IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000541

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Isaac Christian Hampton
Date of birth:	24 July 1998
Date of death:	27 January 2023
Cause of death:	1(a) Multiple injuries sustained in a fall from height
Place of death:	Bushrangers Bay, Two Bays Walking Track, Cape Schanck, Victoria, 3939

INTRODUCTION

1. On 27 January 2023, Isaac Christian Hampton was 24 years old when he died whilst climbing Elephant Rock at Bushrangers Bay in Cape Schanck, Victoria.

2. Isaac was born in Canberra, Australia Capital Territory (**ACT**) and met his long-time friend Oliver Mathe in primary school at Telopea Park in the ACT. He attended the University of Adelaide and the Australian National University where he received Honours in Chemistry.

3. Around July 2022, Isaac moved to Melbourne, Victoria to do his internship rotation with the Australian Defence Force. Oliver was already living in Melbourne, so the pair would catch up around one or two times a week.

4. Isaac was described as a funny, adventurous and outgoing person, who had a close group of friends and was always very happy.

THE CORONIAL INVESTIGATION

5. Isaac'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. Victoria Police assigned Senior Constable Thomas Marshall to be the Coroner's Investigator for the investigation of Isaac's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as friend, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Isaac Christian Hampton 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

Identity of the deceased

10. On 2 February 2023, Isaac Christian Hampton, born 24 July 1998, was visually identified by his uncle, Robert Condon.

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

Medical cause of death

12. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine, conducted an external examination on 30 January 2023 and provided a written report of her findings dated 1 February 2023.

13. The post-mortem CT scan identified an intraventricular and subarachnoid haemorrhage, pneumocerebrum, fracture-dislocation to the left wrist, left haemothorax and bilateral pneumothoraces. Several fractures were also identified, including to the right femur, right acetabulum, os ilium and anterolateral rib, and comminuted facial and frontal bone fractures.

14. The post-mortem examination confirmed multiple and extensive injuries, in keeping with the traumatic injuries identified on the CT scan. The injuries were of a nature that would have caused rapid unconsciousness and death and were not survivable.

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

16. Dr Fronczek provided an opinion that the medical cause of death was *multiple injuries sustained in a fall from height*.

[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.

17. I accept Dr Fronczek's opinion as to the medical cause of death.

Circumstances in which the death occurred

18. On 27 January 2023, Isaac and his friend Oliver had prearranged a day trip to Bushrangers Bay in Cape Schanck. It is understood that Isaac had been to the area a week prior and wanted to take Oliver there to explore.

19. Oliver picked Isaac up from his address in Southbank and drove them to Cape Schanck, arriving around noon.

20. The pair walked for about 10-15 minutes down Two Bays Walking Track to reach the beach at Bushrangers Bay.

21. They first went for a swim, before venturing down the beach to Elephant Rock, a natural rock formation that is detached from the surrounding cliffs.

22. To reach the rock, the pair waded through knee-high water before walking onto what Oliver described as '*kind of like a trail*' that spirals around the rock to reach the top. Oliver described the trail as '*very walkable'* with only a few steep points.

23. Venturing back down the trail, the pair decided to walk around the outside of the rock. At a certain point, the rock formed a cliff with about a 15 or 20 metre drop. The pair sat there for a short period, around a metre and a half from the edge, before deciding to turn around and head back to the beach.

24. Oliver turned around to walk back when he noticed Isaac '*mid-air falling'* and saw him *'hit the rock and kind of bounce'.* He landed between the rocks and the ocean.

25. When Oliver realised that Isaac was unresponsive, he made the decision to climb down the cliff reach him. In doing so, Oliver landed heavily on his legs and arm, causing injury. Reaching Isaac, Oliver tried to keep Isaac's head above water whilst also struggling to not be swept out too far by the waves.

26. Oliver started yelling for assistance from members of the public who were also on the beach.

27. Several people came to their aid, assisting the pair in getting to land. Cardiopulmonary resuscitation (**CPR**) was commenced on Isaac, whilst others walked to get mobile phone reception and call 000 for assistance.

28. At about 7.00pm, emergency services were dispatched to the scene. Life Saving Victoria members were first to arrive via helicopter, followed shortly after by intensive care flight and road paramedics and Isaac's emergency care was taken over from the bystanders.

29. Resuscitation efforts continued until 7.59pm with Isaac being declared deceased. Ambulance Victoria personnel in attendance concluded that all interventions had been performed, and there had been no changes in presentation with Isaac remaining in asystolic cardiac arrest.

FURTHER INVESTIGATIONS

30. As part of my investigation into Isaac's passing, I asked the Coroner's Prevention Unit (**CPU**) to identify whether other unintentional deaths had occurred at the same area in recent years.

31. The CPU identified three other unintentional deaths had occurred at Bushrangers Bay, Cape Schanck since 1 January 2000. Two of the deaths were the result of drownings, from being swept off the rocks by a sudden large wave or being caught in a strong rip current in the surf. The third death was another fatal fall from Elephant Rock, which occurred in 2013.

32. I then directed enquiries to Parks Victoria to obtain further information regarding the management of Bushrangers Bay and Elephant Rock. Parks Victoria provided a response dated 7 November 2024.

33. Parks Victoria explained that, while it is responsible for the management of Mornington Peninsula National Park, which includes most of the beach at Bushrangers Bay, Elephant Rock falls outside of those boundaries and is located on private property.

34. Parks Victoria advised that risk signage is installed along the Two Bays Walking Track from Cape Schanck and the Bushrangers Bay carpark on Boneo Rd, as well as at the head of the stairs to Bushrangers Bay and at the beach access point at the bottom of the stairs. The signs include warnings about unstable cliffs and cliff edges. Parks Victoria further advised that it does not have authority to place signage outside of the boundaries of the national park, such as on Elephant Rock.

35. Parks Victoria also advised that, pursuant to Coroner Jamieson's recommendation in connection with the passing of Ahedah Hamed, additional risk totem signage was installed in March 2024, on entry to the beach at Bushrangers Bay, next to an existing red warning sign. The additional signage includes warnings about unstable cliffs.

36. Parks Victoria further noted their use of signage as an effective risk mitigation tool requires careful consideration of several factors, including the signs' visibility, clarity, placement and visitor behaviour, without regard to which can lead to confusion, complacency or neglect.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Isaac Christian Hampton, born 24 July 1998;

    b) the death occurred on 27 January 2023 at Bushrangers Bay, Two Bays Walking Track, Cape Schanck, Victoria, 3939, from *multiple injuries sustained in a fall from height*; and

    c) the death occurred in the circumstances described above.

38. Having considered all of the circumstances, I am satisfied that his death was a tragic accident.

COMMENTS

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

39. It is regrettable that accidental deaths continue to occur in Bushrangers Bay, and that there have now been two fatalities relating to falls from Elephant Rock in the past ten years.

40. I consider that Parks Victoria has appropriately installed signage, including additional signage in 2024 following a recommendation of this Court, that clearly warns of the hazards present in the area, including unstable cliffs and cliff edges. I accept that Parks Victoria does not have authority to place signage or undertake any other risk mitigation strategy in the area where Elephant Rock is located, being private property.

41. However, despite the signage, it appears that Elephant Rock remains a popular attraction for beachgoers to climb and explore when visiting Bushrangers Bay.

42. The circumstances of Isaac's death highlight the importance of exercising caution when visiting remote and unpatrolled locations such as Bushrangers Bay. I urge visitors to the area to avoid swimming and climbing and to be vigilant to safety risks associated with variable natural conditions, such as unstable cliff edges and unexpected changes to surf conditions.

43. I also commend the swift response of members of the public and emergency services to the scene, in circumstances that were challenging due to the remote location and limited mobile phone reception.

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

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:

Linda Ivatts and Ross Hampton, Senior Next of Kin

Parks Victoria

Senior Constable Thomas Marshall, Coroner's Investigator

Signature:

Judge John Cain
State Coroner
Date: 20 June 2025

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.