



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007184

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**¹*

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Fan Yang
Date of birth:	5 March 1994
Date of death:	27 December 2023
Cause of death:	1a: Drowning in the setting of flash flooding
Place of death:	Centre Road Buchan Victoria 3885

¹ Amended on 24 March 2026 to correct a typographical error at paragraph 3. Amended on 31 August 2026 to correct a material mistake at paragraph 62.

INTRODUCTION

1. On 27 December 2023, Fan Yang was 29 years old when he drowned in a flash flooding event in Buchan, where he was camping with his partner Lee Wu (Tina)². At the time of his death, he lived in Clayton with Tina.
2. Fan Yang was known to friends and family as Andrew³.
3. Andrew is remembered as an incredibly smart, creative and inventive young man. He enjoyed art, music and video game development. He had a popular YouTube channel with over 162,000 subscribers, where he shared his passion for designing video games.

Background

4. Andrew was born in Luan, China to Haitao Yang and Jinhui Qin. He had a young sister, Anna. Just before his fourth birthday the family emigrated to Canada where they lived in London, Ontario.
5. Andrew studied mechatronics engineering at the University of Waterloo. He graduated in 2017, after which he began working at AdHawk Microsystems, a startup that developed eye-tracking technology. Here he met Tina, who was doing an internship at the company. They had a shared interest in piano and spent their lunch breaks playing together.
6. In September 2019, Andrew and Tina moved to Melbourne as Tina was to complete her PhD in electrical engineering at Monash University. Andrew continued to work remotely for AdHawk Microsystems.
7. Andrew and Tina planned to move back to Canada at the completion of her PhD, and they planned to marry. At the time of their deaths, Tina was a few months away from graduating.
8. Andrew and Tina had a very loving relationship and were supportive of one another. According to Tina's sister Jamie, Tina was more outgoing and Andrew was quieter, and "*they complemented each other perfectly*". Andrew's sister Anna noted they had the same interests, behaviours and mannerisms. They enjoyed spending time together playing piano, taking dance classes and learning how to cook.

² COR 2023 007176.

³ I will refer to him as Andrew throughout my finding, save for where formality requires I use his legal name.

THE CORONIAL INVESTIGATION

9. Andrew'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.
10. 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.
11. 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.
12. Victoria Police assigned an officer to be the Coronal Investigator for the investigation of Andrew's death. The Coronal 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.
13. This finding draws on the totality of the coronial investigation into the death of Fan (Andrew) Yang 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.⁴
14. This finding was authored by Coroner Audrey Jamieson (as her Honour then was) and handed down on 12 March 2026. On 20 May 2026, Parks Victoria made a request under section 76 of the Act that the finding be amended to remove an inaccuracy in the body of the finding. I, Coroner Sara Dennis, have made the requested amendment which does not alter Coroner Audrey Jamieson's original findings or conclusions.

⁴ 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

15. At around 10am on 26 December 2023, Andrew and Tina left their apartment and travelled to the Buchan Caves Reserve (**the Reserve**) Campground in Tina's car, a blue Mazda sedan. They arrived at around 2:48pm.
16. According to Bureau of Meteorology (**BOM**) data, it was approximately 22.7 degrees Celsius in Buchan, and 4.8mm of rain had fallen since 9am.
17. According to Parks Victoria staff employed at the Reserve, they regularly checked the weather of their own volition, and they did so on 26 December 2023. They did not recall receiving any weather alerts or warnings via the BOM or the Vic Emergency app.
18. At 3:30pm, Andrew and Tina joined a pre-booked tour of the Royal Cave. At this time, the weather was cloudy. There were about 18 participants, led by Cave Guide Ranger Alina Bright. During the tour, the lights within the cave turned on and off a couple of times. This was unusual but Ms Bright thought it may have been done by another Cave Guide leading a group ahead of her.
19. Cave tours usually last around 45 minutes, but Ms Bright noted that this tour took longer than average as the visitors were walking slowly and taking lots of photos.
20. At 4:17pm, while the group were in the cave, the Bureau of Meteorology issued a Watch and Act Severe Thunderstorm Warning for the region, which stated "*thunderstorms are likely to produce heavy, locally intense rainfall that may lead to dangerous and life threatening flash flooding, damaging winds and large hailstones*", and "*never drive, walk or ride through floodwater.*"
21. As the group came to the end of the tour, they observed water cascading down the walls and running down the stairs leading to the exit of the cave. The rain was heavy and visibility out of the cave was poor. Most of the group stayed in the cave with the door open for a few minutes before beginning to leave.
22. Ms Bright called the Visitor Centre to seek advice from her colleague, Customer Service team member Linelle Moreland, on what to do as some of the group did not want to leave the cave. As she was on the phone, most of the group left the cave and proceeded towards the car park. She explained to Ms Moreland that most of the group had left, so not to worry about her call.

23. While Ms Bright was on the phone to Ms Moreland, another tour group approached the cave exit, led by Cave Guide Chelsea. Some of the group left the cave while others gathered under the shelter just outside the door.
24. Ms Bright and Chelsea told remaining visitors that they were going back into the cave system to turn the lights off, as the tours had finished for the day. When they had done so and returned to the cave exit, all the visitors had left.
25. It is unclear exactly when Andrew and Tina left the cave.
26. At around 4:50pm, Park Rangers Helen McDonnell and David Davidson located a large tree that had fallen across the road near the Royal Cave, preventing people from exiting the area. Ranger McDonnell contacted the Visitor Centre and requested that a message be passed on for tour groups to remain at the caves until they had cleared the area. It is unclear whether this message was passed on.
27. CCTV footage shows Tina's Mazda driving past the Visitor Centre at 4:56pm. Another vehicle is seen driving across Bridge 3, slightly east of the Visitor Centre. Andrew and Tina momentarily stop prior to Bridge 3, before proceeding across. The water is seen rapidly rising over the bridge and roadway.
28. The evidence indicates that Andrew and Tina exited the car due to it getting stuck in the floodwaters and were swept away.
29. Tina's body was located at around 6:30pm, near Bridge 1 in the campground. Andrew's body was located at around 3:30pm the following day, near the Buchan River Swing Bridge, approximately 5km from the campground.
30. A backpack belonging to Andrew was located at a property on the banks of the Buchan River on 30 December 2023. It contained clothing, a diamond engagement ring and two airline tickets.

Identity of the deceased

31. On 3 January 2024, the DNA profile of the deceased was compared with the DNA profile of Jinhui Qin, Andrew's mother. The results of the analysis supported the view that the deceased was a child of Jinhui Qin.

32. On 4 January 2024, Coroner Paul Lawrie considered the available evidence and determined that the cogency and consistency of all evidence relevant to the identity of the deceased supported a finding that the deceased was Fan Yang, both 5 March 1994. Accordingly, he signed a Determination by Coroner of Identity of Deceased (Form 8).

Medical cause of death

33. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination of the body of Andrew Yang on 29 December 2023. Dr Bedford considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (CT) scan and scene photographs and provided a written report of his findings dated 16 January 2024.
34. The external examination was in keeping with the history. The post-mortem CT scan showed a distended stomach with fluid, fluid in the airways and minor lung changes. No skeletal injuries were identified and there were no acute cerebral changes.
35. Toxicological analysis of post mortem blood samples did not identify the presence of any alcohol or other common drugs or poisons.
36. Dr Bedford provided an opinion that the medical cause of death was 1(a) DROWNING IN THE SETTING OF FLASH FLOODING.

INCIDENT LOCATION

37. The Buchan Valley is a long and narrow valley, ranging from 10-25 kilometres wide and over 75 kilometres long. It is relatively steep and vegetated with native forests and areas of pasture.
38. The Buchan Caves Reserve is located within the Buchan Valley and covers an area of 258 hectares. It is jointly managed by Parks Victoria and the Gunaikurnai Land and Waters Aboriginal Corporation.
39. The Reserve is a popular tourist destination offering camping and guided cave tours for visitors. Holidays, including Boxing Day, are some of the busiest days of the year. On 26 December 2023 the campground was booked out, as were the cave tours. Ms McDonnell estimated that around 800 people attended cave tours on the day, as well as other day visitors to the Reserve.

40. Caves Road is the only road in and out of the Reserve. It traverses through the Reserve and has seven bridge crossings:

Bridge 1 – Located at the Caves Swimming Pool and crosses Spring Creek.

Bridge 2 – Located 500m west of Bridge 1 at Catalpa Flat. Crosses Spring Creek.

Bridge 3 – Located 150m west of Bridge 2, near the entrance to the main campground. Crosses Spring Creek.

Bridge 4 – Located 500m west of Bridge 3, past the main campground and the Visitor Centre. Crosses Spring Creek.

Bridge 5 – Located 150m from Bridge 4, east of the Royal Cave car park. Crosses Fairy Creek.

Bridge 6 – Located 150m past Bridge 5, west of the Royal Cave car park. Crosses Fairy Creek.

Bridge 7 – Located 150m past Bridge 6, east of the Fairy Cave car park. Crosses Fairy Creek.

41. The SES Local Flood Guide for Buchan says that *“Buchan is at risk of both riverine flooding and flash flooding, which can happen separately or at the same time. Both are usually caused by heavy rain fall.”* It identifies that during flash flooding, Spring Creek may quickly rise, overflowing its banks.
42. The Reserve had been impacted by 10 flood events between 2016 and 2021. The extent and impact of these events is unclear, though it is apparent that none were as severe as that on 26 December 2023.

PARKS VICTORIA’S EMERGENCY PREPAREDNESS & RESPONSE

43. My investigation into Andrew and Tina’s deaths was conducted through a prevention lens: focussing on the emergency preparedness of the Reserve and the response to the weather event, including the policies and procedures in place and the training provided to Parks Victoria staff, and whether improvements to these systems had been made to reduce the risk of a like-situation occurring in the future.
44. Stephen Kleinitz, Eastern Commercial Operations Manager at Parks Victoria, provided two statements regarding Parks Victoria’s emergency management procedures and enclosed copies of the Emergency Management Plan (**EMP**) 2023 – 2024, and the 2024 – 2025 version.

45. I was also greatly assisted by the coronial brief which contained comprehensive and candid statements provided by the Parks Victoria employees working on the day of the flood.

Emergency preparedness

Emergency Management Plan 2023 - 2024

46. The EMP in place at the time of the flood had last been reviewed in September 2023. It contained Emergency Response Instructions (**ERIs**) for various emergencies, including, relevantly, ‘Natural Event (Flood, Windstorm, Earthquake)’.
47. The EMP noted that “*floods occur on an irregular basis within the area*” and advised that warnings are issued by the BOM and can be monitored via their website.
48. The relevant ERI listed the following points under the heading ‘Preparation’:
- *Participate in emergency response scenario planning and exercises with lead agency (being the Victorian State Emergency Service).*
 - *Maintain liaison with lead agency.*
 - *Monitor severe weather warnings from BOM.*
 - *Search and rescue and first aid equipment regularly inspected maintained.*
 - *Relevant staff trained and current in level 2 first aid.*
49. The following items were listed under the heading ‘Response’:
- *Contact 000 for police/ambulance/fire authority response.*
 - *Notify Parks Victoria Officer in Charge*
 - *Contact park office for additional assistance, if required.*
 - *Provide assistance, secure the scene and minimise further risk if possible.*
 - *Provide safe refuge to effected persons.*
 - *Gather and record details.*
50. The ERI listed several issues specific to the Reserve, including:
- *Difficulty in safe access.*
 - *Extreme weather conditions.*
 - *Steep / muddy / sandy terrain.*
 - *Remote area and delayed response times*

- *Helicopter landing sites.*
- *Varying road classes*
- *High visitor usage*
- *Poor phone / radio reception*
- *Potential for hazardous substances due to waste water treatment plant*
- *Underground cave network*

51. The EMP also included, *inter alia*, an emergency contact list, general information regarding the Reserve, a Register of Potential Emergency Events which listed the likelihood of a natural event as ‘likely’, and a Training Register.
52. Mr Kleinitz advised the Court that at the time of the flood, all ongoing staff at the Reserve were involved in the annual review of the EMP, which included a review of the previous EMP and the application of learnings into the new EMP. The new version would then be presented to all staff at one of the monthly staff safety briefings.

Staff training

53. Mr Kleinitz advised that staff took part in several simulation training exercises for emergency scenarios such as cave rescues. Mr Kleinitz noted that in-person simulation training was mostly focussed on medical incidents as they were the most common incident occurring at the Reserve.
54. Desktop training was provided for other events/scenarios such as fires and floods, with the last desktop training for a flooding scenario conducted in 2019. However, Mr Kleinitz noted that this exercise was for a more moderate flooding event. He said “*systems and procedures that supported staff preparation, and pre-event planning and response, to the December 2023 flood was not tested because an event of this magnitude had not been experienced before.*”
55. At the time of the December 2023 flood, Parks Victoria did not have a specific training module for a weather event of that magnitude, or for severe flash flooding.
56. This was reflected in the statements of several individual employees who stated that they had access to the EMP and generic emergency procedures outlining who to contact in case of an emergency but did not know of any policy or procedure in place in respect of flooding or harsh weather events.

57. Staff did appear to be acutely aware of the risk of flooding despite the lack of specific procedures, as the area had flooded previously. Ms McDonnell noted that staff would regularly check the weather on their phones and were aware that one area of the campground was subject to minor flooding in heavy rainfall, which was *“always in the back of [their] mind”*.
58. Staff were aware of the evacuation point for the Reserve – being the camp kitchen – but noted that evacuation procedures were geared towards a fire event, and not a flood. Other training was focussed on cave rescue and what to do when someone was injured inside a cave.

Parks Victoria response on 26 December

59. It is unclear what, if any, information Tina and Andrew were provided on arrival to the Reserve or if they were generally aware of the dangers of flooding.
60. Ranger Team Leader Leanne Hodge explained the process of day visitors arriving for a cave tour – they attend the Visitor Centre, are checked off on a manifest and given a ticket and are directed to the cave entrance. Before a tour begins, the Cave Guide calls the Visitor Centre to confirm the number of attendees. The Cave Guide provides an introduction to attendees, including a warning to be aware that the path in the cave can be slippery, narrow and low in sections.
61. Cave Guide Ms Bright did not recall providing any information to the tour group on completing the tour of Royal Cave other than to say words to the effect of *“it doesn’t look like it is going to stop soon – it is only rain – so we will have to go out anyway”*. Ms Bright noted that she did not know the Reserve was flooding until she herself had left the cave. She had only recently started as a Cave Guide, on 13 December 2023.
62. I acknowledge that the flooding of the magnitude experienced on 26 December 2023 was unprecedented and that the weather event occurred with very little warning, and I do not intend to criticise the response or actions of Parks Victoria employees on the day.
63. On the day of the incident there were two Park Rangers rostered on due to it being a busy period. Rangers Ms McDonnell and Mr Davidson were in effect responsible for the entire Reserve, including supervision of casual staff. Ms McDonnell and Mr Davison planned on leaving the Reserve at 4:30pm when their shift ended. At that time, *“wind absolutely whipped through the Reserve ... it came from nowhere”*.

64. Ms McDonnell and Mr Davidson immediately ventured into the Reserve and began clearing hazards from the roads, helping visitors to their cars while it still appeared safe to do so, and provided instruction to visitors. As they did so, they were in contact with the Visitor Centre advising Ms Moreland of the situation. Ms McDonnell told Ms Moreland to advise the group at the cave to stay at the exit, but it appeared that the group had already left by this time.
65. Ms McDonnell also recalled calling her manager, Jordan Gardiner, to inform him of the situation at the Reserve and requested that he advise the necessary parties. She also called Triple Zero as at that time, the floodwaters were still rising, and Ms Moreland was stuck on a bridge in fast moving floodwater. Ms McDonnell, at great risk to her own safety, rescued Ms Moreland from the bridge.
66. Once it became apparent that it was unsafe to drive, Parks Victoria staff took remaining visitors to the ‘old office’, a building that they assessed as being safest as it was on higher ground. There, they accounted for visitors, provided food and dry clothing and kept them calm.
67. After the floodwaters had subsided, Ms McDonnell and Mr Davidson went to assess the damage, which he noted to be “*severe devastation*”. They checked the cars that had remained before to ensure no one was inside them and collected medication for a visitor.
68. Ranger Team Leader Leanne Hodge was not rostered to work on the day of the incident. When she noticed the heavy rain, she drove to the Reserve, arriving at around 5:10pm. She liaised with Parks Victoria staff and emergency services and regularly updated Mr Kleinitz, who was interstate at the time.
69. Visitors and staff remained at the ‘old office’ until past 9pm, when they were able to be safely escorted from the Reserve.

RESTORATIVE & PREVENTATIVE MEASURES

70. Tragic as it was, the 2023 flood clearly provided the impetus for Parks Victoria to assess the emergency preparedness of the Reserve.
71. Mr Kleinitz acknowledged this, stating:

The intensity and speed of the December 2023 flood provided a significant learning opportunity and vital new information needed to improve and respond to these types of severe weather events. As a result of its assessment of the December 2023 flood, Parks Victoria

believes its preparedness for dealing with any further severe weather event of this type is greatly improved and the impacts to people and property would be greatly reduced.

72. Parks Victoria have implemented a significant suite of improvements to the Reserve's emergency preparedness and response.

Updated EMP

73. A revision of the EMP was completed in September 2024, with regular updates since. The revised EMP consists of two documents – an 'All Hazards Guide' and 'Emergency Response Instructions' for different types of emergencies.
74. The ERI for flood outlines the triggers for activating that ERI, including, relevantly "*Flash Flood – localised storm/heavy rainfall. Forecast of heavy localised rain / localised flash flooding risk*". It provides detailed steps for staff to follow once the triggers have been met and allocates those actions to specific staff members. It lists who must be notified of an event, including external and internal stakeholders.
75. The ERI for flood also includes a new Severe Weather Planning procedure that establishes process to be followed by operational staff in preparing for severe weather or flood events. On a day with a severe weather warning, considerations include reducing access to the full Reserve, providing advice to campers, distribution of wet weather gear, communications checks and confirming daily hierarchy of control.

Communications

76. There was no phone reception in the caves at the time of the flood, and employees were required to use a landline at the end of the cave system to contact the Visitor Centre.
77. Fibre optic cables have since been installed between the cave entrances, and Mr Kleinitz advised that Parks Victoria is continuing to investigate the most appropriate technology to use within the cave system to improve lines of communication. UHF (Ultra-High Frequency) radios have been supplied to all vehicles and at cave entrances and exits, and Parks Victoria is undertaking regular testing and training of same.
78. Parks Victoria has also commenced discussions with emergency service organisations in relation to communication compatibility to ensure better coordination and response during emergencies. The current EMP also contains reporting requirements and inter-agency contact details for emergency situations.

79. Parks Victoria have worked to improve lines of communication between the organisation and the neighbouring community through multiple channels such as direct mail, social media, site visits and community groups. Operational staff at the Reserve participated in the Buchan Business and Tourism Association and the Community Recovery Committee, with these groups being the main conduit of information from Parks Victoria to the community.

Alerts and signage

80. A siren is being installed at the Visitor Centre. A monitor showing Victoria Emergency warning and advice, with Bureau of Meteorology info scrolling is also being installed.
81. New signage has been installed to communicate the revised evacuation plans to visitors. The signage will be inspected half-yearly as part of Parks Victoria's regular review of emergency protocols.

Staffing, inductions and training

82. Parks Victoria now provides training to new and existing staff on severe weather triggers, how to activate the pre-event planning and respond to severe weather, including flooding incidents, and emergency flood situations. Pre-peak season training is held, and regular Guide staff meetings include emergency training sessions. Staff also work with emergency service organisations include Victoria Police, SES, CFA and Ambulance Victoria to coordinate annual emergency scenario training.
83. The staff induction process has been updated to include information about previous emergencies, and the contents of the EMP. New and existing staff receive pre-peak season training on what to do in an emergency, including flash flooding.
84. Ranger staff hold pre-shift briefings that include weather alerts, contractors working on site, the number of expected visitors and the names of staff rostered on that day. Additionally, in peak periods a whiteboard is used to inform all staff of this information.
85. Duty cards have been established for Cave Guides, running through the steps to respond to an incident and what their focus should be. These cards are available at the office and throughout the cave network.
86. A second Ranger is now rostered to be on-site for all busy weekends.

Other

87. Parks Victoria have established a process for emergency response out of hours when no staff are on site, and the visitor guide and pre-arrival email have been updated accordingly.
88. The installation of flood level indicators and a boom gate was investigated but found to be unfeasible.

COMMENTS

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

89. On the afternoon of 26 December 2023, more than 60 millimetres of rain fell in 30 minutes over the Buchan Caves Reserve. The resulting flood caused major damage to buildings and the road network. During the initial clean-up phase more than 250 tonnes of debris was cleared away.
90. This was an exceptional and unprecedented event that those most familiar with the area were not anticipating, nor prepared for.
91. Ms Moreland, who had lived in Buchan for 21 years and worked for Parks Victoria for 16 years stated *“I remember the lightning, the thunder, the wind and the force of the water was like nothing I had ever seen or experienced before.”*
92. Leanne Hodge, Ranger Team Leader at Buchan Caves Reserve since 2009, said *“we’ve never had anything as significant as the 30th December 2019, when the massive fires came through, and the 26th of December 2023, when we had the major flooding event”* and *“it was hard to comprehend the force of the water when it came through.”*
93. Leading Senior Constable Raymond Moreland, Station Commander of the Buchan Police Station for 21 years, said *“I have never seen rain and a storm like this before that was impacting the town. The storm was more suited to a tropical storm in the north of Australia.”*
94. The footage, photographs and witness statements describing the event are sobering and clearly depict the devastation caused.
95. Despite the lack of specific procedures or training on the incident at hand, once the severity situation was identified, Parks Victoria staff were quick to respond.

96. I commend them for this, and in particular I acknowledge the efforts of Park Rangers Ms McDonnell and Mr Davidson who immediately, and at great risk to their own safety, ventured into the weather to assist their colleagues and visitors to the Reserve.
97. Parks Victoria acted quickly and appropriately following the event to enact measures that I consider will go some way to ensuring the safety of staff and visitors to the Reserve should a similar event occur in the future. The new EMP is far more comprehensive than the version current in December 2023, and the training provided to staff and infrastructure/technology improvements will support this.
98. The only outstanding prevention measure I can envision is physical signage at key locations (such as bridges and carparks) reminding visitors not to drive through floodwaters. I would imagine many people are cognisant of the dangers of doing so, but for various reasons, such as seeing others do so before them or wanting to escape the area, make an impulse decision to drive through. Signage may therefore act as the final opportunity to prevent these tragic incidents.

RECOMMENDATIONS

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

- (i) In the interests of preventing like deaths and promoting public health and safety, I recommend that Parks Victoria consider installing signage in key locations throughout the Buchan Caves Reserve (for example, at car parks and bridges) warning of the dangers of driving through flood waters.

FINDINGS AND CONCLUSION

99. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Fan Yang, born 5 March 1994;
 - b) the death occurred on 27 December 2023 at Centre Road, Buchan, Victoria 3885;
 - c) I accept and adopt the medical cause of death ascribed by Dr Paul Bedford and I find that Fan Yang died from drowning in the setting of flash flooding;

100. AND, having considered the available evidence, I find that Fan Yang died in an unprecedented flash flooding event at the Buchan Caves Reserve, in circumstances where he and his partner drove through floodwaters.
101. AND, given the unprecedented nature of the flooding event, I make no adverse findings in relation to any Parks Victoria employees working during the flood, who I find responded to the event with the information they had to hand and within the confines of their training and experience.
102. AND, although Parks Victoria's emergency preparedness procedures did not prepare staff for an event of this magnitude, I find that Parks Victoria have acted swiftly and appropriately in implementing restorative and preventative measures. I am unable to find with any certainty that Fan Yang's death would have been prevented had those restorative and preventative measures been in place at the time of the 2023 flood.
103. AND FURTHER, Fan Yang's death is a stark and tragic reminder of the danger of driving through floodwaters.

I convey my sincere condolences to Andrew'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:

Jinhui Qin, Senior Next of Kin

Lander and Rogers on behalf of Parks Victoria

Senior Sergeant Mathew Argentino, Coronial Investigator

Signature:



Coroner Sara Dennis

Date: 31 August 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.
