IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000310

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Frank Mellia
Date of birth:	4 September 1983
Date of death:	14 January 2023
Cause of death:	1(a) Drowning in the setting of a very high blood alcohol level
Place of death:	Yarra River, Warrandyte State Park, Warrandyte, Victoria
Keywords:	Drowning, river waters, alcohol intoxication

INTRODUCTION

1. On 16 January 2023, Frank Mellia was 39 years old when he was found deceased in the Yarra River at Warrandyte. He had been missing, feared drowned, since he was last seen in the river on the afternoon of Saturday, 14 January 2023. At the time of his death, Mr Mellia lived in Derrimut with his parents and his partner Jessica Milazzo.

BACKGROUND

2. Mr Mellia had not had formal swimming lessons as a child and was not a confident or strong swimmer. A few months prior to his death, Mr Mellia had attempted to swim in open water whilst on a boat tour in Italy. He soon got into difficulty and required assistance from a lifesaver. Ms Milazzo stated:

   > *Although Frank really loved the beach, he would never swim too far out because he wasn't a confident swimmer. He was not a very good swimmer and was the type of person that would panic very easily around water.*

3. Mr Mellia had a history of anxiety, depression, and insomnia for which he was prescribed sertraline, melatonin and diazepam. These difficulties contributed to his misuse of alcohol, which he used as a coping mechanism. He was supported by his general practitioner who referred Mr Mellia to a psychologist for cognitive behavioural therapy. Unfortunately, Mr Mellia ceased his psychological treatment in mid-2021 due to financial difficulties.

4. In early 2022, Mr Mellia's suffered worsening symptoms of anxiety and depression with associated alcohol abuse and panic attacks. His general practitioner arranged a further referral to a psychologist and provided contact details for self-referral to an alcohol and other drugs counselling intake service. Mr Mellia did not however engage with these services prior to his death.

THE CORONIAL INVESTIGATION

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

8. Senior Constable (SC) Darren Snowden acted as the Coroner's Investigator for the investigation of Mr Mellia's death. SC Snowden conducted inquiries on my behalf and compiled a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Frank Mellia 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.[1]

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

Circumstances in which the death occurred

10. On Saturday, 14 January 2023, Mr Mellia had lunch with his parents at their home in Derrimut. The weather was hot with the temperature reaching 37ºC. After lunch, Mr Mellia arranged to meet his friends Benjamin Tribuzi and Kathy Huynh at the Yarra River in Warrandyte for a swim in the river. He packed a suitcase with the intention of spending the night at their home in Ferntree Gully, and he told his mother that he would return for dinner with his family the following night.

11. At approximately 2.00pm, Mr Mellia travelled via a ride share vehicle to Taroona Reserve, Warrandyte.

12. Taroona Reserve is located on the southern side of Yarra River. It is bounded by Everard Road to the south and joins with Pound Bend Reserve to the west. Andersons Creek enters the Yarra River on the eastern edge of Taroona Reserve, adjacent to Stiggants Reserve. The relevant stretch of the river is approximately 30 meters wide. The area includes public open

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[1] 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.

space and recreation facilities, a carpark and picnic area, and access to the river. It is a popular swimming location, particularly in hot weather.

13. The Warrandyte reach of the Yarra River is dominated by partly and fully submerged rock reefs, shallow and deep pools of water and submerged and emerging large woody debris. According to Melbourne Water, these features are common in natural river systems, and may present hazards to swimmers and paddlers. Although there are warning signs warning of strong currents, submerged objects and sudden drops at other parts of the Warrandyte River Reserve, there are no warning signs at Taroona Reserve – where Mr Mellia is likely to have entered the river.

14. Due to road works, Mr Tribuzi and Ms Huynh parked their car some distance away from the arranged meeting point and then walked down to Taroona Reserve where they met up with Mr Mellia. He was sitting with his suitcase by the carpark near the reserve. Mr Tribuzi offered to go and bring his car to the reserve carpark so that Mr Mellia could load his suitcase in it. Mr Tribuzi declined Mr Mellia's offer to accompany him back to the car and suggested that Mr Mellia stay with Ms Huynh while he was gone.

15. Approximately five minutes later, Mr Mellia walked off towards the river while Ms Huynh waited for Mr Tribuzi in the carpark. Ms Huynh had Mr Mellia's mobile phone and suitcase.

16. Mr Tribuzi returned approximately 15 minutes later and found Ms Huynh. They loaded the suitcase in the car before walking down to the river together to find Mr Mellia. The riverbank was busy, with approximately 40 people in and around the water. Mr Tribuzi noted the variable water depth, with some people standing in chest-deep water and others jumping into areas of deeper water.

17. Mr Tribuzi and Ms Huynh spent approximately fifteen minutes in and around the water looking for Mr Mellia but were unable to locate him. They then walked along the track next to the river in both directions. They checked nearby public toilets and asked passers-by. They searched without success for approximately an hour.

18. Mr Tribuzi and Ms Huynh then left the reserve to look in nearby bars and restaurants, heading towards Yarra Street, Warrandyte. At 5.10pm they attended Warrandyte Police Station to report Mr Mellia missing. As the station was unmanned, the report was transferred to the Doncaster Police Station.

19. Constable Watson at Doncaster Police Station completed a missing person report in which Ms Hunh disclosed that Mr Melia was possibly intoxicated, also that he had a drinking problem and was depressed.

20. Mr Tribuzi and Ms Huynh continued to search Yarra Street for another 10 minutes before returning to Taroona Reserve at the request of police to show where they had last seen Mr Mellia. They also assisted in the search for Mr Mellia's belongings, which were found on a large rock at the river entrance to the Taroona Reserve. Among the belongings were Mr Mellia's t-shirt and shorts and it appeared he had removed his clothing before going into the water.

21. At 3.30pm, police received a separate report from two members of the public who had witnessed a male struggling in a section of rapids at about 3.00pm. They had seen a male wearing a cap floating downstream treading water approximately 100 metres from where they were sitting on the riverbank in a secluded area. The male did not say anything to them as he passed. However, a short time later, he drifted into a section of rapids where they observed him go under the water and re-appear several times before going beneath the surface and failing to re-appear. They subsequently saw a cap floating along the river which they believed belonged to the man they had sighted but they were not sure whether he had exited the river at a spot they could not see. Also, other people nearby apparently appeared unperturbed.

22. Police commenced an extensive search for Mr Mellia involving general duties police, Public Order Response Teams, Search and Rescue, Airwing, and the State Emergency Service. Search and Rescue patrolled in a grid pattern between Taroona Reserve and Pound Bend Reserve, and ground units patrolled along the riverbanks and local bars and restaurants in Warrandyte. A command post was also set up at the Taroona Reserve car park, with Mr Mellia's family and friends assisting in the search effort.

23. On 16 January 2024, at 10.51am, an SES crew member found Mr Mellia's body face down in an eddy 10 metres from the entrance to the Pound Bend tunnel and approximately 650 metres downstream from the point he is thought to have entered the water.

Identity of the deceased

24. On 16 January 2023, Frank Mellia, born 4 September 1983, was visually identified by his de facto partner, Jessica Milazzo.

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

Medical cause of death

26. Forensic Pathologist, Dr Paul Bedford of the Victorian Institute of Forensic Medicine performed an autopsy on 20 January 2023 and provided a written report of his findings dated 31 March 2023.

27. The post-mortem examination revealed features in keeping with the known circumstances. There were no signs of injury or internal pathology that were likely to lead to death. A computed tomography (CT) scan revealed pleural effusions with bilateral increased lung markings. Minimal watery fluid was found in the lungs.

28. Toxicological analysis of postmortem samples identified the presence of ethanol (alcohol) at a very high blood concentration of 0.33g/100mL. Nordiazepam[2], sertraline[3] and propranolol[4] were also detected in postmortem samples – all were at unremarkable levels.

29. Dr Bedford commented that the level of alcohol intoxication would have led to a decreased ability for Mr Mellia to protect himself physically whilst swimming in the river.

30. Dr Bedford provided an opinion that the medical cause of death was 1 (a) drowning in the setting of a very high blood alcohol level.

31. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Frank Mellia, born 4 September 1983;

    b) the death occurred on 14 January 2023 at the Yarra River, Warrandyte State Park, Warrandyte, Victoria, from drowning in the setting of a very high blood alcohol level; and

    c) the death occurred in the circumstances described above.

[2] A metabolite of diazepam. The concentration of 0.03 mg/L is consistent with therapeutic use of diazepam.
[3] An antidepressant for use in cases of major depression. The concentration of 0.3 mg/L is unremarkable.
[4] Commonly used for the treatment of high blood pressure and arrythmias. The concentration of 0.2 mg/L is unremarkable.

33. Having considered all the circumstances, I am satisfied that Mr Mellia's death was the result of misadventure and that he drowned shortly after he was last seen in the river at approximately 3.00pm on 14 January 2023.

34. Rivers are notorious for hidden dangers. Riverbeds are often uneven with difficult footing, deep holes and underwater obstructions. Stretches of difficult banks may make exit impossible. Currents can be unpredictable, and the force of flowing water is often underestimated. The relevant stretch of the Yarra River at Warrandyte is no exception.

35. I am satisfied that Mr Mellia had a very high blood alcohol concentration when he entered the water. This would have grossly impaired his judgement and his ability to properly coordinate his efforts to swim, or to get to safety once he found himself in faster flowing water. His latent swimming ability was limited and only exacerbated these dangers.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

36. The Royal Life Saving Society Australia's *National Drowning Report 2023*[5] identified that rivers and creeks continue to be the leading drowning location across Australia, responsible for 27% of drowning deaths.[6] In Victoria, 19 people fatally drowned in inland waterways in the 2022-23 financial year, representing a 14% increase upon the 10-year average.[7] The Yarra River is one of the top five river drowning black spots across Australia.[8]

37. Alcohol is a contributing factor in 80% of drowning fatalities. It is linked to impaired judgment, greater risk-taking behaviour, reduced coordination and impaired reaction time.[9]

38. In conjunction with State and Federal Governments, Life Saving Victoria and Royal Life Saving Society Australia have developed the *"Respect the river"* campaign, which is designed to educate the public about the hidden dangers of the Yarra River and other inland waterways,

[5] Royal Life Saving Australia, *National Drowning Report 2023*, available at: https://www.royallifesaving.com.au/__data/assets/pdf_file/0009/76824/National_Drowning_Report_2023.pdf (**National Drowning Report**)

[6] National Drowning Report, pp 2, 8.

[7] Life Saving Victoria, *Drowning report 2022-23*, available at: https://lsv.com.au/LSV-Drowning-Report-2022-23/index.html, (**Victorian Drowning Report**) p 9.

[8] Victorian Government 'Water-Safety' website, available at: https://www.vic.gov.au/water-safety, accessed 8 July 2024.

[9] Victoria Government, 'Water Safety website, available at: https://www.vic.gov.au/water-safety, accessed 8 July 2024.

and to provide information, resources and safety advice concerning inland waterways.[10] Local media organisations have also supported these campaigns.

39. Despite these continued drowning prevention efforts, the overall rates of drowning at inland waterways remains unchanged. As noted by the Royal Life Saving Society Australia:

> *Inland waterways continue to account for more than one third of total drowning deaths in Australia, and men continue to account for more than 80% of drowning deaths at these locations. A greater awareness of water safety and practical tips for swimming and recreating in and around rivers and lakes in Australia, with a specific focus before and during the summer for all communities is recommended."*[11]

RECOMMENDATION

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

> That Parks Victoria review the signage warning the public of river hazards in the Warrandyte River Reserve and particularly, the Taroona Reserve. Among the hazards identified, the signage should warn of the danger of alcohol or drugs in combination with use of the river.

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[10] See Life Saving Victoria, '*Respect the River Campaign – The Yarra River*' published on 10 December 2015, which comprises six short videos outlining the hidden dangers of the Yarra River, available at: https://lsv.com.au/2015/12/10/respect-the-river-campaign-the-yarra-river/ and the Royal Life Saving Society Australia "Respect the River" program which outlines the safety risks and safety tips for staying safe in inland waterways, available at: https://www.royallifesaving.com.au/about/campaigns-and-programs/respect-the-river#:~:text=Royal%20Life%20Saving%2C%20with%20the,%E2%80%9CRespect%20the%20River%E2%80%9D%20program.&text=Whether%20you're%20swimming%2C%20boating,may%20not%20be%20aware%20of..

[11] National Drowning Report, p 37.

ORDERS AND DIRECTIONS

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

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

Rosario Mellia, Senior Next of Kin

Parks Victoria

Melbourne Water

City of Manningham

Life Saving Victoria

Royal Life Saving Australia

S/C Darren Snowden, Coroner's Investigator

ACKNOWLEDGEMENT

I convey my sincere condolences to Mr Mellia's family and friends for their loss.

I thank the Coroner's Investigator and those assisting for their work in this investigation.

Signature:

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Coroner Paul Lawrie

Date : 20 September 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.