IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006890

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	GYS[1]
Date of birth:	1979
Date of death:	26 November 2024
Cause of death:	1a: Multiple injuries sustained falling tree branch vs motor vehicle (driver)
Place of death:	Yarrawonga River Camp Loop Track Yarrawonga Victoria 3730

[1] This finding has been de-identified for the purpose of publication by order of Coroner Dimitra Dubrow.

INTRODUCTION

1. On 26 November 2024, GYS was 45 years old when he died in Yarrawonga. He is survived by his wife, IJA and their four children.

2. At the time of his death, GYS and his family were camping in the Yarrawonga Regional Park campsite for four weeks.

THE CORONIAL INVESTIGATION

3. GYS'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.

4. 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.

5. 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.

6. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of GYS's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence. The Court also requested additional information from the State Emergency Service **(SES)** and Parks Victoria **(PV).**

7. This finding draws on the totality of the coronial investigation into the death of GYS 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.[2]

[2] 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

Circumstances in which the death occurred

8. On the morning of 26 November 2024, GYS, IJA and their son, PQJ, attended the Yarrawonga Woolworths to purchase some daily supplies. They then returned to their campsite that was located at the Yarrawonga River Camp near the Loop Track. Loop Track is a single lane gravel road running in a northwest to southeast direction surrounded by river red gum trees on both sides. It runs along the edge of the Murray River. There are no specific marked camping areas, but campers utilise the flat grass open areas off the track to camp. GYS and his family were staying in a tradie trailer, and they used swags and gazebos for camping.

9. On this day, IJA observed the weather to be warm and sunny, with occasional clouds in the sky. At approximately 5 pm, she noticed a shift in the weather but remained unconcerned. According to the SES, 26 November 2024 was a warm to hot day with very high humidity and predicted thunderstorms across much of Victoria with severe thunderstorms possible becoming more likely as the day progressed.

10. At 10.19 am, the SES received an updated forecast from the Bureau of Meteorology (**BOM**) for severe thunderstorms across northern Victoria between Echuca and Wodonga, and as far south as Mt Baw Baw. At 1.50 pm, BOM issued its first severe thunderstorm warning.

11. At approximately 7pm, a storm hit the region with heavy rain, hail and strong winds. IJA noted that the gazebo began to collapse, and the family retreated to their vehicle, a navy-blue Jeep Cherokee XJ (**Jeep**) for safety. Due to the heavy winds and large hail stones, GYS decided to move the Jeep to a different location to avoid damage to the windscreen. GYS sat in the driver's seat; IJA sat in the passenger seat and their son was seated behind her. The trailer was not attached to the Jeep at the time.

12. GYS turned left from the campsite and travelled south onto the Loop Track. As they were driving, a vehicle from the opposite lane approached them. The driver informed them that a fallen tree was blocking the track ahead (southbound track). After hearing this, GYS decided to turn around and travel north-west along the Loop Track, in an attempt to exit the Yarrawonga Regional Park. IJA stated that GYS was *'driving at a slow speed due to the lack*

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

of visibility from the heavy hail.' She also noted that GYS was an excellent and cautious driver with a lot of experience in both on and off-road driving.

13. Shortly thereafter, the Jeep was struck by a large fallen tree branch. IJA noted the front windscreen was shattered inwards, and the car roof was caved in. She looked next to her and saw GYS's body. She could not see his head, but it was apparent that he had sustained unsurvivable injuries.

14. IJA and her son proceeded to exit the Jeep. They were assisted by witnesses, TXI and his partner, GRZ. TXI noted that IJA and PQJ appeared to be in shock. GRZ called emergency services.

15. At approximately 7:14 pm, police received a report that a tree had fallen across a motor vehicle on the Loop Track. They arrived at the scene at about 7:31 pm. SES and Country Fire Rescue (**CFR**) were also in attendance.

16. Upon arrival, police observed the blue Jeep station wagon with a large tree branch across the front cabin of the vehicle, directly impacting the driver. The emergency services crews gained entry to the vehicle and verified that GYS was deceased.

17. At approximately 7:46 pm, the SES Commander on scene, advised police that another severe storm event was expected to impact the area as a severe thunderstorm warning had been issued by the BOM for the area. The emergency crews were advised to move away from the scene as there was a significant risk of falling trees.

18. Before evacuating the site, SES members and police secured the scene.

19. The emergency crews evacuated the site at about 8:13 pm and returned to the scene at approximately 9:03 pm.

Police Investigation

20. Senior Constable (**SC**) Graeme Weldon of the Wangaratta Highway Patrol team who is a qualified heavy vehicle diesel mechanic attended the scene.

21. He observed that the Jeep on Loop Track was facing a north westerly direction with a large river red gum branch laying between the driver's side and passenger side bonnet. The head of the branch was touching the ground on the left side of the Jeep. SC Weldon noted that GYS was positioned in the driver's seat where it was clear the large branch had impacted his head.

22. SC Weldon noted that at the collision scene, the road was 4.8 metres wide. The Jeep came to a stop approximately 1.73 metres from the left shoulder to the left rear wheel and 0.78 metres from the right shoulder to the right wheel. The tree which the large branch broke away from was on the northeastern side of the road and 0.02 metres from the road edge. The branch broke away approximately 22.8 metres from the ground.

23. The Jeep had been travelling slightly right of centre when it collided with the tree branch. The initial impact was made directly on the front side of the Jeep, directly above the driver's head and then falling across the Jeep.

24. SC Weldon noted that the base of the fallen tree branch had a small amount of dead wood which was from a branch that had broken away some time ago. He concluded that the fallen tree branch was caused by the wind from the storm that passed the area at the time of the collision. It was estimated that the tree branch had an estimated wet weight of approximately three tonnes. The branch was measured at over 19 metres, with the main branch separating into three limbs.

25. SC Weldon inspected the Jeep at the scene and observed it to be in good mechanical repair.

Identity of the deceased

26. On 26 November 2024, GYS, born 1979, was visually identified by his wife, IJA.

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

Medical cause of death

28. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine conducted an external examination on 28 November 2024 and provided a written report of his findings dated 6 December 2024.

29. The post-mortem examination revealed catastrophic nonsurvivable head and spinal injuries.

30. The post-mortem computerised tomography (CT) scan showed comminuted skull vault and base of skull fractures with intracranial air, bilateral lung changes, minor subarachnoid haemorrhage, T3/4 fracture dislocation of the spine, small right pneumothorax, sternal, right clavicle and multiple spinous process fractures.

31. Toxicological analysis of post-mortem samples identified the presence of ethanol (0.01 g/100ml), delta-9-tetrahydrocannabinol, 11-OH-delta-9-tetrahydrocannabinol and 11-nor-delta-9 carboxy-tetrahydrocannabinol (THC-COOH). This finding is consistent with GYS's use of medicinal cannabis.

32. Dr Bouwer provided an opinion that the medical cause of death was *1(a) multiple injuries sustained falling tree branch vs motor vehicle (driver).*

33. I accept Dr Bouwer's opinion.

FURTHER INVESTIGATION

34. As part of my investigation into GYS's death, I requested information from Parks Victoria **(PV)** in relation to;

    a. How they monitor and assess tree health, and the risks associated with falling tree trunks and branches; and

    b. Any assessment of fallen tree trunks or branches and the circumstances of this incident.

35. PV provided a response on 5 June 2025 that indicated that their assessment of tree risk is based on the likelihood versus consequence principle set out in its Risk Management Framework (Risk Management, ISO 31000). This considers;

    a. The likelihood of injury to visitors from falling trees or limbs depending on the condition of the trees, the number of visitors and their level of exposure (which is increased significantly if visitors are stationary over an extended period); and

    b. The potential consequence of a falling tree or limb is serious injury or death if visitors are in the fall zone at the time.

36. PV noted that they will prioritise assessment and works for trees in areas where visitors are encouraged to be stationary such as, allocated campsites, campgrounds, picnic areas, tent sites, picnic tables, toilet blocks, amenities and lookouts. They explained that their assessments focus on Target Trees, which are any trees that sit above or within striking distance of a visitor facility and could cause personal injury or death if it partially or completely fell.

37. PV stated that in this case, the fallen tree limb was approximately 19 metres in length, with an estimated weight of 0.75 tonnes. PV Ranger John Hutchison who was on site, assessed the

tree and noted that the limb was of solid form at the breakage point with no signs of decay. It was concluded that the cause for this limb to fall, along with approximately another 150 trees and branches in the same location, was due to the unexpected cyclonic severe weather system occurring at the time.

38. PV noted that inspections of forested areas along roads occur less frequently compared to campgrounds. This is because they are deemed to be a lower risk as they are not areas where people congregate. Therefore, tree risk assessment would be undertaken where a concern is raised by a member of the public or when PV staff members identify a hazard whilst travelling along the road.

39. PV added that the Loop Track involved in the accident is not a public road listed on the Roads Register established under the *Road Management Act 2004* and PV is not the responsible road authority for the Loop Track. However, they do undertake maintenance work on the track.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was GYS, born 1979;

    b) the death occurred on 26 November 2024 at the Yarrawonga River Camp Loop Track Yarrawonga Victoria 3730, from multiple injuries sustained from a falling tree branch against a motor vehicle (driver); and

    c) the death occurred in the circumstances described above.

41. Having considered all the circumstances, I am satisfied that GYS's death was the result of a tragic accident.

I convey my sincere condolences to GYS'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:

IJA, Senior Next of Kin

Parks Victoria, C/o Barry Nilsson Lawyers

Leading Senior Constable Graeme Weldon, Coronial Investigator

Signature:





Coroner Dimitra Dubrow

Date: 15 November 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.