres of water.

23. On 22 April 2016, Coroner Audrey Jamieson deliver her finding into Mr Miles's death and noted the mixed responses regarding Coroner Spooner's recommendation for PFDs to be worn whilst rock-fishing. Her Honour agreed that the use of PFDs was a *"sound strategy"* to address continuing deaths occurring during rock fishing and did not accept the arguments against the implementation of mandatory PFDs. She was not convinced by 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. Coroner Jamieson determined that a strong preventative approach, such as that being trialled in New South Wales where PFDs are mandatory, was justified. She therefore

[9] *Finding into death without Inquest regarding Shu Dong Zhang* COR 2012 0917, unpublished.
[10] *Finding into death without Inquest regarding Daniel Michael Miles* COR 2015 0295, published.

made a recommendation that the Victorian Minister for Sport consider implementing laws in Victoria that mandated the use of PFDs while rock fishing.[11]

24. In response, the then Victorian Minister for Agriculture (the Hon, Jaala Pulford MP), responded that she had instructed Fisheries Victoria to work with LSV, recreational fishers, VRFish, fishing media, local councils, multi-cultural groups and relevant agencies to give higher priority to the safety of rock fishers. She was supportive of an enhanced education and awareness program, including the deployment of additional safety measures such as angel rings in Victoria across all high-risk areas. The Minister also noted that Victoria would continue to closely monitor developments in New South Wales regarding the (then) trial of mandatory PFDs.

Safety Management Meetings and Plan for Rock Fishing

25. The meetings held in April and July 2010, which were arranged by Coroner Spooner and the CPU, were designed to facilitate the creation of a new Safety Management Plan for Rock Fishing with the assistance of key stakeholders such as LSV and Parks Victoria. In turn, the plan was then to be used by these same key stakeholders to shape future preventive strategies involving rock fishers. Meetings were not conducted after July 2010 because they were not envisaged as an ongoing process but rather as a means to an end.

26. There is evidence to demonstrate that the safety management plan created in 2010 and recommendations made by Coroner Spooner in 2011 influenced key stakeholders in developing prevention strategies for rock fishing.

27. For example, LSV introduced a three-year state-wide campaign that adopted public awareness strategies targeting rock fishers and identified at-risk communities with the support of key stakeholders such as VRFish and Fisheries Victoria. The priority message for the campaign was to encourage all rock fishers to wear a lifejacket while fishing. The project undertook the following initiatives:

    (a) releasing radio and press advertising targeting Chinese and Vietnamese communities;

[11] Although Coroner Jamieson directed her recommendation to the Victorian Minister for Sport, it later became apparent that the Minister with a responsibility for rock fishing was actually the Victorian Minister for Agriculture (at that time the Hon Jaala Pulford MP). The Minister provided a response to the coroner on 16 December 2016.

(b) conducting workshops for Chinese and Vietnamese rock fishers to provide fishing tips and educate about rock fishing safety;

(c) placing roadside and car park signs in targeted locations to highlight key rock fishing safety messages; and

(d) conducting observational studies and surveys of rock fishers were used to inform and track progress of the communications campaign.[12]

28. With some concern I note LSV's key findings regarding the campaign for rock fishing safety, targeting all rock fishers and specifically at-risk Chinese and Vietnamese communities, which found the success of the campaign was limited as follows:

(a) the rollout of advertising targeting desired behaviour change to safer practices (e.g., wearing a lifejacket) had limited success in terms of behaviour change;

(b) the observational study showed that people were less likely to fish alone as a result of communications outputs;

(c) however, there was no change in other safety behaviours, including no increase in lifejacket wear; and

(d) survey results suggest rock fishers recognise the dangers associated with rock fishing but fail to behave safely.[13]

29. LSV acknowledged the practical difficulties in changing behaviours and that there was a need for further development of innovative drowning prevention strategies.

30. VRFish, as a peak fishing body in Victoria, also worked on the implementation of prevention strategies for rock fishing. For example, in August 2010 and in conjunction with LSV and Fisheries Victoria, VRFish hosted a Rock Fishing Safety Programme at Port Leo Surf Life Saving club for approximately 30 members of the Chinese community, where each

[12] Life Saving Victoria, "Rock Fishing Safety Project", <https://lsv.com.au/research/rock fishing/>, last accessed 16 January 2020.
[13] Life Saving Victoria, "Rock Fishing Safety Project", <https://lsv.com.au/research/rock fishing/>, last accessed 16 January 2020.

attendee received a PFD and messages of safety were reinforced throughout the workshop and the following practical demonstration.[14]

31. It is clear that following the rock fishing deaths in 2009 and the subsequent introduction of a new Safety Management Plan at the behest of Coroner Spooner, there has been an ongoing prevention focus on rock fishing safety in Victoria driven by key stakeholders.

Safety tips

32. I note that the Victorian Fisheries Authority and LSV provide safety tips for rock fishing. I am mindful that various organisations, media, and other rock fishers may read this finding. I therefore take this opportunity to highlight the following risk-minimising measures as recommended by Victorian Fisheries Authority and LSV: [15]

(a) check what and conditions before you go;

(b) inform others of your plans;

(c) ask locals for advice about the fishing spot;

(d) take time to observe the conditions before you start fishing;

(e) observe signage;

(f) never fish alone;

(g) wear appropriate footwear (non-slip soles) and a personal flotation device;

(h) wear light clothing that will allow you to swim easily if you are washed in;

(i) never fish in exposed areas during rough or large seas;

(j) have an escape plan. If the swell threatens your position, leave immediately; and

(k) never turn your back on the sea and stay alert.

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[14] VRFish Response to Coronial Recommendation in the cases of Theam Chheng, Shida Li and Lianwei Wang, P2, 26 July 2011.

[15] Victorian Fisheries Authority, "Rock Fishing", <https://vfa.vic.gov.au/recreational-fishing/recreational-fishing-guide/fishing-safety>, last updated 26 November 2018, accessed 16 January 2020. Life Saving Victoria, "Rock Fishing Safety Project", <https://lsv.com.au/research/rock fishing/>, last accessed 16 January 2020.

Conclusion

33. In the period from 2008 to 2018:

    (a) there were six years where no rock fishing deaths occurred in Victoria (2008, 2010, 2011, 2013, 2016 and 2018);

    (b) there were three years where only one rock fishing death occurred in Victoria (2012, 2014 and 2017); and

    (c) there were two years where more than one rock fishing death occurred in Victoria (2009, with three deaths, and 2015, with two deaths).

34. The three rock fishing deaths that occurred in 2009 prompted the creation of the new Safety Management Plan for Rock Fishing. The available figures indicate that the number of rock fishing deaths in Victoria has fallen and remained low since its peak in 2009.

35. It is not possible to draw any causal connection between the Victorian rock-fishing safety initiatives (particularly the education and awareness programs reaching out to specific groups) and the low frequency of rock fishing deaths since 2016 as rock-fishing deaths are naturally rare. The effect of the safety initiatives is therefore difficult to measure. However, equally with only one death since 2016, there is no evidence to suggest these safety initiatives have been ineffective. On this basis, I defer to LSV's key findings, which I have set out above.

36. I note that nationally most rock-fishing deaths occur in New South Wales, with an average of eight people losing their lives each year. Here, the wearing of an appropriate lifejacket whilst rock fishing has only recently become mandatory in some local government areas. Failing to wear an appropriate lifejacket whilst rock fishing in such areas may result in an A$100 on the spot fine.[16] The recency of this requirement means its success in reducing deaths cannot yet be meaningfully measured. Given the lack of evidence at this point in time, I do not propose to make a recommendation to implement mandatory PFDs for rock fishers in Victoria.

[16] NSW Government Water Safety, "Lifejacket Law", <https://www.watersafety.nsw.gov.au/Pages/Rock-fishing/lifejacket-law.aspx>, last updated 6 February 2019, accessed 16 January 2020.

37. Likewise, I do not believe that further prevention-based recommendations addressing rock fishing are required at this time. Rather, a continuation or increase of existing education and awareness programs in Victoria (in particular those aimed at members of those communities most at risk of drowning whilst rock fishing), as well as studying the progress of the New South Wales Government's mandatory approach to the issue, appears to be the most appropriate and effective way to address rock fishing safety at this time.

Recommendations

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

1. I recommend that Life Saving Victoria work with the Victorian government and other related water safety organisations to continue to educate and increase education among Victorians and the Culturally and Linguistically Diverse community regarding the dangers of rock-fishing and relevant safety initiatives to reduce risk; and

2. I recommend that the Victorian Minister for Agriculture, The Hon. Jaclyn Symes, study the progress of the New South Wales government's mandatory requirement for rock fishers to wear personal flotation devices and implement similar laws in Victoria if the strategy appears successful.

I convey my sincere condolences to Mr Hong's family.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

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

Mrs Nang Keo Tia, Senior Next of Kin
Life Saving Victoria
Minister for Agriculture, The Hon. Jaclyn Symes
Leading Senior Constable Wayne Pattison, Coroner's Investigator, Victoria Police

Signature:

Caitlin English
Deputy State Coroner
Date: 20 January 2020