IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 6418**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	[redacted]
Date of birth:	[redacted]
Date of death:	**21 DECEMBER 2017**
Cause of death:	**DROWNING**
Place of death:	**SKENES CREEK BEACH** **GREAT OCEAN ROAD** **SKENES CREEK VICTORIA 3233**

HIS HONOUR:

BACKGROUND

1. [redacted] was born on [redacted]. He was 41 years old at the time of his death. [redacted] lived with his wife [redacted] and their two children in Sydenham and he was employed as a credit manager.

2. In December 2017, [redacted] and his family were holidaying in Skenes Creek. They had family visiting from India and were staying at a holiday house.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. [redacted] death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and was both unexpected and unnatural.[1]

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial[2]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and

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[1] Section 4, definition of 'Reportable death', *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*
[3] *Keown v Khan* (1999) 1 VR 69.

by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

9. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

   (b) 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

   (c) 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 powers are the vehicles by which the prevention role may be advanced.

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. [redacted] was visually identified by his brother in law [redacted] on 21 December 2017. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

12. On 22 December 2017, Associate Professor David Ranson, Deputy Director, Head of Forensic Services at the Victorian Institute of Forensic Medicine, conducted an inspection on [redacted] body and provided written report dated 28 December 2017, concluding a reasonable cause of death to be "I(a) Drowning". I accept his opinion in relation to the cause of death.

13. Toxicological analysis of post mortem specimens did not detect alcohol, common drugs or poisons.

[4] (1938) 60 CLR 336.

14. Assoc. Prof. Ranson noted the post mortem computed tomography (CT) scan revealed no evidence of significant trauma and no signs of cardiovascular pathology such as aortic or general arterial calcification or cardiac abnormality. The lung fields were clear. The CT scan of the head showed no evidence of trauma.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15. At approximately 12.30pm on 21 December 2018, [redacted] and his two sons went to the beach which was across the road from their holiday house, for a quick swim. According to [redacted] all three were strong swimmers, the boys attended swimming lessons weekly and [redacted] had swum at surf beaches before. Approximately ten minutes later, [redacted] took her niece and nephew across the road to join her family at the beach. When she arrived, one of her sons was coming towards her, he was very distressed and told that this brother and father were in the water and they were gone. [redacted] who could not swim, ran to the road and flagged down a passing van. Emergency services were called. The occupants of the van and [redacted] brother in law, who had just arrived at the beach, went into the water to assist. [redacted] was retrieved from the water unconscious and unresponsive. A man, who was walking along the beach, swam out and rescued [redacted] son.

16. [redacted] began cardiopulmonary resuscitation (CPR). Police and Ambulance Paramedics arrived shortly afterwards and continued with CPR, however [redacted] could not be resuscitated. [redacted] was declared deceased at the scene.

Investigation into prevention opportunities

17. I requested that Life Saving Victoria (LSV) review the circumstances of [redacted] death and to provide advice on any opportunities for prevention.

18. LSV suggested that the council ensure adequate risk measures (including but not limited to signage and public awareness messaging for tourists) are implemented to address the potential for drowning in public spaces. These measures should be re-assessed at appropriate intervals to ensure they remain best practice and in line with relevant standards and that water safety measures be undertaken in consultation with industry experts/stakeholders, such as Life Saving Victoria (the recognised peak water safety agency in Victoria), and be an integrated aspect of the wider Municipal Emergency Management planning framework.

19. Rob Andronaco, LSV's Risk and Spatial Analysis Specialist, added that, "The essence of these three broad principles is that land managers commit to a systematic monitoring and review process. Continuous monitoring and review of coastal hazards ensures that new hazards are detected and managed and linked to modification or maintenance of existing action plans[5]."

20. Based on the response provided by LSV, I had proposed to make the following recommendation:

> I recommend that Colac Otway Shire Council review its Municipal Emergency Management Plan to ensure that adequate risk measures (including but not limited to signage) are in place to prevent incidents of drowning amongst beachgoers in their area. The review should be undertaken in consultation with industry experts and stakeholders such as Life Saving Victoria, and the risk measures should be reassessed periodically to ensure they remain best practice.

21. I then directed that a copy the recommendation be provided to Colac Otway Shire Council (the Council), the Otway Coastal Committee (OCC), and Department of Environment, Land, Water and Planning (DELWP), inviting their comments.

Response from Colac Otway Shire Council

22. The Council stated that they would raise the proposed coronial recommendation at the next Municipal Emergency Management Planning Committee (MEMPC) meeting on 8 November 2018[6]. The Council would also request that MEMPC consider the potential inclusion of drowning or wider coastal safety issues as an emergency risk in the Community Emergency Risk Assessment of the Municipal Emergency Management Plan (MEMP). The Council stressed that the MEMP is not a Council document, and that the MEMPC is not a Council committee. Rather, both are municipal-wide mechanisms that the Council is required to coordinate and develop under the provisions of the *Emergency Management Act 1986 & 2013* (Vic)[7]. As such, the Council could not guarantee that adequate risk measures to prevent incidents of drowning would be included in the MEMP, as the proposed coronial recommendation suggested.

23. The Council added that as they are not responsible for the management of beaches or coastal foreshore within Colac Otway Shire, they cannot provide any advice on the current state of

[5] Email response from Rob Andronaco, LSV, received 25 July 2018
[6] I have not received an update after November 2018 as to whether the MEMPC included drowning and/or wider coastal safety issues in the MEMP.
[7] The 2013 Act operates concurrently with the *Emergency Act 1986* (Vic) with the intention that the 1986 Act will ultimately be repealed.

safety signage or management regimes at either Mounts Bay or Skenes Creek and that the Otway Coast Committee, on behalf of the Department of Environment, Land, Water and Planning, is responsible for managing the section of coastal reserve where both deaths occurred.

24. The Council added that the wider issue of potential drowning at unsafe beaches and the responsibilities of land managers should be addressed in the new state wide Coastal and Marine Policy to be developed by the Minister by December 2019, as directed under the recently introduced *Marine and Coastal Act 2018* (Vic). As the section of coast in question is managed by the OCC on behalf of DELWP, any public safety actions should be included in the associated coastal management plan that covers Skenes Creek, which in turn is to be reviewed by the Minister. Any assessment of coastal hazard and potential expert advice or signage requirements should be undertaken by Life Saving Victoria under the direction of DELWP (as the land manager).

Response of Otway Coastal Committee and Department Environment Land Water and Planning

25. On 21 December 2018, the OCC and DELWP stated that the position of signage at Skenes Creek beach has changed since [redacted] death.

26. The OCC and DELWP stated that they are aware that LSV produced a draft Coastal Risk Assessment and Treatment Plan (Apollo Bay – Kennett River Public Reserves Committee of Management), but believe this plan was never finalised. LSV has advised that this draft Risk Assessment and Treatment Plan would not now be 100% consistent with new risk management, water safety and beach safety flag standards, as all of them have changed since the plan was created.

27. The OCC and DELWP believe that the existing signage at Mounts Bay and Skenes Creek warn of relevant risks, and that the signage at those locations is consistent with the signage along the 28.5 kilometres of coast line managed by the OCC. The OCC and DELWP have listed the review of signage as a priority project and, to that end, the OCC is in discussions with LSV to establish what assistance they can provide, and at what cost.

Issues arising from the responses provided

28. The most relevant issue arising from the responses received is that of the recently introduced *Marine and Coastal Act 2018* (Vic) (the MCA Act). The MCA Act provides a whole-of-government approach to the planning and management of the marine and coastal environment. The Act includes strong objectives and a set of guiding principles to provide direction to decision makers. One of the objectives is to improve community, user group and industry stewardship and understanding of the marine and coastal environment.[8]

29. The Marine and Coastal Reforms Final Transition Plan is created to complement the MCA Act and identifies a program of policy reforms and on-the-ground actions, many already underway, to transition to the new system of management of marine and coastal environments over the coming years. One of the actions listed in the transition plan is as follows:

> **"Support Crown land managers to address risks to public safety on coastal land** DELWP will continue the highly successful Coastal Public Access and Risk grants program to provide financial assistance to coastal Crown land managers to address risks to public safety on coastal land and align with Victoria's Asset Management Accountability Framework"[9]

30. As identified in the response received from the Council, the Crown land manager for the area of coastline where [redacted] drowned is the OCC and that the OCC applied for and was given grants towards three different public safety risk projects in the 2018-2019 period[10].

31. In light of the above, the suggestion made by the Council that that the new state-wide Marine and Coastal Policy should address potential drowning at unsafe beaches and the responsibilities of land managers would be in keeping with both recent previous practice and the final transition plan. The response received on behalf of the OCC and DELWP also indicates that Crown land managers will have continuing responsibility for ensuring that adequate risk measures are in place to prevent incidents of drowning amongst beachgoers.

32. The management of the Victorian coastal and maritime space is undergoing a period of change. It appears that the OCC, like other Crown land managers, will continue to be responsible for such duties as reviewing, maintaining and managing warning signage under

[8] Victoria, Second Reading Speech Marine and Coastal Bill, Legislative Council, 22 February 2018, 586 (Jenny Mikakos)
[9] DELWP, *Victoria's Marine and Coastal Reforms Final Transition Plan, Well Resourced, efficient and effective management, Actions 5.4*, 42, 2017
[10] These projects, according to DELWP, were Skenes Creek Beach Accesses (awarded a grant of A$18, 108), Wye River Boardwalk (A$3,990), and Kennett River Holiday Park Fire Hose Reels (A$4,480).

the new *Marine and Coastal Act 2018* (Vic), at least in the short term. Therefore, depending upon the final content of the Marine and Coastal Policy, the Marine and Coastal Strategy, or any of the other examples cited above, the responsibility for reviewing, maintaining and managing warning signage at beaches (and other risk measures to prevent drownings) in Victoria could be amended or changed entirely in the future.

FINDINGS

33. Having investigated the death of [redacted] and having considered all of the available evidence, I am satisfied that no further investigation is required.

34. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was [redacted], born [redacted];

    (b) that [redacted] died on 21 December 2017, at Skenes Creek Beach, Great Ocean road, Skenes Creek, Victoria from drowning; and

    (a) that the death occurred in the circumstances described in the paragraphs above.

RECOMMENDATIONS

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

    36. I recommend that the Marine and Coastal Council, and thereby the Minister for Energy, Environment and Climate Change, specify in the upcoming Marine and Coastal Policy, the risk measures to be put in place to prevent incidents of drowning amongst beachgoers throughout the state of Victoria (including but not limited to signage). The identification and inclusion of suitable risk measures in the policy, and with whom the responsibility for introducing and maintaining these risk measures lies, should be undertaken in consultation with industry experts and stakeholders such as Life Saving Victoria, forming regional and strategic partnerships where appropriate to achieve this aim.

37. I convey my sincerest sympathy to [redacted] family and friends.

38. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

(a) [redacted] family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 29 July 2018