IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 1147

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MICHELLE HODGSON, CORONER**
Deceased:	**ADRIAN PAUL GIBB**
Date of birth:	20 December 1983
Date of death:	On or about 10 March 2017
Cause of death:	1(a) INJURIES SUSTAINED IN FALL FROM HEIGHT
Place of death:	Buckleys Road, Allansford, Victoria

HER HONOUR:

Background

1. Adrian Paul Gibb was born on 20 December 1983. He was 33 years old when he died on or about 10 March 2017 after falling from a cliff in Allansford.

2. Mr Gibb lived in Mortlake with his dog, Rosie.

3. In the years before his death, Mr Gibb suffered a back injury. The injury eventually affected his ability to lift heavy items and he had to stop working at Bunnings. He was diagnosed with a bulging disc and prescribed pain medication. At times, he also took some of his father's Endone medication. The pain affected Mr Gibb's sleep and he often struggled with insomnia. He occasionally smoked marijuana.

4. After leaving Bunnings, Mr Gibb worked on a farm. However, he struggled with the physicality of the work and again had to stop. He was disappointed that he could not thereafter find work and struggled to keep up with bill payments and other expenses. He moved from Warrnambool to Mortlake to save money.

5. Mr Gibb disclosed to his mother that he suffered depression but did not want to take antidepressants.

6. Despite these ongoing stressors, Mr Gibb's mother said he would not complain and would *"just push through it"*.

7. Mr Gibb's parents last saw him on 2 March 2017, at which time they had dinner together. He appeared in good spirits and was happy for his parents, who were leaving for a cruise on 5 March. He texted his love to his mother as they set sail.

8. Mr Gibb was treated by Dr Marion Lockhart, general practitioner. In addition to back pain, he complained of depression and although he reported suicidal thoughts, he had no plan or intent. He had tried a number of antidepressants but his symptoms did not improve. He was thereafter reluctant to try any further medication. He was referred to counselling in 2014 but did not persist with that treatment.

9. Dr Lockhart last saw Mr Gibb on 7 March 2017, at which time they discussed further treatment for his back pain, including physiotherapy and a trial of a TENS[1] machine. Dr Lockhart stated that Mr Gibb did not voice any suicidal thoughts or sensation of hopelessness at this appointment. He was to return in one month to assess his condition and explore other treatment options.

The coronial investigation

10. Mr Gibb'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. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

12. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

13. 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.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Gibb's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence. I also obtained a statement from Parks Victoria.

15. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

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[1] Transcutaneous electrical nerve stimulation.

[2] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

16. 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.

Identity of the deceased

17. Mr Gibb was visually identified by his brother, Marc Gibb, on 17 March 2017. Identity was not in issue and required no further investigation.

Medical cause of death

18. On 13 March 2017, Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mr Gibb and reviewed a post mortem computed tomography (CT) scan.

19. The examination revealed multiple injuries consistent with a fall from a height.

20. Toxicological analysis of post mortem specimens taken from Mr Gibb identified delta-9-tetrahydrocannabinol.[3]

21. After reviewing toxicology results, Dr Lynch completed a report, dated 15 March 2017, in which he formulated the cause of death as "*1(a) Injuries sustained a fall from height*". I accept Dr Lynch's opinion as to the medical cause of death.

Circumstances in which the death occurred

22. On the morning of 10 March 2017, Paul Ryan walked his dogs to the carpark at the end of Buckleys Road, Allansford. At this time, he observed only one vehicle – a small red car – parked in the carpark.

23. Later that day, he spoke to a friend who mentioned that the red vehicle was still at the carpark and a visibly distressed small dog was jumping against the vehicle. Mr Ryan became concerned.

24. At approximately 5.10pm, Mr Ryan returned to the carpark at Buckleys Road, where the red vehicle remained. Mr Ryan walked to the cliff edge and immediately saw a male, later identified to be Mr Gibb, lying on the rocks approximately 50 metres below. Mr Gibb was wearing a shirt and shorts but no shoes.

[3] Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis.

25. Mr Ryan contacted emergency services. Ambulance paramedics and Victoria Police attended the scene and were taken to Mr Gibb's body. Police conducted a search of the area but did not find anything, including Mr Gibb's shoes. They were also unable to find Rosie.

26. In the following hours, the Country Fire Authority and State Emergency Service recovered Mr Gibb's body. His car keys were found in his pocket. Police conducted a search of Mr Gibb's vehicle but did not find anything suspicious or any suicide note.

27. On 11 March 2017, police members searched Mr Gibb's house but similarly did not find anything suspicious or any suicide note.

28. On 13 March 2017, Mr Gibb's family attended the area to look for Rosie. At that time, they happened to meet Mr Ryan.

29. On 14 March 2017, Mr Gibb's mother returned to the carpark and found Rosie, who was excited to see her.

Buckleys Road carpark, Allansford

30. Senior Constable Tim Brosowsky, Coroner's Investigator, described the area adjacent to the carpark at Buckleys Road, Allansford, as dangerous for unfamiliar visitors. There is a lack of signage, no guard rails, and numerous tripping hazards. The trailhead leaving the carpark is unmarked and unsigned. The only warning sign is a well-worn post located approximately 200 metres south west of the carpark. Senior Constable Brosowsky opined that the signage in the area was inadequate.

31. As part of my investigation, I obtained a statement from John Stevens, Manager Legal at Parks Victoria. Mr Stevens described the area as one where there is sparse low-growing vegetation. There are clear sight lines to the cliff edge from much of the walking track. The substrate consists of uneven rocky surfaces, bare soil, the established stone path, and several unauthorised and informal tracks.

32. Mr Stevens confirmed that there is one sign located on the cliff-side of a walking track that leads from the carpark.[4] The sign is in extremely poor condition and appears to warn of the danger of the cliff edge.

33. Both Senior Constable Brosowsky and Mr Stevens provided the Court with photographs of the sign in situ. I agree with Mr Stevens's assessment that the condition of the sign is poor.

34. Mr Stevens also stated that there are no other safety measures in the area. He surmised that this is because the walking track is no closer than 40 metres to the cliff face. However, he noted that there are numerous unauthorised and informal tracks that lead to the edge of the cliff, including one track immediately to the left of the signage point.

35. Mr Stevens noted that the area is not highly visited, and is managed as a low level of service site.

Intention

36. I have examined the photographs and maps of the area. From the walking track, an informal trail heads south west toward the cliff edge from which Mr Gibb fell. It appears Mr Gibb has left the stone walking track and taken this trail to the cliff edge. The sole warning sign is located further along the stone walking track.

37. Although Mr Gibb was known to regularly take Rosie for walks, there is no evidence before me that he took Rosie for walks in this area or that he was otherwise familiar with the area.

38. It is impossible to say whether Mr Gibb encountered the warning sign. Nevertheless, the view of the water below is unencumbered.

39. Suicide is defined by the World Health Organization as *"an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome"*.

40. Although it is clear that Mr Gibb was suffering from a number of personal stressors at the time of his death, there is no evidence before me to indicate that Mr Gibb intended to take his life. In the days before his death, he renewed his driver's licence and borrowed a DVD from the library. He was said to be looking forward to his parents returning from their

[4] Mr Stevens stated that the sign is located in a south-westerly direction, approximately parallel to, but passing no closer than 40 metres to the cliff face. The sign is located approximately 100 metres from the carpark. I accept that this is the sign to which Senior Constable Brosowsky refers.

vacation. I also find it highly unlikely that he would willingly abandon his beloved dog, Rosie, in the carpark. Mr Gibb's mother believes that he tripped on the terrain while wearing thongs, which is a possible scenario.

41. The evidence suggests Mr Gibb's death was the tragic result of misadventure.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Adrian Paul Gibb, born 20 December 1983;

(b) Mr Gibb died on or about 10 March 2017 at Buckleys Road, Allansford, Victoria, from injuries sustained in fall from height; and

(c) the death occurred in the circumstances described above.

Recommendations

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. Parks Victoria replace the sign located along the walking track that leads from the carpark at Buckleys Road, Allansford, Victoria, and ensure that it meets the relevant Australian Standards.

2. Parks Victoria consider installing vertical signage at the carpark and further signage along the walking track to warn users of the dangers of standing near or approaching the cliff edge.

Publication

As I have made recommendations connected with the death, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

I convey my sincere condolences to Mr Gibb's family.

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

Patricia Gibb, Senior Next of Kin

Lesley Gibb, Senior Next of Kin

Parks Victoria

Warrnambool City Council

Senior Constable Tim Brosowsky, Coroner's Investigator, Victoria Police

Signature:

MICHELLE HODGSON
CORONER
Date: 27 August 2018.