IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007204

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Shuyang Wang
Date of birth:	23 May 1999
Date of death:	28 December 2023
Cause of death:	1a: Drowning
Place of death:	Rosebud Hospital 1527 Point Nepean Road Capel Sound Victoria 3940

INTRODUCTION

1. On 28 December 2023, Shuyang 'Gino' Wang (**Shuyang**) was 24 years old when he drowned at Rosebud Beach. At the time of his death, Shuyang lived in Murrumbeena.

Background

2. Shuyang was born to father Wei Jian Wang (**Mr Wang**) and mother, Qiao Fang (**Ms Fang**), and grew up in Hefei, in the Anhui province of east China. He enjoyed playing basketball at both community and competition levels.

3. According to Mr Wang, Ms Fang attempted to teach Shuyang to swim during his childhood, however, *'his reaction was very horrible and he didn't want to swim'*. He continued that Shuyang *'had no other experience with water sports or activities'*.

4. Around 2018, Shuyang moved to Australia on a student visa and commenced a Bachelor of Arts majoring in Journalism at Monash University. According to Mr Wang, Shuyang found *'it was very hard to keep up'* with his studies due to his poor English. However, Shuyang remained dedicated and was expected to graduate in mid-2024.

5. In Melbourne, Shuyang continued his passion for basketball and earned money through coaching and mowing lawns.

6. Shuyang did not attend a general medical practitioner while in Australia. He was not known to experience any ill health.

THE CORONIAL INVESTIGATION

7. Shuyang'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.

8. Section 52(b) of the Act states that a coroner must hold an inquest into a death where the deceased was *'immediately before death, a person placed in custody or care'*. The definition of *'in custody or care'*, according to section 3, includes a *'person in the custody of a police officer'* or a *'person who a police officer or prison officer is attempting to take into custody'*. Shuyang's death occurred in police presence, however, in the context of an attempted rescue rather than for the purpose of detention or reception into custody. Accordingly, I do not consider that Shuyang was a person *'placed in custody or care'* immediately before his death

and therefore, his death is not subject to a mandatory inquest prescribed by section 52 of the Act.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Shuyang's death. The Coronial 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.

12. This finding draws on the totality of the coronial investigation into the death of Shuyang Wang 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

Circumstances in which the death occurred

13. On 28 December 2023, Shuyang and his friends attended Rosebud Beach where they organised a barbeque. Shuyang and his friend, Jun 'Mark' Chen (**Mr Chen**), were *'playing'*

[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.

in knee-deep water. According to Mr Chen, the water was *'very calm and there [were] not [many] waves'.*[2]

14. At approximately 2pm, Mr Chen began paddling on an inflatable two-person kayak[3] in the shallow water, and before long, Shuyang decided *'he wanted to go out to sea on the kayak'*. The men decided to kayak to the end of the Rosebud pier, which is 300 metres in length, where they could jump into the water. Witness accounts indicate that the kayak *'didn't look fully inflated'* and that Shuyang was not wearing a personal flotation device such as a life vest.

15. Shuyang and Mr Chen reached the end of the pier. Mr Chen alighted the kayak and climbed a ladder to the pier. As he did so, the kayak began to drift away due to the wind. Aware that Shuyang could not swim, Mr Chen returned to the water and attempted to rescue him. However, the wind intensified, and the kayak was pushed further out to sea.

16. Mr Chen became exhausted from swimming after the kayak and returned to the beach. Meanwhile, people on the shore witnessed Shuyang drifting further and at 3:32 pm, contacted emergency services.

17. Shuyang's friend, Yitong 'Jerry' Yan (**Mr Yan**), flew a drone atop Shuyang and the kayak. Footage captured by Mr Yan's drone depicted Shuyang attempting to paddle, however, was not doing so effectively. According to Mr Yan, *'[Shuyang] looked kind of exhausted or rather tired'.*

18. At 3:41 pm, Victoria Police helicopter *'*Polair32*'* arrived at Rosebud Beach and located Shuyang in the kayak approximately 400 metres from shore. At this time, he was *'still paddling and making an effort to return to shore'.* The helicopter hovered 150 feet – approximately 45 metres – above Shuyang.

19. Victoria Police members in the helicopter were determining the most appropriate rescue method. However, as they did so, Shuyang entered the water. The evidence is equivocal on how this occurred, including whether the kayak capsized, or if Shuyang fell or jumped into the water. According to the helicopter pilot, *'it became obvious almost immediately that the*

[2] The Bureau of Meteorology observations for 28 December 2023 for weather site South Channel Island recorded wind speeds as 35 km/hour to 41 km/hour, gusting up to 48 km/hour with a wind direction of south south-west for the period of 2:30pm and 4:30pm.

[3] The kayak was manufactured to EN ISO 6185-1 standards and had several warnings printed in different languages, including *"Paddle sports can be very dangerous and physically demanding. The user of this product should understand that participating in paddle sports may involve serious injury or death."*

kayaker was either very fatigued and/or not a strong swimmer as he appeared to be struggling to keep himself afloat'.

20. Soon after, the pilot *'lost sight of [Shuyang] as he had disappeared below the surface of the water'.* He lowered the helicopter to 80 feet – approximately 24 metres – above sea level. Sea dye was used to show currents in the water.

21. Victoria Police members tried to locate Shuyang for hours, and enlisted volunteer search and rescue organisations and divers.

22. At approximately 5:45 pm, the Victoria Police Search and Rescue Squad located Shuyang on the sea floor, at a depth of approximately 4.8 metres. Shuyang was retrieved from the water and transported by ambulance to Rosebud Hospital, where he was declared deceased.

Identity of the deceased

23. On 28 December 2023, Shuyang Wang, born 23 May 1999, was visually identified by his friend, Danny Li, who completed a formal Statement of Identification.

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

Medical cause of death

25. Forensic Pathologist Dr Yeliena Baber (**Dr Baber**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Shuyang Wang on 29 December 2023. Dr Baber considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) and VIFM contact log and provided a written report of her findings dated 2 February 2024.

26. The post-mortem examination revealed a small foam plume present about the mouth. There are no definitive indicators of a death due to drowning. Rather, it is a cause of death determined by the exclusion of all other possibilities and by consideration of the factual circumstances preceding the death.

27. Toxicological analysis of post-mortem did not identify the presence of any alcohol or other common drugs or poisons.

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

FURTHER INVESTIGATIONS

DOWNWASH FROM POLAIR32

29. During my investigation, I queried whether the downwash generated by the Victoria Police helicopter contributed to Shuyang's fall from the kayak.

Witness Observations

30. 'Downwash' – also known as 'rotor wash' – is a byproduct of the helicopter's main rotor blade. As the rotor blade spins, air is drawn from above the helicopter and thrust downwards. The downwards force of the air is referred to as the 'downwash'. In the context of a water rescue, such as in this instance, downwash can disrupt the water's surface and can create spray and rough water for vessels and swimmers.

31. Several witnesses made observations regarding the helicopter's downwash. Some witnesses did not recall significant downwash:

> *'The chopper hovered about fifty metres above the paddler off to his left as I was looking at him. I assume it was hovering there to avoid [rotor] wash'.*

32. And further,

> *'(. . .) there could have been some draft from the helicopter but I couldn't see anything. It wasn't until the helicopter dropped down lower after the person fell in that the spray was very visible'.*

33. However, other eyewitness accounts suggest otherwise:

> *'The downwind from the helicopter was pushing and blowing the kayak to the light [water]. The kayak was getting pushed from the light water to the dark water'*

34. This echoes the evidence of Senior Constable Lincoln McLean:

> *'The down draft from the helicopter appeared to be causing some issues with the person in the kayak. Approximately 5 minutes later, I saw a part of the kayak blow into the air, and it appeared that the person in the kayak was in trouble. Moments later, I saw the person fall out of the kayak'.*

35. In evaluating the evidence of the witnesses, I note that the helicopter and kayak were located approximately 350 metres from shore, a considerable distance from the witnesses – potentially rendering it difficult for witnesses to discern the exact amount of downwash.

Evidence of Polair32 occupants

36. There were four police members aboard the helicopter at the time of the incident. The helicopter's pilot, Constable Simon Bell (**Constable Bell**), makes clear that he was aware of the helicopter's potential downwash:

> *'I confirmed my downwash was being thrust clear and well behind the aircraft by glancing regularly down through my front quarter window.'*

37. And further,

> *'[Leading Senior Constable] Anderson asked me to move closer to the kayaker (. . .) I confirmed that I would and we both discussed and acknowledged caution with regard to downwash'.*

38. While the helicopter hovered above Shuyang, Constable Bell took active steps to avoid generating downwash:

> *'During [descent towards Shuyang] I repeatedly confirmed by observation of the water below us that our downwash was being thrust behind and away from us and consequently away from the Kayaker. I deduced from this regular observation that the only way our downwash would affect the Kayaker was to be on the coast side of the kayaker and considerably lower. At no stage whilst the kayaker was in his kayak, did I place the aircraft upwind (coast side) of him'.*

39. The systems operator aboard the helicopter, Leading Senior Constable Matthew Webb (**LSC Webb**), also spoke to the helicopter's downwash. He stated:

> *'As the aircraft got into the area of operation there was open discussion amongst the crew not to affect the kayak with the down wash of the rotor blades. The pilot [Constable Bell] then maintained a downwind position from the kayak and the image on the camera indicated there was no down wash affecting the kayak'.*

40. There were two additional members onboard the helicopter. Unfortunately, due to extenuating circumstances, these individuals have been unable to provide statements to the Court. Further,

the camera fitted to the helicopter did not capture the moment when Shuyang entered the water. The footage depicts Shuyang in the kayak – timestamped at 2:44 pm – at which time the camera pans across the sea for a period of 1 minute and 41 seconds. When the camera returns to Shuyang – timestamped at 2:46 pm – he is in the water.

41. Consequently, what caused Shuyang to enter the water, including whether it was due to down wash, is not discernible from the statements and multimedia.

Expert opinion

42. Having reviewed the statements and multimedia, I sought an expert opinion from Paul McKenna (**Mr McKenna**). Mr McKenna has extensive experience as a pilot including in instructional roles. He currently holds the office of Safety Manager for the North Queensland Aero Club and has conducted multiple investigations into flight safety incidents.

43. Mr McKenna considered materials including the coronial brief which contained the statements of witnesses and Victoria Police members, and multimedia captured by the helicopter. On 26 November 2024, Mr McKenna provided me with his expert report assessing whether the helicopter's down wash was a factor in Shuyang's entry into the water.

44. Mr McKenna explained that *'many factors change the flow dynamics and act to increase the down wash generated by the rotor disc',* including the aircraft's weight, wind and flightpath. With respect to the helicopter – an AgustaWestland AW139 model – Mr McKenna stated that *'maximum down wash occurs at approximately 100 feet hover (30 metres) and would be in varying stages of dissipation by 150 feet hover (45 metres) in nil wind'*.

45. Having determined the height at which point the helicopter's down wash is the greatest, Mr McKenna analysed data from the Bureau of Meteorology and the helicopter's onboard computer to determine the wind strength present at the time. Having so considered, Mr McKenna determined the helicopter was in a downwind position to the kayak. This is consistent with LSC Webb's comments regarding Constable Bell's piloting and positioning of the helicopter.

46. The data also demonstrated there was a headwind between 15 and 20 knots, which would have blown the down wash effect *'well clear of the kayak and occupant'*.

47. Mr McKenna then calculated the actual height of the helicopter in relation to Shuyang and the kayak. In doing so, Mr McKenna relied on the footage captured by the helicopter, specifically when Shuyang was last captured prior to the camera panning away.

48. Mr McKenna stated:

> *'It can be established that [the helicopter] was at a 132 feet hover (40 metres). Using trigonometry, it can be calculated that the standoff hover position (datum) was at a distance of 123 metres, twice the distance rotor wash effect could be expected'.*

49. Mr McKenna addressed the 1 minute and 41 seconds during which Shuyang was not captured by the helicopter's camera, and during which time he entered the water:

> *'It can be deduced from the [Forward Looking Infrared] footage, that during that critical 1 minute and 41 seconds where [Shuyang] was not on camera, [the helicopter] was unlikely to have been in a position for any rotor wash to have had any negative impact on the kayak and the occupant'.*

50. This position was consolidated by reference to footage captured of the helicopter from the shore, where *'there are no visual effects of rotor wash on the kayak'.*

51. Mr McKenna encapsulated his conclusion as follows:

52. *'Based on my assessment of the evidence, I assess that helicopter rotor down wash was not a [c]ausal factor in Mr Shuyang Wang entering the water, nor was it likely contributory'.*

WATER SAFETY AMONGST CALD COMMUNITIES

53. Having considered the circumstances of Shuyang's untimely death, I requested that the Research and Policy Unit of the Coroners Prevention Unit (**CPU**)[4] advise me as to the water safety initiatives in place for international students/people from culturally and linguistically diverse (**CALD**) communities, with a view to making pertinent recommendations if appropriate. The CPU consulted with Life Saving Victoria, and Study Melbourne.

<u>Life Saving Victoria</u>

[4] 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.

54. LSV provided a statement under hand of Adjunct Associate Professor Bernadette Matthews, Head of Research, Evaluation and Insights.

55. LSV advised that the definition of CALD used was as per the Australian Bureau of Statistics, with indicators including country of birth, language other than English spoken at home, and proficiency in spoken English.

56. They advised that on average over the past decade, people from CALD communities have been 1.5 times more likely to drown than their non-CALD counterparts and represent approximately one third of drowning deaths each year. In recent years there has been a steady increase in the representation of CALD communities within fatal drowning statistics, with the 2023 – 24 financial year recording the highest number of fatal drownings on record among these communities, with 21 deaths. Most of these incidents occurred at beaches and rivers, creeks or streams, and involved the individual swimming, paddling or wading, or walking near the water.[5]

57. LSV considered that the influence of social media is increasing the drowning risk among younger people as well as new arrivals to Australia who are unfamiliar with the waterways. An example of this involved Jona Kinivuwai[6] who drowned at Number 16 beach in Rye in February 2024 after seeing the beach trending on social media, but without any knowledge of the dangers of this location.

58. LSV noted that unfortunately, these social media posts often do not convey the aquatic dangers and risk, misleading people into believing the locations are suitable for swimming, walking or wading. This, coupled with other factors such as misunderstanding their swimming competency, can lead to devastating outcomes.

59. LSV outlined several relevant programs they are involved in, including:

    - The Victorian Department of Education funded LSV through the Water Safety in Schools (WSiS) initiative to support schools, over a period of two years, to deliver best-practice swimming and water safety education through tailored programs and employment pathways into the aquatic industry and translated key water safety messaging in several languages.

[5] LSV qualified this data by noting that the cultural background or country of birth information is not always captured or reported in fatal and non-fatal drowning data.
[6] COR 2024 003965.

- LSV's Diversity and Inclusion (D&I) business unit works with state and local government, alongside migrant resource centres, settlement services, education providers and charitable organisations to reach CALD communities. In the 2023 – 24 financial year the LSV D&I unit reached 30,000 CALD Victorians.

- LSV chairs and coordinates the Play it Safe by the Water committee and is able to advocate alongside multiple member agencies for broad water safety programs, campaigns and engagements throughout Victoria. Specifically, LSV collaborated with Safe Transport Victoria and the Victorian Fishing Authority to amplify messages around boating and other watercraft safety, including lifejacket use.

60. LSV further advised that several community groups have been set up to address the prominence of drowning among CALD communities. One example is that the Melbourne Sikh community, led by Dr Harpreet Kandra Singh and Randeep Singh Saini, have set up adult swimming programs for CALD communities to learn crucial water safety skills. Another is the Hemant Govekar Foundation,[7] a not-for-profit organisation established to raise awareness and improve water safety among students and new arrivals to Australia.

61. LSV's statement also acknowledged the release of the Inspector-General for Emergency Management's (**IGEM**) Review into Victoria's Water Safety Arrangements, published on 30 July 2024.[8] IGEM made five recommendations, including those of relevance to this matter:

> **1.** that the Victorian Government builds on the progress of the Taskforce to establish a coordinating body that has the accountability, membership, and resourcing to:
>
> **a.** implement the Strategy 2021–25 and monitor progress towards its outcomes
>
> **b.** assess statewide drowning risks and develop water safety policy to address these risks
>
> **c.** identify high-priority cross-government actions and ensure their delivery
>
> **d.** provide visibility and advice to government on emerging risks.

[7] Named in memory of Hemant Govekar, who drowned at Phillip Island in 2017.

[8] Inspector-General for Emergency Management, Review of Victoria's water safety arrangements, < https://www.igem.vic.gov.au/publications/publications/review-of-victorias-water-safety-arrangements>

3. that the Victorian Government establishes an ongoing process to develop and maintain an evidence-based statewide picture of water safety risk.

5. that Victoria Police, with the support of Emergency Management Victoria, responder agencies, and LSV, work together to develop a subplan to the State Emergency Management Plan (SEMP) that clearly articulates roles, responsibilities and arrangements for risk assessment, prevention, operational preparedness and incident control in relation to water-based rescue.

62. The Victorian government has indicated that they supported recommendation 1 in principle and has established the Victorian Water Safety Coordination Forum. The government also supported recommendation 3 in principle but did not support recommendation 5.

63. LSV suggested several recommendations which I consider may assist in bringing water safety awareness messaging to more people from CALD communities, and I intend to make those recommendations.

Study Melbourne

64. Study Melbourne is an initiative of the Victorian government to provide support to international students in Victoria. In the calendar year to December 2023, there were around 287,000 international student enrolments in Victoria.

65. Study Melbourne outlined the following initiatives they undertake:

- Creation and dissemination of assets and information through communication channels such as a monthly eNewsletter, social media (Facebook, Instagram, WeChat and LinkedIn), the Study Melbourne website and printed materials directly to offshore (pre-departure) and onshore international students and to the education sector and other related organisations who work with international students.

- Events, such as the welcome and safety presentation for Indian students at Deakin University, *Let's Go to the Beach* student transition program, Diwali student celebration and a welcome event for Indian students.

- Grants to education providers and community organisations, including the international student water safety project delivered by Life Saving Victoria ($26,000), the international student swimming and water safety at The Lounge, Geelong ($22,000),

water safety theory and practical sessions for international students for the Australia Nepal Public Link ($2,450) and a beach and water safety program at Kangan Institute ($10,000).

RECOMMENDATIONS

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

1. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Water Safety Coordination Forum with the support of Emergency Management Victoria and Life Saving Victoria, develop a suitable instrument, subplan or equivalent framework that clearly articulates roles, responsibilities, arrangements and accountability for risk assessment, prevention, operational preparedness and incident control in relation to drowning prevention.

2. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Water Safety Coordination Forum prioritise data-sharing to fully understand the burden of non-fatal drowning among CALD communities.

3. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Justice and Community Safety and the Department of Treasury and Finance review current campaign spending to enable increased reach of water safety messaging in line with current (at-risk) priority target audiences.

4. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Jobs, Skills, Industry and Regions works together with Life Saving Victoria and other relevant agencies to include safety warnings and messages in its promotion of aquatic locations.

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 Shuyang Wang, born 23 May 1999;

   b) the death occurred on 28 December 2023 at Rosebud Hospital, 1527 Point Nepean Road, Capel Sound, Victoria 3940;

c) I accept and adopt the medical cause of death as ascribed by Dr Yeliena Baber and I find that Shuyang Wang died due to drowning.

2. AND, having considered the available evidence, I find that the predominant factors contributing to the fatal drowning incident were Shuyang Wang's decision to enter the water without an approved personal flotation device, on an improperly inflated kayak which rendered the device unstable.

3. AND I find that in doing so, Shuyang Wang, a young man who was unable to swim and inexperienced around the water, likely did not foresee or appreciate the significant risk posed to his health and safety by entering the water without appropriate safety measures such as a personal floatation device. I further find that his death was preventable.

4. AND FURTHER, I have considered the actions of the Victoria Police members on Polair32 and the opinion of Mr Paul McKenna. While there is a paucity of evidence to indicate exactly how or why Shuyang Wang entered the water, I accept the opinion of Mr McKenna and find that the rotor down wash of the Victoria Police helicopter did not cause or contribute to Shuyang's entry into the water.

5. AND, accordingly, I find that the actions of the attending Victoria Police members were reasonable and appropriate in the circumstances.

I convey my sincere condolences to Shuyang'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:

Lim & Tng Lawyers on behalf of Weijian Wang, Senior Next of Kin

Life Saving Victoria

Safe Transport Victoria

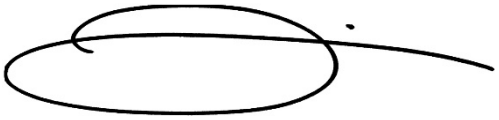
Emma Cassar, Secretary, Department of Justice and Community Safety

Chris Barrett, Secretary, Department of Treasury and Finance

Matt Carrick, Secretary, Department of Jobs, Skills, Industry and Regions

Detective Acting Sergeant Madeleine McDonald, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 14 October 2025

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.