IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000292

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	SK
Date of birth:	31 December 2016
Date of death:	15 January 2021
Cause of death:	1(a) Drowning
Place of death:	The Royal Children's Hospital Melbourne, 48 Flemington Road, Parkville, Victoria, 3052

INTRODUCTION

1. On 15 January 2021, SK was 4 years old when she died at the Royal Children's Hospital following a drowning incident two days prior.

2. At the time of her death, SK lived in Doveton with her mother, SA, and five siblings. Her father was tragically killed in the war in Afghanistan shortly before her birth.

3. SK is remembered as a bubbly, bright young girl. She spoke English and Dari and could recite colours, the alphabet and count to 40 in both languages. She loved to learn and help her mother cook.

Background

4. In May 2019, SK and her family moved from Afghanistan to Australia, where SA's brothers lived. SK was due to start kindergarten in 2021.[1]

5. SA did not know how to swim and SA had not yet discussed water safety with her, believing she was too young to understand. According to SA, she was well behaved and wouldn't run off, and never tried to go near water without her sisters who had learnt to swim.[2]

6. On 8 January 2021, the family went on a camping holiday to the Victorian High Country with SA's brothers and their wives. SK's sisters went swimming in the river, while SK walked through the water supervised. As she was unable to swim, she was not allowed to go into the water alone.[3]

THE CORONIAL INVESTIGATION

7. SK'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

[1] Coronial Brief (**CB**), Statement of SA, dated 3 February 2021.
[2] Ibid.
[3] Ibid.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of SK'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.

11. This finding draws on the totality of the coronial investigation into the death of SK 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.[4]

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

Circumstances in which the death occurred

12. At around 2pm on 13 January 2021, SK and her family visited Lysterfield Lake to have lunch and go swimming as it was a hot day. SA's sister-in-law and her sons were also in attendance.[5]

13. After the group had lunch, they set up a picnic rug approximately half a metre from the water. SK played with a bucket and spade approximately one metre away. SK had been playing for around ten minutes when SA turned to check on her and noticed she was not there. The family began searching for her, assuming she had run off into the trees or had walked off with someone else.[6]

[4] 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.
[5] CB, Statement of SA, dated 3 February 2021.
[6] Ibid.

14. Around five minutes later, a man carried SK from the water. He was approximately two metres into the lake and the water was up to his waist.[7] SK was not moving, and her face and lips were blue.[8]

15. Three bystanders including an off-duty paramedic immediately commenced cardiopulmonary resuscitation (**CPR**) while emergency services were called. SK was vomiting and spitting out water.[9]

16. At 5:56pm, Ambulance Victoria paramedics including the Helicopter Emergency Medical Services (**HEMS**) arrived at the scene and took over resuscitation efforts. At around 6:54pm, the attending paramedics reached an agreement that further resuscitation would be futile. However, a portable ultrasound was used to examine heart movement, which showed a significant heartbeat.[10]

17. At 7:34pm, SK was transported to the Royal Children's Hospital by Air Ambulance, arriving at 7:46pm.[11] Upon arrival at the hospital, SK was transferred to the Intensive Care Unit **(ICU**). A computed tomography (**CT**) brain scan showed devastating hypoxic brain injury.[12]

18. Within 12 hours of admission, SK's diagnosis clinically progressed to brain death, confirmed by radionucleotide scan on 15 January 2021. She was extubated and sadly died at 4:38pm.[13]

Identity of the deceased

19. On 15 January 2021, SK, born 31 December 2016, was visually identified by her uncle, SM, 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 Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of SK on 18 January 2021. Dr Bedford reviewed the E-Medical Deposition Form, Victoria Police Report of Death (Form 83)

[7] CB, Statement of SA, dated 3 February 2021.
[8] CB, Statement of BTE, dated 14 January 2021.
[9] CB, Statement of BTE, dated 14 January 2021; Statement of TA, dated 13 January 2021; Statement of PT, dated 1 February 2021.
[10] CB, Statement of JOD, dated 21 January 2021.
[11] CB, Statement of SD, dated 21 January 2021.
[12] Court File (**CF**), E-Medical Deposition Form.
[13] Ibid.

and post mortem computed tomography (**CT**) scan and provided a written report of his findings dated 21 January 2021.

22. The post-mortem examination revealed signs of medical intervention.

23. Dr Bedford provided an opinion that the medical cause of death was 1 (a) DROWNING.

CORONERS PREVENTION UNIT

24. I asked the Coroners Prevention Unit (**CPU**)[14] to provide me with data on child drownings, for the purpose of identifying any like incidents and examining possible prevention opportunities.

25. The CPU interrogated the Court's surveillance database[15] and provided me with data on drownings of children aged between 0 and 4 years, for the period between 1 January 2017 and 30 November 2021.

26. There were 17 unintentional child drownings identified during that period. 3 of the deaths, including that of SK, occurred in a lake or creek. In 16 of the 17 deaths, inadequate supervision was identified as a factor.

COMMENTS

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

1. SK's tragic drowning highlights the inherent risks of water and the need for close supervision of children around water. It also highlights the importance of water familiarisation among culturally and linguistically diverse (**CALD**) communities and migrants to Australia.

<u>Supervision</u>

2. Whilst I do not intend to cast blame on anyone involved in SK's death and do not suggest that anyone was responsible, the evidence suggests that she entered the water during a brief period in which she was not being watched or otherwise supervised. Unfortunately, this is not at all

[14] 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.

[15] The surveillance database contains information on all Victorian deaths reported to the coroner since 1 January 2000.

uncommon, with almost all drownings amongst children 0-4 years old occurring due to a lack of active adult supervision, even for short periods of time.[16]

3. There are numerous resources aimed at raising awareness of the need to supervise children around water, including Royal Life Saving Australia's 'Keep Watch' program, which has been running for some 25 years. In Victoria, the Royal Children's Hospital provides information on safety around water, noting that adequate supervision means 'never taking your eyes off children in, on or around water' and that children under the age of five must be within arms' reach.[17]

4. It is a fact of life that distractions happen, and that even the most well behaved of children may act unexpectedly, as SK did when she entered the water. However, I absolutely implore all adults supervising children around water to remain vigilant, to always be aware of their whereabouts and to be ready to act at any moment.

Water safety amongst CALD communities

5. In Victoria specifically, 35% of drowning deaths for the period between 2011-2012 and 2020-2021 were people from CALD communities. Life Saving Victoria (**LSV**) notes that people born overseas are over twice (2.31) as likely to drown when comparing drowning rates per head of population and cultural background.[18] Risk factors include amongst CALD communities include lack of swimming ability, water safety knowledge and experience, low levels of awareness and perception of risk and low levels of CPR and first aid skills.[19] Adequate supervision is also a factor.

6. I note with relief that Australian water safety bodies are acutely aware of the issues surrounding water safety and the CALD community and are committed to reducing drowning numbers.

7. The Australian Water Safety Strategy 2030[20] identifies 'multicultural communities' as an area of focus, with the 2030 target being increased availability of programs that meet the needs of different cultural group, and a reduction in the drowning rate among people from multicultural

[16] https://www.royallifesaving.com.au/about/campaigns-and-programs/keep-watch
[17] https://www.rch.org.au/kidsinfo/fact_sheets/Safety_In_and_around_water/
[18] Life Saving Victoria, Victorian Drowning Report 2020/21.
[19] Australian Water Safety Council, Australian Water Safety Strategy 2030.
[20] The Australian Water Safety Strategy, developed in partnership with Australia's leading water safety organisations, sets out the activities of the Australian water safety community in their work towards a reduction of drowning.

backgrounds reduced by 50%.[21] LSV's Diversity and Inclusion Department ruins a suite of educational programs tailored to CALD communities with low level English and/or limited swimming ability, underpinned by their vision that all Victorians will learn water safety, swimming and resuscitation.[22]

8. Finally, I must acknowledge efforts of the individual that retrieved SK from the water, and those that administered CPR whilst waiting for emergency services to arrive. Their bravery and selflessness are to be commended.

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 SK, born 31 December 2016;

   b) the death occurred on 15 January 2021 at The Royal Children's Hospital Melbourne, 48 Flemington Road, Parkville, Victoria, 3052;

   c) I accept and adopt the medical cause of death as ascribed by Dr Paul Bedford and find that SK died from drowning.

2. AND, having considered all of the circumstances, I find that SK's death was due to misadventure after she entered Lysterfield Lake during a momentary lapse of supervision, and, being unable to swim, tragically drowned despite bystanders' best efforts to revive her.

I convey my sincere condolences to SK's family for their loss. I also acknowledge the generosity and compassion of SA in consenting to organ donation during an unimaginably difficult time.

Pursuant to section 73(1B) 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:

SA, Senior Next of Kin

Life Saving Victoria

[21] Australian Water Safety Council, Australian Water Safety Strategy 2030.
[22] https://lsv.com.au/diversityinclusion/educational-programs/

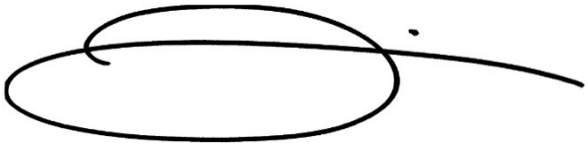
Royal Life Saving Australia

Royal Children's Hospital

DonateLife Victoria

Senior Constable Ashley Hall, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 8 November 2023

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.