IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 005572

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	JV
Date of birth:	22 March 2005
Date of death:	7 October 2023
Cause of death:	1(a) Drowning
Place of death:	Tyers Pumping Station near Pipeline Track, Wirilda Environment Park, Yallourn North, Victoria
Key words:	*Drowning*, *pumping station*

INTRODUCTION

1. On 7 October 2023, JV was 18 years old when he drowned at Tyers Pumping Station at Wirilda Environment Park, Yallourn North.

2. At the time of his death, JV lived in [redacted] with his parents and younger brother.

THE CORONIAL INVESTIGATION

3. JV'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. Victoria Police assigned Constable Bradley Prior to be the Coroner's Investigator for the investigation of JV's death. 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 coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into JV's death, 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.

Background

8. JV worked as an apprentice glazier. He did not have any known medical or mental conditions. He did not drink alcohol or use drugs.

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

Circumstances in which the death occurred

9. On the morning of 7 October 2023, JV was at home with his younger brother, LV, and best friend, RH. They were bored at home so decided to go swimming.

10. The boys considered going for a swim at Lake Narracan, but decided it was too far away. They eventually decided to go to the Tyers Pumping Station (**the Pumping Station**) at Wirilda Environment Park in Yallourn North.

11. Senior Constable Bradley Prior, Coroner's Investigator, described the Pumping Station as an open unfenced area that anyone can access. Steps from the gravel carpark led down to the water's edge to the weir/dam wall. The dam has been deconstructed and all that remained was a concrete wall that sat just below the water's surface and ran the entire width of the river. The wall had two supports (pillars) that were above water level and located in the middle of the water. The pillars in the water are approximately 10 to 15 metres apart.

12. Senior Constable Prior noted the current of the water was extremely strong. There was no fence or other structure to prevent people entering the water at the bottom of the steps. There was also no signage indicating the dangers of the strong water current. The river was bordered on both sides by steep banks and tall trees.

13. The boys arrived at the Pumping Station at about 2.30pm. RH noted that they were all in good spirits on the way there, laughing, happy, playing music, and having a good time.

14. After their arrival, they walked down to the water. RH noted that they were initially concerned and surprised about the strong current and rough conditions. However, they decided it was too late in the day and too much trouble to go elsewhere.

15. JV and LV walked out across the dam wall to the second support pillar. RH walked out across the wall, but the current was too strong for him to get to the second support pillar. He remained at the first pillar.

16. LV jumped into the water from the middle of the wall to the left of the stairs where the water appeared calmer. However, the current subsequently carried him downstream and through the rough water.

17. RH jumped into the water from the first pillar. In his statement to police, he noted that the water was pushing him, but he was able to pull himself from the water using a log in the water. He subsequently returned to the first pillar from which he had jumped.

18. JV jumped into the water from the second pillar.

19. RH observed the current pull JV into the dam wall and then into the slipway, where he became submerged. He resurfaced and resubmerged several times. After the third submersion, JV resurfaced and yelled out for help.

20. LV, now downstream, saw JV flailing his arms about and splashing in the water but could not see his head. He later described the water being like a *"washing machine"* to police. LV subsequently managed to get out of the water at the boat ramp and made his way back.

21. RH tried to get to JV but was pushed back by the current. JV finally resurfaced face down on the far bank.

22. RH telephoned JV's father, HV, to tell him what was happening and then called emergency services.

23. Responding Victoria Police members arrived at the Pumping Station at 3.04pm, observing JV face down in the water. By that time, JV had been face down in the water for about five minutes. Shortly thereafter, JV's parents arrived at the scene with additional emergency service personnel.

24. In the meantime, RH had run down the boat ramp and swum across the river, reaching JV at the bank. HV jumped into the water and swam to JV, subsequently determining that he did not have a pulse.

25. The HEMS Air Ambulance was unable to land due to the tree cover. On-ground paramedics drove around to another entry point at the north side of the river and assisted in pulling JV further from the bank. Sadly, Ambulance Victoria paramedics verified JV's death at 3.47pm.

26. Senior Constable Prior concluded the contributing factors were the fast water current and JV's possible lack of swimming ability. It appeared he had been pulled into a vortex-like effect of the weir and was unable to swim out of it. Notably, Detective Acting Sergeant Shane Wakker stated the area of the river which went over the small spillway created very turbulent water, which he described as a *"back eddy",* that is, water pushing backwards against the normal flow of the river. The back eddy was very strong, and he observed the downward suction of the water back towards the spillway.

27. Senior Constable Prior also noted that there was no fencing along the Tyers River nor around the bottom of the stairs to prevent people entering the water at the weird. He suggested signage indicating the risks and dangers of swimming at the weir.

Identity of the deceased

28. On 7 October 2023, JV, born 22 March 2005, was visually identified by his mother, GV.

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

Medical cause of death

30. Forensic Pathologist, Dr Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 9 October 2023 and provided a written report of his findings dated 12 October 2023.

31. The post-mortem examination was consistent with the reported circumstances. There was no post-mortem evidence of injury of a type likely to have caused or contributed to death.

32. The post-mortem CT scan did not reveal any intracranial haemorrhage, skeletal injury, or substantial natural disease.

33. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

34. Dr de Boer provided an opinion that the medical cause of death was *"1(a) Drowning".*

35. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was JV, born 22 March 2005;

    (b) the death occurred on 7 October 2023 at Tyers Pumping Station near Pipeline Track, Wirilda Environment Park, Yallourn North, Victoria, from 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.

37. The Tyers River at Tyers River Pumping Station is reportedly a popular local swimming location. The conditions there on the day of JV's death were hazardous. Detective Acting Senior Sergeant Shane Wakker observed the turbulence and a strong back eddy. Senior Constable Bradley Prior noted that the area around Tyers River Pumping Station was freely accessible, with no signage to indicate potential danger relating to swimming or the water current. With the intention to prevent similar deaths, I **recommend** that the **Secretary, Department of Energy, Environment and Climate Action** undertake a review of water safety at the Tyers River proximal to Tyers River Pumping Station to establish whether any new countermeasures could be put in place to reduce the risk to swimmers of drowning. While I do not prescribe the form of the review, I note that organisations such as Victoria Police and Life Saving Victoria may have expertise and insights to contribute.

I convey my sincere condolences to JV's family for their loss and acknowledge the sudden and unexpected circumstances in which his death occurred.

Pursuant to section 73(1A) of the Act, I order that this finding be published (in redacted form) 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:

[redacted], senior next of kin

Secretary, Department of Energy, Environment and Climate Action

Life Saving Victoria

Senior Constable Bradley Prior, Victoria Police, Coroner's Investigator

Signature:

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Coroner Sarah Gebert

Date: 10 May 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.