IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 230

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 Bailey Patman

without holding an inquest:
find that the identity of the deceased was Bailey John David Patman
born on 1 October 2002
and the death occurred on 19 January 2012
at Royal Children's Hospital
from:

1 (a) DROWNING

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

I have taken over this investigation from Coroner Spooner who retired in February 2014.

Introduction

1. Bailey Patman (Bailey) was 9 years of age at the time of his death. Bailey resided at 1 Kelvin Avenue, Seaford with his father, Mr Michael Allan. Bailey had two older sisters, Melanie and Chelsey, and a younger brother Joshua. Bailey was a student at Seaford Primary School.

2. Bailey had been the subject of four child protection reports when living with his mother, Ms Kylee Patman. The most recent report in October 2011 was finalised when Bailey moved to the care of his father.

3. A police investigation was conducted into the circumstances of his death.

4. A brief prepared by Victoria Police for the Coroner includes statements obtained from the coroner's investigator, Bailey's sister and father, witnesses and the supervisor of Bailey at

the scene. I have also been provided with two VARE[1] statements taken from child witnesses present at the time of Bailey's death. I have drawn on all of this material as to the factual matters in this finding. I note that despite requests, no medical records could be obtained in relation to Bailey.

Background

5. It was the January school holidays. Seaford, where Bailey lived, is a south eastern suburb 36 km from Melbourne, proximate to the beach and Frankston.

6. On 18 January 2012, Bailey had a sleepover at his sister, Chelsey's house, at 25 Wilson Street, Dandenong.

7. Thursday 19 January 2012 was a mild summer's day, with the forecast for a maximum of 22.8 C and a minimum of 13.8 C.[2]

8. On 19 January 2012, Ms Patman and Bailey's sister Melanie collected him from his sister's house and they did some errands together. Around lunchtime they called in to Mr Allan's workplace for a chat for about 20 minutes. Mr Allan stated that Ms Patman told him she would take Bailey to his house and stay with him until he returned home from work.

9. After lunch, they returned to Mr Allan's house. Bailey asked permission to go to the local skate park to use his scooter. Ms Patman gave her permission.

10. Ms Patman and Melanie then decided to go shopping in Frankston and left the address before Bailey returned home. Ms Patman left a note for Bailey at the front door telling him that his father would be home soon.

Events proximate to death

11. It is unknown whether Bailey attended the Seaford skate park but at about 6.00pm, he and two other friends, Bailey Hamer, 11 and Sam Brennan, 9, went to Sam's house at 58 Austin Road, Seaford. Bailey's address at 1 Kelvin Avenue, Seaford, was in close proximity to the Seaford skate park and to the Austin Road address.

12. Sam's father, Christopher Brennan, was getting ready to go to the local Seaford beach with his two other children, Mai Ann, 10 and Cara, 3. Bailey, Sam and Bailey Hamer asked if they could come to the beach too.

---

[1] Video and Audio Recorded Evidence, Recorded 20 January 2015.

[2] Climate Data Online, Bureau of Meteorology website, www.bom.gov.au.

13. Mr Brennan indicated that they would require permission from their parents. Bailey Hamer rang his parents and was given permission.

14. Bailey and Sam walked to Bailey's home to request permission from his father however his father was not home.

15. Bailey left a note at his father's house indicating he had gone to the beach, also requesting if he could stay at Sam's house for a sleepover that night.[3]

16. Meanwhile, Mr Brennan proceeded to the beach with his two children, Mai Ann and Cara and Bailey Hamer. On the way to the beach, whilst buying the children ice creams, Mr Brennan also bought a bottle of vodka and a soft drink to drink with it at the bottle shop. He consumed an unknown quantity of the vodka whilst at the beach.

17. Bailey and Sam arrived at the beach after about 30 minutes. As Bailey was wearing cargo pants, Mr Brennan asked him if he was going to swim. Bailey indicated that he would not go for a swim but *'he would just be having a splash around.'*[4]

18. The VARE statements of the children present at the beach, detail the following events. Bailey Hamer and Mai Ann went to the pier and jumped off several times before returning to play with Bailey and Sam who were playing in the shallows nearby the pier. Sam and Bailey were diving head first into the waves and 'headbutting' the waves. The group started to drift off, at which point Sam recommended that they go back to where they were originally playing. The group moved, however, Bailey did not move with them and then the group saw Bailey floating in the water, face down. At that point, Mai Ann told Bailey Hamer to go and tell Mr Brennan that Bailey was in trouble.[5]

19. Mr Brennan was playing in a shallow section of water with his three-year-old daughter. He stated:

> *'The other children would have been either 5 metres away or at the most 20 meters away from me, just splashing in the water. The day was a beautiful day with the sun and how calm the water was at this time, so I felt that the kids were very safe where they were playing.'*[6]

---

[3] Coronial brief

[4] Statement of Christopher Brennan p 2, Coronial Brief

[5] Video and Audio Recorded Evidence, Recorded 20 January 2015.

[6] Statement of Christopher Brennan p 2 Coronial Brief

20. As his daughter was getting cold, Mr Brennan took her back to her pram (which he had left under the pier) to dry her off. Whilst he was doing this the other children came up to him screaming that they could not find Bailey in the water.

21. Mr Brennan stated he went to where the kids were playing, looking for Bailey. He then went into the water but failed to find him. He heard someone from shore yell out and he turned to look at the shore area and saw Bailey floating face down, just under the surface of the water.

22. Mr Brennan ran as fast as he could to Bailey, grabbing him and turning him over. He noticed Bailey was cold to touch, his eyes were open and he was not breathing. He began to perform 'mouth to mouth' whilst dragging him closer to shore.[7] When he reached the shore, a bystander, who was a nurse, assisted in administering CPR until paramedics arrived.

23. Bailey was transferred to Royal Children's Hospital via MICA paramedic helicopter, arriving at approximately 8.30pm on 19 January 2012.

24. According to medical depositions from Royal Children's Hospital, Bailey *"arrived in ED at 20:39 hrs, in asystole on monitor, pupils were fixed and dilated. Airway was assessed by ICU team, endotracheal tube was clinically satisfactory, blood stained fluid from mouth noted. 1 x 350mcg dose of adrenaline given via IO route given and CPR continued. Temperature documented at 35.3c, venous blood gas demonstrated profound mixed-acidosis, total CPR time at this point was over 90minutes. It was agreed by all members of team to stop resuscitation."*

25. Bailey died at 8.47pm on 19 January 2012.

Police investigation

26. Leading Senior Constable Gerhard Kaschke attended Seaford beach whist ambulance officers were attempting to revive Bailey. He described the water as shallow with a sand bank some 10 metres from shore. He stated:'*...after this the water gained in depth until it reached another sandbank. Both sand banks caused the depth of the water to decrease to standing level for people up to 4 feet in height, although between both banks, the water depth would increase, to above a child's head.*'[8]

27. Andrew Atkinson was at Seaford beach with his partner and two children on 19 January 2012, at about 6.30pm. When playing with his son in the water approximately 30 metres

[7] Statement Christopher Brenna p 3 Coronial Brief

[8] Statement LSC Kaschke p 2 Coronial Brief

from the beach, he described *'walking into deeper water through a trench, probably at its deepest point 2.5-3 feet deep, before the water became shallower.'*[9] When he walked back to the shore through the deeper trench he described '[it] *seemed to have a pretty vertical and sharp drop into the deeper water.'*[10]

28. Kathleen Seelen was also at Seaford beach with her two children on 19 January 2012, at about 5.30 to 6pm, when she saw what she thought was a body lying on the sand. She minded Mr Brennan's two children at the time and stated *'...a girl of about 10 years and another boy of about 12 years came over to the tent. I sat them down with us. The girl was saying "He wouldn't come back, he wouldn't come back. We told him to come out of the deep water but he wouldn't listen. We though he was mucking around because he was floating...I went and got my Dad." '*[11]

29. Leading Senior Constable Gerhard Kaschke stated that after directing the second ambulance paramedics along a track to the beach where Bailey was he approached Mr Brennan. He stated: *'I...observed that he appeared intoxicated and not very coherent. He appeared unsteady on his feet; his breath[e] smelt of intoxicating liquor and I formed the opinion that this person was drunk. He had 4 other children with him. Three of a similar age to the drowned male and one young child approximately 3 years of age.'*[12]

30. In describing Mr Brennan, Kathleen Seelen stated *'He didn't seem to be coherent.'*

31. With regards to his drinking of alcohol, Mr Brennan stated:

> *'The police came over to me and asked if I'd been drinking. I told him that I'd some but not a lot. He asked me if I'd undergo a breath test and I said I would if he wanted. He told me that I didn't have to if I didn't want to. I then thought about when I first returned to the kids after finding Bailey that I'd had a big mouth full and thought it wouldn't be in my best interest to do so. I noticed that one of the police officers took a photo of my bottle of vodka which was half empty, but the didn't ask me about it. I could have told them that most of the half was mixed in the soft drink bottle.'*[13]

---

[9] Statement Andrew Atkinson p 1 Coronial Brief

[10] Statement Andrew Atkinson p 2 Coronial Brief

[11] Statement Kathryn Seelen p 1 Coronial Brief

[12] Statement LSC Kaschke Coronial Brief

[13] Statement Christopher Brennan p 4 Coronial Brief

32. No police charges were laid in relation to this incident and the VARE statements provided did not describe Mr Brennan as being intoxicated.[14]

Post mortem examination

33. A post mortem autopsy was conducted by forensic pathologist Dr Yeliena Baber at the Victorian Institute of Forensic Medicine on 23 January 2012. Dr Baber formulated the cause of death as 'unascertained'. Dr Baber noted that:

"There were no macroscopic features of drowning. No significant injuries were identified...No fluid was identified within the stomach, although a nasogastric tube had been in situ. No significant pulmonary oedema was identified, however prolonged medical intervention had occurred.

Histology revealed no natural disease processes which would have accounted for Bailey becoming unconscious in the water.

Toxicology was non-contributed.

In my opinion, although the cause of death in this 9 year old male remains unascertained following the performance of an autopsy and ancillary investigations, significant natural disease has been excluded. The circumstances are entirely consistent with drowning, however the autopsy diagnosis of drowning can be difficult to make as there are no specific signs. In this case prolonged CPR may well have removed the 'classical' signs of drowning which include a foam plume around the mouth (which can quickly disappear), bloodstained fluid within the airways and fluid within the stomach.

There are also a number of causes of sudden unexplained death for which there many be no anatomical findings at postmortem. These include cardiac arrhythmias, particularly cardiac channelopathies (for example long QT syndrome, catecholaminergic polymorphous ventricular tachycardia, Brugada syndrome), seizure disorders and metabolic and biochemical derangements which by virtue of postmortem artefacts are difficult to diagnose at autopsy. Given that a number of these conditions, particularly the cardiac conditions are potentially genetically inherited, referral of family members for ECG screening for abnormalities suggestive of cardiac conduction defects is recommended. Such screening is also recommended when the cause of death is unascertained.

---

[14] Video and Audio Recorded Evidence, Recorded 20 January 2015.

Hypothermia may have caused or contributed to death, but it is not possible to prove this autopsy.

This case has been subject to the Institute's technical review process."

Bailey's swimming ability

34. Evidence from the children swimming with Bailey, provided in the VARE statements, indicated that Bailey was not a good swimmer and that he did not like going into the deep water and generally stuck to the shallows. One child stated he could not swim at all. [15]

35. I sought further information in relation to Bailey's swimming ability from Bailey's parents.[16] Michael Allan informed the coroner's investigator that the only swimming tuition Bailey received was through his attendance at Harrisfield Primary school in Noble Park and this was only during his first year there. He stated from his knowledge he was not a very good swimmer. Bailey's mother stated that he was fearful of deep water and she was able to teach him how to 'dog paddle'. She did not feel comfortable taking him to the beach at this point in his life. She stated that Bailey appeared to have a hard time learning how to swim whilst at school, with the teachers informing her that he had difficulties.

36. Bailey attended Harrisfield Primary School in Nobel Park for approximately two years. His father stated Bailey had one year of swimming lessons.

37. Bailey moved to Seaford Primary School half way through 2011. His school has advised that their swimming program for Preps to year 4 was previously held each April. Bailey did not attend this program as he commenced at the school after its completion in 2011. Since Bailey's death, swimming lessons have been re-scheduled to November/early December. The school principal, Michael Browne stated:

> *'It was believed that having the program at this time would enable students to have been involved in an intensive swimming program conducted by trained instructors just prior to the time they would be more likely to be swimming at the beach and in backyard swimming pools, and that this would better prepare them for any dangers that they may encounter whilst swimming.'*[17]

---

[15] Video and Audio Recorded Evidence, Recorded 20 January 2015.

[16] Field interview, 13 April 2014 and email from Leading Senior Constable Gerhard Kaschke dated 13 April 2014.

[17] Email from Michael Browne dated 6 May 2015

38. Seaford Beach is a 4.5km stretch of beach which is patrolled on weekends and public holidays from noon to 5.30pm. The beach was not patrolled at the time of Bailey's death.

Life Saving Victoria – public awareness campaigns

39. Inquiries were made with Life Saving Victoria in relation to this case regarding public awareness campaigns in relation to water safety and supervision at public beaches.

40. Life Saving Victoria[18] recommends parents and carers supervise children closely at all times around water, even when lifesavers or lifeguards are on duty. They recommend that children under 5 years old are always within arm's reach and children aged less than 10 years old are always in sight. Since 2009, media advertising delivered as part of the Play it Safe by the Water campaign has carried the message "20 seconds is all it takes for a toddler to drown. Never take your eyes off children around water." There is also a range of beach safety information available through Surf Life Saving Australia's website[19] and mobile apps, as well as the Victorian Government's water safety website.[20]

41. Life Saving Victoria delivers a number of education programs to school children and the community. Two programs are of particular relevance; the Open Water Learning Experience and the Sink or Swim program.

42. Life Saving Victoria delivers the Open Water Learning Experience (OWLE) program to approximately 5,000 participants each year at Victorian beaches.

43. Life Saving Victoria delivers the Sink or Swim program to approximately 10,000 participants each year in school classrooms. The aim of the Sink or Swim program is to provide participants with an interactive presentation about dangers and hazards found in all aquatic environments, including beaches.

Finding

Dr Baber's observed that the circumstances of Bailey's death 'are entirely consistent with drowning.' In light of my investigation and knowledge of Bailey's swimming ability, I am satisfied that the cause of death of Bailey Patman is drowning.

---

[18] Email from Bernadette Matthews, Life Saving Victoria, Principal Research Associate, 25 March 2013.

[19] www.beachsafe.org.au

[20] www.watersafety.vic.gov.au, http://www.beachsafe.org.au/surf-ed/lifeguards-top-tips and http://www.watersafety.vic.gov.au/home/beach+safety/

Comments

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

Drowning is a leading cause of death of children aged 0-14 years. Whilst there has been a widespread focus on the importance of adult supervision of children around water; a lack of swimming ability among children contributes to an increased risk of drowning.

A recent report from Life Saving Victoria[21] surveyed parents and teachers of children in year 6 at Victorian primary schools. The report estimated that three out of five children are leaving primary school without the ability to swim to basic standards.[22]

The report also found that with respect to water safety knowledge, teachers estimated that 39% of year 6 students lacked adequate water safety knowledge. Children living in areas of greatest socio-economic disadvantage were more likely to lack this knowledge.

Of parents surveyed, 40% said their child had never participated in a school-run swimming program and 12% of surveyed school teachers reported their school did not run a swimming program.

The report states studies indicate that children should be taught basic swimming and water safety skills in the primary school years as this is the ideal time to target children in order to create lasting behavioural patterns. The case for in-school provision of swimming and water safety education is strong. If included as part of the school program, it is easier for children to attend lessons as it forms part of their weekly school routine or timetable.[23]

Life Saving Victoria report the success of multiple strategies that have reduced drownings in the 0-4 years age range, focus is now required on the 5-14 years age group.

Swimming and water safety education is not mandatory in the Victorian school curriculum. Neither Australian Victorian Essential Learning Standards, (AusVELS), nor Australian Curriculum Assessment and Reporting Authority, (ACARA), the two curriculums currently applicable to Victorian schools, have water safety education or swimming lessons as part of the compulsory curriculum.

---

[21] Birch, R., & Matthews B. (2013) *Sink or swim: the state of Victorian primary school children's swimming ability.* Life Saving Victoria: Melbourne.

[22] These standards are being able to swim 50 metres or stay afloat for 2 minutes.

[23] Birch R & Matthews B p 17.

RECOMMENDATION

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

Recommendation 1

I agree with and adopt the recommendation in the Life Saving Victoria 2013 report *Sink or Swim: the state of Victorian primary school children's swimming ability* that swimming and water safety education should be a compulsory skill taught within the primary school curriculum to all Victorian children.

I direct that a copy of this finding be provided to the following for their information only:

Mr Michael Allan
Leading Senior Constable Gerhard Kaschke
Mr Nigel Taylor, Chief Executive Officer, Life Saving Victoria
Mr Justin Taylor, Lifesaving Operations Manager, Seaford Life Saving Club
Mr Michael Browne, Principal, Seaford Primary School

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

Secretary, Department of Education & Training (Commonwealth)
Secretary, Department of Education and Early Childhood Development (Victoria)

Signature:

CAITLIN ENGLISH
CORONER
Date: 8 May 2015