

# IN THE CORONERS COURT OF VICTORIA AT MELBOURNE

COR 2024 000528

# FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Dimitra Dubrow
Deceased:	В
Date of birth:	2000
Date of death:	28 January 2024
Cause of death:	1a: drowning in the setting of mixed drug consumption (ethanol, MDMA, cocaine, ketamine, 2-fluoro-2-oxo-PCE, benzodiazepines)
Place of death:	North Warrandyte Victoria 3113

#### INTRODUCTION

- 1. On 28 January 2024, Barran was 23 years old when he drowned in the Yarra River in an area which backed on to his girlfriend's home in North Warrandyte.
- 2. Be and his girlfriend, General, had been together for almost two years and had been good friends for about five years prior. Be was a competent swimmer and was familiar with this area of water. Both were aware of the dangers of the river and General grew up with clear messaging to be careful swimming in the river.
- 3. This section of the Yarra River flows around the property's southern boundary. The water is deep and can flow swiftly with many underwater obstacles. According to Parks Victoria, this area is not an official entry point or swimming area but can be accessed via informal trails. There is no signage or other visitor infrastructure.

#### THE CORONIAL INVESTIGATION

- 4. Begin a second of a 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.
- 5. 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.
- 6. 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.
- 7. Coroner Katherine Lorenz, (as she then was), initially held carriage of this investigation. I took carriage of this matter upon my appointment in September 2024.
- 8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Barrier 's death. The Coronial Investigator conducted initial enquiries on the Court's behalf, including taking statements from witnesses, and submitted a coronial brief of evidence

9. This finding draws on the totality of the coronial investigation into the death of B

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

- 10. On 27 January 2024, General went out with a number of friends, including Ben, for dinner to celebrate her birthday. The group went to a bar on Chapel Street afterwards.
- 11. The celebrations continued at Games's house from about midnight. No one was overly intoxicated at this point, but they all had had a few drinks. Band had also consumed alcohol and other drugs over the course of the evening.
- 12. Everyone was in good spirits, listening to music, and playing music on the many instruments in the home; B played the drums and was in a band. G stated that "B was really happy. He was just having so much fun".
- 13. Between around 6:30am and 7am on 28 January 2024, B and some of the friends went down to river to swim. No one observed anything unusual about B 's behaviour, and while a little intoxicated, he did not appear to be overly so.
- 14. While swimming, the friends noticed that B was suddenly gone. They described it as happening "in the blink of an eye" and that no one heard or saw anything unusual.
- 15. At about 7:16am, Triple Zero was called and police attended at about 7:38am.
- A large search operation commenced involving multiple police units, Fire Rescue Victoria,
   State Emergency Services, and paramedics from Ambulance Victoria.
- 17. At about 1:09pm, a Police Search and Rescue commenced an underwater search.
- 18. At about 1:26pm, B 's body was discovered about 14m from the bank and 3.5m underwater. There were no obstructions in the area and B 's body was not caught in anything.

<sup>&</sup>lt;sup>1</sup> 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.

- 19. Begain's body was recovered shortly afterwards, and he was confirmed to be deceased by paramedics.
- 20. Attending Police Officers concluded that there were no suspicious circumstances and that the death appeared to be from misadventure.

### Identity of the deceased

- 21. On 28 January 2024, Barrier by his mother, who completed a statement of investigation.
- 22. Identity is not in dispute and requires no further investigation.

#### Medical cause of death

- 23. On 31 January 2024 Forensic Pathologist Dr Michael Duffy from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy provided a written report of the findings.
- 24. Dr Duffy commented that a diagnosis of drowning at autopsy can be difficult as there are no specific signs and so it is a diagnosis of exclusion. Nonetheless, the autopsy showed features suggestive of drowning and there was no significant natural disease.
- 25. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at a concentration of 0.17g/100mL<sup>2</sup>. Also detected were MDMA, cocaine, ketamine, 2-fluoro-2-oxo-PCE,<sup>3</sup> various benzodiazepines, and delta-9-THC (cannabis).
- 26. Dr Duffy provided an opinion that the medical cause of death was 1(a) drowning in the setting of mixed drug consumption (ethanol, MDMA, cocaine, ketamine, 2-fluoro-2-oxo-PCE, benzodiazepines)
- 27. I accept Dr Duffy's opinion.

# FINDINGS AND CONCLUSION

- 28. Pursuant to section 67(1) of the Act I make the following findings:
  - a) the identity of the deceased was B , born 30 June 2000;

<sup>&</sup>lt;sup>2</sup> For comparison, the legal limit for driving is 0.05g/100mL.

<sup>&</sup>lt;sup>3</sup> A synthetic analogue of ketamine

- b) the death occurred on 28 January 2024 at

  North Warrandyte Victoria 3113, from *I(a) drowning in the setting of mixed drug consumption (ethanol, MDMA, cocaine, ketamine, 2-fluoro-2-oxo PCE, benzodiazepines)*
- c) the death occurred in the circumstances described above.
- 29. Having considered all the evidence, I find that Bar's death was the result of misadventure in the context of intoxication with alcohol and other drugs.

#### **COMMENTS**

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

- 1. This Court investigates many drownings each year and is assisted by the collated data from the annual drowning report produced by Royal Life Saving Australia.
- 2. The report for 2024<sup>4</sup> noted that drownings in rivers and creeks had increased and made up 25% of the 323 drowning deaths in Australian waterways. Men continued to account for most of these deaths, at 84%. In 15% of cases of drownings in rivers in creeks, alcohol was involved.
- 3. The report highlights the message of avoiding alcohol and drugs as one of the six key pieces of water safety advice and urges the reader to join in sharing the water safety messages.
- 4. In the words of Bar's mum, "I just hope this doesn't happen to anybody else's baby. It was such an innocent thing. I do think that the river needs more awareness. It's a wild river and people need to know how dangerous it is to swim there. Unfortunately, they don't."

I convey my sincere condolences to Barrell's family, his girlfriend, and friends for their loss.

<sup>&</sup>lt;sup>4</sup> Available at <a href="https://www.royallifesaving.com.au/library/national-drowning-report/national-drowning-report-2024">https://www.royallifesaving.com.au/library/national-drowning-report/national-drowning-report-2024</a>

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

Eastern Health

Constable Patrick Mulachy, Coronial Investigator

Signature:

and

Of Victoria

Coroner Dimitra Dubrow

Date: 18 August 2025

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.