

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 1868

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

I, CAITLIN ENGLISH, Coroner having investigated the death of Jerem Edwards

without holding an inquest:

find that the identity of the deceased was Jerem Bradley Edwards

born on 17 July 1985

and the death occurred on 24 May 2012

at Frankston Beach

from:

1 (a) DROWNING IN THE SETTING OF ACUTE ALCOHOL TOXICITY

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Jerem Edwards was 26 years of age at the time of his death. He resided at 172 Heatherhill Road, Frankston with Justin East. Mr Edwards was employed as a chef at Fratelie's restaurant.
2. A police investigation was conducted into the circumstances of his death.
3. A brief was prepared by Victoria Police for the Coroner which includes statements from Mr Edwards' housemate, father, witnesses and the investigating officer. I have drawn on all of this material as to the factual matters in this finding.
4. On 23 May 2012, Mr Edwards finished work at approximately 10pm before returning home.
5. Mr Edwards attended the Shakespeare Tavern at approximately 11pm with a group of friends.
6. Between the hours of 10pm and 1am Mr Edwards consumed a mixture of beer and spirits.

7. At approximately 1am on 24 May 2012, Mr Edwards and eight other friends left Shakespeare Tavern, when it closed, and drove in two vehicles to the Frankston pier.
8. Carly Burns, who was at the tavern with Mr Edwards, described him as *"quite drunk"* by this stage.¹
9. Mr Edwards initially said that he did not want to go to the pier, but he was convinced to attend.
10. There had been discussion amongst the group about who was going to jump into the water.
11. The group separated at the pier. Mr Edwards and a friend, Melissa White walked approximately 200 metres down the pier whilst the rest of the group walked to the end of the pier.
12. Mr Edwards and Ms White discussed the idea of commencing a relationship together whilst talking on the pier. Ms White stated that Mr Edwards *"was very happy with that and was in a great mood."*²
13. At approximately 1.20am, Mr Edwards stripped down to his shorts and jumped off the pier into the water.
14. Mr Edwards was initially swimming. He then attempted to climb back up a ladder but was swept under water by waves and pushed into a pylon. This was the last time Mr Edwards was seen alive.
15. Ms White immediately called for assistance from the rest of the group who commenced to try and locate Mr Edwards. At least two of the group entered the water in search of him.
16. Police were contacted and attended the pier.
17. Constable Hurwood stated:

'During the search Air Wing and Water Police assistance was requested with a Police Helicopter attending as well as 2 Water Police vessels with Search and Rescue Divers on board...

¹ Ibid, 14.

² Ibid, 11.

*...the Police Helicopter was equipped with a Forward Looking Infra Red (FLIR) camera, however due to the poor weather and choppy water conditions this was of no value during the search.*³

18. According to Constable Hurwood; “[a] thorough search of the water along the pier and beach on both the north and south sides of the pier was conducted by police on foot. Water police were notified and attended with two vessels including divers and conducted grid searches of the water. Air wing were also notified and attended for the search. At approximately 06:00AM police located the body of [Mr Edwards] washed ashore approximately 300 meters (sic) south of the Frankston Pier. The deceased was naked and semi submerged in tidal sand with waves still washing over the body. Police recovered [Mr Edwards’] body and located [Mr Edwards’] shorts approximately 10 meters (sic) higher on the sand.”⁴
19. The temperature range for Frankston on 24 May 2012 was 12.9 – 14.5 degrees Celsius with winds blowing up to 30km/h from the north. The tide was rising with high tide at 4.08am and the water was choppy.
20. Constable Hurwood stated that “[i]nvestigators believe that the deceased death was accidental and as a result of high level of intoxication and poor weather conditions. The deceased was highly intoxicated and incapable of forming any informed and solidly grounded decisions. The deceased formed his own opinion to jump off the pier whilst in the company of only one of his peers who verbally criticised his decision to do so. The weather conditions were poor with low temperatures and high winds. Water conditions were also poor and unpredictable. There are no suspicious circumstances surrounding the deceased's death.”⁵

Post Mortem Examination

21. A post mortem autopsy was conducted by Forensic Pathologist Dr Yeliena Baber at the Victorian Institute of Forensic Medicine on 29 May 2012. Dr Baber formulated the cause of death. I accept her opinion. Dr Baber noted that:

“At autopsy, the body was that of a well nourished adult male with no evidence of injury. The body was covered in sand. Internal examination revealed emphysema aquosum and

³ Coronial Brief, 37

⁴ Coronial Brief, 2.

⁵ Ibid.

heavy, congested and oedematous lung parenchyma. Sand was present throughout the bronchial tree. No significant natural disease was identified.

Histology showed stomach contents within the airways, but was otherwise unremarkable.

Toxicology showed high levels of blood alcohol (BAC) at 0.32g/100ml...BAC in excess of 0.30g/100ml can cause death in the absence of other contributing factors.

The history provided is suggestive of drowning, and features considered consistent with drowning were present at autopsy (emphysema aquosum, pleural effusions and oedematous lung parenchyma), although the classic 'foam plume' was absent. There may have been some contribution by hypothermia.

There was no evidence of injury which may have contributed to or caused death."

FINDING

I find that Jerem Edwards died from drowning in circumstances where he was affected by acute alcohol toxicity.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

Information was sought from Life Saving Victoria (LSV), the peak water safety organisation in Victoria, regarding the dangers of alcohol consumption prior to swimming.

LSV has indicated that alcohol remains a significant contributing factor in unintentional drowning deaths, with an average of nine drowning deaths each year attributable to alcohol use in Victoria from 2000-2013. Therefore, approximately one in four fatal drowning deaths in Victoria involves alcohol.

Research conducted by LSV and the Coroners Prevention Unit⁶ to examine the role of alcohol in drowning deaths in Victoria from 2000 - 2008 found that the number of drowning deaths where alcohol was present remained unchanged from 2000-2008, with an average of nine deaths annually, and males accounted for 82% of the deaths. Other findings included the deceased was most commonly swimming at the time of the incident (24%) and the majority of deaths occurred in major cities (53%).

⁶ The Coroners Prevention Unit is a specialist service for Coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

LSV advised that in the period prior to the death under investigation, that is 2011/2012, the public awareness message 'Don't Drink and Drown' was promoted through the Victorian Government Play it Safe by the Water campaign via radio across key community social occasions such as the Australia Day long weekend and Easter as well as through the Victorian Water Safety Guide. LSV advised that reducing drowning deaths related to alcohol has been identified by LSV as a priority area and is recognised as such in the Victorian Water Safety Master Plan 2012-2015.

I note the recommendation of Coroner Parkinson in the case of Daryl Rolton, Court Reference Number 2009 1473, together with responses from Life Saving Victoria and the Department of Justice.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

1. That Life Saving Victoria continues to develop targeted programs and campaigns for the promotion of public safety messages, such as Don't Drink and Drown, to raise awareness in the community of the dangers of alcohol related drowning across Victoria.

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

Mr Colin Edwards
Constable C Hurwood
Life Saving Victoria
Department of Justice

Signature:



CAITLIN ENGLISH
CORONER
Date: 30 September 2014

