



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 000350

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Amended pursuant to Section 76 of the Coroners Act 2008 on 17 January 2018¹

| | |
|-----------------|---------------------------------|
| Findings of: | ROSEMARY CARLIN, CORONER |
| Deceased: | JAMES LIN |
| Date of birth: | 24 May 1988 |
| Date of death: | 24 January 2016 |
| Cause of death: | 1(a) DROWNING |
| Place of death: | Gunnamatta Beach, Rye, Victoria |

¹ This document is an amended version of the finding into Mr Lin's death dated 19 December 2017. It has been amended pursuant to Section 76 of the *Coroners Act 2008* (Vic) by removing the footnote to paragraph [19] which was inserted in error in the original Finding.

HER HONOUR:

Background

1. James Lin was born on 24 May 1988. He was 27 years old when he died from drowning at Gunnamatta Beach on the Mornington Peninsula.
2. Mr Lin lived in Box Hill with his mother Alice Lin. Other members of his family lived in Taiwan.

The coronial investigation

3. Mr Lin'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.
4. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.²
5. The law is clear that coroners establish facts; they do not 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 into Mr Lin's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence. As Gunnamatta beach is notoriously dangerous, I

² In the coronial jurisdiction facts must be established on the balance of probabilities 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.

requested the Coroners Prevention Unit³ (CPU) to investigate possible prevention opportunities. The CPU interrogated the Court's database and also made enquiries of the relevant surf life-saving authorities (the local Gunnamatta Surf Life-Saving Club and Lifesaving Victoria).

8. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.
9. 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.

Circumstances in which the death occurred

10. Early on the afternoon of 24 January 2016 Mr Lin and two friends, Jesse Foster-Green and Christopher Meszaros travelled to Gunnamatta Beach in Rye for a swim.
11. They parked at the First Carpark, which is approximately 200 metres from the Gunnamatta Surf Life Saving Club (**GSLSC**) and the patrolled part of the beach. They started paddling and swimming at an unpatrolled stretch of the beach approximately 300 metres away from the GSLSC and the red and yellow flags (indicating a safe swimming area).
12. They were dragged down the beach and off a sandbar. They were struggling to keep their footing as large waves broke over them. Mr Lin – described as the weakest swimmer of the three – was unable to make his way back to shore. Mr Foster-Green and Mr Meszaros unsuccessfully tried to pull Mr Lin back in, then swam to shore for help. Mr Foster-Green ran down the beach to alert life guards, while Mr Meszaros tried to keep Mr Lin in his line of sight. Life guards commenced a search and found Mr Lin unconscious in the water. He was retrieved and brought back to shore on a lifeboat.
13. By the time Mr Lin was retrieved he had been in the water alone for approximately 10 minutes. He was not breathing and was unconscious. The life guards commenced cardio-pulmonary resuscitation (**CPR**). Emergency services arrived (including an Air Ambulance) and continued CPR. Mr Lin could not be revived despite approximately 45 minutes of CPR.

³ The CPU comprises researchers, investigators and health professionals who assist Coroners in their investigations, particularly in relation to their prevention role.

Identity of the deceased

14. Mr Lin was visually identified by his friend Jesse Foster-Green on 24 January 2016. Identity was not in issue and required no further investigation.

Medical cause of death

15. On 25 January 2016, Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of James Lin after reviewing a post mortem CT scan. No injuries were identified in the examination or the scan.
16. [REDACTED].
17. After reviewing toxicology results, Dr Baker completed a report, dated 4 March 2016, in which she formulated the cause of death as ‘1(a) drowning’. I accept Dr Baker’s opinion as to the medical cause of death.

Other deaths at Gunnamatta Beach

18. Gunnamatta Beach is an exposed ocean beach with large waves, permanent rips in proximity to major reefs and rocks, shifting sand bars and pronounced changes in depth. Its notoriety as a particularly dangerous beach was cemented in 1998, when four children belonging to the same extended family were swept away and drowned in a rip.
19. The CPU advised that there have been three other deaths at Gunnamatta beach since 2000, two before and one after the death of Mr Lin.
20. On 7 March 2015, two males aged 34 and 42 died at Fingal beach, directly to the east of Gunnamatta Beach.⁴ The two men had been diving for abalone with a third companion, who called emergency services when he lost sight of them. Surf conditions hampered a recovery operation by emergency services. The body of the 32 year old was found one week later and the remains of the 42 year old were recovered over subsequent weeks. A coronial investigation found the death of the 34 year old to be consistent with drowning and that of the 42 year old to be unascertained.

⁴ Fingal and Gunnamatta Beaches are contiguous and for practical purposes form part of the same stretch of beach.

21. On 27 May 2017 a 65 year old male competing in a kneeboard surfing competition fell from his board and was observed floating face down in the water by other competitors. This matter is currently under investigation by another coroner, but current information indicates that rescue efforts were again severely hampered by heavy surf and a rip. By the time the male was brought to shore he was not breathing and could not be revived.
22. Further, a letter from GSLSC President Greg Goulet, which formed part of the Coronial Brief, noted that the weekend after Mr Lin died a Taiwanese national was washed off the same sandbar into a rip. Fortunately there was a board rider in the immediate area who rescued this person prior to the arrival of lifesavers, otherwise *'we would most likely have been looking at another resuscitation case and possible drowning'*.
23. These cases, and Mr Lin's death, illustrate the serious risk posed by surf conditions at this stretch of beach.

Gunnamatta Surf Life-saving Club's perspective

24. The letter from GSLSC President Greg Goulet proposed changes to Gunnamatta Beach to improve its safety, including:
 - changes to signage, to indicate more clearly the location of the patrolled section of beach;
 - the erection of a large flagpole, indicating when the beach patrol is in operation; and
 - redesigning traffic flow in the Gunnamatta Beach car parks, so that drivers are forced to pass through the car park for the patrolled section of the beach before they can proceed on to the car park for the unpatrolled section of the beach.
25. In his letter Mr Goulet noted that GSLSC had discussed changes to signage with Parks Victoria.

Life Saving Victoria's perspective

26. A report provided to the Court by Life Saving Victoria (LSV) Risk and Spatial Analyst, Robert Andronaco, confirmed that Gunnamatta Beach is one of the most dangerous beaches in Victoria, accounting for 16% of all LSV rescues across the state. The hazards include variable water depths, breaking waves, sharks, stingers, two permanent rips and a major

reef. Further, as the beach is relatively accessible from Melbourne and the Peninsula, there is a *'high proportion of adverse aquatic related events'*.

27. Mr Andronaco observed that LSV favours the approach articulated in Coroner Saines's finding in the death of Demet Latifoglu,⁵ particularly the comments in relation to the need for broader community education in water safety *'rather than attempting to modify beachgoer behaviour at the beach itself'*.
28. Mr Andronaco considered that a co-ordinated and systemic approach to safety was necessary, taking into account possible design solutions such as better signage and/or redesign of the Gunnamatta Beach car parks. He proposed the establishment of a surf safety working group on the Mornington Peninsula, made up of representatives from Victoria Police, local government, emergency management officers, Parks Victoria, LSV and local lifesaving clubs to develop local emergency action plans and response strategies for beaches in the area.
29. Whilst Gunnamatta Beach is particularly hazardous, there are clearly risks posed by other beaches in the area. I am persuaded that the best way to improve surf safety for all Victorians is by the establishment of a surf safety working group, as suggested by LSV, with due regard to the proposals of the local lifesaving clubs, such as GSLSC.
30. I direct that a copy of this finding be provided to Life Saving Victoria, the Gunnamatta Surf Life-saving Club, Parks Victoria and the Divisional Commander of Victoria Police Southern Metropolitan Regional Division 4, Superintendent Adrian White, for consideration and implementation of my recommendation.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

- (a) the identity of the deceased was James Lin, born 24 January 1988;
- (b) Mr Lin died on 24 May 2016 at Gunnamatta Beach, Rye, Victoria, from drowning;
and
- (c) the death occurred in the circumstances described above.

⁵ See *Finding into the death of Demet Latifoglu - COR 2012 0275*.

Recommendations

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations:

1. That Victoria Police liaise with Life Saving Victoria, local lifesaving clubs, and other stakeholders, for the purpose of establishing a Mornington Peninsula surf safety working group.
2. That the surf safety working group give specific consideration to the changes suggested by the President of the Gunnamatta Surf Life-saving Club set out above in paragraph [24] of my Finding.

Publication

Given that I have made a recommendation I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

I convey my sincere condolences to Mr Lin's family.

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

Alice Lin

Superintendent Adrian White
Frankston Police Complex
15 Fletcher Street
FRANKSTON VIC 3199
DX 211790

Life Saving Victorian
200 The Boulevard
PORT MELBOURNE 3207 VIC

Greg Goulet
President of Gunnamatta Surf Life-saving Club

Truemans Road

FINGAL VIC 3939

Also by email: ggoulet@msn.com.au

Parks Victoria

Level 10, 535 Bourke Street

MELBOURNE VIC 3000

Senior Constable Matthew Greenfield

Coroner's Investigator

Victoria Police

Signature:



ROSEMARY CARLIN
CORONER

Date: 19 December 2017

Amended on 17 January 2018

