IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 18 1406

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63*
*Section 67 of the Coroners Act 2008*

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| Findings of: | **CORONER DARREN J BRACKEN** |
| Deceased: | **Geoffrey Joseph O'Neill** |
| Date of birth: | 23 June 1926 |
| Date of death: | 25 March 2018 |
| Cause of death: | Head injuries sustained in a fall |
| Place of death: | The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria |

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**HIS HONOUR:**

## BACKGROUND

1. On 25 March 2018, Geoffrey O'Neill was 91 years old when he missed his step and fell down a flight of stairs while attending a basketball game. Mr O'Neill impacted the back of his head in the fall and subsequently died in hospital. Immediately prior to his death, Mr O'Neill lived alone in a unit at Long Island Retirement Village, 129/1 Overton Road, Seaford, where he had resided for 15 years.

2. Mr O'Neill was a retired bus driver and is survived by his son, Peter, and daughter, Annette.

3. Mr O'Neill's known medical history included right hip replacement, cardiac issues[1] and sensitivity to light for which he wore sunglasses when outdoors. He used a walking stick to ambulate. Mr O'Neill's close companion, Valde Hede (**Ms Hede**), believed he used a pacemaker however this was not demonstrated on a post-mortem computed tomography (**CT**) scan.

4. In the two years prior to his death Mr O'Neill had a history of two known falls, the most recent occurring in January 2018 when his trousers caught as he stood up from an armchair causing him to trip. He sustained a laceration to one of his legs and attended hospital for stitching.

## THE CORONIAL INVESTIGATION

### *Coroners Act 2008*

5. Mr O'Neill's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because his death occurred in Victoria, was unexpected and appears to have resulted from an accident or injury.[2]

6. The Act requires a coroner to investigate reportable deaths such as Mr O'Neill's and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

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[1] According to Mr O'Neill's son his father had some heart valves replaced since the mid-1980s and at least one heart attack in approximately 2009 due to blockages in his heart.
[2] *Coroners Act 2008* (Vic) s 4.

(c) The circumstances in which death occurred.[3]

7. For coronial purposes, "*circumstances in which death occurred*",[4] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

8. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[5] It is not the Coroner's role to determine criminal or civil liability,[6] nor to determine disciplinary matters.

9. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

10. Coroners are also empowered to:

(a) Report to the Attorney-General on a death;[7]

(b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[8] and

(c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9]

**Standard of Proof**

11. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities.[10] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[11]

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[3] *Coroners Act 2008* (Vic) preamble and s 67.
[4] *Coroners Act 2008* (Vic) s 67(1)(c).
[5] *Keown v Khan* [1999] 1 VR 69.
[6] *Coroners Act 2008* (Vic) s 69 (1).
[7] *Coroners Act 2008* (Vic) s 72(1).
[8] *Coroners Act 2008* (Vic) s 67(3).
[9] *Coroners Act 2008* (Vic) s 72(2).
[10] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

12. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[12] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[13] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[14]

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

### Identity of the Deceased - Section 67(1)(a) of the Act

13. On 28 March 2018, Peter O'Neill identified the deceased as his father, Geoffrey O'Neill, born 23 June 1926.

14. Mr O'Neill's identity is not in dispute and requires no further investigation.

### Cause of death - Section 67(1)(b) of the Act

15. On 27 March 2018, Dr Joanna Glengarry, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Mr O'Neill's body. Dr Glengarry provided a written report, dated 5 April 2018, in which she opined that the cause of Mr O'Neill's death was '*head injuries sustained in a fall*'. I accept Dr Glengarry's opinion.

16. Dr Glengarry advised that the CT scan showed injuries consistent with the history.

17. Examination of the torso showed sternal wires and pleural fibrosis. There was calcification of the coronary arteries and aorta. Metal clips suggestive of a surgical mesh were present over the anterior abdominal wall. A right hip replacement was in situ.

18. Toxicological analysis of ante-mortem and post-mortem samples detected the presence of drugs that were non-contributory. Alcohol (ethanol) was not detected.

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[11] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but I note that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.

[12] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.

[14] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.

**Circumstances in which the death occurred - Section 67(1)(c) of the Act**

19. On 25 March 2018 at approximately 3.45pm, Mr O'Neill attended Sandringham Family Leisure Centre with Ms Hede to watch her son's basketball final. According to Ms Hede, Mr O'Neill was in a good mood and his health appeared fine.

20. The pair entered basketball court one and walked towards the seating area. Court one is a standard basketball arena with two seating areas on either side of the pitch. There is a low seating area to the right with two rows of seats with just two stairs. There is an upper seating area to the left consisting of two seating areas comprising nine rows of seats each. Running perpendicular to the rows of seats are four flights of stairs with handrails as follows:

    i. On the far left with handrails on the left-side.

    ii. In the middle left with handrails on the right.

    iii. In the middle right with handrails on the left.

    iv. On the far right with handrails on the right side.

21. Each flight of stairs is 107 centimetres wide and has 24 timber polished stairs. The rises of the stairs are 18 centimetres tall and the goings are 26 centimetres long, with curved edges marked in red. The handrails next to each of the four flights of stairs are 91 centimetres tall, made of steel and round in shape.

22. There is artificial light in court one enhanced by several windows at the top of the seating area; Ms Hede told police there was *'plenty of light inside the court'*.[15]

23. In her statement provided to police, Ms Hede recalled that the low set of seats were fully occupied when she and Mr O'Neill arrived. They therefore headed to the higher set of seats on the left side of the pitch. Ms Hede said she and Mr O'Neill had wanted to take the passage of stairs in the middle, however they were told by a staff member that they could not do so as children were using those stairs to get down. They walked to the flight of stairs on the far right.

24. According Ms Hede, she ascended the stairs ahead of Mr O'Neill, who followed approximately two stairs behind her, turning to check on him as they went up. Ms Hede reported she stopped on the sixth stair above the landing and proceeded to take her seat on the

[15] Statement of Valde Hede, Coronial Brief, p.26.

third row. As she did so she again turned to check on Mr O'Neill. She then observed him standing on the fourth stair and miss the fifth stair with his walking stick; Mr O'Neill then fell backwards down the stairs and onto the landing, where he impacted the back of his head. He is believed to have fallen approximately 72 centimetres from the stair down to the landing.

25. Mr O'Neill was not conscious or breathing and two off-duty nurses, who had been spectating, provided cardiopulmonary resuscitation.

26. Ambulance paramedics arrived within about ten minutes of the fall and took over resuscitation efforts. Mr O'Neill was transported by ambulance to hospital where he was diagnosed with an intracranial haemorrhage that was not amenable to surgical intervention.

27. The decision was made in conjunction with Mr O'Neill's family to withdraw life support and Mr O'Neill passed away about three hours after his arrival in hospital.

28. Subsequent to the incident Victoria Police attended the Sandringham Leisure Centre to examine the scene of the incident and took the measurements of the seat, stair and handrail heights detailed in paragraph 21. These measurements were provided as an exhibit to the Coronial Brief (Exhibit Three).

29. The basketball courts contained within the Sandringham Family Leisure Centre are managed by Southern Basketball Association and leased from Bayside City Council (**the Council**). Victoria Police made enquiries with the Council regarding the stadium's compliance with the regulations on height, the presence of handrails, stairs (goings and rises), and any obligations for disabled access and ramps.

30. In response to the request, the Bayside City Council's Municipal Building Surveyor, Brett Turner, personally inspected the site on 21 March 2019 (a year after the incident) and reported his findings by email (undated) to the Coronial Investigator, Senior Constable Kostyantyn Olyeynikov. Mr Turner advised that the only irregularity he could see in the immediate area of Mr O'Neill's fall was a difference in the stair heights for the first few stairs into the seating area; the first few stairs were marginally smaller than those above.[16] It is not clear whether this was a reference to the going or the rise being marginally smaller or both. The measurements provided by Victoria Police for the Coronial Brief do not mention this irregularity. It appears from photographs provided on the Coronial Brief that any variation in

[16] Email correspondence from Kostyantyn Olyeynikov, dated 9 April 2019, forwarding email correspondence received from Municipal Building Surveyor, Brett Turner, with attached images of site inspection time stamped 21 March 2019.

the size of the stairs was indeed marginal. I am unable to say whether any variation contributed to Mr O'Neill's fall or not.

31. Mr Turner commented further that the handrail extension may not be compliant with current legislation however he did not elaborate on the nature of any irregularity.

32. In his email response Mr Turner noted that the legislation applying to the structures as they exist may differ from those in place when they were constructed. Mr Turner advised that a *'detailed regularity report'* would be required to confirm all the information requested as they relate specifically to the incident.

33. The Council does not have a falls risk policy relating to the Leisure Centre. Southern Basketball Australia provided a copy of the Basketball Victoria Code of Conduct, which stipulates that Basketball Victoria and its affiliated associations shall take all reasonable measures necessary to ensure the safety of participants.

***Family Concerns***

34. The court received correspondence from Mr O'Neill's son, Peter O'Neill, dated 4 August 2019, expressing concerns about his father having been purportedly '*turned away from easier access*' to the seating area by staff at the Leisure Centre.

35. The material on the brief indicates that there was no seating available in the more accessible seating area on the right of the pitch. Ms Hede's statement refers to her and Mr O'Neill having determined to sit in the higher seating area on the left. She refers to their wanting to take a central flight of stairs for access, as it was wider than the stairs at the sides and had handrails on both sides, but being turned away by a staff member as children needed to use the stairs as a thoroughfare. The information provided by the coronial investigator was that the higher seating area to which Ms Hede refers is accessed by four identical flights of stairs. It appears that Ms Hede may have been mistaken in her view that there was a central flight of stairs that was better accessible, when in fact what she observed were two identical flights of stairs separated by a central corridor on the lower level.

36. I am not satisfied on the material available that Mr O'Neill was turned away from better accessible stairs at the Leisure Centre.

## RECOMMENDATIONS

37. I recommend that the Bayside City Council compile the 'detailed regulatory report' referred to by Mr Turner in his email to the Coronial Investigator Senior Constable Olyeynikov (undated) in relation to the Basketball Stadium and undertake any work set-out in that report nominated as being required to bring the building into compliance with the relevant 'legislation applying to the structures'.

## FINDINGS AND CONCLUSION

38. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Geoffrey Joseph O'Neill, born 23 June 1926;

    (b) Mr O'Neill's death occurred;

        i. on 25 March 2018 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria;

        ii. from head injuries sustained in a fall; and

        iii. in the circumstances described in paragraphs 19 – 36 above.

39. Pursuant to section 73(1) of the Coroners Act 2008, I order that this finding be published on the internet.

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

    (a) Annette Williamston, senior next of kin.

    (b) Keren Day, Alfred Health.

    (c) The Bayside City Council.

    (d) Senior Constable Kostyantyn Olyeynikov, Coroner's Investigator, Victoria Police.

Signature:


**DARREN J BRACKEN**

**CORONER**

Date: 21 May 2020