IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 0661

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Kyle William Vassil

Delivered On:	27 October 2014
Delivered At:	65 Kavanagh Street Southbank VIC 3006
Hearing Dates:	12 December 2012, 13 December 2012, 15 May 2013, 16 May 2013 and 17 May 2013
Findings of:	PETER WHITE, CORONER
Representation:	Ms Deborah Foy on behalf of Kyle Vassil's family Mr Trevor Wraight on behalf of WorkSafe Mr John Constable on behalf of the Catholic Education Office Melbourne and Catholic Education Commission of Victoria Mr Paul Halley on behalf of the Department of Education and Early Childhood Development Mr Jeremy Ruskin QC with Ms Sarah Thomas on behalf of Aquinas College
Police Coronial Support Unit	Leading Senior Constable Nadine Harrison

I, PETER WHITE, Coroner having investigated the death of KYLE WILLIAM VASSIL

AND having held an inquest in relation to this death on 12–14 December 2012 and 15-17 May 2013

at MELBOURNE

find that the identity of the deceased was KYLE WILLIAM VASSIL

born on 1 October 1997

and the death occurred on 17 February 2010

at the Alpine Ash Mountain Retreat, Spraggs Road, Toolangi, in the State of Victoria,

in the following circumstances:

BACKGROUND

1. On 17 February 2010, Kyle William Vassil (Kyle) aged 12 years, died after becoming submerged while swimming in a dam at the Alpine Ash Mountain Retreat (Alpine Ash) near Toolangi, in the State of Victoria. At the time, he was a year seven student at Aquinas Secondary College (Aquinas), Ringwood and had travelled to the retreat that afternoon with some 78 classmates and a total of 5 teachers and 6 support staff, - which latter group was comprised of youthful graduates from Aquinas. (The Camp Leaders).

2. The student group was supervised by homeroom teachers, Eva Stewart, Leigh Toomey and Mel Campbell. Leigh Toomey was the designated camp co-ordinator for years 7 and 8. The evidence suggests that as camp co-ordinator Leigh Toomey had additional managerial duties, but did not clearly establish the extent of those duties.[1]

3. Year 7 team leader, teacher Adam Pine, attended and School Social Worker Melinda Voigt, was also in attendance. The latter two had travelled to the camp for the day only. Adam Pine had left the camp before the incident under examination, but returned immediately after he was told of the matter, by Leigh Toomey.

4. The Aquinas School had been conducting similar camps at this location over the previous seven years. I note that Leigh Toomey had also attended the facility on a number of previous occasions, in his capacity as a supervising homeroom teacher. It is also relevant that over the previous seven years there had been no incidents involving Aquinas students, getting into

[1] See Leigh Toomey's evidence on this matter at transcript page 430-1, and further discussion under Comments below.

trouble while swimming in the Alpine Ash dam. I am informed by the camp owner and accept that (to his knowledge) there had been no similar previous incidents at this dam over a period of some 50 years.

PURPOSE OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation into a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] In the context of a coronial investigation, it is the medical cause of death which is important (including the mode or mechanism of death) and the context or background and surrounding circumstances of the death sufficiently proximate and causally relevant to the death, but not all circumstances which might form part of a narrative culminating in the death.

6. The broader purpose of a coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role. Coroners are also empowered to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These are effectively the vehicles by which the prevention role may be advanced.

7. This finding draws on the totality of the material, the product of the coronial investigation of Kyle's death. That is, the investigation and inquest brief and the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

ISSUES

8. On the final day of hearing, I identified the following issues for Counsels consideration:

   8.1 The handover of camp co-ordinator duties including:

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[2] Section 67(1) of the Coroners Act 2008.

8.1.1 The training and selection of staff, who were called on to supervise students at the camp;

8.1.2 Management of the scene;

8.1.3 Positions taken by teachers and supervisors at the camp;

8.1.4 Whether the swimming in the dam was properly supervised;

8.2 Whether on the discovery of Kyle's disappearance staff responded appropriately including:

8.2.1 Whether the search was carried out appropriately;

8.2.2 Whether is was appropriate for homeroom teachers, Eva Stewart and later Leigh Toomey to leave the dam area while the search continued;

8.3 Whether it is appropriate to adopt Doctor Ile's findings as to the cause of death, or instead that the opinion of Professor Harper that ventricular fibrillation was the likely cause of death, should be preferred:

8.4 Whether, I should report to the Victorian Registration & Qualifications Authority in relation to a possible recommendation that Independent Schools including Catholic Schools, in Victoria, adopt Department of Education Guidelines in relation to safe student camp procedures and protocols:

8.5 Whether I should make any recommendation to the Australian Holiday Camps association in relation to a requirement that Holiday Camps especially those situated in remote areas, purchase defibrillators, for use in emergency situations:

EVIDENCE

The Family:

Kyle's mother, Mrs Pacita Vassil

9. Mrs Vassil was born in Laguna in the Philippines, and was the mother of Kyle Vassil. She now resides in Bayswater, Melbourne with her mother, brother and seventeen-year-old daughter, Kacy. Mrs Vassil migrated to Australia with her then husband William Vassil, in July 1997 and their son Kyle was born at Moe Hospital on 1 October 1997. Mr and Mrs Vassil separated in 2007.

10. Mrs Vassil stated that Kyle was a normal healthy 12-year-old boy who had no physical problems and was very active in sports, enjoying regular team participation in football and basketball, over weekends. She further described her son as a happy boy.

11. As set out above, he was a year seven student and on arrival at Aquinas had experienced no adjustment difficulties, having come through with many of his friends earlier attending the same primary school.

12. His older sister Kacy, also attended Aquinas school.

13. Kyle was doing well in school. He was also popular, with friends regularly visiting him at the family home.

14. Mrs Vassil further described an occasion around Christmas 2009 when Kyle had a fever. He recovered after one day and did not consult with the family Dr, a Dr Kokgeow Teh of the Boronia Road Medical Clinic. Kyle had not had any breathing difficulties or asthma or according to his mother, had showed any signs of asthma.[3] She also described that he had never taken prescription medication over a prolonged period.

15. Mrs Vassil recalled that she filled out both a medical report form and an excursion agreement form, both concerned with the proposal that Kyle should attend a school (year 7's) camp to be held at the Mountain Ash retreat. When filling out the forms Mrs Vassil recalled that she had truthfully stated that Kyle wasn't on any medication and to the best of

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[3] In later evidence Mrs Vassil agreed that she had told RMH personnel on 6 October 2010, that when he was 8 or 9 years old he had used a 'puffer' on one occasion, following a medical consultation, and that he was not diagnosed as suffering from asthma at that time.

Dr Teh reported that,

'I first treated Kyle Vassil on 5/9/2000. This was for tonsillitis. According to my records, I treated him twice during 2000.'

Concerning the condition of Asthma, 'I treated Kyle in February 2001 and in May 2002. On both occasions, his Asthma was mild associated with an upper respiratory infection. He was prescribed as a result Ventolin.

As far as I am concerned, his asthma was very mild.

The last time I saw Kyle was on 6/6/2003, and that was for warts on his fingers and hands'.

Taken before LSC 24429 on 17/12/2012,

It appears from the exhibit list that Dr Teh's statement was not formally accepted into evidence. To avoid any doubt as to that matter, the statement and medical notes will become Exhibit 26 and is available to interested parties on application.

her knowledge, he didn't suffer from any of the listed medical conditions. She signed this form on 29 January 2010.[4]

16. She was also called upon to sign a second form, an Excursion agreement form, which she understood and signed on 10 February 2010.[5]

17. Kyle commenced at Aquinas at the start of the 2010. His homeroom teacher was Eva Stewart.

18. Kyle was a competent swimmer,

> *'who loved swimming,'*[5]

and had undertaken swimming lessens both at his primary school and also privately.[6] He had experience both in swimming pools and at the beach, but not according to Mrs Vassil, while he was unsupervised, and not,

> *'in lakes or dams or anything like that.'*[7]

19. Kyle could swim unsupervised. He swam at school and swam socially over summer.

20. After his death, Mrs Vassil went to the Alpine Ash dam and confirmed in testimony that Kyle to her knowledge, had no experience swimming in similar environments.

> *'Occasionally when Kyle was swimming he would sometimes get cramps in his legs calf's or toes. Kacy, William (Kyle's father) and I also get the same thing sometimes when we are in water. Sometimes it is from being in the water for a long time and sometimes it is when the water is very cold.'*[8]

21. Mrs Vassil further testified that she did not know Kyle would go swimming on the trip and was not told of that matter by Aquinas personnel, or anyone else. She did not pack a swimming costume for Kyle, and only packed board shorts so he could wear them around camp, although if she had been aware that swimming was planned, she would also have packed his swimmers.

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[4] See statement dated 22 April, 2010 Exhibit 1, and document headed Confidential Medical Report at Exhibit 1(b), which is available to interested parties on application.

[5] See exhibit 1(c).

[6] See transcript page 16.

[7] See exhibit 1(a) at page 4

[8] Ibid.

22. Mrs Vassil also stated that she was never asked by the school if Kyle could swim or if he had taken swimming lessons. She had seen the Year 7 Camp fact sheet, which she used as a guide to help her pack her son's belongings for camp. She also received a letter inviting her to attend an information evening concerning the camp but was unable to attend because of work commitments.[9]

23. In response to further questioning by Senior Counsel representing Aquinas, Mrs Vassil confirmed that both she and her daughter Kacy went to the Royal Melbourne Hospital in October 2010 and undertook exercise electro cardiogram and echocardiogram testing.[10]

24. She further denied saying at that time that,

'He (Kyle) occasionally used a puffer but was not a regular asthmatic,'

or words to that effect. Rather her consistent evidence was that he had used a puffer on one occasion only.

The Students:

Josh Anderson (Josh)

25. Josh was a friend of Kyle's and bussed to the Alpine Ash retreat with his year 7 classmates on Wednesday 17 February 2010. On arrival the group were met by the camp manager, who set out some camp rules and gave instructions about the proper use of camp facilities. He mentioned the dam and stated that the group were not permitted to swim there unless they were supervised. Following the owner's comments, Mr Toomey spoke to the group.

26. After this introduction, the afternoon was spent on supervised activity, which involved a high ropes course and later a flying fox.[11]

27. Mr Toomey then told the group that they could change and go to the dam for a swim, (or undertake another supervised activity). Josh felt comfortable going for a swim as he had learnt to swim at aged 4 years and described him self as a competent swimmer.

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[9] I note that the information sheet used by Mrs Vassil to assist in packing for the camp did refer to, 'swimming gear.' See exhibit 1(d).

[10] See exhibits 1(c) (1) and (2), letters from the RMH, which confirmed that the examinations had failed to establish that either family member had any cardiac symptoms or any other problems with their health, and that there was no indication from these results which, suggested that a genetic heart related defect or illness could have contributed to Kyle's death. See exhibit 27 and also footnote 108 below, which concerns the recent genetic testing conducted in respect of Kyle's father, (and does not suggest that evidence of any genetic defect has been established).

[11] See exhibit 4(b), a diagram of the site setting out the position of the various available activities.

28. Josh changed in his room with roommates who included Nick Cantelo and two others. The group then walked to the dam and on arrival saw that Mr Toomey and two other teachers were already there. A series of photographs showing the area, taken at the same time of day on the day following Kyle's death, later became exhibit 3(b). The area referred to is found in these photographs and also as marked by the witness at exhibits 2(a) and (b).

29. On arrival Josh saw a group of his classmates near the beach, some standing in the shallows others on a slightly elevated area above the beach, to the left as you enter the water from the pathway, which leads down to the dam.

30. The water was described as very cold by all witnesses to this matter. The depth of the water leading from the pathway/beach became deep very quickly, with Josh in water up to his neck only one meter from the shore. Under his feet, the water and dam floor surface, were slushy and black.

31. Josh saw Nick and asked if he wanted to swim to the other side. Nick said yes and then got out to get something. Kyle was also near by swimming around,

    'and he was swimming fine.'[12]

32. Soon after Nick was seen back in the dam and he was with Kyle,

    'and he had his arms under Kyle's arms holding him up.'[12]

33. According to Josh, Kyle appeared to freak out, was breathing heavily, struggling for breath, and splashing around with his hands and arms. This all occurred 1 to 2 meters from shore. Kyle said he was,

    'having an asthma attack.'[13]

    The underlining is mine.

    And then,

    'all of a sudden he was pulling Nick down.'

34. Josh was also holding Kyle, and Nick (was forced) to let go. By this time Josh, who was out of his depth, held Kyle, who was underwater, by his hair.

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[12] See exhibit 2 page 3.

[13] See exhibit 2 page 3.

Before camp Josh knew Kyle from informal basketball games together, on the Aquinas school basketball court. They later met when they both started year 7. Josh described Kyle as *'always very fast with the ball.'*

'I felt that Kyle was pulling me under.... (I let him go intending to take a quick breath with my head above water.) I took a deep breath but, I could not find Kyle.'[14]

Josh then called out for help.[15]

35. He saw a blond haired assistant, an ex student in her early 20's, looking at him as if she appeared not sure if,

'I was mucking around or if I was serious.'

36. She was about 5 meters from the bank at this time.

37. He then got to the bank and spoke with her. He told her with some urgency that

'Kyle had gone under and not come up again.'[16]

38. According to Josh this occurred approximately one to two meters from the bank, at a point where Josh and others, were already out of their depth. The team leaders were standing around above the bank on a grassy area to his right as he made his way out of the dam.

39. Nick was also trying to bring attention to the accident and the fact that Kyle was missing. Both boys were tired and struggled to get their breath, while they shouted for help. Josh was the first to call for help.

40. The blond assistant teacher referred to by Josh, responded,

'Who's Kyle ... (and)...What had happened'

41. Mr Toomey then directed students to get out of the water and (soon) after he went into the water to dive in search for Kyle.[17]

42. Josh in answer to questions by the Court offered that it took around a minute or a minute and a half from the time he lost control of Kyle until he was able to get out of the water. During this period he spoke as loudly as he could calling out,

'Help,'

this as he tried to recover his breath, get to shore and draw attention to Kyle's plight.

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[14] Ibid.

[15] This was apparently one of the first two cry's for help by a student, (the other coming from Nick), and was witnessed by Eva Stewart. See her statement Exhibit 8 at pages 7-8 and her evidence at transcript page 193-94.

[16] Ibid page 4. See ibid page 193-94 and the evidence of Eva Stewart that she saw and heard Josh but has no recollection of speaking to him.

[17] Transcript page 35-6. It took 2 to 3 minutes for everyone to get out of the water.

43. Josh further testified that before entering the water, the students were not identified, or numerically counted. No names were ticked off. There was an inflated tyre tube connected to a rope and a sign pole situated on the bank.[18] The sign post, indicating that the dam was closed, was not in place at the time of the accident.

44. Josh's further evidence was that there were no teachers situated on the sandy area above the bank and that they were to the right of this position as one looks out from the dam. He was in the water for a total of 2-3 minutes only but could not say when Kyle had entered.

45. He agreed with Senior Counsel for Aquinas that the events surrounding Kyle getting into difficulty and the attempted rescue all appeared to happen very quickly. He did not agree that Mr Toomey and Mr Jess got into the water and commenced to search before everyone got out of the water, or that Mr Toomey had blown a whistle.[19]

Nicholas Cantelo (Nick)

46. Nick confirmed much of the evidence given by Josh Anderson.

47. Additionally he stated that the day was pretty hot and sunny. The last activity of the afternoon had been a bush walk and that he wanted to go for a swim.

48. Camp owner Mr Weatherhead said they could go for a swim and that Mr Toomey and others would be there to supervise.

49. Nick arrived first with one other classmate and found that Mr Toomey and two of the men from the camp were already present at the dam side. Then around 7 year 12 camp assistants arrived together.[20]

50. Before entering the water, the students were not given any instructions or told anything in particular. No one asked Nick, or others in his presence, if they could swim. Mr Toomey had a whistle. No one instructed where they should or should not swim. No one instructed as to what they should do in the event of an emergency. There were no loudspeakers, life- boats, rafts, flotation devices or emergency equipment.

51. Some students then entered the water, which was found by all to be extremely cold. Mr Toomey stood on the mound and watched the students swimming, while other teacher(s) and

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[18] See transcript page 46 and 54. See photograph at exhibit 2(c).

[19] See transcript page 53.

[20] See Statement of Nick Cantelo, at exhibit 3 page 4. and transcript page 59.

the year 12 camp attendants stood at or near the position marked with two crosses on exhibit 3(b), i.e. on the entry path slightly above the dam entry and talked together as they watched the some 20 odd students who had entered the water.[21]

52. Mr Toomey had separated himself from the larger group of teachers and assistants.[22]

The underlining is mine.

53. After an estimated 10 minutes in the water, Nick was swimming around by himself some 4-5 meters from shore and out of his depth, when he saw that Kyle was in trouble.[23]

> *'His head was pretty much under water ... the water was up to his mouth .... He looked like he was in a lot of distress so I swam over there. Kyle grabbed me by the neck and shoulder and pulled me under the water. I could not go under for much longer so I pushed him off. When I got to the top of the water, I saw.... Josh Anderson trying to grab Kyle...I was swimming to the bank. I was yelling, Help'* [24]

54. A few seconds later Josh also got to the bank. He was puffing and visibly upset. Some of the teachers and camp attendants asked what had happened.

55. Another student Isabelle Armstrong, (Izzy) dived to try and find Kyle. She kept on going under to look without result.[25] Mr Toomey blew his whistle and told everyone to get out. He jumped in while others were getting out.[26] Mr Jess may also have jumped in.[27]

56. Mr Toomey also told the camp attendants to check the cabins and the people from the camp to ring 000. Some people went and looked in the bush to which both boys protested that Kyle was still in the dam.[28]

57. The camp people and teachers moved all of the students away from the dam, to the cabin area.

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[21] Nick agreed that this appeared to be a good vantage point from which to observe the students below, who had entered the dam. See transcript page 62.

[22] See transcript page 83.

[23] See transcript page 82.

[24] See exhibit 3 at page 5. This occurred when Nick (and Josh) estimates that he was a meter to a meter and a half from shore. See transcript page 74.

[25] Izzy Armstrong also yelled out for help as well while she was still in the water. She did this while continuing with her efforts to duck-dive in search of Kyle. See transcript page 79-80.

[26] See transcript page 83.

[27] See transcript at page 82.

[28] See transcript page 68.

58. Nick could not remember if he had held Kyle under his arms as they both struggled to try to get Kyle to the shore line, (as Josh had earlier testified).[29]

Jay Vandenhout (Jay)

59. Jay Vandenhout also testified as to his observations on 17 February 2010, broadly supporting the testimony of Josh Anderson and Nick Cantelo.

60. Jay arrived at the dam edge with his friend Kyle with whom he had spent the afternoon, while engaging in planned camp activities.

61. They were amongst the last to arrive at the dam.[30] On arrival, they spoke to Mr Toomey who was by himself at the side of the dam. Another teacher, was away from Mr Toomey standing at the other side of the entrance. Another teacher unnamed, and camp leaders, were seen standing in the vicinity of the dam. [31]

62. Thereafter,

> *'Mr Toomey told us the rules. He said he had already told the rest of the group the rules. He said there was to be no pushing, no dunking, no diving, no splashing and no fighting.'*[32]

63. Then Kyle and Jay walked to the dam. Both boys felt the water was cold.

64. The boys then stood in the dam's shallow area and Jay playfully then pushed Kyle in to the water. Kyle kept his head above water.

> *'No one told me off for this.'*

65. After pushing Kyle in, Jay was aware that Kyle could not stand.

66. Kyle then pulled Jay into the deeper area,

> *'where he was.'* [33]
>
> *'to a position where Jay was also out of his depth. Kyle was laughing and appeared to be fine. He looked like he could swim and didn't appear to be struggling with his*

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[29] See transcript page 71.

[30] Statement of Jay Vandenhout at exhibit 4, page 4.

[31] I note here that the evidence of Ms Stewart and other witnesses tends to establish that the teacher in this position was Ms Stewart and that Ms Campbell was not near the dam at this time.

[32] Ibid page 6.

[33] Ibid page 6.

swimming. At this stage the two boys were in the middle of the dam with two other friends namely Josh Anderson and Isabella Armstrong...We all swam around in the middle of the dam for a while... We did this for about 3 or 4 minutes.'[34]

67. At this point Jay decided to get out because he still had his socks on and wanted to take them off.

68. He was out of the water for approximately 20 seconds and then returned to the waters edge. He looked for Kyle but could not see him.

'I heard Josh and Isabella scream out... They were swimming in towards the shallow area towards the teachers... shouting, Help Kyle has gone missing.'

69. They spoke loudly, loud enough to be heard over surrounding noise. They appeared to be distressed.

70. Mr Toomey and a camp leader jumped into the water,

'diving under the water for long periods.'

71. Later in oral testimony, Jay added that as Josh and Izzy shouted out and swam in, Mr Toomey (some three meters away),

'was standing there looking at them trying to figure out what was going on'.[35]

72. Camp Leaders Paul Jess and Emma Phillips were also in the vicinity. Emma Phillips called emergency services.

73. Ms Campbell then took all of the students up to the steps.[36] They remained in the area for approximately two hours and were later escorted back to Melbourne.

74. In further evidence, Jay added that he with Kyle had arrived a little after the others as they had gone back to his cabin where they had both consumed some snacks, he had bought from home. On their way to the dam they saw some of the teachers and camp attendants sitting near the steps at a picnic table where they were eating and talking.[37]

75. When he left the water, Kyle was still swimming around with Josh and Izzy, and appeared to be fine.

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[34] Ibid page 7.

[35] See transcript page 88.

[36] See f/n 31 above. See also steps and cabin lodge area as set out on Alpine Ash Site Plan at exhibit 4(b).

[37] See exhibit 4(b)

Geordy Laidlaw (Geordy)

76. At the relevant time, Geordy was a year 7 student at Aquinas. His homeroom teacher was Mr Toomey. He described himself as an average swimmer and surfer. He stated that his older brother also a student at Aquinas had told him about the camp activities, which were *'great'* and how the water was really cold.[38]

77. Geordy described his swimming experience at the Ringwood Aquatic Centre. He informed that the lifeguards have radios so they can connect with people and how they stand-alone and spread out,

> *'so they can see what is happening...*
>
> *You need life-savers because if someone is struggling you need someone there. Life-savers go through special courses.'*[39]

78. On the afternoon of the day in question, the first day of their planned 3 day stay, they spent time doing various activities following which, they were told by teachers, that they could go for a swim and were given certain directions about what they could and could not do. According to Geordy, there were no flotation devices as such, but there was a rubber tyre attached to a cord situated in the dam.

79. Geordy was three to five meters from Kyle when he thought he saw him go under the water. Then he thought he saw him come up again and he resumed talking with his friends.

80. Geordy further described how several classmates then began to yell out and how the teachers did not respond to the cries as,

> *'I am pretty sure the teachers thought the students were trying to get the teachers in the water for fun and were mucking around. Some of the kids though started swearing at the teachers because they were angry and frustrated with them, because they were not listening to them. Mr Toomey then jumped in the water and I saw Mr Toomey dive in the water and he said he couldn't find anything and then like rang this bell to get all of the students out of the water.'* [40]

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[38] See Laidlaw statement at exhibit 5 page 1.

[39] Ibid page 2.

[40] Ibid page 5. The classmates who were yelling out at this time were identified as Izzy Armstrong, Josh Anderson and Tarryn O'Leary. Geordy did not know classmate Nick Cantelo at that time. As to the language allegedly used by unidentified member(s) of this group see transcript page 123

81. The people involved in the attempt to communicate with teachers were emotional, and felt anger and fear for Kyle and because they were not being taken seriously.

82. Geordy believed there were approximately five teachers and or year 12 camp leaders in the vicinity of the dam at the time of the accident. There was shouting as well as mucking round. He had thought they might be mucking around but then realised they were serious and that Kyle was in danger. Later the teachers reacted to the swearing and entered the water.

Tarryn O'Leary (Tarryn)

83. Tarryn a 12 year old, screamed when she got into the water, because it was so cold. There were about 10 classmates in the water at the time, while others congregated at the beach area. She wasn't sure if this number included Kyle.

84. Some of the group (including Tarryn), raced towards a beach ball, which was about 20 meters away, from the entrance to the dam.

85. The swim warmed her up but it was still very cold. Later her group played around the tyre tube, which was afloat in the dam with an attached cord hanging from it.

86. The part where she and others had entered the dam was about 5 meter wide. The teachers spread around this entry area, but not around the lake. The teachers present included Mr Toomey, Ms Campbell and Ms Stewart. Camp leader Paul Jess was also present.

87. After around 10 minutes Tarryn swam to shore and stood on the bank in knee depth water. Tarryn was in this position when she saw Josh Anderson in a distressed state,

> *'looking like he was struggling to swim.'*[41]

88. He was yelling out for help saying things,

> *'like Kyle is under there,'*

and Izzy helped Josh. Then the three students Josh, Jay and Izzy were all yelling out for help. Then Izzy dove under the water but without success, and both she and Josh were crying.

89. Tarryn realised that the matter was very serious and she spoke to Mr Toomey. He was standing about 3 meters from the edge of the lake.[42]

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[41] See Tarryn O'Leary statement, exhibit 6 at page 6.

90. He went in to the water but was looking in the wrong area.[43] Then team leader, Paul Jess, also got into the water and the students were escorted away from the dam. (The underlining is mine)

91. In her oral testimony, Tarryn stated that while she hadn't seen Kyle, she did see Josh splashing and his head go under the water's surface, (in a manner which was suggestive of an involuntary action). Josh was around 5 meters from her at this time.[44]

92. Later Izzy helped Josh out of the dam, which was difficult as the dam floor was mushy. It was also clear that Josh was serious, with his cries for help,

> *'desperate and urgent.'*[45]

93. Finally, it was probably 40 seconds to a minute before the teachers realised something was wrong.

> *'then Toomey said to me are you dead serious.'*

To which I said,

> *'I am dead fucking serious. And then I think because you don't normally speak to teachers like that, he knew...'*[46]

The Teachers

Eva Stewart

94. Eva Stewart was Kyle's homeroom teacher (Year 7 Maroon) and attended the camp activity held at Mountain Ash retreat.

95. Year 7 Maroon was part of the Mackillop team, which also comprised Year 7 Orange and Year 7 Purple. Leigh Toomey was the homeroom teacher for 7 Orange while Mel Campbell, was the homeroom teacher for 7 Purple.

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[42] See transcript at page 138.

[43] At transcript page 140 Tarryn elaborated on the area of search and described how Mr Toomey was searching in a different position about two meters, from where she earlier saw Josh struggling, and how he was followed to that (wrong) area by camp leader, Paul Jess.

[44] See transcript page 136-7.

[45] Ibid.

[46] See transcript page 139

96. The supervisors of the camp were the three-homeroom teachers and six camp leaders. Additional Aquinas staff, Melinda Voigt and Adam Pine, were also at the camp on 17 February, 2010.

97. The camp leaders were Emma Phillips, Paul Jess, Mathew Allard, Patrick Mills, Megan Lane and Kate Cridland, all of whom were ex-students at the school. In addition, the camp had its own staff who were responsible for the running of some of the higher risk activities.

98. In the day's leading up to the camp, Eva Stewart spoke with her class about camp related issues. These concerned issues of safety and about remaining within the camps boundaries. She did not speak about swimming but did say there was a chance that they might go swimming.

99. On the morning of 17 February 2010, she travelled to camp by bus with her students. On arrival, they received a briefing from the camp manager, Stephen Weatherhead.

100. They then engaged in the camp activities planned for that afternoon, finishing at around 5 pm following which the students were given the option of going to the dam for a swim, with dinner to be served at 6 pm.

101. Eva Stewart waited for her 7 Maroon students to change for swimming and then walked down to the dam. When she arrived Leigh Toomey and camp leaders Emma, Paul, Kate and Meg were at the dam with around 20 students standing on the bank or in the vicinity.

102. Leigh, Paul Jess and she stood to the left of the beach area, while the three female camp leaders were to their right, and just in front.[47]

103. At this time, they were approximately four meters from the waters edge. While in this position Eva Stewart focused on the students on the bank and in the water (and a particular student from her homeroom), while Lee Toomey and Paul Jess focused on the students in the water. Camp leaders Kate Cridland, Emma Phillips and Meg Lane were standing in the centre of the entry area to the water watching approximately 20 students in the water at this point, who were within about 3 to 4 meters from the waters edge. Additionally there were about 15-20 students standing on the bank in the area,

'around us'. [48]

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[47] See exhibit 8 at page 6.

[48] See exhibit 8 (a) notes of event prepared by Eva Stewart for the school solicitor, on 21 February 2010.

104. While Eva Stewart had not swum in the dam, she was aware that the water was very cold and that the dam floor falls away very quickly and was quite deep. The water was dark and murky and you could not see the bottom. [49]

105. In her written statement Exhibit 8, Eva Stewart further stated,

> *'At approximately 5.20 pm, ...(Josh Anderson)... was calling out for help. (He) was quite distressed. He said something like, "he's gone under and hasn't come up yet."*
>
> *A few other students were calling out similar things. I also heard the name "Kyle" mentioned. I assumed this was a reference to Kyle Vassil.*
>
> *Leigh Toomey then questioned Josh about what he had said and as to whether he was serious. When it became apparent there was an issue Leigh asked around as to whether or not anyone had seen Kyle get out of the water. They said they had not seen Kyle get out of the water. This all happened very quickly. At that point Leigh and (camp leader), Paul Jess entered the water and began to search for Kyle. I went up to the camp area to check for Kyle in the rooms in case he had gone up there. I checked the toilet shower areas... I also spoke to children who were playing volleyball... and to homeroom teacher Mel Campbell... No-one had seen him. I then ran back to the water hole. Leigh and Paul were still searching the waterhole. I then began to call 000...*
>
> *At that point, the students were evacuating the water. Mel, Leigh, who had got out of the water at that stage, and I then walked the students to the meeting area. They were then seated in their individual classes and head counts were conducted.*
>
> *These headcounts were done on 3 or 4 separate occasions. At that point, it was established that only Kyle had not been accounted for. I was aware that camp leaders Mathew and Paul had remained at the dam continuing to search for Kyle.'* [50]

106. Eva Stewart gave additional sworn testimony on the second day of inquest.

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[49] See statement of Eva Stewart at Exhibit 8 page 1.

[50] Ibid pages 7-8. See also exhibit 8(a) an earlier statement made by Eva Stewart for the schools solicitor in which she records that on receiving the report, Leigh Toomey asked a few questions e.g. 'Are you serious?' The students said hey were. See also transcript page 183 where the witness retracted her earlier statement that she had heard students say they were 'almost certain', that Kyle had not got out of the water.

107. In earlier discussion between the homeroom teachers, it was confirmed that there would be a one hour break between 5 pm and dinner at 6 pm and that this would be an opportunity for those students who wanted to, to take a swim.

108. On the day Leigh Toomey, the four camp leaders and herself, said they would go down to the dam while homeroom teacher Mel Campbell and social worker Mel Voigt remained at the top with the other students.

109. This arrangement was established in a voluntary way, rather than as a result of any one person's direction.

110. Eva Stewart had been to the camp on three earlier occasions. She had not been involved in any earlier risk assessment concerning the use of the dam. She was also not familiar with the swimming capabilities of those present, but for the one student she was specifically keeping an eye on.[51]

111. Eva Stewart further confirmed that there was no buddy system instituted at the dam and that she did not know actually how many of the 80 students who had by then reached Alpine Ash, went down to the dam on the afternoon under examination.

112. While standing with Mr Toomey and Paul Jess to the left of the beach area, she was about three to four meters behind the 15-20 students who were not in the water. The three other camp leaders Megan Lane, Emma Phillips and Kate Gridland stood two to three feet in front of both teachers and Paul Jess, and slightly to their right.[52]

113. She positioned herself so that she could keep an eye on this group as well as those in the water. Some of those standing near by came and spoke to her with others making comments and talking at different times while Mr Toomey, Paul Jess and she were watching the water and scanning the area.[53] She and her colleagues also spoke to each other as they continued to watch.

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[51] See transcript page 177.

[52] See transcript page 199.

[53] See transcript page 179.

114. Eva Stewart further confirmed that she first heard Josh calling out in regard to Kyle while he, Josh, was still in the water. Later he spoke directly to Mr Toomey as other students also called out for help.[54]

115. The underlining is again mine.

116. According to Eva Stewart, she did not hear any students swear. She had blond hair at the time, (but had no recollection of speaking directly to Josh Anderson).[55]

117. Then Leigh asked if anyone had seen him get out of the water. The response was in the negative but Eva Stewart believing that he may have got out and left the scene without being observed, took it upon herself undertake a search of the cabins, car park and kitchen area.

118. This choice left Mr Toomey to manage the search at the dam.

119. Eva Stewart further agreed there was no emergency management plan put in place either before or after Kyle's disappearance.

120. Further Eva Stewart stated that she did not consult with Mr Toomey before leaving the scene. She was also unable to say whether any one remained to assist the students still in the water, or to look for signs of life in the water while Mr Toomey, Paul Jess (and later Mathew Allard and Patrick Mills), undertook their search.

121. She told the Court that following the death of Kyle, all homeroom teachers were required to complete a first aid course.

Leigh Toomey [56]

122. On Jan 27 2009, Leigh Toomey met with Steve McGrath (his predecessor as camp co-ordinator), and both men then went to the Alpine Ash retreat, where they met with Steven King, who was then the camp manager. Leigh Toomey states that he had attended the retreat on three previous occasions in his capacity as a homeroom teacher.

123. The purpose of the meeting was to ensure that all of the activities were going ahead and to talk about the procedures in case of a bush fire.[57] The first camp began on 10 February and

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[54] Ms Stewart was satisfied that these various calls related to Kyle only and not to separate instances of disappearance. See transcript page 202.

[55] See transcript page 193-94.

[56] Leigh Toomey a physical education teacher at Aquinas was appointed as the Camp Co-Coordinator for years 7 and 8 at the beginning of 2009, taking over at that time from Steve McGrath.

lasted for three days. Leigh Toomey, who was not a homeroom teacher to this group, attended on the first day to help new homeroom teachers familiarise themselves with the camp and to help with orientation. He left the retreat to return to school at the end of activities on the first day.

124. On the afternoon of 17 February 2009 Leigh Toomey over saw his year 7 homeroom class, and they were also supervised by two camp leaders to undertake separate activities, these concluding at about 5 pm. All of the groups then re assembled in the assembly area and after discussions with home room teacher Melissa Campbell, it was resolved to offer students the opportunity for a swim before dinner, which was scheduled for 6 pm. About half of the 80 students indicated that they wished to go for a swim. Leigh Toomey determined to organise supervision for those wishing to swim while Melissa Campbell was to supervise those who did not. Leigh Toomey then arranged for a sufficient number of camp leaders to be present at the dam, and he spoke to his young charges, about safety issues.

125. According to Leigh Toomey, he then walked down to the dam, with camp leaders Megan Lane and Kate Gridland. Soon after students began arriving and some 15 began to swim with Leigh Toomey, Megan Lane and Kate Gridland initially providing supervision for this group.[58]

126. Thereafter camp leader Paul Jess arrived and went in to the dam for a swim. He was followed to the scene by fellow leader Emma Phillips and by home room teacher Eva Stewart. The leaders (and teachers) then supervised by standing along the sandy entrance, with up to 30-35 students in the water at any one time, half of whom stood in the shallows and half of whom swimming in water, which was out of their depth.

127. Leigh Toomey stated that between 5.20 and 5.25 pm, he took up a position approximately 1 meter from the waters edge right next to a wooden pole, which was on the left side of the sandy beach.

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[57] See exhibit 15(a) a document said to have been prepared on 21 February 2010 (after the day of the incident under examination) from hand written notes prepared on 1 February 2010, following Leigh Toomey's visit to the retreat on 27 January 2010, when he met with camp Manager Steve King.

The record is headed Risk Assessment of year 7 Camp 2010, and talks about the waterhole still being open, the sandy beach and the temperature of the water being checked. See also transcript page 452 where Mr Toomey concedes that his original hand written notes on which the typed exhibit 15(a) is based, did not include a reference to risk assessment in its heading.

[58] See statement of Leigh Toomey at Exhibit 15, page 3.

'The first thing I noticed that something was wrong, about 4-5 meters in from the waters edge directly in front of where I was standing , something captured my attention. I saw a student later identified as Josh Anderson who appeared to be struggling in the water. Josh was on his own and there was no one else within a meter of him. I kept my eye on him and after a few seconds he looked like he had recovered and began to swim back to the sandy entrance where a lot of other students were standing in the shallow water. He got out of the water and I saw he was distressed and he yelled out "help" once or twice. At this stage, some of the leaders had gone over to Josh and he told us that Kyle had gone. Someone asked Josh if he was serious and it was clear within a few seconds that something was wrong. Josh was panting and finding it hard to breathe.

I immediately took off my shoes ..., and waded into the water where Josh was seen struggling earlier... it crossed my mind that the reason why Josh was struggling was because Kyle had pulled him down.'

128. Leigh Toomey further stated that he continued to dive for a couple of minutes with Paul Jess, and then Patrick Mills and Mathew Allard joined them.

129. He continued to dive for about 5-10 minutes and could touch the bottom of the dam. He then determined to leave the dam because there was no confirmation that Kyle had been in the dam at all, and to make sure emergency services had been called, and that Kyle had not been found.

130. He went back to the recreational area where he also assembled his homeroom group to account for all students. [59]

131. In oral testimony, Leigh Toomey further stated that:
    - the water at or near the shore permitted visibility to a distance of 12 to 16 inches;
    - on takeover from the former camp co-ordinator Steve McGrath, that there was no formal assessment of the risks associated with the use of the dam save that he had checked the conditions at the dam at the first camp, one week earlier, in preparation for swimming there;[60]

[59] See statement of Leigh Toomey dated 20/4/2010 at exhibit 15 pages 3 and 4.

[60] The checking referred to was conducted by putting his hand in the water. See transcript page 404.

- that given the warm weather conditions that the offer to Year 7 students of the use of the dam as an optional recreational activity outside of structured activity, was a reasonably good possibility;[61]
- that exhibit 1(f) provided to parents, which stated that the water was clear, meant that he was saying that the water hole was, clean,

  'in that it was in my opinion it was safe to swim in.'[62]

- that he did not seek permission from individual families for their children to swim, or seek information about their individual swimming abilities, but that he had confidence in the environment.
- that unusually when he suggested to students at around 5 pm that they might swim, that camp staff and the camp manager Steve King, were not present.
- that he was not specifically aware that the camp activity dam was out of bounds unless prior approval was provided by Retreat staff and the activity was carried out under adult supervision;
- that he had not previously been aware of or witnessed such discussions between camp staff and school staff concerning the use of the dam;
- that prior to the camp he was not aware of the swimming qualifications of camp leaders and whether any held a bronze medallion certificate;
- that around 40 students indicated a wish to participate in the swimming activity but that because of the recent commencement at the Aquinas School of most of this group, that he didn't know them and could not identify most of them;
- that he spoke with camp leaders and was confident that a sufficient number would attend the dam to provide supervision to the students intending to swim;
- that he did not inquire as to whether the students felt comfortable swimming in deep water or ask if they were competent and able to swim;
- that he was not aware of any of the students trying to trick teachers/camp leaders into going into the water;
- that staff were not informed they may have to go into the water;
- that neither students or staff were told what to do in the case of an emergency;

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[61] The temperature on February 17 at the retreat, was believed to be 28 degrees. See transcript page 417. The temperature in the water was later estimated to be approximately 12 by Sergeant Velthuis. See transcript page

[62] See transcript page 400.

- that no instruction was given to him about how to supervise students swimming in the dam, and that he relied on his own common sense and experience as a home room teacher, rather than his experience as a camp leader;
- that no advice was given to the students going into the dam as to what to do if they got into difficulty, and needed assistance;
- that he stood directly next to the wooden post on the left side of the beach, as shown in photograph exhibit 15(b) and better shown in exhibit 3(b) photo 4, while supervising students;
- that when he saw Josh Anderson his head was above water at all times and he looked like he was having difficulty swimming and that he corrected himself and swam back to shore,

'so in my eyes that immediate danger had passed.'[63] ;

- that later Josh, whom he did not previously know, came from the water screaming for help and that after it was apparent that something was amiss and he then jumped into the water; [64]
- that there was not an effective communication as to what had happened to Kyle and as to where it had happened; [65]
- that there had not been an instruction to students to put their hand up if they were in difficulty in the water and that such an instruction is given in surf lifesaving;
- that he dived in where he believed he had earlier seen Josh struggling, which was out of his depth and that he walked out as far as he could and then swam out,

'another two or three meters beyond that and then I began searching'.[66]

- that this initial diving was done feet first, which did not allow him to reach the bottom, and that he dived between 8 to 10 times before he touched the bottom;
- that he did not know the depth of the water in which he was searching, or if Kyle was on the bottom, and that had he have known of that he would have first searched on the bottom;

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[63] See transcript page 431.

[64] See transcript page 422-23.

[65] See transcript at pages 425 and 431-3.

[66] See transcript page 427.

- that he considered that he was the manager of the camp and that the search was managed diligently; [67]
- that he had no knowledge of lifesaving qualifications of any of the camp leaders; [68]
- that he hadn't seen Josh's head pulled below the water surface;
- that he had no explanation (despite considerable soul searching), for why teachers and camp leaders had not seen the 'clues' unfolding below them. [69]
- that when he took on the role as camp co-ordinator, there was a process already in place and an electronic folder and documentation was handed over by his predecessor Steve McGrath.
- that this material did not include policy documents, such as, The Catholic Education Commission of Victoria, supervision of student ratios for camps, excursions and outdoor activities, dated May 2002 or the state school equivalent or the guidelines promulgated by the Department of Education and Early Childhood Development. (DEECD). See brief pages 317 -368.
- that at the relevant time he also was not aware of these policy documents, or of the conditions of entry to the Alpine Ash retreat general conditions of hire document; [70]
- that his communication with parents about the camp had not included that the dam was three meters deep, that it had a very steep slope at entry, that the water was dark and visibility poor, and that there was no lifesaving equipment at the scene, and the water was very cold. [71]
- that the school had not established whether the ex year 12 students invited to participate as camp leaders, had any particular skill set and they were not given any briefing or supervision in regard to their duties at the dam, or told what to do in the event of an emergency; [72]
- that only two of the teachers/camp leaders who attended at the dam , i.e. himself and Paul Jess were wearing bathers and were ready to go in to the water;

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[67] See transcript page 430 and 439.

[68] See transcript at page 443.

[69] See transcript page 446. '*I have asked myself that question over and over.*'

I believe the word used by the witness was 'clues', not 'cues' as is set out in the transcript, see page 446.

[70] See discussion of issues raised by counsel for the Vassil family at transcript page 448-50.

[71] See transcript pages 454-55, which establishes to my satisfaction that Mr Toomey did not specifically address the issue of the existing water conditions, with family members.

[72] See transcript page 463-4.

- that no one in attendance had received training in regard to rescue from water;
- that everyone in the water was swimming to his right hand side and that when he saw Josh Anderson, he was on his own and that he didn't see either Kyle or Nick Cantelo in that area or hear anyone, other than Josh, cry out for help;
- that he was now familiar with the State School guideline and that had this guideline been applied on the day under examination, that no students would have been permitted to swim in the dam because the dam was a type 3 venue, (unclear water) and separate assessments of students swimming capacity, had not been undertaken; [73]
- that had he discovered camp leaders talking among themselves and being distracted by that behaviour, while supervising the swimmers, he would have spoken to them about that matter;
- that had he observed that camp leaders were being obstructed in their view, he would also have spoken to them;
- that when he left the water to search for Kyle away from the dam, after 20 odd dives, that

  'there was a hope a wish in my mind ...that hopefully there was another explanation,'

The Camp Leaders

Kate Cridland.[74] (Kate)

132. Kate was present on the beach with fellow camp leaders and teachers Mr Toomey and Ms Stewart. Her duties were to supervise the children who attended in the dam area.

133. The first and only thing she saw was a young student, (Josh Anderson) get out of the water in a distressed manner and state that,

'a boy had not come back up.'

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[73] I note with approval that Aquinas School was directed to comply with this guideline by WorkSafe Victoria following an investigation of this matter, and that this direction has now been complied with by the Aquinas school and across Victoria by many, but as yet not all Catholic Schools.

Specifically the Aquinas school was directed to assess each individual students swimming capability before permitting students to swim in a type 3 venue (unclear water).

[74] Kate Cridland was a recent graduate of Aquinas and a university student of 18 years of age, at the time of the incident under examination. She made a statement to police dated 7 April 2010, which became Exhibit 9.

She also made notes of her observations 2 days after 17 February 2010, which became Exhibit 9(b).

134. This discussion took place with Mr Toomey and was confirmed, with Kyle then being named as the missing student.

135. Kate saw he was distressed but wasn't surprised when Leigh asked if he was joking.

> *'It was a bit of a running joke to get the teachers into the water because it was quite cold.'*[75]

136. Kate then escorted the children away from the area.

> *'I herded them up the hill... and checked all the cabins and bathrooms telling all students to go to the steps immediately.*
>
> *The students were split into their three classes, and two head counts were done.'*[76]

137. Kate had received an invite to attend camp over the telephone from Mr Toomey. This was a paid position. She did not receive any particular instruction, but considered that she was familiar with what her role was to be, from her earlier attendance at Alpine Asb, while a year 7 student. She did not pack her bathing costume.

138. At around 5 pm she went to the dam because most of the kids were heading in that direction. She stood in the position marked in exhibit 9(b), near the waters edge on the right side of the beach area. Mr Toomey, Ms Stewart and Paul Jess were about one foot behind the other female camp leaders, with Kate farthest away and to their left.

139. Her view was not obstructed and for the majority of the time she watched students in the dam, speaking only when students on the bank approached to speak or ask a question. She maintained a watch by scanning, i.e. watching all of the swimmers and not just a section of the dam. The scene was noisy and the students were seen to be enjoying their swim.

140. According to Kate, on understanding there was an emergency,

> *'(we) ... acted under our own steam. We kind of thought what was appropriate and acted upon that.'*[77]

141. Kate further stated that there were no specific discussion about what her role would be and no direction as to who was to supervise herself and the other camp leaders. There was no

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[75] See transcript page 215..

[76] See exhibit 8(b)

[77] Transcript page 209.

discussion about swimming or the use of the dam and no specific discussions about risk management or emergency management.

142. No one had asked her to go to the dam or provided any direction as to how she was to supervise students, once she got there.

143. Kate did not hear any bad language but pointed out that she was farthest away from Mr Toomey when such language was (allegedly) used.

144. In answer to questions from Mr Weatherhead, the Alpine Ash owner, Kate agreed that the position she stood at was approximately five feet in height above the waters edge, and that she was in a good position to see every body in the water.[78]

Paul Jess[79] (Paul)

145. Paul had previously attended approximately 10 camps at the Mountain Ash retreat and had swum in the dam approximately five times.

146. Paul confirmed much of the earlier evidence given by teacher Mrs Stewart and fellow camp leaders including Kate Cridland.

147. There was no formal process or discussion to determine who would supervise the swimming activity. On arrival at the dam, Paul found that Leigh Toomey and camp leaders Meg and Kate had already arrived to supervise year 7 students and that Emma and teacher Eva Stewart arrived soon after.

148. On previous occasions, it was also the case that Paul had not received any direction about his responsibilities as a camp leader.[80]

149. Following his arrival, Paul immediately went in for a swim, staying in for about 5 minutes. As soon as he got in, he felt the freezing water and felt short of breath.[81] During this period, the students and remaining school staff began to arrive and some of the students commenced to make their way into the dam.

150. All of the teachers and camp leaders supervised from the same area i.e. on the right side of the beach area, which was where swimmers would enter the dam.

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[78] Transcript page 229.

[79] At the time of the incident Paul Jess was a 22 year old, fourth year Physical Education student at Deakin University.

[80] See transcript page 271.

[81] See statement of Paul Jess 30/3/10, at exhibit 11.

'We were all standing together watching the kids and Eva was standing behind us, just talking to some kids.'[82]

151. Paul was familiar with the retreat and its various activities. He was a keen and accomplished swimmer, but with no formal life saving qualifications.

152. On Friday 19 February 2010, Paul attended a meeting at Aquinas and there after compiled notes of the incident at Alpine Ash retreat, which had occurred two days earlier.[83]

153. These notes record that Josh complained to Lee Toomey at approximately 5.25 pm, some 3-4 minutes after Paul exited the dam, and staff commenced to supervise the students who were swimming.

154. After a brief exchange between Leigh Toomey and Josh, Leigh immediately rushed into the water and began diving,

> *'in the area where Josh had come from,... Paul following Leigh into the water some 10 seconds later, where he began diving and searching...*
>
> *20-25 students still in the water at this stage, no one had said or seen anything or raised alarms...*
>
> *Leigh and I kept diving, the water was very deep and murky. Mat and Pat, (camp leaders), came down and assisted search. Leigh left the water while we continued the search and went back to the area where the kids were.*
>
> *Matt and I continued diving, bubbles were sighted.*
>
> *(We), dove to the bottom for 20-25 minutes, no sign of Kyle.*
>
> *While we were still in the water, Police arrived. Leigh had come back down at this stage and he told the police what had occurred. Police asked us all what had happened, where we were and what we did-out of water at this stage...*
>
> *Waited at the scene until Search and Rescue arrived at approximately 7 pm.*
>
> *Asked me what area we thought he was in, pointed out the area we were searching in.*

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[82] See statement of Paul Jess 4/8/10 at exhibit 11(a) page 2.

[83] See statement at exhibit 11(b).

Diver completed 2-3 sweeps before finding the body. I walked back to the steps passing Leigh on my way up. We spoke...

By this stage, the students were packed on busses.' [84]

155. In oral testimony Paul gave a somewhat more amplified version of the initial discussion between Josh and Leigh Toomey, stating that he had only heard Josh say that Kyle was gone, and did not hear Josh or others call out for help, in relation to Kyle. This evidence concerning his not hearing Josh's cry for help was later retracted. [85]

156. Paul further testified that he was not persuaded by what was said by Josh. He did not hear other students yelling, or calling out, or in distress, and nor did he see Isabelle Armstrong continue to duck dive into the water.

157. Then while Leigh commenced to take off his clothing in preparation to enter the water, Paul asked Josh.

'Whereabouts' I asked Josh 'Whereabouts ?'

'He just pointed in the general direction, that I saw him walking out of the water.' [86]

158. The witness was then referred to the police photographs exhibit 3(b) photo 7, which shows the position where Kyle's body was located.

'We were probably (searching) just behind that, (going out) just.

Paul then confirmed that Josh was the only person at the scene who was asked for directions.'

159. He was then further questioned about the conditions underwater during the search and stated that he could reach the bottom but on doing so, had to go straight back up for air.[87] At the bottom, he touched mud and weeds and then had to go back up for air. As he grew tired, this process slowed. He was speaking to Matt who had also joined the dive and they dove in a five-meter diameter area. Leigh had left the water to go up to the area where the students had congregated. There were later three in the water as Pat also joined.

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[84] See exhibit 11(d) page 1-2. The witness prepared this statement on 17.2.2010 at the request of the schools solicitor.

[85] See transcript page 280-1.

[86] In later oral testimony Paul stated that he asked Josh 'Whereabouts' in a group discussion 'and followed instructions from Leigh as to where to go'. Transcript page 310.

[87] See transcript page 282.

160. Paul stated that he dived approximately 40 times.

161. When asked about his earlier statement,

> *'I couldn't hold my breath long enough to get to the bottom.''*[88]

162. Paul replied that he,

> *'could hold his breath long enough to get to the bottom but once down there, there wasn't much time he could spend down there because I was obviously short of breath.'*[89]

And further,

Coroner,

> *'Just reflect on that for a moment because if you were able to get to the bottom and you dived 40 times in this area and if we assume that Kyle was at the bottom in this non-currented area of water, one would expect that you would have made contact with him?*
>
> *Maybe, but as I said before, when I looked at the phone I think we were maybe just a meter back from where he was.'*

163. The underlining is mine.

> *'That's why I asked you about the diameter. If you are a meter back you still would have encompassed the area where he was found?*
>
> *Obviously that was a rough 5 meter diameter and obviously we had no sense of direction underneath, where we had dived before, or where we had to dive next.*
>
> *...you believe It is possible that you missed him because you didn't go over each part in a mathematical (methodical) way?*
>
> *Yes.*
>
> *You just dived and it is possible you didn't dive immediately over the area where Kyle had come to rest?*

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[88] See witnesses statement at exhibit 11 page 3.

[89] See transcript at page 284. See later evidence under examination by senior counsel for Aquinas, School in which the witness offered that he touched the bottom with his hand on 80-85% of his (40) dives. See transcript at page 302. Under further questioning from Senior Counsel the witness confirmed that he did touch the bottom. He was not sure why a contradicting account was in his statement, but suggested that he may have said he did not have enough breath to stay at the bottom. See Transcript at page 310.

Very possible, yes.'

Mathew Allard[90] (Mat)

164. Patrick and Mat ran down to the dam. The found Leigh Toomey and Paul discussing where to look. Leigh Toomey stayed a couple more minutes and then,

> *'had to leave to ensure that the police were notified and the other students were supervised.'*

165. Paul, Patrick and Mathew continued the search.

166. Later the camp owner Stephen Weatherhead came down and he suggested the search be conducted by the divers, using their feet.

167. Other people came down and were looking for bubbles. These people directed Mat's attention to an area where bubbles were seen, and he began to search by duck diving in that area. This water was about 2.5 to 3 meters deep and he was able to touch the bottom in about one dive in three. There was about half a meters visibility.

168. Sergeant Elks from Kinglake police arrived after 25 to 30 minutes and Mat together with Paul and Pat, got out of the water. Mat then returned to his cabin and changed, while Paul stayed at the dam. 10-20 students were watching a movie in the TV room and the rest of them were crying. Mat assisted in comforting the students. At about 6.30 pm the students had dinner. Adam Pine arrived and told the students they were going home that evening. Later that night Mat was told that Kyle's body had been found within half a meter of where he had been looking. [91]

169. There were no life buoys or any other devices to assist in searching for Kyle. The camp owners' suggestion that he use the tyre with attached cord while searching in the dam was tried, but proved to be unhelpful.[92]

170. In oral testimony, Mat further stated that when he arrived Leigh Toomey and Paul were in the water talking to each other about where to search.

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[90] Mathew Allard was a camp leader at the year 7 Mountain Ashe retreat camp, and a former Aquinas college student. On 10 February 2010 after the completion of Alpine Ashe staff led formal activities, he became engaged in a conversation with co-camp leader Patrick Mills about 50 meters away from the dam. At around 5.15 to 5.20 pm, he heard a commotion and spoke to one of the female camp leaders who was running to wards the cabin area. This person told Mat that 'someone is missing.'

[91] See first statement of Mathew Allard 30/3/2010, at exhibit 13 pages 3 and 4.

[92] See second statement of Mathew Allard 4/ 8/2010, at exhibit 13 (a) at page 3.

171. They were in water about three to four meters from shore. Leigh Toomey had to leave, as he was responsible for the other students.

> *'He gave me.. he told me a general location to search around saying it was around that area or something like that. Just keep looking around that area.'*[93]

> *'Difficulty I encountered consisted of the visibility in the water and of course finding the appropriate location to search through.'*[94]

172. Further difficulty was encountered in getting to the bottom and then getting back up and having to spend time at surface level catching one's breath, before commencing another dive. The greatest difficulty (and energy spent) was because of the depth of the dive.

173. The area where Kyle was found in 2 to 2.5 meters of water was a couple of meters back from where we had all been searching, i.e. was a couple of meters closer to the shore.[95]

174. According to the witness the position they were told to search by Mr Toomey was *'where the bubbles were'*, as shown in photo at the bottom of page 7 of exhibit 3(b).[96]

The Camp Owner

Stephen Weatherhead

175. Stephen Weatherhead testified that the Alpine Ashe retreat business was owned by himself, while the retreat property was owned by his wife's family trust.

176. On 7 February 80, year 7 students arrived at the retreat for a two night stay along with 15 teachers and leaders.

177. At 5.30 pm he received a call from the camp manager Steven King and was told that a child was missing in the dam and that emergency services had been contacted.

178. Mr Weatherhead immediately went to the scene:

> *'The dam is spring fed and is and about 8 foot deep. People have swum in this dam for the past 50 years. To my knowledge nothing has ever happened to anyone in the past.'*[97]

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[93] See transcript page 342.

[94] Ibid.

[95] See discussion at transcript 347-48.

[96] See transcript at page 344-47.

[97] See witness statement at exhibit 23 page 1.

179. On arrival, he saw about six leaders in the water searching for the child. A teacher told him that they had done a search and that one child was missing.

180. In oral testimony, Mr Weatherhead stated that he had never sought or required proof that a teacher/leader supervising swimming activity in the retreat dam was suitably qualified with a bronze medallion or equivalent qualification.[98] He further stated that he had never required users to bring safety or rescue equipment to the dam.

181. Mr Weatherhead acknowledged that correspondence with the Australian Camps Association should have disclosed that the dam site was a potential hazard on the property. He further stated that the water was pure mountain water straight out of a virgin forest, and only became dirty when people got in and stirred up the sediment.[99]

182. Mr Weatherhead also stated that he had not been aware of the State School protocol in relation to state schools and recreational swimming, (DEECD), before the visit of the WorkSafe investigator.

183. Following this visit however, he had fenced in the whole of the dam and built up the area as shown in photographs, exhibit 4(c)(1) and (2).

The Investigation

Sergeant Victor Velthius

184. Sergeant Velthuis the police diver, testified about the water temperature in dams generally. He said,

> *'Usually with dams ...it's usually fairly warm on top . And you know it varies ...on the conditions of the whether over a couple of days. Yeah it could be a meter and a half of quite warm water on the top , but on the bottom-or you know after that its usually very, very cold. Dams are probably some of the coldest places you could swim in.'*

185. He estimated that the temperature in the dam was,

> *'Oh look it could be anywhere from around 12 degrees, roughly but – yeah'*[100]

186. But had earlier stated in his statement, (exhibit 7) that,

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[98] See transcript page 693 and Retreat Agreement document at exhibit 16(a).

[99] See transcript page 699.

[100] See transcript page 164.

'I commenced a dive sweep of the area and after several sweeps located (Kyle) approximately 7 meters from the bank (see above picture and bubble location) in approximately 2.5 meters of water. The visibility was zero, temperature at 19.2 degrees with no current on the bottom. He was lying face down on the bottom, with body straight. The dive duration was 6 minutes in total.'

The underlining is mine.

187. He also gave evidence as to his dive to recover Kyle and that the recovery took place in front of the beach and that the 7 meters referred to above, was the measurement taken along the dam floor from the waters edge.

Doctor Kokgeow Teh[101]

188. The statement of Dr Teh, the family GP, tends to establish that Kyle had two minor bouts which may have been asthma related while an infant of two years of age, and that he had had no further relevant history.

Forensic Pathologist Dr Linda Iles[102]

189. Dr Iles conducted an autopsy examination on 19 February 2010. Prior to autopsy, she had been provided with a broad police outline of what was believed to have occurred at the Alpine Ashe retreat dam, at the time of Kyle's submersion. This included the information that while struggling, Kyle had said to one of his friends that he was having an asthma attack.

190. No clear cause of death was identified by Dr Iles at post mortem. Examination showed features suggesting that the body had been immersed in water for a period of time. Dr Iles further reported that there were no convincing pathological changes indicating drowning.

'Whilst this does not preclude this boy's drowning death, or at least a contribution of drowning to his death, events preceding him going underneath the water appear to be of significance.'[103]

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[101] See letter from Dr Teh setting out Kyle's known medical history, which is set in full at footnote 3. This document together with the attached copy of clinical notes is found at (now added) exhibit 26, as referred to in footnote 3.

[102] Dr Isles is a Senior Forensic Pathologist at the Victorian Institute for Forensic Medicine, (VIFM).

[103] See Post Mortem report exhibit 18 at page 10.

191. Dr Iles then went on to examine the possibility that a cardiac event had caused or contributed to death. She noted that there are a number of recognized cardiac symptoms, which may result in cardiac arrhythmias and sudden death, for which there may be no anatomical findings at post mortem.

> *'These include conditions such as Long QT syndrome, Brugada syndrome, idiopathic ventricular fibrillation, and CPVT....Some forms of Long QT syndrome are thought to account for a number of cases of drowning in those who are strong swimmers, and where there are no other precipitants for possible drowning.'*

192. Dr Iles further stated that,

> *'...(she) could not exclude one of these disorders and recommended that Kyle's next of kin undertake a cardiac review by a specialist in cardiac electrophysiological medicine.'*[104]

193. Dr Iles found that there was a limited degree of narrowing of the thoracic aorta consistent with aortic co-arctation, but that there was no enlargement of the heart for his height or weight or radiological changes or changes in the inter-costal arteries macroscopically, which might otherwise suggest physiological compromise following from a partial narrowing of the aorta.

> *'Thus while the possibility that this young man has sustained a cardiac arrhythmia related to increased stress on the heart due to aortic narrowing, resulting in pulmonary oedema and shortness of breath prior to him being immersed, can not be entirely excluded, given the lack of any objective findings to indicate he had...a physiologically significant aortic narrowing in life, I am reluctant to ascribe it as his cause of death.'*[105]

194. Dr Iles also found some bruising around Kyle's neck, chin and collar bone which she considered consistent with the activity of the class mates who had struggled to help him while they were together in water, out of their depth.

195. There were no other drugs or poisons found. There was no suggestion that anaphylaxis was a factor. There were no changes indicative of chronic asthma, which I note is consistent with the history provided by both his mother and GP, Dr Teh.

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[104] Ibid page 11.

[105] Ibid.

196. In oral testimony, Dr Iles further elaborated. She stated that she was satisfied that there had been some relatively sudden event, which had precipitated Kyle becoming immersed and that this was heralded by a shortness of breath.

197. One possible cause of this event was that supported by Professor Harper that Kyle had suffered from ventricular arrhythmia. Another could be a respiratory condition such as asthma, anxiety or panic, all leading to a sudden shortness of breath.

198. Dr Iles further referred to pulmonary oedema but could not be specific as to whether the oedema in the lungs came from inhalation, or from an acutely failing heart.

199. When you inhale fresh water, the water actually leaves your lungs and enters your circulation and death may be precipitated by acute heart failure because you rapidly expand your blood volume, but also your cells inside your blood because of a change in electrolytes, and that can precipitate a cardiac arrhythmia,

> *'...so its not as straight forward as you have water in your lungs therefore you can't take in oxygen.'*[106]

200. Dr Iles then went on to discuss the concept of 'dry drowning', which can occur when someone is observed to go into the water, often quite cold water and who are later found not to have particularly heavy lungs or other classic signs of drowning. A further aspect of dry drowning can include the intake of cold water very suddenly across the back of your throat, which causes vagal inhibition that can precipitate a cardiac event.

> *'...so that's why I have not put drowning as the cause of death and I have put all these caveats on there because unfortunately we just do not have a gold standard to say that someone drowned or not.'*[107]

The underlining is mine.

201. Dr Iles further stated that the testing undertaken on Kyle's mother and sister to seek to understand if there was any genetic cardiac defect (Long QT syndrome), which contributed to death, did not disclose any genetic abnormalities, but that did not provide a wholly definitive answer, with additional testing to continue in Sydney. There was at the time of her

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[106] Transcript page 578.

[107] See transcript page 579.

testimony no evidence of an underlying genetic pool, which may have predisposed Kyle to the development of an arrhythmia.[108]

202. Dr Iles was additionally asked whether, if Kyle did have Long QT syndrome, it was that syndrome or drowning which caused death. In response she stated that If Kyle had arrhythmia associated with Long QT then his ability to survive in the water would be compromised and going under and inhaling water would have led to death.

203. Dr Iles was then further examined on the reasons for the underlying cause leading to submersion, remaining undetermined.

204. The fact that Kyle was seen to be swimming happily and playing normally, with something acute then happening, causing a loss of control, left a number of possibilities open. Loss of bodily heat leading to hypothermia was a possibility but she would have expected him to complain that he was cold or tired, rather than he was having an asthma attack.

205. (Also, the fact that he was in cold water was likely to be very neuroprotective, *'as it slows everything down.'* This may have enabled him to survive for a longer time with a successful cardio pulmonary resuscitation, taking place up to five minutes after submersion, a possibility in this case.)

206. She further stated that if in fact Kyle had gone into ventricular fibrillation as suggested By Professor Harper, that CPR would not then be possible, with a shock, i.e. a defibrillator needed to restore heart function.[109]

207. Her further testimony was that had Kyle been taken out while he was in ventricular tachycardia, that he may have spontaneously reverted to a normal cardiac rhythm, or required CPR to assist that process.

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[108] See transcript page 584, with that testing only able to establish the positive existence of Long QT Syndrome, but not able to exclude the possibility that it exists, i.e. not withstanding a negative result.

I am informed that at the time of writing, the result of this further testing of samples received from Kyle's mother and sister as part of the 'Tragedy Study', was that nothing significant was found.

I have also now sought additional information on the state of the genetic testing undertaken in respect of Kyle's family through VIFM, (Dr Iles) and have been informed that similar testing has now been conducted in respect of Kyle's father, 'who was suffering from a broken leg at the time.'

'Nothing clinically was detected at that time; however assessment was limited by his inability to exercise. No further testing is planned'.

See Dr Iles email to the Coroner dated 12/09/2014, which will become exhibit 27, and is available to interested parties on request.

[109] See transcript page 587-58.

208. In conclusion, while Dr Iles considered that ventricular fibulation might have been a factor, that it was a speculation and only one of several possibilities, none of which she felt able to confirm following her autopsy examination.

Professor Richard Harper[110]

209. In Professor Harper's view anyone of four conditions referred to by Dr Iles could have been a precipitant to Kyle's death.

210. All four of these conditions, long QT syndrome (LQTS), Brugada syndrome, idiopathic ventricular fibrillation and catecholaminergic polymorphous ventricular tachycardia, (CPVT), - belong to a class of disorders known as channelopathies.

211. Disorders of this kind can predispose to lethal or potentially lethal cardiac arrhythmias such as ventricular tachycardia or ventricular fibrillation. In patients with these disorders arrhythmias may be precipitated by factors such as exertion and emotional distress or a combination of stressors. The most common ventricular arrhythmia associated with the channelopathies is a form of ventricular tachycardia known as Torsade-de-pointes.

212. An episode of Torsade-de-pointes often results in syncope but fortunately on most occasions the arrhythmia reverts spontaneously back to normal rhythm and the individual recovers.

213. In some circumstances however Torsade-de-pointes can degenerate into ventricular fibrillation which is a uniformly fatal arrhythmia unless corrected within three to four minutes. Individuals with channelopathy disorders may present with recurrent episodes of syncope but unfortunately in some cases the first clinical manifestation can be sudden death,

> *'...as I believe was the situation in this case. I think it most likely that Kyle Vassil did suffer from a cardiac channelopathy, which resulted in him having a lethal cardiac arrhythmia whilst swimming in the dam and subsequently resulted in his immersion and death.'*[111]

214. Of the four conditions listed in Dr Iles report, the two most likely causes according to Professor Harper were the LOQTS and CPVT syndromes. Indeed so strong is the known association that the Cardiac Society of Australia and New Zealand guidelines state that,

> *'...syncope associated with swimming is due to LQTS until proven otherwise... CPVT has also been associated with swimming related death...Both LQTS and*

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[110] Professor Harper is an eminent cardiologist and Emeritus Professor in Cardiology at Monash Medical Centre.

[111] See Professor Harper's statement at exhibit 19 page 2 and 3.

CPVT are genetically determined conditions and both generally have an autosomal dominant mode of inheritance. Assuming that Kyle Vassil did suffer from either LQTS or CPVT is likely to have passed the abnormal gene onto a child...The fact that neither parent has had any clinical evidence of these syndromes does not necessarily mean that they do not possess the abnormal gene because typically channelopathies have a variable degree of clinical expression.. Genetic testing is generally a more reliable way of making the diagnosis but again is not conclusive.'[112]

215. Professor Harper was further questioned concerning the additional hypothesis offered by Dr Iles. Professor Harper offered that the co-arction referred to by Dr Iles can result in hypertension and left ventricular hypertrophy.

'As I understand there was no clinical history of hypertension in the deceased but hypertension can sometimes be overlooked... (Dr Iles findings at autopsy suggest that co-arctation was relatively mild. As such, she believed it unlikely that this condition caused the boy's death, with which Professor Harper agreed)...

... the presence of left ventricular hypertrophy (as found by Dr Iles) could have made it more likely that ventricular tachycardia, which is not necessarily lethal, degenerated into a fatal ventricular fibrillation.'[113]

216. Professor Harper was asked a later question about the significance of Kyle's attempts to hold on to other students. He replied that,

'When (Kyle) was clutching the other children (Nick and Josh), he couldn't have been in ventricular fibrillation then because in ventricular fibrillation you loose complete consciousness.'

Court: *'So do you believe he was suffering from tachycardia?*

I do, yes.'

Assistant:

'Well the evidence is that he was under water and he was pulling boys down while under the water...if a person is completely submerged under water and they're

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[112] Ibid page 3 and 4.

[113] See transcript page 526.

experiencing ventricular tachycardia, not fibrillation, would that person be attempting to breathe?

That person would yes if they were under water they would probably be attempting to breathe but... in that situation they could easily loose consciousness. Hard to speculate how much breathing would occur and again, I don't know how much water was in the lungs.

In that hypothetical situation would you expect that person to take water into the lungs ?

Yes.

...you said there was evidence of oedema in the lungs. And you say oedema is a fluid?

Yes

Is it possible that the oedema could have been caused by water and not fluid from the body?

Again, I don't think I have the expertise.'[114]

Aquinas College Headmaster, Mr Tony O'Byrne[115]

217. Aquinas College Headmaster Mr O'Byrne commenced his statement by reflecting upon the Schools deep sorrow for the death of Kyle.

218. Mr O'Byrne informed that the School had used the Alpine Ashe retreat for year 7 orientation camps since 2003. From that time the school was to notify the then manager/owner Mr Weatherhead, when the dam was to be in use so that his son who had life saving qualifications or experience could attend and provide support. Over time and with his son's departure from that role, the College provided,

'relevant supervisors when swimming was undertaken.'[116]

219. Mr O'Byrne further informed that Year 7 swimming assessments had not been undertaken, because of the timing of the camp at the beginning of the year.

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[114] See transcript 561-62.

[115] Aquinas College is a Catholic co-educational secondary college located in Ringwood Victoria, which currently has approximately 1650 students enrolled across years 7 to 12.

[116] See exhibit 20 at page 1.

220. The possibility of swimming while at the camp, was raised with parents at an information evening but no information was collected in respect of each child's swimming capacity, or were parental permissions to swim, sought. Later such permissions were collected in respect camps undertaken by year 8 and 9 students.

221. Mr O'Byrne further testified as to his actions upon receipt of the news concerning Kyle, and how with his wife, he then visited Mrs Vassil's family home. The group including Kacy, then determined to drive to Alpine Ashe retreat, but en route were informed of the recovery of Kyle's body, following which they returned to Mrs Vassil's home.

222. After the circumstances of Kyle's death were established, Aquinas recognised the need to review its policies specifically,

> *'those relating to risk management and recreational swimming. This was confirmed when Worksafe undertook its investigation and the issuing of various improvement notices.'*[117]

223. Prior to Kyle's death the College was aware of the Victorian Department of Education and Training Guidelines and had a copy of the circulars referred to in those guidelines.

224. Mr O'Byrne was however not aware of the updated Department of Education and Early Childhood Development Guidelines, the (DEECD) safety guidelines, for Education Outdoors.[118]

225. Since being referred to the DEECD guidelines Aquinas has implemented new policies to ensure compliance with the DEECD guidelines as well as instigating an,

> *'extensive risk management policy including:*
>
> *Aquinas College Recreational Swimming Policy attached at AJB 2;*
>
> *Aquinas College Water Activities Safety Policy*
>
> *attached at AJB 3 and*
>
> *Aquinas College Risk Management Briefing Policy*
>
> *attached at AJB 4:'*[119]

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[117] See statement of Mr O'Byrne at exhibit 20 page 3.

[118] See exhibit 20 and attachments

[119] See ibid.

226. Further, according to Mr O'Byrne detailed assessments are now undertaken prior to student camps in respect of all activities to be undertaken by the students. Formal risk assessment documentation is then provided to the teacher in charge and professional development activities focus on the completing of risk assessments have been provided to ensure staff, are familiar with identifying risk.[120]

227. Additionally where the camp or school activity involves swimming, students are assessed as to whether they have the necessary swimming skills to participate in that activity and parents are also consulted and their permissions sought. In cases where the activity involves an aquatic activity like for example kayaking or tubing, students are required to have met the requirements defined in the DEECD guidelines for participating in an aquatic activity for a type 2 venue. Under these guidelines a type 2 venue is defined as,

> *'deep water and/or flowing water at non-surf beaches, lakes and dams. The water in type 2 venues is clear. Water turbidity, temperature and submerged objects should also be assessed.'*

228. A type 3 venue includes,

> *'all beaches with direct access to ocean waters, any beach exposed to ocean swell and any beach or lake that is exposed to currents strong winds or large waives. Type 3 venues also includes type 1 and 2 venues where the water is not clear.'*[121]

229. The underlining is mine.

230. It was not in dispute that the dam under examination was a type 3 venue.

231. It is also the case that the school now maintains an electronic register recording each students present swimming level, and whether that student has passed the assessment for swimming at a type 2 venue.

232. Life saving equipment purchased by the school is also taken to aquatic events. Currently the College owns one throw rope and three safety buoys plus a number of whistles and vests. Further the School now complies with DEECD guidelines concerning staff safety

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[120] See attachment AJB 5 at exhibit 20.

[121] See brief page 363.

qualifications held and training undertaken, which is supported by an electronic College staff training and qualification register.[122]

Finding

The Scene

233. I accept as both truthful and reliable the evidence given by the students who testified before me in this matter.

234. Specifically, I find that 4 to 5 minutes after commencing his swim Kyle got into difficulty at or near the front of the beach area, at a point relatively close to the waters edge. Soon after Josh Anderson became aware that Kyle was in trouble, when he saw Nick Condelo holding Kyle at or near the water surface level, under his arms, while he Kyle, was struggling for breath.

235. I am also satisfied that Josh then attempted to help support Kyle and that immediately thereafter, that he saw Kyle pulling Nick from a position where Nicks head was above the water surface level, to a position where his head could not be seen, i.e. below the waters surface. A few seconds later Nick emerged, head first, having freed himself from Kyle's grip.

236. Again, I find that Kyle then pulled Josh down below the water surface level, which action ultimately forced Josh to let go of Kyle, whom he held by the hair.

237. I am satisfied that Josh too then emerged from the water surface, in a headfirst position, while struggling for breath. Soon after he began to call for help, but no one answered.

238. I note here (as I did during the hearing) that both Nick and Josh were pulled below the water surface by the actions of a by then desperate Kyle, and were in very cold and opaque water, and out of their depth. Both boys were able to free themselves and return to the surface. In these circumstances, it is clear beyond any doubt that neither boy had any other choice open to him.

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[122] See attachment AJB 9 ibid. It is apparent from the attachment that the current register appears to include a majority of all teaching staff, and that it properly extends to former students and possibly others, who are performing a camp leader like role. I am also pleased to observe that those listed in this category include several camp leaders who assisted on the occasion under examination.

239. I further find that all of these actions, and specifically the manner of the movement of the participant's heads, in and out of the water, were innately suspicious, this given the circumstances and the unfamiliar environment in which they occurred.

240. It was also the case that these movements were accompanied by struggle and splashing, which was later followed by the physical and emotional distress of several of the students, near the dam entrance. This distress was specifically evident from the appearance and behaviours of Josh Anderson who persisted with his attempt to draw attention to Kyle's plight. Isobel Armstrong, Tarryn O'Leary and Jay Vandenhout joined him in this effort. [123]

241. I commend this group, (along with Nick Cantelo), for their selfless and passionate endeavours undertaken as they were, to protect their missing classmate.

242. I further find that Kyle' body was found approximately seven meters from the shore, but note here that the preponderance of the eye witness evidence suggests that he had become submerged at a point when he was significantly closer to shore. The (variable) evidence on this matter suggests that Kyle was last seen as little as one to two meters, (and as much as four to five meters), away from the shore line. These estimates and Sgt Velthuis evidence concerning his later finding of Kyle, (which I accept), tend to establish that for uncertain reason Kyle moved or was caused to move into deeper water, after he became submerged.

243. I further find that the two duty teachers and the four camp assistants, whose primary duty was to maintain observation over the approximately 20 students swimming at that time, were all one to two meters above the shore line, at the relevant time.

244. I am further satisfied that this authority group were standing next to each other, almost in a line on the beach above the waters edge, and that their views were generally above the line of vision at which they may have been obstructed by students standing in the area below.

245. I accept from the evidence of teachers Leigh Toomey and Eva Stewart, that neither teacher saw or comprehended what was happening, in the water in front of them. I also accept that the four camp leaders did not see, or comprehend these events.

246. Having regard to all of the evidence, and to Counsels submissions, I find that I cannot exclude the possibility that the collective failure to understand what was going on below

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[123] Both Nick and Josh were pulled down into the water from below, and their heads entered the water in this manner, as distinct from a duck diving or from being dunked from a force applied downwards to the head. Initially Kyle had also disappeared from sight, in a similar fashion. See discussion of these issues by the Court with Eva Stewart at transcript page 183-84 and Leigh Toomey from transcript page 446.

them occurred in part because Eva Stewart, together with members of the camp leader group, were distracted by others who were standing and talking in the area. This occurred at least in part because this group were not directed to isolate themselves from the non-swimming students, or to separate from and not to converse with each other.

247. Further and despite evidence to the contrary, I do not exclude the possibility that some were obstructed by persons standing between their own position, and the area of dam in which Kyle, Nick and Josh, were swimming.

248. More significantly, I find however, that those like Leigh Toomey and Eva Stewart, who acknowledge witnessing struggling in the water, (Leigh Toomey), and the yelling out from the water by an obviously distressed Josh Anderson, (Eva Stewart and Leigh Toomey), simply did not understand what they were seeing and the lethal nature of the threat, which existed at that time.

249. Put in other words, what most of the group were watching, was misinterpreted because they were untrained in issues to do with water safety, and as a result were not familiar with what to look out for.[124]

250. It was for this reason that when the suspicious movements described above and the immediate reaction of Kyle's classmates to what they had just seen in the water, all resulted in no significant response from the authority group, that there was a heightening in the level of frustration and anguish felt by the students.

251. I further find that it was because of this lack of a (time critical) response by members of the authority group, that Tarryn O'Leary spoke with Leigh Toomey in the aggressive manner, which is set out above.[125]

252. I further find that these events occurred over a period of between 2 to 3 minutes, following the point when Kyle became submerged.

253. I also find that when Leigh Toomey came finally to accept the seriousness of the situation, that the response by both himself and Eva Stewart was sub-optimal.

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[124] As a result, they were unable to distinguish what was actually taking place, from what they thought was a scene where some 20 children were simply playing excitedly, but otherwise normally, in a cold country dam.

[125] Both Leigh Toomey and Eva Stewart testified that they had no recollection of hearing students using bad language during the period leading up to the acceptance that Kyle was missing and believed to be in danger. See transcript at page 435 (Leigh Toomey) and page 194 (Eva Stewart).

While I am satisfied that such language was in fact used, I do not discount the possibility that its use was overlooked and later forgotten, by two teachers who had far more important matters to focus on at that time.

254. In this regard the decision of Eva Stewart to immediately depart from the scene and to conduct a search away from the dam area, this without consultation with Leigh Toomey, was unhelpful to their objective to affect a rescue of Kyle.[126]

255. Further Leigh Toomey's own decision to later leave the scene, to assist in the management of the larger student body who had moved back towards the camp centre some 150 meters above the dam, was similarly unhelpful.[127]

256. It was in these circumstances then that the major bulk of the rescue effort was left in the hands of youthful camp leaders Paul Jess, Mathew Allard and Patrick Mills, this without meaningful input from senior teaching staff and without the benefit of their ongoing management.

Investigation into cause

257. I have reviewed the evidence of Mrs Pacita Vessel, together with that of Forensic Pathologist Dr Iles, expert witness Professor Harper, Kyle's family doctor, Dr Teh and the evidence in respect of cardiologist examinations conducted on Mrs Vassil and Kyle's surviving sibling Kacy Vassil, at the Royal Melbourne Hospital in late 2010.[128] I have further considered the circumstances at the dam site and the evidence of those who were witnesses to Kyle's behaviour at this time, as well as the evidence of Sergeant Velthius, who supervised the recovery.

258. I have further reviewed the opinion evidence of Professor Harper, and the material underpinning the conclusions drawn by both Professor Harper and the examining pathologist, Dr Iles. I have additionally considered the parties various submissions.

259. As a result I find that there is insufficient evidence to allow me to determine the exact factor or factors and the physiological process, which caused, or contributed to, Kyle's submersion.

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[126] The fact that while at the dam Eva Stewart determined to keep an eye out for one particularly vulnerable student, should not have impacted upon the manner in which she provided supervision to other swimmers in the dam, or upon how she reacted to student reports concerning the immediate threat to Kyle's life.

[127] See discussion below in comments, concerning the failure to manage the search. See also comments concerning the manner in which the search commenced and the failure of senior staff to properly debrief students who were witnesses to Kyle's disappearance.

See also discussion of these matters, with Leigh Toomey at transcript page 421-23, Eva Stewart at transcript page 202, Paul Jess at transcript 284-5 and with Mathew Allard from transcript page 342.

[128] See also footnote 108 above concerning the recent testing of Kyle's father, in respect of the possibility that QT syndrome was a contributing factor in Kyle's death.

260. Rather the events, which preceded submersion, can only be set out as possibilities. They include anxiety, panic, asthma, hypothermia and vagal inhibition leading to a cardiac event, including ventricular tachycardia, which may or may not have led to a ventricular fibrillation, after submersion.

261. In this regard, I further find that the evidence supporting ventricular fibrillation as the mechanism leading to loss of function and to submersion, is itself inconsistent with the fact that the evidence establishes that Kyle continued to struggle while submerged.

262. It is also relevant that nothing was found at autopsy, or in the later testing of surviving family members, which suggested that Kyle had suffered from a cardiac event.

263. As Professor Harper and Dr Iles both suggested however, (and I accept), the possibility remains that Kyle became arrhythmic and fell below the surface, and that he then commenced to struggle for breath, and ultimately suffered from the onset of a ventricular fibrillation.

264. I further note that according to Dr Iles, Kyle's reactions as recounted by Josh Anderson, did not suggest hyperthermia.

265. I further observe that the histology report of the respiratory system is consistent with an early history of asthma, with the finding of,

> *'mild mucosal chronic inflammatory cell in filtration'*,

but does not reflect the existence of a chronic asthma.

266. I also note that the histology examination found evidence of patchy areas of,

> *'debris collection within the airways and alveolar air spaces'*,

which is consistent with the intake of water while struggling for breath, but again does amount to a proof of that fact.[129]

267. Having so considered the matter and having particular regard to the sequence of events, I find myself satisfied that Kyle had been swimming at the Mountain Ashe retreat dam for approximately 4 to 5 minutes when he found himself in severe difficulty, and that this difficulty contributed to, or caused him to later become submerged.

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[129] See exhibit 18 at page 9.

268. I further observe that his behaviour at the time as described by his friends, was consistent with anxiety and panic, which may have arisen because of his belief that he was suffering from an asthma attack, and while he struggled to breathe.

269. Thereafter Kyle became submerged and the attempted grappling of Nick and then Josh from below the waters surface, took place with Kyle unable to breach the surface during this time.

270. I conclude then that the uncertain evidentiary position concerning the reason(s) for his panic are such that I am unable to make specific findings as to precisely what event(s) gave rise to Kyle's panic and submersion, and to his later demise.

271. However such a finding does not exclude water inhalation as a factor that contributed to his death, and having reviewed that matter again and indeed having directed myself as to the law concerning circumstantial evidence, I find that following an event of uncertain character, Kyle became panicked and then submerged, where he unintentionally inhaled water while struggling for breath, and that this was a factor, which also contributed to his death.

272. It follows that the cause of Kyle Vassil's death was,

From: 1(a) UNASCERTAINED IN THE SETTING OF IMMERSION

2 THE INVOLUNTARY INHALATION OF WATER AFTER IMMERSION

COMMENTS

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

273. It is not in dispute that the dam water was extremely dirty and cold and that when the rescue commenced, that visibility under the water was negligible. I find, and it is self evident that these conditions created special difficulties for those called upon to participate in the rescue.

274. The evidence further establishes that no consideration was given to the crisis management issue, by either Aquinas school personnel or the Alpine Ashe retreat management, before the incident under examination.

275. Further, put at its highest, the evidence establishes that Leigh Toomey and Eva Stewart, (the most senior teacher present at the dam), had received little instruction in regard to water safety and the supervision of a swimming activity at the dam, or on how to properly manage

an emergency response.[130] It is also relevant that there had been no substantive analysis undertaken by the school concerning swimming at this site, and that little or no current advice about the safe use of the dam had been passed on to the year 7 homeroom teachers as a group.[131]

276. Leigh Toomey did not provide instruction to Eva Stewart or to the camp leaders then present, as to how they should conduct their supervision, and as to what sort of student behaviour they should be alert too. I find that this group, including Mr Toomey himself, were broadly ignorant of this matter.

277. In addition, Leigh Toomey and the others later engaged in the rescue, did not know what to expect on water entry, and how to best achieve their own submersions, or how deep they may have to dive to locate Kyle and bring him up.

278. Teaching staff in particular did not sufficiently co-ordinate the response or indeed understand whether the dam and its contents were likely to be influenced, by for example, a creek related water movement, the topography of the dam floor or the impact of the movement of the rescue team, while engaged in their search.

279. Again, the precision of the rescue attempt was further limited by the failure to identify the students who had relevant information to offer about where it was that Kyle was last seen, and by the failure to debrief those students.[132] I note here that the evidence of Paul Jess, Mathew Allard and Tarryn O'Leary referred to above, points to the likelihood that the initial search unwittingly focused on an area, which was in fact behind where Kyle had last been seen.

280. Further, the rescue did not include an attempt to manage the dive in the sense of an ongoing debriefing concerning the progress of the search and where each dive should occur. I am satisfied that such a course would have helped avoid duplication of effort, which was increasingly important as time was being eaten up, and while the search was becoming more physically and psychologically demanding.

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[130] As a result, it seems that at least some staff remained in teacher mode, rather than student safety mode, and emphasised elimination of the possibility that Josh Anderson and others were engaging in some sort of prank, rather than focusing on the much more time critical fact, that Josh Anderson was attempting to communicate.

[131]. See discussion of these matters by Counsel for the Vassil family with Eva Stewart, at transcript pages 185-189.

[132] See also Leigh Toomey's observations about the lack of effective communication concerning where Kyle was last seen, at transcript pages 425 and at pages 431-33.

281. Again the management of the task did not include an ongoing review to establish whether each diver was able to continue to dive to the floor of the dam, this to achieve an understanding of whether their physical effort(s) were being employed in the most efficient manner, and a consideration of any viable alternatives.

282. It is also relevant that the evidence did not establish that either Leigh Toomey or Eva Stewart, or indeed any one else was aware that camp leader Megan Lane, who left the dam side to look for the camp manager and who later searched the cabins away from the scene, was herself trained and retained a current CPR certification. This knowledge, had it been known, may have been expected to result in senior staff directing her to remain at the scene to assist with any resuscitation attempt, in anticipation of Kyle's recovery. [133]

283. Over and above these factors, the remaining camp leaders Paul Jess, Mat Allard and Patrick Mills, (together with Leigh Toomey for a shorter period before them), continued a very difficult task in deteriorating conditions, and in very cold water. I commend them all for their effort and their commitment to this task.

284. As above it is also relevant however that with the departure of Leigh Toomey, the remaining camp leaders were left with insufficient direction as to where and how to continue the search, and as before, did not have access to flotation devices, protective clothing, or other diving equipment. [134]

285. I further note here my view that the absence of flotation devices, and in particular of swimming flippers and facemasks plus a lifeline, was significant. In addition, that this hindered an effective sweep out from at or near the shallows along the floor of the dam, to the adjacent area where Kyle's body was later found by police, (after a short search), some seven meters from the shore.

286. I further find that there was an ongoing failure by members of teaching staff to take charge and provide specific direction to each other and to the camp leaders. This arose perhaps because of a school culture, which emphasised a collegiate approach to decision making, or instead because the authority of Leigh Toomey to issue direction to senior staff teacher Eva

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[133] See transcript pages 272 and 322. (Paul Jess had received some earlier training in CPR. The extent of that training is uncertain on the evidence but it is clear that he did not have valid CPR certification at the time under examination).

[134] These three young men were in the water for between 20 and 25 minutes, diving head immersed, into water later estimated by the police diver to be possibly as cold as 12 degrees. Moreover they faced this extremely difficult task with little direction, no equipment and in conditions, which I find are likely to have negatively impacted their own ability to function effectively.

Stewart, was never specifically raised or resolved by either of the teachers, or by a more senior member of staff.[135]

287. Finally, and central to all of this was the failure of the Aquinas School to undertake (or to outsource), an appropriate assessment of the risk involved in the voluntary swimming activity at the dam.[136] Further error arose concerning the Aquinas failure to provide instruction to its employees as to what to look out for and how to best position themselves to supervise that activity, and further as to how to manage an emergency response in connection with that activity.[137]

288. I note here that effectively there were no guidelines in place concerning outdoor school swimming activity at Aquinas at the time of this tragedy.

289. I am further satisfied that the failure to earlier undertake an appropriately comprehensive risk management assessment, concerning the use of the Alpine Ashe Retreat dam and to adopt an appropriate response to such assessment, proved critical.

290. In these circumstances, it was at the very least incumbent upon the school to institute on its own initiative, inquiries concerning each individuals swimming capacity, before permitting

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[135]See statement of Leigh Toomey at Exhibit 15(b) pages 1-2.

I note that the homeroom teachers were left to take charge of the group at respective year 7 camps and that Leigh Toomey was present at the camp on this occasion, in his capacity as a homeroom teacher. The evidence suggests that no specific direction was provided to teachers attending this camp, as to who was to take charge of safety, or discipline related issues, or in the case of an emergency.

[136] The risk assessment so called, undertaken by Leigh Toomey was at best superficial. See exhibit 15(a). By way of contrast see the Pre Camp Risk Assessment suggested by the DEECD protocol at page 328 of the Brief. (which suggests a consideration of the following matters),

a) What specific risks does this environment present?

b) What supervision issues does this environment present?

c) What emergency response requirements do you have to put in place for this particular environment?

d) What if any equipment is required to enable the organiser to adequately respond to an emergency in the environment?

The responsibility for conducting a risk assessment should be given to persons who are qualified to undertake such a task. The evidence did not establish that Leigh Toomey or Stephen McGrath before him, had ever received instruction in risk assessment or were otherwise qualified to assess risk, and so far as I have been able to establish Leigh Toomey never asserted to his employer that he was so qualified.

See transcript page 453 where Leigh Toomey discusses the standard of the risk assessment undertaken before the camp.

The owner of Alpine Ash allowed use of the dam on condition that it was a supervised activity, organised by Aquinas staff. The evidence establishes that Mr Weatherhead never at any point sought to establish whether Aquinas staff possessed the expertise needed to manage this activity (transcript page 693), or that he ever personally addressed the issue of how to undertake a dam floor rescue.

[137] See discussion at transcript page 453 where Leigh Toomey described the handover process when he became camp co-ordinator.

that individual to swim in the prevailing cold and dirty water conditions, then known to the school. We now know that this did not occur.[138]

291. I also note the advice of Mr Andronaco, a senior risk consultant from Life Saving Victoria, that in circumstances where a child could not be seen underwater, that he would not have allowed children to swim in the dam, this irrespective of how well experienced they were.[139]

292. The further concession by Leigh Toomey, that had the DEECD guidelines been in place, the children would not have been permitted to swim in this "type 3" venue (because they had not been tested for swimming competence), is also relevant.[140]

293. I further hold that the absence of instruction and support to Aquinas employees concerning how to conduct risk assessment, as well as to the need for on-going risk management and as to the taking of appropriate safety precautions in respect of both swimmer supervision, and emergency management, were all significant omissions, which adversely impacted, (separately), both upon Kyle's submersion, and the later attempts made to effect his rescue.[141]

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[138] I have no reason to suppose that if such a process had been completed, it would have resulted in the exclusion of Kyle from this activity.

[139] See transcript at page 624

[140] See evidence of Leigh Toomey at pages 469- 470.

[141] I consider that at some point prior to the commencement of swimming activity the school should have undertaken a risk assessment by a properly trained teacher or other, and then followed the direction there given, (as may be revised from time to time).

Leigh Toomey agreed that no training was provided to Camp leaders either by him or the school concerning the supervision of activities or of the swimming activity. And it was not in dispute that the provision of appropriately qualified staff and the support of those staff with training and equipment were important aspects of the successful management of safety at this site.

(I also note that the DEEECD protocol states that a School Council should as part of an approved process, 'ensure that staff members attending have the competence to provide necessary supervision of students through out the program'. See Brief at page 323).

I am also satisfied that at least some of the teacher/camp leader group should have had lifesaving qualifications and been qualified in CPR, with this number, ideally 2 to 3 persons, instructed as to their role in the event of an emergency and prepared and ready to commence and rotate delivery of resuscitation, as circumstances required.

Again all of the camp leaders/teachers etc should also have been specifically instructed in respect of the manner of their supervision of year 7 students on this occasion, and have been comfortable in the use of (provided) safety equipment, which might reasonably have included diving aids such as masks, flippers and protective swimwear.

Similarly, all staff should have been instructed in respect of the possible need for an emergency response, and have prepared for their work task by dressing appropriately and arriving at the dam side in readiness to enter.

The provision of appropriate resuscitation equipment and appropriate instruction in its use required to support such a response, is again referred to at Recommendation 2 below.

294. I also find that had the emergency rescue effort been undertaken with earlier appropriate school sponsored direction including safety supports in place, that there is no reason to believe that Kyle would not have been bought from the dam in a timely way.

295. Had this occurred, again with those same directions and supports concerning resuscitation in place, there was a strong possibility that if collapse then took place, or if it had already taken place, that it could have been reversed.[142]

296. Finally, it is clear that Kyle's loss has had a major emotional impact, of course upon his immediate family, but also upon the whole of the Aquinas School community and particularly upon those involved in the events, under examination.

297. All of the evidence suggests that Kyle was a happy and carefree youngster, who had made an excellent impression in the short time he had been at the school, that he was well liked by his peers and that he enjoyed a life, which was full of promise.

298. It is also apparent that the School, (with the assistance of Victorian Workcover Authority), has recognised that failings in its own management systems may have contributed to his loss and that under the direction of the Schools Principal, have aggressively reviewed and now improved those systems. I note with approval that all of the policies referred to above are now in use at Aquinas and appear to be well matched to the needs of both students, and their supervisors.

299. I further note that the improvements introduced, have been based upon the State School DEECD guidelines discussed above, and that in some areas those guidelines have been further enhanced by decisions taken at Aquinas.

300. It is also the case that the Catholic School Principals Association has endorsed the DEECD guidelines, perhaps recognising as Principal O'Byrne did, the significant systems improvement offered by the guidelines, at a reasonable cost.

RECOMMENDATIONS

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

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[142] If Kyle had indeed collapsed because of a ventricular fibrillation, or if he had not been bought from the dam before the onset of a ventricular fibrillation, (following an earlier cardiac event), then a defibrillator would have been needed to aid in his resuscitation. See the evidence of Dr Iles and Professor Harper referred to above, and Recommendations 4 and 6 below.

301. During the course of this inquest, we have reviewed the DEECD Safety Guidelines for Education Out Doors.[143] These guidelines have provided me with an apparently first rate measure to help assess what occurred at the Mountain Ash retreat, and to better understand how the incident might have played out, had these or similar guidelines been in place, and in practise, at the relevant time.

302. The fact that these same guidelines, are now under review themselves, further speaks to the professionalism of those responsible for these practices, and their ongoing implementation.

303. In the result, I am pleased to be able to commend these guidelines to the National Catholic Education Commission, and to other interested parties.

- 1) I recommend to the National Catholic Education Commission, that if such has not already occurred, that all Victorian Catholic Schools voluntarily adopt the DEECD protocol, concerning the management of safety issues relating to all school student swimming and related water based sporting activity.[144]
- 2) I further recommend that the responsible Minister and the Victorian Regulation and Qualifications Authority (VRQA), give consideration to promoting the notion of a voluntary adoption of the DEECD protocols, by all Victorian Schools, this by the inclusion of same within the VRQA Guide, and in all other related VRQA materials.

This initiative is recommended to seek to ensure that all presently non-compliant Victorian non-government Schools, push towards achieving full compliance with the DEECD protocol in respect of swimming and other water based activity, as soon as is reasonably possible.

- 3) I recommend that at or near this time, (that is when full compliance is in reach for all non government schools) that the VRQA consider making compliance a condition of registration, in respect of all schools in the State.
- 4) I further recommend that the Aquinas School (and other similarly interested parties), purchase a defibrillator or defibrillators, and obtain instruction in their use, for deployment at all student camps, and at such other sporting activities as the School's medical officer may advise.

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[143] The guidelines are set out in full from Brief page 317-368.

[144] The full DEECD Safety Guidelines for Safety Outdoors guidelines are set out from Brief page 317-368.

- 5) Having regard to the to the availability of first rate and cost effective safety equipment in support of swimming, I further recommend that all Catholic Schools purchase and maintain appropriate levels of safety equipment as advised by Lifesaving Victoria, this through periodic requests for risk management advice emanating from the Catholic School Principals Association, to Lifesaving Victoria.
- 6) I similarly recommend that all active "organisation" members of the Australian Camps Association, also purchase a defibrillator, and obtain instruction in its use.

Conclusion

Finally, I wish to thank the witnesses, who assisted by giving evidence to this Inquest, together with those who made written submissions. I also wish to thank Counsel for their assistance, together with my Assistant, Sergeant Nadine Harrison, and the Informant, Sergeant John Elks. I also thank the Victorian Workcover Authority for what was a thorough investigation of the events under examination.

I also wish to thank Mrs Vassil and her daughter Kacy, for their contribution and ongoing attendance during the course of the hearing. I appreciate that this must have been a deeply upsetting experience for them both.

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

The family of Kyle Vassil

The Minister for Education

The Secretary of the Department of Education and Childhood Development

The Chief Executive of the Catholic Education Commission of Victoria

The Chief Executive of the Principals of Catholic Schools Association

The Chief Executive of the National Catholic Education Commission

The Chief Executive of the Australian Camps Association, and through his good offices for the Association's distribution to all members

The Chief Executive of the Victorian Workcover Authority.

The Principal Aquinas School, Ringwood

Mr Steven Weatherhead, Alpine Ashe Retreat Toolangi, Victoria

Mr Adam Pine

Ms Eva Stewart

Mr Leigh Toomey

Mr Paul Jess

Mr Mathew Allard

Mr Patrick Mills

Mr Josh Anderson

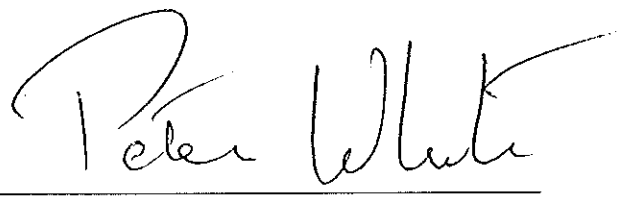
Mr Nick Cantelo

Mr Jay Vandenhout

Ms Tarryn O'Leary

Ms Isobelle Armstrong

Signature:



PETER WHITE

CORONER

Date: October 27, 2014.