MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to s57(1)(c) of the *Coroners Act* 1995)

I, Simon Cooper, Coroner, having investigated the death of RA

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is RA;

b) RA died as a consequence of injury sustained in a witnessed fall from height;

c) The cause of RA's death was massive head injury; and

d) RA died on 7 May 2020 at the Royal Hobart Hospital, Hobart, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into RA's death. The evidence includes:

- Police Report of Death for the Coroner;
- Tasmanian Health Service Report of Death to the Coroner;
- An opinion of the forensic pathologist who conducted the autopsy;
- The results of toxicological analysis of samples taken at autopsy;
- Affidavits confirming identification and life extinct;
- Affidavits of RA's father, sworn 12 August 2020;
- Affidavit of FM, sworn 13 May 2020 and related police interview;
- Affidavit of TK, sworn 28 July 2020 and related police interview;

- Affidavit of JW, sworn 25 June 2020 and related police interview;
- Affidavits of attending and investigating police officers;
- Medical reports and records – Patrick Street Clinic, Ulverstone;
- Medical reports and records – Tasmania Health Service, North West Regional Hospital, Royal Hobart Hospital and Air Ambulance;
- Forensic and photographic evidence; and
- Report from the Medical Advisor to the Coronial Division.

Background

RA was born in Burnie on 28 October 2002. At the time of his death, he was aged just 17 years and living with his parents and sister in northern Tasmania.

He grew up on Tasmania's North West coast, attending local schools. When he died, RA was in Grade 12. Like many people his age, he had a part-time job and worked after school.

Reportedly, RA was an active child. As he grew older, he played a number of sports at high level. He was a particularly gifted Australian rules football player, representing Tasmania in the Under 15s in Western Australia and in the under 16s All Nation Tournament, where he received the most valuable player award.

Selected to play senior football for Penguin aged just 16, he suffered a severe concussion, which saw him hospitalised. His father and mother noticed his behaviour appeared to have changed following the injury, seemingly being unable to concentrate and appearing withdrawn.

He also played cricket and was an active member of the Tasmanian Endurance Riders Club.

RA was evidently a popular and personable young man. His death is simply tragic.

Circumstances of Death

On 5 May 2020, RA was at home with his family. Because of the impact of Covid 19, RA, like many people in the community at that time, had experienced a lengthy period of confinement at home with little interaction with friends (aside from social media contact). He was missing that contact very much.

At about 4.30pm that day RA was picked up by a friend, NP. RA told his parents that he and NP were going to visit a friend, FM. He let his parents believe that the young men intended to stay at FM's home and not go anywhere else.

In fact, they remained at FM's home for an hour or so before driving in FM's car to a nearby take away fast food outlet where they bought some food, before driving to Heybridge, parking near the river and eating. The boys spent about an hour or so at Heybridge. Shortly after, the boys, still in FMs car, went to the Penguin High School. There they met another friend, JW (who had come in his own car).

The three boys walked from the car park at the Penguin High School to the Penguin Primary School (the schools are located together on Ironcliffe Road). They went to the primary school with the intention of climbing onto the roof and jumping onto a shade sail. It was something the boys had all done before.

When they got to the primary school, the boys climbed onto the roof. JW jumped onto the sail first and then all followed suit. They repeated the jump a number of times. When all three were on the shade sail, RA jumped in the air from a standing position on the sail (from the description given by FM, rather as if he was bouncing on a trampoline). As he landed, the sail tore and RA went through it, landing on the concrete approximately 3.5 m below. RA's fatal fall occurred at approximately 10.30pm.

Initially, JW and FM thought RA had just been winded. When they went to see him, they were unsure whether he was being serious and was really injured, or whether he was joking. After a short time (in the order of 3 to 5 minutes), RA began to scream and JW and FM realised the situation was serious. Both boys saw a bruise developing on the right side of his forehead.

At approximately 10.45pm, FM called another friend, TK, who lived nearby. FM told TK that RA was injured and asked for help. TK went immediately to the school in his ute. JW and FM picked up RA and carried him out of the school grounds, put him in the back seat of TK's ute and took him to the North West Regional Hospital (NWRH).

When they arrived at the NWRH, FM told staff that RA had been injured while playing basketball. Self-evidently, this was not true.

Medical treatment

Medical records indicate that RA arrived at the NWRH at about 11.30pm. It was immediately apparent to staff RA was gravely injured. Upon admission, his pupils were unequal and he was drowsy and incoherent. After assessment, an immediate CT scan of his brain was performed. The scan showed a significant brain bleed. Emergency staff at the NWRH contacted the Neurosurgical team at the Royal Hobart Hospital (RHH), and a decision was made to transfer him to Hobart by air ambulance.

RA arrived at the RHH at 5.40am on 6 May 2020. He underwent an urgent left hemicraniectomy, during which an intracranial pressure monitor was inserted. Sadly, the injury to his brain was so extensive as to be unsurvivable and he was declared brain-dead in the afternoon of 7 May 2020.

RA was approved by a Coroner for organ donation.

Investigation

After the organ donation procedure was completed, and formal identification carried out, RA's body was transferred to the hospital's mortuary. At the mortuary, experienced forensic pathologist, Dr Christopher Lawrence, performed an autopsy. Dr Lawrence expressed the opinion that the cause of RA's death was the head injuries he sustained in the fall from the shade sail. I accept Dr Lawrence's opinion. Toxicological analysis of samples taken at autopsy did not detect the presence of alcohol or drugs.

Subsequent investigation carried out by local police involved, inter alia, interviewing FM, TK, and JW in the presence of their parents. Those interviews lead to the truth being told about the circumstances of RA's fatal fall. A review of the treatment, including the transfer of RA to the RHH, was carried out, at my request, by the Medical Advisor to the Coronial Division, Dr Anthony J Bell. Dr Bell, a highly experienced emergency physician, expressed the opinion that RA was appropriately assessed, and appropriately transported to Hobart, within acceptable timeframes.

I accept Dr Bell's opinion.

Conclusion

I am satisfied that RA died as a consequence of a massive, unsurvivable head injury sustained in the circumstances outlined earlier in this finding. I am satisfied that his fall was the result of a tragic accident.

Neither alcohol nor drugs played any role in his death.

I am satisfied that the treatment he received at the NWRH and the RHH and during his transfer between those hospitals was of an appropriate standard.

Comments and Recommendations

I consider that the boys with RA should have called an ambulance rather than taking him to hospital themselves.

The decision, no doubt motivated by panic, not to tell staff at the NWRH the truth about how RA was injured was the wrong decision. I **comment** that it is essential that medical staff have as accurate a history as is possible upon the admission of a person to hospital. The boys with RA were in a position to have provided that history and did not do so. Nonetheless, I do not consider, given the nature of the injury he suffered, that the misleading information given to medical staff at the NWRH upon RA's admission altered the ultimate outcome.

I convey my sincere condolences to his family and loved ones.

Dated 7 June 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner