IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001836

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Audrey Jamieson
Deceased:	Elaine Betty Sime
Date of birth:	11 September 1947
Date of death:	03 April 2020
Cause of death:	1(a) MULTI-ORGAN FAILURE SECONDARY TO POLY-TRAUMA AND LIKELY BEE-STING RELATED TOXIDROME.
Place of death:	The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052

INTRODUCTION

1. On 3 April 2020, Elaine Betty Sime was 72 years old when she died at The Royal Melbourne Hospital (RMH) after she was admitted on 2 April 2020 with injuries sustained when a tree fell on her while walking at the Ruffey Lake Park Trail in Templestowe.

2. At the time of her death Ms Sime lived in Templestowe with her husband, Stuart Sime (Stuart) to whom she had been married for approximately 50 years. The couple had two adult sons, Matthew and Allister.

3. Ms Sime and her husband were an active couple. According to Stuart, they walked every day and Ms Sime went to a gym regularly where she 'swam and did water aerobics'. Stuart described his wife as 'fit and healthy'.[1]

Medical History[2]

4. Dr Michelle Hesse of the Templestowe District Medical Centre (TDMC) was Ms Sime's usual doctor (GP). According to Dr Hesse, Ms Sime, whose general health was 'excellent', had been a patient of the TDMC since 1999 and she became Ms Sime's GP in 2007.

5. Ms Sime's medical records held by the TDMC reflected the following health concerns:

   i. In the year 2000, Ms Sime had been diagnosed with Hypertension;[3]
   ii. In 2007, Ms Sime was diagnosed with Osteopaenia[4] and Low Vitamin D;
   iii. In 2015 Ms Sime sought medical treatment for Carpal Tunnel Syndrome;[5] and
   iv. In 2016 Ms Sime underwent a laparoscopic cholecystectomy to remove her gallstones.

6. At the time of her death, Ms Sime's prescription medication included:

   i. Citracal + D;[6] and

[1] Coronial Brief of Evidence [CB], statement of Stuart Sime.

[2] CB, statement of Dr Michelle Hesse

[3] Colloquially referred to as high blood pressure.

[4] A medical condition that occurs when the body does not make new bone as quickly as resorbs old bone

[5] A medical condition in which the patient experiences a numbness and tingling in the hand and arm caused by a pinched nerve in the wrist.

[6] Indicated as a dietary supplement to boost calcium and Viatmin D levels.

ii. Gopten.[7]

THE CORONIAL INVESTIGATION

7. Ms Sime'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.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Sime'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.

11. This finding draws on the totality of the coronial investigation into the death of Elaine Betty Sime 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.[8]

[7] Indicated for the treatment of Hypertension.

[8] 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[9]

Events at Ruffey Lake Park Trail

12. On 2 April 2020 at approximately 7.50 am, Ms Sime and her husband left their home to go for a walk along the Ruffey Lake Park Trail, Templestowe. According to Stuart, although the conditions were wet because it had been raining during the night, it was not raining at the time when he and his wife set out on their walk. When they had walked 'about 30 metres down the track' he heard a 'loud cracking noise behind' him and when he turned to see where the noise was coming from, he 'saw the tree falling'. Overwhelmed by the falling tree, Stuart turned to look at his wife but before he could do anything, he was pushed to his knees by the falling tree. The evidence indicates that the couple were separated by the fallen tree.

13. Stuart stated further that he was not sure what happened to Ms Sime or where she was because he was covered in foliage, feeling 'lost in there'. As he battled to free himself from the branches and foliage, he heard an 'almighty roar' as swarming bees attacked his face. He tried to fight the bees but they continued to sting him and when he reached for his phone the bees 'swarmed onto his phone' which made it difficult for him to unlock his phone to call for help. Eventually, Stuart managed to phone his son, Allister whose wife, Claire, raised the alarm and called the emergency services number '000' while Stuart was on the phone with his son.

14. Still fighting off the bees and while the phone call to Allister remained connected, Stuart managed to find his wife under a branch which he estimated to be 'about 200mm in diameter'. According to Stuart, when he lifted the branch to free his wife, he noticed that she was bleeding from a cut on her head and she was 'covered in bees' which were 'swarming all over her'. Pulling her jacket's hood over her head to shield her face from the bees, he encouraged her to stand so that they could move away from the swarm of bees, but she did not respond and was 'just groaning'. When Stuart realised that his wife was unable to stand, he took her by her wrists and moved her 'to the edge of the tree'. The evidence indicates that Stuart managed to free Ms Sime from the sheer weight of the fallen tree but she remained covered by its branches and was still under attack by the swarm of bees.

15. At approximately 8.09 am, officers of the Metropolitan Fire Brigade (MFB) arrived at the scene and dispersed the swarm of bees by spraying water. After the MFB managed to contain the

[9] CB, statement of Stuart Sime who describes the events as they unfolded at the Ruffey Lake Park Trail.

swarm of bees, they set about treating Ms Sime by initially 'applying oxygen' and removing the bees.[10]

16. Ambulance Victoria (AV) paramedics arrived soon after the MFB and with the assistance of the MFB officers, moved Ms Sime approximately 100 metres away from the location of the fallen tree where they examined her, provided further treatment by removing the bees from her body and prepared her to be transported to hospital. According to the AV paramedic, Ms Sime potentially had 'hundreds of bee stings to face, head, torso and limbs'.[11] (sic)

17. At approximately, 8.39 am, Ms Sime was taken from the scene by the AV paramedics and transported to the Royal Melbourne Hospital (RMH), the closest major trauma service. *En route* to the RMH, the AV paramedics treated Ms Sime's symptoms which included managing her lowered blood pressure by administering adrenaline to counteract the 'massive envenomation' that Ms Sime had suffered. In addition, the AV paramedics administered a 'bolus of fluid' to stabilise Ms Sime's blood pressure.

Royal Melbourne Hospital

18. On 2 April 2021 at 9.12 am, Ms Sime was admitted to the RMH emergency department (ED) and attended to by Dr Jordan Hamilton.[12]

19. According to Ms Sime's record, her blood pressure on admission was 'normal', at 123/52 mmHg but her heart rate, at 104 beats per minute, was elevated. After her admission, however, her blood pressure dropped to 70/40 mmHg and her heart rate increased to 140 beats per minute. Dr Hamilton noted that Ms Sime had a 'large scalp laceration which contained 15 bees' and 'she had multiple bee stings to her face, chest, abdomen and all four limbs'.

20. On further examination, by taking a series of computed tomography (CT) scans of Ms Sime's brain, chest, abdomen, pelvis and her spine, Dr Hamilton ascertained that Ms Sime had suffered the following injuries:

    i. Fractured sternum;

[10] CB, statement of fireman, Peter Castles according to whom the Victoria Police were already at the scene when the MFB arrived.

[11] CB, statement of Av paramedic, Calum Reid.

[12] CB, statement of Dr Shane Belvedere who made the statement from the medical records held by the RMH. Dr Jordan Hamilton was not available when the statement was made on 25 August 2020.

ii. Multiple rib fractures and 'left sided 4-9 flail segment';

iii. Right and left haemopneumothoraces (collapsed lungs with surrounding blood);

iv. 'Right lower lobe lung laceration'; (sic)

v. Left acetabular (hip) fracture;

vi. T11 anterior vertebral body fracture;

vii. Multiple transverse process fractures in the thoracic spine;

viii. Right C7 transverse process fracture;

ix. Potential liver laceration; and

x. Haemorrhagic subarachnoid contusion right of the right frontal lobe (bleed in brain) and 10 mm subgaleal haematoma.

21. After Ms Sime's medical condition was assessed in the ED, her injuries were managed by way of specialist referrals, in accordance with RMH protocol and relative to the degree of injury she had suffered. Ms Sime's treatment included the following:

i. Right and left intercostal (between the ribs) catheters were surgically inserted to drain the excess blood and remove the air from her thoracic cavity;

ii. Ms Sime's haemorrhagic subarachnoid contusion was treated by the RMH neurosurgery department; and

iii. Ms Sime's spinal fracture and her hip fracture were treated by the RMH orthopaedic surgery department.

22. The evidence indicates that over the next 24-hour period Ms Sime developed 'multi-system organ failure with increased need for blood pressure support'. According to the RMH records, Ms Sime suffered kidney failure and required renal dialysis. She also developed liver failure and suffered a heart attack.

23. When another CT scan was taken, the RMH medical team observed a hypo-perfusion or decreased blood flow to multiple intra-abdominal organs. Recognising Ms Sime's poor

prognosis, medical support was withdrawn in consultation with Ms Sime's family and with their consent.[13]

24. On 3 April 2020 at 10 pm, Ms Sime passed away surrounded by her family.

Identity of the deceased

25. On 3 April 2020, Elaine Betty Sime, born 11 September 1947, was visually identified by her son, Allister Sime who signed a formal Statement of Identification.

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

Medical cause of death

27. Forensic Pathologist, Dr Brian Beer of the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of the body of Elaine Betty Sime on 6 April 2020. Prior to the examination, Dr Beer reviewed a post-mortem computed tomography (CT) scan, the E-Medical deposition Form from the RMH and the Police Report of Death, Form 83. Dr Beer provided a written report of his findings dated 6 April 2020.

28. The post-mortem examination revealed crush injuries including fractures of the cervical vertebrae, sternum and pelvis in keeping with the stated clinical history which, coupled with the bee stings, resulted in multi-organ failure.

29. Toxicological analysis of post- and/or ante-mortem samples was not conducted.

30. Dr Beer provided an opinion that the medical cause of death was 1 (a) MULTI-ORGAN FAILURE SECONDARY TO POLY-TRAUMA AND LIKELY BEE-STING RELATED TOXIDROME.

INVESTIGATIONS

31. Following the incident at the Ruffey Park Lake Trail on 2 April 2020, the ensuing investigation identified that the site where the incident occurred fell under the Management of the Manningham City Council (MCC). Mr Arran Provis, an arborist employed by the MCC, examined the tree and found that the tree had failed at its base due to significant decay within its trunk. There was, however, one 'remaining healthy branch' with foliage. The evidence

[13] Coronial File, COR 20.1836 [CF], RMH E-Medical Deposition Form.

indicates that this branch with the leaves intact, struck Ms Sime and her husband when the tree failed.[14]

32. As part of the investigation, the MCC Risk Department enjoined the investigative role of the Victorian Workcover Authority (*WorkSafe*) in workplace-related incidents. The evidence indicates that this process involving *WorkSafe* was initiated after Ms Sime's passing but before the MCC had learned of her passing.[15]

WorkSafe Investigation

33. On 7 April 2020, Michael Tyrrell, an inspector employed by *WorkSafe*, conducted a site inspection pursuant to the applicable prescripts of the *Occupational Health and Safety Act 2004* (The Act). According to Mr Tyrrell, the circumstances of the incident were explained by members of the MCC management who met him at the site when he conducted his inspection and examination of the site and made the relevant enquiries in the execution of his duties.

34. The *WorkSafe* investigation did not reveal any conduct by the MCC in breach of The Act. Consequently, *WorkSafe* did not issue any Notices or Directions under The Act and declined to prosecute.[16]

FURTHER INVESTIGATIONS

35. Having ascertained that the MCC was responsible for the management of the area in which the incident occurred and having been apprised of the outcome of the *WorkSafe* investigation, I interrogated the MCC's role in the management and maintenance of the area where the incident occurred in order to identify any opportunities to prevent similar incidents in future.[17]

[14] CB, statement of Arran Provis. Initially, there was some doubt as to whether the Ruffey Lake Park Trail fell within purview of MCC's management or whether it was Crown Land and, as such, administered by the Department of Environment, Land, Water and Planning (DELWP). After some enquiries were made, it was established that the site was indeed Crown Land but that 'was under a committee of management with' the MCC, a statutory obligation as envisaged by section 15(1) of the *Crown Land (Reserves) Act 1978 (Vic).*

[15] CB, statement of Arran Provis and the WorkSafe Entry report of Michael Tyrrell. MCC was informed of Ms Sime's death on 9 April 2020.

[16] CF, electronic correspondence from *WorkSafe* to the Court, dated 13 August 2021.

[17] CF, letter from the Court to MCC's solicitors, Maddocks Lawyers, dated 17 August 2021.

36. My investigation identified that:[18]

i. Prior to the incident, the MCC held limited records of their management of Crown Land which the MCC was obliged to maintain pursuant to the prescripts of section 15(1) of the *Crown Land (Reserves) Act 1978 (Vic)*;
ii. The MCC did not hold records for the maintenance and pruning of the failed tree which struck Ms Sime; and
iii. The MCC policy does not consider bees as pests.

37. However, my investigation identified further that, in response to the incident, the MCC had implemented measures to improve its management strategies of the area where the incident occurred, including the following:

i. The MCC developed a geographic information system (GIS) to map, identify and assign responsibility of areas of Crown Land where the MCC's statutory obligation to maintain Crown Land applies;
ii. The MCC convenes regular meetings with stakeholders to proactively manage and improve its maintenance service in these areas;
iii. The MCC has committed to undertake both reactive and proactive routine inspections of the areas under its management, aimed at improving the duties imposed by its statutory obligations;
iv. The MCC, in accordance with its standing policy, has renewed its commitment to apply appropriate risk management principles to all inspections carried out by the Council;
v. The MCC has committed to remove trees which pose an unacceptable risk to both property and life where the risk cannot be minimised by other risk reduction options or strategies;
vi. The MCC has committed to remove trees showing signs of pestilent infestation and/or untreatable disease;
vii. The MCC has committed to cyclic inspections of land falling within the purview of its management regime, aimed at proactively managing risks;

[18] CF, letter from Rachelle Quatrocchi, Director City Services at the MCC to the Court, dated 7 September 2021. This letter to the Court addressed my further investigation in the letter from the Court to MCC, dated 17 August 2021.

viii. The MCC introduced a Tree Asset Management system along the Ruffey Lake Park Trail and initiated a further management plan to address risks; and

ix. Despite the MMC's policy not identifying bees as pests, the MCC has committed to relocate active colonies to abate any nuisance or risk posed to life or property.

38. Following the incident, the MCC was also specifically engaged in the maintenance of the Ruffey Lake Park Trail to improve public safety in that specific area. The beehive and the fallen tree were removed.

COMMENTS

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

39. The purpose of a coronial investigation of a *reportable death*[19] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[20]

40. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[21]

41. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of

[19] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act).

[20] Section 67(1).

[21] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

recommendations by coroners, generally referred to as the *prevention* role.[22] Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[23] These are effectively the vehicles by which the coroner's prevention role can be advanced.[24]

42. It is important to emphasise that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[25]

43. To satisfy the requirements of my *prevention* role, I interrogated the MCC's maintenance management policy in light of the Council's statutory obligations in this regard and particularly after *WorkSafe* declined to prosecute and did not issue any Notices or Directions under the *Occupational Health and Safety Act 2004 (Vic)*.

44. Despite, the outcome of the *WorkSafe* investigation which, the evidence indicates, did not identify any MCC work-related deficiency, the MCC implemented measures to improve its maintenance service operations in the area where the tree failed and caused injury to Ms Sime and her husband. The evidence indicates further that the MCC implemented these measures in response to the unfortunate incident which led to Ms Sime's injuries and consequently, her untimely and tragic death. I commend the proactive stance adopted by the MCC which serves to prevent similar incidents in future.

---

[22] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[23] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[24] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[25] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

45. Although earlier routine inspections of the area may have prevented risks to public safety, it is not possible to be definitive on whether an earlier routine inspection would have altered the outcome for Ms Sime. Identifying that this specific tree was decayed may have been overlooked or minimised as a risk on a routine inspection given the presence of green foliage in the tree's canopy. Obversely, the weight of the available evidence indicates the existence of the likelihood that routine inspections apposite to the MCC's statutory obligations to maintain the area may have prevented risks to public health and safety.

46. Consequently, the weight of the available evidence indicates that, if the MCC had taken a proactive role to satisfy its statutory obligations to maintain the area where the incident occurred any earlier, Ms Sime's injuries and subsequent death may have been prevented. The evidence indicates further that the MCC held 'limited formalised records about areas of Crown land where it had a statutory obligation to manage and maintain that land'.[26] (sic) This apparent lack of proper record-keeping procedures supports a conclusion that the MCC did not ever monitor the safety of the area where the incident occurred despite the area's status as a designated public walkway.

47. The corollary of this conclusion provides further support for the view that Ms Sime's death may have been prevented by proactive monitoring of the area within the purview of the statutory obligation imposed upon the MCC. In light hereof, I invited the MCC to make submissions in anticipation of any comments I may make connected with the death.[27]

48. On 16 December 2021, the MCC delivered written submissions for my consideration which outlined the following:

    i. Prior to the incident the MCC applied a 'reactive approach' in areas 'such as the Ruffey Creek Trail' which were 'not included in the Council's preventative tree management plan'. The evidence indicates that the previous plan was focused on street trees rather than other public areas where the incident occurred;

[26] CF, statement from Rachelle Quatrocchi, Director City Services, MCC.

[27] CF, Letter from the Court addressed Maddocks, Lawyers for the MCC dated 30 November 2021, in terms of which the MCC was invited to make submissions either in writing or orally at a Mentions Hearing which was to be listed for this purpose. The MCC elected to make written submissions.

ii. After the incident the MCC adopted a comprehensive review of the tree management system and implemented a more proactive approach to the management and maintenance of all vegetation in the municipality. The evidence indicates that the MCC has now shifted its focus to include all areas within in the municipality.

iii. The MCC has endorsed and implemented a Tree Management Plan (TMP) which outlines best practices for the assessment, management and documentation of trees which fall within its jurisdiction. This TMP is currently in place.

49. The MCC submitted further that the sheer scale of vegetation in the public open spaces within its jurisdiction, together with the extreme weather patterns currently experienced in Victoria, attributed to global climate change phenomena, does not enable the MCC to express any view as to whether their current TMP could have prevented Ms Sime's death if it had been in place when the incident occurred.

50. However, in a subsequent submission, the MCC expressed the view that its current TMP in place to manage risks associated with trees in public open spaces which, according to the Council, is 'a best practice risk-based system' will 'to the extent reasonably practicable, reduce the possibility of future incidents of this nature occurring'. (sic) This submission substantiates my view that Ms Sime's death was preventable in the factual matrix of this matter which prompted my invitation to the MCC for submissions in this regard. The evidence in this matter supports the view that if this 'risk-based system' was adopted and in place at the material time when the tree in question failed and caused the injuries which resulted in Ms Sime's death, the possibility of the injuries suffered by Ms Sime could have been reduced and the fatal consequences obviated.

51. I acknowledge the risk assessment process conducted by the MCC following Ms Sime's death and I commend the MCC's efforts in developing a system to monitor and manage future risks posed by vegetation to public health and safety. Consequently, I have determined that pertinent recommendations in this matter are not required because I am satisfied that the MCC has taken reasonable steps in response to Ms Sime's death to reduce risks posed by vegetation to public health and safety in an attempt to prevent like deaths.

FINDINGS AND CONCLUSION

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[28] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

   a) the identity of the deceased was Elaine Betty Sime, born 11 September 1947;

   b) the death occurred on 03 April 2020 at The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052;

   c) I accept and the adopt the medical cause of death as ascribed by Dr Beer and I find that Elaine Betty Sime died from multi-organ failure secondary to poly-trauma and likely bee-sting related toxidrome.

3. I find that the Manningham City Council failed to honour its statutory obligation, as envisaged by section 15(1) of the *Crown Land (Reserves) Act 1978 (Vic)*, to maintain the Ruffey Lake Park Trail, the public area where the tree failed which caused Ms Sime's injuries;

4. I find that if the Manningham City Council had been actively engaged in monitoring the Ruffey Lake Park Trail public area under its control and keep proper records relating to the maintenance of the trees in this public area, the possibility of the tree failing would have been reduced;

5. I find that the failure to monitor and manage the trees at the Ruffey Lake Park Trail at relevant and material time, was an opportunity lost to alter the outcome for Elaine Betty Sime. The lack of records indicates a lack of monitoring which represents an opportunity lost to identify the decaying tree and to take the action necessary to abate the risk to public health and safety;

[28] *Briginshaw v Briginshaw* (1938) 60 CLR 336

6. AND having considered all the circumstances, I find that Elaine Betty Sime's death was premature and the likelihood exists that her death may have been prevented if the Manningham City Council had actively engaged in discharging its statutory obligations to maintain the area where the incident occurred as envisaged by section 15(1) of the *Crown Land (Reserves) Act 1978 (Vic).*

I convey my sincere condolences to Ms Sime'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:

Stuart Sime

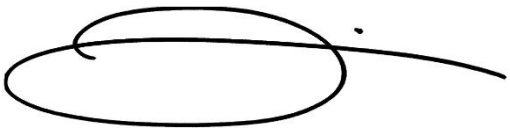
Dale McQualter, Maddocks Lawyers, for Manningham City Council

Kellie Gumm, Royal Melbourne Hospital

Daniel Lewis, Medicolegal Manager, Royal Melbourne Hospital

Senior Constable Jason Brown, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 10 February 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.