

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002093

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of: AUDREY JAMIESON, Coroner

Deceased: Chieu Kheang Chua

Date of birth: 7 January 1984

Date of death: 13 April 2024

Cause of death: 1a: Drowning

Place of death: Point Roadknight Beach
Anglesea Victoria 3230

Keywords: Drowning; rock fishing; Point Roadknight;
Anglesea; water safety

INTRODUCTION

1. On 13 April 2024, Chieu Kheang Chua (**Chieu**) was 40 years old when he drowned while fishing for crabs at Point Roadknight. At the time of his death, Chieu lived in Keysborough with his wife and two children.
2. Chieu was born in Cambodia and moved to Australia with his wife in 2012. He worked as a warehouse operator and enjoyed crab fishing with his friends on weekends. Chieu had gone crab fishing at Point Roadknight at least three times in 2024.
3. Chieu had a medical history of type 2 diabetes and hypertension. He had no known mental health history.

THE CORONIAL INVESTIGATION

4. Chieu'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.
5. 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.
6. 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.
7. Victoria Police assigned an officer to be the Coronal Investigator for the investigation of Chieu's death. The Coronal 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.
8. This finding draws on the totality of the coronial investigation into the death of Chieu Kheang Chua 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

9. On Saturday 13 April 2024 Chieu organised to go crab fishing at Point Roadknight with three friends; Vannly Leap (**Vannly**), Sorphorn Sok (**Sorphorn**) and Nang Sam (**Sam**). The four men travelled together from Keysborough and arrived in Anglesea sometime after 8.00pm.
10. There is a large general warning sign at the entrance to the Point Roadknight beach carpark and smaller version of the sign at the pathway to the beach. Both signs are in English only and display general warnings (including strong currents and incoming tides), safety information and regulations. There is a QR code which takes the user to the 'Beachsafe' application. The application can be translated into 132 different languages and provides information on the current weather conditions (including wind, swell and tide) at the location. It was unclear on the evidence whether the group had accessed this information.
11. Given it was dark, the group put on head torches before making their way from the Point Roadknight beach carpark to the rock shelf on the point. The large rock shelf has an uneven surface with jagged rocks, numerous rock pools and seaweed coverage making the surface slippery. The rock shelf is fully exposed at low tide yet fully covered at high tide with open ocean waves crashing over the southern side. When the group arrived at Point Roadknight there was an incoming tide with large swell, however the darkness made it impossible to see the size of approaching waves.
12. Once on the rocks, the men separated into pairs to search for crabs. The group was not wearing or carrying any Personal Floatation Devices. Chieu and Sorphorn were looking for crabs on the southern (open ocean) side of the rock shelf.
13. After approximately five minutes, Sorphorn was knocked over by a large wave. Once he regained his footing, he was unable to locate Chieu in the dark. He soon realised that Chieu must be in the water, so called out to the others who were approximately 50 metres away.

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.

14. After a few minutes, the group spotted Chieu floating face down in the water approximately three metres from the rock ledge. It is unknown whether Chieu was also knocked off his feet by a large wave, or slipped before entering the ocean. Further, it was unable to be determined on the evidence whether Chieu was conscious when he entered the water, or whether he was a competent swimmer.
15. Vannly jumped into the water and pulled Chieu to the rock ledge. Sam and Sorphorn attempted to lift Chieu from the water but were unable to. They held onto Chieu while Vannly climbed out of the water. The three men were then able to lift Chieu from the water. Chieu was unconscious and not breathing. Sorphorn called Triple Zero and the group performed cardiopulmonary resuscitation (**CPR**) as instructed by the operator.
16. Approximately five minutes later police members arrived on the scene and took over CPR. Paramedics arrived shortly after and established that Chieu was in a non-shockable rhythm. He remained unresponsive with no signs of life.
17. By this time the tide was quickly rising with water rushing over the rock shelf. For the safety of all, the decision was made to move Chieu to the beach to continue CPR. Police members and Chieu's friends carried him across the rock shelf. This took approximately five minutes due to the difficulty involved with carrying Chieu's weight in the darkness and over uneven and slippery rocks.
18. After approximately ten minutes of further CPR on the beach, paramedics declared Chieu deceased at 9.16pm.

Identity of the deceased

19. On 13 April 2024, Chieu Kheang Chua, born 7 January 1984, was visually identified by his friend, Sorphorn Sok, who completed a statement of identification.
20. Identity is not in dispute and requires no further investigation.

Medical cause of death

21. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 15 April 2024. Dr Zhou considered the Victoria Police Report of Death (Form 83), scene photos from Victoria Police, VIFM contact log, and post-mortem computed tomography (**CT**) and provided a written report of her findings dated 18 April 2024.

22. The post-mortem examination revealed two parallel linear orange/red abrasions on the anterior neck indicative of blunt force trauma to the region and/or neck compression. The circumstances of retrieval from the water were difficult, followed by Chieu being carried across difficult terrain. In the process of doing this, Chieu's shirt was grabbed on multiple occasions to assist in pulling him up. Review of body worn camera footage showed that his shirt was pulled tightly around the left side and back of his neck.
23. Dr Zhou recommended an autopsy given the anterior neck linear abrasions did not match the distribution where the shirt was pulled tightly on the body worn camera footage. However, there was a next of kin objection to autopsy on religious/cultural grounds. Dr Zhou noted that it was possible the observed injuries were caused by a tightly pulled shirt about the anterior neck, however other causes were unable to be excluded.
24. The post-mortem CT scan showed CPR-related rib fractures. No other acute skeletal trauma was identified.
25. Toxicological analysis of post-mortem samples identified the presence of trace amounts of paracetamol (<5mg/L). The presence of any alcohol or other common drugs or poisons was not identified.
26. Dr Zhou provided an opinion that the medical cause of death was 1(a) DROWNING. The cause of death was formed with considerable weight being given to the reported surrounding circumstances of the death. Dr Zhou noted that should accounts of the circumstances change, the cause of death, explanatory comments, and opinion as to the manner of death may require reconsideration.

COMMENTS

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

1. Victorian coroners have investigated several drowning deaths of people who were engaged in activities proximate to the ocean but did not intend to enter the ocean. I requested the Coroners Prevention Unit (CPU)² identify drowning deaths of people who were swept into the ocean from the shore. The CPU identified 23 deaths in Victoria between 1 January 2015 and 31

² The 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.

December 2024. Of these deaths, 13 people were rock fishing, nine people were walking or playing near the water but did not intend to swim, and one person was fishing from a pier or from the shoreline (not rock fishing). Further analysis showed that 12 (52%) of the deaths were of people born overseas.

2. The circumstances of this case were analogous to rock fishing, which involves fishing from rock ledges along the coastline of the ocean. Rock fishing is a notoriously dangerous sport secondary to the unpredictable nature of the ocean and treacherous terrain where rock fishing is typically carried out.³
3. Life Saving Victoria (LSV) recommends staying safe by wearing a lifejacket, light clothing and appropriate footwear, fishing with a friend, carrying a rope and float, checking the weather and water conditions prior to fishing, and never fishing in exposed areas during rough or large seas.⁴
4. In the 2015 matter of Daniel Miles, I recommended that the Hon. John Eren MP, the Victorian Minister for Sport, consider implementing laws in Victoria that mandate the use of Personal Floatation Devices while rock fishing.⁵ The Hon. Jaala Pulford MP, the Minister of Agriculture, responded to my recommendation, advising that Fisheries Victoria had been instructed to work with LSV, recreational fishers, VRFish, fishing media, local councils, multi-cultural groups and relevant agencies to give higher priority to this matter.⁶
5. In 2022, in the matter of Yik Sua Hong, my colleague Deputy State Coroner Caitlin English (as she then was) recommended that LSV and the Victorian Government continue to increase education among Victorians and the Culturally and Linguistically Diverse (CALD) community regarding the dangers of rock fishing and relevant safety initiatives to reduce risk.⁷ Deputy State Coroner English further recommended that the Victorian Minister for Agriculture, The Hon. Jaclyn Symes, study the progress of the New South Wales

³ Rock Fishing, Royal Life Saving Australia, <<https://www.royallifesaving.com.au/stay-safe-active/activities/rock-fishing/#:~:text=Rock%20fishing%20involves%20fishing%20from,year%20occur%20when%20rock%20fishing>>.

⁴ Rock Fishing, Life Saving Victoria, <<https://lsv.com.au/research/rock-fishing/#:~:text=Wear%20light%20clothing%20and%20appropriate,Observe%20first%2C%20fish%20later>>.

⁵ Form 38 Finding into Death Without Inquest in the matter of Daniel Miles, dated 22 April 2016, <https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/danielmichaelmiles_029515.pdf>.

⁶ Response of the Minister for Agriculture, Finding into Death Without Inquest of Daniel Miles, dated 16 December 2016, <https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/2015%2B0295%2Bresponse%2Bto%2Brecommendation%2Bfrom%2Bminister%2Bof%2BAgriculture_miles.pdf>.

⁷ Form 38 Finding into Death Without Inquest in the matter of Yik Sua Hong dated 20 January 2020, <https://www.coronerscourt.vic.gov.au/sites/default/files/2020-01/YikSuaHong_175638.pdf>.

Government's mandatory requirement for rock fishers to wear personal floatation devices and implement similar law in Victoria if the strategy appeared successful.

6. In 2022 the Victorian Fisheries Authority (VFA) conducted a two-year trial mandating the use of Personal Floatation Devices at ten high risk locations along the Victorian coast.⁸ At the completion of the trial, the VFA issued the *Fisheries (Rock Fishing Safety) Notice 2024*, continuing the Personal Floatation Device mandate at the designated high-risk locations. The trial has now been extended to February 2026, and although no publicly accessible evaluation of the trial has been released, reports from the VFA indicate that the trial has led to improved safety of rock fishers.
7. The VFA has been proactive in delivering education sessions to communities alongside providing resources in multiple languages and signage at the ten high risk locations where life jacket use is now mandated. In addition, Victoria Police and LSV have been delivering education sessions to inform rock fishers about the legislative requirements.
8. A similar regime was implemented in New South Wales under the *Rock Fishing Safety Act 2016*.⁹ In 2022 Surf Life Saving Australia (SLSA) collaborated with UNSW Sydney to explore the impact of mandatory lifejacket legislation on unintentional rock fishing drowning deaths. The research identified that rock fishing unintentional drowning deaths at declared areas had reduced in the five years since the legislation was implemented, although this reduction was not statistically significant. SLSA suggested that '*increased enforcement of fines, and extension of legislated declared locations may increase efficacy*'.¹⁰
9. Unfortunately, the inherent risks of rock fishing and unpredictability of the ocean cannot be completely counteracted by rock fishers being safety conscious and carrying floatation devices. Rock fishers must also be aware of the weather conditions and abstain from fishing in exposed areas during rough or large seas.¹¹ This was demonstrated in the matter of *Tranh Nguyen*, where my colleague Coroner Leveasque Peterson noted that the conditions at sea and

⁸ Rock Fishing Safety, Victorian Fisheries Authority, <<https://vfa.vic.gov.au/recreational-fishing/rock-fishing-safety>>.

⁹ Rock fishing lifejacket law and declared areas, NSW Government, <<https://www.nsw.gov.au/environment-land-and-water/coasts-waterways-and-marine/rock-fishing-lifejacket-law>>.

¹⁰ New study explores effectiveness of mandatory lifejacket legislation at high-risk rock platforms, Surf Life Saving Australia, <<https://sls.com.au/new-study-explores-effectiveness-of-mandatory-lifejacket-legislation-at-highrisk-rock-platforms/>>.

¹¹ Rock Fishing, Life Saving Victoria, <<https://lsv.com.au/research/rock-fishing/#:~:text=Wear%20light%20clothing%20and%20appropriate,Observe%20first%2C%20fish%20later>>.

the lack of available light meant that assistance could not be effectively deployed.¹² However, the VFA recommends that *‘no matter where you are, always wear a lifejacket when rock fishing’*.¹³

10. The VFA provides a link to the Bureau of Meteorology (**BOM**) *‘Check the weather before you go rock fishing’* webpage.¹⁴ The webpage identifies five vital checks to be completed prior to rock fishing, including swell, tide, wind, marine warnings and changing weather. Additionally, the BOM explains the features of each type of warning and the types of conditions that are potentially hazardous. Links are available to translations of the webpage in simplified Chinese, traditional Chinese, Korean, Vietnamese and Bahasa Malaysia.
11. Further, Chieu’s death highlights the vulnerability of individuals born overseas to accidental drowning in Australian coastal waters. LSV estimated in the 2022-23 Victorian Drowning Report that 54% of all fishing-related deaths since the 2014-15 report involved people of CALD backgrounds.¹⁵ Additionally, 21 people (39% of all fatalities) known to be of CALD backgrounds fatally drowned over the 2022-23 period, the highest on record. As to rock fishing specifically, LSV data indicates that that 72% of those who fatally drowned while rock fishing since 2000 were from CALD backgrounds.
12. LSV’s Diversity & Inclusion Department provides water safety education to Victoria’s CALD population.¹⁶ LSV delivers practical and theoretical programs to a wide variety of groups, including newly arrived refugees, asylum seekers, migrants and international students. The aim is for all Victorians to be equipped with crucial aquatic knowledge. In the 2023-24 financial year the LSV delivered water safety education to 30,000 CALD Victorians.

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 the Victorian Fisheries Authority publicly release the evaluation of

¹² Form 38 Finding into Death Without Inquest in the matter of Thanh Nguyen, dated 24 October 2024, <<https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202024%200002678%20Thanh%20Nguyen%20Form%2037-Finding%20into%20Death%20Following%20Inquest-Final.pdf>>.

¹³ Rock fishing safety, Victorian Fisheries Authority, <<https://vfa.vic.gov.au/recreational-fishing/rock-fishing-safety>>.

¹⁴ Check the weather before you go rock fishing, Bureau of Meteorology, <<http://www.bom.gov.au/marine/about/check-rock-fishing.shtml>>.

¹⁵ Drowning Report 2024, Life Saving Victoria Drowning Report, <<https://lsv.com.au/drowning-report-2024/>>.

¹⁶ Educational programs (multicultural), Life Saving Victoria, <<https://lsv.com.au/diversityinclusion/educational-programs/>>.

the trial of mandatory lifejacket use at the 10 high-risk zones identified along the Victorian coastline to complement the drowning data available.

- (ii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Fisheries Authority and Minister for Outdoor Recreation update the legislative requirement to wear lifejackets to extend to all coastal rock platforms across the state of Victoria.
- (iii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Minister for Outdoor Recreation consider the mandatory wearing of lifejackets or use of other safety equipment for all users of rocky platforms along Victoria's coastline, including for those walking on rocks.
- (iv) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Fisheries Authority consult with Life Saving Victoria regarding incorporating the legislative requirement to wear lifejackets into current compliant static water safety signage at these zones, to avoid the over-saturation of signage and to avoid the risk of temporary signage being damaged or removed.
- (v) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Minister for Outdoor Education or other appropriate entity explore how real-time hazardous surf and weather conditions could be communicated to those attending high-risk locations, for example through push notification via the VicEmergency App, BeachSafe App or Bureau of Meteorology website.

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 Chieu Kheang Chua, born 7 January 1984;
 - b. the death occurred on 13 April 2024 at Point Roadknight Beach, Anglesea, Victoria 3230;
 - c. I accept and adopt the medical cause of death ascribed by Dr Chong Zhou and I find that Chieu Kheang Chua died from 1(a) DROWNING;
2. AND, I am satisfied that the cogency of the surrounding circumstances permit me to make the finding that Chieu Kheang Chua drowned after unintentionally entering the water while rock fishing at Point Roadknight. I note that it is unclear on the evidence whether he was knocked by

a wave into the water, was conscious when he entered the water, or whether the anterior neck abrasions were caused by a tightly pulled shirt about the anterior neck, however I find that there are no suspicious circumstances associated with this death.

3. AND, I note that although it is unclear whether Chieu Kheang Chua was aware of the weather conditions at Point Roadknight, the conditions on the 13 April 2024 were dangerous with exposure to large swell and uneven and slippery rocks. Further, the conditions were compounded by darkness and the lack of Personal Floatation Device use which prevented the timely location, extrication and resuscitation of Chieu Kheang Chua.
4. Chieu Kheang Chua's death is a tragic reminder of the dangers of rock fishing and the overrepresentation of CALD community members among drowning deaths in Victoria.

I convey my sincere condolences to Chieu'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:

Huy Leng Tang, Senior Next of Kin

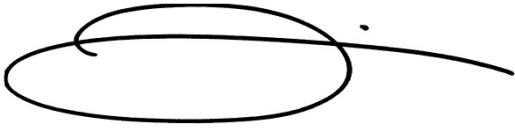
Victorian Fisheries Authority

Steve Dimopoulos MP, Minister for Outdoor Recreation

Life Saving Victoria

Leading Senior Constable Darren Looker, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 7 November 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.
