

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000603

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:	Jack Mitchell Bird
Date of birth:	22 June 2006
Date of death:	11 December 2022
Cause of death:	1(a) Consistent with drowning
Place of death:	Murray River/Lake Mulwala, Mulwala, New South Wales, 2647

INTRODUCTION

1. On 11 December 2022, Jack Mitchell Bird was 16 years old when he drowned while on holiday in New South Wales. At the time of his death, Jack lived at 619 River Road, Kialla, Victoria, 3631 with his family.
2. Jack was described as an animal lover, who enjoyed being outdoors and riding motorcycles. Jack obtained an apprenticeship as a fitter and turner in 2022 and completed his first year of a TAFE course in mechanical engineering.
3. At the time of his passing, Jack held a general marine licence, which was valid until February 2026. He did not have any restrictions on that licence. His father noted that Jack was experienced with boats and owned his own 'tinny'. When their home was flooded in 2021, Jack took his younger sister out on the tinny and was confident when operating boats.

THE CORONIAL INVESTIGATION

4. Jack'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.
5. 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.
6. 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.
7. Victoria Police assigned Detective Senior Constable (**DSC**) Aaron Simmonds to be the Coroner's Investigator for the investigation of Jack's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, witnesses and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Jack Mitchell Bird 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

9. On 15 December 2022, Jack Mitchell Bird, born 22 June 2006, was visually identified by his father, Trevis Bird.
10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. Forensic Pathologist Dr Bernard I’Oons, from Forensic Medicine Wollongong, conducted an examination on 20 December 2022 and provided a written report of his findings dated 20 April 2023.
12. The post-mortem examination did not reveal any significant injuries to the surface of the body. Moderate decomposition was present. The body was fully clothed, with shorts, multiple layers of shirts and heavy work boots, which were all wet.
13. Dr I’Oons noted that drowning is a diagnosis of exclusion requiring a full internal examination to exclude other causative factors. Confidence in this diagnosis relies on eyewitness accounts and the absence of external injuries or positive CT findings.
14. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at a low level. Dr I’Oons opined that this was likely the result of post-mortem production secondary to decomposition, rather than ingestion. No common drugs or poisons were detected.
15. Dr I’Oons provided an opinion that the medical cause of death was *consistent with drowning*.

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.

16. I accept Dr I'Ons' opinion as to the medical cause of death.

Circumstances in which the death occurred

17. Jack and his close friend, James Doyle, planned a trip to Lake Mulwala, near the Victorian/New South Wales border. Their fathers, Trevis Bird and Gerard Doyle, also planned to attend, however Trevis was unable to attend due to work commitments. The Doyle family owned a holiday cabin on Kyffins Reserve in New South Wales, located on Lake Mulwala.
18. On the morning of 10 December 2022, Trevis assisted Jack to prepare his fishing and camping gear, prior to the arrival of Gerard and James. Gerard and James arrived between 9.00am and 10.00am, to collect Jack. The trio travelled to the Kyffins Reserve camping area in Mulwala, on Lake Mulwala. Travelling separately to Jack, James and Gerard, were family friends of Gerard (Anthony and Bianca Cook and their two children).
19. That afternoon, at about 3.00pm, Jack and James deployed a fishing boat (registered to Gerard) onto Lake Mulwala. The boat was a 12-foot punt with a 15 horsepower pull-start motor. It was equipped with five life jackets. The pair spent several hours on the lake and returned to their campsite between 9.00pm and 9.30pm. Whilst on the lake, both Jack and James were wearing life jackets.
20. The next morning, Jack and James awoke at about 7.00am and entered the fishing boat at about 7.30am, accompanied by James' dog, Coco. The boat was fitted with life jackets, however neither Jack nor James was wearing a life jacket. At the same time, Gerard and his family friends entered the lake on another (larger) boat.
21. James operated the boat, whilst Jack sat in the back of the boat. James held a General Marine Licence with no restrictions, which was valid until 2026. The pair trawled for fish, then decided to travel along the lake to look for another fishing spot. The pair found a spot just outside the Sebel Yarrawonga Silverwoods Resort (**'the Sebel Resort'**), where they stopped and fished for about 90 minutes, but did not catch anything. By this time, the wind gusts had increased, resulting in choppy conditions on the lake.
22. When the boat was between 400m and 500m from the Sebel Resort, it encountered very choppy water and both James and Jack were ejected from the boat. The boat continued motoring away from the boys, whilst the boys tried to swim towards the Sebel Resort, calling out for help. A nearby witness, Simon Dowling, observed the boat motoring without anyone

- operating it. He called out to the boys and tried to find a floatation device but was unable to locate one. Due to the poor conditions, Simon was initially unable to enter the water to assist.
23. Simon's yelling caught the attention of several other witnesses. One witness, Shane Brady, located a large orange inflatable cushion from the pool area of the Sebel Resort, and gave it to Simon. Shane's friend, Jamie Culpitt, instructed the boys to stay calm and float on their backs. Jamie opined that Jack did not appear to be a competent swimmer.
 24. Jack disappeared under the water and did not resurface. Simon decided to jump into the water to help. He could not recall if Jack was already under the water when he entered the water. Shortly thereafter, a guest at the Sebel Resort, Lewis Kerr, heard the commotion and ran to assist, as he was a competitive swimmer. Simon and Lewis reached James at about the same time and gave him the inflatable cushion. Meanwhile, witness Thomas Harding used his own boat to reach Lewis' location. Lewis boarded the boat and the pair commenced searching for Jack. Simon escorted James back to shore, with the assistance of the inflatable cushion.
 25. Victoria Police and New South Wales Police members commenced a joint search operation for Jack, which spanned four days. On the evening of 15 December 2022, local resident Ross Holcombe was walking along a bike track that runs from the edge of Lake Mulwala to Corowa. As he followed the path alongside the lake, he stopped and looked out onto the water, towards the Sebel Resort. Just as he was about to leave and start walking home, he observed what appeared to be a body floating in the water. He was aware of the incident that occurred on Lake Mulwala a few days prior and thought this may have been related, so he immediately called 000 to report his discovery.
 26. Police attended the scene and launched a police vessel on the lake. At about 7.00pm, police reached the location where the body was seen. Members of the Corowa Volunteer Rescue Association (VRA) attended about 40 minutes later and assisted with retrieval of the body. The body was later identified as that of Jack Bird. Police did not identify any suspicious circumstances or signs of third-party intervention in connection with Jack's passing.

FAMILY CONCERNS

27. In his statement to the Court, Trevis queried why Jack and James were not being supervised on the water, and why the pair were not wearing life jackets. Trevis noted that on 10 December 2022, there were many boats out on the lake, as the conditions were good, and the water was relatively still. He noted that on 11 December 2022, there were very few vessels out on the

water, due to the choppy conditions, and queried why the boys were on the water when the conditions were poor.

28. Jack's mother, Tammy Bird, noted that she and Trevis were very strict regarding life jackets, and always ensured their children were wearing them when on a boat. She was surprised and did not understand why Jack was not wearing a life jacket on this occasion.
29. I note that both Jack and James held a general marine licence, with no restrictions, and that they had both operated boats before. They were therefore aware of their obligations and presumably were aware of the importance of wearing life jackets whilst on a boat. I am unable to determine why Jack and James were not wearing life jackets on 11 December 2022, particularly when they were both wearing life jackets on 10 December 2022. However, I am satisfied that this was a contributing factor in Jack's death. I cannot now determine that a life jacket would have prevented Jack's death, however if he was wearing a life jacket, he may have been able to remain above the water long enough to be rescued.

FURTHER INVESTIGATIONS

Use of life jackets

30. The Coroner's Investigator, DSC Simmonds, prepared a coronial brief in this matter, with statements and materials obtained from both New South Wales and Victoria.
31. DSC Simmonds noted that Jack and James were not legally obliged to wear a life jacket whilst the boat was under operation in NSW. In Victoria, wearing a life jacket is mandated. DSC Simmonds suggested that I consider making a recommendation to mandate the wearing of life jackets or personal floatation devices whilst a boat is being operated in New South Wales. He opined that not wearing a life jacket, the extra weight Jack was carrying due to his clothing and shoes, as well as an element of panic were all contributing factors to Jack's death. I accept this opinion.
32. I also accept DSC Simmond's recommendation and will recommend that the State Government of New South Wales and mandate the wearing of life jackets/personal floatation devices whilst a boat is in operation.

Use of 'dead man switch'

33. DSC Simmond also noted that the outboard motor on the boat was equipped with a 'dead man switch', however it did not appear to be in use at the time of the incident. One of the witnesses

to the incident, Marcus Cummins, who observed the boat that Jack and James were in, noted that the dead man switch was “*secured to the motor with a U-bolt and hadn’t been used at all*”. Marcus opined that the switch should be secured to the driver but conceded that a lot “*of people don’t always do that*”.

34. I note that if the dead man switch was connected as intended to James, when he was ejected from the boat, the engine would have stopped. This may have prevented the boat from motoring away from the boys and may have enabled them to climb back onto the boat more easily. I cannot determine that proper use of the dead man switch would have prevented Jack’s passing, however I note that it would have offered a better chance of survival.
35. Although most boat owners and users would be aware of the presence of the dead man switch, I intend to publish this finding as a timely reminder of the benefits of its use.

FINDINGS AND CONCLUSION

36. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Jack Mitchell Bird, born 22 June 2006;
 - b) the death occurred between 11 December 2022 at Murray River/Lake Mulwala, Mulwala, New South Wales, 2647, from *consistent with 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 the New South Wales State Government consider mandating life jackets/personal floatation devices for all people on and/or operating a boat or other vessel.

I convey my sincere condolences to Jack’s family for their loss.

Pursuant to section 73(1B) 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:

Trevis Bird, Senior Next of Kin

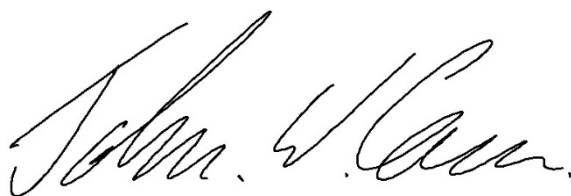
Boating Vic

New South Wales State Government

Teresa O’Sullivan, New South Wales State Coroner

Detective Senior Constable Aaron Simmonds, Coroner’s Investigator

Signature:



Judge John Cain
State Coroner
Date: 7 November 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.
