IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007408

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Alison Debra Johns
Date of birth:	13 April 2017
Date of death:	27 December 2022
Cause of death:	1a: DROWNING
Place of death:	Lake Nagambie, Nagambie, Victoria, 3608
Keywords:	Child drowning, Lake Nagambie, water safety, supervision, inland waterways, Life Saving Victoria

INTRODUCTION

1. On 27 December 2022, Alison Debra Johns[1] was 5 years old when she died in circumstances consistent with drowning. At the time of her death, Alison lived in Wendouree with her mother, Rebecca Johns (**Rebecca**).

Background

2. In 2022, Rebecca noticed Alison experienced challenges assimilating with her peers. Medical practitioners suspected that Alison had autism spectrum disorder (**ASD**) and certain developmental issues, but these had not been formally diagnosed. Rebecca was exploring processes to better support her daughter's needs.

3. Alison loved spending time in the water and had attended three swimming lessons at the time of her death. She required the assistance of a flotation device when swimming. Alison had spent a significant amount of time swimming in the backyard pool of her great-aunt, Sandra Guy (**Sandra**), during which time she would wear a life vest.

4. However, while confident around water, Rebecca stated that Alison was a *'very nonskilled swimmer'* and *'was not that great [at swimming] when the water got too deep'.*

THE CORONIAL INVESTIGATION

5. Alison'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.

6. 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.

7. 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

[1] Referred to throughout this finding as 'Alison', unless more formality is required.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

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

9. Deputy State Coroner Paresa Spanos initially held carriage of the investigation until it came under my purview in July 2023 for the purposes of gathering additional material, finalising the investigation and handing down findings.

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

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On 27 December 2022, Alison, Rebecca, Sandra and other members of their extended family and friends set up a picnic at Lake Nagambie for the day. The group comprised approximately 14 people. Alison and Rebecca arrived at Buckley Park on the lakeshore at approximately 11am.

12. The Johns family had visited Lake Nagambie many times in the past, and although Alison had previously swum in Lake Nagambie, she had not swum at Buckley Park before. The group set up a small gazebo approximately two metres from the water's edge, near the carpark and the children's playground. The water was described as murky in colour, and at the edge near the gazebo there was a dense collection of reeds. A yellow buoy was present approximately 15 metres from the bank of the lake.

13. Alison was swimming in Lake Nagambie with the assistance of a small '*inflatable floatie ring*' that had been borrowed from another child. The inflatable ring is considered under

[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.

consumer standards to be an aquatic toy rather than a swimming and flotation aid, as this type of ring is not attachable to its wearer.[3]

14. Between noon and 1pm, the group ate lunch. Alison removed the inflatable ring while she ate her lunch and put it back when she returned to swim.

15. After lunch, Rebecca decided to go for a swim to the buoy. Not wishing Alison to swim with her into the deeper water, Rebecca *'told her to go get some sunscreen on, so [Rebecca] had a chance to swim out to the buoy while [Alison] wasn't in the water'.*

16. While swimming to the buoy, Rebecca reported that she returned to face the lakeshore and saw one of the adults applying sunscreen to Alison. Shortly thereafter, Rebecca noticed that Alison had returned to the water with the inflatable ring on. Rebecca yelled out to Alison and told her to return to the lakeshore as there was not anyone with her in the water. At this time, there were reportedly two adults on the lakeshore, with others having left to purchase fish and chips in town.

17. When Rebecca neared the buoy, she turned around and noticed that Alison's inflatable ring was in the water but could not see her daughter anywhere. She then heard one of the adults ask, *'where's Alison?'.* Rebecca and others in the water returned to the shore and commenced searching for Alison, including around Buckley Park and the carpark. Sandra searched for Alison in the water.

18. Alison could not be located either in the water or on the bank of the lake by any of the adults present. At 2:41pm, approximately 10 minutes after Alison had gone missing, emergency services were contacted.

19. As Victoria Police members arrived, Sandra located Alison in the reeds near the lake's edge, fully submerged in water that was approximately one metre deep. Sandra pulled Alison from the water, and police members commenced cardiopulmonary resuscitation (**CPR**). Ambulance Victoria paramedics arrived and took over CPR, but were unable to revive Alison.

20. At 4:10pm, after significant efforts to revive her, paramedics declared Alison deceased.

[3] *See in this regard* https://www.productsafety.gov.au/business/search-mandatory-standards/swimming-and-flotation-aids-mandatory-standard.

IDENTITY OF THE DECEASED

21. On 27 December 2022, Alison Debra Johns, born 13 April 2017, was visually identified by her mother, Rebecca Johns, who completed a formal Statement of Identification.

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

MEDICAL CAUSE OF DEATH

23. Forensic Pathologist Dr Melanie Archer (**Dr Archer**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Alison Johns on 20 December 2022. Dr Archer considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) scan and VIFM contact log and provided a written report of her findings dated 18 January 2023.

24. The post-mortem examination did not demonstrate injuries that could have caused or contributed to the death.

25. Dr Archer noted that drowning does not result in specific findings at post-mortem examination, although some findings can suggest or support such a conclusion. The post-mortem CT scan demonstrated fluid in the left maxillary sinus, moderate density stomach contents and increased patchy lung markings.

26. Toxicological analysis of post-mortem samples did not identify the presence of alcohol or other commons drugs or poisons.

27. Dr Archer provided an opinion that the medical cause of death was 1(a) *drowning*.

28. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

29. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Alison Debra Johns, born 13 April 2017;

    b) the death occurred on 27 December 2022 at Lake Nagambie, Nagambie, Victoria, 3608, from 1(a) *drowning*; and

    c) the death occurred in the circumstances described above.

30. Having considered all of the circumstances, I find that Alison Debra Johns' death was the result of a tragic accident.

31. I find that during a short lapse in supervision, Alison Debra Johns entered the water at Lake Nagambie alone and drowned. Alison was described as confident around water, but at just five years old, her swimming skills were limited.

32. While there were adults present both in the water and on the bank of the lake, there did not appear to be any adult with '*eyes on her*' at all times. Alison Debra Johns drowned without being observed, in circumstances in which she was swimming with the aid of an inflatable ring that was easily removable, and where there was no lifeguard present. In such circumstances, the need for close and continuous supervision by an adult was paramount.

33. While avoiding blame of any adult present, and noting that Alison Debra Johns' tragic death will weigh heavily on all who were present that day, I consider that it is appropriate to comment on any opportunities to prevent the future deaths of children in similar circumstances. In this regard, I have made comments below with regard to the importance of supervision, as well as water safety at inland waterways, and Lake Nagambie in particular.

COMMENTS

Importance of supervision

1. At my request, the Coroners Prevention Unit (**CPU**)[4] provided me with statistics on the prevalence of inland waterway drownings amongst children. The CPU identified that between 2014 and 2024, 40 children aged 0-5 years drowned in Victoria. Of these 40 children, 12 (30%) of these deaths occurred at inland waterways.

2. Of the 40 drowning deaths among children aged 0-5 years between 2014 and 2024 identified by the CPU, 36 (90%) occurred where the child was not appropriately supervised. More specifically, 10 of the 12 inland waterway drowning deaths (83%) occurred in the absence of adequate supervision.

[4] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health; as well as staff who support coroners through research, data and policy analysis.

3. The Royal Children's Hospital and KidSafe Victoria publish resources on water safety regarding children. Both organisations emphasise the need for supervision of children under the age of 16. The Royal Children's Hospital states:

> *'Never take your eyes off children in, on or around water.*
>
> - *Supervision means constant visual contact, not the occasional glance.*
> - *You should actively supervise children, even if they can swim.*
> - *Avoid all distractions, including using a phone or answering the door.*
> - *Do not leave older children (under the age of 16) to supervise younger siblings.*
> - *Children under five must be within arms' reach, and children under 10 must be clearly and constantly visible and directly accessible.'*[5]

4. On 12 November 2024, Coroner Sarah Gebert handed down her findings into the drowning death of two-year-old, Master K. While Master K drowned in a public swimming pool, and not in an inland waterway, pertinent comments about supervision were made by her Honour.

5. In particular, Coroner Gebert discussed the longstanding comments of coroners regarding children and water safety. Her Honour wrote:

> *'I highlight the following broad themes as follows:*
>
> - *Bodies of water are a temptation to young children because they represent a fun activity and adventure;*
> - *However, children do not adequately understand the dangers of water;*
> - *Parents therefore need to be vigilant and exercise adequate supervision of children in and around bodies of water;*
> - *A brief lapse of vigilance can have tragic consequences;*
> - *Children can drown in as little as 20 seconds without making any noise;*
> - *Children can drown in shallow water (only a few centimetres deep);*
> - *Use of life vests or other buoyance aids are not a substitute for close, focussed and active supervision; and*

[5] The Troyal Children's Hospital Fact Sheet entitled "*Safety: Swimming Pools*". Accessible at: https://www.rch.org.au/kidsinfo/fact_sheets/Safety_Swimming_pools/

- *Adults should not assume someone else is supervising the child.'*[6]

6. I note that Alison was at Buckley Park with several adult friends and family members. In group settings, it is easy to assume that children are being supervised by other adults present.

7. Royal Life Saving Australia reminds adults:

> *'(. . .) it is crucial to ensure that one responsible adult is always actively supervising children whenever they have access to water, including social gatherings around water. Tragically, drowning incidents have occurred when one adult assumes someone else is watching the children.'*[7]

8. In making the above comments, I emphasise that I do not purport to criticise any of the adults present at the lake that afternoon, who have faced deep and ongoing distress as a result of Alison's death. Noting that the issue of adequate supervision of children is a recurring theme, I echo the words of Coroner David Ryan in the Finding into the Death of KW,[8] referred to also by Coroner Sarah Gebert in the Finding into the Death of Master K:

> *These findings and comments are not made by way of criticism of KW's parents who have suffered a devastating tragedy. They are deserving of sympathy and not judgment. The comments are provided as a salutary warning to all caregivers of children so that drowning deaths relating to inadequate supervision can be prevented in the future. The importance of ensuring the safety of children around water cannot be overstated and it should be discussed and planned by caregivers beforehand. It is timely to reiterate and emphasise this message now with another summer having just begun, and much of the Victorian community having recently emerged from lockdowns imposed to manage of the Covid-19 pandemic. As a result, many children will be enthusiastically embracing the opportunity to engage in water-based activities with friends and family, in circumstances where few of those children would have had the opportunity over the last couple of years to develop and improve their swimming skills with organised lessons'.*

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[6] Finding without Inquest into the Death of Master K (COR 2021 006361). Accessible at: COR 2021 006361 Form 38 - Finding into Death without Inquest - Master K_Redacted.pdf (coronerscourt.vic.gov.au).

[7] Royal Life Saving Australia's media release entitled *'Keep Watch: Always Supervise Children Around Water'*. Accessible at: Keep Watch: Always Supervise Children Around Water | Royal Life Saving Society - Australia.

[8] Finding without Inquest into the Death of KW (COR 2020 6780). Accessible at: [deidentified] COR 2020 006780 Form 38-Finding into Death without Inquest-Approved.pdf.

Water safety at inland waterways

9. The risk of drowning is inherent in all aquatic activities. However, the tragic circumstances of Alison's death also highlight, amongst other things, the particular importance of water safety at inland waterways.

10. The incidence of inland waterway drownings is well documented. In its report, *'Drowning in Rivers, Creeks, Lakes and Dams'*, Royal Life Saving Australia documented 924 people drowned in inland waterways between 2011 and 2021. 39% of these deaths occurred during the summer months, and 30% occurred during school holidays.[9]

11. These statistics are echoed in Life Saving Victoria's 2022-23 '*Drowning Report'* which demonstrated that, in 2022-23, 19 of the total 59 accidental, fatal drownings occurred at inland waterways. This represents an increase of 14% on the 10-year average.[10]

12. As noted above, the CPU provided me with additional statistics on the prevalence of inland waterway drownings amongst children. Of the 40 children aged 0-5 years who drowned in 2014-2024 in Victoria, 12 (30%) of these deaths occurred at inland waterways.

13. Royal Life Saving Australia appropriately identified that, '*inland waterways are not patrolled by lifeguards, and should someone get into trouble, there may be no one there to assist'*.[11] The lack of lifeguards or other patrolling at inland waterways emphasises the need for parents and other caregivers to be vigilant and maintain active supervision of children at all times.

14. In response to the increasing fatalities at inland waterways, Life Saving Victoria has implemented various education and prevention campaigns. In its 2023-24 Annual Report, its Executive Director, Paul Shannon, stated:

> *'Given the rise in drowning incidents in inland waterways, we have prioritised building dynamic and well-prepared communities, including inland waterway environments. Our initiatives have involved comprehensive research presentations aimed at regional Victorian land and waterway managers'*.[12]

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[9] Royal Life Saving Australia report entitled *'Drowning in Rivers, Creeks, Lakes and Dams'* accessible at: https://www.royallifesaving.com.au/__data/assets/pdf_file/0006/72456/RLS_InlandWaterwaysReport2023_LR.pdf.

[10] Life Saving Victoria report entitled *'Drowning Report 2022-23'* accessible at: https://lsv.com.au/LSV-Drowning-Report-2022-23/index.html.

[11] Royal Life Saving Australia "*Inland Waterways*" accessible at: https://www.royallifesaving.com.au/stay-safe-active/locations/inland-waterways

[12] Life Saving Victoria report entitled *'Annual Report 2023-24'.* Accessible at: Report 2023-2024 - Life Saving Victoria (lsv.com.au).

15. As part of its broader education efforts, Life Saving Victoria organises a free, annual *'Inland Waterways Forum'*. According to Life Saving Victoria, the forum provides *'a unique opportunity for those involved in or responsible for community safety, emergency management, aquatic sports and recreation, education and local governance to come together and contribute to the collective effort in drowning prevention'.*

16. The forum was held on 30 May 2024 and brought together 120 attendees from federal, state and local level authorities, emergency services, land managers and industry representatives. Life Saving Victoria's Annual Report of 2023-24 wrote of the event's success, stating, *'the annual forum continues to prove a significant and successful event that focuses on water safety planning for inland waterways, leading to increased community engagement and planning commitment from local councils'.*[13]

17. I commend Life Saving Victoria for its continued and concerted efforts to raise awareness on preventing drownings at inland waterways. It is promising that in the time since Alison's death, these efforts have increased, which I hope will assist in improving inland water safety as Victoria enters the 2024-25 summer season, in addition to the initiatives outlined below.

Water safety measures at Lake Nagambie

18. Lake Nagambie is a popular destination for families to visit, particularly during the summer months. Buckley Park is one of multiple parks and picnic areas on the Lake Nagambie shore which allows direct access to the water. Buckley Park also features a playground. There is a fence at the top of Buckley Park, however, it does not enclose the entire park.

19. Lake Nagambie, and Buckley Park, fall within the Strathbogie Shire Council (**the Council**).

20. After a flood of November 2022, the Council conducted a test on Lake Nagambie. The results indicated the water level started at 0.7 metres deep at the shore and increased to a depth of 1.7 metres to two metres towards the centre/middle of the lake.

21. At the time of Alison's drowning, Buckley Park had no signage regarding water safety nor indicating the depth of the lake. There are no barriers restricting access to the lake and it is open to the public at all times. As with other inland waterways, Lake Nagambie is not patrolled by lifeguards, including during the summer months.

[13] Life Saving Victoria report entitled *'Annual Report 2023-24'.* Accessible at: Report 2023-2024 - Life Saving Victoria (lsv.com.au).

22. On 26 and 29 January 2023, Life Saving Victoria piloted the allocation of lifeguard-patrolled sites at four of Victoria's main inland waterways. These sites included Lake Nagambie, selected due to its historical risk of drowning incidents and anecdotal evidence regarding visitation patterns.[14]

23. Lifeguards patrolled Lake Nagambie over the two days, performing numerous preventative actions and rescues. Notably, Life Saving Victoria learned that the lake was quieter than was anticipated over this long weekend due to the impacts of the 2022 flooding.

24. Following the success of their pilot project – exemplified through the numerous preventative actions and rescues – Life Saving Victoria *'strongly recommends'* establishing lifesaving patrols at inland swimming locations including Lake Nagambie.

25. Life Saving Victoria funded this program itself, and unfortunately, has noted that it does not currently have sufficient resources to continue the program at Lake Nagambie, nor at other inland waterways.

26. Life Saving Victoria informed the Court it remains *'committed to offering lifeguard services at high-risk locations in peak periods and has applied for State Government funding for 2025 to cover this type of inland waterway supervision activities at Victoria's top ten most dangerous inland locations'.*

27. Critically, in circumstances in which Lake Nagambie is an '*unmanaged waterway*',[15] Life Saving Victoria also noted that '*the sourcing of funding to deliver services at inland waterways will require clear accountability for water and land managers, on their roles and responsibilities to provide safe environments for water recreation*'.

<u>The way forward to improving the safety of inland waterways such as Lake Nagambie</u>

28. I consider that Alison's drowning highlights the need for further consideration of appropriate safety measures at inland waterways.

[14] Statement of Life Saving Victoria, 12 August 2024, p. 1.

[15] In November 2023, Strathbogie Shire Council resigned from its position as the waterway manager of Lake Nagambie. According to Safe Transport Victoria, the role of a waterway manager is to manage vessel activities on waters under their control, allocate and manage moorings and berths, provide and maintain navigation aids, appropriate signage of water levels, hazards and rules applying to the waters and control navigation and vessel movement. At the time of writing, Safe Transport Victoria describes Lake Nagambie as an '*unmanaged waterway*'. Strathbogie Shire Council, on its website, notes that '*Safe Transport Victoria is now responsible for the waterway*' - https://www.strathbogie.vic.gov.au/things-to-do/boating-and-fishing/.

29. I note in this connection that Life Saving Victoria has applied for State Government funding to offer lifeguard services during peak periods at Victoria's top ten most dangerous inland locations. I consider this to be an appropriate and evidence-based way forward to improving swimmer safety at inland locations such as Lake Nagambie.

30. Further, while on the evidence before me, it cannot be determined whether any additional infrastructure such as fencing or signage may have prevented Alison's death, it may be relevant to consider whether any additional safety measures might assist in alerting attendees to Lake Nagambie of the dangers associated with swimming in inland waters, particularly unsupervised.

31. To support such initiatives, I agree with the statement of Life Saving Victoria that clear accountability is required for water and land managers on their roles and responsibilities to provide safe environments at inland waterways.

32. This is particularly critical in my view given that, despite that the Coroners Court has liaised with Strathbogie Shire Council, Safe Transport Victoria, and Goulburn-Murray Water, there still appears to be uncertainty as to which entity is responsible for swimmer safety at Lake Nagambie (as opposed to the safety of users and passengers of vessels in this area). While water safety is considered a shared responsibility across the community and all levels of government, this gap raises, in my view, significant concerns regarding the safety of members of the public using the area for recreational aquatic activities.

33. Accordingly, given the public health and safety issues at stake, and noting that the work of the Victorian Water Safety Taskforce which developed the Victorian Water Safety Strategy 2021-2025 has transitioned to a forum coordinated by Emergency Management Victoria (**EMV**), I see it as prudent to notify my finding to EMV for further consideration of roles and responsibilities for swimmer safety in inland locations such as Lake Nagambie, including lifeguard patrolling, along with the following targeted recommendation.

RECOMMENDATION

1. I recommend under section 72(2) of the Act that **Strathbogie Shire Council** consult with the Victorian Water Safety Coordination Forum, Life Saving Victoria and any other appropriate body, to ensure appropriate safety measures are in place at Buckley Park on Lake Nagambie (including appropriate signage, depth warnings, fencing or other identified safety measures) to promote the safety of those engaging in recreational water activities such as swimming.

I convey my sincere condolences to Alison's family and friends for their loss and I acknowledge the sudden and traumatic circumstances in which she died. I further recognise the brave and intensive efforts of the first responders to this tragic incident.

DIRECTIONS

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court website in accordance with the rules. I direct that a copy of this finding be provided to the following:

Rebecca Johns, Senior Next of Kin

Rick Nugent, Emergency Management Commissioner, for attention of the Victorian Water Safety Coordination Forum

Life Saving Victoria

Royal Life Saving Australia

Strathbogie Shire Council

KidSafe Victoria

Safe Transport Victoria

Commissioner for Children and Young People

Senior Constable Joshua Bagdadi, Coronial Investigator

Signature:

Ingrid Giles

CORONER

Date: 5 December 2024

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.