IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 38

REDACTED FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, HEATHER SPOONER, Coroner having investigated the death of CIE

without holding an inquest:

find that the identity of the deceased was CIE

and the death occurred on 4 January 2010

at Royal Children's Hospital, 50 Flemington Road, Parkville

from:

1 (a) Hypoxic/Ischaemic Encephalopathy

1 (b) Effects of drowning.

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

1. CIE was 12 years of age at the time of her death. CIE's parents are CE and NE who had separated shortly before her death. CE and NE had four girl children together and CE also had an older daughter. CIE, her two sisters and her older stepsister were living with their mother at the time of CIE's death, while CIE's other two sisters were residing with their father. CIE was due to start Year 7 in 2010.

2. On 3 January 2010, CIE, her two sisters and their friend, MM, were playing in the waters of Lake Victoria off a sandy beach near Seagull Drive Boat Ramp in Loch Sport. The girls got in trouble when they came upon an area of deep water. A resident of Loch Sport heard the girls' pleas for help and rushed to their aid. She was able to provide assistance but CIE was unconscious when brought to the shoreline. CPR was applied by bystanders and ambulance personnel. CIE was subsequently transported by air ambulance to the Royal Children's Hospital (RCH). CIE died at the RCH on 4 January 2010.

Medical investigations

3. An inspection and report was performed by Dr Malcolm Dodds, Forensic Pathologist, Victorian Institute of Forensic Medicine on 5 January 2010. He advised that a reasonable cause of death would be 1(a) Hypoxic/Ischaemic Encephalopathy and 1(b) Effects of drowning. An external examination showed an occasional minor scratch like abrasion but there was no evidence of significant trauma.

4. A toxicological analysis of specimens taken at the RCH revealed no drugs or poisons present.

Visit to Loch Sport

5. CIE, her 14-year-old sister, her 13-year-old sister and their friend MM also aged 13 years, were staying at the girls' grandfather's holiday house. CIE's grandfather had a partner called MD. The house was located in Loch Sport. CE and the children had been there since Saturday 2 January 2010 and planned to stay for a week.

Sunday, 3 January 2010

6. According to MD, sometime after lunch on Sunday, 3 January 2010, she was up on the deck of their house doing a jigsaw puzzle with CIE, when she noticed the other three girls, '*walking out the front gate of the property and turn right up Seagull Drive towards the boat ramp.*' She asked CIE whether she was going with the other girls and CIE replied that she was not aware that the girls had planned to go anywhere. MD said that CIE left about 10 minutes after that conversation. MD said that a while later, CIE's mother CE said she was going down to the beach with the girls and she would take the dog.

7. According to CE, the girls walked to the nearby lake and she drove her car taking her father's dog. She said that she followed the girls in the car and that once '*we got to the water, the girls jumped in. They were knee deep. I was a couple of meters away playing with the dog. A short time later, I walked back to the car to get beach towels. The car was parked about three minutes walk from where we were.*'

8. At approximately 2.19pm, a local resident was on the deck of her holiday house, which is located approximately 120 metres from the waters edge of Lake Victoria, when she heard girls making noises in the distance. She said she knew the time was 2.19pm as she had just left a message for her sister-in-law which was logged at 2.17pm. Initially she thought that the '*girls were mucking around'* but she *'then heard a girl scream out in a way that m*ade [her] *believe that something was wrong towards the beach area.'*

9. According to the local resident, she headed towards the beach and saw a young girl, obviously exhausted, making her way towards the boat ramp with a damaged bikini top. The local resident asked if she was alright and she replied "*no, they can't swim*". She ran to the other side of the sandpit and could see a girl in the water waving and another girl in shallower water. The local resident swam out, she estimated not more than 60 metres, and brought the girl who had been waving for assistance to an area of water where she could stand. She reported that by this time, the girl who had first raised the alarm and the girl she spotted in shallow water, were at the waters edge calling out a girl's name. The local resident could not see anyone else out in the water but was assured: "*Yes, she's out there.*" The local resident then yelled out for an ambulance to be called as there was a girl unaccounted for.

10. The local resident stood on tiptoes and saw a person floating in the water at a similar distance as the first girl she pulled out, but off to the right. The local resident reported that she found the girl in shallow water, which was just above her waist. This girl was later identified as CIE. She said that as she drew the girl into the shore, others joined in the rescue. The rescuers came across another deep pocket of water and had to swim to complete the rescue.

11. It is apparent from the local resident's evidence that there was confusion amongst people on the shore line prior to CIE being retrieved from the water as to what was happening. The local resident observed '*a man at the boat ramp leaning on a bicycle'* as the girls' friend

MM was emerging from the water and '*I was screaming out 'Call an ambulance' to the people on the shore. As I got closer I think people on the shore realised what was happening and they jumped into the water and we all took hold of her.*'

12. CIE's mother reported that when she returned from getting the towels from the car she heard someone yell, *"Get an ambulance, get help."* She said that she ran back to the car to get her mobile phone but realised it wasn't there. She then drove back to the house to seek help. MD confirmed that '*CE came running into the house and said 'CIE's drowned and the girls are out in the water and can't get back. I turned my back for a minute to go and get towels. I heard (one of her other daughter's) screaming. I went back to the beach.*'

13. CE reported that she drove back to the lake and found the girls sitting on the beach with towels around them. She asked where CIE was and was directed to her daughter lying prone on the shore line with CPR being applied.

14. According to the local resident, CE hugged her and thanked her for rescuing the girls. CE was in shock and required medical treatment including oxygen being administered. She was subsequently taken to the Sale Hospital for treatment.

15. It was estimated by one of the girls at the scene that CIE had been under the water for about 10 minutes before she was found. Following her rescue, CPR was applied by bystanders including a nurse and coast guard and then ambulance personnel, for approximately 55 minutes in total. An air ambulance arrived at approximately 3.00pm and transported CIE to the RCH. CIE was admitted at approximately 5.07pm and was noted to have suffered prolonged cardiac arrest following a salt water drowning. There was no evidence of other injuries upon admission.

16. At the scene, the investigating member, Leading Senior Constable Adrian Drysdale, said he observed that two of the girls had only bikini bottoms on, that they were distressed, shocked and all they said was that '*she*' couldn't swim.

17. The girls were taken to their grandfather's holiday house and reportedly said to L/S/C Drysdale that: '*while swimming either (one of two sisters) had walked into deeper water and could not swim. When it became apparent she was in trouble the other girls went to help. When the other girls went to help they got into trouble as well and were panicking. The other girls were able to get footing on the sand but CIE could not. While the other girls were trying to help CIE, she was grabbing and pulling at the girls and had ripped their swimming tops off in the struggle*". He said that this was the version recounted by all three girls on the day of the drowning.

Monday, 4 January 2010

18. On Monday 4 January 2010, tests on CIE revealed no brain activity. She was subsequently extubated and passed away at approximately 12.17 pm surrounded by a large network of family and friends.

Lake Victoria

19. The town of Loch Sport is located in the Shire of Wellington, approximately 56 km east of Sale and 270km from Melbourne. Loch Sport is situated on the shores of Lake Victoria, which is part of a chain of coastal lagoons commonly known as the Gippsland Lakes.

Conditions on 3 January 2010

20. On 3 January 2010, the weather was fine and the wind speed was 16 knots, gusting to 19 knots. The temperature was 19 degrees Celsius at 2.00pm on 3 January 2010.

21. A survey was done by Mr Mark Spyker, the Hydrographic Services Manager for Gippsland Ports, who estimated that from the relevant shoreline shallow water of 0.8 meters average depth extended out to approximately 145 metres before dropping rapidly to a depth of 3 metres and that there was also a depression of 2 metres depth located approximately 75 metres from the shore line North West of the dredged material ground.

22. The area is prone to sand shifting, with changing water depths as a consequence. Lake Victoria is not generally regarded as a swimming area and is mainly used for boating activities. There is no surf life saving club.

Public health and safety risks at the relevant waters

23. The Loch Sport Lake Victoria Foreshore is the recreational beach area for the Loch Sport Township. The Lake Victoria Foreshore Reserve (the Reserve) includes eight kilometres of foreshore which is crown land reserved under the *Crown Land (Reserved) Act 1978* for public use and recreation. The Reserve is managed by the Department of Sustainability and Environment (DSE) through a local committee of management known as the Loch Sport Foreshore Committee of Management (the Committee). Members of the Committee are appointed by the relevant minister.

24. The area of responsibility of the Committee ends at the lake low water mark, the bed of Lake Victoria is managed by DSE and the waterway is the responsibility of the Gippsland Ports Committee of Management Inc.

25. Investigations reveal three warning signs located around the shoreline at the time of CIE's death, two located near the boat ramp and one located at the landfall from the boat harbour. They depicted the following:

- One sign showing '*Warning – Take Care'– Dredging has taken place at the boats ramps resulting in changes to water depths. Boat owners and parents of small children please take note of these changed conditions*".
- Two signs showing a symbol representing that there may be a sudden drop in sand level.

26. A statement was sought from the DSE to outlined whether any post incident review was conducted following CIE's death and if so, the outcome of that review. Mr Rob Stewart, Program Manager – Public Land, Land and Fire, Gippsland Region, DSE provided a statement in June 2012.

27. Mr Stewart said that the Committee has a Management Plan (the Plan) for the area which is in the process of being updated. The Plan addresses the issue of public safety around the foreshore and provides that regular inspection of the beaches and the foreshore is required to indentify emerging safety issue. The management strategy in respect of public safety issue includes the conduct of an annual safety audit as part of the risk management strategy.

28. Mr Stewart advised that while the Plan provides for an annual inspection, the Committee monitors the foreshore more regularly- approximately monthly.

29. Mr Stewart confirmed the presence of two warning signs installed at the Seagull Drive boat ramp which are maintained by the Committee. He said that *there are two single-sided warning signs that have a steep drop off illustration as well as the words: 'deep water'. There is also a warning sign advising that dredging has taken place in the area resulting in changes to water depths and advising additional care. These signs are located next to the*

car park which is the only access by road to the lake. The signs are also placed beside a picnic area and two walking tracks which represent the main access points to the beach area.

30. Mr Stewart advised that waters were not subject to tides or underwater currents but are subject to steep drop offs and there are *numerous signs to alert the public to this risk.*

31. Mr Stewart further advised that the Committee met shortly after the incident but were unable to identify any risks which are not properly addressed or subject to an appropriate warning. *The Committee considered whether there were any additional measures which could be taken to prevent a similar death occurring in the future* but considered that additional signage was not required.

32. The evidence suggests that there was adequate signage highlighting the risks of associated with the relevant waters at Lake Victoria.

Parental Supervision

33. CIE's mother confirmed in her evidence that she had been supervising the girls but had left the scene for a few minutes to retrieve towels and that this occurred at the time they got into trouble.

34. Unfortunately the incident demonstrates the importance of children and young people being supervised around waterways. It further emphasises how quickly circumstances can become dangerous, even it what appears to be safe swimming conditions.

Swimming education

35. CIE was a former student of a Primary School and had attended from Grade Prep in 2003 to Grade 6 in 2009. The school teaches swimming from Grade Prep to Grade 4 each year. It is an intensive program run one day a week for five weeks per year based on Australian Royal Life Saving Society methodology. The swimming program is "Water Safety, Survival and Swimming Skills". They teach the student skills from the first three levels of the program. Level one is 'Developing Water Discovery and Developing Water Awareness'. Level two develops 'Water Sense' and Level 3 teaches skills in 'Becoming Water Wise.'

36. There is no record of whether CIE completed the course (the school does not keep records) but the principal said that it "*is my general understanding that CIE and her sisters would have attended swimming lessons.*" But went on to say that in 2009, CIE 's Grade 6 year, she was required to do a 50 metre water safety and swimming test, to be allowed to attend a water component of the Grade 6 camp. However, she chose not to do the swimming test (she paid to do the test) and did not attend the camp. The program is based on parent permission.

37. CIE's parents thought she had been taught swimming at school, but the standard was not high enough. It is likely that they signed the appropriate authorities for CIE to participate in swimming programs. It is not clear however, whether CIE chose not to participate on more than the occasion documented above.

38. The children involved in the incident appear to have thought that CIE couldn't swim. MD states that one of CIE's sisters told her on 3 January 2010 that "*CIE can't swim*".

39. It is unclear on the evidence exactly how well CIEcould swim, although it is likely she was not a strong swimmer.

40. The course offered by the Primary School appears to be of an adequate standard and resourced sufficiently for children who wanted to participate to do so.

41. It is evident however, from other water related deaths that even where a person is a good swimmer, they can get into trouble trying to save others or by being overcome by the unpredictability of conditions in the water.

Conclusion

42. The circumstances suggest that all the girls, including CIE, intended to stay in the shallow waters of Lake Victoria and stumbled upon deep waters unintentionally. They appear to have been drawn further out to an area of deep water. The following version of events was recounted by all the girls to the investigating member on the day. One of the girls (not CIE) slipped on a sand ledge, which bordered the deep water and got into trouble. The other girls offered assistance, including CIE, but all got into difficulty and panicked. CIE appears to have been in the most difficulty and she has been overcome by the situation including depths of between 2 - 3 metres. CIE may not have had well developed swimming skills. The other girls have attempted to assist, but they have been unable to do so.

Finding

43. Having considered all the evidence I find that CIE died on 4 January 2010 as a result of 1 (a) Hypoxic/Ischaemic Encephalopathy and 1 (b) Effects of drowning in the circumstances described above.

COMMENTS

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

1. The primary responsibility to ensure that a child is a competent swimmer rests with a parent or caregiver. Our education system has great opportunity to support parents, where possible, to meet with this responsibility.
2. This investigation highlights the importance of current Watersafety messages such as '*check its ok to swim*' and '*read and obey the water safety signs*' (where a beach is not patrolled).
3. I have therefore directed that a copy of my finding (a redacted version) be provided to the Minister for Education to incorporate any learnings from CIE's tragic death in the development of future water safety projects and learn to swim programs (and how they are administered) in Victorian schools.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that a redacted version of my finding be published on the internet.

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

Ms CE

Mr NE

Victorian Government Solicitor's Office on behalf of the Department of Sustainability and Environment

Leading Senior Constable Adrian Drysdale, Investigating Member

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

Minister for Education

Lifesaving Victoria

Australian Watersafety Council

Signature:

Heather Spooner
Coroner
Date: 28 September 2012