IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004420

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	Hunter Patrick Boyle
Date of birth:	21 July 2018
Date of death:	12 August 2020
Cause of death:	1(a) CONSISTENT WITH DROWNING
Place of death:	Goulburn Valley Health, Shepparton Public Hospital, 2 Graham Street, Shepparton, Victoria, 3630

INTRODUCTION

1. On 12 August 2020, Hunter Patrick Boyle (**Hunter**) was 2 years old when he died at Goulburn Valley Health at Shepparton Public Hospital.

2. Prior to his death, Hunter resided with his parents, Mr Matthew Boyle, and Ms Ashlie-Jane Napolitano in Shepparton.

3. Hunter was cherished by his family and friends. He was affectionately known to his family as 'Hurricane' due to his nature and mannerisms. Ms Napolitano stated that Hunter's '*goal in life from early on was to make everyone laugh, he loved everyone*.'[1] Hunter was an energetic little boy and was very fond of animals.

4. In March 2020, due to the COVID-19 pandemic, Ms Napolitano began working from home and found it difficult to attend to her computer-based work and care for Hunter during the day. While it was Ms Napolitano's preference that Hunter be at home with her, Hunter was often cared for by his relatives, including his grandfather, Mr Geoffrey Boyle (**Geoffrey**) who generally took care of Hunter 2 or 3 days per week.[2]

THE CORONIAL INVESTIGATION

5. Hunter'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. 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.

7. 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.

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[1] Coronial Brief (**CB**), pg 27.
[2] CB, pg 43.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Hunter's death. The Coroner's Investigator, Detective Acting Sergeant Josh Coombs, conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, paramedics, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Hunter Patrick Boyle including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

10. On 12 August 2020, Hunter Patrick Boyle, born 21 July 2018, was visually identified by his father, Mr Matthew Boyle.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

12. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine conducted an external examination of Hunter on 13 August 2020 and provided a written report of his findings dated 18 August 2020.[4]

13. The post-mortem examination revealed signs of medical intervention with no unexpected signs of trauma. A post-mortem CT scan showed no significant pathology and no evidence of unexpected skeletal trauma.

14. Toxicological analysis of post-mortem samples identified the presence of morphine and midazolam which were administered in a hospital setting.

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[3] 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.

[4] CB, pg 63.

15. Dr Young provided an opinion that the medical cause of death was:

    1 (a) CONSISTENT WITH DROWNING.

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

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

17. At around 8.30am on 12 August 2020, Geoffrey attended the residence of Ms Napolitano and Mr Boyle.

18. Ms Napolitano was getting Hunter ready for the day, and he was wearing a grey jumper, blue tracksuit pants and Paw Patrol gumboots. Ms Napolitano spoke with Geoffrey and commenced working from home whilst he and Hunter returned to his rental property in Northey Road, Grahamvale.[5]

19. The property is 1.39 acres in size and was situated to the west of a further 1.51-acre lot. Geoffrey had rented both premises for several years. Situated on the 1.51-acre lot was a small dam that is fed by natural rainfall and run off from adjoining sheds. Additionally, the dam is fed by a pipeline from a nearby irrigation channel.

20. After they arrived home, Geoffrey fed Hunter breakfast. At 10.30am, Hunter walked to the refrigerator and removed some carrots from the fridge. He said '*Terry, Terry, Terry,'* which is the name of Geoffrey's horse.[6]

21. Geoffrey responded that they would go and get Terry. Hunter was excited and they walked through the rear door of the dwelling, across a rear yard to a pedestrian gate through the boundary fences between the two Northey Road properties. The gate between the properties is made of a repurposed length of pool fencing which swings inward to the 1.51-acre lot. The gate is secured by a metal chain.

22. Geoffrey opened the gate and he and Hunter entered the paddock. Once at the property, Hunter fed Terry the carrots. When the carrots had been eaten, Hunter gave Terry a kiss on the nose and said, '*all gone*.' Geoffrey and Hunter started walking towards the front of the property.[7]

23. Geoffrey recalled that Hunter was with him for a distance of two steps. He walked towards the chicken coop and thought that Hunter was still beside him. As he reached the fence level

[5] CB, pg 29.
[6] CB, pg 43.
[7] CB, pg 44.

with the chicken pen, Geoffrey looked down and realised Hunter was not present. It had only been 30 seconds to a minute.[8]

24. Geoffrey's first thought was that Hunter had perhaps gone back towards the house to get more carrots as he had done that before. Geoffrey looked over the fence towards the house as he expected to see Hunter walking, but Hunter was not there. Geoffrey walked to the dam but still could not see him. He commenced yelling out Hunter's name.

25. Geoffrey scanned the area again and observed Hunter floating face down in the dam in the centre of the property. He was in the south-eastern corner approximately 1-1.5 metres from the dam's edge. Hunter was submerged with only his grey hoodie poking through the water.[9]

26. Geoffrey immediately entered the dam which was knee deep and retrieved Hunter who was unconscious. He rolled Hunter on his side and removed grass and what appeared to be green algae from Hunter's mouth and airways. Geoffrey commenced cardiopulmonary resuscitation (**CPR**). He also contacted emergency services and Ms Napolitano.

27. Between 11:23am and 11:29am, members of Rural Ambulance Victoria and Victoria Police arrived at the Northey Road property.[10] Ms Napolitano had also arrived. CPR was continued and the initial observation by paramedics was that Hunter was cold to the touch, pulseless and unconscious. Endotracheal intubation was performed which was determined to be initially successful. However, this diminished a short time later and a decision was made to reinsert a supraglottic airway.[11]

28. Further treatment was administered, and Hunter was transported to Goulburn Valley Health (**GVH**), arriving in the GVH Emergency Department at 11:54pm. A team of specialty doctors were in attendance and aided with resuscitation attempts. Hunter was determined to be in a hypothermic state and was actively warmed to return him to a normal temperature. Regular updates and consultations were made with the Royal Children's Hospital Paediatric Infant Perinatal Emergency Retrieval (**PIPER**) Unit.[12]

29. Over the following hours, resuscitation attempts continued. At 1.51pm, the PIPER Unit arrived at GVH and were briefed on Hunter's situation and treatment. It was determined that resuscitation attempts would continue until Hunter was warm, but with the express

[8] CB, pg 44.
[9] Ibid.
[10] CB, pgs 78 – 80 and 85 – 87.
[11] CB, pg 85.
[12] CB, pg 58.

understanding that given the prolonged downtime, there was a small chance of any meaningful survival outcome. This prognosis was discussed with Hunter's parents.[13]

30. At 2.37pm, medical staff achieved a return of spontaneous circulation. After a brief period of stabilisation, Hunter was intubated. At this time, his direct care was transferred to the PIPER Unit and Hunter was being prepared for transport to the Royal Children's Hospital (**RCH**).[14]

31. Hunter was attached to the transport monitoring equipment, however there was an issue with his ventilation and medical staff were of the belief that the ET tube had become displaced. Hunter was successfully re-intubated and his ventilation transiently improved. However, Hunter started to deteriorate and any attempted movement, even to change monitoring leads from the GVH systems into the PIPER portable units would often result in minutes of acute deterioration, requiring changes in ventilators and vasopressors.

32. After all attempts were made to stabilise Hunter to enable an emergency flight to the RCH, the PIPER Unit determined in consultation with Dr Jason Musci that transportation to Melbourne would likely not be beneficial.[15]

33. Discussions were held with Hunter's family to advise them of the prognosis. Hunter subsequently died at 6.24pm in his parents' arms.[16]

Police scene examination of the Northey Road property

34. Police examined the Northey Road property and located a 4-litre ice cream container floating in the south-eastern extremity of the dam. The significance of this container has not been determined by police. Located in close proximity to the container was a heel impression in mud of what appeared to be a child's right shoe. Subsequently, police located a left blue coloured gumboot worn by Hunter at the bottom of the dam which matched the imprint. The boot was in an upright position, suck in approximately 1 inch of heavy, sticky mud. The position of the boot was facing away (north) from the southern edge of the dam, towards the deeper section of the dam. It was determined that the gumboot was located approximately 1.5 metres from both the southern and eastern edges of the dam.[17]

[13] CB, pg 59.
[14] Ibid.
[15] CB, pg 60.
[16] CB, pg 31.
[17] CB, pg 91 – 92.

35. Investigators believe that Hunter entered the dam whilst out of sight of his grandfather for unknown reasons, perhaps to retrieve the ice cream container. It was determined that he entered the dam in the south-eastern corner and had moved in a general northerly direction. It is probable that Hunter either lost his footing, causing him to fall into the water, or alternatively, he had his foot and gumboot stuck in the mud. During attempts to free his foot, this has caused him to lose balance and fall into the water. Hunter ingested algae and water whilst attempting to extricate himself from the dam and given the cold water, his core body temperature plummeted, causing a hypothermic state.[18]

FINDINGS AND CONCLUSION

36. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Hunter Patrick Boyle, born 21 July 2018;

    b) the death occurred on 12 August 2020 at Goulburn Valley Health, Shepparton Public Hospital, 2 Graham Street, Shepparton, Victoria, 3630, in circumstances consistent with drowning and;

    c) the death occurred in the circumstances described above.

37. I find that Hunter's death was accidental.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

38. Hunter's death is an unimaginable tragedy for his family as well as the wider community. Unfortunately, drowning is one of the leading causes of unintentional death for Australian children. In 2020/21, 25 children aged between 0-4 drowned in Australia. This is an 108% increase on 2019/20 and a 9% increase on the 10-year average.[19]

39. Children can drown in as little as 20 seconds and in only a few centimetres of water. The KidSafe Victoria Drowning Information Sheet[20] notes that '*children are adventurous and enjoy exploring their environments. They are often attracted to water but have little*

[18] Summary of incident authored Coroner's Investigator, Detective Acting Sergeant Josh Coombs.
[19] Royal Life Saving National Drowning Report 2021 https://www.royallifesaving.com.au/research-and-policy/drowning-research/national-drowning-reports/Explore-the-national-drowning-report-2021
[20] https://kidsafe.com.au/wp-content/uploads/2019/03/Drowning-Information-Sheet.pdf

understanding of the danger that it poses. The physical build of young children also places them at risk as they are 'top heavy' and prone to falling in water due to a lack of balance. Drowning can occur quickly and silently.'

40. It is imperative, especially in the lead up to the next summer season, that the Victorian community continue to be reminded of the dangers of unintentional drowning in young children in both large and small bodies of water.

Response from Life Saving Victoria

41. In order to determine what recommendations may assist in preventing future drowning deaths in children, the Court wrote to Life Saving Victoria (**LSV**), an organisation whose mission is to prevent aquatic related death and injury in all Victorian communities.

42. On 19 November 2021, Dr Bernadette Matthews (Principal Research Associate & General Manager) and Mr Andy Dennis (General Manager Training and Aquatic Industry) at LSV provided a response to the Court outlining the following:

    a) The risk of young children aged 0-4 years drowning in or around the home, is amplified if the home environment includes large bodies of water, such as agricultural dams.

    They noted that '*one of the most effective primary drowning prevention methods particularly for young children is to create a barrier around the waterbody in order to passively restrict access. The introduction of mandatory home pool and spa barriers has significantly reduced child drowning in these waterbodies in Victoria.*

    In regard to restricting access to water, current recommendations for farms include providing a safe play area which is a securely fenced house yard or play area, for young children to play and to provide a barrier to dams, farm machinery and vehicles, and other farm hazards.'[21]

[21] https://www.royallifesaving.com.au/stay-safe-active/locations/farm-water-safety

b) Other prevention opportunities for child drowning include the four components of the Royal Life Saving Australia '*Keep Watch Campaign*'[22] which are:

i. **Supervise**-actively supervising children around water and focusing all attention on children at the time that they are in, on or around the water.

ii. **Restrict-**Restrict Children's access to water which may include having barriers around water.

iii. **Teach**-Teach children water safety skills so that they are water confident such as learn to swim classes.

iv. **Respond**-Learn how to respond in case of an emergency, such as carrying out CPR and calling Triple Zero 000 in an emergency.

43. Further, the LSV noted that in relation to farms, '*Keep Watch @ The Farm includes the promotion of active supervision in or around water on farms, child safe play areas; filling in any unused holes where water can gather such as ditches and postholes; and securely covering water storage such as wells and tanks. Child water safety on farms is also promoted via the Victorian Play it Safe by the Water Campaign*[23] *and as part of overall child safety on farms through Farmsafe Australia.*[24]'

44. I thank the LSV for their response as well as the various institutions and organisations involved in these different campaigns. These campaigns are vital to ensuring the safety of our children, particularly in rural areas.

45. In addition, I commend Ms Napolitano and Mr Boyle for their work in trying to establish and pilot the Hunter Boyle Children's Swim Program[25] for Shepparton. This program aims to fund 12 months' worth of swimming lessons and education around water safety to vulnerable children between 6 months -12 years of age.

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[22] https://www.royallifesaving.com.au/about/campaigns-and-programs/keep-watch/keep-watch-actions

[23] https://www.watersafety.vic.gov.au/resources#:~:text=A%20%27child%20safe%20play%20area%27%20can%20be%20used,Ensure%20all%20gates%20on%20your%20property%20are%20closed.

[24] https://storage.googleapis.com/kms-au.appspot.com/sites/farmsafe-new/assets/e2bcc5ec-703e-4835-98ac-46a0a21afa60/Farmsafe_%235Factsheet%20Child%20Safety%20on%20Farms_2020_FAR.pdf

[25] https://www.givenow.com.au/crowdraiser/public/thehunterboylechildrensfoundation

RECOMMENDATIONS

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

46. In accordance with the response of LSV, I recommend that water safety campaigns run by relevant organisations such as Farmsafe, KidSafe, LSV and local government in Victoria, continue to promote public awareness of:

    i. how quickly children can get into danger around water, with a particular focus on waterbodies around the home and the differences between rural and urban water hazards;

    ii. the importance of fencing and/or safety barriers where appropriate to restrict access to water hazards and serve as a visual and physical barrier for children;

    iii. the wearing of high visibility clothing for children on rural properties to aid the visibility of children when on the property and to potentially decrease the search time for victims;

    iv. the removal of any items floating in dams that may attract children into the water and;

    v. having an emergency action plan in place where inland water bodies are present.

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

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ashlie Napolitano & Matthew Boyle, Senior Next of Kin

Detective Acting Sergeant Josh Coombs, Coroner's Investigator

KidSafe Victoria

Life Saving Victoria

Farm Safe Australia

Secretary, Department of Jobs, Precincts and Regions

Department of Justice and Community Safety

Minister for Agriculture

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date : 28 April 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.