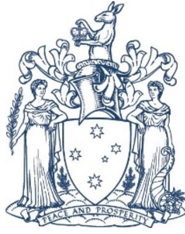

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5489

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Mr L
Date of birth:	██ August 1979
Date of death:	29 October 2017
Cause of death:	*Consistent with Drowning*
Place of death:	Mounts Bay, Apollo Bay, Victoria
Key Words	*Drowning death, coastal environment*

Introduction

1. Mr L, born ██ August 1979, was 38 years of age at the time of his death. He was a Pakistani National who lived in Cambridge, London with his wife Mrs L and his two sons, H, aged 8 and A, aged 6. His twin brother, Mr P lived in ██████, Victoria with his family.

2. Mr L was a mechanical engineer.

3. At the time of his death, Mr L, his wife and children were on holidays in Australian (a planned stay of 3 weeks) and travelled with his twin brother, his mother and his brother's sons, aged 3 and 5 years, to Apollo Bay on 27 October 2017 intending to remain for a few days.

4. On the afternoon of 29 October 2017, Mr L drowned at Apollo Bay's back beach, Mounts Bay.

The Coronial Investigation

5. Mr L's death was reported to the coroner as it appeared to fall within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). A reportable death includes a death that appears to be unnatural or violent, or to have resulted, directly or indirectly, from an accident or injury.

6. A coroner independently investigates reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

7. 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 to the making of recommendations by coroners. This is generally referred to as the 'prevention' role of the coroner.

8. Victoria Police assigned Senior Constable Margaret Anderson (**SC Anderson**) to be the Coroner's Investigator for the investigation into Mr L's death. SC Anderson conducted

[1] This is 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.

inquiries on my behalf,[2] including taking statements from witnesses and compiling a coronial brief of evidence. The brief comprises of statements from Mr L's wife, his brother, the forensic pathologist who examined him, ambulance paramedics, investigating police as well as other relevant documentation.

9. Information and advice was also sought from the Coroners Prevention Unit (**CPU**) in relation to the management of risks associated with coastal areas and any prevention opportunities. The CPU obtained relevant information from various bodies including Life Saving Victoria (**LSV**), the recognised peak water safety agency in Victoria.

10. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my tasks as coroner and that further investigation was not required.

11. Whilst I have reviewed all the material gathered as part of the investigation, this finding includes only those matters which are directly relevant to the investigation and, allow the findings, comments and recommendations to be understood.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 29 October 2017, after visiting the Cape Otway Lighthouse, Mr L and his family attended Mounts Bay, which is a back beach at Apollo Bay (locally known as the first beach car park) for a *swim/play.*

13. Mr L's brother, Mr P, described the water as cold but the air temperature as warm, with sunny skies and *fairly strong wind.*

14. Sometime around 1.30pm, Mr L and his brother entered the water (on a second occasion) and were out in the waves about 30 metres from the shore, some 5 to 7 metres away from each other. Neither could touch the ocean floor. At that time, they decided to body surf back to the shore.

15. Mr P said, *We swam into the waves. The waves were sporadic, sometimes it would be fairly flat then a few waves would come. We were in the water for about 20 minutes when I realised we were about 30 meters from the shore. We were both swimming as we couldn't touch the sea floor. Mr L was about 5 to 7 meters from me. We decided to try to body surf into the beach. I realised I was being pushed back and I was finding it hard to get a wave into the beach.*

[2] The carriage of the investigation was transferred from Deputy State Coroner English.

I was struggling to get back into the beach, and was swimming as hard as I could to get back onto the beach. After about 2 minutes I managed to get my feet back onto the floor. I then walked out of the surf.'

16. Mr P said that he knew his brother was a better swimmer than him but when he looked back, he saw him struggling for a few minutes, and then stop swimming after which his body was lying face down in the waves about 20 to 30 metres from the beach.

17. Mr L's wife raised the alarm with two local surfers in the car park, Mr C and Mr M, who immediately took their surfboards and entered the water. They paddled out to Mr L and returned his body to the beach where they commenced CPR with the assistance of Mr P. Mr L was however unconscious with no signs of life.

18. Emergency services were called and two ambulance paramedics arrived at approximately 2.18pm, following which CPR was performed for 50 minutes along with other life saving measures, but he was unable to be revived.

19. Mr P said that both he and his brother had swimming lessons when they were 8 to 10 years of age and that his brother had snorkelled in the Seychelles in May 2017. Mr L had brought his snorkel and mask with him on that day.

20. Mr L's wife said there were *big waves but it didn't seem too rough to swim.* She said of her husband's swimming ability that he,

    was a good/competent swimmer, He has swum on a number of occasions over the time I have known him. He has swum a number of times in different beaches including Spain. About 6 months ago we went to the Seychelles on a holiday where Mr L did a lot of swimming in big waves as well as body surfing and snorkelling.

21. She said that he had no known medical condition and described him as fit and healthy.

22. Mr M observed that *there did not appear to be any rips, just a sweep running south towards Marengo.* He said that the beach was not ideal for swimming unless you are experienced. Mr C said that, *I'm experienced in the ocean so I would have been ok to swim there but for people who are not experienced, I reckon it was not a good place to be swimming at the time. Definitely not.*

23. SC Shane Franke, Water Police Squad, who attended the scene described *the conditions on the day of the incident as being completely unsuitable for swimming.* He said,

    The swell was in the 4 ft range with waves closing out onto a shallow sand bar. There was a large rip running along the area where the male had entered the water and the wind was

extremely strong from the NW. I had been told the male had been snorkelling in the surf with his brother when he got himself into trouble. I am completely baffled by this as the conditions were in no way suited to swimming..'.

24. SC Franke said that he observed signage depicting symbols of large waves and strong surf whilst he was in the car park and noted that there was a patrolled beach situated a few minutes away.

25. The Coroner's Investigator took various photos of the scene including a photo of a sign near the entrance of the beach which, amongst other things, indicated 'Large Waves' (with a pictorial symbol), 'Dangerous Currents' (with a pictorial symbol) and 'Swimming Dangerous' (with a pictorial symbol of a red cross over a swimmer).

IDENTITY

26. On 29 October 2017, Mr P visually identified his brother, Mr L, born ██ August 1979.

27. Identity is not in dispute and required no further investigation.

CAUSE OF DEATH

28. On 30 December 2017, Dr Michael Burke, a forensic pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination and provided a written report, dated 7 December 2017. In that report, Dr Burke concluded that a reasonable cause of Mr L's death was *'Consistent with Drowning*'.

29. The family objected to the recommendation that an autopsy to be performed to clarify whether Mr L had suffered a cardiac event in the water, based on religious and cultural grounds. The objection was upheld.

30. Nevertheless, Dr Burke determined that given the circumstances surrounding the death, the most probable cause of death was drowning.

31. Toxicological analysis identified no common drugs or poisons in Mr L's blood.

32. I accept and adopt Dr Burke's opinion as to the medical cause of death.

Exploration of Prevention Opportunities

Management responsibility

33. The Otway Coast Committee (**OCC**) on behalf of the Department of Environment, Land, Water and Planning (**DELWP**) manage the area of coastline where Mr L drowned.[3] This responsibility would encompass ensuring that risk measures are in place to prevent incidents of drowning amongst beachgoers.

The Marine and Coastal Policy

34. I note that the *Marine and Coastal Act 2018* was introduced on 1 August 2018 and that the Marine and Coastal Policy 2020 (**the Policy**) was finalised in March 2020. Chapter 10 of the Policy deals with recreation and tourism, which outlined amongst other matters, a need to maintain public safety.[4]

35. The Policy provides that *Coastal and Marine Management Plans* are to be prepared by Crown Land managers (such as OCC) which *translate marine and coastal policy and strategy to on-ground action.*

Advice from Life Saving Victoria

36. LSV were asked to review the circumstances of the death and provide expert advice to the Court. Issues identified by LSV include that Mr L was:

  a. An overseas tourist

  b. Swimming at a location unpatrolled by lifesavers,

  c. Swimming in conditions reportedly unsuitable for this activity, and

  d. Signage at the beach access point.

37. LSV noted with respect to these issues (a to c) that key public awareness messages delivered through the Play it Safe by the Water (**PISBTW**) campaign in Victoria include:

- Be aware and prepared for conditions
- All beaches can be dangerous

---

[3] The OCC are recognised as a Committee of Management with the responsibility of managing Crown Land reserves under the Crown Land (Reserves) Act 1978 (Vic), and thus have responsibility *to manage, improve, maintain and control the reserve, using reserve-derived revenue.*

[4] 10.3 *Use strategic and spatial planning to locate opportunities for safe and sustainable recreation and tourism developments that: a. respond to identified demand b. minimise impacts on environmental and cultural values c. minimise impacts on other users d. maintain public safety e. respond to the carrying capacity of the site f. minimise exposure to coastal hazard risks and risk posed by climate change.*

- Conditions can change quickly
- Read safety signs to understand dangers
- Swim between the red and yellow flags wherever possible
- Learn how to spot and avoid rip currents – find out more at beachsafe.org.au or download the beachsafe app
- Understand the conditions and ensure your skills/activities are appropriate before entering the water.

38. LSV noted that these messages are provided to those living in Victoria through public awareness campaigns and in particular through the PISBTW campaign. However, given that Mr L was an overseas tourist these messages would ideally be provided on relevant travel websites when people are choosing destinations to visit and via travel agencies and accommodation providers in Australia. LSV outlined a number of different projects which sought to address this issue.[5]

39. The LSV also considered that the public signage present at the time of Mr L's death was not consistent with the AS/NZA 2416 (Parts 1 & 3) Standard (Water safety signs and beach safety flags). For example, the aquatic safety sign was positioned on its own offset from the entrance point. As per Clause 5.1.1(e) the aquatic safety sign should take precedence over other signs except for escape routing signs.

<u>OCC and DELWP</u>

40. By correspondence to the Court dated 21 December 2018[6], OCC and DELWP indicated that the signage and the position of signage at Mounts Bay had not changed and that they considered that the existing signage warn of the relevant risks, and the signage at the location is consistent with the signage along the 28.5 kilometres of coast line the OCC manages.

41. They did however indicate at that time that a review of the signage was a priority project and they were in discussions with LSV about the project.

42. To date, no information has been made available to the Court that a project such as this has been undertaken.

[5] Blackspot and VISIT.s
[6] From Thomson Geer Lawyers.

COMMENTS

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

44. Mr L's death was preventable. He was enjoying an overseas holiday with his mother, wife, twin brother, young sons and nephews and found himself in dire trouble in a manner not anticipated by him or those present. Mr L had no known health issues and was regarded as a competent swimmer, by those close to him.

45. The LSV Drowning report (2018/19) noted that there were 56 losses of life in Victoria to drowning in the reporting period. This was Victoria's highest annual drowning toll in more than two decades and 17 more than the average number of drowning incidents in Victoria over the past 10 years (2008/09-2017/18). The report noted that in 2018/19, 41% (23) of all drowning deaths occurred in coastal environments (bay/beach/ocean), making it the most common location for drowning. The deaths represent a 46% increase in drowning deaths in coastal waterways compared with the 10-year average of 16.

RECOMMENDATIONS

46. Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:[7]

    a. That the OCC ensure adequate risk measures (including but not limited to signage and public awareness messaging for tourists) are undertaken in relation to the coastline it manages to address the potential for drowning in public spaces.

    b. That these measures should be re-assessed at appropriate intervals to ensure that they remain best practice and in line with relevant standards.

    c. That water safety measures be undertaken in consultation with industry experts/stakeholders, such as Life Saving Victoria (the recognised peak water safety agency in Victoria), and form part of the Coastal and Marine Management Plans required to be prepared under the Coastal and Marine Policy 2020.

[7] The OCC were provided with draft recommendations for comment, but no response was received regarding the proposed recommendations.

FINDINGS

47. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the Act that Mr L, born ██ August 1979, died on 29 October 2017 at Mounts Bay, Apollo Bay, Victoria, from a cause '*Consistent with Drowning*', in the circumstances described above.

48. I convey my sincere condolences to Mr L's family for their loss. I acknowledge the tragic circumstances of his death which no doubt has had an immeasurable and continuing impact on his loved ones.

49. Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that a redacted version of the finding be published on the Internet.

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

Mrs L, senior next of kin

Otway Coast Committee

Department of Environment, Land, Water & Planning

Life Saving Victoria

Senior Constable Margaret Anderson, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

CORONER

Date: 31 August 2020