IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005243

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

*Amended on 5 June 2025 pursuant to section 76 of the **Coroners Act 2008 ****

Findings of:	Coroner Simon McGregor
Deceased:	Cienna Ros'Se Jervies
Date of birth:	16 March 2011
Date of death:	19 September 2023
Cause of death:	1(a) Drowning
Place of death:	Ocean Grove Beach 155 Bonnyvale Road Ocean Grove Victoria 3226
Keywords:	Drowning, Ocean Grove Beach, safety signage, water safety

** Foot note 17 was amended to correct a typographical error.*

INTRODUCTION

1. On 19 September 2023, Cienna Ros'Se Jervies was 12 years old when she drowned at Ocean Grove Beach. At the time of her death, Cienna lived at 66 Narawi Avenue, Clifton Springs, Victoria with her parents and two brothers.

2. Cienna was born in Victoria on 16 March 2011, the second of three children to parents Jodie and Brent. At the time of her passing, she was in Year 7 at Bellarine Secondary College. Cienna had a large circle of friends and took part in many extracurricular activities, including camping and volunteer work with the Salvation Army. She had participated in swimming events throughout her schooling and lived close to the beach her whole life. The family home also had a backyard swimming pool that she used frequently.

3. Cienna had no mental or physical health concerns and enjoyed a happy and loving home life.

THE CORONIAL INVESTIGATION

4. Cienna'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.

5. 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.

6. 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.

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

8. This finding draws on the totality of the coronial investigation into the death of Cienna Ros'Se Jervies 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.[1]

9. In considering the issues associated with this finding, I have been mindful of Cienna's 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

10. On 19 September 2023, Cienna attended Ocean Grove Beach near the Collendina Holiday Park with her mother, her grandmother, Iris, her younger brother, Cohen, and her friend Ebony, who was also 12 years old.[2]

11. The section of the beach they attended, near beach marker 6W, was signposted as having strong currents, submerged objects and slippery rocks. Visitors were advised to swim between surf lifesaving flags under supervision.[3] At the time of their attendance, there were no flags present and the beach was not patrolled.[4]

12. At approximately 6:00 pm, Cienna, Ebony and Cohen were swimming by the water's edge, with Iris and Jodie sitting approximately 15 meters up the shore. Iris recalled that they had observed the girls by the water's edge and glanced away for only a second and could no longer see them.[5] They began screaming for help from passers-by and called triple zero.[6]

13. Witness Elise Campbell was jogging along the beach and observed Jodie and Iris shouting towards the water and was flagged down by the pair. Ms Campbell immediately entered the

[1] 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.
[2] Statement of SC Alex Flight, Coronial Brief.
[3] Exhibit 3 – Scene photographs, Coronial Brief.
[4] Statements of SC Alex Flight and Elise Campbell, Coronial Brief.
[5] Statement of SC Alex Flight, Coronial Brief.
[6] Summary of SC Alex Flight, Coronial Brief.

water and swam out to Cienna and Ebony, who were close together approximately 50 metres out and drifting further from shore. The pair were caught in a large rip with large waves rolling in consistent sets. Ms Campbell managed to get hold of both girls and attempted to swim them back towards the shore, but a large wave dumped all three of them and they became separated. Ms Campbell resurfaced and had lost sight of Ebony but could still see Cienna, who was calling out to Ms Campbell for help. By this time, Ms Campbell was herself caught in a rip and unable to swim in any direction, with waves repeatedly crashing over her and forcing her underwater.[7]

14. At the same time, witness Adam Marriott was walking along the beach while returning from a run and was flagged down by Jodie and Iris. Mr Marriott immediately entered the water and managed to reach Ebony in very rough conditions. Mr Marriott was able to bring Ebony back to shore. Ebony was extremely distressed and screaming that Cienna was still in the water.[8]

15. Mr Marriott re-entered the water and was able to reach Cienna approximately 100 metres from the shore. By this time, she was unresponsive and unable to assist in her own rescue, and Mr Marriott thought she may have already passed away. Mr Marriott could not reach the bottom and was battling against rolling sets of waves and strong currents. Both Mr Marriott and Ms Campbell were ultimately forced to leave Cienna as they were battling exhaustion and struggling to remain afloat. With great difficulty they managed to make it back to shore.[9]

16. After some difficulty ascertaining the correct location, Senior Constable Andrea Dell and First Constable Lauren La Spina arrived at the scene at approximately 6:20 pm and observed both Mr Marriott and Ms Campbell exiting the water in states of extreme exhaustion.[10] Both Mr Marriott and Ms Campbell required medical treatment at the scene due to ingesting water, exhaustion and hypothermia, as they had been in the water for a significant period of time.[11]

17. From approximately 6:30 pm, more police members arrived at the scene and assisted in the search efforts. The water conditions were rough, with waves breaking in consistent sets and rough seas up to 100 meters from the shoreline where Cienna had last been seen.[12]

[7] Statement of Elise Campbell, Coronial Brief.
[8] Statement of Adam Marriott, Coronial Brief.
[9] Statements of Adam Marriott and Elise Campbell, Coronial Brief.
[10] Statement of FC Lauren La Spina, Coronial Brief.
[11] Statement of SC Andrea Dell, Coronial Brief.
[12] Statement of LSC Mick Tatlock.

18. At 6:54 pm, a police helicopter located Cienna approximately 100 metres offshore in swell, around 40 minutes after she had last been seen unresponsive by Mr Marriott. Senior Constable Kylie Bevan of the flight crew was winched down and collected Cienna from the water, then assisted her to awaiting paramedics on the shore. Paramedics commenced CPR and maximal resuscitation efforts, but Cienna was unable to be revived and was formally pronounced deceased at the scene.[13]

Identity of the deceased

19. On 19 September 2023, Cienna Ros'Se Jervies, born 16 March 2011, was visually identified by her father, Brent Jervies.

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

Medical cause of death

21. Specialist Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an external examination on 20 September 2023 and provided a written report of his findings dated 21 September 2023.

22. Dr Burke found no evidence of any injuries that may have caused or contributed to death.

23. A post-mortem computed tomography (**CT**) scan was also unremarkable.

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

25. On the basis of his findings and the circumstances of her death, Dr Burke provided an opinion that the medical cause of death was 1 (a) drowning.

26. I accept Dr Burke's opinion.

[13] Statements of LSC Mick Tatlock and SC Alex Flight, Coronial Brief.

EXPERT REVIEW OF BEACH SAFETY

27. The death of any young person is an occasion of extreme distress for their family, friends and wider community. A drowning death at a Victorian beach is additionally a matter of considerable public interest as local residents and visitors make decisions about their summer holiday plans and activities. As such, and with a view to identifying any opportunities for prevention of similar deaths in the future, I directed that expert opinion be sought about the adequacy of safety signage at the Ocean Grove Beach specifically and Victorian safety signage standards more generally.

28. For clarity, I am not of the view that inadequate safety signage was a contributing factor in Cienna's death, as I am satisfied that Cienna and her family, as local residents, were aware of the risks of swimming at the beach. Rather, I have sought to identify prevention opportunities as they may relate to less familiar visitors to this beach and the surrounding area.

29. Mr Andy Dennis, General Manager, Aquatic Capability, Life Saving Victoria, provided me with a statement of his expert opinion dated 2 August 2024. In his report, Mr Dennis observed that Collendina beach (as the relevant section of Ocean Grove Beach is locally known) occupies most of the open bay between Point Lonsdale and Barwon Heads. It is 6 km long, extending from the reefs west of Point Lonsdale beach to 1 km west of the Collendina beach car park. The only public access is at the car park, together with tracks over the foredune from the caravan park.

30. The beach faces south-south-east and for the most part is backed by 10 to 20 metre high, vegetated dunes, with a few blowouts. It receives waves averaging between 1 to 1.5 metres, which break over a wide, low gradient surf zone and occasional reefs and rocks. Persistent rips occur every 250 metres, with some permanent rips against the more prominent reefs. During bigger seas, waves break on outer, deeper reefs.

31. Mr Dennis reported that in the past eight years, there have been five drowning incidents along the Ocean Grove coastline (including fatal and non-fatal drowning). This suburb falls within the Greater Geelong local government area, which is the third most dangerous Local Government Authority in Victoria for fatal drowning. The responsibility for the Collendina beach area is currently divided between the Barwon Coast Committee of Management, City

of Greater Geelong and the Borough of Queenscliff. It is understood that the incident occurred within the City of Greater Geelong area of responsibility.

Beach safety signage

32. Mr Dennis explained that the provision of water safety information through signage is recognised nationally and internationally as a component of the drowning prevention chain. This is demonstrated by its regular inclusion in strategies, standards, guidelines and other similar resources. However, there is a limited evidence base regarding the effectiveness of aquatic safety signage in providing information, creating compliance, and influencing behaviour.

33. The effectiveness of signage is reliant on several design elements including location, size/height, colour/contrast, shape, symbols/pictorials, signal words, and format. Additionally, effectiveness is influenced by several non-design, human behavioural factors, including attention, comprehension, attitudes/beliefs, motivation, familiarity, and memory.

34. Mr Dennis stated it is critical that signage is designed and installed in alignment with best-practice standards, but that there remains a gap and some contradiction between what is recommended by research and the actual signage standards, in terms of how to design, develop and implement signage effectively. These contradictions lead to signage being less effective than intended, as compliance is prioritised over effectiveness. Examples include but are not limited to poor design, overprovision of signage, and desensitised readers.

35. Further, current recognised standards relating to aquatic safety signage are complex and subject to frequent changes.[14] This contributes to stakeholders prioritising compliance over effectiveness and makes it increasingly difficult for land managers and duty holders to stay up to date, and to design, manufacture and install signage that is both compliant and effective.

Adequacy of safety signage at Collendina beach

36. In August 2024, Mr Dennis conducted an assessment of the existing safety signage at Collendina beach using Life Saving Victoria's Safety Signage Assessment process. This process considers the following factors, resulting in a score out of 5 for each element:

[14] In the last two years the following standards impacting aquatic safety signage have been changed/updated:
ISO7001 (2023) - Graphical symbols - Registered public information symbols.
ISO3864-3 (2024) - Graphical symbols - Safety colours and safety signs.
ISO20712-3 (2024) - Water safety signs and beach safety flags.

a) Compliance: Emergency marker, location, warnings, safety information, prohibitions.

b) Content: Clarity, relevance, accuracy, comprehensiveness, consistency.

c) Condition: Visibility, legibility, structural integrity, maintenance, durability.

37. Mr Dennis's assessment focused on the beach near the 6W beach marker, as well as the safety signage at the nearest beach access points to the immediate east and west of the location. The exercise resulted in a score of 3/5 for compliance, 2/5 for content, and 2/5 for condition. Of particular note, Mr Dennis made the following observations:

a) The signage was in poor condition. This included general fading and stickers placed over existing content, including a 'crime wave' sticker partially placed over the complimentary text which had been warning of 'slippery rocks', but was now only partially visible.

b) There was an inconsistent approach to emergency markers (EM) and emergency beach access area numbers (EBAN). Two of the three locations had EBAN provisions and the third had an EM. A consistent approach is recommended, to improve location identification and emergency response, as recommended by Triple Zero Victoria.

c) The signage did not include a safety mandatory provision identifying the need for parents/guardians to actively supervise children. This provision should be a standard inclusion on beach signage and was included in one of the two neighbouring signs.

d) The single sign at the incident location was located at the entry point to the path leading to the beach location. Mr Dennis considered that additional signage on the path may be beneficial as the signage is located approximately 60-100 metres away from the beach.

e) There were several differences between the regulation (i.e. council by-law) elements of the signage across the three nearby signs, reducing consistency and subsequently familiarity. Mr Dennis explained that these inconsistencies could reduce recall and compliance.

Multilingual signage

38. When asked about the feasibility of multilanguage safety signage, Mr Dennis opined that as hundreds of languages are spoken across Australia, the provision of safety information in each

language is impractical. Instead, symbols should be provided with simple complementary text, and it is a provision of signage standards that the text be in English.

39. Mr Dennis added that in recent years, quick response (**QR**) codes have been increasingly incorporated into safety signage. These codes direct users to online content (e.g. BeachSafe) which can be maintained remotely and independently from the physical signage. Mr Dennis recommended the use of QR codes to assist in the provision of current/accurate information, whilst reducing physical signage clutter.

New South Wales water safety guidance

40. In the course of my investigation, I considered other states' approaches to water safety guidance, including the New South Wales Office of Local Government's *Practice Note 15: Water Safety*[15] ('Practice Note 15'). This document provides guidance to councils and is intended to 'strengthen their water safety functions and responsibilities'. I sought Mr Dennis's expert opinion as to the merit and feasibility of the Victorian Government providing land managers such as local councils or coastal committees with water safety guidance in the form of a practice note similar to that currently in operation in NSW.

41. Mr Dennis opined that Practice Note 15 provides clear alignment to legislation and creates sound understanding, coordination and collaboration. Foremost, Practice Note 15 identifies the responsibilities of all government and non-government agencies and their roles in water safety. In NSW, councils manage public safety on public land and waterways. In Victoria there is no documented acceptance of water safety responsibility, which results in councils and land managers being unclear on whose responsibility it is to mitigate risks.

42. Mr Dennis considered that the introduction of a resource and mandate equivalent to NSW's Practice Note 15 could be a 'game-changer' in Victoria, in that it would address a key gap, where there is no prescribed water safety minimum standards for local government under existing legislation.[16] Additionally, he considered this approach would increase the likelihood that the complexities of drowning prevention would be addressed in a more cohesive and holistic manner by responsible stakeholders. He recommended that a set of Water Safety

[15] NSW Office of Local Government, Department of Planning and Environment (2017): https://www.olg.nsw.gov.au/wp-content/uploads/OLG-Water-Safety-Practice-Note-15-Update.pdf

[16] The exceptions to this are general duty of care and due diligence obligations mandated under health and safety legislation and water quality provisions.

Arrangements similar to those addressed in NSW's Practice Note 15 be developed under the Victorian State Emergency Management Plan.[17]

43. He emphasised that to achieve the desired outcomes, any Victorian water safety resource of this kind must be clearly aligned to both legislation and Government/industry support resources, that those resources must be appropriately and independently validated, and that all provisions must align to drowning prevention research, best practice and recognised governmental strategies. Additionally, resources must complement and not duplicate, contradict or contrast one another.

44. I accept Mr Dennis's opinion and adopt this recommendation.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Cienna Ros'Se Jervies, born 16 March 2011;

    b) the death occurred on 19 September 2023 at Ocean Grove Beach, 155 Bonnyvale Road, Ocean Grove Victoria 3226, from drowning; and

    c) the death occurred in the circumstances described above.

46. Having considered all of the circumstances, I am satisfied that Cienna's death was the tragic result of misadventure in the context of treacherous ocean conditions.

47. I commend Ms Campbell and Mr Marriott for their courageous and selfless efforts in going to Cienna and Ebony's aid in extremely difficult circumstances.

48. I convey my sincere condolences to Cienna's family for their profound loss.

[17] Mr Dennis added that this would also be consistent with Recommendation 5 of the Inspector General Emergency Management's *Review of Victoria's water safety arrangements* (July 2024): https://www.igem.vic.gov.au/publications/review-of-victorias-water-safety-arrangements.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That Emergency Management Victoria consider developing a resource similar to NSW's *Practice Note 15: Water Safety* under the Victorian Statement Emergency Plan with a view to clarifying, coordinating and strengthening the water safety functions and responsibilities of Victorian water safety duty holders.

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:

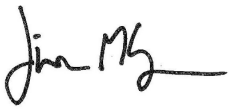
Jodie O'Connor and Brent Jervies, Senior Next of Kin

Andy Dennis, Life Saving Victoria

Emergency Management Victoria

Constable Alex Flight, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 06 June 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.