IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2024 000175**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Paul Lawrie |
| Deceased: | Viet Quy Dinh |
| Date of birth: | 22 December 1984 |
| Date of death: | 9 January 2024 |
| Cause of death: | DROWNING |
| Place of death: | Port Phillip Bay<br>Altona Victoria 3018 |
| Keywords: | Snorkelling, weight belt design and use, snorkelling equipment |

## INTRODUCTION

1. On 9 January 2024, Viet Quy Dinh was 39 years old when he drowned at Altona Beach.[1] Mr Dinh resided in Deer Park, Victoria, with his wife, Van Ahn Dao, and his two children. He came to Australia from Vietnam in 2008 and gained his permanent residency in 2014. He worked as a baker for a large supermarket.

2. According to his wife, Mr Dinh was a confident swimmer, having learnt to swim as a boy in Vietnam. He also taught his two sons to swim. He frequently swum at Altona Beach and in the two years prior to his death, he often went snorkelling and abalone fishing at Altona Beach with his friend, Nho Nguyen.

## THE CORONIAL INVESTIGATION

3. Mr Dinh'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. Senior Constable (SC) Darryl Patterson was assigned as the Coronial Investigator for the investigation of Mr Dinh's death. SC Patterson conducted inquiries on my behalf and compiled a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Mr Dinh, 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.[2]

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[1] In the area of 37°52'25"S 144°50'04"E.

[2] 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

7. At 2:00pm on 9 January 2024, Mr Dinh and Mr Nguyen went to Altona Beach to gather abalone. Lifeguards were patrolling Altona Beach at the time, however the area where the two men were swimming was not patrolled.

8. At this time, the weather was clear, and the air temperature was approximately 24°C. A southerly wind was blowing at between 17 to 34 km/h (9 to 18 kts) producing small choppy waves. Visibility in the water was poor.[3]

9. Mr Dinh was wearing a wet suit and gloves, snorkel, mask, neoprene water shoes and a 10.95 kilogram weighted belt. He was not using a buoyancy compensating device (or other buoyancy aid) and he was not wearing fins.

10. Mr Dinh and Mr Nguyen spent 10 to 20 minutes in the water before Mr Nguyen returned to the shore. Mr Nguyen stated:

> *We were swimming out together. About halfway through I was already exhausted and I had to swim back and I had to take off the belt.*
> *I was getting tired and needed to go in. I had to take off my belt first because it was like 5 kilos and I needed to breathe properly.*

11. Mr Nguyen looked for Mr Dinh from the shore but could not find him. He searched for 20 minutes, with no success. Mr Nguyen then went back into the water to continue his search but still could not locate Mr Dinh.

12. At 3:40pm, Mr Nguyen alerted a lifeguard[4] from Surf Lifesaving Victoria (**SLV**) who immediately initiated a multi-agency response. Other lifeguards were in the water within one minute, followed by various SLV watercraft. They were soon joined by the SLV helicopter. At 3:55pm, Victoria Police units including Water Police and the Search and Rescue Squad began searching for Mr Dinh.

[3] A Victoria Police Search and Rescue diver reported the visibility at less than 0.5 meters at 5.30pm.
[4] This happened to be the Chief Lifeguard for the region.

13. At 6:55pm, a police diver from the Search and Rescue Squad located Mr Dinh on the sea floor at a depth of 3.2 meters, with his weight belt still on. Mr Dinh was recovered from the water, and at 7:55pm, a paramedic declared him deceased.

**Identity of the deceased**

14. On 9 January 2024, Viet Quy Dinh, born 22 December 1984, was visually identified by his wife, Van Anh Dao, who completed a formal Statement of Identification.

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

**Medical cause of death**

16. Forensic Pathologist, Dr Judith Fronczek, of the Victorian Institute of Forensic Medicine conducted an examination on 10 January 2024 and provided a written report of her findings dated 11 January 2024.

17. The post-mortem examination revealed minor abrasions to the head and a foam plume in the oropharynx.[5]

18. There are no post-mortem indicators specific to drowning. It is a conclusion reached in the absence of other potentially contributing factors and from the known circumstances surrounding the death.

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

20. Dr Fronczek provided an opinion that the medical cause of death was '1(a) DROWNING'.

21. I accept Dr Fronczek's opinion.

**Cause of the drowning**

22. I note that the weight belt worn by Mr Dinh was very basic. The belt itself was made of woven nylon and had a lifting clasp style buckle for donning, doffing and adjustment. This buckle appears to be made of powder-coated aluminium and is of a relatively low profile compared with some plastic lifting clasp style buckles. The weight was a single lead weight of approximately 11 kg.

[5] The oropharynx is the middle portion of the throat, behind the mouth.

23. I am satisfied that the most likely cause for the drowning is that Mr Dinh became fatigued in deep and choppy water. Despite his wetsuit, he was negatively buoyant whilst wearing his weight belt and, once he got into trouble, he was unable to dump it in time or made the mistake of deciding not to dump it when he needed to do so. His lack of swim fins would make it more difficult to swim up to the surface. Additionally, the great advantage fins can provide when swimming on the surface was missing.

24. Regarding the potential that Mr Dinh was unable to dump his weight belt in time, I note that the relatively low profile of the buckle in combination with his diver's gloves may have impeded his ability to lift the release on the buckle. Alternatively, or in combination, the belt may have slid around his body so that the buckle was hard to reach or find quickly.

25. Whilst it is not possible to exclude entirely some other cause, such as an acute medical event, there is no evidence of this and nothing of the kind suggested in Mr Dinh's known medical history.

26. Finally, I note it remains possible that Mr Dinh suffered a blackout while breath holding. This can occur with little warning and cannot be excluded.

**FINDINGS AND CONCLUSION**

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

    a) the identity of the deceased was Viet Quy Dinh, born 22 December 1984;

    b) the death occurred on 9 January 2024 at Port Phillip Bay, Altona, Victoria 3018, from DROWNING; and

    c) the death occurred in the circumstances described above.

**COMMENTS**

Pursuant to section 67(3) of the Act I make the following comments –

28. Mr Dinh was snorkelling with a substantially laden weight belt, and he did not have the benefit of a buoyancy compensation device and fins as would a properly equipped scuba diver. If wearing a substantial wetsuit, as Mr Dinh was, a weight belt is necessary to offset the buoyancy of the wetsuit in order to dive effectively beneath the surface.

29. There is however an inherent risk with this combination of equipment. Moreover, the risk is exacerbated by the absence of fins which provide a significant advantage when swimming to the surface.

30. It is imperative that weight belts used in this manner must be designed with ease of dumping as the first priority. The construction, material, and placement of weights should be aimed at reducing the likelihood that the belt may slip around the body and move the buckle away from its intended position. The design of the buckle must be such that, when released, the entire belt is released without catching. The profile of the buckle must be such that it is easy to manipulate, even with heavily gloved fingers.

31. There are many products on the market that appear to meet these requirements, and others that are far more basic. Swimmers snorkelling with a weight belt should select a high quality belt that they know they can dump quickly and easily, every time. Safety messages should also emphasise that the weight belt should be dumped without hesitation if the swimmer is in any difficulty.

32. Victorian Fisheries Authority – 'Be Smart When Snorkelling' information includes the following advice:

> ***Use a dive float or flag***
> *A dive float tells other water users where you are.*
>
> ***Use a wetsuit, mask and snorkel, gloves, and flippers***
> *Having well fitted equipment will make your snorkel comfortable and help you collect fish safely.*
>
> ***Get a weight belt with a quick release buckle***
> *If you are finding it difficult to keep your head above water, undo and drop your weight belt. Without a weight belt, your wetsuit will help you float and you can signal for help.*

33. Life Saving Victoria has reported that in 2024 there were 54 fatal drownings in Victoria, compared to the 10 year-mean of 47. Of the total of 54 drownings, 46 (85%) were males.

34. Moreover, 2024 saw the highest number of drownings among multi-cultural populations in Victoria on record, with 21 drownings recorded among people from culturally and linguistically diverse backgrounds. This represents 39% of all fatalities for the year.[6] In the

[6] *Life Saving Victoria Drowning Report – 2024* at pages 6, 7 and 20

last decade, 156 people known to have been born overseas have drowned in Victoria, representing 32% of all drowning deaths.[7]

35. These data reveal a disturbing trend and are a reminder of the need for all organisations and government agencies having a role or interest in water safety to regularly review the effectiveness of their safety messaging and programs. Campaigns must remain up to date and seek the most effective means to reach the public. Persons from culturally and linguistically diverse backgrounds are tragically overrepresented in these statistics, and special efforts must continue to be made to reach this cohort.

## ACKNOWLEDGEMENTS

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

I thank the Coronial Investigator and those assisting for their work in this investigation.

## DIRECTIONS

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:

Van Anh Dao, Senior Next of Kin

Life Saving Victoria

Royal Life Saving Australia

Victorian Fisheries Authority

Senior Constable Darryl Patterson, Coronial Investigator

[7] *Life Saving Victoria Drowning Report – 2024* at page 20

Signature:


Coroner Paul Lawrie

Date: 30 September 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.