IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 000464

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Reema Sondhi
Date of birth:	1 March 1981
Date of death:	24 January 2024
Cause of death:	1(a) Drowning
Place of death:	Forrest Caves Beach, Southwest Coast of Phillip Island, Victoria
Key words:	*Multiple drowning deaths, coastal waters, Phillip Island, Bass Coast, CALD, water awareness and safety*

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 000465

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Jagjeet Singh Anand
Date of birth:	4 March 2000
Date of death:	24 January 2024
Cause of death:	1(a) Drowning
Place of death:	Forrest Caves Beach, Southwest Coast of Phillip Island, Victoria

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 000466

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Kirti Bedi
Date of birth:	19 September 2003
Date of death:	24 January 2024
Cause of death:	1(a) Drowning
Place of death:	Forrest Caves Beach, Southwest Coast of Phillip Island, Victoria

IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	Court Reference: COR 2024 000476

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Suhani Anand
Date of birth:	13 June 2003
Date of death:	25 January 2024
Cause of death:	1(a) Complications following an out of hospital cardiac arrest due to drowning
Place of death:	Alfred Hospital, 55 Commercial Road, Melbourne, Victoria

INTRODUCTION

1. On 24 January 2024, Reema Sondhi, Jagjeet Singh Anand, Kirti Bedi, and Suhani Anand, were members of a large family group who attended Forrest Caves Beach.

2. Sadly, Reema, Jagjeet, and Kirti fatally drowned that day. Suhani was pulled from the water and died in hospital the next day.

3. Reema Sondhi was aged 42 years. She was the wife of Sanjeev Sondhi and the sister of Ankur Chhabra. She was a stay-at-home mother and described as a very happy person. Reema and her husband lived in India. They arrived in Australia on 7 January 2024 for a planned holiday to visit her brother and extended family. Reema was described as having limited exposure to beaches; she did not have any swimming experience. At the time of her death, Reema and her husband were staying with Ankur and his family in Clyde.

4. Jagjeet Singh Anand was aged 23 years. He was the nephew of Reema Sondhi and Ankur Chhabra and the brother of Suhani Anand. Jagjeet had arrived in Australia in late 2018 on a student visa. He had completed his nursing degree and was working as a registered nurse. At the time of his death, he was a permanent resident. He was also described as having limited swimming ability. He would occasionally visit a local pool but had no formal training. He lived with his sister in Cranbourne.

5. Kirti Bedi was aged 20 years. She was the sister of Amrita Chhabra and sister-in-law of Ankur Chhabra. She had arrived in Australia from India in mid-2023 on a student visa and was studying a Bachelor of Psychology at Deakin University and was working a variety of jobs in cleaning and food services within the aged care sector. Kirti was described as having no formal swimming training and was unable to swim. She lived in Clyde with her sister and brother-in-law.

6. Suhani Anand was aged 20 years. She was the sister of Jagjeet Singh Anand and niece of Ankur Chhabra and Reema Sondhi. She had arrived in Australia from India in late 2022 on a student visa. She was studying a Bachelor of Nursing at Federation University and worked as a personal care assistant in aged care. Suhani was described as having no formal swimming training and was unable to swim. She lived in Cranbourne with her brother.

THE CORONIAL INVESTIGATION

7. The deaths were reported to the coroner as they fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. 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.

9. 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.

10. Victoria Police assigned Sergeant Leigh Cole to be the Coroner's Investigator for the investigation the deaths. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a combined coronial brief of evidence for all the deaths.

11. This finding draws on the totality of the coronial investigation into the deaths, 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 deaths occurred

12. On 24 January 2024, Reema Sondhi, Jagjeet Singh Anand, Kirti Bedi, and Suhani Anand went on a family day trip to Phillip Island. In all, there were nine people in the group, including two young children.

[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. During the day, the group visited the Phillip Island Chocolate Factory and the National Vietnam Veterans Museum in Newhaven.

14. After leaving the Museum, they had planned to see the Penguin Parade in Summerlands but stopped at Forrest Caves Beach to eat their packed lunch after seeing a sign by the road. They parked their cars and made their way down to the beach.

15. Ankur, Amrita, and Sanjeev all later stated to police that they did not notice any warning signs about the beach or the lack of Life Saving Victoria patrols on their journey from the carpark to the beach.

16. After eating lunch, the children began to play in the shallow water along the shoreline. They were subsequently joined by some of the adults. None of the group were dressed in swimming attire as they had not planned to go swimming that day.

17. Ankur stated that Reema, Jagjeet, Kirti, and Suhani and one other adult, Sanjeev, were in water below waist height when he asked everyone to get out of the water so they could make their way to the penguin parade. They all responded that they wanted to stay in the water a bit longer. Ankur described the group as having fun. He noted that there were no big waves at the time.

18. Ankur and Amrita helped the children change out of their wet clothes. At about this time, the adults began making their way in from the water whilst holding hands. However, when Ankur and Amrita looked back toward the water a short time later, it appeared that some of the adults were asking for help by waving their arms. The group of five were now in a different location to where they had previously been in the water.

19. Sanjeev stated that as he and the others began to leave the water, which was about knee-height, a large wave knocked them off their feet and into the waves. Further waves then crashed over him. Whilst he was able to eventually stand up and get to the shoreline, he was unable to see what had happened to the other people in the water.

20. Ankur stated that he tried to swim to the others, but the waves were large, and he was pushed back. The large waves began pulling the four remaining adults in the water further out.

21. On the shore, Ankur, his wife, and Sanjeev yelled for help, alerting others on the beach.

22. Emergency services were contacted by other beachgoers at about 3.30pm. The beachgoers subsequently retrieved three unconscious females from the water, bringing them onto the sand. They were unable to retrieve the fourth person due to the rip and dangerous conditions.

23. Victoria Police members arrived at the scene at 3.42pm, finding three people on the beach receiving cardiopulmonary resuscitation (**CPR**) from members of the public. The fourth person remained unaccounted for. One of the police members subsequently saw a person in the water but when he went to retrieve them, he lost sight of them in the waves and returned to shore.

24. The first Ambulance Victoria paramedics arrived at the scene at about 3.44pm and began providing treatment to those onshore.

25. During this period, further emergency personnel were dispatched to and arrived at the scene. A boat from Cape Woolamai Life Saving Club (**LSC**) was also dispatched.

26. At 3.55pm, the Victoria Police Airwing arrived and directed the LSC boat to the remaining person in the water, a male, who was located unconscious in knee-deep water not far from the shoreline. He was taken back to the beach where CPR was commenced.

27. Members from the Woolamai LSC also arrived at the scene to assist with resuscitation efforts.

28. CPR and Advance Life Support Resuscitation was performed for an extended period on the beach on the four unconscious adults by paramedics and additional members from Victoria Police and the Woolamai LSC.

29. After approximately 45 minutes of treatment with no signs of life, paramedics declared Reema, Jagjeet, and Kirti deceased.

30. Suhani was flown to Alfred Hospital, arriving at approximately 5.52pm. Following initial treatment and assessment in the Emergency Department, Suhani was transferred to the Intensive Care Unit where she subsequently passed away the following morning, 25 January 2024.

The beach

31. As part of the coronial investigation, Sergeant Cole obtained a statement from Detective Senior Constable (**DSC**) Kane Treloar who is a Life Saving Victoria volunteer, who holds a number of qualifications related to water safety and rescue, and has significant experience in

the area. DSC Treloar has provided a number of expert statements to the Court in the past analysing and providing opinion in relation to water-related deaths.

32. According to DSC Treloar, Forrest Caves Beach, officially known as Forrest Bluff West Beach, is located in Newhaven on the southern coast of Phillip Island, approximately one hour and 45 minutes from Melbourne. As a southwest facing beach, it is highly exposed and susceptible to high energy swells that come from Bass Strait. Beaches along the southern side of Phillip Island are known for their strong rips. The Australian Beach Safety and Management Database Program rates the beach as 'highly hazardous'.

33. Following the deaths, DSC Treloar reviewed the airwing footage at the time of the incident and photographs of the beach. He subsequently identified a single primary rip that was in effect at the time of the incident. He noted that the type of rip is known as a transverse bar and rip. A choppy swell of between 0.5 metres and 1 metre had formed around the outside of the rip. These conditions were typical along this part of the coastline.

34. Commonly, beaches such as Forrest Bluff West have a single breaking zone that has surf of a consistent size as the surf travels shoreward, washing up on the shoreline. From there, the water on the shoreline uses the rip current to return it out to sea. This occurs for normally less than 100 metres before the water has a loss of power and never normally extends beyond the back of the breaking waves. Being this far out and unable to touch the bottom will cause swimmers to become distressed.

35. As beachgoers walk onto the beach, they will have an elevated view across the beach and would be able to view and assess surf conditions. Directly in front of the stairs leading down to the beach on this day is where the primary rip was in existence. This has been identified as the area the deceased entered the water on the day of the incident.

36. The dark water at the front of the rip would have appeared inviting to those of limited swimming ability. The areas where broken waves were located would actually have been a much safer place to swim as the currents would have pushed any swimmers back towards the shore. However, DSC Treloar noted that it is common that persons later requiring rescue from rips will misjudge this darker and less turbulent water as safer, when in reality it takes this appearance because it is flowing back out to sea and away from shore.

37. DSC Treloar noted that all of the deceased had limited or no swimming ability nor knowledge of Australian beaches and that only an experienced swimmer with experience and understanding of rips would have been able to extricate themselves. The easiest way for this

to occur was to swim into the rougher water, which would have been counterintuitive to a person who was near drowning and with limited swimming experience.

Warning signs at the beach

38. According to Sergeant Cole, signage with general beach warnings was prominently displayed directly at the entrance where you would commence walking out to the beach at Forrest Bluff West. On the day of the incident the sign was clearly displayed and visible without any obstruction.

Photograph of the warning sign, located along the path from the carpark to the entrance to the beach.

39. The sign provided the following information:

(a) the first section displayed general warnings with pictorial representations indicating 'No Lifesaving Service', 'Dangerous Currents', and 'Submerged Objects';

(b) the next section detailed specific information in English about the availability of Lifesaving Services. It stated, *"This beach is not patrolled"*. It also detailed that Woolamai Beach is patrolled during certain times and is 4.5km away; and

(c) the third section detailed beach regulations including prohibited behaviour.

40. Sergeant Cole noted there is no provision on the signs for translation to foreign languages.

41. He also noted that there is no current Australian Standard in relation to aquatic signage. The most recent Australian Standard in relation to this signage was AS/NZS 2416:2010, which was withdrawn in Australia in 2021.

Conclusion

42. Sergeant Cole concluded his investigation by outlining the following contributing factors:

(a) while there was signage in place warning of the dangers of swimming at Forrest Bluff West, the family group did not notice, pay attention to, or think relevant any signs at the commencement of the walking track to Forrest Bluff West that warned that the beach was unpatrolled and had dangerous currents;

(b) given that no one in the group had any swimming attire, they did not have an intention on entering the water but subsequently did so fully or mostly clothed;

(c) each of the deceased had no or limited swimming ability and had little or no experience in ocean swimming;

(d) the group appears to have entered the water where a rip was occurring;

(e) it is likely the group believed this was a good place to swim as the water appeared calm;

(f) the group were subsequently dragged out into the rip; and

(g) they did not have the knowledge, skills, nor experience to navigate their way back to the beach.

43. He also referred to suggested recommendations made by Detective Acting Sergeant Madeleine McDonald, Coroner's Investigator for a drowning death at Rosebud,[2] which he considered were relevant to his investigation:

(a) develop adequate signage including a multilingual format (the deceased in that matter had English as their second language). This was also a coronial recommendation made

[2] This coronial investigation remains ongoing.

by then Deputy State Coroner Caitlin English in regard to the deaths of Ross and Andrew Powell;[3] and

(b) education and promotion of Surf Life Saving Australia's 'BeachSafe' application (**app**) via social and mainstream media to encourage members of the public to check and use the information provided before attending the beach.

Identity of the deceased

44. Ankur Chhabra had the difficult task of visually identifying his family members:

    (a) Reema Sondhi, born 1 March 1981;

    (b) Jagjeet Singh Anand, born 4 March 2000;

    (c) Kirti Bedi, born 19 September 2003; and

    (d) Suhani Anand, born 13 June 2003.

45. Ankur signed a formal Statement of Identification to this effect for each of the deceased.

46. Identity is not in dispute in any of these cases and no further investigation is required.

Medical cause of death

47. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted external examinations on each of the deceased on 25 January 2024 and provided written reports of her findings dated 5 February 2024.

48. Dr Archer's findings and her medical opinion regarding the cause of death for each deceased are outlined below. I accept Dr Archer's opinion for each case.

Reema Sondhi

49. The post-mortem examination was consistent with the reported circumstances. There was no evidence of any injuries that could have caused or contributed to death. There were signs of

[3] See Finding into Death Without Inquest regarding Ross William Powell, COR 2019 2001, and Finding into Death Without Inquest regarding Andrew Francis Powell COR 2019 2002, both published 4 April 2022.

resuscitation. Toxicological analysis of post-mortem samples identified the presence of amlodipine[4] and bisoprolol.[5]

50. Dr Archer provided an opinion that the medical cause of death was *"1(a) Drowning"*.

Jagjeet Singh Anand

51. The post-mortem examination was consistent with the reported circumstances. There was no evidence of any injuries that could have caused or contributed to death. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

52. Dr Archer provided an opinion that the medical cause of death was *"1(a) Drowning"*.

Kirti Bedi

53. The post-mortem examination was consistent with the reported circumstances. There was no evidence of any injuries that could have caused or contributed to death. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

54. Dr Archer provided an opinion that the medical cause of death was *"1(a) Drowning"*.

Suhani Anand

55. The post-mortem examination was consistent with the reported circumstances. There was no evidence of any injuries that could have caused or contributed to death. Toxicological analysis of ante-mortem samples collected on 24 January 2024 identified the presence of midazolam.[6]

56. Dr Archer provided an opinion that the medical cause of death was *"1(a) Complications following an out of hospital cardiac arrest due to drowning"*.

---

[4] Amlodipine is indicated for hypertension and angina.
[5] Bisoprolol is indicated for hypertension.
[6] Midazolam is derivative used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.

FURTHER INVESTIGATION

Bass Coast Shire Coastal Risk Assessment

57. As part of the coronial brief, Sergeant Cole provided information about the Bass Coast Shire Coastal Risk Assessment project, which was developed as part of the Surf Life Saving Australia Beach Drowning Black Spot Reduction Program in 2019.

58. The objective of the project was to conduct a coastal risk assessment of priority sections of Bass Coast Shire. The risk assessment process facilitated both signage and other multifactorial treatment and control options specific to the identified priority sites. Forrest Bluff West was one of the identified priority sites.

59. The Bass Coast Shire Coastal Risk Assessment Report (**the Report**) for the aquatic signage at Forrest Bluff West notes, *"Defined access sign noted at time of assessment. Consider reviewing content, placement and sizing of sign content"*.[7]

60. The Report was delivered to all coastal land managers within the Bass Coast Shire Local Government Area, including Bass Coast Shire Council, Parks Victoria, and Phillip Island Nature Parks in September 2019. It made recommendations to mitigate beach hazards as follows:[8]

    (a) standardising beach safety signage across the region to meet the AS/NZS 2416 – Water safety signs and beach safety standard (which has now been withdrawn in Australia);

    (b) implementing a process for continuous monitoring and review of hazards, to ensure that new hazards are detected and managed and linked to modification or maintenance of existing action plans; and

    (c) undertaking ongoing reporting to communicate the risk mitigation activities and outcomes, providing information to inform decision-making, improve risk management activities and facilitate interaction with stakeholders

61. According to Royal Life Saving Australia, Standard AS/NZS 2416 has been replaced by the International Standard ISO 20712, which guides the design and application of water safety signs. Noting the changes were subtle, Royal Life Saving Australia indicated there is no

---

[7] Life Saving Victoria, Bass Coast Shire Coastal Risk Assessment Report, Project Stage 2, page 400.
[8] Bass Coast, Report recommends Bass Coast beach safety strategies, 9 December 2019, https://www.basscoast.vic.gov.au/about-council/news-listing/report-recommends-bass-coast-beach-safety-strategies.

immediate need to update recent signage. However, signage should be reviewed periodically as part of ongoing continual improvement safety practices.[9]

62. The Report was released publicly this year.

Multicultural Engagement Network

63. Given that each of the deceased were born overseas and had not resided in Australia for a relatively lengthy period, I obtained a statement from Nick Grant-Collins, Acting Coordinator Community Resilience at Bass Coast Council, regarding the work of the Multicultural Engagement Network as part of my investigation.

64. Mr Grant-Collins advised that the Multicultural Engagement Network was initially established to support public health messaging through Culturally and Linguistically Diverse (**CALD**) Communities Task Force funding.

65. Specifically with respect to drownings and following the drownings that are the subject of this investigation, Bass Coast Shire and Mornington Peninsula Shire convened a group of southeast Melbourne councils committed to collaboration and innovation to drive better beach safety outcomes for all community members, with a strong emphasis on engagement with CALD communities.

66. The group recognised that while the vast majority of coastland and coastal hazards are located in Bass Coast Shire and Mornington Peninsula Shire, the movement of communities across southeast Melbourne is such that engaging with these communities in Casey, Cardinia, and Dandenong councils was critical to the success of broader campaigns.

67. Along with those councils, Belgravia Leisure was identified as a key partner in the cross-council water safety group. The Multicultural Engagement Network was also identified as a key partner in the work of the cross-council water safety group and have been engaged to support key messaging campaigns.

68. The cross-council water safety group developed a community capacity building, messaging, and advocacy agenda. They also developed, implemented, and evaluated digital and print beach safety messaging campaigns in consultation with Life Saving Victoria, including

---

[9] Royal Life Saving Victoria, Updates to Health and Safety Guidance, Regulations & Standards for Aquatic Facilities, https://www.royallifesaving.com.au/about/news-and-updates/news/2024/oct/updates-to-health-and-safety-guidance,-regulations-and-standards-for-aquatic-facilities.

messaging designed to address the dangers of wading and entering the water at unpatrolled beaches.

69. Currently, the cross-council water safety group has identified three key Strategic Priority Areas (community capacity building, environmental and infrastructure improvements, and advocacy) and is in talks with Life Saving Victoria to develop a cross-council framework document.

70. Further, in partnership with local land managers and Life Saving Victoria, Bass Coast Council is scoping improvements to emergency markers, as well as implementation of signage audits and new secondary hazard signage at high-risk beaches.

Life Saving Victoria's engagement with the CALD community

71. Life Saving Victoria has a stand-alone Diversity and Inclusion Department to engage with Victoria's CALD communities.

72. Over a period of 17 years, Life Saving Victoria has engaged with over 250,000 new arrivals, refugees, international students, and migrants to provide targeted education and training. In the 2023-24 year, they delivered activities to over 28,000 CALD community members via 764 separate water safety education and training focussed activities and courses. Beach safety, rip awareness, and signage are key components of most of these activities.

73. Life Saving Victoria also provides learn to swim lessons to Victorian CALD community members, with nearly 1,100 participants receiving lessons in 2023-2024 through a variety of sources.

Coroners Prevention Unit review of similar fatal incidents

74. As part of my investigation, I also asked the Coroners Prevention Unit (**CPU**) to compile statistics on unintentional deaths at beaches along the Victorian coastline between 1 July 2014 and 28 October 2024.[10]

[10] 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.

75. The CPU identified 75 unintentional coastline drowning deaths of swimmers between 1 July 2014 and 28 October 2024. Among these, 36 deceased were born overseas.[11]

76. Table 1 shows the annual number of unintentional coastline drowning deaths among swimmers by the deceased's place of birth.

Table 1. Annual number of unintentional coastline drowning deaths among swimmers by place of birth, Victoria 1 July 2014 to 28 October 2024. (‡ denotes part year to 28 October 2024).

Financial year	Australia	Overseas	Unknown	Total
2014/15	3	2	-	5
2015/16	3	7	-	10
2016/17	4	-	1	5
2017/18	4	4	-	8
2018/19	3	4	-	7
2019/20	1	1	-	2
2020/21	4	5	-	9
2021/22	1	2	-	3
2022/23	1	3	7	11
2023/24	3	8	2	13
2024/25‡	-	-	2	2
Total	**27**	**36**	**12**	**75**

77. Table 2 shows the monthly number of unintentional coastline drowning deaths among swimmers across the period. The summer holiday months generally had the highest number of unintentional coastline drownings among swimmers. Additionally, in January 2024 there was a substantial spike compared to other years. This was due to the incident involving four deaths that are the subject of the current investigation.

Table 2. Monthly number of unintentional coastline drowning deaths among swimmers, Victoria 1 July 2014 to 28 October 2024. (‡ denotes part year to 28 October 2024).

Year	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2014							-	1	-	-	-	2
2015	1	1	-	-	-	-	-	-	-	-	1	1
2016	4	2	1	-	-	1	-	-	1	-	-	-
2017	1	1	1	-	1	-	-	-	-	1	-	3
2018	3	1	-	-	-	-	-	-	-	-	-	4
2019	3	-	-	-	-	-	-	-	-	-	-	-
2020	2	-	-	-	-	-	1	-	-	-	1	4
2021	1	-	1	1	-	-	-	-	-	-	-	1
2022	2	-	-	-	-	-	1	-	-	-	-	2
2023	2	3	1	2	-	-	-	-	1	-	-	-
2024‡	7	3	1	-	1		1	1				
Total	**26**	**11**	**5**	**3**	**2**	**1**	**3**	**2**	**2**	**1**	**2**	**17**

[11] In 12 deaths, the CPU were unable to identify country of birth.

78. Table 3 shows the monthly number of unintentional coastline drowning deaths among swimmers born overseas. As in Table 2, the highest number of these drownings occurred during the summer holiday months each year.

Table 3. Monthly number of unintentional coastline drowning deaths among swimmers born overseas, Victoria 1 July 2014 to 28 October 2024. (‡ denotes part year to 28 October 2024).

Year	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2014						-	-	-	-	-	-	1
2015	1	-	-	-	-	-	-	-	-	-	1	1
2016	4	1	-	-	-	-	-	-	-	-	-	-
2017	-	-	-	-	-	-	-	-	-	1	-	1
2018	1	1	-	-	-	-	-	-	-	-	-	3
2019	1	-	-	-	-	-	-	-	-	-	-	-
2020	1	-	-	-	-	-	-	-	-	-	1	4
2021	-	-	-	-	-	-	-	-	-	-	-	1
2022	1	-	-	-	-	-	1	-	-	-	-	2
2023	-	-	-	-	-	-	-	-	-	-	-	-
2024‡	6	1	1	-	-	-	-	-	-	-		
Total	**15**	**3**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**2**	**13**

FINDINGS AND CONCLUSION

79. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased were:

(i) Reema Sondhi, born 1 March 1981;

(ii) Jagjeet Singh Anand, born 4 March 2000;

(iii) Kirti Bedi, born 19 September 2003;

(iv) Suhani Anand, born 13 June 2003;

(b) the deaths of Reema, Jagjeet, and Kirti occurred on 24 January 2024 at Forrest Caves Beach, Southwest Coast of Phillip Island, Victoria, from drowning;

(c) the death of Suhani occurred on 25 January 2024 at Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, from complications following an out of hospital cardiac arrest due to drowning; and

(d) the deaths occurred in the circumstances described above.

COMMENTS

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

80. The statistics outlined above highlight the particular vulnerability of persons born overseas to accidental drowning in Victorian (and Australian) coastal waters.

81. Life Saving Victoria estimates that 36 per cent of drowning deaths from 2012-13 to 2021-22 were of people born overseas. Eighty-two per cent of the fatal drownings involving people from CALD communities resided in major cities, and the mean length of time living in Australia was surprisingly 20 years. The most common activities prior to drowning incidents were swimming, paddling or wading (31 per cent), walking or recreating near water (18 per cent), and fishing (17 per cent).[12]

82. Life Saving Victoria's Aquatic Injury Prevention Agenda 2024-25, identifies Aboriginal and Torres Strait Islander peoples, people from CALD backgrounds, and international tourists and students as a high-risk population and notes that urgent work is needed to progress its water safety strategies.[13]

83. Life Saving Victoria identifies the following relevant water safety issues associated with high-risk populations, including multicultural communities:[14]

    (a) lack of understanding or preparedness for open waterway conditions and dangers, particularly rip currents or strong currents;

    (b) lack of swimming ability;

    (c) people swimming outside the red and yellow flags at patrolled beaches, or swimming at unpatrolled beaches;

    (d) not reading aquatic safety signs and supervising others while not having adequate water safety skills or knowledge themselves; and

    (e) lack of water safety messages and programs which are accessible and appropriately tailored for CALD communities.

---

[12] Life Saving Victoria, Aquatic Injury Prevention Agenda 2024-25, page 19, https://lsv.com.au/wp-content/uploads/AIPA-2024-25-Final.pdf.
[13] Life Saving Victoria, Aquatic Injury Prevention Agenda 2024-25, page 9.
[14] Life Saving Victoria, Aquatic Injury Prevention Agenda 2024-25, page 22.

84. Persons born overseas who visit or reside in Australia are unlikely to be familiar with the risks posed by beaches nor how to respond – education we often repeatedly receive as children as part of our early childhood education.

85. Victorian coroners have, over the years, made multiple comments and recommendations about strategies to mitigate these risks.[15] There is no one easy solution to prevent ongoing fatal drownings. Education about water awareness and safety is paramount.

86. It appears that in many cases, including this coronial investigation, clear signage warning of risks alone is inadequate.

87. Life Saving Victoria's work with migrants and new arrivals, and the Multicultural Engagement Network's work with the cross-council water safety group, are both evidence that the particular drowning risks faced by CALD communities in Victoria are understood and that concerted efforts are underway to address these risks.

88. I note that the BeachSafe app is a simple and easy to read resource for beachgoers to help them make educated decisions about safe places swim. Information on the Beachsafe app is also available in multiple languages.

89. I support the ongoing work in this area and, in the lead up to the summer season, I implore the Victorian community and visitors to our state to be aware of the risks of Australian beaches and take precaution where needed.

90. I convey my sincere condolences to the affected families for their loss which tragically occurred in the setting of a joyful family day where no one could have imagined the devastating outcome. The deaths of Reema, Jagjeet, Kirti, and Suhani have also had a profound effect on the wider community which has prompted continued work and diligence around opportunities to promote water safety prevention in Victoria. The investigation also served to highlight the extreme dangers posed by water which appears deceptively safe to beachgoers, as happened on this occasion.

91. I commend the actions of the other beachgoers and responding emergency services personnel who retrieved the deceased from the water and commenced heroic resuscitation efforts.

---

[15] See especially the Finding into death without inquest regarding Jil Jayeshbhai Khokhara, COR 2024 001564, published 1 October 2024, which outlines contributing factors in drowning deaths for persons born outside of Australia and the various strategies implemented by the Royal Life Saving Society, Australian Water Safety Council, and Life Saving Victoria to try to address this issue.

DIRECTIONS

92. 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.

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

Sanjeev Sondhi, senior next of kin for Reema Sondhi

Gurmeet Singh & Sonia Anand, senior next of kin for Jagjeet Singh Anand and Suhani Anand

Manmohan Lal & Roop Rani Bedi, senior next of kin for Kirti Bedi

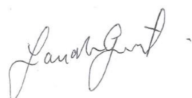
Bass Coast Shire Council

Life Saving Victoria

Alfred Hospital

Sergeant Leigh Cole, Victoria Police, Coroner's Investigator

Signature:



____

Coroner Sarah Gebert

Date: 09 December 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.