IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 007107

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	HRZ
Date of birth:	2004
Date of death:	6 December 2024
Cause of death:	1(a) Drowning
Place of death:	Lerderderg River, Lerderderg State Park, Darley, Victoria
Keywords:	Drowning; Lerderderg River; Water Safety

INTRODUCTION

1. On 6 December 2024, HRZ was 20 years old when she drowned in the Lerderderg River. At the time of her death, HRZ lived in Corio with her parents and siblings and her partner, RNV.

2. HRZ was born in a town on the border of Thailand and Myanmar and spent most of her childhood in a Thai refugee camp in Mae Hong Son. In 2019, when HRZ was around 15 years old, she moved to Australia with her family and settled in Corio.

3. In or around July 2022, HRZ met RNV via an online gaming platform. RNV described HRZ as a happy person and a lovely young girl.

4. At the time of her death, HRZ was not known to have any mental or physical health conditions.

5. HRZ did not know how to swim, however RNV stated that she was not afraid of the water and wanted to learn swimming.

THE CORONIAL INVESTIGATION

6. HRZ's death was reported to the coroner as it 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.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of HRZ'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.

10. This finding draws on the totality of the coronial investigation into the death of HRZ 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 death occurred

11. Around 3.30pm on 6 December 2024, HRZ, RNV and HRZ's childhood friend, PMK, arrived at the Mackenzies Flat Picnic Area in the Lerderderg State Park. It was a hot day, and they intended to swim in the Lerderderg River (**the river**).

12. The river runs through the Lerderderg State Park and past the Mackenzies Flat Picnic Area which is located at the end of Lerderderg Gorge Road in Darley. Access to the river is a short walk from the main car park. The river mainly flows on rock and sand bed. The main waterhole area of the river that is accessible for swimming is approximately 60 metres by 20 metres with large pockets of deep water surrounded by boulders. There is a walking track that crosses the river.

13. Upon their arrival, HRZ, RNV and PMK walked from the main car park towards the main river opening. They crossed over the river using the walking track and headed about 100 metres upstream to a shallow clearing where there were very few people swimming. According to RNV, the water was at chest height and HRZ had no issues standing up in the water.

14. RNV knew that HRZ could not swim but stated that HRZ and himself had attended the river four or five times previously and he tried to teach her how to swim.

15. Approximately 20 minutes later, HRZ, RNV and PMK noticed that the crowd at the main waterhole had reduced, so they left their belongings at the clearing and headed to the main waterhole where they began swimming. Shortly after, they crossed the main waterhole where the waters were shallow to the other side. They walked up onto a rocky area on the northern side of the river where they sat down and dangled their legs in the water over the edge of

[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.

rocks. The rocky area on the northern side of the river has visible rock faces above and just below the water line and the water appears dark as there is a sharp drop to a depth of approximately two metres below.

16. After approximately five to eight minutes sitting on the rocks, HRZ, RNV and PMK decided to leave as it started to rain. RNV and PMK swam from the rocks to the other side of the river to collect their belongings. As HRZ could not swim, she started to walk around the shallow side of the waterhole using the rocks that were under the water, however she slipped off and fell into the water.

17. RNV and PMK did not see HRZ slip off the rocks. When they turned around, they observed HRZ in the water with her hands thrashing around as she struggled to stay afloat. RNV swam back across the waterhole, grabbed HRZ's hand and attempted to pull her up. As RNV grabbed hold of HRZ however, she began pulling him under and RNV took in a lot of water. RNV continued to try and retrieve HRZ, but he eventually had to get out of the water to prevent himself from drowning and to regain his strength. He got back into the water 10 to 20 seconds later and tried to search for HRZ for approximately another minute, but he could not find her. Meanwhile, PMK was yelling for help.

18. When RNV got out of the water, at approximately 4.38pm, he immediately contacted emergency services. Soon after, some members of the public nearby who heard the yelling came to their aid. The bystanders jumped into the water where RNV indicated HRZ was and began looking for her.

19. Victoria Police members arrived at approximately 4.50pm but HRZ was still unable to be seen. At 4.56pm, members of the Victoria State Emergency Service (**SES**) attended and began searching for HRZ from the water's edge.

20. At approximately 5.10pm, the Victoria Police Air Wing arrived but HRZ could not be sighted from above and infrared signalling was unsuccessful. Later, at approximately 7.30pm, the Victoria Police Search and Rescue Squad arrived. A police diver entered the water and sadly located HRZ deceased at the bottom of the river at a depth of approximately 1.6 metres.

21. Victoria Police did not identify any suspicious circumstances surrounding HRZ's death.

Identity of the deceased

22. On 10 December 2024, HRZ , born 2004, was visually identified by her partner, RNV.

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

Medical cause of death

24. Forensic Pathologist Associate Professor (**A/Prof**) Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 9 December 2024 and provided a written report of his findings dated 10 December 2024.

25. The post-mortem examination findings were consistent with the reported circumstances and revealed minor blunt force injuries to the right eye and right upper lip. A post-mortem computed tomography (**CT**) scan did not demonstrate substantial natural disease or substantial injury.

26. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

27. A/Prof de Boer provided an opinion that the medical cause of death was *"1(a) Drowning"*.

28. A/Prof de Boer commented that drowning is a diagnosis of exclusion and does not present with specific post-mortem findings. A diagnosis of drowning is therefore heavily reliant on the circumstantial information and the reasonable exclusion of alternative causes of death.

29. I accept A/Prof de Boer's opinion as to the cause of death.

FURTHER INVESTIGATIONS

Parks Victoria

30. Parks Victoria is the authority responsible for managing Lerderderg State Park. A statement was obtained from David Petty (**Mr Petty**), District Manager of the Western Basalt region. Mr Petty stated that at the time of HRZ's death, there were three water safety signs at the Mackenzies Flat Picnic Area. One was appended to the rotunda north of the main access path leading from the car park off Lerderderg Gorge Road. A second sign was on the northwest side of the same path, and there was a third sign near the waterhole on the northeast side of the river. The information on the signs includes that swimming is not recommended as there are no lifesaving services available, and that there are slippery rocks, strong currents and submerged objects.

31. Mr Petty indicated that after HRZ's drowning, additional temporary warning signs were put in place with simpler signage and using key symbols warning of the dangers. An example of the new sign provided included that swimming is not advised as no lifesaving services are present, and that there is deep water.

32. An interagency meeting was held on 12 December 2024 which included members from the State Emergency Service, Victoria Police and Parks Victoria. At the meeting, it was discussed that Lerderderg State Park is becoming increasingly popular, and it was agreed that further collaboration is required on the safety considerations that are promoted on Parks Victoria's website. It was also recommended that the 'warning' text on the signs be translated into different languages, and for QR codes to be added to the signs for visitors to obtain further information.

33. Mr Petty mentioned that there was a previous incident in November 2023 where a male, who was not a confident swimmer, also drowned in the Lerderderg River.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was HRZ, born 2004;

    b) the death occurred on 6 December 2024 in the Lerderderg River at Lerderderg State Park, Darley, Victoria, from drowning; and

    c) the death occurred in the circumstances described above.

35. Having considered all of the circumstances, I am satisfied that HRZ's death was the result of a tragic accidental drowning. I also acknowledge RNV's brave and considerable efforts in attempting to rescue her.

COMMENTS

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

36. This Court investigates many drownings each year and is assisted by the collated data from the annual National Drowning Report (**the Report**) produced by Royal Life Saving Australia.

37. The Report for 2025[2] covered 1 July 2024 to 30 June 2025 and noted that drownings in rivers and creeks had increased since the previous year and made up 28% of the 357 drowning deaths in Australian waterways in 2024/25.

38. Additionally, drowning deaths in the 15–24 year age group represented 12% of all drowning cases in 2024/25, and these deaths most frequently occurred at rivers or creeks (39%).

39. The country of birth was known for 53% of people who drowned in 2024/25. Of those, 61 people (32%) were born overseas. The Report highlights that multicultural communities are a priority population in the Australian Water Safety Strategy (**AWSS**) 2030. New research[3] has explored migrant adults' knowledge, attitudes towards water safety and their participation in swimming and water activities, and drowning prevention programs focusing on multicultural communities. Identified risks toward drowning once in Australia included limited exposure to the water and a lack of safety knowledge and skills prior to migrating. Study participants reported having limited awareness of water safety, shaped by their previous experiences and environments, but that they perceived swimming as essential for inclusion in the Australian community.

40. The Report advised that to achieve the AWSS goal of reducing drowning by 2030, swimming and water safety programs need to effectively reach migrant communities. The Report further noted that this new research supports the need for dedicated swimming and water safety programs for migrant adults and provides new insights into the enablers and barriers to participation.

I convey my sincere condolences to HRZ's family, her partner, and friends 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.

[2] Available at <https://www.royallifesaving.com.au/library/national-drowning-report/national-drowning-report-2025>.
[3] Stacey Willcox-Pidgeon, Susan G Devine, Richard C Franklin, Adult migrants urgent need for drowning prevention in Australia: water safety perceptions, attitudes, and behaviours, *Health Promotion International*, Volume 40, Issue 4, August 2025, daaf109, https://doi.org/10.1093/heapro/daaf109.
Stacey Willcox-Pidgeon, Richard C Franklin, Susan G Devine, Drowning prevention strategies for migrant adults in Australia: a qualitative multiple case study, *BMC Public Health*, Volume 25, article number 1911, May 2025, https://doi.org/10.1186/s12889-025-23104-5.

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

RNV, Senior Next of Kin

Senior Constable Malcolm McDonald, Coronial Investigator

Signature:

Coroner Dimitra Dubrow

Date: 18 September 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.