IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0289

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Amanda Bourke
Date of birth:	28 April 1973
Date of death:	18 January 2018
Cause of death:	1(a) Drowning
Place of death:	The Cutting, Gormans Road, Tower Hill, Victoria

INTRODUCTION

1. Amanda Bourke was a 44-year-old woman who lived in Kirkstall with her fiancé, Kevin Knowles, at the time of her death.

2. Ms Bourke was the much-loved daughter of Phillip (now deceased), and Annette and the beloved sister of Jason and Aaron.

3. Ms Bourke drowned at a beach known as The Cutting at Tower Hill on 18 January 2018.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Bourke's death was reported to the Coroner as it appeared to have resulted, directly or indirectly, from an accident or injury, and so fell within the definition of a reportable death in the *Coroners Act 2008.*

5. The role of a coroner is to independently investigate 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.

6. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers.

7. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

IDENTITY

8. On 18 January 2018, Kevin Knowles visually identified his fiancée, Amanda Bourke, born 28 April 1973.

9. Identity is not in dispute and requires no further investigation.

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[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.

BACKGROUND

10. Ms Bourke's brother, Jason, provided a detailed statement to the Court in which he lovingly described his sister's childhood and later life.

11. He noted that during her teenage years, Ms Bourke began using marijuana, which eventually led her to using other drugs such as heroin.

12. After completing high school in 1990, Ms Bourke stayed in Warrnambool with her family and later had a short-lived relationship that produced a son who was later taken from her care. However, she kept in contact with her son until the time of her death.

13. In 2008, Ms Bourke began a relationship that lasted several years, which also produced a daughter.

14. Mr Bourke described his sister's life as *"tough"*, and frankly noted that she had opportunities to change her life but chose to associate with other drug users and involve herself in the *"drug scene"*, which eventually led to a short period of imprisonment.

15. He noted that he moved back to Warrnambool in 2011, at which time his sister looked well and she informed him that she had stopped using drugs and was making a new life for herself and her daughter. Mr Bourke said, *"We had high hopes for Amanda as did our other family members that she was turning her life around and she was going to make a go of it. We were all happy for her. She even enrolled herself back at TAFE to upgrade her qualifications, so she could get back into the workforce."*

16. However, Ms Bourke sadly returned to the drug scene after 2012 when she recommenced a relationship with a former partner. This culminated in her daughter being taken from her care and Ms Bourke became estranged from her mother and siblings.

17. Mr Bourke stated that he was later saddened and shocked to learn that his sister was in a relationship with Mr Knowles, that she was a victim of family violence, and had been implicated in the death of an associate.

18. Mr Bourke concluded his statement by saying that his sister *"wasn't always an angel in her life, but she tried"* and she dearly loved her children. He noted that her family would never forget her beautiful smile and her infectious laugh.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

19. On the evening of 17 January 2018, Ms Bourke and Mr Knowles had dinner at home. Mr Knowles stated they had been home for a couple of days and had not had anything to drink or used any drugs during this time. Ms Bourke had a *"chuff"* of marijuana at about teatime and Suboxone (buprenorphine), which he injected into her arm. Mr Knowles had a few stubbies of beer before dinner. The couple retired to bed at approximately 10.30pm.

20. On the morning of 18 January 2018, Ms Bourke and Mr Knowles awoke at approximately 10.00am. At about midday, they travelled to Warrnambool and did some grocery shopping.

21. They finished shopping at approximately 2.30pm and visited a friend in Warrnambool. Mr Knowles went to the gym while Ms Bourke stayed at their friend's house.

22. Mr Knowles returned at approximately 3.30pm. The couple had planned to go swimming that day and when they got back into the car and continued driving, they discussed where they should go. They wanted to avoid bumping into acquaintances at Warrnambool beach, so Ms Bourke suggested a spot at Gormans Lane, Tower Hill, which was near a friend's house.

23. The couple parked and walked to the beach. Ms Bourke pointed at a river that ran into the ocean, which Mr Knowles described being *"flat water like a big pond."* Mr Knowles said he did not want to swim there due to sharks.

24. The couple walked past the flat water to the beach. Ms Bourke said, *"Oh well, we'll just swim here,"* and headed into the water. Mr Knowles stated that he voiced concern to Ms Bourke as it was 40 degrees Celsius but there weren't any people on the beach. Appearing to reassure him, Ms Bourke said, *"It's just a quiet spot"*.

25. According to the coronial brief, the couple had elected to swim at a beach known as 'The Cutting', which is located at the southern end of Gormans Road in Tower Hill. This beach is mostly used by surfers.

26. The couple waded into waist-high water approximately 30 metres from the shore. Mr Knowles stated the sea was wavy and choppy and at times the waves broke over their heads. They were in the water for approximately 20 minutes.

27. Mr Knowles stated that Ms Bourke jumped onto his back while he was standing on a sandbank.

28. At about this time, a passer-by, Michael Wright, and his wife were walking along the beach. They stated they saw a couple cuddling in the water. Mr Wright said that they *"seem[ed] to be alright."* They walked on for a few more metres before stopping to talk to a dog walker.

29. Mr Knowles stated that he subsequently moved from his footing and found that he could no longer touch the sea floor. He went under the water and Ms Bourke slipped off his back. She called out to him for help. Mr Knowles grabbed her, but the motion of the waves broke his grip and he momentarily lost sight of Ms Bourke.

30. When Mr Knowles regained sight of Ms Bourke, she was 20 metres away and floating on top of the water. The choppy waves obscured his sight again.

31. Mr Knowles stated that he saw a man on the beach waving at him. He started swimming to the shore, but it seemed as though he was getting pulled back out to sea. He began shouting at the man for help.

32. Mr Wright stated that when he happened to look out to the sea, he saw a man (Mr Knowles) trying to swim to shore. Mr Knowles started yelling for help. Mr Wright could see Ms Bourke floating on her back on the water's surface.

33. Mr Wright took off his shirt and ran into the water. Mr Knowles stated that at this point he could not see Ms Bourke and did not know where she was.

34. Mr Wright stated that he crossed through a large channel that is commonly known to contain a large and dangerous rip. He reached a sandbank and a large hollowed area where Ms Bourke was located.

35. Mr Wright recalled that the waves and the rip were so strong that it took him three attempts to reach an area where he was able be in control.

36. When Mr Wright eventually found Ms Bourke, he grabbed hold of her, and began swimming her back to the shore. When he reached knee-high water, Mr Knowles assisted in bringing her back to shore. He stated that the waves continued to crash over Ms Bourke's face, and he could see her mouth was open and she appeared to be a *"funny colour"*. Mr Wright's wife, Kerryn Hollis, noted that even with an incoming tide, the sea was dragging Ms Bourke back with great force.

37. Once on the shore, they rolled Ms Bourke onto her side and she vomited water. A female passer-by who happened to be a nurse, Tara Trickey, and a male ran over and immediately

started administering cardiopulmonary resuscitation (**CPR**). Ms Trickey noted that Ms Bourke was not breathing and during CPR copious amounts of water came out of her mouth.

38. At some point, Ms Hollis felt for Ms Bourke's pulse. She noted, *"She was still warm and there was a pulse."*

39. Another passer-by, Michelle Butters, contacted emergency services on her mobile telephone. She asked Ms Hollis for the location. Ms Hollis replied that the beach was known as The Cutting, in Killarney, but it appeared that the emergency call-taker could not find the location and kept requesting more information. Ms Hollis stated that Ms Butters grew frustrated with the emergency call-taker and after 15 minutes requested that Ms Hollis take over. Ms Hollis asked why the ambulance was taking so long as it should only have taken 10 minutes. She stated that the emergency call-taker said that she wanted to get the correct details, to which Ms Hollis replied, *"What is so difficult about The Cutting, Gormans Lane, Tower Hill"*. Ms Hollis asked to be put through to the local ambulance, which was not possible.

40. Ms Hollis sent Mr Knowles to the car park to wait for the ambulance. According to Mr Knowles, a female bystander said to him, *"You know she's got a pulse,"* and *"I've rang [sic] the ambulance so you can run up to the car park to direct them to where we are."* Mr Knowles ran up to the car park and waited.

41. Ms Trickey stated that she also spoke to an emergency services call-taker as some point and advised them that Ms Bourke was non-responsive. In her statement, she stated that she performed all the normal checks in relation to airways, breathing, and circulation. Ms Trickey recalled that Ms Bourke's airway was full of fluid, there was no rise and fall of her chest, and no pulse. Her pupils were extremely dilated.

42. When an ambulance did not appear, Mr Knowles returned to the beach where the bystanders were still working on Ms Bourke. Mr Knowles asked whether she would be alright, to which a female bystander replied, *"She's going to be alright."*

43. Mr Knowles returned to the carpark and waited for the ambulance to arrive.

44. Ms Trickey and her friend continued administering CPR until first responders arrived.

45. Ms Bourke could not be revived and was transported to Warrnambool Hospital where she was declared deceased at 7.55pm.

46. Leading Senior Constable Gregory Creek, the first Coroner's Investigator, concluded that Mr Knowles and Ms Bourke likely lacked knowledge of the area, including the sea conditions, currents, and rips, which contributed to Ms Bourke's drowning.

The beach

47. Leading Senior Constable Creek stated that to access the beach persons must travel south down Gormans Road from the Princes Highway in Tower Hill. At the most southern point of Gormans Road there is a carpark to the left. Following the road to the east leads to the second carpark at the end of the road.

48. An access walking track to the south leading to the beach is approximately 50 metres in length. The beach track entrance has warning signs erected indicating that swimming is not advised, that there are strong currents and submerged rocks, and there is no life-saving service at the beach.

49. On entering the beach, there is a lake area to the north east (likely what Mr Knowles described as a river), beach and dunes to the east, and beach and dunes to the west.

50. Leading Senior Constable Creek stated that The Cutting is known to have strong undercurrents, rips, moving sandbanks, hollows and channels, dropping off quickly to waist or chest-level depths, with generally strong wave motion. It is more commonly used to the west as a surfing area.

51. Leading Senior Constable Creek noted that other Port Fairy beaches have signs erected with location codes to be quoted when emergency services are contacted. The Cutting did not have similar signs erected at entry points. He therefore suggested that signage with location information be installed at The Cutting to alleviate future confusion when emergency services are called.

Signage at the beach

52. As part of his investigation, Leading Senior Constable Creek sought advice from Life Saving Victoria regarding whether the signage located in the area complied with applicable standards.

53. Rob Andronaco, Risk and Spatial Analysis Specialist at Life Saving Victoria, subsequently advised that the signage appeared to be mostly consistent with Part 1 of the AS/NZS 2416.1:2010 standard, however noted the following inconsistencies:

(a) the 'Swimming Not Advised' symbol was not the correct symbol as required by the relevant standard. The symbol requires a red cross to be placed over the swimmer to indicate that swimming is not advised. Supplementary text is also required indicating the nature of the hazard that makes swimming inadvisable. The sign did not have any such text or warning and therefore did not effectively educate beachgoers as to why swimming is not advised; and

(b) the 'No Lifesaving' graphic also did not comply with the relevant standard. The symbol on the sign could be interpreted to mean warn against swimming in between the flags rather than warning that swimming is inadvisable due to no lifesaving services being available.

54. Parks Victoria also reviewed the signage in the area and confirmed the above inconsistencies. In June 2018, Matthew Jackson, Chief Executive Officer of Parks Victoria, noted that Parks Victoria was in the process of updating the signage to reflect their signage manual.[2] The new icons and text would warn:

(a) that swimming was not advised due to rough surf; and

(b) that there was no lifesaving service and that children must remain under supervision at all times.

55. Despite the inadequacy of the signage, Mr Andronaco appropriately noted that there is no way to know whether changing the signage would have made a difference to Mr Knowles and Ms Bourke electing to swim at that beach at that particular time. He further noted from an aquatic safety signage application perspective, warning recognition and recall rates are generally less than 50 per cent.[3] Life Saving Victoria therefore recommends multiple risk treatments and prevention programs be utilised in conjunction with safety signage strategies in order to increase awareness, interpretation, and behavioural compliance of signs.

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[2] Mr Jackson noted that the Parks Victoria Signage Manual has been developed with a key focus on current Australian Standards and, as it relates to water safety specifically, closely follows the 2006 Signage Manual compiled by Life Saving Victoria.

[3] See Bernadette Matthews et al. 'Warning signs at beaches: Do they work?' (2014) 62 *Safety Science* 312.

56. Mr Jackson confirmed that there had not been any other drowning incidents on the beach or any beach five kilometres east or west in the past 10 years or more.

Emergency services response

57. The Inspector-General for Emergency Management **(IGEM)** conducted an investigation into the call-taking and dispatch of emergency services for Ms Bourke and compiled a detailed report dated 14 June 2019. I do not intend to repeat the contents of that report given its thoroughness but note the IGEM's investigation revealed the following:

    (a) at 5.36pm on 18 January 2018, a call was made to 000 to request emergency services to attend to Ms Bourke, which was transferred to an Emergency Services Telecommunications Authority **(ESTA)** call-taker;

    (b) the caller reported the location to be Killarney Beach and also gave a conflicting piece of location information, stating the beach was 'The Cutting';

    (c) at 5.38pm, Ambulance Victoria and Victoria Police were notified. However, the patient's location was entered as Killarney Beach, not Rutledges Cutting in the relevant computer system. These locations are more than six kilometres apart. Ambulance Victoria and Victoria Police were therefore dispatched to Killarney Beach;

    (d) at 5.44pm, whilst paramedics and police were *en route* to Killarney Beach, police requested the assistance of State Emergency Service given the possibility of challenging terrain;

    (e) the ESTA call-taker had remained on the phone with the caller during this period and subsequently recognised that the location was not Killarney Beach. This recognition occurred before the arrival of the first emergency services personnel at the wrong location;

    (f) at 5.50pm, the location was then verified to be Gormans Road, Tower Hill, the access road to Rutledges Cutting Beach. This was 12 minutes after Ambulance Victoria and Victoria Police were notified to dispatch;

    (g) the ESTA call-taker immediately notified ambulance resources via pager and radio with the correct address but did not make clear in the message that this represented a

change of location. This meant that emergency services continued to Killarney Beach;

(h) at 5.52pm, the Country Fire Authority and State Emergency Service were notified to attend a rescue at Killarney Beach. This was seven minutes after the initial request for State Emergency Service assistance from police;

(i) the Country Fire Authority and State Emergency Service were subsequently dispatched to Killarney Beach;

(j) at 5.55pm, the first paramedics arrived at Killarney Beach and could not find the patient. The correct location was updated via radio;

(k) at 5.57pm the first ambulance arrived at The Cutting. This was 21 minutes after the 000 call was answered;

(l) at 6.03pm, Victoria Police arrived at The Cutting, after first attending Killarney Beach;

(m) at 6.05pm, the Country Fire Authority arrived at The Cutting; and

(n) at 6.19pm, State Emergency Service arrived at The Cutting after first attending Killarney Beach, which was 34 minutes after the police request.

58. The IGEM found that although the ESTA call-taker had recognised the correct location of the event prior to the first responders arriving at Killarney Beach, they did not pass this information on in an effective and timely manner. This meant that each emergency services agency arrived at Killarney Beach one after the other and worked out for the themselves that it was the incorrect location. This was due to issues related to the sharing of information across agency dispatchers and multi-agency event management.

59. Addressing the root causes of the identified issues, the IGEM made a number of recommendations for improvement, which I will not repeat here. The ESTA has confirmed that it accepts the IGEM's recommendations and is committed to continual improvement in its delivery of services.

60. Todd Richards, Quality Improvement Officer at ESTA, noted that this event highlighted the challenges that can be encountered with verification of remote or beach locations. He noted:

Initial location information of Killarney Beach was provided (not Rutledges Cutting or Tower Hill). Killarney Beach, Killarney, forms part of the same stretch of the Belfast Coastline as Rutledges Cutting, Tower Hill. Further, the additional location information of 'The Cutting' reflects how the locals refer to this stretch of beach, rather than the name of the beach as recorded on the map information used by ESTA. Those on scene also mentioned 'The Basin', which could suggest that they were at the location that the ESTA call-taker initially thought (which in fact proved to be incorrect). ... All of these factors contributed to difficulty in pinpointing the location of the patient.

61. I also note that in his letter to the Court, Mr Richards welcomed any recommendations that may assist with location verification in remote/beach areas.

Ms Bourke's Community Corrections Order

62. At the time of her death, Ms Bourke was subject to a 12-month Community Corrections Order (**CCO**) combined with imprisonment. The CCO component commenced on 7 December 2017 upon Ms Bourke's release from custody. For the majority of her CCO, Ms Bourke was under the supervision of Geelong Community Correctional Services.

63. While not directly relevant to the circumstances of Ms Bourke's death, the Justice Assurance and Review Office (**JARO**) identified some missed opportunities for case management of Ms Bourke.

64. In its report, the JARO identified Ms Bourke as a high-risk offender with an extensive history of family violence, drug use, and intermittent offending. One of the conditions of her CCO was to be assessed and receive treatment (including testing) for drug abuse or dependency as directed.

65. Ms Bourke missed two appointments with Community Correctional Services for drug-related reasons and advised police that she continued to struggle with her drug use. The JARO acknowledged that these missed appointments inhibited her referral to drug and alcohol treatment or drug testing referrals. Despite the lack of attendance, Community Correctional Services was aware that Ms Bourke was struggling to cope but there was a lack of planning and case management to address her drug use.

66. However, the JARO identified that Mr Bourke's case manager prioritised her family violence issues and contacted a number of external organisations to obtain further

information about Ms Bourke's circumstances and the best way to assist her. The JARO noted that a significant amount of pre-supervision planning was undertaken in preparation for Ms Bourke's attendance, which did not eventuate.

67. Following its review of Ms Bourke's death, the JARO did not make any recommendations.

CAUSE OF DEATH

68. On 19 January 2018, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 9 March 2018. In that report, Dr Young concluded that a reasonable cause of death was '*Drowning*'.

69. Toxicological analysis identified the presence of ethanol (alcohol) and methylamphetamine.

70. Dr Young also identified a number of injuries, including small abrasions on Ms Bourke's right forearm, left hand and wrist, and right knee and bruises on her left thigh. In addition, there were signs consistent with medical intervention.

71. Dr Young confirmed there were no unexpected signs of trauma. The computer tomography (CT) scan did not show any significant pathology.

72. He noted that post mortem diagnosis of drowning can be difficult and is essentially one of exclusion, as there are no specific signs. In the absence of any significant injuries, the circumstances in this case were consistent with drowning.

73. I accept Dr Young's opinion as to cause of death.

FINDINGS AND CONCLUSION

74. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Amanda Bourke, born 28 April 1973, died on 18 January 2018 at The Cutting, Gormans Road, Tower Hill, Victoria, from drowning in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with Ms Bourke's death:

1. I acknowledge that Ms Bourke's forensic history and her estrangement from her family does not detract from the fact that she was a beloved member of her family who very much miss her, and her death was a tragedy.

2. Although on first examination there were a number of unusual aspects to Ms Bourke's death, which I discuss below, I am satisfied that her death was the result of a tragic accident.

The beach and signage

3. The evidence from Leading Senior Constable Creek and witnesses make clear that the conditions of the sea at the beach known to locals as The Cutting were treacherous. These conditions included swell, rips and undercurrents, and a varying seafloor. These hazards were well known to locals but remained wickedly hidden to any out-of-towners. Indeed, this is evidenced by Ms Bourke and Mr Knowles jumping straight into the water while the locals, such as Ms Hollis, wondered why the couple were swimming there – an area known for its substantial rips.

4. Mr Wright, the rescuer, stated that the waves and rip were so strong that it took him three attempts to get through to an area where he was able to control his actions. His wife, Ms Hollis, stated that it took her husband about 10 minutes to swim 50 metres and bring Ms Bourke to shore. When Mr Wright was bringing Ms Bourke back to shore, the sea tried to drag her back *"with great force"*.

5. Given the hidden dangers of this beach, it is paramount that there is adequate signage warning of those dangers in the area. While I note Mr Andronaco's caution that warning recognition and recall rates are generally less than 50 per cent and that there is no way to know that the signage would have affected Mr Knowles and Ms Bourke's decision to swim at the beach that day, I am satisfied that the signage did not comply with relevant AS/NZS standards. However, I do not propose to make a recommendation that the signage be updated given Parks Victoria has advised it was in the process of replacing the inconsistent icons and text.

Confusion regarding location

6. An extremely frustrating aspect of this case is the confusion of by-standers and emergency services as to the correct location of Ms Bourke's rescue. As Mr Richards noted, the location was reported to be 'Killarney Beach' and 'The Cutting' and people at the scene also referred to the location as 'The Basin'.

7. It is not an uncommon scenario for out-of-town visitors to be unaware of the exact location of a beach. They may drive down an unsealed road, park in the closest carpark, and then proceed to walk for kilometres down the beach, not realising the exact location or name of the beach upon which they are walking. Likewise, it is not unusual for a beach or other area to be known by locals as another name.

8. In recognition of this phenomenon, some beach warning signs provide an emergency marker (code) to quote should emergency services be required. Leading Senior Constable Creek identified that Port Fairy beaches have signs erected with such codes to be quoted when emergency services are contacted. The Cutting did not have similar signs erected at beach entry points. He therefore suggested that signage with location information be installed at The Cutting to alleviate future confusion when emergency services are called.

9. I accept that the confusion regarding location and subsequent delay in the arrival of emergency services may have been avoided had passers-by been able to quote a unique code to the ESTA call-taker. I will therefore make a recommendation that Parks Victoria include a unique emergency marker code on each warning sign at beaches along the Belfast Coastal Reserve.

The delay of emergency services

10. I am satisfied that there was a delay in paramedics and other emergency services arriving at the scene due to the confusion surrounding the correct location and for the reasons set out in the IGEM's report.

11. There is inconsistent evidence as to Ms Bourke's condition when she was pulled out of the sea. While Ms Hollis stated that she checked for and felt Ms Bourke's pulse, Ms Trickey stated that there was no pulse. However, both noted that Ms Bourke was unconscious and unresponsive. I also note that Ms Trickey, a registered nurse, and her friend administered CPR until emergency services arrived at the scene.

12. I am therefore unable to be satisfied that the delay contributed to or caused Ms Bourke's death.

Whether Mr Knowles took action to bring about Ms Bourke's death

13. In July 2018, Ms Bourke's family filed a submission to the Court outlining their concerns with the investigation. This submission formed the basis for their request for inquest, which was subsequently withdrawn in January 2020.

14. In summary, their concerns referred to inconsistent evidence in the coronial brief, particularly to the reliability of Mr Knowles' evidence, which led to their concerns that Mr Knowles had taken action to bring about Ms Bourke's death.

15. Ms Bourke's family was also concerned by the delay in paramedics arriving at the scene, which I have addressed above.

Inconsistent evidence

16. Ms Bourke's family identified that Mr Knowles made inconsistent statements in the coronial brief as follows:

    (a) Mr Knowles stated that Ms Bourke ingested marijuana and buprenorphine the night before her death, but these were not detected in the post mortem toxicological analysis; and

    (b) Mr Knowles stated that the lady administering CPR said Ms Bourke had a pulse and was going to be alright, but in her statement Ms Trickey (the female who had administered CPR) stated there was no pulse.

17. Mr Knowles' statement regarding Ms Bourke's drug use during the evening preceding her death and the post mortem toxicology report appear inconsistent. Given the cause of Ms Bourke's death is drowning, I do not intend to obtain an expert report regarding why certain drugs may not have been identified during post mortem analysis.

18. The drugs that were identified during post mortem analysis were ethanol (0.01 g/100mL) and methylamphetamine (~ 0.03 mg/L). Given the low concentration of these drugs, they are unlikely to have significantly contributed to Ms Bourke's cause of death.

19. In regard to the family's concerns that Mr Knowles was told Ms Bourke had a pulse:

(a) Mr Knowles stated a lady said Ms Bourke had a pulse and that she had contacted emergency services and instructed him to go to the car park to wait. Later he states that he asked a lady whether Ms Bourke was going to be alright and the lady told him Ms Bourke would be alright. In the context of his statement, it appears the 'lady' in both of these scenarios refers to the bystander who happened to be a nurse;

(b) Ms Hollis stated that she had detected a pulse and she sent Mr Knowles up to the car park to wait for the ambulance; and

(c) Ms Trickey, the nurse who administered CPR, stated that Ms Bourke had no pulse. Her statement does not specify whether she spoke to Mr Knowles.

20. There appear to be inconsistencies regarding who told Mr Knowles that Ms Bourke was going to be alright and instructed him to wait for the ambulance in the car park. I am satisfied that either Ms Hollis or Ms Trickey told Mr Knowles that his fiancée would be alright, possibly to calm him (even if the information was untrue), and instructed him to wait in the car park. Mr Knowles may or may not be mistaken about which 'lady' spoke to him. Either way, I am satisfied these inconsistencies are minor and do not significantly muddy the narrative.

History of family violence

21. The Bourke family's submissions referred to the significant history of family violence between Mr Knowles and Ms Bourke and Mr Knowles' extensive criminal history.

22. Between 21 November 2016 and 20 November 2017, Ms Bourke was the affected family member named in an intervention order against Mr Knowles. The order was granted in response to an incident occurring on 17 November 2016.

23. On 26 January 2017, police observed Ms Bourke with a black eye. When questioned, Ms Bourke reported that Mr Knowles had punched her the previous night and disclosed further incidents of violence occurring since August 2016. Police applied for an intervention order on Ms Bourke's behalf, however I do not have a record of that order being granted before me.

24. Ms Bourke's family referred me to an article appearing in *The Standard* on 16 February 2017, which refers to Mr Knowles being arrested and held in custody after assaulting Ms Bourke on 26 January 2017. Ms Bourke appears to have given evidence regarding the

previous violence committed against her by Mr Knowles. Magistrate Michael Coghlan is quoted as saying he held grave gears for Ms Bourke's welfare.

25. While I am satisfied that that was a history of violence committed by Mr Knowles against Ms Bourke, there is no evidence to suggest he took any action to bring about Ms Bourke's death on 18 January 2018. The post mortem inspection report identified minor injuries including abrasions and bruises. There were no significant injuries and no unexpected signs of trauma.

26. While I acknowledge that the Bourke family held significant concerns about the history of family violence, as noted above the coronial standard of proof is upon the balance of probabilities and the Court is guided by the principles set down in *Briginshaw v Briginshaw*. There is no evidence that satisfies me that Mr Knowles took action to bring about Ms Bourke's death. The evidence before me, which includes in the post mortem inspection report and the accounts of the other beachgoers, provides me with a comfortable level of satisfaction that Ms Bourke's death was the result of a tragic accident occurring on a day in which the sea conditions were treacherous.

Involvement in the death of Stephen Johnston

27. Ms Bourke's family was also concerned that Mr Knowles had reason to bring harm to Ms Bourke because she could provide evidence against him regarding his involvement in the death of Stephen Johnston.

28. In the *Finding into Death with Inquest into the death of Stephen James Johnston,*[4] Coroner Simon McGregor found *inter alia*:

    (a) Mr Knowles and Ms Bourke associated with Mr Johnston on the evening preceding his death, 7 December 2016;

    (b) Ms Bourke was interviewed by police in relation to this incident and provided a statement in which she confirmed that Mr Knowles had assaulted Mr Johnston;

    (c) Mr Knowles wrote letters to Ms Bourke about the incident, which were tendered during the inquest;

    (d) Mr Knowles and Ms Bourke both tampered with evidence at the scene of the assault and stole Mr Johnston's car and bank cards; and

[4] Finding delivered on 12 February 2020.

(e) they sought to conceal evidence of the assault.

29. Coroner McGregor ultimately found that Mr Knowles was responsible for Mr Johnston's injuries and subsequent neglect that caused his death and made a referral to the Director of Public Prosecutions pursuant to section 49(1) of the Act as he believed an indictable offence may have been committed in connection with Mr Johnston's death.

30. While I am satisfied that Ms Bourke may have been the only witness to Mr Johnston's assault and therefore could directly inculpate Mr Knowles, for the reasons set out above, I remain satisfied that the cause of Ms Bourke's death was drowning, being an accident caused by treacherous sea conditions, rather than by Mr Knowles' deliberate action(s).

RECOMMENDATIONS

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

1. In order to prevent further instances where the response of emergency services is delayed due to confusion or unawareness of the correct emergency location, I **recommend** that **Parks Victoria** review the warning signs along the Belfast Coastal Reserve to ensure unique emergency marker codes are included where appropriate.

I convey my sincere condolences to Ms Bourke's family for their loss.

I commend Michael Wright and the other passers-by who attempted to assist Ms Bourke on the beach.

Pursuant to section 73(1) of the Act, I direct this finding be published on the Internet.

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

Kevin Knowles, senior next of kin

Ms Bourke's family (care of Archbold & Co Legal)

Parks Victoria

Emergency Services Telecommunications Authority (care of K&L Gates)

Inspector-General of Emergency Management

Justice Assurance and Review Office

Detective Leading Senior Constable Craig Wastell, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 20 November 2020