IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005157

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Lincoln Mark Harris
Date of birth:	24 February 2000
Date of death:	31 August 2024
Cause of death:	1a: Drowning
Place of death:	Rye Pier Napier St and Nepean Highway Rye Victoria 3941
Keywords:	Drowning, personal flotation devices, life buoys

INTRODUCTION

1. On 31 August 2024, Lincoln Mark Harris (**Lincoln)** was 24 years old when he died at Rye Pier. At the time of his death, Lincoln lived in Balaclava, Victoria with his partner, Jiwon Han **(Jiwon).** At the time of his death, Lincoln worked as an apprentice refrigeration and air conditioning mechanic.

2. He is remembered by his parents Mark Harris and Bridget Styles as loving, gentle and selfless.

THE CORONIAL INVESTIGATION

3. Lincoln'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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Lincoln's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Lincoln Mark Harris 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]

[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.

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

Circumstances in which the death occurred

7. On 31 August 2024 sometime after 1:00pm, Lincoln and Jiwon arrived at Rye Pier to go fishing in Port Phillip Bay. There was a strong wind at the pier, and the Bureau of Meteorology issued a warning for damaging surf conditions along the Mornington Peninsula.

8. While they were fishing, Jiwon went back to their car to use the nearby public bathrooms and collect a second camping chair. On her way to the bathroom, Jiwon received a call from Lincoln, who told her that he had accidentally caught a seagull in his fishing line and needed her help. She told him she was coming back to help and made her way back to the car to get the camping chair.

9. When Jiwon got back to Lincoln, he stood up out of his camping chair, which then flipped over due to the strong winds. When the chair flipped, two of Jiwon's bags fell into the sea. As Jiwon was trying to free the seagull, Lincoln asked if Jiwon needed the bags, but she did not answer.

10. Lincoln then proceeded to take his jacket and shoes off and removed his phone from his pocket to give to Jiwon. He then jumped into the sea to retrieve the bags.

11. Lincoln was able to collect one of the bags, but as he tried to swim back, he was overcome by the strong sea swells and struggled to stay afloat with his head repeatedly going under the water. He started calling for help and fisherman attempted to help by holding out their fishing rods for him to reach on to. Witnesses also tried to look for a flotation device or life ring along the pier, but none were available.

12. Despite Lincoln's strong swimming ability, he was unable to keep his head above the water and was swept away by the waves.

13. At approximately 2:40pm, emergency services were notified, and Victoria Police (**VP)** officers Ambulance Victoria (**AV)** paramedics and Fire Rescue Victoria attended the pier. VP's search and rescue squad were also called to attend.

14. Two search and rescue officers jumped into the water and began an urgent snorkel search in line formation. One of the bags was located at approximately 30 metres out from the pier. The officers continued to swim out to look for Lincoln, travelling towards yellow markers in the water.

15. At approximately 3:11pm, as the officers swam towards the markers, a police helicopter hovering approximately 300 metres further away dropped green sea dye into the water and deployed an orange smoke flare. The officers then swam towards the position, where they discovered Lincoln's body on the surface of the water.

16. The officers made several attempts to revive Lincoln in the water by cardiopulmonary resuscitation (**CPR)** which were unsuccessful. An officer then towed Lincoln back to the beach, where AV paramedics commenced CPR again. Lincoln was sadly unable to be revived and was declared deceased.

Identity of the deceased

17. On 31 August 2024, Lincoln Mark Harris, born 24 February 2000, was visually identified by his partner, Jiwon Han.

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

Medical cause of death

19. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 2 September 2024 and provided a written report of his findings dated 5 September 2024. A post-mortem computed tomography (**CT)** scan

20. The post-mortem CT scan revealed bilateral lung changes. Toxicological analysis of post-mortem samples identified the presence of delta-8-tetrahydrocannabinol (4ng/mL).[2]

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

22. I accept Dr Bedford's opinion.

INVESTIGATION

23. As no life buoys or personal floatation devices were available at Rye Pier at the time of Lincoln's death, the Court sent correspondence to Parks Victoria outlining a proposed recommendation that life buoys be made available on Rye Pier.

[2] A psychoactive cannabinoid found in cannabis

24. A representative from Parks Victoria responded that the successful use of life buoys was contingent on several factors which they "considered too variable to ensure their effective use". They noted that they have developed a risk treatment plan with an emphasis on preventative controls (such as signage and education), but there were no current standards that mandated the installation of lifebuoys. They wrote that assessments did not support the installation of life saving devices but may include installing other safety mechanisms including handrails and safety ladders during major pier and jetty reconstruction projects.

25. In a subsequent letter, Parks Victoria confirmed that they were not opposed to the potential implementation of public rescue equipment such as lifebuoys at Rye Pier, however they had not taken a definitive position about their installation. They noted their approach was to ensure any such decision was informed by an evaluation process and guided by their Visitor Safety Strategic Approach and was further supported by their internal risk management framework.

26. Parks Victoria confirmed they have initiated discussions with Life Saving Victoria to explore options for participating in a broader evaluation of public rescue equipment on piers and jetties. They are also aware of research being undertaken by Surf Life Saving Australia which will assess the effectiveness of public rescue equipment at a range of aquatic settings, which they see as an opportunity to assess which equipment would be most appropriate and effective at settings like Rye Pier, what additional mechanisms would be effective, and ensure decisions are consistent with sector-wide evidence.

27. Parks Victoria concluded that while they are open to implementing lifebuoys or alternative measures, they are to be supported by "robust evidence and deemed reasonably practicable within the specific operational and environmental context of the site".

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Lincoln Mark Harris, born 24 February 2000;

    b) his death occurred on 31 August 2024 at Rye Pier Napier St and Nepean Highway Rye Victoria 3941, from 1(a) drowning, and;

    c) his death occurred in the circumstances described above.

29. Having considered the circumstances and available materials, I consider that Lincoln's death was a tragic case of drowning as he selflessly attempted to retrieve Jiwon's bags which had fallen into the ocean.

30. While access to life buoys may not have prevented Lincoln's death, I am satisfied that the availability of such a device is a reasonably practicable measure which may prevent similar deaths and minimise the distress and trauma of bystanders who are rendered helpless to assist in an emergency.

RECOMMENDATIONS

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

(i) In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that life buoys be made available by Parks Victoria on Rye Pier.

I convey my sincere condolences to Lincoln's family and loved ones 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:

Jiwon Han, Senior Next of Kin

Bridget Styles

Senior Constable Ben Blanche, Coroner's Investigator

Signature:

Coroner Kate Despot

Date: 10 August 2026

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.