IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006742

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Lee Lee Heah
Date of birth:	08 April 1955
Date of death:	19 November 2024
Cause of death:	1a: HEAD AND CHEST INJURIES SUSTAINED IN A FALL FROM A HEIGHT DURING A CLIMBING INCIDENT
Place of death:	Mount Arapiles Victoria 3409
Key words:	Rock climbing, traditional climbing, buddy checks, safety harness, Dyurrite, Mount Arapiles

INTRODUCTION

1. On 19 November 2024, Lee Lee Heah[1] was 69 years old when she died while rock climbing at Dyurrite (**Mount Arapiles**), Victoria. At the time of her death, Lee Lee lived in Christchurch, New Zealand, where she worked as a criminal barrister.

2. Lee Lee's sister recalls that Lee Lee was *"adventurous from a young age."* She loved adventure sports, including rock climbing, bouldering, ice climbing, trekking, surfing and sky diving. Lee Lee's friend, Alisa Woodruff (**Alisa**) recalled that Lee Lee was also an experienced mountaineer and had climbed Ama Dablam in Nepal. Lee Lee would frequently travel overseas to participate in these sports.

3. In November 2024, Lee Lee and Alisa travelled together to Australia to climb Mount Arapiles. Alisa was familiar with the area, having previously visited Mount Arapiles on around 5 occasions. She considered that they were both *"well experienced and well prepared for this trip,"* with Lee Lee previously leading the climbing on grade 16[2] sports routes.[3]

4. The pair had climbed together for approximately 20 years. Alisa considered that the trip was *"training"* for Lee Lee, who was preparing for other overseas climbing trips. She recalls that Lee Lee was seeing a personal trainer to build training programmes and that she had been going bouldering. They had prepared for this trip by going climbing together.

5. On 16 November 2024, the pair arrived at the town of Natimuk, where they booked accommodation near Mount Arapiles. Lee Lee brought a complete set of traditional climbing[4] gear with her, and the '*Arapiles Selected Climbs*'[5] (hereinafter referred to as **the Guidebook**) as a guide to the different trails on Mount Arapiles.

6. The day before Lee Lee's death, the pair had climbed the 150-metre Siren trail on Mount Arapiles, which is rated as a grade 9 climb. Lee Lee led a portion of this climb.

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[1] Referred to throughout this finding as 'Lee Lee', unless more formality is required.
[2] Climbing grades are subjective, with higher numbers indicating harder climbs. Most grade systems are specific to a particular style of climbing.
[3] Sports climbing is a type of free climbing where bolts are permanently bolted into the rockface and pre-placed for climbers to use.
[4] Traditional climbing involves climbers finding and placing removable protection gear into rock features as they climb. In traditional climbing, the lead (first) climber will place protection into the rock while simultaneously ascending, which is then removed by the ascending second climber.
[5] Authored by Simon Mentz and Glenn Tempest, this book is a climbing guide to Mount Arapiles.

THE CORONIAL INVESTIGATION

7. Lee Lee'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.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Lee Lee'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.

11. This finding draws on the totality of the coronial investigation into the death of Lee Lee Heah 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.[6]

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

Circumstances in which the death occurred

12. At around 9:30am on 19 November 2024, Lee Lee and Alisa arrived at the base of the Eskimo Nell trail at Mount Arapiles. Eskimo Nell is a grade 10 traditional climbing trail, totalling 130 meters and consisting of four sections. They commenced their ascent at 10:30am.

[6] 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.

13. At approximately 3:00pm, Lee Lee and Alisa reached Pitch 4, which is the final section of the trail. The Guidebook describes that this section involves: *"crawl 13m (9)*[7] *R(ight)-wards behind huge block and then up short awkward chimney. Belay either on top of block or on small ledge above. 30m (10)*[8] *up the line which gets progressively steeper until exciting moves deposit you on top."* The Guidebook also proposes an easier alternative pathway, which is leftward below the final chimney and finishing up at a grade 8.

14. Alisa recalls that Lee Lee was *"pretty confident"* and she climbed first, with Alisa belaying. Alisa observed Lee Lee place *"2-3 pieces"* of climbing protection, which took her a few attempts. As she was trying to find her footing and get her legs up, Lee Lee fell. As she fell, her protection ripped out from the wall and she inverted in the air, before landing on the rock at the top of the chimney.

15. Alisa immediately contacted emergency services. She was unable to reach Lee Lee and she detached herself from the belay site, crawled back through the crawl space and out onto a ledge where she called out for help. Nearby climbers heard Alisa's cries for assistance and an experienced rock climber in the area (the **rock climber**) free climbed up to Lee Lee's location.

16. The rock climber observed that Lee Lee was lying face-down on the rock. She was wearing a helmet and had applied the chin strap. She was also wearing her harness, which remained attached to the wall with one piece of protection (a cam). Three pieces of protection (being two nuts and a cam) had slid down the rope to where the harness was attached to Lee Lee and had ripped off the wall as she fell.

17. The rock climber assisted Alisa to climb up to the ledge where Lee Lee was located. They commenced Cardiopulmonary Resuscitation (**CPR**). Other climbers also reached the scene and assisted with CPR until the arrival of emergency services.

18. On arrival of Ambulance Victoria's Helicopter Emergency Medical Service (**HEMS**), Lee Lee was declared deceased by paramedics.

Identity of the deceased

19. On 19 November 2024, Lee Lee Heah, born 8 April 1955, was visually identified by her friend.

[7] Grade 9.
[8] Grade 10.

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

Medical cause of death

21. On 20 November 2024, Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination, reviewed a post-mortem Computed Tomography (**CT**) scan and provided a written report of his findings dated 27 November 2024.

22. The post-mortem examination showed injuries consistent with a fall from a height and did not reveal any unexpected signs of trauma.

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

24. Dr Young provided an opinion that the medical cause of death was *'1(a) head and chest injuries sustained in a fall from a height during a climbing incident.'*

25. I accept Dr Young's opinion.

FURTHER INVESTIGATION

Climbing Equipment

26. Leading Senior Constable Rhys Pratt (**LSC Pratt**) of Victoria Police's Search and Rescue Squad (**SAR**) attended the scene. LSC Pratt observed that Lee Lee's helmet showed *"major damage to the right and rear,"* which was consistent with impact sustained from falling from a height. He did not observe any damage to the helmet's webbing or chin strap, and the helmet buckles were in working order.

27. LSC Pratt assessed Lee Lee's climbing protection as standard for what traditional climbers use to protect themselves while lead climbing, that she had an *"appropriate"* amount of gear and that this was in good condition. LSC Pratt also reviewed the harness, webbing and buckles, which were all in working order.

28. Crime Scene Officer Leading Senior Constable Christine Huf (**LSC Huf**) from the Wimmera Crime Scene Services at Stawell Police Station examined items taken from the scene, including the climbing ropes, helmet and harness. LSC Huf did not identify any defects or areas of damage on the ropes. LSC Huf observed damage to the helmet on the rear and right side, which was consistent with the damage identified by LSC Pratt.

Harness Ties

29. LSC Pratt examined Lee Lee's harness, which had the usual crotch loop, waist loop and a belay loop connecting the two together. LSC Pratt advised that *"it is standard practice when you tie into the rope to feed the rope through crotch and waist loop."* LSC Pratt observed that while Lee Lee was tied into her harness with a *"standard and appropriate"* re-threaded figure 8 knot, this had been tied into the crotch loop only, rather than through both the crotch and waist loop. Solely tying into the crotch loop may increase the risk of inverting on a fall, as happened when Lee Lee fell.

30. In light of LSC Pratt's observations, I sought further information from Alisa on her recollections as to how Lee Lee was tied into her harness during the climb. In her response on 15 August 2025, Alisa confirmed that she had reviewed photos taken on the day of the climb and observed that Lee Lee was *"not tied in correctly,"* which Alisa had not noticed at the time. Further, Alisa was unsure whether they had completed buddy checks on each other's harnesses and tie-in knots before and during the climb.

Route

31. The evidence was not clear as to whether Lee Lee strayed off the route (as outlined in the Guidebook) prior to her fall. The rock climber who first reached her following her fall opined that based on his experience, Lee Lee mistakenly went off route and that the placement of her climbing protection indicated that instead of going right and following the route, she turned left and found herself in *"unexpectedly difficult terrain."* This is disputed by Alisa, who does not believe that Lee Lee was off route.

32. LSC Pratt did not form a view on whether Lee Lee had gone off route, instead noting that it is not uncommon for circumstances to arise where climbers identify weaknesses in the rock and move around the trail. Additionally, while the Guidebook and other resources are available as guides for different climbs, they provide brief descriptions for different climbs rather than comprehensive instructions to climbers for each route. In particular, the Guidebook itself provides two alternative pathways for the relevant section of the climb.

Placement of Climbing Protection

33. In traditional climbing, climbing protection is not pre-installed into the rock. Instead, the first climber will place pieces of protection into the rock and then clip their rope into it. If a climber falls, LSC Pratt explained that: *"the rope then pulls on the most recent piece of protection and*

stops the fall. If the protection gets pulled out due to poor placement the leader continues fall until the rope is taken up by the piece below it."

34. In circumstances where climbing protection is poorly placed and a person falls; multiple pieces of climbing protection can sequentially rip out of the wall in a 'zipper effect.' In this instance, the force of Lee Lee falling ripped out the climbing protection that she had placed. As the belayer, Alisa would not have been able to minimise the length of the fall.

35. LSC Pratt noted that each piece of climbing protection should be tested in both a downward and horizontal pull, as the "*piece you fall on will sustain a downward pull, however, every piece below it will be pulled horizontally. If the pieces come out on a horizontal pull, every piece will be pulled out except the one you are hanging on."*

36. LSC Pratt opined that Lee Lee appeared to have *"limited experience placing traditional protection"* and that while she had experience in sports climbing and mountaineering, this does not necessarily correlate to traditional climbing and knowing how to correctly and confidently place climbing protection.

37. In correspondence with the Court, Lee Lee's sister disputed this, and noted that Lee Lee had experience in both traditional climbing and other forms of climbing, and had previously climbed at Mount Arapiles.

Physical Condition

38. Alisa recalls that on the day of the climb, Lee Lee was *"tired and in pain."* She had also lost a shoe the previous day and was therefore wearing climbing shoes in a larger size, which may have contributed to her struggling to find her footing.

39. As part of my investigation, and as per the usual process for this kind of investigation, I obtained Lee Lee's medical records which contain relevant physical health concerns, including that Lee Lee had been intermittently experiencing episodes of vertigo for over a decade which had been increasing in frequency. On one occasion in around 2018 - 2019, there was an incident where she experienced vertigo while hiking and required assistance descending.

40. In an appointment with her General Practitioner in March 2022, Lee Lee disclosed that she was attending vestibular physiotherapy to manage the episodes of vertigo, and she was prescribed prochlorperazine to be taken as needed for treatment. Lee Lee's medical records

also reference previous injuries which had occurred while she was rock climbing, such as several head injuries from falls while she was wearing a helmet, ankle sprain, and injuring her tailbone after she fell from a height of 1 meter and landed on it while climbing.

41. Most significantly, Lee Lee's medical history notes that on 8 November 2018, she had to be helicoptered off Ama Dablam after she developed severe frost bite to her ring finger and left middle fingertip, resulting in complete necrosis. On 17 May 2019, Lee Lee underwent surgical amputation of the fingertips of her right ring and left middle fingers.

42. I asked LSC Pratt about the impact that the loss of these two fingertips may have had on Lee Lee's ability to traditional climb. LSC Pratt explained that climbing strength relies on a number of different factors, including finger strength,[9] grip strength[10] and forearm power/endurance.[11] He considered that if Lee Lee had any impingements due to the loss of these fingers, her climbing experience would have made her aware of how this had affected her and she would have otherwise been able to generate force.

43. LSC Pratt's view was that the loss of these fingertips was not a significant limiting factor, as Lee Lee had completed the other sections of the climb and was nearing the top of the trail when she fell.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Lee Lee Heah, born 8 April 1955;

    b) the death occurred on 19 November 2024 at Mount Arapiles, Victoria, from head and chest injuries sustained in a fall from a height during a climbing incident; and

    c) the death occurred in the circumstances described above.

[9] Finger strength is the ability to place fingers in a specific shape and hold that shape to avoid slipping off the hold. Training for traditional climbing commonly involves training specific fingers in order to strengthen the tendons and pulleys responsible for curling and uncurling your fingers.

[10] Grip strength is the amount of pressure that a person can generate through squeezing your hand together. Some holds on a climb protrude rather than indent and therefore require grip strength to maintain purchase.

[11] Forearm power/endurance is the ability to repeat the two above techniques, despite forearm fatigue.

45. Having considered all of the circumstances, I am satisfied that Lee Lee's death was the tragic result of injuries sustained following an accidental fall from a height of around 8 metres while she was traditional climbing at Dyurrite (Mount Arapiles). I am satisfied that the fall occurred in circumstances where Lee Lee had faced issues with placement of her climbing equipment, leading to it sequentially pulling out of the wall as she fell instead of arresting her fall. Further, the fall occurred in circumstances where Lee Lee was climbing while fatigued, in pain and where she did not have the correct fitting shoes, which resulted in her struggling to find her footing and either losing her grip or being unable to maintain her hold.

46. I am also satisfied that, on this day, Lee Lee had not tied into her harness correctly, resulting in her inverting as she fell. Further, I am satisfied that Alisa was not at fault and could not have prevented Lee Lee's death. In making this finding, I note that as the protection Lee Lee had placed had failed, even if Alisa had performed a buddy check and checked that Lee Lee was correctly tied into her harness, Lee Lee would still have fallen from an unsurvivable height.

47. While there is not sufficient evidence for me to be satisfied on the balance of probabilities that Lee Lee's medical history, including episodes of vertigo and the previous amputation of two fingertips contributed to her fall, these are still relevant factors to inform my finding. Further, while the evidence is unclear as to whether Lee Lee strayed off route, I do not find that this is material to the cause and circumstances of Lee Lee's death, given that it is not uncommon for climbers to deviate from suggested routes where the situation requires.

48. I am satisfied that there were no equipment failures or defects which contributed to Lee Lee's death. I have not identified any direct prevention opportunities.

COMMENTS

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

1. While I have not identified any direct prevention opportunities, the circumstances of Lee Lee's tragic death underscore the significant risk of serious injury and death associated with traditional climbing. Since I commenced my investigation into Lee Lee's death, it is regrettable that there has been another fatality at a different trail on Mount Arapiles. Such tragic deaths highlight the importance of exercising all available safety precautions and taking proper risk mitigation activities when undertaking such high-risk activities, irrespective of ones' experience level.

2. While Lee Lee was a deeply experienced climber who her sister notes had climbed Mount Arapiles before, the evidence before me suggests that she was more experienced in sports climbing, which does not necessarily correlate to traditional climbing, particularly as the lead climber on an unguided climb. Traditional climbing can carry significant risk, including because it relies on sufficient knowledge and experience to correctly place protective gear.

3. Parks Victoria provides a brief visitor guide to Mount Arapiles, which states that *"climbing should only be undertaken by climbers with experience and training, or under the guidance of skilled and qualified instructors."*[12] Experience and knowledge in placing climbing protection should be learned from an experienced guide, or through attending a climbing club or company, and this knowledge should be enforced through consistent practice.

4. Given the inherent risk associated with traditional climbing, it is imperative that climbers, regardless of their experience level, avoid complacency with safety measures. This includes ensuring that buddy checks of harnesses and tie-ins are completed at the start of the climb and before each new section of a climb, that climbers horizontally test climbing protection and that climbing should not be attempted when an otherwise experienced climber does not feel that they have the necessary stamina to climb that day. Furthermore, traditional climbing is an extremely cognitively demanding activity, and even the strongest and most experienced climbers will ultimately fatigue and place themselves at risk of falls when they are climbing at their limit.

5. In this connection, while I have identified the factors that contributed to Lee Lee's fall as part of my investigation, it is worth emphasising that those engaging in activities like rock climbing – which is not a regulated sport – are typically well-versed in the risks and of the need to take seriously the safety measures that can mitigate those risks. There is no evidence that Lee Lee or her climbing partner had a different approach, or that they acted recklessly or with disregard for their own safety. Rather, Lee Lee's death demonstrates what can happen when a combination of smaller factors (ill-fitting shoes, equipment placement, fatigue, poor tying-in) can operate together to increase the risk of a fatality.

I convey my sincere condolences to Lee Lee's family and friends for their enormous loss. It is clear to me that, even beyond those who knew and loved her best, and who continue to grieve for her, Lee Lee's death has been deeply felt across the legal community in Aotearoa, and by the climbing

[12] At: http://www.parks.vic.gov.au/-/media/project/pv/main/parks/documents/visitor-guides-and-publications/mount-arapiles-tooan-state-park/mount-arapiles-tooan-state-park-visitor-guide.pdf?rev=790194d0c2144a9b80cf1f1fbe2219dd.

community in Victoria and more widely. Lee Lee's sense of adventure, her love for the outdoors, her compassion as a lawyer and her indefatigable spirit have created an indelible mark on those who met her.

ORDERS AND DIRECTIONS

I order that a copy of this finding to be published on the Court's website in accordance with the Rules.

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

Senior Next of Kin

Parks Victoria

Leading Senior Constable Rhys Pratt, Victoria Police

A/Sergeant Meaghan Husman, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 17 July 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.