IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000283

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	DK
Date of birth:	25 September 2010
Date of death:	14 January 2025
Cause of death:	1a : HEAD INJURIES
Place of death:	Canyon Lane Bright Victoria 3741
Keywords:	Accidental fall; River diving

INTRODUCTION

1. On 14 January 2025, DK was 14 years old when he died in an accidental fall near Canyon Lane, Bright. At the time of his death, DK lived in Kew East, Victoria, 3102 with his parents, WK and QK and two younger siblings, FK and CK.

THE CORONIAL INVESTIGATION

2. DK'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.

3. 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.

4. 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.

5. Victoria Police assigned Senior Constable Melinda Stewart to be the Coronial Investigator for the investigation of DK'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.

6. This finding draws on the totality of the coronial investigation into the death of DK 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.[1]

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[1] 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.

7. In considering the issues associated with this finding, I have been mindful of DK's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

8. On 12 January 2025, DK's family arrived in Bright for their annual family holiday and had been coming to Bright for approximately five years with a group of family friends. The group of family friends included HY and PY, and their two children, VY and JY.

9. On 14 January 2025, both families attended together at Howitt Park to swim in the Ovens River. This was a common activity enjoyed by many families visiting Bright. Around 4.30 pm, the families decided it was time to leave for their dinner reservation. DK's mother had noticed that the children had not returned yet, so she walked down the river to find them.

10. DK and the other children were located at the bend in the Ovens River at the end of Canyon Lane. The Ovens River has high embankments on both sides close to this bend and there is a spot above a deep-water hole in the river that is commonly used by young people to jump into the river. This embankment is approximately five metres above the water level, and there are several rock shelves beneath the embankment.

11. DK's mother was unable to get the children to return to Howitt Park so PY went to assist her. PY reported that he was able to see the children jumping from the embankment at the end of Canyon Lane and called out to the children to encourage them to come down and return to Howitt Park.

12. At around 4:48 pm, DK is believed to have jumped into the river from the embankment at the end of Canyon Lane and lost his footing, falling forward onto the rock shelves below and landing on the rock ledge adjacent to Ovens River. There were no witnesses that saw DK fall or land on the rock ledge. Several witnesses, including Mr Petrus Christiaans, heard a loud sound made when DK hit the rock shelves, and then children yelling for help.[2] Both PY and Mr Christiaans as well as another woman attended to DK immediately whilst contacting emergency services for assistance.[3]

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[2] *Coronial Brief,* Statements of Petrus Christiaans and PY.
[3] Ibid.

13. Ambulance paramedics arrived on scene at 5:00 pm and continued the attempts to resuscitate DK, but were ultimately unsuccessful and he was pronounced deceased at 5:40 pm.[4]

Identity of the deceased

14. On 14 January 2025, DK, born 2010, was visually identified by their close friend's father, PY.

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

Medical cause of death

16. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 15 January 2025 and provided a written report of his findings dated 15 January 2025.

17. The post-mortem examination revealed evidence of scattered bruises and abrasions but no unexpected signs of trauma. Post-mortem CT scans showed significant and fatal head injuries comprising of fractures to the left side of the cranial vault and base of skull and subarachnoid haemorrhage.

18. Dr Young provided an opinion that the medical cause of death was 1(a) HEAD INJURIES and I accept his opinion.

FURTHER INVESTIGATIONS

19. In June 2025, I made a request to the Alpine Shire Council for information relating to statistical data and reports of serious accidents, injuries or fatalities that occurred within one kilometre of the fatal incident.

20. In a statement dated 10 July 2025, Mr William Jeremy, Chief Executive Officer of the Alpine Shire Council confirmed the following:

    a) One serious accident/injury and one fatality had occurred within 1 kilometre of the fatal incident in the last ten years. One involved a cycling accident and the other was a swimming incident;

    b) There are no signs warning visitors of the dangers of swimming and/or jumping from rocks within 850m of the location of the fatal incident; and

[4] *Coronial Brief*, Statement of Ambulance Paramedic Timothy Johnson.

c) Between 850m and 1km east of the location of the fatal incident, along Canyon Walk is an area within Howitt and Centenary parks known as the Bright River Pool. The River Pool is created by a weir. There are multiple signs within the parks in the vicinity of the river pool warning visitors of the general dangers of the river environment and advising no diving/jumping. Jumping is permitted from a designated jumping platform installed in November/December and removed in March/April each year.

21. The Alpine Shire Council confirmed no current or pending proposals to add signage or other infrastructure in vicinity of the fatal incident.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was DK, born 2010;

    b) the death occurred on 14 January 2025 at Canyon Lane, Bright, Victoria, 3741, from 1(a) HEAD INJURIES; and

    c) the death occurred in the circumstances described above.

23. Having considered all of the circumstances, I am satisfied that DK's death was the unintended consequence of impacting a rockface along the embankment of the Ovens River.

RECOMMENDATIONS

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

(i) That **Alpine Shire Council** consider the installation of additional signage along Canyon Walk closer or next to the accident site in this case. This additional signage should remind visitors and warn them of the hazards present in the area and the need for caution around the water and rocks.

I convey my sincere condolences to DK'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.

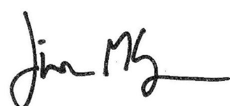
I direct that a copy of this finding be provided to the following:

WK & QK, Senior Next of Kin

William Jeremy, CEO, Alpine Shire Council

Senior Constable Melinda Stewart, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 21 May 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.