IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	**COR 2021 000269**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Ahedah Hamed
Date of birth:	24 December 1975
Date of death:	13 January 2021
Cause of death:	1(a) Drowning
Place of death:	Bushrangers Bay, Cape Schanck, Victoria, 3939
Keywords:	Drowning; Bushrangers Bay; recommendation

INTRODUCTION

1. On 13 January 2021, Ahedah Hamed was 45 years old when she drowned at Bushrangers Bay on the Mornington Peninsula. At the time of her death, Ahedah lived in Epping and worked at a post office.

2. Ahedah is survived by her four children.

THE CORONIAL INVESTIGATION

3. Ahedah'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.

4. 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.

5. 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.

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

7. This finding draws on the totality of the coronial investigation into the death of Ahedah Hamed 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.[1]

[1] 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.

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

Circumstances in which the death occurred

8. At around 12:30pm on 13 January 2021, Ahedah and a group of five friends attended Bushrangers Bay beach. Ahedah could not swim, and the others were not strong swimmers. According to her friend Amani, it was a 'beautiful sunny day' with a calm ocean.[2]

9. Bushrangers Bay is an isolated bay at the back of Cape Schanck. It is a dangerous beach with unpredictable rips, strong currents, rocky reefs and large waves. It is unpatrolled and has limited access for emergency services. Swimming at Bushrangers Bay is not recommended.[3] At the time of the incident, there was no warning signage on the beach.[4]

10. At approximately 3:30pm, the group were standing on the rock pools at the front area of the bay. The weather had become extremely windy. A large wave hit the rock face and spilled over to where the group were standing, causing them to lose their footing. Another wave then hit the rock face, pulling all but Amani into the water. Amani moved clear of the rocks and attempted to call emergency services but was unable to due to poor telecommunications coverage.[5]

11. Beachgoer Oliver and his partner Laura observed three people holding each other treading water, and another, later determined to be Ahedah, floating face down in the water around 20 metres further out. Laura ran to a rocky outcrop and was able to call emergency services. Other beachgoers, including an off-duty lifeguard, attempted to rescue the group.[6]

12. At approximately 3:45pm, police officers and Ambulance Victoria paramedics arrived at the scene. Due to the remote location, they were delayed by having to drive through rural private property. Once at the scene, they were directed to the area of the beach, which was unable to be accessed by vehicle and was approximately five minutes away by foot.

13. Emergency services observed five people in the water, two of whom were rescuers. They were advised that a sixth person, Ahedah, was also in the water but could no longer be seen. Using

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[2] CB, Statement of Amani Mazloum, dated 10 September 2021.
[3] https://www.parks.vic.gov.au/places-to-see/sites/bushrangers-bay-walk
[4] Court File (**CF**), Email from First Constable Christopher Hindley to Coroners Court of Victoria, dated 11 August 2022.
[5] CB, Statement of Amani Mazloum, dated 10 September 2021.
[6] CB, Statement of Oliver Paterson, dated 22 September 2021.

binoculars, First Constable Petyka Slattery located Ahedah floating face down a few hundred metres from the rest of the group.[7]

14. The Victoria Police Airwing, Air Ambulance and Westpac Helicopter Rescue Service arrived and winched Ahedah into a helicopter, transporting her to a staging area on a nearby property. Others in the water were rescued via helicopter or the Victoria Police Marine Rescue Unit.[8]

15. Tragically, Ahedah was pronounced deceased at the scene.

Identity of the deceased

16. On 14 January 2021, Ahedah Hamed, born 24 December 1975, was visually identified by her son, Kudar Hamed, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Joanna Moira Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Ahedah Hamed on 14 January 2021. Dr Glengarry reviewed the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of her findings dated 18 January 2021.

19. The post mortem examination revealed features in keeping with the clinical history and known circumstances. There were minor abrasions of the skin, but no significant trauma was identified.

20. Toxicological analysis of post mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.[9]

21. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) DROWNING.

[7] CB, Statement of First Constable Peyka Slattery, dated 7 August 2021.
[8] Ibid.
[9] Court File (**CF**), Toxicology Report of Sophie Widdop, Forensic Toxicologist, dated 5 February 2021.

CORONERS PREVENTION UNIT REVIEW

22. With a view to identifying similar incidents and therefore any pertinent prevention opportunities, I asked the Coroners Prevention Unit (**CPU**)[10] to provide me with data on unintentional ocean drowning deaths in Victoria.

23. The CPU interrogated its surveillance database[11] to identify all unintentional ocean drowning deaths reported to the Victorian coroner between 1 January 2012 and 30 September 2022, where there was evidence that the deceased did not intend to enter the ocean.

24. The CPU identified 25 relevant drowning deaths. Of these 25 deaths, 11 were people who were rock fishing, 11, including Ahedah, were people walking or playing near the water but did not intend to swim, and three were people fishing from a pier or from the shoreline.

COMMENTS

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

1. Ahedah's death highlights the inherent risks associated with water, particularly the ocean where conditions can change from calm to hazardous in an extremely short time. The risks were amplified for Ahedah because she could not swim.

2. Victorian coroners have investigated numerous drowning deaths and made appropriate recommendations with a view to preventing like deaths from occurring. Most relevant to the circumstances of Ahedah's death, Coroner Clive Alsop investigated the death of Leighton Erbs,[12] who died at 'The Oaks' beach at Cape Patterson, after a large wave swept him from a rocky area into the ocean. There was no warning signage at the beach, and its location is only accessible by foot, making it difficult for emergency services to attend.

3. Coroner Alsop handed down his finding into the death on 2 December 2014 and made the following recommendation:[13]

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[10] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[11] The surveillance database contains information on all Victorian deaths reported to the coroner since 1 January 2000.

[12] COR 2013 004727.

[13] COR 2013 004727 *Form 38 Finding into Death without Inquest,* dated 2 December 2014.

Pursuant to my powers under the Coroners Act, I recommend the immediate installation of clear signs, explaining in simplistic language, the dangers of the region and the possibility of quick changes in the sea from conditions of relative calm to those of extreme danger.

4. There is no way to know whether signage warning Ahedah to the dangers present at Bushrangers Bay would have changed the tragic outcome, however, I am of the view that any information as to hazards can only be beneficial in the sense that it allows people to make decisions about their behaviour with safety in mind.

5. Whilst I acknowledge that the Parks Victoria[14] website describes Bushrangers Bay as a 'dangerous beach' and outlines specific hazards, it is ultimately unrealistic to expect that all visitors will research the location prior to visiting. Clear, visible signage at the beach itself, or the pathway leading to the beach, is an effective means of communicating hazards and the need for caution.

RECOMMENDATIONS

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

(i) With the aim of preventing like deaths and promoting public health and safety, I recommend that Parks Victoria consider the installation of signage at Bushrangers Bay that clearly and concisely warns visitor of the hazards present in the area and the need for caution around the water.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Ahedah Hamed, born 24 December 1975;

   b) the death occurred on 13 January 2021 at Bushrangers Bay, Cape Schanck, Victoria, 3939;

   c) I accept and adopt the medical cause of death as ascribed by Dr Joanna Moira Glengarry and I find that Ahedah Hamed died from drowning;

2. AND, having reviewed the evidence before me, I find that Ahedah Hamed likely did not fully appreciate the dangers of the ocean at Bushrangers Bay and the potential for sudden condition

[14] Parks Victoria is a statutory authority of the Victorian Government responsible for managing an estate of more than 4 million hectares, including 3000 land and marine parks and reserves.

changes, and due to her inability to swim was unable to stay afloat until emergency services arrived to effect a rescue.

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

Pursuant to section 73(1B) 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:

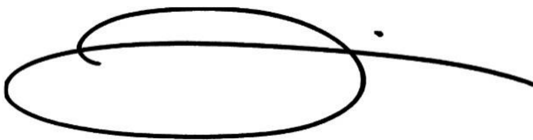
Kudar Hamed, Senior Next of Kin

Parks Victoria

Life Saving Victoria

First Constable Christopher Hindley, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 22 November 2023

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.