IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2025 000492**

**FINDING INTO DEATH FOLLOWING INQUEST**

*Form 37 Rule 63(1)*

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

**Inquest into the Death of PCH**

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| Delivered On: | 23 March 2026 |
| Delivered At: | Coroners Court of Victoria<br>65 Kavanagh Street, Southbank |
| Hearing Dates: | 23 March 2026 |
| Findings of: | Judge Liberty Sanger, State Coroner |
| Counsel Assisting the Coroner: | Ms Jess Syrjanen, Senior Coroner's Solicitor |
| Keywords | Drowning; child in care; Child Protection; epilepsy |

***Aboriginal and Torres Strait Islander readers are respectfully advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.***

## INTRODUCTION

1. On 25 January 2025, PCH was 14 years old when she passed at the Broken River K12 Streamside Reserve in Benalla, Victoria. PCH is survived by her three older siblings.

2. When PCH was two years old, she and her siblings were placed into the care of her maternal grandmother, RC by Child Protection. RC described PCH as a "*shy child growing up and even up until her teenage years…but was full of sass and attitude*".[1] PCH loved building Lego, playing board games, card games and going swimming. She also loved camping and spending time with her family.[2]

3. PCH excelled at school and had a good group of friends. She enjoyed the 'hands-on' style subjects like woodworking, metal work and cooking. She was due to commence Year 9 when she passed.[3]

4. PCH's medical history included developmental delay, epilepsy and attention deficit hyperactivity disorder (**ADHD**). She was managed by various specialists for her ADHD and epilepsy. At the time of her passing, she was prescribed lisdexamphetamine for her ADHD, melatonin for sleep and lamotrigine for her epilepsy.[4]

5. In November 2024, RC noted that PCH experienced six or seven seizures, so she consulted with her treating clinicians, who changed her epilepsy medication from sodium valproate to lamotrigine, and referred her for an MRI. When PCH's general practitioner (**GP**) reviewed her in in December 2024, they documented that lamotrigine appeared to be working well as she had not experienced any seizures for a month.[5]

## THE CORONIAL INVESTIGATION

6. PCH's passing 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,

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[1] Coronial Brief (**CB**), Formal statement of RC dated 28 January 2025, 5-1.
[2] Ibid.
[3] Ibid.
[4] CB, Formal statement of RC dated 28 January 2025, 5-1, 5-2.
[5] CB, Carrier Street Clinic Medical Records, 10-1, 10-2.

unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. As PCH was subject to a Long-Term Care Order (**LTCO**) at the time of her passing, she was deemed 'in care' pursuant to the Act. I held an inquest into her passing on 23 March 2026 pursuant to section 52(2)(b) of the Act.

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 Leading Senior Constable Phillip Barnden to be the Coronial Investigator for the investigation of PCH's passing. 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. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

11. This finding draws on the totality of the coronial investigation into the passing of PCH 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]

[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

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

### Identity of the deceased

12. On 25 January 2025, PCH, born [redacted], was visually identified by her grandmother, RC.

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

### Medical cause of death

14. Forensic Pathology Registrar Dr Felicity Barnes supervised by Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 29 January 2025 and provided a written report of their findings dated 22 August 2025.[7]

15. Dr Barnes noted the circumstances in which PCH was found (face down in the water) raised the possibility of drowning as the cause of death. The diagnosis of drowning can be challenging in the post-mortem setting as there are no specific features of drowning that can be seen at the time of the autopsy, and therefore the diagnosis is highly reliant on supportive circumstantial information and exclusion of other possible causes of death. The events preceding her being found in the water were not witnessed.[8]

16. Non-specific findings that are commonly reported in cases of drowning include a foam plume around the mouth, heavy and over-distended lungs (emphysema aquosum), blood-stained and frothy sputum in airways, fluid in the chest cavity (pleural effusions), and watery stomach contents. In this case, there was a small amount of frothy, blood-stained sputum in the airways, bilateral pleural effusions and watery stomach contents.[9]

17. Dr Barnes noted PCH's history of epilepsy with increasing seizure frequency and her apparent inability to extricate herself from the water raised the possibility of seizure as a cause or significant contributing factor to her death. Non-specific findings that may support the

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

7 CB, Medical Examiner's Report, 1-1 to 1-15.

8 Ibid, 1-3.

9 Ibid.

diagnosis of a recent seizure include prone position, oral trauma, petechiae or ecchymoses of the head and/or neck and injuries to the protruding areas of the head or limbs. None of these features were identified at the autopsy.[10]

18. The post-mortem examination of the brain demonstrated some minor changes within the hippocampi of uncertain significance but no epileptogenic focus. On review of PCH's medical notes, this is in keeping with an antemortem MRI performed.[11]

19. The post-mortem examination did not demonstrate any significant natural disease that could have caused or contributed to death.[12]

20. Biochemical analysis of the vitreous humour was non-contributory.[13]

21. Microbial testing of the post-mortem samples isolated *Aeromonas hydrophila/caviae, Klebsiella oxytoca, Streptococcus thoraltensis and Clostridium sordellii. Aeromonas hydrophila/cavaie* and *Klebisella oxytoca* are both bacteria commonly found in water. *Streptococcus thoraltensis* and *Clostridium sordellii* are bacteria commonly found in the digestive tracts of various animals and therefore may be found in water in the setting of faecal contamination. There was no evidence of infection identified at autopsy and these microbiological findings were favoured to be due to post-mortem artefact.[14]

22. Toxicological analysis of post-mortem samples identified the presence of amphetamine,[15] atropine[16] and lamotrigine.[17] Alcohol was not detected.[18] Atropine was administered by paramedics during their treatment and attempted resuscitation.[19]

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[10] Ibid.
[11] Ibid, 1-4.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Amphetamine is an indirectly acting sympathomimetic phenethylamine derivative thought to enhance dopaminergic and noradrenergic neurotransmission. It is both abused for its stimulant effects and used therapeutically, as was the case here.
[16] Atropine is indicated for cardiac slowing, irritable bowel syndrome, paralysis of accommodation and pupil dilation for eye examinations, urinary incontinence, and can be used as an antidote for anticholinesterase poisoning.
[17] Lamotrigine is a substituted asymmetric triazine compound used as an anticonvulsant.
[18] CB, Toxicology Report, 2-1.
[19] CB, Ambulance Victoria records, 9-9.

23. There were no significant injuries that could have caused or contributed to death that were identified post-mortem.[20]

24. Dr Barnes provided an opinion that the medical cause of death was 1(a) Drowning in a person with epilepsy.[21]

25. I accept Dr Barnes' opinion as to the medical cause of death.

**Circumstances in which the passing occurred**

26. On 24 January 2025, RC and PCH travelled together to a campground in Benalla, next to the Broken River. RC noted that she and her family have been camping at this location for about five years and that the weekend of PCH's passing was the third time they had travelled to that location in the past month. RC explained that she and her family were very familiar with the campsite and river.[22]

27. RC and PCH arrived at the campsite between 4.00pm and 4.30pm and set up their swags. RC's son, AC, his partner, BC, and their children were present at the campsite. AC's friend, TM and his daughter, and BC's parents, BB and LB were also present at the campsite. RC noted that other family and friends were due to arrive over the weekend.[23]

28. PCH took her night-time medication as per usual that evening and went to bed at about 10.30pm. RC retired to bed about half an hour later. RC noted that PCH was happy and did not observe any concerns.[24]

29. On the morning of 25 January 2025, RC provided PCH with her morning medication, which she took at about 8.30am with her breakfast. After finishing breakfast, PCH returned to her swag to get changed into her bathing suit. PCH and her cousin, SS, decided to walk down to the river to wash their hair.[25]

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[20] CB, Medical Examiner's Report, 1-4.
[21] Ibid, 1-3.
[22] CB, Formal statement of RC dated 28 January 2025, 5-2.
[23] Ibid.
[24] Ibid.
[25] Ibid, 5-3.

30. SS returned to the campsite sometime later, while PCH was still washing her hair. RC changed her clothes in the caravan and when she emerged, she asked SS about PCH's whereabouts. SS advised RC that PCH was still at the river, washing her hair. RC called out for PCH, who did not respond.[26]

31. RC approached the river and observed PCH "*lying face down in the water*".[27] RC yelled out to alert her family members, then entered the water to retrieve PCH. BB also entered the water and assisted RC in removing PCH.[28]

32. LB and RC commenced cardiopulmonary resuscitation (**CPR**) while TM called Triple Zero. While performing CPR, RC noted that PCH vomited "*a lot of water and vomit*".[29]

33. Victoria Police arrived on scene first and took over CPR from RC and LB. Ambulance Victoria (**AV**) paramedics arrived on scene and took over CPR from police. Paramedics were able to briefly achieve a return of spontaneous circulation (**ROSC**); however, this was not sustained. Paramedics continued resuscitation for about an hour but sadly were unable to revive PCH and she passed at the scene.[30]

34. Victoria Police investigated the incident and did not identify any suspicious circumstances or evidence of third-party intervention in connection with PCH's passing.

## FURTHER INVESTIGATIONS

35. As part of my investigation, I directed further information be obtained including PCH's medical records and Child Protection records. I also requested statements from PCH's GP, Dr David Rogers, and paediatrician, Dr Niroshini Perera.

36. Dr Perera explained that PCH's first seizure occurred in 2019. She was conveyed to the emergency department at Northeast Health Wangaratta and later underwent an electroencephalogram (**EEG**) at the Royal Children's Hospital (**RCH**). The EEG findings

[26] Ibid.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] CB, Ambulance Victoria records, 9-8, 9-9.

were abnormal and in keeping with a genetic generalised epilepsy with photosensitivity and she was commenced on sodium valproate. PCH also underwent an MRI in 2019 which was normal.[31] PCH experienced two generalised tonic-clonic seizures without a clear precipitant.

37. In 2024, the RCH gradually changed PCH's medication from sodium valproate to levetiracetam, then weaned her off levetiracetam and commenced lamotrigine. On 12 November 2024, RC and PCH returned to Dr Perera and advised that PCH recently experienced two further seizures on 29 October and 7 November 2024. The latter occurred while PCH was walking to school and may have been triggered by sunlight, as she was not wearing sunglasses at the time. Dr Perera consulted with the RCH neurology team and agreed to increase PCH's lamotrigine dose to 100mg morning and night.[32] Dr Perera also commenced PCH on a trial of lisdexamphetamine, to assist with managing her ADHD.

38. Dr Perera last reviewed PCH on 12 December 2024. She documented that there had been no further seizures since the two in October/November. PCH underwent an MRI earlier that year, which did not show a cause for her epilepsy.[33] PCH also reported that the lisdexamphetamine trial was very positive, so Dr Perera provided a further prescription.

*Management or restrictions on activities*

39. Dr Perera explained that in 2020, PCH had an epilepsy management plan. The plan recommended that PCH be supervised for any activities "*off the ground*" such as swimming, cycling and climbing activities. She noted that there were no issues with PCH participating in strenuous activities.[34]

40. It appears that during PCH's last presentation to treating clinicians in late-2024, her seizures were stable and well-controlled. I am satisfied that there are no issues with her medical management or treatment.

[31] CB, Statement of Dr Niroshini Perera dated 15 January 2026, 8-1, 8-2.
[32] Ibid.
[33] Ibid.
[34] Ibid.

## FINDINGS AND CONCLUSION

41. Having held an inquest on 23 March 2026 and pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was PCH, [redacted];

    b) the passing occurred on 25 January 2025 at Gouldings Camping Area - Broken River K12, Streamside Reserve, Benalla Victoria 3672, from drowning in a person with epilepsy; and

    c) the passing occurred in the circumstances described above.

42. Having considered all of the evidence, I am unable to determine whether PCH accidentally drowned while washing her hair, or whether she experienced a seizure, which caused her to drown while washing her hair. I note that her epilepsy appeared to be well-controlled prior to the incident, and she did not experience any seizures on the day before or day of the fatal incident. There is no evidence to suggest that PCH's passing was caused by anything other than a medical event and/or tragic accident and I am satisfied that there are no prevention opportunities.

I convey my sincere condolences to PCH's family for their loss.

Pursuant to section 73(1B) 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:

RC, Senior Next of Kin

Commission for Children and Young People

Ms SC (C/- Hannover Re Australia)

Royal Children's Hospital

Leading Senior Constable Phillip Barnden, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 23 March 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 inquest. 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.