Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Georgia Amy Lewtas

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

a) The identity of the deceased is Georgia Amy Lewtas (“Georgia”);

b) Georgia’s death occurred as a result of drowning in water at the Mersey Bluff in Devonport, Tasmania on 11 December 2017;

c) The cause of death is global hypoxic brain injury; and

d) Georgia died on 17 December 2017 at the Royal Hobart Hospital, Hobart in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation of Georgia’s death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; police and witness affidavits; medical records and reports; forensic evidence; and information from the Devonport Council and Devonport Surf Life Saving Club.

I make the following further findings.

Georgia was born on 10 November 2003 to Christopher Lewtas and Lynette Jago. She was aged 14 years at the time of her death. In about 2010, her parents separated but remained on good terms and both shared a close relationship with Georgia.

Georgia attended St Brendan Shaw College in Devonport, Tasmania, from year 7 onwards and was in year 8 when she died. She had a close circle of friends with whom she enjoyed spending time, including her best friend, RT, who was swimming with Georgia on the day of the incident leading to her death.

Georgia was a healthy teenage girl with no known medical issues. Her interests included posting make-up tutorials on YouTube, swimming, and shopping with her friends. Her parents described her as a normal teenager and an outgoing, bright and friendly young girl.

On Sunday 10 December 2017, Georgia and RT arranged a sleepover at Georgia’s house (the home of Ms Jago) for that night. RT arrived at Georgia’s house at 7.00pm. During the course of the evening, Georgia and RT discussed going to the Bluff the next day for a swim.
The Bluff is a rocky headland area, approximately 20 metres in height, overlooking the Bass Strait west of the mouth of the Mersey River in Devonport. The Bluff can be accessed by a walking track from the adjacent Bluff Beach. Bluff Beach is backed by a large foreshore reserve comprising the Devonport Surf Life Saving Club, a skate park, car park and picnic and playground facilities. The whole area is a heavily frequented recreational and tourist destination.

On 11 December, Ms Jago drove Georgia and RT to the Bluff, dropping them off at the back of the complex that houses the Drift Café and the Devonport Surf Life Saving Club. Ms Jago was unaware that the girls were going swimming as she thought her daughter was dressed very nicely for a day on the beach, instead believing they were going to meet a group of friends.

Both Ms Jago and Mr Lewtas describe in their affidavits that Georgia’s swimming ability was reasonable without being particularly strong. Based on previous incidents, Mr Lewtas believed that Georgia did not have a full appreciation of risks and the limits of her abilities, particularly when with her friends.

The evidence of events leading up to Georgia drowning comes principally from the affidavit made by RT for the investigation. She provided a credible account, which I accept.

Georgia and RT commenced swimming on the flat rocks just to the left of the Surf Club and Drift Café. They swam at this location for some time. Upon exiting the water, the two girls ate lunch on the grassed area outside the Drift Café. During this time, RT asked Georgia if she wanted to go swimming around the corner where she usually swam with her older brother. The weather looked calm and RT believed there would not be any danger. Georgia agreed and they proceeded to walk to the blowhole area of the Bluff precinct.

When they arrived at the area, the two girls put down their bags at a distance back from the water’s edge. Georgia asked RT to jump in first and asked some questions about which rocks should be used for jumping. RT jumped from the rocks into the water. Georgia then proceeded to jump in the water. The girls were approximately two to three metres from the rocks, treading water. RT believed that Georgia was starting to struggle, as the waves were getting bigger. RT also noticed that the time between the waves was becoming shorter and so she decided to get out of the water.

They both swam back to the same point from which they had jumped in. Georgia attempted to get out of the water but struggled to get a foot or handhold. She tried to get out of the water using the timing of the waves, but did not have the upper body strength to lift herself. RT, when she was still in the water, tried to help by supporting Georgia’s body while she tried to get out. This proved unsuccessful as RT was slipping on the rocks. RT noticed that the wind had increased substantially and the waves were still increasing in size.

RT managed to exit the water and started to assist Georgia, using her right arm to grab hold of Georgia, when a large wave separated the girls. Georgia was pulled underwater and RT
saw her being “tumbled around”. RT could not determine whether Georgia had hit her head on any rocks.

When Georgia resurfaced, it appeared that she was sucking in water from the sea spray of the waves going over her head. RT recalls that the waves continued to increase and that there were a lot of white caps with spray. She believed that Georgia was beginning to struggle to stay afloat and she felt that Georgia was on the verge of a panic attack.

Georgia started calling out RT’s name and was yelling that she did not want to die and drown. RT tried to reassure Georgia and told her to swim out to where it was less rough. Georgia drifted out a little more and called out for RT, but then appeared to pass out into unconsciousness. RT then saw Georgia roll onto her stomach in the sea, face down in the water. She was no longer moving.

RT yelled Georgia’s name a number of times but there was no response. She re-entered the water and swam to Georgia as she had drifted away from the rocks. RT rolled Georgia’s body over and tried to hold her head so that her face was above water. RT started to swim away from the rocks where the water was not as turbulent. During this time, Georgia did not move or speak. A large wave came over the top of the girls and separated them. After numerous further rescue attempts, RT made the decision to exit the water, as it was getting too rough. She was barely able to lift herself onto the rocks. She called emergency services at 3.35pm. Police had already received a call earlier at 3.33pm from Mr Peter Smith who was nearby and saw that the girls were in trouble. Police vehicles were immediately dispatched to the area.

At 3.39pm, Police Communications called Surf Life Saving member, Tony Who, to ask if the Devonport Surf Life Saving Club had anyone nearby to get a boat out to Georgia. Mr Who informed Police Communications that he would make contact with the available personnel.

At 3.42pm police officers, Constable Annika Coles and Constable Loretta Lincolne, arrived at the lighthouse carpark on the Bluff. Upon running down the footpath they saw Georgia floating face down in the water about 20 metres from the rocks. The officers made the decision to swim to Georgia and removed their vests, belts and shoes.

In their affidavits for the investigation Constables Coles and Lincolne described entering the water, which was extremely cold with waves crashing heavily onto the rocks. They described commencing to swim to Georgia, who was about 35 metres away from them, with the waves remaining large and strong. The officers became separated and Constable Coles, who was ahead of Constable Lincolne, stated that she kept losing sight of Georgia, who appeared to be floating further away.
Due to the dangerous conditions and the likely inability to reach Georgia and hold her afloat, the officers decided to return. They describe their difficulty breathing upon their return.

After exiting the water, two males approached Constables Coles and Lincolne and indicated that they would assist. One male, Anthony King, stated that he was a strong swimmer. Both males removed their clothes and entered the water. Upon re-assessment, the other male determined that the conditions were too hazardous and returned to shore.

Mr King swam out to Georgia. In his affidavit for the coronial investigation, he stated that the water was very choppy with a lot of swell. When he reached Georgia, he rolled her onto her back and put her head under his arm to try to keep it above water. He noticed no signs of consciousness.

Mr King attempted to swim back to shore but was unable due to the rough conditions. The waves were breaking over their heads. He attempted to give resuscitation to Georgia in the water in between waves. Mr King stated that he began to tire and feared he may drown. It is likely that he had swum a distance of at least 150 metres. He laid on his back in the water with Georgia’s head under his arm and tried to stay calm until help arrived. Once he saw that a rescue boat was on its way he attempted to resuscitate Georgia again.

Once the rescue boat arrived, Surf Club member Mr Luke Emmett and Constable Matthew Habermann lifted Georgia into the boat and chest compressions were commenced. Due to the size of the boat, Mr King was unable to board and remained in the water hanging onto the side of the inflatable rescue boat to return to shore.

The evidence, based on police communications information, reveals that Georgia had been face down in the water and unresponsive for 12 to 14 minutes.

Once onshore, Mr Emmett disembarked from the rescue boat, lifted Georgia from it, and ran the short distance to solid sand. He placed her on the sand and attempted to clear Georgia’s airway before commencing chest compressions. Senior Constable Gray relieved Mr Emmett before ambulance officers arrived on the scene.

Ambulance officers continued CPR and treatment. They noted that there was seawater present in Georgia’s airway. Georgia was conveyed to the ambulance and transported to the Mersey Community Hospital (MCH). During transport, Georgia went into cardiac arrest and was in a state of arrest upon arrival at the MCH.

Upon treatment and stabilisation at the MCH, air ambulance transferred Georgia to the Royal Hobart Hospital. During the course of the week that followed, Georgia was medically assessed and it was determined that there was no neurological activity and she was dependent upon a ventilator to breathe. Discussions were had with her parents and a decision was made to withdraw life support.
On Sunday 17 December 2017, Georgia’s condition started to deteriorate before life support was withdrawn. Georgia passed away at 8.05am. Official time of death as reported by Dr David Riggs was 10:31am.

On 19 December 2017, pathologist, Dr Donald Ritchey, conducted an autopsy. He determined that the cause of Georgia’s death was global hypoxic brain injury sustained during drowning. I accept Dr Ritchey’s opinion as to the cause of death. I note that toxicological testing of Georgia’s blood revealed no alcohol or drugs.

Weather information allows me to determine that the wind speed increased in the period leading to the incident. In particular, the Bureau of Meteorology recorded a large increase in wind speed at 2.30pm. Close to the incident wind speed was about 37km/h from the north-west, with the swell also from the north-west at a height of 2 metres with white caps.

I am satisfied that the water was very rough. It is unlikely that the full extent of the conditions were appreciated by Georgia and RT, having come from a more sheltered area. Further, I find that the water was very cold, likely between 14.1 and 18.3 degrees. At this low temperature, Georgia may have suffered cold water shock, weakening her and causing her to be unable to make her way back. In addition to any physiological shock, the evidence indicates that Georgia’s swimming ability was not sufficiently strong to safely manage the rough water. It also appears that an element of panic further hampered her ability to prevent herself becoming submerged.

I make no criticism of RT in this finding. Although she encouraged Georgia to jump and swim from the rocks at the Bluff, she did not place undue pressure on Georgia to do so. Georgia willingly agreed, even though she had not previously been swimming at that spot. Georgia’s behaviour and actions whilst at the rocks before entering the water also indicated that she was happy to participate. I accept that, to RT, the water did not initially appear overly rough or dangerous. RT’s actions of re-entering the water, which had subsequently become dangerously rough, showed courage in the face of a most distressing situation. Her attempts at rescuing Georgia in the water and her actions in promptly calling emergency services also deserve praise. Unfortunately, the death of her good friend in such circumstances may continue to impact upon her greatly.

Comments

For this investigation, I have been provided with detailed information from the Devonport City Council (“the Council”), Surf Life Saving Tasmania (SLST) and the Devonport Surf Life Saving Club (“the Club”).

The management of the Bluff Precinct in Devonport is the responsibility of the Council. The Bluff headland, where Georgia and RT had been swimming, is natural, rugged coastline which is accessed by many visitors using the walking track around the headland. The headland is an increasingly popular area for both swimming and rock fishing. However, due to the rocky terrain adjoining the deep cold water of Bass Strait and rapidly changing weather conditions, there are significant risks associated with both of these recreational activities.
In recent times, drownings have occurred in 2003 and 2010. Additionally, there are regular water rescues undertaken by members of the Club as well as civilians who are nearby and witness persons in trouble.

The Club’s rescue members, who maintain a presence on Bluff beach, perform foot patrols upon the headland area when possible during the summer months. However, the Club advises that its major rescues in the area have occurred outside patrol times.

Following the drowning in 2010, a detailed Coastal Risk Assessment and Treatment Plan was prepared by Surf Life Saving Tasmania in 2011, in conjunction with the Council, to assist in determining appropriate risk mitigation to prevent loss of life and injury to persons in the area.

As a result of that Plan, the Club developed strategies to ensure that its rescue equipment is well maintained and ready and that there is an emergency response rescue team on call to the police. Indeed, the Club’s emergency response in this case was exemplary. The Council also placed safety signage in the areas identified in the plan. “No swimming” symbols were included on the signage in accordance with the appropriate national standards. The signage has been maintained and regularly inspected by Council staff. The evidence indicates that RT and Georgia likely passed one “no swimming” sign on the way to their swimming spot on the headland. As is a common occurrence where an area is popular for recreation, the sign did not deter them from swimming.

As a result of Georgia’s death the Plan was updated in 2018 by Surf Life Saving Tasmania. Again, this document is thorough and contains recommendations in the following areas to be implemented by the Council in conjunction with Surf Life Saving Tasmania and/or the Club:

- Development of a program for collection and analysis of attendance and incident data to inform safety strategies;
- Updating safety signage systems;
- Developing and delivering education programs regarding safety in the area;
- Developing and implementing an Emergency Action Plan;
- Controlling or defining access to the area;
- Enhancing lifeguard services and consider installation of life rings;
- Updating the Plan at appropriate intervals.

I observe that several of the above recommendations were also included in the 2011 Plan and appear not to have been implemented. I acknowledge that the Council has a wide area of responsibility, including other coastal precincts, and is best placed to determine how its resources should be prioritised. Similarly, SLST and the Devonport Surf Club are also best placed to allocate their limited resources.

Nevertheless, considering the risks associated with use of the headland, the Plan should be reviewed regularly by the Council and SLST to determine and prioritise which safety strategies are to be implemented and the time frames for completion. It would appear to me that the development of a program for collection and analysis of attendance and incident data is a critical initial strategy which is necessary to inform and prioritise further action based upon risk.
Recommendation

I recommend that the Devonport City Council and Surf Life Saving Tasmania, together with other stakeholders, regularly review and update the Coastal Risk Assessment and Treatment Plan for the Bluff headland with a view to determining, prioritising and implementing strategies to prevent injury and death in the area.

Conclusion

I commend the actions of Constable Annika Coles and Constable Loretta Lincolne, who in the course of their duty, risked their own safety to try and rescue Georgia.

I particularly commend the remarkable actions of Anthony King who entered the water in treacherous conditions, reached Georgia and kept her afloat for an extended period of time, then performing resuscitation upon her.

I extend my appreciation to investigating officer Constable Craig Dawkins for his comprehensive investigation and report in this difficult case.

I convey my sincere condolences to the family and loved ones of Georgia Amy Lewtas.

Dated: 12 February 2019 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner