IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006672

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Loi Ngoc Pham
Date of birth:	21 July 1976
Date of death:	16 November 2024
Cause of death:	DROWNING IN THE SETTING OF RECREATIONAL SNORKELING
Place of death:	Port Phillip Bay Waters off Altona Beach Altona, Victoria 3018
Keywords:	Snorkeling; snorkeling equipment; abalone fishing; drowning; culturally and linguistically diverse background

INTRODUCTION

1. On 16 November 2024, Loi Ngoc Pham was 48 years old when he drowned while snorkelling for abalone off Altona Beach. At the time of his death, Mr Pham lived at Point Cook with his wife and daughter.

2. Mr Pham was described as a confident swimmer. He regularly visited Altona Beach to snorkel for abalone with his friend and had been doing so for approximately one year prior to his death.

THE CORONIAL INVESTIGATION

3. Mr Pham'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. 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.

6. Senior Constable (SC) Yuvraj Sharma acted as the Coronial Investigator for the investigation of Mr Pham's death. SC Sharma conducted inquiries on my behalf and compiled a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Loi Ngoc Pham 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

8. On the morning of 16 November 2024, Mr Pham collected his friend, Tuan Phan, from his home in Werribee. The pair planned to snorkel and collect abalone from the rocks off Altona Beach.

9. Mr Pham and his friend arrived at Altona Beach at approximately 8.45am. Tuan Phan recalled that Mr Pham was equipped with a snorkelling mask, floating vest and weight belt. Although Tuan Phan did not say that Mr Pham also had a snorkel, and neither a mask nor a snorkel was eventually recovered, it is highly likely that Mr Pham was also equipped with a snorkel. The floating vest referred to by Tuan Phan was a yellow kayaking buoyancy vest tied to Mr Pham's weight belt with approximately 10 metres of light line. Also tied to the vest on approximately 0.3 metres of line was an abalone catch bag.

10. Mr Pham and Tuan Phan both entered the water, however after a short time Tuan Phan said that he was going to return to the shore because the water was too cold. Mr Pham continued into deeper water to snorkel alone.

11. Tuan Phan continued to gather abalone on the shore. He lost sight of Mr Pham and did not see him for about two hours. Tuan Phan eventually became concerned and requested Hong Tran (another person at the beach but previously unknown to Tuan Phan) to ask the lifeguard for assistance. Tuan Phan and Hong Tran then approached volunteer life saver, Jason Dalby.

12. They advised Mr Dalby that there was a person out in the water, under a yellow buoy. They also explained that the person had been in the water for two or three hours. Mr Dalby went to the lifesaving tower and used binoculars to locate the buoy, which was approximately 400 metres from the shore.

[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.

13. Mr Dalby updated Life Saving Victoria (**LSV**) by radio and advised that he was alone and required assistance. He also called his captain, who was 10 to 15 minutes away.

14. Mr Dalby entered the water at 11.30am and paddled out to the buoy where he found Mr Pham lying face down in the water. Mr Dalby rolled Mr Pham onto his back and saw that he was unresponsive and not breathing.

15. Additional LSV volunteers arrived, followed soon after by members of the Water Police. Mr Pham's body was soon recovered from the water. SC Roulston of the Water Police concluded that Mr Pham's legs and hips were stiff from rigor mortis, indicating that he had been dead for some time. Once Mr Pham's body was returned to the shore, paramedics confirmed that he was deceased.

16. Police investigators noted that LSV volunteers were on duty that day and patrolling Altona Beach, but the patrol area did not extend to the area where Mr Pham was snorkelling. The recorded air temperature at 9.00am that day was 21ºC, with a southerly wind of 21 kts (39 km/h).[2] Overhead images taken from a helicopter during the recovery operation show the sea state as a slight chop, with no visible white caps. Surface water temperature for the northern portion of Port Phillip bay was approximately 18ºC.

17. When found, Mr Pham was approximately 550 metres out from the end of the Altona Pier in five to six metres of water. He was wearing a full wet suit, without gloves, booties or hood. He was also wearing a weight belt fitted with four weights. These appear to be a type weighing 1.3 kg each, therefore totalling 5.2 kg. Mr Pham was not wearing fins and there is no evidence that he was equipped with fins at the outset.

18. The "yellow buoy" referred to by some witnesses does not correspond to any buoy or navigation aid. There are none shown on the electronic marine charts for the area in which Mr Pham was found. I am satisfied that the "yellow buoy" was in fact the yellow buoyancy vest which was tied to Mr Pham's weight belt by approximately 10 metres of line.

19. Police did not identify any suspicious circumstance in connection with Mr Pham's death.

[2] Measured at Altona.

Identity of the deceased

20. On 16 November 2024, Loi Ngoc Pham, born 21 July 1976, was visually identified by his friend, Tuan Phan.

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

Medical cause of death

22. Forensic Pathology Registrar Dr Felicity Barnes[3] from the Victorian Institute of Forensic Medicine conducted an autopsy on 20 November 2024 and provided a written report of her findings dated 8 April 2025.

23. The post-mortem examination revealed a foam plume around the mouth, fluid in the maxillary sinuses, pulmonary oedema, watery stomach content, bleeding at the insertion of the neck muscles and tongue, bleeding into the heart muscle and cerebral oedema. These findings can be seen in the setting of drowning. However, Dr Barnes noted the diagnosis of drowning is highly reliant on circumstantial evidence, as there are no specific features of drowning that can be seen at the time of autopsy.

24. There was no significant natural disease identified on post-mortem examination and as such, there was no evidence to suggest an acute medical event occurred while Mr Pham was in the water. However, an autopsy cannot exclude non-structural natural causes of unconsciousness that may contribute to drowning, such as abnormal heart rhythms (arrythmias) or seizure.

25. The post-mortem examination identified minor blunt-force injuries to the arms, legs and lower abdomen. Dr Barnes opined that these injuries could have been caused by Mr Pham's movement in the water before or soon after the death. There were no significant injuries that could have caused or contributed to the death.

26. Toxicological analysis of post-mortem samples identified the presence of chlorpheniramine at non-toxic levels. Chlorpheniramine is an antihistamine commonly used in cold and flu preparations.

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

[3] Supervised by Forensic Pathologist Adjunct Associate Professor Sarah Parsons.

28. I accept Dr Barnes' opinion save that, based upon all the available evidence, I am satisfied on the balance of probabilities that the cause of death is drowning, and the cause of death may be fully detailed as "Drowning in the setting of recreational snorkelling".

FURTHER INVESTIGATIONS

29. As part of the investigation, I referred this case to the Coroner's Prevention Unit (**CPU**)[4], to obtain further data concerning deaths which have occurred in the context of snorkeling.

Data extracted

30. The CPU searched the Court's surveillance database, which contains information on all Victorian deaths reported to the Coroner since 2000. The CPU identified 13 deaths between 1 January 2020 and 16 December 2024 (including Mr Pham) where the deceased had been snorkelling.

31. In 11 of the 12 cases (excluding Mr Pham), the deceased was confirmed to have been born in South-East Asia. This included five deceased (excluding Mr Pham) who were born in Vietnam. Four of the 12 cases occurred at Altona Beach. At least three of these four drownings occurred when the deceased was snorkelling for abalone.

Previous coronial recommendations

32. Other coroners have examined the overrepresentation of persons from culturally and linguistically diverse backgrounds in snorkelling related deaths. Pertinent recommendations are summarised below.

Xu Zhou and Xuan Truong Ha

33. Mr Zhou[5] died while snorkelling for abalone at Altona Beach. He died the same day as Mr Ha,[6] who was swimming and diving for abalone at Williamstown Beach. Then Deputy

[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.

[5] Finding into death without inquest – Xu Zhou.

[6] Finding into death without inquest – Xuan Truong Ha.

State Coroner Caitlin English commented on the overrepresentation of people of South-East Asian descent who have drowned while diving or snorkelling for abalone.

34. Deputy State Coroner English conducted an extensive investigation and obtained further information from Life Saving Victoria. Her Honour recommended:

    1. *Life Saving Victoria updates its public awareness messaging to include abalone fishing and promote this messaging through targeted education, social media channels, and other relevant websites.*
    2. *Life Saving Victoria work with recreational fishing organisations and agencies that promote recreational fishing to include safe practices for abalone fishing; and*
    3. *The Victorian Fisheries Authority update the Victorian Recreational Fishing Guide and its other resources to include information about abalone fishing safety and the risk of drowning whilst abalone fishing.*

Do Hung Vu

35. Coroner Paresa Spanos (now Deputy State Coroner) investigated the 2022 death of Mr Vu,[7] who died while snorkelling for abalone at Altona Beach. Mr Vu was described as a competent swimmer, however only had about six months' experience in snorkelling for abalone.

36. Her Honour restated the above recommendations by then Deputy State Coroner English and noted her support for the ongoing work of the Victorian Fisheries Authority and Life Saving Victoria in promoting this education to culturally and linguistically diverse communities.

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 Loi Ngoc Pham, born 21 July 1976;

    b) the death occurred on 16 November 2024 at Port Phillip Bay, Waters off Altona Beach[8], Altona, Victoria 3018, from drowning in the setting of recreational snorkelling; and

    c) the death occurred in the circumstances described above.

[7] Finding into death without inquest – Do Hung Vu.
[8] 37º 52.669′ S; 144º 49.833′ E

COMMENTS

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

39. Eleven months earlier, on 9 January 2024, Viet Quy Dinh[9] drowned while snorkelling off Altona Beach. He was a 39 year old man originally from Vietnam. He was snorkelling for abalone and wearing a wetsuit with a substantially laden weight belt. He did not have the benefit of any buoyancy device or fins.

40. On 12 January 2024, Gensheng Zhao[10], a 56 year old man, drowned while snorkelling for abalone close to Seal Island in Bass Strait. He was wearing a "shorty" wetsuit, wetsuit booties and gloves, goggles with snorkel, weighted belt and fins. He was not using a buoyancy compensation device or other buoyancy aid.

41. I repeat and expand upon the comments I made in those cases.

42. If wearing a substantial wetsuit, a weight belt is necessary to offset the buoyancy of the wetsuit in order to dive effectively beneath the surface. There is however an inherent risk with this combination of equipment. Moreover, the risk is exacerbated by the absence of fins which provide a significant advantage when swimming to the surface.

43. It is imperative that weight belts used in this manner must be designed with ease of dumping as the first priority. The construction, material, and placement of weights should be aimed at reducing the likelihood that the belt may slip around the body and move the buckle away from its intended position. The design of the buckle must be such that, when released, the entire belt is released without catching. The profile of the buckle must be such that it is easy to manipulate, even with heavily gloved fingers.

44. There are many products on the market that appear to meet these requirements, and others that are far more basic. Swimmers snorkelling with a weight belt should select a high quality belt that they know they can dump quickly and easily, every time. Safety messages should also emphasise that the weight belt should be dumped without hesitation if the swimmer is in any difficulty.

[9] COR 2024 0175
[10] COR 2024 0236

45. The Victorian Fisheries Authority – 'Be Smart When Snorkelling' information includes the following advice:

    (a) Use a dive float or flag. A dive float tells other water users where you are.

    (b) Use a wetsuit, mask and snorkel, gloves, and flippers Having well fitted equipment will make your snorkel comfortable and help you collect fish safely.

    (c) Get a weight belt with a quick release buckle If you are finding it difficult to keep your head above water, undo and drop your weight belt. Without a weight belt, your wetsuit will help you float and you can signal for help.

46. The *Drowning report* by Life Saving Victoria for 2024-25 reported that there were 52 fatal drownings in Victoria, an increase of 9% against the average for the preceding decade. Of the total of 52 drownings, 55% were males. 2024-25 again saw a very high proportion (37%) of fatal drownings involving people from multicultural populations in Victoria. This is close the highest number on record for drownings among multi-cultural populations in Victoria. In 2023-24, there were 21 drownings recorded involving people from culturally and linguistically diverse backgrounds. This represented 39% of all fatalities for the year.

47. These data reveal a disturbing trend and are a reminder of the need for all organisations and government agencies having a role or interest in water safety to regularly review the effectiveness of their safety messaging and programs. Campaigns must remain up to date and seek the most effective means to reach the public. Persons from culturally and linguistically diverse backgrounds are tragically overrepresented in these statistics, and special efforts must continue to be made to reach this cohort.

ACKNOWLEDGEMENTS

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

I thank the Coronial Investigator and those assisting for their work in this investigation.

ORDERS & 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:

Szu Hsuan (Michelle) Lu, Senior Next of Kin

Life Saving Victoria

Victorian Fisheries Authority

Senior Constable Yuvraj Sharma, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 02 July 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.