IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 001234

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Do Hung Vu
Date of birth:	14 February 1957
Date of death:	5 March 2022
Cause of death:	1(a) Drowning
Place of death:	Hobsons Bay, approximately 50 metres off Altona Beach, Victoria
Key words:	Abalone diving, fatal drowning, culturally and linguistically diverse background

INTRODUCTION

1. On 5 March 2022, Do Hung Vu was 65 years old when he drowned while fishing for abalone in Hobsons Bay. At the time, Mr Vu lived in Sunshine with his wife.

2. Before migrating to Australia in 1996, Mr Vu worked as a labourer in the construction industry and he continued this work after arriving in Australia.

3. Mr Vu had separated from his wife, Ngoc Nguyen, before leaving Vietnam but they rekindled their relationship in or about 2012. At the time of Mr Vu's death, they resided together. Mr Vu's daughter had moved to Australia in 1994.

4. Mr Vu's medical history included type 2 diabetes, high blood pressure, and respiratory issues with associated symptoms of coughing and wheezing.

5. His hobbies included gardening, fishing, snorkelling, and diving for abalone. While he was described as a competent swimmer, he was not an overly experienced diver as he had only started to dive for abalone in the six months preceding his death.

THE CORONIAL INVESTIGATION

6. Mr Vu'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.

7. 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.

8. 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.

9. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Vu'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.

10. This finding draws on the totality of the coronial investigation into Mr Vu's death, 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]

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

Identity of the deceased

11. On 7 March 2022, Do Hung Vu, born 14 February 1957, was visually identified by his son-in-law, Simon Khuu, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

13. Forensic Pathologist, Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 7 March 2022 and provided a written report of his findings dated 10 March 2022.

14. The post-mortem examination revealed findings in keeping with the clinical history and reported circumstances.

15. Routine toxicological analysis of post-mortem samples did not detect any alcohol or any commonly encountered drugs or poisons.

16. Dr Beer provided an opinion that the medical cause of death was *"1(a) Drowning"*.

17. I accept Dr Beer's opinion.

[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.

Circumstances in which the death occurred

18. At about 10.00am on the morning of 5 March 2022, Mr Vu drove to Altona Beach alone and subsequently entered the water to dive for abalone. At the time there were other divers in the water also diving for abalone, but they were not friends of Mr Vu.

19. There are no witness accounts to suggest that Mr Vu experienced any difficulties in the water. However, Mr Vu was subsequently found unresponsive on the bottom of the seabed by one of the other abalone divers. The diver and his friends dragged Mr Vu from the water and onto the rock groyne approximately 50 metres from the foreshore, opposite the intersection of Bayview Street and The Esplanade, Altona. Their efforts were considerable as Mr Vu was still wearing his diving weight belt, his wetsuit, boots, and facemask.

20. Once Mr Vu was on the rocks, the other divers began administering cardiopulmonary resuscitation and another witness called emergency services at 10.48am.

21. Responding Ambulance Victoria paramedics arrived at the scene at 10.56am and observed signs indicating Mr Vu was already deceased. They verified his death at 11.06am.

22. Leading Senior Constable Rory Kay, Coroner's Investigator, described the weather as fine and overcast with a forecast temperature of 23ºC that day. It was cool to mild when he arrived at the scene and there had been significant rain overnight. There was a very light westerly breeze and a slight ripple on the water with no waves.

23. Leading Senior Constable Kay noted there were no suspicious circumstances connected with Mr Vu's death or evidence to indicate his death was due to anything other than drowning.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Do Hung Vu, born 14 February 1957;

    (b) the death occurred on 5 March 2022 at Hobsons Bay, approximately 50 metres off Altona Beach, Victoria;

    (c) the cause of Mr Vu's death was drowning; and

    (d) the death occurred in the circumstances described above.

COMMENTS

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

25. According to Life Saving Victoria's (**LSV**) *Victorian Drowning report 2021/2022,* 53 people fatally drowned within Victorian waterways in 2021/20222. Of this number, 40 (75 per cent) were male and the age group with the most fatal drownings in that period were those aged 65+ years.[2] Twenty-six per cent of fatal drownings occurred in coastal waterways (14 at beaches, oceans, and bays).[3]

26. Of the 53 fatal drownings, four individuals (eight per cent) were identified to be from culturally and linguistically diverse (**CALD**) communities. However, at the time of publication of the report, country of birth was unknown for the remaining 49 people who fatally drowned this year.[4] In previous years (2012/2013 to 2021/2022), approximately 50 per cent of country of birth data was known. This data revealed that people born overseas accounted for 42 per cent of drowning deaths and were almost two-and-a-half (2.42) times more likely to fatally drown when comparing rates per head of population and cultural background. The data revealed that 132 people from CALD communities fatally drowned over this most recent 10-year period.[5]

27. While up-to-date data for abalone diving related drownings is not available, the Court has previously obtained data which has revealed that in the period from 1 January 2009 to 12 April 2019, 14 people died while diving for abalone. The most common age bracket was 40 to 59 years, followed by 26 to 39 years.[6]

28. Sadly, deaths of abalone divers from the CALD community are not unknown in this jurisdiction. At least six of the 14 abalone diving related deaths were individuals who were born overseas. Coincidentally, they were all from either Vietnam or China. Another three individuals appeared to be of Asian descent, but it is not apparent whether they were born overseas. It therefore appears that between 50 and 70 percent of the identified abalone diving deaths involved individuals known or considered to have been born overseas and/or to be of Asian descent.

[2] Life Saving Victoria, *Victorian Drowning report 2021/2022,* page 6, available at: https://lsv.com.au/wp-content/uploads/LSVDrowningreport2122_2022-12-06_03-45-16.pdf.
[3] Life Saving Victoria, Victorian Drowning report 2021/2022, pages 6-7.
[4] Life Saving Victoria, Victorian Drowning report 2021/2022, page 15
[5] Life Saving Victoria, Victorian Drowning report 2021/2022, page 15
[6] Data retrieved from the National Coronial Information System.

29. The over-representation of persons of Asian background in these statistics has been addressed in three previous coronial findings where the issue of diving/fishing for abalone was addressed, and recommendations were made.

30. Deputy State Coroner English, as she then was, investigated the deaths of Xu Zhou[7] and Xuan Truong Ha,[8] both of whom died on the same date – 6 January 2018 – whilst diving for abalone at Altona Beach and Williamstown Beach respectively. Both the deceased were CALD individuals. As part of the coronial investigation, her Honour sought a submission from LSV outlining the education they provide to CALD communities, including the specific education targeted to abalone divers.

31. LSV provided a detailed submission in which their Principal Research Associate Dr Bernadette Matthews outlined the LSV's work with Victoria's various multicultural communities, which included delivering water safety messaging to over 20,000 multicultural Victorians each year and more broadly via the *Play it Safe by the Water* public safety campaign.

32. The recent increase in the number of abalone diving drownings,[9] also prompted the LSV to target this particular cohort of water users so that safety messages were updated to reflect abalone fishing. In addition, the LSV applied for a grant through the Victorian Fisheries Authority's (**VFA**) Recreational Fishing Grants Program to expand the reach of fishing safety messages, with specific regard to abalone and rock fishing.

33. In their submission. the LSV helpfully suggested some ways in which education regarding safety for abalone diving could be improved, especially in CALD communities:

    (a) update public awareness messaging to include abalone fishing and promoted through targeted education, social media channels and relevant websites;

    (b) the Victorian Recreational Fishing Guide and other VFA resources be updated to include information on abalone fishing safety and the risk of drowning; and

    (c) programs/activities by recreational fishing organisations/agencies that promote recreational fishing should include safe fishing practices, noting that, particularly for

---

[7] Finding into death without inquest regarding Xu Zhou, dated 23 July 2020, available at: https://coronerscourt.vic.gov.au/sites/default/files/2020-07/XuZhou_008918.pdf.

[8] Finding into death without inquest regarding Xuan Truong Ha, dated 23 July 2020, available at: https://coronerscourt.vic.gov.au/sites/default/files/2020-07/XuanTruongHa_009018.pdf.

[9] Dr Matthews's submission notes that according to Life Saving Victoria's statistics, there were five drowning deaths in 2018 and 2019 that occurred while abalone fishing. In the previous 16-year period, there was only one similar death.

culturally and linguistically diverse communities this should include abalone fishing and rock fishing safety.

34. Deputy State Coroner English subsequently made recommendations in line with the suggestions made by Dr Matthews. Coroner Jamieson later echoed her Honour's recommendations in the matter of Swee Chuan Ho.[10]

35. The VFA accepted and implemented the recommendations made in the matter of Xu Zhou. In a response dated 15 February 2022,[11] Chris Padovani, A/Director Fisheries Management, Science, Policy, Licensing and Communications, advised that the online version of the 2021 Recreational Fishing Guide, the VFA website and the VicFish mobile application now included relevant information about abalone fishing safety and the risk of drowning. The 2021 Recreational Fishing Guide and 'Safety around the water' webpages had also been translated into Chinese and Vietnamese and published on the VFA website. The hard copy of the 2022 Recreational Fishing guide will soon be printed and will include relevant dive safety information. I note that the 2022 Recreational Fishing Guide,[12] which is also available in other languages, provides the following safety advice:

> *Diving for abalone is relatively safe, but there is a risk of drowning. To stay safe, you must:*
>
> - *Dive when sea conditions are good*
> - *Always dive and stay with a friend so there is someone there to help if you get into trouble. Use a dive flag to let others know where you are.*
> - *If conditions are not right, find a better spot or dive on another day*

36. The VFA has also developed broader education material regarding snorkelling safety that has been published on the VFA website in multiple languages. Throughout 2021 the VFA further promoted dive safety messaging at multi-agency community events and used SBS language radio to increase the Chinese and Vietnamese communities' knowledge around dive safety.

---

[10] Finding into death without inquest regarding Swee Chuan Ho, dated 28 September 2020, available at: https://coronerscourt.vic.gov.au/sites/default/files/2020-09/SweeChuanHo_076219.pdf.

[11] The Victorian Fisheries Authority's response is available at: https://coronerscourt.vic.gov.au/sites/default/files/2022-03/20180089%20Response%20to%20recommendations%20from%20Victorian%20Fisheries%20Authority_ZHOU_0.pdf.

[12] Victorian Fisheries Authority, Victorian Recreational Fishing Guide 2022, page 31, available at: https://vfa.vic.gov.au/__data/assets/pdf_file/0008/864539/7176-VFA-Fishing-Guide-2022-7.0.pdf.

37. In its response to the Zhou recommendations, VFA noted they would continue to investigate other opportunities to further assist the Victorian community to understand the risks associated with dive fishing, and the actions individuals are required to undertake to mitigate those risks.

38. Similarly, the LSV also implemented the Zhou recommendations. In a response dated 19 February 2021,[13] Dr Nigel Taylor, Chief Executive Officer, advised that LSV was updating their public awareness messaging to include abalone fishing safety as part of general water safety information conveyed in classroom/community education sessions for members of Victoria's CALD community and the development of a CALD Virtual Reality Google Expedition with two of the scenes focusing on safe fishing (one on abalone fishing). Abalone fishing safety messaging was also included in the Victorian Government's *Play it Safe by the Water* public safety campaign. Unfortunately, the LSV's application for a grant to expand the reach of fishing safety messages to include both abalone and rock fishing safety was unsuccessful. However, the LSV advised that they would re-apply as well as continue to seek and apply for funding through other sources to promote abalone and other fishing safety messaging.

39. The LSV also advised that it continues to work with recreational fishing organisations and agencies such as the VFA to include safe practices for abalone fishing.

40. Given the work of the VFA and LSV in this area, I do not propose to make any further recommendations. I support the ongoing work of both organisations which is targeted to the culturally and linguistically diverse communities.

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

I commend the actions of the other divers who retrieved Mr Vu from the water and administered cardiopulmonary resuscitation until paramedics arrived.

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.

---

[13] Life Saving Victoria's response is available at: https://coronerscourt.vic.gov.au/sites/default/files/2021-03/2018%200089%20Response%20to%20recommendations%20from%20Life%20Saving%20Victoria_ZHOU.pdf.

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

Ngoc Nguyen, senior next of kin

Life Saving Victoria

Victorian Fisheries Authority

Leading Senior Constable Rory Kay, Victoria Police, Coroner's Investigator

Signature:

____

Coroner Paresa Antoniadis Spanos

Date: 01 February 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.