

# IN THE CORONERS COURT OF VICTORIA AT MELBOURNE

COR 2024 007152

# FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Dimitra Dubrow
Deceased:	Andrew Ewen Mallett
Date of birth:	30 May 1983
Date of death:	28 November 2024
Cause of death:	1(a) Undetermined
Place of death:	Artillery Rock, Great Ocean Road Separation Creek Victoria 3234
Keywords:	Missing Person; Suspected Death; Presumed Drowning

# **INTRODUCTION**

- 1. On 28 November 2024, Andrew Ewen Mallett was 41 years old when he disappeared in the water, presumed drowned, at Artillery Rock, a fishing spot along the Great Ocean Road near Lorne.
- 2. Andrew was a strong swimmer and had always been very fit and healthy. He had also taken up under water hockey in the past year.
- 3. At the time of his death, Andrew lived in Dolphin Heads, near Mackay on Queensland's central coast, with his wife. The couple had two children together.
- 4. On or around 5 November 2024, the couple were in the process of separating when Andrew decided to take a solo driving holiday in the family's white Tesla. Over the rest of November, Andrew drove down the east coast to the Gold Coast, Sydney, Melbourne, and then Lorne.

### THE CORONIAL INVESTIGATION

- 5. The *Coroners Act 2008* (**the Act**) requires coroners to investigate reportable deaths and to ascertain, if possible, the identity of the deceased person, the cause of death, and the circumstances in which the death occurred. The purpose of a coronial investigation is to establish those facts, not to cast blame or determine criminal or civil liability.
- 6. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.<sup>2</sup> For coronial purposes, death includes suspected death.<sup>3</sup>
- 7. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred are limited to events which are sufficiently proximate and causally related to the death.
- 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.

<sup>&</sup>lt;sup>1</sup> Section 67(1) of the Act.

<sup>&</sup>lt;sup>2</sup> See Section 4 of the Act for the full definition of "reportable death".

<sup>&</sup>lt;sup>3</sup> See Section 3 of the Act for the definition of "death".

- 9. The coronial investigation of a suspected death differs significantly from most other coronial investigations which commence with the discovery of a deceased person's body or remains. Absent a body or remains, the coronial investigation focuses on the last sighting of the person suspected to be deceased and any evidence of proof of life since.
- 10. Victoria Police reported Andrew's presumed death to the Court on 9 December 2024. I subsequently took carriage of the investigation. A member of Victoria Police, First Constable, Ashleah Ansley, was assigned to be the Coronial Investigator and compiled a brief of evidence.
- 11. This finding draws on the totality of the coronial investigation into the death of Andrew Ewen Mallett. 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.
- 12. Finally, in the coronial jurisdiction, facts must be established on the balance of probabilities.<sup>4</sup>

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

### Circumstances in which the death occurred

- 13. On 28 November 2024, Andrew has made his way to Lorne on his solo driving holiday.
- 14. At about midday, Andrew called his mother to wish her a happy birthday. Andrew's mother stated that he sounded at peace and seemed to be in an "*incredibly good head space*".
- 15. Andrew also sent a text message to his father saying that he was planning on driving on to Apollo Bay and then to Ballarat.
- 16. At about 1:45pm, Andrew drove to Artillery Rock. Signage at Artillery Rock notes multiple hazards including strong currents, unexpected large waves, submerged rocks, slippery rocks, and that no lifesaving service is available. Other available information about Artillery Rock documents extensive bull kelp forests which pose an entanglement risk for divers.
- 17. Other people were also in the area to fish off the rocks. They recalled interacting with Andrew and that he had said words to the effect of "I might dive, I have my suit in the boot I might give it [spear fishing] a go off the rocks". Andrew seemed pleasant, was smiling, and "seemed

<sup>&</sup>lt;sup>4</sup> 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.

like a gentleman". They also stated that they had fished in this spot a lot and that the swell was large and waves were crashing on the rocks higher than usual.

- 18. About 15 minutes later, Andrew was seen struggling in the water and called for help. One of the people fishing attempted to throw an orange buoy out to Andrew but it fell short. Andrew went under the water and was not seen again.
- 19. The Coronial Investigator reported that the buoy at Artillery Rock is managed and monitored by Parks Victoria and has a length of rope measuring 20 to 30 metres attached to it, unless some or all is taken and used by visitors. Parks Victoria monitors the buoy and replaces missing rope from time to time. The buoy used on the day had rope attached.
- 20. Police attended soon afterwards and a joint search of the area with Search and Rescue, airwing, and air ambulance commenced.
- 21. Search and Rescue divers conducted a tandem dive. The sea state was rough, and the swell was heavy and surging. The divers stated that they had to hold onto the kelp to avoid being dragged away from the rock shelf. The kelp was described as an entanglement hazard and was at heightened risk owing to the large swell.
- 22. Despite a thorough search, Andrew could not be located.
- 23. Police searched the immediate surrounding area including the white Tesla. They found an empty spear gun box and Andrew's wallet with various ID documents and bank cards.
- Also found were the medications escitalopram, <sup>5</sup> atomoxetine, <sup>6</sup> and clonidine <sup>7</sup>. Andrew was 24. also prescribed lisdexamfetamine<sup>8</sup> having been diagnosed with ADHD in late 2023 by a psychiatrist. This medication was ceased at his last appointment on 6 November 2024, and Andrew had disposed of this medication while in Sydney earlier in the month. There was no lisdexamfetamine found in the Tesla.
- On 29 November 2024, Search and Rescue returned to recommence diving. However, the 25. conditions had worsened, and it was not safe to proceed. A foot search was conducted but did not find any useful evidence.

<sup>5</sup> An anti-depressant.

<sup>&</sup>lt;sup>6</sup> A medication for management of ADHD.

<sup>&</sup>lt;sup>7</sup> A blood pressure medication used off-label to treat insomnia associated with other medications.

<sup>&</sup>lt;sup>8</sup> Commonly referred to by the brand name Vyvanse, this medication is a stimulant used in the management of ADHD.

- 26. On or around 5 December 2024, the search resumed with Search and Rescue, airwing, State Emergency Services (SES), a drone operator, and a canine unit taking part.
- 27. There were no findings from the searches conducted over the following weeks.
- 28. There have also not been any other indicators of life since that time by way of bank transactions or mobile phone activity.

# Identity of the deceased

- 29. The evidence supports the conclusion that Andrew Ewen Mallett, born 30 May 1983, was the person who entered the water at Artillery Rock.
- 30. Identity is not in dispute and requires no further investigation.
- 31. A DNA sample was collected from a relative and added to the Victorian Missing Persons DNA Database. This database is maintained by the Victorian Institute of Forensic Medicine (VIFM) and aims to match missing persons to unidentified human remains (UHR).
- 32. No matches were identified at the time of entry. Should there be a match against any human remains discovered in the future, Andrew's family will be notified.
- 33. Similarly, a forensic odontologist reviewed Andrew's dental records and provided an opinion that a dental comparison could be possible to identify Andrew from any subsequently discovered human remains.

### Medical cause of death

- 34. Following Andrew's disappearance, his body was not recovered. As such, the usual postmortem examination by a Forensic Pathologist at VIFM did not occur.
- 35. A cause of death is unable to be determined.

#### FINDINGS AND CONCLUSION

- 36. Having considered all the evidence, I find that Andrew is deceased having likely drowned sometime after entering the water at Artillery Rock.
- 37. Pursuant to section 67(1) of the Act I make the following findings:
  - a) the identity of the deceased was Andrew Ewen Mallett, born 30 May 1983;

b) the death occurred on 28 November 2024 at Artillery Rock, Great Ocean Road Separation Creek Victoria 3234, from an undetermined cause, likely drowned.

c) the death occurred in the circumstances described above.

38. I further find that the death was the result of misadventure being that Andrew misjudged the area and entering the water to spearfish when the conditions were not safe to do so.

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

Pursuant to section 73(1A) of the Act, this finding is to be published on the internet in accordance with the rules.

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

Nyree Mallett

Tessa Walsh

F/C Ashleah Ansley, Coronial Investigator

Signature:

and

Or Victoria

Coroner Dimitra Dubrow

Date: 27 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.