IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2019 0762

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**SWEE CHUAN HO**
Date of birth:	**13 November 1989**
Date of death:	**10 February 2019**
Cause of death:	**Drowning**
Place of death:	**Ocean floor, approximately 20 metres offshore, Davey's Bay-Pelican Point beach, Mount Eliza Victoria 3930**

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

1. Swee Chuan Ho was a 29-year-old Malaysian national male who lived at 4/36- 38 Church Street, Mitcham Victoria 3132 at the time of his death.

2. On 10 February 2019, Mr Ho was abalone diving off Davey's Bay- Pelican Point beach in Mount Eliza. Thirty minutes after telling his friends he was returning to shore, Mr Ho was no where to be found. Approximately two hours later, Mr Ho's body was recovered from the ocean floor.

3. Mr Ho's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Mr Ho, reviewed a post mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death, Form 83.

5. Dr Lynch commented that the findings of the external examination were consistent with the history. A plume of froth was noted about the mouth. The post mortem CT scan revealed increased lung markings.

6. Dr Lynch ascribed the cause of death to drowning.

Police investigation

7. Senior Constable (**SC**) Michael Davies was the nominated Coroner's Investigator.[1] At my direction, SC Davies investigated the circumstances surrounding Mr Ho's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by friends, witnesses and investigating officers.

8. During the investigation, police learned that Mr Ho was a Malaysian national residing in Australia. Mr Ho arrived in Australia on 16 December 2012.

9. On 9 November 2015, Mr Ho lodged an application for a protection visa.

10. On 25 November 2015, Mr Ho was granted a bridging visa.

11. On 17 March 2016, Mr Ho's protection visa was denied. The decision was affirmed by the Administrative Appeals Tribunal on 23 December 2016. At the time of his death, the Department of Immigration and Citizenship confirmed that Mr Ho did not hold a valid visa to reside in Australia.

12. Mr Ho was of a reasonable fitness level and had no known medical or mental health issues. He enjoyed recreational snorkelling. The coronial brief summary details that family confirmed that Mr Ho learnt to swim and snorkel as a teenager. Mr Ho held a valid recreational Victorian Fisheries Authority license. In Port Philip Bay, the licence allows recreational divers to catch a maximum of five abalone with a minimum diameter of ten centimetres. Mr Ho owned his own snorkelling equipment including a wetsuit, snorkel, goggles, flippers and weight belt with weights.

13. Mr Ho's friend, Ching Ket Tan, detailed that he had known Mr Ho for approximately eighteen months prior to his death. During that period, the pair had been snorkelling together on approximately ten occasions. Mr Ho did not experience any difficulty in the water on these occasions.

[1] 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 receives directions from a Coroner and carries out the role subject to those directions.

14. On 10 February 2019 at approximately 3.00pm, Mr Ho attended a pre-arranged day trip to go abalone diving at Davey's Bay- Pelican Point beach, Mount Eliza. There were seven people in total on the trip.

15. At the time, the weather was fine, with an air temperature of 23 degree Celsius. The water temperature was approximately 18 degrees Celsius and was calm, with a light northerly wind of less than 20 kilometres an hour. The conditions were considered good for snorkelling.

16. The deepest section of water at the chosen location is approximately 3.5 metres, with an average depth of 2.5 metres.

17. At approximately 3.15pm, Mr Ho and Mr Tan and Fu Kai Loon entered the water and went out to where the water was deeper than they could stand. Mr Ho was wearing his wetsuit, goggles, snorkel, weight belt and flippers. He also had a mesh catch bag to hold abalone.

18. Yok Foo Yap and Chin Jin Leow also entered the water and swam out to where the water was approximately neck high. Mr Yap and Mr Leow exited the water after approximately 30 minutes and returned to Mr Woei and Pooyee Hin, who had been watching from the shore.

19. At approximately 4.00pm, Mr Ho asked Mr Tan if he wanted to return to shore. Mr Tan told Mr Ho that he would wait for Mr Loon. Mr Ho advised that he was returning to shore.

20. At this time, Mr Yap, Mr Leow and Mr Woei were looking out at three divers in the deep water. They noted one diver separate from the other two divers. Mr Yap and Mr Leow observed the separated diver, believed to be Mr Ho, sink beneath the surface of the water and not reappear. Mr Yap entered the water to have a closer look. A person resurfaced and Mr Yap assumed this was the same diver who had submerged moments earlier. Relieved, Mr Yap returned to the beach.

21. At approximately 4.30pm, Mr Tan and Mr Loon returned to the shore and were surprised to discover that Mr Ho had not returned yet. They returned to the water and searched for Mr Ho for approximately 20 minutes. Mr Ho could not be located.

22. At approximately 5.00pm, Mr Tan asked an unknown person in the area, Callum Paul, to contact emergency services on their behalf due to language difficulties.

23. Approximately ten minutes later, several Victoria Police units, including Water Police Squad and Air Wing, attended the area and its surrounding beaches. Marine volunteer rescue boats also aided in the search and rescue.

24. At approximately 5.50pm, Victoria Police Air Wing identified a possible sighting of Mr Ho.

25. At approximately 6.10pm, Victoria Police- Water Police Squad marine rescue divers located Mr Ho's body on the ocean floor at a depth of approximately 7.5 metres.

26. At approximately 7.00pm, Ambulance Victoria formally declared Mr Ho deceased.

27. Investigating officers noted that Mr Ho was wearing an eight kilogram weight belt and had eight kilograms of abalone on his person.

28. In finalising the coronial brief, SC Davies stated that,

> Police are aware of several other recent drownings of similar circumstances in the vicinity and recommend that more signage (in multiple languages) regarding the risks of diving for extended periods of time without sufficient breaks may assist in preventing incidents in the future.

COMMENTS

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

1. As part of my investigation, I referred this matter to the Coroners Prevention Unit (CPU)[2]. At my direction, the CPU prepared a summary of similar drownings in the area and whether there were prevention opportunities to be pursued in this matter (see **Attachment A**).

2. This CPU determined that the most appropriate way to present the data was by financial year. There were two reasons for this. Firstly, reporting by financial year enables deaths

[2] The Coroners Prevention Unit is a specialist service created for coroners to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

over each summer to be grouped together and secondly, this reporting method is consistent with peak Australian water safety bodies, such as Life Saving Victoria.

3. The CPU initially identified 51 drownings of swimmers at beaches in Victoria between 2015/2016 through to 2019/2020. Table 1 of Attachment A shows the annual frequency of drownings deaths of swimmers at beaches by age group. Those aged 25 to 44 years represented the highest age group of drownings, at 37.2%.

4. Table 2 of Attachment A shows the frequency of drowning deaths of swimmers at beaches by local government areas (**LGA**) of the incident. Mornington Peninsula, the LGA that Mr Ho died within, had the highest incidents of drowning deaths, totalling 18 and representing 35.8%.

5. For each of the 18 deaths identified, the CPU further identified the suburb within the Mornington Peninsula LGA that the deaths occurred. This is represented at Table 3 of Attachment A. Mr Ho entered the water at Davey's Bay- Pelican Point beach in the suburb of Mount Eliza.

6. The CPU further identified that of the 18 deaths that occurred within the Mornington Peninsula LGA, five[3] had occurred in the setting of abalone diving[4]. Three[5] of these five deaths occurred in the suburb of Mount Eliza during 2018 and 2019.

7. I note that Deputy State Coroner Caitlin English investigated the drowning deaths of Xu Zhou[6] and Xuan Troung Ha[7] whilst diving for abalone on 6 January 2018. Both the deceased were culturally and linguistically diverse (**CALD**) individuals.

8. Deputy State Coroner English sought a submission from Life Saving Victoria detailing the education they provide to CALD communities, including the specific education targeted to abalone divers.

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[3] Of the five identified deaths, three cases were closed with findings and two remained open at the time of writing Attachment A. The two cases included the death of Mr Ho.

[4] CHO, Young Rok COR2015 6502, XU Meng COR2018 1640, CHEN, XIA Yang COR2018 6473, HO, Swee Chuan COR2019 0762, XU, Wenbiao COR2019 1248

[5] XU Meng COR2018 1640, HO, Swee Chuan COR2019 0762, XU, Wenbiao COR2019 1248

[6] COR2018 0089

[7] COR2018 0090

9. I note that the death of Swee Chuan Ho whilst diving for abalone is not unique in Victoria, but rather one of an increasing number of drownings related to abalone fishing in recent years, particularly amongst members of CALD communities.

10. Life Saving Victoria have also noted this recent increase, and were prompted to target this particular cohort of water users, not only by updating their existing awareness messaging to include advice on abalone fishing safety, but also by applying for a grant through the Victorian Fisheries Authority's Recreational Fishing Grants Program to expand the reach of fishing safety messages, with specific regard to abalone and rock fishing.

11. Life Saving Victoria have proposed a project that would support a state-wide grassroots campaign to educate the recreational fishing community on how to enjoy and participate in fishing, whilst observing appropriate safety measures to avoid injury or loss of life, and which would build on previous safety campaigns through inclusion of grassroots community-based ambassadors and development of marketing collateral that can be distributed through social media channels, as well as community events and fishing forums.

12. Furthermore, I note that Deputy State Coroner English in her recent investigation into the deaths of the abovementioned two individuals, made several recommendations to both Life Saving Victoria and the Victoria Fisheries Authority to update their safety messaging and promote safe practices for abalone fishing through targeted education, social media channels and other relevant resources and websites.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety and preventing like deaths, I echo the recommendations made by Deputy State Coroner English, given that they address the core prevention issue raised by the death of Swee Chuan Ho:

    a. Life Saving Victoria updates its public awareness messaging to include abalone fishing and promote this messaging through targeted education, social media channels, and other relevant websites.

    b. Life Saving Victoria work with recreational fishing organisations and agencies that promote recreational fishing to include safe practices for abalone fishing.

    c. The Victorian Fisheries Authority update the *Victorian Recreational Fishing Guide* and its other resources to include information about abalone fishing safety and the risk of drowning whilst abalone fishing.

2. With the aim of promoting public health and safety and preventing like deaths, I recommend that Mornington Peninsula Shire Council work with Life Saving Victoria, the Victorian Fisheries Authority and any other relevant bodies to provide messaging about the risk of drowning whilst abalone fishing, and to promote safe practices for abalone fishing, in the Mornington Peninsula Local Government Area.

FINDINGS

1. I find that Swee Chuan Ho, born 13 November 1989, died on 10 February 2019 approximately 20 metres offshore at Davey's Bay- Pelican Point beach in Mount Eliza, Victoria 3930.

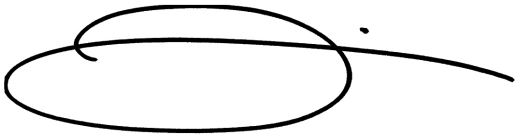
2. I accept and adopt the cause of death ascribed by Dr Matthew Lynch and I find that the cause of Swee Chuan Ho's death was drowning in circumstances where he had been abalone diving off Pelican Point near Mount Eliza.

Pursuant to section 73(1A) 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:

Bee Guat Ng
The Proper Officer, Mornington Peninsula Shire Council
The Proper Officer, Life Saving Victoria
The Proper Officer, Victorian Fisheries Authority
Senior Constable Michael Davies

Signature:



AUDREY JAMIESON
CORONER
Date**: 28 September 2020**

Coroners Court of Victoria

COR 2019 0762

CORONIAL FINDING INTO THE DEATH OF SWEE CHUAN HO

ATTACHMENT A

Data summary of drownings involving members of CALD communities diving for abalone

Coroners Court of Victoria
65 Kavanagh Street, Southbank
Tel: (03) 8688 0700
Email: courtadmin@coronerscourt.vic.gov.au

Coroners Prevention Unit
General Advice Memo

Coroners Court of Victoria

To:	Coroner Jamieson	**From:**	CPU
Subject:	Data summary of drownings involving members of CALD communities diving for abalone	**Date:**	7 August 2020
Keywords:	Drownings, Mornington Peninsula, abalone diving/fishing, Culturally and Linguistically Diverse communities, CALD communities		

1. Background

The CPU prepared this background material on the frequency of beach drownings in the Mornington Peninsula involving members of Culturally and Linguistically Diverse (CALD) communities diving for abalone to assist the coroner's investigation.

2. Case identification

2.1 Data Source

The data source for this memorandum was the Coroners Court of Victoria (CCOV) surveillance database. The surveillance database contains information on all Victorian deaths reported to the coroner since 1 January 2000.

2.2 Definitions

The CPU used the following definitions:

- **Beach:** water along the coastline of Victoria, including bays and inlets.
- **Swimmer:** any person who intentionally entered the water to swim, snorkel, wade, paddle, walk or similar.
- **Drowning:** a death caused or contributed to by immersion in water.

2.3 Inclusion criteria and case identification

The Coroners Prevention Unit (CPU) searched the surveillance database for all drowning deaths of swimmers at a beach that were reported to the CCOV between 1 July 2015 and 30 June 2020.

For each death that met the inclusion criteria, the CPU reviewed the Police Report of Death for the Coroner (Form 83) circumstances and where available, the coronial finding, to determine the circumstances of the individual's death and the location of the fatal incident (by Local Government Area (LGA), suburb and, where possible, beach). For those deaths that occurred in the Mornington Peninsula, the CPU recorded whether the deceased was diving for abalone at the time of the fatal incident, and if so, whether the deceased was from a culturally and/or linguistically diverse community.

2.4 Limitations

The CPU noted that some deaths are still under investigation and therefore can only be coded on the information that was available at the time. Even when the case is closed, the amount of information can vary significantly between deaths, depending on a range of factors including the depth and focus of the coronial investigation. Therefore, this may have impacted the accuracy of the results reported.

3. Frequency of beach drowning deaths, Victoria

The CPU has presented these results by financial year because; a) reporting by financial year enables deaths that have occurred over each summer to be grouped together and b) this reporting is consistent with how peak Australian water safety bodies (such as Life Saving Victoria) present their drowning and water safety data.

The CPU identified 51 drownings of swimmers at beaches in Victoria. Table 1 shows the annual frequency of drowning deaths of swimmers at beaches by age group. Those aged 25-44 represented the highest age group of drownings (37.2%).

Table 1. Annual frequency of drowning deaths of swimmers at beaches by age group, Victoria, Financial Years 2015-2020

Financial Year	0-4	5-14	15-24	25-44	45-64	65+	All
2015/16	-	1	-	7	1	2	11
2016/17	-	-	-	2	3	2	7
2017/18	-	-	2	7	3	1	13
2018/19	-	-	2	3	6	5	16
2019/20	-	-	-	-	2	2	4
Total	**0**	**1**	**4**	**19**	**15**	**12**	**51**

3.1 Location of beach drownings

Multiple deaths occurred at Woolamai Beach (n=4), Gunnamatta Beach (n=3), Colonnades Beach (n=2), Davey's Bay Beach (n=2), Lorne Beach (n=2), Mornington Pier (n=2), Rye Yacht Club Beach (n=2), and Sherbrook Beach (n=2).

The incident locations for the remaining 31 deaths were as follows: Apollo Bay Back Beach, Artillery Rocks, Aspendale Beach, Beacon Vista, Bushrangers Bay Beach, Cape Nelson, Cape Schanck, Cowes Beach, Inverloch Beach, London Bridge Beach, Mordialloc Beach, Number One Beach Venus Bay, Number 16 Beach Rye, Ocean Grove Surf Beach, Point Roadknight Beach, Portarlington Beach, Ranelagh Beach, Sandringham Beach, Seaford Beach, Separation Creek, Shelley Beach, Skenes Creek Beach, Sorrento Beach, South Beach Somers, Southern Ocean Beach (Belfast Coastal Reserve), St Andrew's Beach, St Paul's Beach, Thirteenth Beach Barwon Heads, Torquay Surf Beach, Williamson's Beach, and Williamstown Beach.

Local councils are heavily involved in drowning prevention initiatives; therefore these beaches were compiled by the LGA within which they are situated. Table 2 (over page) shows the frequency of drowning deaths of swimmers at beaches by LGA of fatal incident. Mornington Peninsula (n=18, 35.8%), Bass Coast (n=10, 19.6%, which includes Woolamai Beach), Greater Geelong (n=4, 7.8%) and Surf Coast (n=4, 7.8%) were the LGAs with the highest number of deaths.

Table 2. Overall frequency of drowning deaths of swimmers at coastal beaches by local government area, Victoria, Financial Years 2015-2020

Local Government Area	Total
Mornington Peninsula	18
Bass Coast	10
Greater Geelong	4
Surf Coast	4
Colac Otway	3
Corangamite	2
Hobsons Bay	2
Kingston	2
Bayside	1
Frankston	1
Glenelg	1
Moyne	1
Port Phillip	1
South Gippsland	1
All	**51**

As the Mornington Peninsula LGA was the region in which most of these deaths occurred, the CPU then concentrated their search on this area and identified the suburb and (where possible) the beach at which these deaths occurred. These deaths were located as follows:

Table 3. Overall frequency of drowning deaths of swimmers at coastal beaches in the Mornington Peninsula LGA, Financial Years 2015-2020

Suburb	Beach	Total
Fingal	Gunnamatta Beach	3
Mount Eliza	Davey's Bay Beach (n=2), Ranelagh Beach	3
Rye	Rye Yacht Club Beach (n=2), Number 16 Beach	3
Mornington	Mornington Pier	2
Sorrento	Sorrento Beach, St Paul's Beach	2
Cape Schanck	Cape Schanck	1
Flinders	Bushrangers Bay Beach	1
Portsea	London Bridge Beach	1
Somers	St Pauls Beach	1
St Andrews Beach	St Andrews Beach	1
All		**18**

4. Abalone-related drowning deaths, Mornington Peninsula

As shown in section 3.1 above, the CPU identified 18 deaths of individuals who drowned at beaches in the Mornington Peninsula LGA between 1 July 2015 and 30 June 2020. For each of the 18 identified deaths, the CPU then examined the text of the Form 83 and, where available, the coronial finding to establish which individuals had entered the water for the purpose of obtaining abalone; five relevant deaths were identified.

Of the five relevant deaths, three cases were closed with findings, and two remained open at the time of writing.

Of the three closed cases, none included recommendations or comments. All three cases were closed by way of a finding without inquest.

5. Discussion

The CPU is aware that in two recent coronial findings promulgated by Deputy State Coroner Caitlin English, the issue of individuals who drowned whilst diving/fishing for abalone was addressed, and recommendations made. Both these deaths occurred outside the Mornington Peninsula LGA.

In summary, Deputy State Coroner English investigated the deaths of Xu Zhou[1] and Xuan Truong Ha[2], both of whom died on the same date – 6 January 2018 – whilst diving for abalone, at Altona Beach and Williamstown Beach respectively. Deputy State Coroner English was particularly concerned that these individuals were two of a total of 14 people who died whilst diving for abalone in Victoria between 2009 and 2019, and that between 50 and 70 percent of these deceased were known to have been born overseas and/or to be of Asian descent. Deputy State Coroner English therefore sought a submission from Life Saving Victoria outlining the education they provide to CALD communities, including the specific education targeted to abalone divers.

Life Saving Victoria provided a detailed submission to Deputy State Coroner English in which their Principal Research Associate Dr Bernadette Matthews outlined the work that LSV have done with Victoria's various multicultural communities and suggested the following as possible ways in which education regarding safety for abalone diving could be improved, especially in CALD communities:

- update public awareness messaging to include abalone fishing and promoted through targeted education, social media channels and relevant websites;
- the Victorian Recreational Fishing Guide and other Victorian Fisheries Authority resources be updated to include information on abalone fishing safety and the risk of drowning;
- programs/activities by recreational fishing organisations/agencies that promote recreational fishing should include safe fishing practices, noting that, particularly for culturally and linguistically diverse communities this should include abalone fishing and rock fishing safety.

Deputy State Coroner English then made recommendations based upon the suggestions made by Dr Matthews, suggesting action for both Life Saving Victoria and the Victorian Fisheries Authority, but given that they were made so recently no responses to these recommendations have been received by the Court at the time of writing this report.

1 Coroners Court of Victoria, COR 2018 0089, finding promulgated 23 July 2020.

2 Coroners Court of Victoria, COR 2018 0090, finding promulgated 23 July 2020.