IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000026

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	YOA[1]
Date of birth:	September 2014
Date of death:	2 January 2022
Cause of death:	1(a) Drowning
Place of death:	Snowy River, Jarrahmond, Victoria, 3888
Keywords:	Snowy River, Jarrahmond, Wood Point camping ground, Jindabyne Dam, drowning, river

[1] This Finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with pseudonyms of randomly generated three letter sequences to protect their identity and to redact identifying information.

INTRODUCTION

1. On 2 January 2022, YOA was seven years old when he died in circumstances suggestive of drowning. At the time of his death, YOA lived in Capel Sound, with his mother, THV, and his brother, XLZ, who was eight years old.

THE CORONIAL INVESTIGATION

2. YOA'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.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of YOA's death. The Coroner's 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.

6. This finding draws on the totality of the coronial investigation into the death of YOA 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]

[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.

7. In considering the issues associated with this finding, I have been mindful of YOA's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

8. On 26 December 2021 at 2.30am, YOA arrived at Wood Point Camping Ground in Jarrahmond, on the banks of the Snowy River, with his mother and brother. The family had planned to stay at the campsite until the new year and set up their campsite near the river. THV stated that YOA had a week of swimming lessons in Rosebud and XLZ was able to doggy-paddle however neither child was a very competent swimmer.[3]

9. On 1 January 2022 at approximately 5.00pm, THV stated that she was sitting in the shallows of the Snowy River watching YOA play in the water approximately 30 metres away with XLZ and several other children who had arrived on the same day.[4] THV had brought pool noodles for her sons' use however they were not using them that day or wearing any flotation devices.[5]

10. THV approached the group of children to gather them for dinner, however she realised that she was unable to see YOA or his brother.[6] She asked the other children where he was however they were unsure.[7] Soon after, other campers observed XLZ in the deeper water of the river being swept downstream by the strong currents.[8] THV immediately raised the alarm. An adult witness was able to swim out and bring him back to shore, but there was no sign of YOA.[9]

11. Other campers began searching for YOA in the river and along the bank but were unable to locate him. Due to the lack of phone reception in the area, a camper had to drive several kilometres to contact emergency services who attended the area approximately 30 minutes later and began coordinating a search for the missing child.[10]

[3] Coronial brief, statement of THV dated 27 January 2022, page 77.
[4] Coronial brief, statement of THV dated 27 January 2022, pages 77-78.
[5] Coronial brief, statement of Kate O'Callaghan dated 13 February 2022, page 66.
[6] Coronial brief, statement of THV dated 27 January 2022, page 78.
[7] Coronial brief, statement of Kate O'Callaghan dated 13 February 2022, page 68.
[8] Coronial brief, statement of Senior Constable Chris Morris dated 19 January 2022, page 89.
[9] Coronial brief, statement of Kate O'Callaghan dated 13 February 2022, page 67.
[10] Coronial brief, statement of Sergeant A. Craigie dated 26 April 2022, page 81.

12. An intensive search involving members of Victoria Police, Ambulance Victoria, Country Fire Authority, and the State Emergency Service was carried out and, on 2 January 2022 at 9.46pm, YOA was located by a police diver submerged in a deep pool in the river, approximately 35 metres away from the sandbar. He was as deceased.[11]

The incident scene

13. The Snowy River where the incident occurred was between 20 and 40 metres in width in front of the campsite, with a sandy beach area that gradually dropped away with a sandbar at the edge that was approximately five metres in width and 30 metres in length. The water along the sandbar was between 0.5 to one metre deep before dropping off into deeper water approximately four metres in depth, with several areas of strong current.[12]

14. Recent water releases from the nearby Jindabyne Dam had significantly increased the river flow and created areas of unevenly deposited sand which created areas of turbulent water and soft sand. Department of Environment, Land, Water, and Planning (**DELWP**) employee Gary Carr described the ensuing effect as being "almost like quicksand", noting that the sand, including the sandbar that the children were likely playing on at the time of the incident, was especially dynamic in nature and changed hourly, which was often underestimated by visitors to the area.[13]

15. Mr Carr stated that DELWP did not generally receive notifications from the Jindabyne Dam (administered by Snowy Hydro) but monitored stream flows via the Bureau of Meteorology website. Mr Carr further noted that there are no warning signs regarding the dangers of the river or potential floods at the campsite, however such information was available online.[14]

Identity of the deceased

16. On 2 January 2022, YOA, born in September 2014, was visually identified by his uncle.

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

[11] Coronial brief, statement of Senior Constable Geoff Hanckel dated 5 January 2022, page 87.
[12] Coronial brief, statement of Kate O'Callaghan dated 13 February 2022, page 66; statement of Senior Constable Chris Morris dated 19 January 2022, page 89.
[13] Coronial brief, statement of Gary Carr dated 2 February 2022, page 100-101.
[14] Coronial brief, statement of Gary Carr dated 2 February 2022, page 101-102.

Medical cause of death

18. Forensic Pathologist Registrar Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 4 January 2022 and provided a written report of her findings dated 13 January 2022. This report was co-signed by Dr Hans de Boer, a Forensic Pathologist at VIFM.

19. The post-mortem examination revealed findings consistent with the history given. No fractures were identified.

20. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

21. Dr Ho provided an opinion that the medical cause of death was from 1 (a) drowning.

22. I accept Dr Ho's opinion.

FINDINGS AND CONCLUSION

23. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[15] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

24. It is vital that parents and carers keep in front of mind that children are inherently spontaneous, unpredictable, and do not make the same decisions about safety, especially around water, that adults would commonly make. To be effective, supervision of children around water should be from within about five metres, and certainly no more than 10 metres away. Proper safety equipment, including inflatable flotation devices, should routinely be used, no matter the setting.

[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

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

a) the identity of the deceased was YOA, born in September 2014;

b) the death occurred on 2 January 2022 at Snowy River, Jarrahmond, Victoria, 3888, from *drowning*; and

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

YOA's unfortunate death, whilst tragic in its circumstances, presents several opportunities to prevent similar occurrences in the future. Therefore, pursuant to section 72(2) of the Act, I make the following recommendations:

(i) *I recommend that the DELWP install appropriate signs at the Wood Point campsite to warn visitors of the dangers of swimming in the river, including the dangers OF sudden floods and strong currents;*

(ii) *I recommend that the DELWP liaise with Snowy Hydro to establish a real-time warning system to notify DELWP employees and relevant personnel about water releases from the Jindabyne Dam;* and

(iii) *I recommend that the DELWP liaise with the appropriate authorities to conduct a feasibility study of installing/improving mobile phone reception and coverage in the and around the area of the Wood Point camping ground to allow for prompt emergency notifications if required.*

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

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

THV, Senior Next of Kin

TWD, Senior Next of Kin

Huihua Yang, Department of Families, Fairness, and Housing

Liana Buchanan, Commission for Children and Young People

The Honourable Lily D'Ambrosio, Coordinating Minister for DELWP

Erica Edmands, President, Kidsafe

Leading Senior Constable Ray Moreland, Victoria Police, Coroner's Investigator

Signature:

CORONER SIMON McGREGOR

CORONER

Date: 28 September 2022

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.