IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005753

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Ying Sun
Date of birth:	27 January 1971
Date of death:	30 September 2024
Cause of death:	1a : DROWNING
Place of death:	Cape Schanck Lighthouse 420 Cape Schanck Road Cape Schanck Victoria 3939
Keywords:	Drowning

INTRODUCTION

1. On 30 September 2024, Ying Sun was 53 years old when she drowned near Cape Schanck Lighthouse . At the time of her death, Ying was travelling with her spouse, Jie Chen, from Taiwan visiting their son, Honglin Chen, who resided in Australia.

2. Ying resided with Jie in Taichung City in Taiwan and their son, Honglin Chen was studying in Australia.

3. On 19 September 2024, Sun and Jie travelled to Australia to visit Honglin who booked accommodation in Rosebud to enjoy a holiday with his parents. Honglin planned to visit the Cape Schanck area with his parents to see the lighthouse and beach which were well-known tourist attractions in Victoria.

4. Ying was reported to be in general good health and was a good swimmer.

THE CORONIAL INVESTIGATION

5. Ying'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.

6. 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.

7. 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.

8. Victoria Police assigned Senior Constable Ravinay Singh to be the Coronial Investigator for the investigation of Ying's death. The Coronial 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.

9. This finding draws on the totality of the coronial investigation into the death of Ying Sun 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]

10. In considering the issues associated with this finding, I have been mindful of Ying'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

11. On 30 September 2024, Ying, Jie and Honglin travelled to Cape Schanck. The family parked their vehicle at the Cape Schanck Coastal Walking car park near the Cape Schanck Lighthouse.[2]

12. The family walked down the boardwalk towards the beach area and at the end of the boardwalk they decided to turn left and walk towards the rocks near Black Rock Beach. Honglin advised that the waves were not large at the time and decided to walk on the rocks towards a fisherman nearby to see what the fisherman had caught that day.[3]

13. After a few minutes on the rocks, the family decided to turn around and head towards the beach. As they headed with their backs facing the sea, a large wave hit them from behind and all three family members were knocked off their feet and onto the rocks. Jie and Honglin managed to get to their feet however Ying had difficulties getting up. Witnesses reported observing a second wave strike and hit the family causing Ying to be dragged into the water off the rocks.[4]

14. Mr Trwstan Drewes witnessed the two waves strike the family and yelled out to Ying to encourage her to make her way towards safety back to shore but she appeared to be drifting further out to sea. Mr Drewes then jumped into the water to attempt to assist Ying but when he was approximately five metres into the water when he observed Ying to have already

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[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] *Coronial Brief,* Statements of Honglin Chen and Jie Chen.

[3] Ibid.

[4] *Coronial Brief*, Statement of Trwstan Drewes.

drifted further towards the sea and did not want to risk his life as it was unsafe to proceed further.[5]

15. A separate witness who had also observed the incident from the rocks called emergency services and Victoria Police attended the scene trying to coordinate a rescue of Ying.[6] Police members blocked off the carpark area and called in a Police Airwing Helicopter which arrived shortly later and located Ying floating in the water towards the beach, Ying's body was retrieved and the airwing landed at the nearby light house with police and paramedics in attendance.[7] Ying appeared lifeless with multiple cuts to her hands, arms and legs due to being washed up on sharp rocks. Her body was cold to touch and she was pronounced deceased on site by attending paramedics.[8]

Identity of the deceased

16. On 30 September 2024, Ying Sun, born 27 January 1971, was visually identified by their spouse, Jie Chen.

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

Medical cause of death

18. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 1 October 2024 and provided a written report of her findings dated 2 October 2024.

19. The post-mortem examination revealed evidence of multiple bruises and abrasions likely due to impact with rocks and other rough surfaces in the water.

20. Post-mortem CT scans revealed no evidence of significant traumatic injuries.

21. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

22. Dr Fronczek provided an opinion that the medical cause of death was 1(a) drowning and I accept her opinion.

[5] Ibid.
[6] *Coronial Brief*, Statement of Kate Aird.
[7] *Coronial Brief*, Statements of Leading Senior Constable Paul Oregan and Sergeant Ronald Trainer.
[8] *Coronial Brief*, Statement of Ambulance paramedics John Carolan and Christopher Wardell.

FURTHER INVESTIGATIONS

23. As part of my investigation into Ying's death, I asked the Coroner's Prevention Unit (**CPU**)[9] to identify whether other unintentional deaths had occurred at the same area in recent years.

24. The CPU identified four other unintentional deaths had occurred at Cape Schanck since 1 January 2000.[10] Two of the deaths were the result of drownings, from being swept off the rocks by a sudden large wave or being caught in a strong rip current in the surf. The third and fourth deaths were fatal falls from the Elephant Rock area, which occurred in 2013 and 2023 respectively.[11]

25. I note that in previous coronial investigations that Parks Victoria has confirmed that the management of Mornington Peninsula National Park, includes all the trails leading to Bushrangers Bay and the area surrounding the lighthouse. This does not include large sections of the beach at Bushrangers Bay which is private land and falls outside their jurisdiction.

26. Parks Victoria advised that risk signage is installed along the Two Bays Walking Track from Cape Schanck and the Bushrangers Bay carpark on Boneo Rd, as well as at the head of the stairs to Bushrangers Bay and at the beach access point at the bottom of the stairs. The signs include warnings about unstable cliffs and cliff edges. Parks Victoria has previously advised that it does not have authority to place signage outside of the boundaries of the national park, such as on Elephant Rock.

27. Parks Victoria also further advised that, pursuant to Coroner Jamieson's recommendation in connection with the coronial investigation into the death of Ahedah Hamed, additional risk signage was installed in March 2024, on entry to the beach at Bushrangers Bay, next to an existing red warning sign. The additional signage includes warnings about unstable cliffs.

28. Parks Victoria further noted their use of signage as an effective risk mitigation tool requires careful consideration of several factors, including the signs' visibility, clarity, placement and visitor behaviour, without regard to which can lead to confusion, complacency or neglect.

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[9] 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.

[10] Previous coronial investigations, COR 2019 000409, COR 2021 000269, COR 2013 005285 and COR 2023 000541.

[11]

FINDINGS AND CONCLUSION

29. 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.[12] 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.

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

    a) the identity of the deceased was Ying Sun, born 27 January 1971;

    b) the death occurred on 30 September 2024 at Cape Schanck Lighthouse, 420 Cape Schanck Road, Cape Schanck, Victoria, 3939, from 1(a) drowning; and

    c) the death occurred in the circumstances described above.

31. Having considered all of the evidence, I am satisfied that the collision was the tragic result of Ying's failure to exercise caution whilst walking in an area known to be dangerous due to previous fatalities.

32. I commend the swift response of members of the public and emergency services to the scene, in circumstances that were challenging due to the remote location and limited mobile phone reception.

COMMENTS

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

33. It is regrettable that unintentional deaths continue to occur in Cape Schanck, and that there have been several fatalities in the area in the past ten years.

34. I consider that Parks Victoria has appropriately installed signage, including additional signage in 2024 following a recommendation of this Court, that clearly warns of the hazards present

[12] *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…'.

in the area, including unstable cliffs and cliff edges.[13] However, despite the signage, it appears that Cape Schanck remains a popular attraction for beachgoers to climb and explore when visiting Bushrangers Bay and the surrounding beach areas.

35. The circumstances of Ying's death and other similar deaths in the area, highlight the importance of exercising caution when visiting remote and unpatrolled locations such this. Despite the recent changes to signage in March 2024 noted by Parks Victoria, there continues to be a significant risk of serious injury and death. I urge visitors to the area to avoid swimming and climbing and to be vigilant to safety risks associated with variable natural conditions, such as unstable cliff edges, unexpected changes to surf and water conditions.

36. I previously investigated a similar drowning case[14] where I engaged an expert, Mr Andy Dennis (General Manager – Aquatic Capability, Life Saving Victoria), who confirmed that there remains a gap in best practice standards for the design and installation of warning signage. A contradiction sometimes arises between what is recommended by research and actual signage standards, these contradictions can lead to signage being less effective as compliance is prioritised over effectiveness.

37. Mr Dennis considered the feasibility of multilingual safety signage and noted that hundreds of languages are spoken across Australia. He recommended 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 updated independently from the physical signage. I agree with Mr Dennis's recommendation in utilising QR codes to assist in the provision of current/accurate information in multiple common visitor languages whilst reducing physical signage clutter.[15]

RECOMMENDATIONS

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

    (i) That **Parks Victoria** consider the installation of additional signage at the end of the boardwalk towards Black Rock Beach. This additional signage should remind visitors

[13] See the coronial investigation into the death of Ahedah Hamed COR 2021 000269, available online at: https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202021%20000269%20Form%2038%20-%20Finding%20into%20Death%20without%20Inquest.pdf
[14] COR 2023 005243 – Cienna Ros'Se Jervies
[15] Ibid.

and warn them of the hazards present in the area and the need for caution around the water and rocks.

(ii) That **Parks Victoria** consider updating all hazard warning signage in the area with QR codes to link to information on the Parks Victoria website that is available in multiple languages to ensure international visitors have access to relevant information in their own languages.

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

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.

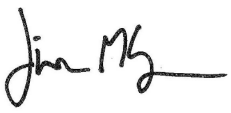
I direct that a copy of this finding be provided to the following:

Jie Chen, Senior Next of Kin

Parks Victoria

Senior Constable Ravinay Singh, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 18 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.