IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000622

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

*Amended pursuant to section 76 of the **Coroners Act 2008** on 22 June 2026*[1]

Findings of:	Coroner Therese McCarthy
Deceased:	YWB [redacted]
Date of birth:	23 November 1978
Date of death:	1 February 2025
Cause of death:	1(a) Drowning
Place of death:	Hopkins River, Warrnambool, Victoria
Keywords:	Drowning; Hopkins River; Water Safety

[1] This document is an amended version of the Finding into Death Without Inquest regarding YWB [redacted] dated 26 May 2026. An error arising from an accidental slip in paragraph 28 has been corrected pursuant to section 76 of the *Coroners Act 2008* (Vic).

INTRODUCTION

1. On 1 February 2025, YWB [redacted] was 46 years old when he drowned in the Hopkins River in Warrnambool. At the time of his death, YWB lived in Warrnambool with his wife, [redacted] and their two sons, [redacted] and [redacted]

2. YWB was a family man who loved and cherished his family dearly. Despite working every weekend, he always made time for his sons. He coached their cricket team, managed their football team, and enjoyed Sundays as a day to spend time with them. They often travelled to Melbourne to attend football games and to see his esteemed Richmond Tigers play. Furthermore, he enjoyed family holidays and family activities. [redacted] reported that as a family, they did a lot and *"had a great life"*.[2]

3. YWB had a keen interest in sports, particularly cricket and football, but he also had a love and passion for horse racing and would look forward to the May Racing Carnival each year.

4. YWB excelled as a sales consultant working for Metricon Homes since around 2013. He was described by his colleagues as funny, professional, hardworking, and successful in his role.[3] YWB was a people person and was well regarded in both the local community and his industry.

5. Over the years, YWB and [redacted] also successfully built and sold homes together as investment ventures and were able to achieve financial stability. They had plans to retire in Queensland once their sons were adults.

6. In April 2023, YWB was shocked to receive a diagnosis of non-insulin dependent type 2 diabetes which he then managed by taking metformin and weekly Ozempic injections, monitoring his diet, and going for regular walks. He also lost a lot of weight after his diabetes diagnosis.

7. YWB last saw a general practitioner at Ochre Medical Centre Jamieson on 3 January 2025. I have reviewed the medical records which note that YWB reported he had been well, and a blood test was organised which later showed that he had good diabetic control. He was given a referral for a routine surveillance transthoracic echocardiogram to monitor his pulmonary

[2] Coronial Brief, Statement of [redacted]
[3] Coronial Brief, Statements of Christine Brunt and Simon Lofts.

stenosis[4] that was reported as mild in 2022.[5] YWB had no recorded instances of hypoglycaemia.[6]

THE CORONIAL INVESTIGATION

8. YWB'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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of YWB's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. In July 2025, I assumed carriage of the investigation into YWB's death after the retirement of then Coroner John Olle for the purpose of finalising the investigation and making findings.

13. This finding draws on the totality of the coronial investigation into the death of YWB 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.[7]

[4] Pulmonary stenosis is the narrowing of the valve between the lower right heart chamber and the lung arteries that causes the valve to become thick or stiffened, reducing blood flow to the lungs.
[5] Medical records of Ochre Medical Centre Jamieson.
[6] Statements of Dr Ken Chuah and Dr Selby King.
[7] 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

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

Circumstances in which the death occurred

14. In the week before his death, YWB was unusually exhausted and snoring heavily. He was also experiencing twitching in his left arm and had been complaining of feeling unwell, but he still pushed himself to go to work.[8]

15. In the evening of 31 January 2025, YWB attended a friend's birthday celebration with his family, but [redacted] noticed that he did not eat much.

16. In the morning on the following day, being 1 February 2025, [redacted] witnessed YWB fall over at home. YWB then went to work at the opening of a new display home. YWB appeared happy and normal to his colleagues but was observed to wander off a few times.[9]

17. Later in the evening, after YWB had returned home from work and had dinner with his family, he was playing cricket in the backyard with his sons whilst [redacted] was having a bath. The boys recalled that YWB kept kneeling, coughing, and dry reaching. YWB briefly laid down outside and then went into bed. Shortly after, around 7.55pm, he left home in his 2016 Nissan Navara ST-X utility (**the Nissan**). The boys believed that YWB was going to the hospital.

18. A neighbour's closed-circuit television (**CCTV**) footage appeared to show YWB stumbling around the front of his house before leaving in the Nissan. YWB commenced driving in a southerly direction on Witton Boulevard before driving on a nature strip, performing an erratic U-turn, and then driving in a northerly direction back past his house at speed. YWB appeared to be driving erratically.[10]

19. YWB proceeded to drive to Johnson Drive at the Deakin University Warrnambool Campus, but the Nissan came off the road, drove through the adjacent parking lot at an angle before continuing through the surrounding grassland, and straight into the Hopkins River (**the river**). A witness nearby heard loud revving of an engine and then saw the Nissan briefly before it

provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[8] Coronial Brief, Statement of [redacted]

[9] Coronial Brief, Statements of Christine Brunt and Simon Lofts.

[10] Coronial Brief, Statement of Leigh Evans.

entered the water.[11] The Nissan became submerged in the water approximately five metres from the embankment.[12]

20. Once in the river, the witness observed YWB exit the Nissan through the driver's window and attempt to swim to safety. YWB did not know how to swim and had a fear of water.[13] The witness ran to the side of the river and attempted to give YWB instructions, but he was screaming and struggling to tread water for a short time until he stopped moving. Sadly, YWB was unable to swim to the riverbank and drowned. Emergency services arrived, but it was apparent that YWB was already deceased in the river.[14]

Victoria Police investigation post-accident

21. Light tyre marks were found in the grassed embankment coming out of the nearby parking lot which led down the hill and into the river, but no skid marks or brake marks were present.[15]

22. Leading Senior Constable Brett Gardner (**LSC Gardner**) of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit conducted a mechanical examination of the Nissan. LSC Gardner found that the Nissan had been impacted at its front. Due to the extent of damage, he was unable to assess the operation of the electronic components of the braking system but advised that from what he was able to examine, he found no mechanical faults, failures or conditions with the Nissan which could have caused or contributed to the accident.[16]

Identity of the deceased

23. On 3 February 2025, YWB [redacted] born 23 November 1978, was visually identified by his wife, [redacted]

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

[11] Coronial Brief, Statement of Anna Thompson.
[12] Coronial Brief, Statement of Leading Senior Constable Paul McGovern.
[13] Coronial Brief, Statement of [redacted]
[14] Coronial Brief, Statements of Constable Daniel Klat, Senior Constable Kyle Buchanan, Leading Senior Constable Paul McGovern.
[15] Coronial Brief, Statement of Sergeant Tom Morris.
[16] Coronial Brief, Statement of Leading Senior Constable Brett Gardner.

Medical cause of death

25. Forensic Pathologist Associate Professor (**A/Prof**) Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 4 February 2025 and provided a written report of her findings dated 5 March 2025.

26. The post-mortem examination revealed pericellular fibrosis of the heart, moderate coronary artery atherosclerosis, and hepatic steatosis with focal acute inflammation. There were a cluster of injuries on the right side of the face comprising a bruise and two lacerations, and bruises on the limbs.

27. There were no significant injuries or significant natural disease that could have caused or contributed to death.

28. A/Prof Parsons commented that although there was no significant natural disease, YWB had moderate atherosclerosis and that 46 years old is a relatively young age to have such significant atherosclerosis. She recommended that YWB's immediate family members address cardiovascular health as some causes of atherosclerosis can be genetic.

29. Toxicological analysis of post-mortem samples identified the presence of metformin[17] and doxylamine.[18]

30. A/Prof Parsons provided an opinion that the medical cause of death was *'1(a) Drowning'*.

31. I accept A/Prof Parsons' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was YWB [redacted] born 23 November 1978;

    b) the death occurred on 1 February 2025 in the Hopkins River, Warrnambool, Victoria, from drowning; and

    c) the death occurred in the circumstances described above.

[17] Metformin is an antidiabetic drug used to treat maturity-onset diabetes.
[18] Doxylamine is an antihistamine agent and sleep-inducing agent.

33. Taken in its totality, the available evidence supports a finding that it was YWB's inability to swim and extricate himself from the river that primarily led to his death and that his death was the result of a tragic accidental drowning.

COMMENTS

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

34. 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.

35. The Report for 2025[19] 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.

36. Additionally, drowning deaths in the 35–49 year age group represented 17% of all drowning cases in 2024/25, and these deaths most frequently occurred in beaches (33%) and rivers and creeks (24%).

37. One of the three National Imperatives in the Australian Water Safety Strategy (**AWSS**) 2030 is to strengthen swimming and water safety skills for all. The Strategy advises that a lack of swimming and water safety skills remains a key vulnerability that increases drowning risk. Specific hazards, such as deep and open water, and unfamiliar aquatic environments, further compound these risks. Simple water safety advice including learning swimming, water safety and lifesaving skills can save lives.

I convey my sincere condolences to [redacted] [redacted] and [redacted] and YWB's extended family 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.

[19] Available at <https://www.royallifesaving.com.au/library/national-drowning-report/national-drowning-report-2025>.

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

[redacted] Senior Next of Kin

Leading Senior Constable Paul McGovern, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 26 May 2026

Re-signed: 22 June 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.