IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007194

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	YJ
Date of birth:	[redacted]
Date of death:	28 December 2023
Cause of death:	1a: Head injuries sustained from impact by a large falling branch from a gum tree
Place of death:	Burnells Road Upotipotpon Victoria 3669

INTRODUCTION

1. On 28 December 2023, YJ was 6 years old when he died after being struck by a falling tree branch.

THE CORONIAL INVESTIGATION

2. YJ'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.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of YJ's death. The Coronial 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.

6. This finding draws on the totality of the coronial investigation into the death of YJ 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. Following Christmas 2023, YJ's family went camping at a family friend's property in Upotipotpon in northeast Victoria. This was a regular Boxing Day camping event with family and friends attending at the location for over 30 years. In 2023, around 12 people were camping at the site.

8. Upotipotpon had experienced significant rain and high winds over the two days prior to YJ's death.

9. On 28 December 2023, the weather was pleasant and sunny with little to no wind. YJ and his younger sister spent the morning playing together.

10. At around 8am, while the children were playing frisbee, a branch from a large gum tree fell from a height of around 30 metres and struck YJ to the head. Tragically, he sustained catastrophic injuries and died at the scene.

Identity of the deceased

11. On 28 December 2023, YJ, born 3 October 2017, was visually identified by his father, who completed a Statement of Identification.

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

Medical cause of death

13. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of YJ on 29 December 2023. Dr Bedford considered the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of his findings dated 16 January 2024.

14. The external examination and CT scan showed catastrophic head injuries in keeping with the circumstances.

15. Dr Bedford provided an opinion that the medical cause of death was 1(a) HEAD INJURIES SUSTAINED FROM IMPACT BY A LARGE FALLING BRANCH FROM A GUM TREE.

COMMENTS

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

1. For the period of January 2015 to June 2025, the Court recorded 31 deaths where people were struck by falling trees or branches. Of those deaths, five occurred while the person was camping. These are not large numbers in absolute terms, but that does not take away from the fact that each was a tragic and unexpected death.

2. YJ's case can be differentiated from many others in that he was camping on private property via an informal arrangement with property owners who were known to the family – rather than camping on public land or a commercial campground where there would be a reasonable expectation for safety inspections including tree assessments to occur.

3. There is no evidence that anyone could have anticipated the tree branch falling in this instance and the fact that such incidents are difficult to predict, and therefore avoid, was a common theme arising out of the other deaths investigated. It follows that preventing like deaths from occurring in the future is a difficult task.

4. Awareness is a feasible risk reduction and thus preventative tool for both the property owner and those using that private land for recreation. Private property owners should regularly check the trees on their property, particularly if it will be used for recreational purposes such as camping. If risks are identified, the property owner should engage a qualified arborist to assess the tree before people enter the area.

5. Parks Victoria has previously published characteristics of potentially dangerous trees:

    - *Dead and/or decaying tree, or major branches*
    - *Signs of cracks or splits up and down the trunk*
    - *Signs of the ground lifting or moving at the base of the tree or roots*
    - *Tree is leaning heavily to one side, possibly in combination with the above characteristics*

6. For campers, they note:

    Where possible, always camp under clear skies and avoid parking or sitting under trees. If you plan to camp near trees, look up at trees for any signs of leaning and hanging or broken

branches and at the base of the tree for any signs of soil movement that may indicate a lack of stability in the tree. If you see these signs, do not camp near the trees.

7. I acknowledge that this is not an infallible strategy and trees do fall and drop branches without warning. However, being outdoors in beautiful surroundings is a privilege that Victorians enjoy daily, and it is important to mitigate the risks of doing so wherever possible.

RECOMMENDATIONS

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

(i) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Strathbogie Shire Council consider disseminating information/reminders to property owners about the importance of regularly checking trees on one's property.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was YJ, born [redacted];

   b) the death occurred on 28 December 2023 at Burnells Road, Upotipotpon, Victoria 3669

   c) I accept and adopt the medical cause of death ascribed by Dr Paul Bedford and I find that YJ died from head injuries sustained when he was struck by a falling branch.

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

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:

YJ's parents, Senior Next of Kin

Strathbogie Shire Council

Leading Senior Constable Jarrod Toomer, Coronial Investigator

Signature:

AUDREY JAMIESON

CORONER

Date: 28 January 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.