IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001661

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Joyce Elizabeth Tyndall
Date of birth:	7 September 1955
Date of death:	27 March 2022
Cause of death:	1(a) Drowning
Place of death:	46 Cemetery Road, Nathalia, Victoria, 3638

INTRODUCTION

1. On 27 March 2022, Joyce Elizabeth Tyndall was 66 years old when she passed away in a kayaking incident. At the time of her death, Ms Tyndall lived in Nathalia, Victoria with her partner, Donald Baker.

2. Ms Tyndall grew up in and around the Nathalia area, where she spent most of her life. As a child, she spent a lot of time swimming in the Barmah River or at the local pool. She was described as a capable swimmer and keen kayaker. She kayaked regularly and was careful to always wear a lifejacket. Her kayaks and lifejackets were noted to be in a good condition and were well maintained.[1]

THE CORONIAL INVESTIGATION

3. Ms Tyndall's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Tyndall's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

[1] Statement of Alison Tyndall dated 28 June 2022.

7. This finding draws on the totality of the coronial investigation into the death of Ms Tyndall including evidence contained in the coronial brief. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

8. Ms Tyndall and Mr Baker lived in a house on Cemetery Road, Nathalia, which backs onto Broken Creek. On 27 March 2022, Ms Tyndall and Mr Baker were visited by their friends, who paddled up the Broken Creek, to their home. Their friends left at about 3.30pm, at which point Ms Tyndall and Mr Baker decided to go kayaking.[3]

9. Ms Tyndall and Mr Baker pushed their two-person kayak into the water. They each put on lifejackets and used dual-ended paddles in the water. The couple paddled upstream from their house towards the Nathalia town weir (**'the weir'**). Mr Baker reported they were having a good time while kayaking together.[4]

10. As the couple approached the weir, Mr Baker suggested they paddle to the waterfall. He suggested that they "*go to the concrete and then paddle back*". As the kayak approached the section where the water rushes through the weir, the front of the kayak started taking on water. The kayak became submerged and flipped over, causing Ms Tyndall and Mr Baker to be trapped under the canoe. Mr Baker felt the currents pulling him under the water, despite wearing a lifejacket.[5]

11. Mr Baker recalled seeing Ms Tyndall "*bobbing up and down*". He climbed onto the concrete spillway and reached down to pull her out of the water. She was unresponsive, so Mr Baker attempted cardiopulmonary resuscitation (**CPR**); however, as he had never been trained in first aid, he was unsure how to perform CPR.[6]

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[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[3] Statement of Donald Baker dated 31 March 2022.

[4] Statement of Donald Baker dated 31 March 2022.

[5] Statement of Donald Baker dated 31 March 2022.

[6] Statement of Donald Baker dated 31 March 2022.

12. Mr Baker rushed over to his neighbour's property, where his neighbour, Rodney Whyte, was mowing the lawn. He told Mr Whyte that Ms Tyndall had drowned and he needed help. Mr Whyte called his partner and asked her to notify their neighbour, Peter Sheahan, who had a key to locked gates, preventing access to the weir.[7]

13. When Mr Whyte arrived at Ms Tyndall's location, he observed she was unresponsive. He immediately commenced CPR. Mr Sheahan arrived to unlock the gate while Mr Whyte was performing CPR. Victoria Police arrived shortly thereafter and assisted with CPR.[8]

14. The Nathalia Community Emergency Response Team (**CERT**) arrived on scene, followed by Ambulance Victoria. CERT continued CPR until paramedics arrived, however paramedics were unable to revive Ms Tyndall. She was declared deceased at the scene.

15. Police investigated the scene and recovered Ms Tyndall's lifejacket and kayak which were both inspected. There were no mechanical or other issues identified with either item. The paddles used by Mr Baker and Ms Tyndall were never recovered. Police did not identify any suspicious circumstances or third-party involvement in Ms Tyndall's death.

Identity of the deceased

16. On 27 March 2022, Joyce Elizabeth Tyndall, born 7 September 1955, was visually identified by her brother, Kevin Botterill.

17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 29 March 2022 and provided a written report of her findings dated 31 March 2022.

19. Dr Fronczek reviewed the post-mortem computed tomography (**CT**) scan, which revealed minimal pleural effusions, enhanced lung markings and bilateral anterolateral rib fractures. There were no intracranial haemorrhage or fractures noted.

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[7] Statement of Rodney Whyte dated 15 July 2022.

[8] Statement of Rodney Whyte dated 15 July 2022.

20. Toxicological analysis of post-mortem samples identified the presence of sertraline and paracetamol.

21. Dr Fronczek provided an opinion that the medical cause of death was 1 (a) Drowning.

22. I accept Dr Fronczek's opinion.

FAMILY CONCERNS

23. Joanne Tyndall wrote to the Court and expressed her concerns about signage in and around the Nathalia town weir in relation to her mother's passing. In her statement to police, Alison Tyndall detailed her recent experience kayaking on Broken Creek with her family, about three months prior to this incident.

24. Joanne queried whether there were any warning signs erected on the approach to the weir from the waterway, and whether the existing signs were sufficient to appropriately warn water users of the risk. Joanne also expressed concern that there were no safety barriers or exclusion zones preventing the public from accessing the weir.[9]

25. Alison recalled that she paddled on Broken Creek at Christmas in 2021 with her stepson and daughter. The group paddled to the weir "*unaware of any dangers with Mum fully aware of our whereabouts*".[10] Joanne similarly commented that she was raised in the township of Nathalia and was entirely unaware of the dangers associated with weirs.[11]

FURTHER INVESTIGATIONS

26. Coroner's Investigator, Leading Senior Constable Bernard O'Dwyer, provided photographs of the weir, where the incident occurred. On the northern side of the weir, there is a tall cyclone fence preventing access from the gravel road that runs alongside Broken Creek. On the fence are two signs – one is a security notice that warns of surveillance cameras in use in the area. The other is a sign that reads, "*NO SWIMMING*".[12]

27. On the southern side of the weir, there is a tall cyclone fence preventing access by pedestrians. It has the same "*NO SWIMMING*" and surveillance camera in use signs, with a third sign

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[9] Concerns of care from Joanne Tyndall dated 6 April 2022.
[10] Statement of Alison Tyndall dated 28 June 2022.
[11] Concerns of care from Joanne Tyndall dated 6 April 2022.
[12] Coronial brief, Folio of Photographs, Exhibit 6.

stating, "*NO ENTRY*".[13] There are no signs visible in the approach to the weir for persons swimming or kayaking on Broken Creek.

28. As part of my investigation, I directed the operators of the weir, Goulburn-Murray Water (**GMW**), to provide a statement to the Court. GMW explained that the Nathalia weir is a regulating structure which passes water downstream but also maintains a constant level of water by operating in 'upstream level mode'. It also provides a pumping pool for GMW customers to divert water from the Broken Creek. GMW also diverts water from Broken Creek to Nathalia's water supply.[14]

29. GMW noted that it operates and maintains "*approximately 4,487km of irrigation channels and 3,162km of drains"*.[15] In addition, "*GMW's channel control equipment fleet consists of approximately 3,379 regulating structures to control flow rate and head of water throughout the longitudinal channel systems, including Broken Creek*".[16]

30. GMW explained that while they have erected some signage and fencing around the Nathalia weir, it is not always possible to erect and maintain signage, buoys, or exclusion zones at all locations, due to the large volume of assets that it maintains. In their statement to the Court, GMW advised that signage, buoys, and barriers to mark exclusion zones can be subject to vandalism or degradation. It further opined that "*Buoys may also provide a false sense of security as they are not always able to be deployed effectively*".[17]

31. As a result, GMW runs an annual Public Awareness Campaign and promotes this campaign heavily on multiple channels including through media releases, local newspapers, GMW's website and social media. GMW also provides water safety messaging in GMW's customer newsletters. GMW noted that in the 12 months prior to Ms Tyndall's passing, 14 media releases were published regarding water safety. An update was provided to GMW customers in November 2021. The update included, amongst other things, the following passage:

> "*While swimming in a channel may be tempting on a hot day, it is dangerous thanks to a range of hidden risks – strong undercurrents, hidden pipes, weeds and debris, gates that can open and close quickly, and submerged trees, sandbars and rocks*".[18]

[13] Coronial brief, Folio of Photographs, Exhibit 5.
[14] Statement of Warren Blyth dated December 2022.
[15] Statement of Warren Blyth dated December 2022.
[16] Statement of Warren Blyth dated December 2022.
[17] Statement of Warren Blyth dated December 2022.
[18] Statement of Warren Blyth dated December 2022.

32. I am satisfied that in the circumstances, it is not practical for GMW to construct barriers and buoys around the Nathalia weir. I note that GMW provides media releases and other updates through a wide variety of channels to alert local residents of the dangers associated with weirs. However, I consider that it is reasonable for GMW to erect additional signage on approach to the weir from downstream, so that water users are appropriately warned of the risks and dangers associated with weirs.

FINDINGS AND CONCLUSION

33. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Joyce Elizabeth Tyndall, born 7 September 1955;

    b) the death occurred on 27 March 2022 at 46 Cemetery Road, Nathalia, Victoria, 3638, from drowning; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

(i) That GMW consider erecting appropriate safety and warning signage along the banks of Broken Creek that is visible to water users as they approach the Nathalia town weir from downstream;

(ii) That GMW reiterates the grave dangers posed to water users by weirs in their annual public awareness campaigns; and

(iii) That Safe Transport Victoria consider the publication of a factsheet which warns water users of the significant dangers associated with weirs.

I convey my sincere condolences to Ms Tyndall's family for their loss.

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

Donald Baker, Senior Next of Kin

Joanne Tyndall

Goulburn-Murray Water

Safe Transport Victoria

Leading Senior Constable Bernard O'Dwyer, Coroner's Investigator

Signature:

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Coroner David Ryan

Date : 13 September 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.