IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005282

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Bailey James Blackwell
Date of birth:	19 January 2006
Date of death:	22 September 2023
Cause of death:	1a : HEAD INJURY IN A FALL FROM A HEIGHT
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004

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 22 September 2023, Bailey James Blackwell (**Bailey**) was 17 years old when he passed at the Alfred Hospital. At the time of his passing, Bailey lived at [redacted] [redacted] with his mother and siblings.

2. Bailey, a young Aboriginal man, is remembered by his mother as a "happy go lucky boy" who was "full of energy" and a "social butterfly".

THE CORONIAL INVESTIGATION

3. Bailey'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, 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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Bailey's passing. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence. Further investigation was conducted by the Court at my direction.

6. This finding draws on the totality of the coronial investigation into the passing of Bailey James Blackwell 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.

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

Circumstances in which the passing occurred

7. On 21 September 2023, Bailey, his brother Ryan, and three friends were together at the local skatepark for most of the morning and mid-afternoon. At approximately 3:00pm, the group rode to the Big Hill, a lookout viewing area located on Scenic Road, Stawell.

8. The group accessed an abandoned cave-like tunnel at the bottom of Big Hill, which was accessed from Scenic Road. The tunnel was not fenced off from pedestrian access. Walking through the tunnel provided access to a gorge area that provided a path to the top of an open cutting (cliff).

9. Bailey, Ryan and two group members then walked to the top of the open cutting by a grassed path that goes up the cliff face. They then walked around the top of the open cutting, walking to a fence line that began at a fire lookout tower, situated approximately 105 metres southeast from the intersection of Reefs Road, Big Hill Road, and Scenic Road. [2]

10. Bailey then walked along the fence line, along the wall of the open cut area for approximately 92 metres, before coming to a stop at a small pile of trees. Just below, on the open cutting cliff face, was a tree which protruded from the wall.

11. Bailey then told his friends he wanted to jump onto the ledge where the curved tree was protruding out from the cliff face, approximately one meter away, and one meter down. At this stage, it was approximately 5:35pm. Bailey then jumped onto the ledge at the tree, where he spent a short time before trying to jump back to where his friends were situated.

12. Bailey jumped a small distance and grabbed the edge of the ground with both hands. The ground then began crumbling where his hands were gripped. His footing slipped, and Bailey's hand grip released, causing him to fall.

13. As Bailey fell, his head struck the cliff face. He fell approximately 20 metres to the ground.

[2] The fence line restricted access from the Big Hill lookout carpark and seating area to the open cut area, but there was no signage installed along the length of the fence restricting access beyond the fence posts into the open cut area. The fence was situated so, that one could easily walk around the end posts of the fence to access the outside wall of the open cut area.

14. Bailey's friends then attended to him immediately, dialling Triple Zero for ambulance assistance.

15. At approximately 5.40pm, Ambulance Victoria (**AV)** paramedics arrived at the gorge. They performed an initial assessment and commenced assisted ventilations. State Emergency Services (**SES)** and Victoria Police members attended a short time later to assist AV paramedics. At 6.01pm, the Mobile Intensive Care Ambulance (**MICA)** paramedics attended to Bailey. The MICA paramedics intubated Baily, stabilised his spine, and transported him to Stawell Public Hospital.

16. At Stawell Public Hospital, Bailey was met by Helicopter Emergency Medical Service paramedics, who accompanied him as he was airlifted by Air Ambulance to the Alfred Hospital (**the Alfred)**. At 9.00pm, Bailey arrived at the Emergency and Trauma Centre of the Alfred.

17. Upon arrival to the Alfred, Bailey was administered blood products, and received an intercostal catheter on his right side, and a left finger thoracostomy.

18. At 9.31pm Bailey was taken for a computer tomography (**CT)** scan, which revealed a severe brain injury, extensive intracranial haemorrhage and skull base fractures, and a large laceration to the left lung and bilateral punctured lungs.

19. The neurosurgical, trauma and emergency consultants were involved in discussions before and after the CT scans and came to the consensus opinion that Bailey's injuries were sadly non-survivable.

20. Doctors attempted to keep Bailey alive and comfortable so his family could say goodbye as they commuted from Stawell. However, his condition further deteriorated. At 11.20pm, other treatments were withdrawn and Bailey was palliatively extubated.

21. On 22 September at 12:06am, Bailey sadly passed away.

Identity of the deceased

22. On 22 September 2023, Bailey James Blackwell, born 19 January 2006, was visually identified by his aunt, Julie Day.

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

Medical cause of death

24. Senior Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and provided a written report of his findings dated 28 September 2023. Dr Burke also considered results from a post-mortem CT scan.

25. The CT scan revealed injuries consistent with the stated history.[3]

26. Toxicological analysis of ante-mortem samples identified the presence of substances that were administered to Bailey during treatment.[4]

27. Dr Burke provided an opinion that the medical cause of death was 1(a) head injury in a fall from a height.

28. I accept Dr Burke's opinion.

FURTHER INVESTIGATIONS

29. Following Bailey's passing, I sought further information about the safety and access at the Big Hill site. After meeting with and obtaining site images from the Coroner's Investigator to confirm and better understand the route taken by Bailey and the various access points, I requested a statement from the local government, Northern Grampians Shire Council (**NGSC)** addressing the following:

    a) Is the NGSC responsible for management/control of the "Big Hill" site, and if not, advise who is;

    b) Was there signage or fencing at the time of the incident to prevent pedestrian access or to advise that access is prohibited?

    c) Is further secure fencing/signage being considered in the wake of Bailey's passing.

30. The NGSC confirmed that that the Crown/Department of Energy, Environment and Climate Action (**DEECA)** was the responsible land manager at the site of the "Big Hill". They stated that fencing was erected on the elevated areas, and no access prohibited signage in place. NGSC also stated a risk review would be undertaken for the portion of the land they have

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[3] Medical Examiner's Report of Dr Michael Burke dated 28 September 2023.
[4] VIFM Toxicology Report of Alex Kotsos, Senior Forensic Toxicologist dated 26 October 2023.

tenure over, notwithstanding it was not the location of the incident, and they have no authority over the parcel of land where the incident occurred or the access gained.

31. Following this response, I then requested DEECA to provide a statement to the same questions posed to NGSC.

32. A DEECA representative advised that the area of the incident is unreserved Crown land under DEECA's management. The statement noted that there was fencing at the location to prevent pedestrian access, however there was no signage to advise that access is prohibited.

33. DEECA had not otherwise been advised of the incident until receiving contact from the Court and had therefore not made any changes to signage and fencing at the location. However, they stated that any recommendations made by me would be considered to improve site safety.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Bailey James Blackwell, born 19 January 2006;

    b) his passing occurred on 22 September 2023 at The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004, from 1(a) head injury in a fall from a height; and

    c) his passing occurred in the circumstances described above.

35. Having considered all of the circumstances and available materials, I consider that Bailey James Blackwell's passing was a tragic case of misadventure.

36. While prohibitive signage at the fence line at the Big Hill site near the open cutting area may not entirely prevent persons from going around the fence posts and approaching the area, I am satisfied that appropriate signage will, at the very least, warn people that progressing beyond the fence line is dangerous and they do so at their own risk.

37. Further, I find that preventing access to the gorge area via Scenic Road may prevent persons from accessing alternate routes to the open cutting areas.

38. As a matter of procedural fairness, DEECA were given an opportunity to respond to the proposed recommendations.

39. DEECA advised the Court that the proposed recommendations had been reviewed and accepted to ensure improved site safety into the future. DEECA advised it will make necessary amendments to warn of the risks at this site and improve public safety.

40. I therefore make the below recommendations.

RECOMMENDATIONS

41. Pursuant to section 72(2) of the Act, I make the following recommendations to the Department of Energy, Environment Climate Change:

    (i) That signage be installed at the fence line at the Big Hill site in Stawell at the carpark, near where the incident occurred, to prevent further pedestrian access to the open cutting area and warn of risk;

    (ii) That fencing be placed across the tunnel/cave entrance on Scenic Road to prevent pedestrian access to the open cutting; and

    (iii) That signage prohibiting access into the tunnel/cave entrance on Scenic Road also be installed.

I convey my sincere condolences to Bailey's family, friends, loved ones and his community for their profound 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:

Donna Frichot, Senior Next of Kin

Glenn Blackwell, Senior Next of Kin

Department of Energy, Environment and Climate Action

Northern Grampians Shire Council

Senior Constable Cameron Holland, Coroner's Investigator

Signature:

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Coroner Kate Despot

Date: 24 February 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.