IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006754

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Rosy Loomba
Date of birth:	7 March 1982
Date of death:	12 December 2020
Cause of death:	1(a) Multiple injuries, predominantly head, sustained in a fall from a height
Place of death:	Boroka Lookout, Mount Difficult Road, Halls Gap, Victoria, 3381
Keywords:	BOROKA LOOKOUT; GRAMPIANS NATIONAL PARK; FATAL FALL; FENCING; SIGNAGE

INTRODUCTION

1. Rosy Loomba was 38 years old when she died on 12 December 2020. Mrs Loomba was born in India and migrated to Australia in 2010. She worked as a Disability Support Worker.

2. Mrs Loomba is survived by her husband Basant Loomba, and their children Ansh and Akks. She was described by her husband as a loving mother and the perfect life partner for him.

THE CORONIAL INVESTIGATION

3. Mrs Loomba'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.

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. 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.

6. Victoria Police assigned Senior Constable Sarah Bartorelli to be the Coroner's Investigator for the investigation of Mrs Loomba's death. The Coroner's Investigator 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.

7. This finding draws on the totality of the coronial investigation into the death of Mrs Loomba 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]

[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

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

Identity of the deceased

8. On 16 December 2020, Rosy Loomba, born 7 March 1982, was visually identified by her husband, Basant Loomba, who signed a formal statement of identification to this effect.

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

Medical cause of death

10. On 14 December 2020, Dr Yeliena Baber, Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Baber considered the Victorian Police Report of Death Form 83 and the post-mortem computed tomography (**CT**) scan and provided a written report of her findings.

11. Examination of the post-mortem CT scan showed multiple bilateral temporoparietal skull fractures, frontal and right facial fractures, pneumocranium, C2/3 dislocation, bilateral haemopneumothoraces (greater on the left), fractures of left tibia and fibula, right pubic rami, all lumbar transverse processes, right scapula, right ribs 1-11, left ribs 4, 9-11. There was also a malunited right clavicle.

12. Dr Baber provided an opinion that the medical cause of death was 1 (a) multiple injuries, predominantly head, sustained in a fall from a height. I accept Dr Baber's opinion.

Circumstances in which the death occurred

13. On 12 December 2020, Mrs Loomba and her family drove from their home in Craigieburn to have a picnic in the Grampians with another family. The families stopped at a number of lookouts along the way and arrived at Boroka Lookout at about 2:10pm.

14. The lookout in this area is fenced, however the fence is easily scaled. There were a number of people in the area who climbed over the fence and took photos on a rock ledge which protrudes out from the cliff. The lookout is renowned on Instagram with many people scaling the safety barriers to have their photo taken on the rock ledge. The rock is known as "Selfie Rock". At

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

the time of the Loombas arrived there were approximately 30 people at the lookout and there was a small queue of people lining up to have their photo taken.

15. Mrs Loomba and her husband climbed over the fence and had photos taken of themselves standing on the rock. Mrs Loomba turned to walk back to her friends and children but lost her balance on a step down. She fell to the right with her lower body still on the rock, and her upper body hanging over.

16. Mr Loomba jumped down to her and tried to pull her back up but was unable to reach her hand. He held onto her legs and her clothing but was unable to grasp her. Mrs Loomba fell over the edge.

17. Mr Loomba and other witnesses called out to Mrs Loomba but did not receive a response. Police and emergency services attended the scene and were able to abseil down the cliff face. They located Mrs Loomba approximately 30 metres down the cliff face. She was retrieved at approximately 9pm and confirmed deceased.

18. A small area of the fence line at Boroka Lookout was noticed to be damaged, with a wire in the wire fence becoming loose. The Coroner's Investigator was of the view this damage was caused by people standing on the wires to scale the fence.

19. Victoria Police investigated the incident and determined that Mrs Loomba's death was not suspicious and was a tragic accident.

FURTHER INVESTIGATIONS

20. Upon receipt of the Coronial Brief, I contacted Parks Victoria regarding the safety barriers in place at Boroka Lookout. Parks Victoria advised that routine safety inspections of Grampians National Park are regularly undertaken.

21. Parks Victoria provided a copy of the asset review for the Boroka Lookout area as of 23 June 2020, which did not identify the loose wires in the wire fencing. I consider this to be a minor structural issue of the fencing in this area and am not of the view that it contributed to Mrs Loomba climbing over the fence or her subsequent fall.

22. In 1999, Coroner Timothy McDonald handed down a finding regarding a death which occurred at Boroka Lookout in April 1999. It was recommended at this time that Parks Victoria carry out a review to ensure that adequate provisions were available for safe viewing

at the lookout. As a result of this recommendation, Parks Victoria installed additional infrastructure and signage at Boroka Lookout in 2022.

23. Despite this earlier recommendation, I am of the view that extra signage could be added to this area to prevent such deaths occurring in the future. I note that adventurers and park attendees may continue to climb fences to access lookouts in order to get a photo or for their own curiosity. Mrs Loomba's death is a reminder of the dangers associated with ignoring signage and fencing which is put in place to keep people safe.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Rosy Loomba, born 7 March 1982;

    b) the death occurred on 12 December 2020 at Boroka Lookout, Mount Difficult Road, Halls Gap, Victoria, 3381, from multiple injuries, predominantly head, sustained in a fall from a height; and

    c) the death occurred in the circumstances described above.

25. I convey my sincere condolences to Mrs Loomba's family for their loss.

RECOMMENDATIONS

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

    I recommend that Parks Victoria install additional signage at the Boroka Lookout warning people of the dangers of a fall and to stay within the safety fencing. The sign should expressly state that people have been seriously injured and died at this location.

27. Pursuant to section 73(1A) 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:

Mr Basant Loomba, Senior Next of Kin

Ms Margaret Gillespie, Executive Director People, Safety and Risk, Chief Legal Counsel, Parks Victoria

Mr Jason Borg, Regional Director Western Region, Parks Victoria

Senior Constable Sarah Bartorelli, Coroner's Investigator

Signature:

Jacqui Hawkins, Deputy State Coroner

Date : 18 July 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.