IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 1926

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	MD
Date of birth:	20 September 1972
Date of death:	17 April 2019
Cause of death:	1(a) injuries sustained in a deer attack
Place of death:	Regional Victoria
Keywords:	Deer attack, accidental death

INTRODUCTION

1. On 17 April 2019, MD[1] was 46 years old when he was died from injuries sustained in a deer attack. At the time of his death, MD lived at his home in regional Victoria with his wife and children.

THE CORONIAL INVESTIGATION

2. MD'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.
3. 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.

4. 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.

5. Victoria Police assigned Leading Senior Constable Jason Bray to be the Coroner's Investigator for the investigation of MD's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of MD 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]

[1] This is a pseudonym.
[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.

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

Circumstances in which the death occurred

7. MD's home was semi-rural farmland consisting of a home and farmland of approximately two acres. The property was surrounded by farmland and located near a small township.

8. The family kept a pet male deer, which had grown from a fawn into a fully-grown adult buck whilst in their care. The deer was kept in a 50 metre by 20 metre wire-fence enclosure on the property. The enclosure was situated at the rear of the property, among other enclosures and paddocks, and near sheds.

9. The deer was a male Californian Wapiti with a mix of red and elk breed. It had a full set of antlers measuring 735 millimetres and 675 millimetres in length. The top antlers were 415 millimetres apart. The family had raised pet deer for several years and were familiar with their behaviours.

10. In the days leading up to the incident, MD's wife, LP,[3] had observed that the deer's behaviour had changed, and she had advised MD that she was no longer prepared to enter the enclosure. The deer had started displaying more dominant behaviours, including marking its territory by urinating and calling out for other deer.

11. On Wednesday 27 April 2019, at approximately 8.00am, MD went to the deer enclosure to feed the animal. He did this every morning before leaving for work. MD usually distributed pellets within the deer pen. The available evidence suggests MD did this that morning.

12. The deer enclosure only had one point of entry and exit, via a gate. The gate was always left open as a precautionary measure to ensure a quick getaway if required. On the day of the incident, the gate was left open.

13. SW,[4] MD's son, observed that the deer may have become entangled in wire fencing. The evidence suggests MD may have tried to untangle the deer from the wire fencing. Approximately one week prior to the incident, the deer had caught its antlers in wire around a tree and had to be disentangled. The deer's behaviour changed following this.

14. Whilst in the deer enclosure, MD was attacked by the deer. The deer forced MD onto the ground and pinned MD down with its antlers. The deer punctured MD's body.

[3] This is a pseudonym.
[4] This is a pseudonym.

15. MD sustained a number of injuries, including antler puncture wounds to his head, neck, chest, abdomen, upper limbs, lower limbs, back and buttocks.

16. MD yelled out for help. LP and SW heard MD's cries for help and ran from the house and into the deer pen to assist him. LP and SW used available instruments to deter the attack, including stones, timber and a cross bow.

17. SW then left the deer pen to get a firearm from a nearby shed. However he then heard LP screaming and returned to the deer pen before he had time to locate a gun.

18. LP attempted to intervene, and the deer positioned itself between LP and MD. The deer then lowered its head and placed the tip of its antlers against LP's right knee. LP immediately felt the force of the animal when this happened.

19. The deer then attacked LP. SW observed LP entangled in the wire fencing. MD and LP exchanged goodbyes, as they came to the realisation that one or both of them would not survive.

20. An off-duty ambulance officer, JN,[5] lived next door. JN heard screams and commotion from the family property and went over to assist. JN observed that LP was wrapped up in the fence inside the enclosure. JN noted that the deer had blood on its antlers. JN observed that MD was lying on the ground of the enclosure, moaning and groaning.

21. JN went to a nearby shed. He located and loaded a shotgun and returned to the scene. He aimed the shotgun at the deer. He shot the deer three times. The deer did not appear to be affected from the shots.

22. The deer then walked over to JN and stood facing JN, who was standing behind the fence. Once the deer had relocated to the rear of the enclosure, JN entered the enclosure and went to assist LP. He quietly disentangled LP from the wire, making a conscious effort to be quiet so as to not draw the attention of the deer. Once JN had untied LP, he carried her out of the enclosure.

23. JN then returned to the deer enclosure and dragged MD along the ground towards the gate. SW assisted JN, pulling MD out of the enclosure.

[5] This is a pseudonym.

24. JN and SW placed MD next to LP, who was still lying on the ground. MD was no longer breathing, and he did not have a pulse. JN determined that MD had tragically died.

25. Ambulance support arrived and confirmed that MD was deceased. Police arrived and safely shot the deer.

26. LP was conveyed via airlift to Melbourne and, although she required significant medical attention, gratefully survived.

Identity of the deceased

27. On 17 April 2019, MD, born 20 September 1972, was visually identified by his brother.

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

Medical cause of death

29. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 18 April 2019 and provided a written report of her findings dated 24 May 2019. Dr Glengarry also reviewed the Police Report of Death for the Coroner (Form 83), scene photographs and the post-mortem computed tomography (**CT**) scan with arteriography and venography.

30. The post-mortem examination revealed rigor mortis was present in the jaw, arms and legs and that stasis lividity was indistinct. The CT was examined in conjunction with forensic radiologist, Dr Chris O'Donnell. The CT showed no skull fracture, spinal fracture or intracranial haemorrhage. There was no limb fracture. There were small anterior rib fractures and small bilateral pneumothoraces in keeping with resuscitation. There was a small amount of blood in the lower abdomen, around the liver and around the spleen. No pelvic fractures were identified. There were puncture wounds anterior to the left shoulder, across the abdomen and lower torso and to the legs, the right more so than the left. These appeared relatively superficial on the post-mortem CT scan. There was no air or evidence of air embolism.

31. Toxicological analysis of post-mortem samples identified the presence of paracetamol (<5.0 mg/L).

32. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) injuries sustained in a deer attack.

33. I accept and adopt Dr Glengarry's opinion.

FURTHER INVESTIGATIONS

34. The Australian Deer Association Inc (**ADA**) was contacted in relation to this incident. The ADA was established in September 1969 and has a long history of initiating deer research and related conservation activities, including lobbying to increase hunting opportunities and campaigning for access to public land for hunting.

35. The ADA has promoted safe, responsible and ethical hunting as a cornerstone of condition of membership for over 50 years.

36. ADA advised that, whilst kept in captivity, deer species (with the exception of reindeer) have never been domesticated. Deer are considered wild animals. There are several recorded incidents of deer attacking humans whilst in captivity. These attacks have occurred where the animal has been well socialised with humans and has therefore '*lost its fear*' of humans. Deer attacking humans in the wild is incredibly rare.

37. Deer have a clearly defined mating season known as the 'rut', 'roar' or 'bugle'. The mating season coincides with the deer being in '*hard antler*'. A deer's antlers grow afresh every year, and they mature out of their soft growing stage into hardened sexual weapons.

38. In Australia, mating season or the 'rut' typically commences in late March and runs for four to five weeks. During this period, the male deer exert dominance over each other by both vocalising and fighting in an effort to pass their genetics on by mating with female deer.

39. Deer in a rut fight amongst their own and are prepared to attack one another to mate successfully. During this phase they would not distinguish between a human and another deer, and thus can display those same rut tendencies towards humans.

40. The rut will occur irrespective of whether there are female deer in the area. The rut is a cyclical phenomenon associated with increased testosterone.

CPU REVIEW

41. This matter was referred to the Coroners Prevention Unit (**CPU**) to determine whether there were any prevention opportunities available.[6] The CPU also researched the dangers of keeping deer as pets.

42. CPU's research noted that, for the protection of handlers, other deer and facilities, male deer should have their antlers removed annually before the development of hard antlers.[7]

43. When born in the wild, deer are not meant to be raised either alone or as part of a human family: it is unfair to separate them from their herd and natural habitat, as they are difficult to domesticate. Deer will tolerate the presence of humans when humans feed them.

44. Even when bred in captivity, deer do not make good pets. While deer can be tamed, and appear small and manageable at first, they become increasingly unmanageable as they mature. Domesticated deer may attack humans during mating season and can turn dangerous to protect their young.[8]

45. Research also revealed that those keeping fewer than six deer are very likely to be holding tamed animals. Male deer that have been hand-raised are more dangerous than other deer because they have no fear of humans. In Western Australia, it is therefore a condition that those holding fewer than six deer hold only females.[9]

46. The CPU conducted a search to identify other deaths in Australia caused by deer attack. There were only two other recorded deaths where a deer was involved, and neither case had a similar factual matrix to MD's tragic death. However, further research revealed that between July 2010 and June 2020, there were 22 cases of people being injured by deer presenting to Victorian emergency departments. Of those 22 cases, seven people were injured when struck by the deer's antlers.

---

[6] The Coroners Prevention Unit (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.

[7] Animal Welfare Victoria, 'Code of Accepted Farming Practice for the Welfare of Deer', <https://agriculture.vic.gov.au/livestock-and-animals/animal-welfare-victoria/pocta-act-1986/victorian-codes-of-practice-for-animal-welfare/code-of-accepted-farming-practice-for-the-welfare-of-deer>, accessed 27 June 2022.

[8] Animal Wised, "Deer as Pets: Guidelines and Tips – can deer be domesticated?" https://www.animalwised.com/deer-as-pets-guidelines-and-tips-1199.html, accessed 27 June 2022.

[9] West Australian Department of Primary Industries and Regional Development, <https://www.agric.wa.gov.au/livestock-management/fallow-and-red-deer-keeping-requirements?page=0%2C4>, accessed 27 June 2022.

47. Registering pets with local councils is a requirement pursuant to the *Domestic Animals Act 1994* (Vic). However, the registration requirement only applies to cats and dogs. Furthermore, the family property was registered as farming and therefore none of the relevant restrictions about the registration of animals would have applied, even if pet deer did require registration.

48. Animal Welfare Victoria administers legislation responsible for setting standards relating to animal welfare, however the focus of their work is maintaining animal welfare standards rather than human safety.

49. The Code of Accepted Farming Practice for Deer does not specifically address handling techniques; however it does state that male deer should have their antlers removed annually prior to the development of hard antler, and that the removal of velvet antler is the responsibility of a vet.[10]

50. Part A of Schedule 4 of the *Wildlife Regulations 2013* (Vic) Act outlines that people who have Fallow Deer, Hog Deer, Rusa Deer, Red Deer and Wapiti Deer for private purposes are exempt from requiring a license.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was MD, born 20 September 1972;

    b) the death occurred on 17 April 2019 at a location in regional Victoria from injuries sustained in a deer attack; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

[10] Code of Accepted Farming Practice for the Welfare of Deer, <https://agriculture.vic.gov.au/livestock-and-animals/animal-welfare-victoria/pocta-act-1986/victorian-codes-of-practice-for-animal-welfare/code-of-accepted-farming-practice-for-the-welfare-of-deer#:~:text=Deer%20have%20the%20following%20basic,establishment%20of%20herd%20social%20hierarchy> accessed on 28 June 2022.

(i) I recommend that Agriculture Victoria circulate a safety warning and/or information sheet for pet deer owners to remind them that it is best practice for deer to be de-antlered prior to mating season.

(ii) I further recommend that, given that deer owners are not required to register their pets, vets in rural and regional communities display information relating to deer handling safety.

(iii) Given there is currently no requirement to register pet deer, I recommend that local councils in rural and regional communities consider compulsory registration of pet deer to ensure that owners can be made aware of the dangers related to holding pet deer.

I convey my sincere condolences to MD's family for their 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:

LP, Senior Next of Kin

The Honourable Gayle Tierney MP, Minister for Agriculture

Leading Senior Constable Bray, Coroner's Investigator

Signature:

Coroner John Olle

Date : 29 June 2022

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.