IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005996

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Kanady Moo
Date of birth:	8 July 2007
Date of death:	3 November 2020
Cause of death:	1(a) CONSISTENT WITH DROWNING
Place of death:	Werribee River, Werribee, Victoria, 3030
Keywords:	Drowning

INTRODUCTION

1. On 3 November 2020, Kanady Moo was 13 years old when he drowned in the Werribee River. At the time of his death, Kanady lived with his parents and his four siblings in Werribee. Kanady was born on 8 July 2007 in a refugee camp in Thailand, where he spent most of his life.[1]

2. Kanady's mother, Ms Lwe Say, stated that whilst living in the refugee camp, Kanady attended school every day and was '*described by his teaches as a friendly kid who loved to make friends*'.[2] Ms Say further stated that Kanady never had any major health issues or mental health issues.[3]

3. Kanady enjoyed spending time with his friends and his other hobbies included playing guitar and making music. Ms Say stated that Kanady '*loved to rap around the house and write his own songs down in a book*'.[4]

4. In 2018, Kanady's family moved to Australia to live while seeking asylum. Kanady's family settled in Werribee with other members of the Karen community. Kanady attended an English Language School and subsequently attended Wyndham Central College. Ms Say stated that Kanady had almost finished year 7 when he passed away.

5. Prior to moving to Australia, Kanady had never been swimming and had not attended swimming lessons. At the time of his death, Kanady did not know how to swim.

THE CORONIAL INVESTIGATION

6. Kanady'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.

7. 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

[1] Coronial brief (**CB**), pg 10.
[2] Ibid.
[3] CB, pg 11.
[4] Ibid.

criminal or civil liability.

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.

9. Victoria Police assigned First Constable Ashlee Blick to be the Coroner's Investigator for the investigation of Kanady's death. The Coroner's Investigator conducted inquiries, including taking statements from witnesses – such as family, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Kanady Moo 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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

11. On 3 November 2020, Kanady Moo, born 8 July 2007, was visually identified by his mother, Mrs Lew Saw.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

13. Specialist Forensic Pathologist, Dr Sarah Parsons from the Victorian Institute of Forensic Medicine, conducted an external examination on 4 November 2020 and provided a written report of her findings dated 6 November 2020.

14. The post-mortem examination revealed linear bruising on the upper left chest with no signs of medical intervention noted. A post-mortem CT scan did not show any abnormalities.

15. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol

[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.

or any commons drugs or poisons.

16. Dr Parsons provided an opinion that the medical cause of death was:

    1 (a) CONSISTENT WITH DROWNING.

17. I accept Dr Parson's opinion as to the cause of death.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

18. On 3 November 2020, Kanady's parents spent the afternoon at the Rose Garden in Werribee. Ms Say asked Kanady to attend but he chose to stay at home with his brothers.

19. During the day, Kanady's friends attended the family home and asked him to come outside and ride his bike. Kanady's brothers did not let him play with his friends, because they were responsible for him while their parents were away.

20. Later that afternoon, Kanady's parents returned home, and they had dinner together as a family. At or around 6:00pm, Ms Say released that she had not heard from Kanady and noticed that he was not at home. Ms Say had not noticed Kanady leave the family home and subsequently noticed that his bike was gone. Ms Say stated that she assumed '*he had gone for a ride in the street with his friends*'.[6]

21. Kanady and his friends attended the Werribee River to swim. Kanady's friend had heard of a tree that other children in the area used to jump into the river. The tree had a wooden plank which was used as a platform.

22. At approximately 7:20pm, Kanady jumped off the platform and into the water. As he entered the water, he began to drown, as he had no prior experience with swimming and the water was too deep for him to stand.

23. Ms Hilden Tibben was walking her dog along the river when she heard Kanady's friends calling out for help. Ms Tibben approached the river and saw Kanady drowning. Ms Tibben did not have her mobile phone with her and ran to a nearby house to ask for assistance.

24. Ms Tibben spoke to Ms Katie Benson and told her Kanady was drowning in the river. Ms Benson went down to the river with her partner and asked Kanady's friends where they had

[6] CB, pg 11.

last seen him. Ms Benson stated that she jumped in the water and began searching for Kanady. Ms Benson's attempts to rescue Kanady were unsuccessful and she '*could not see any movement or bubbles*'. As Ms Benson left the water, she recalled being exhausted and that she struggled to get out of the river. Ms Benson also recalled that by the time she got out of the water her husband was on the phone to 000.[7]

25. At approximately 7:30pm, Victoria Police arrived on scene, along with Ambulance Victoria and Fire Services. Victoria Police Airwing conducted an aerial search of the river and riverbanks; however, their search was unsuccessful. By the time emergency services arrived on scene, a large number of community and family members were in attendance at the scene.

26. At 8:00pm, Ms Say received a call from her family telling her about the accident at the Werribee River and that Kanady had drowned.

27. Victoria Police Search and Rescue and State Emergency Services also attended the incident site. Victoria Police arranged for foot patrols to take place along the banks of the river and at or around 8:30pm, SES boats entered the water and began searching the river with a spotlight. The search conditions were challenging, and the boats were asked not to patrol the point of entry to the river to avoid stirring up the riverbed.

28. At or around 10:00pm, Sergeant Mark Braun of Victoria Police Search and Rescue entered the water with his search team to attempt to find Kanady. At approximately 10:30pm, Kanady's body was located in approximately 6 metres of water, caught in snags on the bottom of the riverbed very close to where he had entered the water.[8]

FURTHER INVESTIGATIONS

29. Taking into account the circumstances of Kanady's death, I sought information from Wyndham City Council regarding any steps taken to encourage safe swimming practices at the area on the Werribee River where Kanady drowned.

30. The Court wrote to Wyndham City Council and asked for a response to four questions:

    a) At the time of Kanady's death, were there any water safety signs or lifesaving equipment

[7] CB, pgs 14 – 15.
[8] CB, pgs 24, 32 and 35.

installed at the swimming spot?

b) Since Kanady's death, have any water safety signs, or lifesaving equipment been installed at swimming spot? If not, please explain why.

c) Are there other known swimming spots within the City of Wyndham and if so, are water safety signs or lifesaving equipment installed at these spots?

d) Are there any programs or initiatives run by Wyndham City Council that are used to educate the refugee community on water safety?

31. On 8 June 2022, Mr Cam Atkins, Manager Sport and Recreation provided a response on behalf of Wyndham City Council.

32. In his letter to the Court, Mr Atkins stated that Melbourne Water is the management authority for the Werribee River and the area where Kanady drowned is not a designated swimming location.

33. Mr Atkins confirmed that at the time of the incident, there was no signage or lifesaving equipment installed at this location. Mr Atkins also confirmed that Werribee South Beach is the only known swimming spot within the Wyndham City Council area to have signage installed at the car park warning visitors of strong currents.

34. Further, Mr Atkins stated that the following water safety programs and initiatives are currently in place within the Wyndham City Council area:

- LSV has been engaged to provide a supervised 'red and yellow' flag area at Werribee South Beach for both the 2020-21 and 2021-22 summer periods. It was anticipated that this would continue into 2022-23.

- To complement the lifeguarding service, LSV has been engaged to, '*deliver a series of water safety initiatives including: Water Safety Education Information Stall, Beach Water Safety Sessions and Pool Water Safety Sessions*'.

- At AquaPulse, Wyndham City Council's largest aquatic centre, the following water safety programs have been delivered:

    - Watch Around Water;

- Culturally and linguistically diverse programs in partnership with LSV;
- Learn to Swim;
- Water Safety for Non Swimmers;
- Stroke Development for Aquatic Members; and
- Women's Only Swimming Sessions.

35. Whilst I do not make any criticism of the steps that have been taken by Wyndham City Council to implement water safety programs and initiatives within its local government area, it may be appropriate for Wyndham City Council to consult with Melbourne Water and LSV to consider the installation of water safety signs at popular swimming spots in Wyndham City Council, including the area on the Werribee River where Kanady drowned.

Water safety education for children and young people and refugee communities

36. In order to identify any broader opportunities to prevent future drowning deaths in children and young people in Victoria, particularly in refugee communities, the Court sought advice from both Life Saving Victoria (**LSV**) and the Department of Education (**the Department**).

Access to swimming and water safety programs for children and young people in Victoria

37. In its response dated 1 June 2023, the Department outlined the broader context for water safety in Victoria as follows:

> *Victoria has a complex aquatic environment with many pools, lakes, rivers, dams, bays and a lengthy ocean coastline. The responsibility for swimming and water safety is led by the Department of Justice and Community Safety through Emergency Management Victoria (**EMV**), in line with the Victorian Water Safety Strategy. The Department of Education sits on the Victorian Water Safety Taskforce and shares responsibility for water safety prevention and response activities with a range of other government agencies and authorities. The Department of Jobs, Skills, Industry and Regions (through Sport and Recreation Victoria) and the Department of Education share a key responsibility for building the capabilities of Victorians in swimming and water safety.*

38. With regard to school swimming and water safety programs, the Department provided:

School swimming and water safety programs are an important part of ensuring that all Victorian children and young people have access to swimming and water safety education.

...

Department funding and resources for swimming and water safety programs in primary, specialist schools and ELS ensure that the overwhelming majority of Victoria students have access to swimming and water safety education prior to entering secondary school. This is consistent with the requirements of the Victorian Curriculum (F-10), and the goal for all students to be able to demonstrate the skills and knowledge in the [Victorian Water Safety Certificate] by the end of Year 6.

39. It emphasised that since 2017, the Victorian Government has significantly increased swimming funding to schools with $132.6 million invested in school swimming and water safety education.

40. The Department considered that had Kanady grown up in Victoria, he would have been supported to learn to swim through a range of programs, including the swimming component of the school curriculum. However, tragically, as Kanady spent the majority of his primary school years overseas, he did not have this opportunity.

41. In recognising this significant gap, the Department highlighted that subsequent to Kanady's death, funding has been introduced for all English Language Schools (**ELS**) to provide swimming programs. ELS provide intensive English language education for students (Year levels F–10) entering the education system without sufficient skills in English, prior to transitioning to a mainstream school, and thus represent a crucial opportunity to target students from a refugee or migrant background who may not have had access to swimming and water safety lessons.

42. As noted by the Department, Kanady did attend an ELS before subsequently enrolling and attending Wyndham Central College in 2020. Tragically, he did not have the benefit of these programs which were only implemented in 2021. However, I am hopeful that future students in Kanady's circumstances will now have access to free swimming lessons through an ELS.

43. In addition, I note that the Department has indicated its intention to conduct an evaluation in 2023 of the effectiveness of swimming and water safety funding and programs, with particular

consideration of the needs of students identified as being at risk. I commend this initiative and suggest that the evaluation should specifically consider the effectiveness of the newly-introduced ELS swimming programs at targeting newly arrived refugee students.

Targeted water safety education for refugee communities

44. At a broader level, the Department recognised the increased numbers of fatalities for children and young people from refugee and migrant communities and emphasised the need for ongoing work to improve communication and education regarding the dangers of waterways and the various swimming and water safety programs available in Victoria.

45. In its response dated 4 November 2021, LSV advised that its Diversity and Inclusion team work closely with the Karen community in the Werribee area to assist with funded community swimming lessons, classroom visits and beach excursions. It estimated that several hundred Karen youth and children had learned to swim through LSV programs, with a number of Karen youth having also completed accredited training in surf lifesaving, swim teaching and pool lifeguarding.

46. While there has been progress made through LSV's initiatives in improving the swimming and water safety in the new arrival community, they continue to be identified as at-risk of experiencing a drowning incident.

47. LSV considered it vital that any swimming and water safety messaging and education draws attention to the dangers of inland waterways, as well as coastal locations. This messaging should also be available in the languages of new arrival communities to ensure that the information is understood.

48. This view was supported by the Department who agreed with the need to improve targeted communication to refugee, new arrival migrant and culturally and linguistically diverse (**CALD**) communities about the risks of Australian waterways and the supports and programs available to learn to swim and build safety around water. The Department indicated it would welcome opportunities to further collaborate with LSV, EMV, and other relevant organisations in this regard.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Kanady Moo, born 8 July 2007;

b) the death occurred on 3 November 2020 at Werribee River, Werribee, Victoria, 3030, from consistent with drowning; and

c) the death occurred in the circumstances described above.

49. I find that Kanady's death was accidental.

COMMENTS

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

50. Kanady's death is an unimaginable tragedy for this family as well as the wider community. Unfortunately, drowning is one of the leading causes of unintentional death for Australian children. In 2020/21, 14 children aged between 5 – 14 years drowned in Australia. This is a 56% increase on 2019/20 and a 27% increase on the 10-year average. 5 of the 14 drowning deaths were in a river or creek with 71% of all drowning deaths in this age group were males.

51. It is imperative, especially in the lead up to the next summer season, that the Victorian community is reminded of the danger of unintentional drowning in children in both large and small bodies of water.

52. I commend the work being undertaken by LSV and the Department to increase targeted communication to refugee, new arrival migrant and culturally and linguistically diverse (**CALD**) communities with regard to swimming and water safety programs.

53. I am hopeful that through continued cooperation of these agencies, future deaths in circumstances such as Kanady's can be prevented.

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

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:

Law Say & Kaw Loe Way Htoo, Senior Next of Kin

Department of Education and Training

Life Saving Victoria

Wyndham City Council

First Constable Ashlee Blick, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date: 1 August 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.