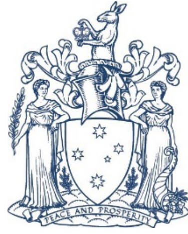

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002091

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Brent Robert Trickey
Date of birth:	1 March 1984
Date of death:	24 April 2021
Cause of death:	1(a) GUNSHOT WOUND TO THE ABDOMEN
Place of death:	Mountain View Farm, Rose River Road, Dandongadale, Victoria, 3737
Keywords:	Hunting in remote area, emergency services delay, fatal shooting by fellow hunter

INTRODUCTION

1. On 24 April 2021, Brent Robert TRICKEY (**Brent**) was 37 years old when died from a gunshot wound sustained during a deer-hunting expedition at McCready Track, Dandongadale, Victoria. At the time of his death, Brent lived at 39 Hazeldean Road, Yarragon, Victoria, 3823 with his wife, Liana Burns (**Liana**).

2. Brent is survived by his wife, his parents, Leanne Ambrose and Robert Trickey, and eight siblings.

<u>Background</u>[1]

3. Brent worked as a concreter for approximately 20 years. According to Liana, Brent ran his own concreting business and employed people to work in his business 'on a casual basis'.

4. Liana described her husband as 'an outdoor person' and one who 'loved his deer hunting' during the winter months. Brent's passion for deer-hunting started when he was introduced to the hobby when he was 'fourteen years old'.

5. During the summer months, on the other hand, Brent 'loved his fishing' and when the 'tides were right', he 'would go Marlin fishing'. His favourite hobby was deer hunting, however. Liana related further how Brent's 'prized trophies' from his deer-hunting and Marlin fishing expeditions adorned the walls in their home.

6. Brent usually went hunting with the same 'hunting crew'. According to Liana, she knew the hunters in Brent's 'hunting crew' circle because he had gone out hunting with the same group of 'ten to fifteen hunters' almost 'every weekend unless there was something [else] significant on' over a period of 'approximately five years'.

<u>The hunting trip</u>

7. On 23 April 2021 at approximately 11 am, Brent picked up a fellow hunter, Steven Williams (**Steve**), who was a member of his usual 'hunting crew'. Brent and Steve then set out on their designated journey and arrived at McCready Track at approximately 6 pm.

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[1] Coronial Brief of Evidence [**CB**], statement of Liana Burns.

8. According to Steve, he and Brent were the first to arrive at the campsite and, on this particular hunting trip, it was the 'third weekend' that he and Brent 'have been hunting in that area'. The last members of their hunting crew arrived at around 11 pm.

9. On the following day, all the hunters got up and had their breakfast standing around the campfire in preparation for the day's hunt. Steve related how they usually waited until 'right on daylight' so that they could see where they were walking.

THE CORONIAL INVESTIGATION

10. Brent'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.

11. 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.

12. 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.

13. Victoria Police assigned an officer, Detective Leading Senior Constable (**DLSC**) Mark Berens, to be the Coroner's Investigator (**CI**) for the investigation of Brent's death. The CI 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.

14. This finding draws on the totality of the coronial investigation into the death of Brent Robert Trickey 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]

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

Circumstances in which the death occurred

15. On 24 April 2021, around daybreak, Brent and his fellow hunters set out from their campsite on their deer-hunting expedition with their scent hounds.[3] Hunting with a pack of dogs, was the hunting crew's preferred style of hunting as opposed to tracking their quarry.[4]

16. At approximately 7.15 am, the hunting crew released their dogs to begin the hunt along the banks of the Dandongadale River, in the vicinity of an area 'known to hunters as The Junction'. The evidence indicates, however, that as the hunt progressed, the hunting crew were constantly on the move in pursuit of deer, guided by their scent hounds.[5]

17. Around 9.30 am, near the confluence of the Dandongadale River and Wild Dog Creek, one the dogs set upon a deer. A fellow hunter, Scott Watkins (**Scott**), then informed Brent and his hunting partner, Mark Rietmueller (**Mark**), that one of the dogs was in pursuit of a deer, heading in their direction. According to Scott, the 'radio reception' in the area was of a poor quality. Scott described the radio reception as 'cutting in and out'. [6]

18. However, 'not long after' Scott informed Brent and Mark that a deer was heading in their direction, Brent relayed a radio message which made Scott believe that he was closing in on the deer. Scott explained that from what he could make out by Brent's 'whispering' over the radio call, was that 'he was close to the bail up', which in hunting jargon means that the deer has stopped in its tracks, held at bay by the dog.

19. According to Scott, after this radio contact with Brent, he 'tried to radio through to Mark a couple of times to say what he thought was happening' but he did not hear 'anything back' from Mark at the time. The next time he received a radio call was when he 'heard Mark come on the radio screaming that he had 'shot Brent'. Scott did not hear the gunshot, however.

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

[3] CB. Statement of Ronald Bell.

[4] CB. Statement of Steven Williams.

[5] CB, statement of Ronald Bell

[6] CB, statement of Scott Watkins.

20. Before making his way to where Brent and Mark were, Scott moved to higher ground to get better reception so that he could make radio contact with other hunting crew members to alert them to the incident so that they could contact emergency services. When Scott reached Brent and Mark, he discovered that Mark had 'wrapped' Brent because he complained that he 'felt cold'. Scott also discovered that Brent struggling to breathe.

21. According to Scott, Mark explained that when he took aim to fire at the deer, he waited 'a number of times for the dog to clear' before he fired his firearm. Mark explained further that while he was taking aim to shoot the deer as soon as 'the dog was clear', he had no idea that Brent was there'. Mark fired the shot when the 'dog was clear' and 'then just heard Brent yell'.

22. Another member of the hunting crew, James Greenwood (**James**) called '000'. According to James, he was on the phone with the emergency services call-taker 'for two hours' trying to direct them to the exact location. James directed the call-taker to a nearby helipad, but the call-taker appeared to misunderstand him and kept referring to an 'airstrip'. James remained on the phone with the emergency services call-taker while other hunting crew members lit a fire and 'tried to make as much smoke' so that their location could be identified more easily.[7]

23. James explained further that, as it became more difficult for him to give the '000' call taker directions to their location, he asked the call-taker 'to get the helicopter to talk' to him so that he could direct it to the nearby helipad. The call-taker then told James that 'they couldn't' do that. Around the same time, James and his fellow hunters noticed a helicopter circling the area. However, after circling for a short while the helicopter moved away from the area where Brent was and appeared to go in the direction of the 'airstrip [to which] the operator had' referred to on the call.[8]

24. James was in contact with Mark via the radio at the time he and he told Mark to keep Brent warm. According to James, Mark told him that Brent 'wasn't bleeding bad[ly], just breathing hard and saying that he was getting cold'. As James was checking in with Mark 'every five minutes or so', he knew that Brent's condition had not changed for about one hour.[9]

25. However, at about 11.10 am, approximately two hours after the incident occurred, Brent passed away.

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[7] CB, statements of James Greenwood and Scott Watkins.
[8] Ibid.
[9] CB, statement of James Greenwood.

26. At approximately 2.30 pm, members of Victoria Police Search and Rescue Squad arrived near the location where the incident had occurred and were ushered to where Brent was by hunting crew members, approximately 20 metres away. According to Leading Senior Constable (**LSC**) David Crane, on closer inspection, he was unable to find Brent's pulse and 'no signs of life [were] detected'.[10]

Identity of the deceased

27. On 27 April 2024, Brent Robert TRICKEY, born 1 March 1984, was visually identified by his wife, Liana Burns, who signed a formal Statement of Identification.[11]

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

Medical cause of death

29. Forensic Pathologist Dr Sarah Parsons of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy upon the body of Brent Robert Trickey on 26 April 2021 and provided a written Medical Examiner's Report (**MER**) of her findings dated 12 November 2021.

30. The post-mortem examination revealed a 'gunshot' entry wound to the left arm and the abdomen. Dr Parsons commented that the 'wound tract extends through the left kidney (. . .) through the soft tissues of the retroperitoneal fat and into the liver'. According to Dr Parsons, 'Bullet jacket fragments' were retrieved from the arm and 'along the wound tract'.[12]

31. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any other commons drug or poisons.[13]

32. Dr Parsons provided an opinion that the medical cause of death was 1 (a) GUNSHOT WOUND TO THE ABDOMEN.

VICTORIA POLICE INVESTIGATIONS

33. Victoria Police including members of the Homicide Squad Crime Command (**HSCC**) conducted a full investigation the circumstances within which the death occurred.

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[10] CB, statement of LSC David Crane

[11] CB, Statement of Identification.

[12] CB, MER.

[13] CB. VIFM Toxicology Report of Maria Pricone, Senior Toxicologist.

34. The HSCC did not identify any suspicious circumstances or conduct connected with Brent's death.[14]

35. However, on 23 August 2021, for the sake of clarity, the HSCC referred the matter to the Office of Public Prosecutions (**OPP**) for their review of the brief of evidence and requested the OPP to provide an opinion.

36. On 7 April 2022, having considered the material contained in the brief of evidence compiled by the HSCC, the OPP declined to prosecute.

37. I have considered the opinion of the OPP, and I am satisfied, to the standard applicable in my jurisdiction, that neither suspicious circumstances nor the conduct of any person is connected with Brent's death.

38. However, having considered the evidence of the hunting crew with regard to their interaction with the Emergency Services Telecommunications Authority (**ESTA**), as it was then known, I was concerned that what appeared to be a misunderstanding or miscommunication about the location of the incident may have caused a delay in first responders reaching Brent.[15]

39. Consonant with my duty as an investigating coroner to contribute to a reduction in the incidence or number of preventable deaths, I considered whether the outcome for Brent could have been altered, if the first responders were able to find the location where the incident occurred in a timely manner. The evidence before me indicated that the first helicopter which circled the location where the incident occurred, left that area after being directed to another location by the ESTA call-taker.

40. Further, given that the evidence indicated that Mark had considered the position of the dog more than once before he discharged his firearm, I had further concerns about the visibility of the fellow hunters to their own hunting crew. The evidence indicates that Brent was not visible immediately before Mark discharged his firearm to shoot the deer.

[14] CB, statements of Detective Leading Senior constable Mark Berens,

[15] On 15 December 2023, Triple Zero Victoria replaced ESTA. For the purposes of my Finding, however,

41. Consequently, to advance my investigation and to assist me to determine whether Brent's death was preventable, I referred the matter to the Coroners Prevention Unit (**CPU**) for their review of the circumstances within which the death occurred.[16]

42. At my direction the CPU examined deer hunter safety, particularly whether wearing high visibility hunting apparel could have altered the outcome for Brent and secondly, whether the inability of the ESTA call-taker to direct first responders to the exact location where the incident occurred was an opportunity lost to alter the outcome for Brent.

CPU REVIEW

43. In their review of the circumstances within which the death occurred, noting the Victoria Police investigation, the CPU opined that the critical factors in the fatal shooting were the dense vegetation in the area which obscured Brent from sight and the lack of radio communication to indicate that the hunter was about to shoot a deer.

44. I have reviewed the evidence in this regard and, given that the incident occurred in a densely wooded area, I am satisfied that wearing high visibility clothing or blaze orange hunting apparel would not have altered the outcome for Brent. The evidence indicates that even if Brent had worn blaze orange hunting apparel, he would not have been visible at the time the Mark took aim to shoot the deer and discharged his firearm.

<u>The ESTA response to the emergency call</u>

45. The CPU reviewed the transcript of the calls between the ESTA call-taker and James. Even though the transcript indicates that, on two occasions, James provided the correct Global Positioning System (**GPS**) coordinates for the ESTA call-taker to direct emergency services to the location where Brent was injured, the CPU noted the inability of the two parties to the call to clearly and quickly identify the location where the incident occurred. Consequently, first responders were unable to get to Brent in a timely manner.

46. In their review of the GPS coordinates as provided by James to the ESTA call-taker, the CPU found that GPS coordinates are commonly expressed in three notations—as decimal degrees,

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[16] The CPU was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

as degrees and decimal minutes or as degrees, minutes and seconds. The evidence indicates that when James provided the GPS coordinates to the ESTA call-taker, he did so using the first notation, citing the GPS coordinates as decimal degrees.[17]

47. The evidence indicates further that when the ESTA call-taker entered the GPS coordinates, as dictated by James in decimal degrees, the result their system produced identified a different location to where the incident occurred, which the ESTA call-taker then relayed to emergency services. Consequently, the first responders were directed to a different location.

48. Similarly, when the ESTA entered the second set of coordinates in decimal degrees, as dictated by James, the result again produced a different location.

49. In their examination of the GPS coordinates which James had dictated to the ESTA call-taker, as decimal degrees, the CPU findings corresponded to a different location to where the incident occurred, not dissimilar to where the ESTA call-taker had directed the emergency services crew. However, using the second notation, as degrees and minutes, the CPU discovered that the GPS coordinates indicated the exact location where the incident occurred, along the Dandongadale River, South of the McCready Track.

50. Having considered the CPU review on this point, to clarify how it came to be that emergency services had missed an opportunity to reach Brent in a timely manner after he was injured, I resolved to interrogate this aspect further.

FURTHER INVESTIGATIONS

51. Consequently, assisted by the CPU, I obtained statements from ESTA responding to pertinent questions raised by my investigation into Brent's death.

52. In a directed statement request, ESTA was asked to respond to the following questions:

    i. How ESTA usually establish the exact location of an incident in a rural or remote area;
    ii. How ESTA operators are trained to enter GPS coordinates into ESTA systems and further, what mechanisms and procedures were in place to check their accuracy;
    iii. The format in which ESTA systems can accept latitude and longitude coordinates;

[17] CB, Crime Scene Examination, page 8. The CPU entered the GPS coordinates which James provided to the ESTA call-taker into the Geoplanner website, https://www.geoplanner.com . This website allows for GPS coordinates to be entered in three ways:
i. As decimal degrees;
ii. As degrees and decimal minutes; and
iii. As degrees, minutes and seconds,

iv. The format in which the ESAT operator who spoke to James entered the latitude and longitude coordinates into the ESTA systems during the call;

v. Whether it is possible for ESTA operators to provide details of Ultra High Frequency (**UHF**) radios to rescue helicopters so that those in the helicopter can speak to individuals on the ground directly; and

vi. The exact reasons as to why the Helicopter Emergency Medical Service (HEMS) unit left the area and why they could not locate Brent;

53. In response to my request ESTA provided two statements—the first from Fiona Crawford, the manager at ESTA's Emergency Communications Services (**ECS**) and the second from Nicole Ashworth, the Executive Director of ESTA's ECS.

Response from Fiona Crawford

54. Ms Crawford informed me that ESTA is the organisation responsible for dispatching emergency services in Victoria, comprising Ambulance Victoria (**AV**), Victoria Police, the Country Fire Authority (**CFA**), Fire Rescue Victoria (**FRV**) and the Victorian State Emergency Service (**VICSES**). ESTA operates state-wide, around the clock for emergency call-taking and dispatch services for all these organisations.

55. ESTA is responsible for AV call-taking and dispatch functions for the entire State of Victoria. Ambulance call-takers (**ACT**) at ESTA receive calls for assistance from members of the public, emergency services personnel and medical professionals via Telstra's E000 service, and process these calls in line with ESTA's Ambulance Standard Operating Procedures (**SOP**s). These SOPs provide clear and concise instructions on the provision of event management, including directing the response of appropriate ambulance resources for AV.

56. Emergency calls are processed as follows: a person places a call to 000, where a Telstra operator asks if they require the services of police, fire or ambulance. The Telstra E000 operator then transfers the call to an ESTA call-taker trained in the relevant emergency service who will begin asking the caller some preliminary questions. These questions are used to determine where an ambulance is required, and any other initial information relevant to the incident.

57. In this case, the call from James was directed to an ACT working at ESTA, who proceeded to follow a structured call taking process. This process follows a question-and-answer

methodology and is designed to provide information which the ACT enters into their Computer Aided Dispatch System (**CAD**).

58. When an ambulance event is accepted in CAD by an ACT, an emergency Ambulance Dispatcher (**AD**) will manage the dispatch of that event in accordance with SOPs and based on the priority assigned to the event, with Priority 0 as the highest and most urgent, and Priority 5 as the least urgent. AV determines the priority and response for each event type. ESTA staff are unable to alter the event priority or response that is assigned to an event, but they can update their system with answers received from the caller. AV personnel can make assessments and alter the event priority or response requirements.

59. ESTA call-takers also follow a verification process to try and obtain the most accurate location of any incident, with four levels of verification ranging from precise addresses (including a street/road number and suburb) at the highest level, to just the locality of the incident at the lowest level. Once these levels have been worked through, an ACT may then be required to use other CAD verification functions to obtain an accurate location, including latitude and longitude location entry.

60. The CAD system used at ESTA defaults to the traditional method of entering latitude and longitude coordinates. If a caller provides latitude and longitude coordinates in the modern or hybrid format, the call-taker 'would need to be able to convert the method to traditional, in order to input the coordinates'.[18].

61. ESTA operators are trained in entering all three standard entry formats of latitude and longitude coordinates – traditional (degrees, minutes, seconds), modern (decimal) and hybrid (degrees, minutes, seconds and decimal combined). ESTA call-taker training modules include scenarios where they are required to verify incident locations using latitude and longitude coordinates, they have access to optional training packages which include further training on latitude and longitude coordinates, and each call-taker's desk has a reference flipchart they can use which includes a page explaining the three coordinate formats and how to enter them into their CAD.

62. The ACT who handled the call from James (**ACT-1**)[19] recalled having trouble verifying Brent Trickey's location, and stated they were provided with three different sets of latitude and

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[18] Statement of Fiona Crawford dated 2 May 2023, Page 13, Paragraph 101.

[19] The name of the ACT in question has not been provided to the Court, and thus they are referred to here (and in Fiona Crawford's statement) as ACT-1.

longitude coordinates by James. ACT-1 believes that they tried several times to input the coordinates provided, using all three entry formats, but these kept verifying 'to a residence in a nearby town in Dandongadale'[20]. ACT-1 also recalled seeking assistance from the team leader to verify the location of the incident.

63. ESTA call-takers do not communicate directly with rescue helicopter units, but they can enter annotations into CAD remarks. As such, it is possible for an ESTA call-taker to enter the details of UHF radios where any user of the CAD system can see them. In this case, ACT-1 recorded the fact that the group with Brent Trickey could be contacted on UHF channel 8 in the CAD notes. However, any helicopter unit would need to be IRIS/MDT capable[21] to access the CAD system whilst in the air.

64. As an alternative, ESTA dispatchers (but not call-takers) have access to all CAD notes and can relay this information over the air to any responding emergency services, be they ground or air-based.

65. ESTA could not explain why the Helicopter Emergency Medical Service (**HEMS**) unit left the scene, nor why they could not locate the deceased (other than the issues identified above regarding the difficulties establishing the location through James), because the HEMS unit is an Ambulance Victoria rather than an ESTA resource.

<u>Response from Nicole Ashworth</u>

66. According to Ms Ashworth, it is rare for ESTA ambulance call-takers to enter latitude and longitude coordinates, with only 253 events requiring this information between 2018 and 2023. By contrast, ESTA managed more than 4,696,341 ambulance calls and dispatched 4,927,559 ambulance events in the same period.

67. The incident in which Brent Trickey was killed highlighted the difficulty that ESTA employees may experience using latitude and longitude coordinates to verify event locations. The call-taker, under observation from an assistant team leader, was unable to verify Brent Trickey's location using the coordinates provided by James.

68. ESTA therefore considers this an area of capability within the organisation which requires further training and improvement. Accordingly, ESTA will review and revise the training for

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[20] Statement of Fiona Crawford dated 2 May 2023, Page 9, Paragraph 79 (g).

[21] IRIS/MDT are remote devices which are fitted to emergency units and which can provide access to event information in the CAD system.

entering latitude and longitude coordinates and event verification for their Ambulance Victoria call takers and use this event in a de-identified form as a case study for training.

69. Having reviewed the evidence obtained from ESTA in response to my directed statement request, my attention was drawn to the factors which, according to Ms Crawford, caused the confusion in establishing the exact location where the incident occurred. In my view, these factors are relevant to my duty as coroner to contribute to a reduction in the number of preventable deaths and to determine whether the inability of the ACT-1 to identify Brent's location and the subsequent inability of the emergency services to reach him in a timely manner was tantamount to an opportunity lost to alter the outcome for Brent.

70. I turn now to consider Ms Crawford's evidence in this regard.

Issues arising from ESTA's response

71. In consultation with ACT-1, Ms Crawford advanced the following reasons for the inability of the ESTA call-taker, ACT-1, to identify the location of the incident:

    i. The deceased and his party were in a remote area and did not have mobile phone reception;

    ii. The three sets of longitude and latitude coordinates provided by James (as entered into CAD by ACT-1) indicated a verification point in a nearby town which did not match the description of the deceased's location as provided by James;

    iii. ACT-1 did not enter the coordinates into the event remarks in CAD, and they therefore weren't visible or known to the dispatchers or emergency service officers;

    iv. James was not calling from the same location as the deceased and ACT-1 was not confident that James knew the deceased's location;

    v. ACT-1's response to the situation became focussed on confirming James' location so that emergency service crews could access the deceased from James' location; and

    vi. As it became more difficult to locate both the deceased and James it became more difficult to communicate with James and keep him engaged in the call as the situation evolved and became increasingly heightened.[22]

[22] Statement of Fiona Crawford dated 2 May 2023, Page 11, Paragraph 82, Points (a) to (f) inclusive.

72. In my consideration of Ms Crawford's evidence, I noted that aspects of her evidence were incongruent with key points of my investigation. I now to consider these key points in turn.

Latitude and longitude coordinate problems

73. According to Ms Crawford, ACT-1 claims to have attempted to verify all three sets of coordinates provided during the call, using all three possible entry formats (traditional, modern and hybrid)[23], but these coordinates indicated a location in a nearby town rather than the location described by James.

74. Ms Crawford stated further that the assistant team leader at the State Emergency Communication Centre (**SECC**) observed ACT-1 whilst they attempted to verify the coordinates, and that ACT-1 had asked them for assistance in doing so. No further information is provided about any actions taken by the assistant team leader, if any. Ms Crawford's evidence indicates that she believed that the assistant team leader observed no error in ACT-1's attempts to enter the coordinates. In this regard, however, I note that when the CPU tested the coordinates provided by James by entering them in the hybrid format[24] , the exact location where the incident occurred was correctly identified. In my view, therefore, the weight of the available evidence does not support Ms Crawford's belief on this point.

75. In their further review of the statements submitted by ESTA, the CPU found support for a contention that a possibility existed that a technical error may have occurred. In the execution of their duties, the CPU referred me to the Victorian Government's initiative to conduct a Capability and Service Review (**CSR**), led by Graham Ashton.[25] The aim of the CSR was to review the state capability and service delivery of ESTA, including recommendations for improvements to service delivery and to properly enable an improved future state. The final report was delivered to the Victorian Government in March 2022 which set out the desired state capability and service delivery of ESTA.[26] As part of the report's section on technology services, Graham Ashton noted the following the future of the CAD system:

> *As previously raised in this report, the Review identified that the current CAD system will not meet the future needs of ESTA staff, ESOs and the community […] For instance, the CAD system does not meet the needs of dispatchers in the current geospatial solution. Dispatchers often have a third screen*

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23 Statement of Fiona Crawford dated 2 May 2023, Page 13, Paragraphs 102-103.

24 The CPU used the Geoplaner website for this purpose, located at https://www.geoplaner.com.

25 Former Chief Commissioner of Victoria Police, 2015-2020.

26 Emergency Services Telecommunications Authority, *Capability and Service Review: Final Report*, Page 5, "Purpose of the Review".

dedicated to Google Maps so they can more accurately direct first responders[27]*.*

76. In contradistinction to Ms Crawford's claim, in light of the CSR, the available evidence supports a conclusion that human error and/or a technical error in the CAD system, may have resulted in the inability of the ESTA call-taker to identify Brent Trickey's location correctly.
77. Additionally, the CPU considered that ACT-1's failure to enter the coordinates provided by James into the event remarks in CAD meant that an opportunity for dispatchers or emergency service officers to double-check the coordinates – and perhaps identify and rectify the problem – was lost.

<u>The ESTA call-taker's assessment of the information provided by James</u>

78. ACT-1 claimed that they did not have confidence in James knowing Brent Trickey's location, because he was not calling from the same location as Brent Trickey. However, guided by the CPU's review of the call transcripts, I am not convinced that this was a fair assessment of James' ability to relay the GPS coordinates to the ESTA call-taker. The weight of the available evidence supports a conclusion that James had correctly relayed the coordinates of Brent's location to ACT-1 and further, that it appears to have been the inability of ACT-1 (and other ESTA staff) to translate this information into the correct location that was most problematic.

79. Moreover, James was very specific from the outset of the call as to his location, Brent's location, their positions relative to each other, and that a helicopter would likely be needed to evacuate Brent and convey him to a hospital for appropriate medical attention. James' opening statement to ACT-1 was "I need a helicopter […] I need an air ambulance." Although he initially did not have latitude and longitude coordinates available to provide to the ESTA operator, he was clear that he was on a helipad at McCready Track, and that the accident had occurred 'up the river on the Dandongadale, probably three Ks upriver from where McCready hits the bottom'. When he confirmed the location later, James stated that it was three kilometres past the helipad on the Dandongadale River.

80. Further, I noted that it was ACT-1 who first used the term "McCready Airfield" which appears to introduce into the conversation the idea that James is at another airfield rather than the helipad on the McCready Track.

[27] Emergency Services Telecommunications Authority*, Capability and Service Review: Final Report*, Chapter 8: Technology Services, Page 53, "Key Considerations for the Future State: The future of the Computer Aided Dispatch System".

81. In her statement, Ms Crawford quoted from the CAD remarks made by ACT-1, noting the following:

> *Greenwood advised ACT-1 that the deceased and his party did not have mobile telephone reception and he was calling from McCready Helipad, approximately 3 kilometres away from the deceased, located on the Dandongadale River. […]*
> *At 09:38:37 hours, and based on the information provided by Greenwood, ACT-1 entered the following into CAD with respect to the deceased's location "LOCATED ROUGHLY 3KMS PAST MCREADY AIRFIELD, NIL O/S PH DUE TO RECEPTION". […]*
> *At 11:11:42 hours, ACT-1 recorded that "@@ CALLER NOW ADV ON HELIPAD ON DANDEONGADALE [sic] BUFFALO DIVIDE, NOT VERIFYING, HAD CONFIRMED MULTIPLE TIMES IN CALL WAS HELIPAD ON A/A".*

82. In my view, Ms Crawford's quotations provide further support for the conclusion that ACT-1 had incorrectly verified James' location to a different airfield. However, it is also notable that the specific helipad at which James was waiting was 'not a common place location that is verifiable within CAD'.

83. In his statement dated 25 April 2021, James related that he 'kept trying to tell her to send them to the helipad, but she just kept saying "airfield", I kept telling her it wasn't the airfield, they can't come that way, to come to the helipad.

84. I note further that, in their review of the facts of this matter, the CPU found that ACT-1's assessment of James' information overlooked the fact that he had been required to move to a different location in order for him to even make a call to emergency services, as there was no mobile phone signal in the area where the incident occurred.

85. Ultimately, in the course of my investigation, I was unable to distil any plausible explanation for ACT-1's apparent belief that James was not providing the correct GPS coordinates for location where the incident occurred. However, a likely explanation appears to be the possibility that ACT-1's inability to properly translate the latitude and longitude coordinates, provided by James, which then resulted in that call-taker's further dismissal of James' descriptions of the location and the belief that the GPS coordinates he provided were inaccurate.

<u>The HEMS unit withdrawing from the search for Brent</u>

86. Given that James and his fellow hunters were able to see the helicopter and recognise that it was travelling in the wrong direction, before withdrawing from the area entirely, ESTA were asked to comment on why the HEMS unit left the scene and why they could not locate Brent. According to Ms Crawford, the HEMS unit is an Ambulance Victoria resource and she therefore did not know the why the HEMS unit left the area 'save for the issues identified above in relation to the issues with identifying the location from [James].'[28]

87. In this regard, I noted that Ms Crawford made the following pertinent reference to the CAD notes in her statement:

> *At 11:02:01 hours, the following was recorded in CAD by a Victoria Police PCLO, "...FROM S+R. HEMS IS OVERHEAD AND WILL LOWER A PARAMEDIC DOWN TO VICTIM" and then "HEMS WILL THEN GO REFUEL AND RETURN APPROX 1 HOUR TO SCENE". It is not clear to ESTA why the Victoria Police PCLO entered this comment about an AV resource.*[29]

88. In my review of the factual matrix of this matter, however, there is no evidence available to me to support the contention that the HEMS unit lowered a paramedic to assist Brent before leaving the area. It therefore appears that the CAD note was based on the erroneous assumption that the HEMS unit was directly over the location where the incident occurred and further that a paramedic could be lowered to assist Brent. In my view, Ms Crawford's belief that a paramedic had indeed been lowered to render assistance is misguided, given that the hitherto incontrovertible evidence before me which supports a conclusion that the HEMS unit was not at the correct location and departed from the area because it was low on fuel.

89. The evidence indicates that after James made the "000' call, his attempts to ensure that emergency services personnel could reach Brent were thwarted by the inability of the ESTA call-taker or any other ESTA employee on duty at the time to enter the GPS coordinates into the ESTA systems, as provided by James, in a format which would produce an accurate result to enable emergency services personnel to locate Brent in a timely manner.

90. However, given that HEMS unit only circled the area at 10.45 am, approximately one hour and fifteen minutes after Brent was injured and further, given that Brent had succumbed to his injuries at approximately 11.10 am, I am not satisfied, to the applicable standard, *on the balance of probabilities*, that any medical assistance would have altered the outcome for

[28] CB, statement of Fiona Crawford dated 2 May 2023
[29] Ibid.

Brent. In my view, the available evidence is not sufficiently cogent to support a conclusion that Brent's death was preventable in the circumstances.

91. Accordingly, I now make apposite findings in this matter.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Brent Robert TRICKEY, born 01 March 1984;
   b) the death occurred on 24 April 2021 at Mountain View Farm, Rose River Road, Dandongadale, Victoria, 3737.
   c) I accept and adopt the medical cause of death as ascribed by Dr Parsons and I find that Brent Robert Trickey died from a gunshot wound to the abdomen.

2. The factual matrix of this matter indicates that Brent Robert Trickey was injured while he was on a deer-hunting expedition with his usual 'hunting crew'. The factual matrix indicates further that Brent Robert Trickey and Mark Rietmueller were tracking a deer, held at bay by their hunting dogs, when Brent was injured.

3. The evidence indicates that the gunshot wound to Brent Robert Trickey's abdomen which caused his death resulted from a projectile discharged from a firearm, fired by Mark Rietmueller in circumstances where Mark Rietmueller aimed and fired the shot at the deer which he and Brent Robert Trickey had been tracking. The evidence indicates further that the projectile entered and exited the deer targeted by Mark Rietmueller before striking Brent Robert Trickey. Consequently, I find that Brent Robert Trickey's death was caused by the projectile fired by Mark Rietmueller.

4. Further, given that that the incident occurred in a densely wooded area where Brent Robert Trickey was wholly obscured from view by the dense vegetation, the weight of the available supports a conclusion that, when Mark Rietmueller took aim at the deer and discharged his firearm, Brent Robert Trickey was not visible to him. Accordingly, I find that Brent Robert Trickey's death was a tragic accident.

5. Having considered all the evidence, I am satisfied that the available evidence supports a conclusion that the emergency services were unable to locate Brent Robert Trickey in a timely manner.

6. However, given the time at which the emergency services helicopter was first observed to be circling the area, I am not satisfied that the available evidence is sufficiently cogent to enable me to make any definitive finding that the inability of the emergency services to locate Brent Robert Trickey in a timely manner is connected with or contributed to his death. Consequently, I am unable to find that the outcome for Brent Robert Trickey could have been altered if the emergency services personnel had located him in a timely manner.

7. AND, having considered all the evidence, I am further satisfied that the available evidence is not sufficiently cogent to enable me to make any definitive finding that the conduct of any person or entity contributed to Brent Robert Trickey's death. Accordingly. I make no adverse comments about or findings against any person or entity.

8. However, as my investigation revealed that systemic or technical deficiencies in ESTA's response to James' call may have contributed to the delay in reaching Brent Robert Trickey, given my role as an investigating coroner to contribute to the reduction in the incidence or number of preventable deaths, I make the following pertinent comments.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. It is clear to me that there was a substantial delay in emergency services reaching Brent after he was shot. Some delay was of course inevitable, given the remoteness of the location where the incident occurred, on the Dandongadale River south of the McCready Track. However, this delay was substantially increased by the inability of the ESTA call-taker – identified in Ms Crawford's statement as ACT-1 – to verify the latitude and longitude coordinates being provided to her by James.

2. Ms Crawford stated that ACT-1 recalled having trouble verifying Brent's location, and also that they recalled seeking assistance from the team leader to verify the location of the incident.

3. Ms Crawford also described ESTA operators as being trained in entering all three standard entry formats of latitude and longitude coordinates into their Computer Aided Dispatch (CAD) systems; that is traditional (degrees, minutes, seconds), modern (decimal) and hybrid (degrees, minutes, seconds and decimal combined). She added that their training includes scenarios where they are required to verify incident locations using latitude and longitude coordinates,

that they have access to optional training packages which include further training on latitude and longitude coordinates, and that each call-taker's desk has a reference flipchart they can use which includes a page explaining the three coordinate formats and how to enter them into their CAD.

4. However, during their examination of the case, the CPU's investigators tested the coordinates provided by James by entering them in the hybrid format and found that they matched Brent's location exactly. The CPU advised me that they could not explain why, if ACT-1 entered the same coordinates in the hybrid format into their CAD as claimed, they indicated a location in a nearby town rather than Brent's location.

5. The CPU could only suggest that either human error on the part of ACT-1 and the team leader, and/or a technical error in the CAD system, as having been responsible for their inability to identify Brent's location correctly.

6. The possibility of a technical error in the CAD system has previously been identified in a Capability and Service Review into ESTA. In March 2022, Graham Ashton (the former Chief Commissioner of Victoria Police) produced a final report on the desired future state capability and service delivery of ESTA, at the behest of the Victorian Government. As part of the report's section on technology services, Graham Ashton noted the following regarding the future of the CAD system:

   […] the Review identified that the current CAD system will not meet the future needs of ESTA staff, ESOs and the community […] For instance, the CAD system does not meet the needs of dispatchers in the current geospatial solution. Dispatchers often have a third screen dedicated to Google Maps so they can more accurately direct first responders.

7. I am aware from Ms Ashworth's statement that ESTA considers the verification of an incident's location by using latitude and longitude coordinates as an area of capability within the organisation which requires further training and improvement. As such, ESTA intends to review and revise the training for entering latitude and longitude coordinates and use this event in a de-identified form as a case study for training.

8. It is of course to ESTA's credit that they have identified an area of their operations which requires improvement, and that they are seeking to learn from this incident and improve their training and procedures as a result.

9. However, without knowing exactly how or why ESTA's systems or procedures failed to quickly establish Brent's location, I cannot identify a clear prevention opportunity to pursue in this case.

10. Instead, I have decided to provide a copy of this finding to the Victorian Inspector-General of Emergency Management (**IGEM**) for their consideration. IGEM's remit is to provide assurance to government and the community in respect of Victoria's emergency management arrangements and fostering their continuous improvement, which it does by undertaking objective reviews, evaluations and assessments of Victoria's emergency management arrangements and the sector's performance, capacity and capability. IGEM would therefore seem to be the ideal body to consider whether any human or technical errors adversely affected the efforts to locate and treat Brent Robert Trickey, and to suggest necessary changes if any such errors are found.

I convey my condolences to Brent's family for their tragic 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:

Liana Burns, Senior Next of Kin

Victorian Inspector-General of Emergency Management

DLSC Mark Berens, Coroner's Investigator

Sergeant Jacqueline Sadler, Coroner's Investigator

Signature:

Coroner John Olle

Date: 14 August 2024

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.