



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000562

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Sajeevan Selvaraj
Date of birth:	9 August 2001
Date of death:	29 January 2025
Cause of death:	1a: Consistent with drowning
Place of death:	St Kilda Beach Pier Road St Kilda Victoria
Keywords:	International student, drowning, Life Saving Victoria

INTRODUCTION

1. On 29 January 2025, Sajeevan Selvaraj¹ was 23 years old when he died by accidental drowning at the St Kilda Pier, Melbourne. At the time of his death, Sajeevan lived with his friends and other international students in Oakleigh, Victoria.
2. Sajeevan was born in Tamil Nadu, India, to his parents, Saravanan and Thenmozhi Selvaraj. He had one sister, Sharulatha. The remainder of his family live in Chennai in India.
3. On 16 February 2023, Sajeevan moved to Australia to study. At the time of his death, Sajeevan had recently completed a masters of Artificial Intelligence at RMIT University.
4. Sajeevan was a kind, well-liked and respectful person.² He was an extrovert, enjoyed socialising and made many friendship connections with other Indian students. He was considered by his father as the hope of the family and the family sacrificed much of their comforts, so they could educate Sajeevan in Australia.
5. Sajeevan had no known mental health or physical health concerns.³
6. Sajeevan did not know how to swim and never attended swimming lessons. His father reported that Sajeevan was not interested in water-based activities and as such was cautious around water. He avoided deep water due to '*his awareness of his own limitations*'.⁴

THE CORONIAL INVESTIGATION

7. Sajeevan'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. 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.

¹ Referred to throughout this finding at 'Sajeevan', unless more formality is required.

² Statement of Saravanan Selvaraj, dated 5 June 2025, Coronal Brief.

³ Statement of Saravanan Selvaraj, dated 5 June 2025, Coronal Brief.

⁴ Statement of Saravanan Selvaraj, dated 5 June 2025, Coronal Brief.

9. 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.
10. Former Coroner John Olle originally had carriage of this investigation until July 2025 including requesting the preparation of a brief. I assumed carriage of this matter on 28 July 2025 for the purpose of conducting additional investigative steps and making findings.
11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Sajeevan's death. The Coronial Investigator conducted inquiries at the request of the Court, including taking statements from witnesses – such as family, friends, witnesses from the beach and investigating police officers – and submitted a coronial brief of evidence.
12. This finding draws on the totality of the coronial investigation into the death of Sajeevan Selvaraj 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.⁵

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

Circumstances in which the death occurred

13. On Wednesday 29 January 2025, Sajeevan and seven friends, Lourdes, Pranava, Krithik, Lokesh, Ocean, Priyanka, and Subash, were celebrating the completion of their university studies and working on visa applications to remain in Australia for work. Sajeevan's friends reported that they were all very happy that night and were thrilled to have passed their exams.
14. At about 7:00pm, Sajeevan and his friends went to the St Kilda Pier. They walked to the end of the pier and had intended to jump into the water. They watched others jumping off but decided against it, as they '*did not know the depth of the water*'.⁶ Instead, they headed back to the shoreline on the south side of the pier.

⁵ 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.

⁶ Statement of Priyanka Kugapriya, dated 18 July 2025, Coronial Brief; Statement of Pranava Kumar Sivashanmugam, dated 9 July 2025, Coronial Brief.

15. At the time the group arrived at St Kilda beach, the tide was 0.3 metres high.⁷ The temperature was 18 degrees Celsius with southerly gusts of wind of 22 kilometres per hour and the sky was partly cloudy. The water was mildly choppy with small waves.
16. At about 8:00pm, the group entered the water approximately 20 meters from the pier's rock wall.⁸ As the St Kilda Surf Life Saving Club operate between 11:00am to 7:00pm on weekdays, the beach was not patrolled, and no flags were present to indicate safe swimming locations along the shoreline.
17. The water was '*normal and quiet*', there were no rough waves, and other people were also swimming at that location.⁹ Those group members who could swim did so, whilst Sajeevan stayed in the shallow water and did not venture past his knee height. His friends recalled that he was always careful around water due to his inability to swim; that he did not take risks and would never go far into water.¹⁰
18. Suddenly, the group noticed the water had changed and the depth was at hip height. Sajeevan, Pranava and Priyanka were dragged into deeper water. They struggled to keep their heads above water and could not reach the ocean floor.¹¹
19. Pranava observed Sajeevan to be scared and panicked. Pranava stayed in the water and attempted to help Sajeevan, but he, himself, quickly became fatigued and overwhelmed.¹² Pranava lost contact with Sajeevan and saw him being pulled further out from the shore and towards the rocks. Pranava struggled to keep his own head above water, experienced short episodes of loss of consciousness and could not reach the bottom in order to stand. Despite this, he swam towards Sajeevan and saw him disappear under the water. Upon reaching him, tried to lift his head but Sajeevan '*did not respond at all*' and, therefore, was unable to assist in his own rescue.¹³
20. By this time, Ocean and Priyanka exited the water and ran to Lourdes on the beach. At 8:20pm, Lourdes, realising that Sajeevan was missing, called Triple Zero.

⁷ At 9:00pm, the tide reached a low of 0.1 meters.

⁸ Lourdes remained on the beach and did not enter the water.

⁹ Statement of Pranava Kumar Sivashanmugam, dated 9 July 2025, Coronial Brief.

¹⁰ Statement of Priyanka Kugapriya, dated 18 July 2025, Coronial Brief; Statement of Pranava Kumar Sivashanmugam, dated 9 July 2025, Coronial Brief.

¹¹ Statement of Priyanka Kugapriya, dated 18 July 2025, Coronial Brief; Statement of Pranava Kumar Sivashanmugam, dated 9 July 2025, Coronial Brief.

¹² Statement of Pranava Kumar Sivashanmugam, dated 9 July 2025, Coronial Brief.

¹³ Statement of Pranava Kumar Sivashanmugam, dated 9 July 2025, Coronial Brief.

21. Lokesh, Subash and Krithik came out of the water shortly afterwards. Pranava was the last to reach the shoreline and was extremely fatigued after experiencing, what he termed, and others observed, to be a '*panic attack*'.¹⁴
22. Prior to the arrival of emergency services, other beachgoers searched along the shoreline, pier and also in the water. In particular, a French tourist searched the water for more than 30 minutes, in increasingly difficult weather, conditions approaching nightfall and changing water conditions.¹⁵
23. Mr Liam Smith (**Mr Smith**), an off-duty rescue watercraft surf lifesaver at the Williamstown Swimming and Surf Life Saving Club, coincidentally passed St Kilda Beach when he observed the multiple emergency units and flashing lights at the St Kilda Pier. He arrived on the scene at 8:21pm and assisted in the search.
24. Another off-duty lifesaver, Mr Nicholas Wood (**Mr Wood**), was also close to St Kilda when he received and responded to a Life Saving Victoria (**LSV**) Incident Alert Notification. At 8:21pm, Mr Wood attended the scene to offer assistance.¹⁶
25. At 8:24pm, two Victorian Police officers arrived on the scene. Several other police units attended, at different times during the course of events, including a police airwing unit and a water police unit.
26. At 8:28pm, Ambulance Victoria (**AV**) paramedic crews arrived and waited on standby at the shoreline.
27. At 8:57pm, the police helicopter sighted Sajeevan under the water approximately 50 metres from the shoreline, near the rocks. The police water unit was unable to approach this location due to the shallow water, choppy waves and proximity to the pier rock wall.
28. Under the direction of police, Mr Smith, Mr Wood and Fire Rescue Victoria (**FRV**) members, entered the water near the sighting location. After searching for around five minutes, a FRV member found Sajeevan under the water.
29. At 9:02pm, Sajeevan was carried out of the water and cardiopulmonary resuscitation (**CPR**) efforts were commenced. The automatic emergency defibrillator conducted one round of

¹⁴ Statement of Priyanka Kugapriya, dated 18 July 2025, Coronial Brief.

¹⁵ Statement of Acting Sergeant James Levhcenko, dated 2 April 2025, Coronial Brief.

¹⁶ Statement of Nicholas Wood, dated 10 July 2025, Coronial Brief.

analysis and instructed ‘*no shock advised*’. AV paramedics assessed that further resuscitation attempts were futile, as Sajeevan had already passed away.¹⁷

Identity of the deceased

30. On 31 January 2025, Sajeevan Selvaraj, born 9 August 2001, was visually identified by his friend, Lourdes Sanjula John.
31. Identity is not in dispute and requires no further investigation.

Medical cause of death

32. Associate Professor Sarah Parsons (**A/Prof Parsons**), Forensic Pathologist, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 30 January 2025 and provided a written report of her findings dated 4 February 2025.
33. The post-mortem examination revealed no injuries. A computed tomography (CT) scan showed patchy increased lung marking consistent with drowning.
34. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.
35. A/Prof Parsons opinion was that the medical cause of death was ‘1(a) *Consistent with drowning*’.
36. I accept A/Prof Parsons opinion. Further, given the circumstances of Sajeevan’s death, I am satisfied that he, in fact, drowned.

FURTHER INVESTIGATIONS

Safety signs

37. The St Kilda Pier entrance has two signs, written in English, that depict safety warnings regarding potential hazards whilst swimming at the pier. A large sign indicates the dangers of ‘*shallow water*’ and ‘*submerged objects*’. A smaller sign, additionally, notes the risk of ‘*variable water levels and drop off*’ and ‘*currents*’ that are depicted in words underneath visual icons.

¹⁷ Statement of Nicholas Chapman, dated 8 July 2025.

Parks Victoria

38. As part of the investigation into Sajeevan's death, Parks Victoria provided a statement to the court on the location and conditions at St Kilda Beach and Pier on the day that he died.¹⁸
39. Parks Victoria noted that the specific section of St Kilda Beach is classified as a 'course and fine-grained sand beach, with a flat to moderate slope' that is categorised as a 'semi-exposed' area.¹⁹
40. Parks Victoria stated that on 29 January 2025:
- a) There were no significant current movements at the location;
 - b) Wave conditions would likely have been '*choppy*' and '*rough*' due to moderate wind strength throughout the day; and
 - c) There were no construction works that would have impacted the beach or water conditions.
41. Parks Victoria do not manage signage along the breach and pier, as this responsibility falls to Life Saving Victoria, as the operator of the St Kilda Life Saving Club. However, Park Victoria's website offers water safety tips for people visiting Victorian beaches that states:²⁰
- 'Beaches may have hazards such as rips, strong undertows and sudden changes in weather conditions. Stay safe at the beach by only swimming where there are lifeguards and by staying in between the red and yellow flags.'*

FINDINGS AND CONCLUSION

42. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- d) the identity of the deceased was Sajeevan Selvaraj, born 9 August 2001;
 - e) Sajeevan's death occurred on 29 January 2025 at St Kilda Beach Pier Road St Kilda Victoria 3182, from 1(a) drowning; and
 - f) his death occurred in the circumstances described above.

¹⁸ Parks Victoria act as the Local Port Manager of Port Phillip Bay.

¹⁹ Statement of Parks Victoria, dated 2 September 2025.

²⁰ Parks Victoria, Water Safety (Webpage) Accessible at [Water safety](#).

43. Having considered all of the circumstances, I am satisfied that Sajeevan's death was the result of his unfamiliarity with water, his inability to swim and the consequent lack of awareness of how to cope in deep water once he was in difficulty.
44. I commend the actions of Pranava in attempting to rescue his good friend. I acknowledge that Pranava also experienced difficulty, distress and danger whilst in the water and that his efforts to assist Sajeevan increased the risk to his own personal safety.
45. I note also the response of the general public, tourists and other people on the beach who responded to the unfolding emergency that night. I praise Mr Smith's and Mr Wood's voluntarily and proactive responses to this emergency, whilst off duty. The Victorian community is well-served by such selfless conduct of these particular LSV members.
46. I also acknowledge Sajeevan's family. The death of any young person is an occasion of extreme distress for their family, friends and the wider community. The death of a young person, far from their home and family can place the family in particular distress as they need to decide how best to accompany the body of their loved child home. There is no support for death related expenses. For Sajeevan's family, his education was funded by other family members saving to ensure he had every opportunity and they invested in his future and his capacity to support them after he obtained his qualifications. On so many levels, this loss is apparent.
47. It is acknowledged that the loss of Sajeevan in such tragic circumstances has caused considerable hardship for his family. I have read the detailed correspondence between Sajeevan's father and Victoria police and acknowledge the efforts of the family to contribute to this investigation and to assist the court to understand Sajeevan's nature his many talents and kind heart.

COMMENTS

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

48. A drowning death at a popular Victorian beach, in the height of summer, is a matter of considerable public interest and concern. Students who attend our universities as part of international programs require all sorts of supports which importantly include some steps to ensure they know how to keep themselves safe on Australian beaches.

49. Victorian coroners have, over the years, made multiple comments and recommendations about strategies to mitigate the risks of drowning in Victorian coastlines.²¹ There is no single, or easy, solution to prevent fatal drownings. Education about water awareness and safety is paramount. It appears that in many cases, including this coronial investigation, clear signage warning of risk alone is inadequate.
50. The Coroners Prevention Unit (CPU)²² has previously compiled statistics on unintentional deaths at beaches along the Victorian coastline between 1 July 2014 and 28 October 2024. The CPU identified 75 unintentional coastline drowning deaths during that time period, of which 36 deaths were attributed to people born overseas.²³ This highlights the particular vulnerability of people born overseas to accidental drowning in Victorian coastal waters.

Life Saving Victoria's engagement with the culturally and linguistically diverse (CALD) community

51. Each year, LSV publishes information on Victorian drowning deaths. LSV estimates that, on average over the past ten years, 37% of Victorian drowning deaths are attributable to people who were born overseas, including people visiting temporarily and permanent Australian residents.²⁴ Life Saving Victoria considers that people born overseas are a high-risk population,²⁵ especially those people who were born in India, China, Vietnam, England and Italy.²⁶
52. Life Saving Victoria's analysis of drowning data has identified some particular water safety issues pertaining to people born overseas. The key factors impacting water safety include:²⁷

²¹ See especially the Finding into death without Inquest regarding Jil Jayeshbhai Khokhara, COR 2024 001564, published 1 October 2024, which outlines contributing factors in drowning deaths for persons born outside of Australia and the various strategies implemented by the Royal Life Saving Society, Australian Water Safety Council, and Life Saving Victoria to try to address this issue. See also the Finding into death without Inquest regarding Reema Sondhi, COR 2024 000464, Jagjeet Singh Anand, COR 2024 000465; Kirti Bedi, COR 2024 000466; Suhani Anand, COR 2024 000476.

²² 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.

²³ In 12 deaths, the CPU were unable to identify country of birth.

²⁴ Life Saving Victoria (2025) Victorian Drowning Report 2024 – 25. Available at https://issuu.com/lifesavingvictoria/docs/lsv_drowning_report_2024-25 ('Drowning Report').

²⁵ Life Saving Victoria (2024) *Aquatic Injury Prevention Agenda 2024-25*, page 9.

²⁶ Drowning Report, page 20.

²⁷ Life Saving Victoria (2026) *Aquatic Injury Prevention Agenda 2026 – 2027*, page 44.

- a) Lack of understanding or preparedness for open water conditions and dangers, particularly rips or currents;
 - b) Lack of swimming ability;
 - c) Swimming outside the red and yellow flags or swimming at unpatrolled beaches;
 - d) Not reading aquatic safety signs;
 - e) Supervising others in the water whilst not having adequate water safety skills or knowledge themselves; and
 - g) Lack of water safety messages and programs which are accessible and appropriately tailored for Culturally and Linguistically Diverse (CALD) Communities.
53. Since 2007, LSV has operated a stand-alone Diversity and Inclusion Department to engage Victoria's CALD communities. The Diversity and Inclusion team has connected with over 300,000 new arrivals, refugees, international students, and migrants to provide targeted education and training.
54. In 2024 – 2025, LSV engaged with Melbourne's international student population through the delivery of water safety education to more than 2,300 students at universities, TAFEs and language schools.²⁸
55. I also note that Melbourne universities are aware of, and are attempting to, address water safety issues and the risks for international students. Melbourne University first launched their water safety program in 2017. This free aquatic education program, delivered in partnership with LSV, provides a 5-week program of one 30-minute lesson per week. The program teaches students the necessary water safety, stroke technique and survival skills for safe and enjoyable water activities in pools and at beaches.²⁹
56. Monash University, in collaboration with Surf Life Saving Australia and the UNSW Beach Safety Research Group, developed an innovative approach to water safety education through a practice reading exercise as preparation for examination under the International English Language Testing System. The reading exercise educates users on essential Australian beach safety, such as dangerous rip currents and understanding beach safety signs, whilst providing an opportunity to practice reading skills.³⁰

²⁸ Life Saving Victoria (2025) *Annual Report 2024 – 2025*, page 26. Available at https://issuu.com/lifesavingvictoria/docs/life_saving_victoria_annual_report_2024_25.

²⁹ <https://sport.unimelb.edu.au/news/safety-first-for-international-students-in-the-water>.

³⁰ Masaki Shibata, Jasmin C Lawes, Rebecca Stolper, Janice Ford, Amy E Peden, and Hideo Watanabe, 'Public Health Promotion Through Language Learning: Improving Migrants' Australian Beach Safety Knowledge Through a Reading

57. RMIT University is similarly aware of the need to address water safety of international students. Once per year during summer, RMIT offers international students an immersive, hands-on beach safety session at Port Melbourne Beach, led by LSV professional lifesavers. Throughout the year, a heavily subsidized ‘Learn to Swim’ program provides lessons over an 8-week period to boost water confidence, improve stroke technique and learn essential water safety and survival skills.³¹ On 11 September 2025, RMIT’s Indian Club hosted a student event that included water safety education provided by a LSV Diversity and Inclusion Officer.³²
58. I commend LSV for their identification of the issues of this high-risk population and of the Diversity and Inclusion team’s preventative efforts in empowering people born overseas to improve their awareness, knowledge and skills in safe enjoyment of Victorian waters.
59. I also praise Melbourne’s universities in their efforts to engage international students in a range of programs that provide water safety education, swimming lessons and real-life beach experiences under the safety of professional lifesavers.
60. Whether or not Sajeevan had any awareness of these programs or not, is not known. What is known is that until this fateful day, Sajeevan was very careful around and in the water, but had no capacity to respond to a sudden change in the tidal conditions. This is the kind of training that is essential for all international guests, because conditions can be so changeable.

I convey my sincere condolences to Sajeevan’s family and friends for their profound and tragic loss on what should have been a day of celebration of academic achievement for Sajeevan with the hope of remaining in Australia to work following his studies. I acknowledge that Sajeevan was a treasured son and brother for which his loss has been emotionally and financially devastating for his family.

Exercise for English Language Proficiency Tests’ *Health Promotion Journal of Australia*, 37:1 (2026). Available at <https://pubmed.ncbi.nlm.nih.gov/41266091/>.

³¹ <https://www.rmit.edu.au/students/student-life/events/2026/feb/learn-to-swim>.

³² RMIT University, Strengthening connections and support for Students (website, 15 September 2025). Available at [RMIT Indian Club](#).

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:

Selvaraj & Thenmozhi Selvaraj Saravanan, Senior Next of Kin

Life Saving Victoria

Parks Victoria

Senior Constable Gregory Mcrae, Victoria Police, Coronial Investigator

Signature:



Coroner Therese McCarthy

Date: 06 October 2026

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.
