IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 006747

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Garry William Ledger
Date of birth:	12 April 1947
Date of death:	20 September 2025
Cause of death:	1a: COMPLICATIONS OF ACUTE RENAL IMPAIRMENT IN THE SETTING OF PELVIC AND LUMBAR FRACTURE SUSTAINED IN A FALL IN A MAN WITH IDIOPATHIC CARDIOMYOPATHY
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004
Keywords:	Tram safety, Yarra Trams, falls risk, older people, safety measures, public safety campaign, future upgrades

INTRODUCTION

1. On 20 September 2025, Garry William Ledger[1] was 78 years old when he died at the Alfred Hospital approximately three weeks after a fall on a tram in Melbourne. At the time of his death, Garry lived in Glenelg, South Australia, with his wife Gerlinde Ledger (**Gerlinde**).

2. Garry is survived by his wife and two daughters, Nicole and Martine, along with their partners and children (being Garry and Gerlinde's grandchildren).

3. Earlier in his life, Garry worked as a primary school teacher and later as a taxi driver, though was retired at the time of his death. He enjoyed working in the local community garden and was a member of the Marino Probus Club. Garry kept fit by walking 45 minutes a day, working out at the gym, and playing golf.

4. Garry had a number of medical issues, all of which were well-controlled. His past medical history included atrial fibrillation with a permanent pacemaker / implantable cardioverter-defibrillator, diabetes mellitus, hyperthyroidism, chronic kidney disease, gastro-oesophageal reflux disease, and cardiomyopathy.

5. His regular medications included warfarin, bisoprolol, amiodarone, dapagliflozin, ezetimibe/simvastatin, esomeprazole, and Entresto.

THE CORONIAL INVESTIGATION

6. Garry'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.

7. 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.

8. 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

1 Referred to throughout my finding as 'Garry' unless more formality is required.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Garry's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family and the forensic pathologist.

10. This finding draws on the totality of the coronial investigation into the death of Garry William Ledger. 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

11. Garry and Gerlinde arrived in Melbourne from South Australia on the morning of 28 August 2025. They were staying for one night only in order to attend the French Impressionism art exhibition at NGV International the following day.

12. After checking into their hotel, Garry and Gerlinde decided to catch a tram to St Kilda for lunch, at which they had a glass of wine, and walked around the community garden. They then walked along Acland Street to catch a tram back in the direction of the city.

13. Gerlinde states that they boarded the tram route 16 at approximately 2:55pm, towards the middle of the tram. Gerlinde reported that Garry used his Myki to tap on, but prior to being able to grab hold of a support, the tram took off, and Garry '*fell flat on his back, knocking his head as well*'.

14. Shortly, afterwards, it was determined that Garry required transport to hospital and '000' was called by a Yarra Trams employee.

15. Upon arrival of paramedics, Garry reported no loss of consciousness and had full recollection of events. He complained of pain in his neck and lumbosacral region and reported some difficulty moving his legs. He was hemodynamically stable at the scene and during transport.

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.

16. Upon arrival at the Alfred Hospital (**The Alfred**), Computed Tomography (**CT**) imaging of the head, cervical spine, chest, abdomen and pelvis demonstrated that Garry had: (a) a comminuted L4 vertebral body fracture with approximately 20% loss of height, with no retropulsion and intact posterior elements (fracture of the lumbar spine); (b) a minimally displaced right superior and inferior pubic rami fractures (pelvic fractures); and (c) no other traumatic injuries.

17. Garry was admitted under the Trauma Service for ongoing management.

18. On 2 September 2025, Garry developed acute delirium, loose stools, and a markedly elevated C-reactive protein (**CRP**), peaking at 360. He was referred to the Trauma Geriatric Service (**TGS**), commenced on intravenous ceftriaxone, intravenous fluids, and the Entresto was withheld. A delirium screen, including chest X-ray and CT brain imaging, demonstrated no acute pathology.

19. On 16 September 2025, Garry developed transient right lower limb weakness and increased delirium. A stroke code was activated. CT brain and perfusion imaging demonstrated no intracranial haemorrhage, no acute ischaemic stroke, and no large vessel occlusion. Over subsequent days, Garry showed improvement in his symptoms (including in bowel symptoms, down-trending inflammatory markers, and partially improved renal function), and variable improvement in cognition, consistent with fluctuating delirium.

20. However, Garry's renal function remained impaired, and plans were made to repatriate Garry to Adelaide for ongoing management via a General Medicine admission at Flinders Medical Centre, with an aeromedical transfer booked for 22 September 2025.

21. Before this could occur, on 20 September 2025 at 4:06am, Garry was found unresponsive by his bedside nurse. Cardiopulmonary resuscitation (**CPR**) was commenced immediately, and a Code Blue was activated. Garry was found to be in asystole ('*flatlining*').

22. Despite extensive treatment and ongoing resuscitation efforts, there was no return of spontaneous circulation, and Garry was declared deceased at 5:01am.

Identity of the deceased

23. On 20 September 2025, Garry William Ledger, born 12 April 1947, was visually identified by his wife Gerlinde Ledger.

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

Medical cause of death

25. Forensic Pathologist Dr Joanne Ho (**Dr Ho**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 22 September 2025 and provided a written report of her findings dated 8 October 2025.

26. Dr Ho noted that the external examination and post mortem CT scan were consistent with the clinical history, which was provided to her by way of a medical deposition and medical records from The Alfred. The post mortem CT scan also showed hemoperitoneum (blood within the abdomen) with a 'sentinel clot' centred about the liver. Dr Ho opined that, given the antemortem imaging findings, this finding may be secondary to cardiopulmonary resuscitation.

27. Toxicological analysis was not performed, noting that Garry had been in hospital for over three weeks when he died.

28. Dr Ho provided an opinion that the medical cause of death was 1*(a) complications of acute renal impairment in the setting of pelvic and lumbar fracture sustained in a fall in a man with idiopathic cardiomyopathy*.

29. I accept Dr Ho's opinion.

INCIDENT REPORT

30. Yarra Trams completed a driver incident report (**incident report**) following Garry's fall on the tram on 28 August 2025, a copy of which was provided to the Court. It was noted therein that, at the time of the incident, a student driver was driving the tram, who was being supervised by a Yarra Trams 'trainer driver'.

31. The incident report recorded that, at 2:57pm on the day of the incident, the tram doors were closed at the stop near Luna Park after passengers had alighted from and boarded the tram, and power was then slowly applied to the tram.

32. A loud thud was heard in the saloon. The trainer driver stopped the tram to investigate, and discovered that Garry had fallen. Garry said that he was sore in the back area, but that he was '*okay*'.

33. Garry was assisted into a seat by the trainer driver, who said he would be back to check on him shortly. The tram then continued along route 16.

34. At the Police Memorial stop, Gerlinde approached the driver and requested an ambulance be called for Garry. Once at The Arts Centre stop, the trainer driver evacuated the tram after announcing that a passenger was experiencing a medical issue, with '000' being called in the meantime.

35. Paramedics attended, assessed Garry, and took him off the tram via the disabled passenger door, transporting him to hospital.

CPU REVIEW

36. In considering the circumstances of Garry's death, I noted that, even prior to this incident, and like many older people in our community, Garry had several serious health conditions. However, those health conditions were well-managed, and it was his fall on the tram on 28 August 2025 that precipitated his deterioration and ultimate death some three weeks later.

37. I considered that addressing the risk of falls on trams – particularly for older persons like Garry who may be more vulnerable to such falls, and who may have comorbidities that increase the risk of a serious adverse outcome after a fall – is a public health and safety issue of great significance. Therefore, I determined to refer Garry's case to the Coroners Prevention Unit (**CPU**) to inform me about the relevant data, and the current approaches around Australia to managing the risk of falls on trams, including whether there are any opportunities for improvements to the approach to safety in trams in Melbourne.[3]

38. The CPU searched the Court's internal databases and advised that, including Garry, there were six deaths occurring after a fall on a Melbourne tram between 2010 and 2025. The CPU further advised that all the deceased were male and were aged between 64 years and 89 years, and three of the six deaths occurred in the most recent three years examined (2023-2025).

39. Together with this advice, the CPU also drew my attention to a TrackSAFE Foundation study published in 2025,[4] which summarises fatalities and injuries across the Australian light rail network in the period 2016-2021. Data for the study was drawn from the Office of the National Rail Safety Regulator (**ONRSR**) notifiable occurrences dataset. Briefly, a notifiable

3 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.

4 TrackSAFE Foundation, *Fatalities & injuries on Australian light rail 2016-2024*, Canberra: TrackSAFE Foundation, April 2025.

occurrence is an accident or incident associated with railway operations that must be reported to the ONRSR.[5] The ONRSR:

> *[…] has responsibility for regulatory oversight of rail safety in every Australian state and territory, to promote and improve national rail safety and ensure the safety of the community.*[6]

40. The study's authors reported that there were nine fatalities and 994 injuries across the Australian light rail network which were notified to the ONRSR during the period, with most occurring in Melbourne (the researchers noted that there is approximately 250km of light rail track in Melbourne compared to 25km in Sydney, 20km on the Gold Coast, 16km in Adelade, and 12km in each of Parramatta and Canberra). They stated:

> *Between 2016-2021 62% of serious and minor injuries were the result of slips, trips and falls onboard or alighting or disembarking.*

41. Unfortunately, the researchers did not break down the data further to elucidate injuries from falls while on board a tram. Also, the researchers noted that on 1 July 2022, reporting requirements for slips, trips and falls changed due to the *Rail Safety National Law National Regulations (Reporting Requirements) Amendment Regulations 2022*, which is a reason why their study did not include more recent data.

42. Non-fatal injury data can be very important in understanding the magnitude of a public health issue, because often deaths only represent a small part of the burden of overall harms. Therefore, I resolved to contact ONRSR, to find out more about their notifiable occurrences and what they know about injuries resulting from falls on trams.

ONRSR correspondence

43. I directed the CPU to write to ONRSR Chief Executive Dr Natalie Pelham (**Dr Pelham**) with questions about the criteria for reporting slips, trips and falls as notifiable occurrences on light rail to the ONRSR; how these criteria have changed over time; and how many slips, trips and falls on light rail in Victoria are reported to the ONRSR each financial year.

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5 Office of the National Rail Safety Regulator, "Notifiable occurrences", updated 26 March 2026, <https://www.onrsr.com.au/operator-essentials/reporting-requirements/notifiable-occurrences>, accessed 16 April 2026.

6 Office of the National Rail Safety Regulator, "What we do", updated 1 June 2026, <https://www.onrsr.com.au/about-onrsr/what-we-do>, accessed 112 June 2026.

44. Dr Pelham's response letter dated 14 May 2026 was very helpful, and I was grateful for her insights. In brief, she explained:

a) Prior to 1 July 2022, there was a requirement to report occurrences of persons falling while travelling on a train, excluding falls that resulted from health conditions. Between 1 July 2016 and 30 June 2022 there were 1635 slip, trip or fall instances reported on board Victorian light rail; an average of 273 per year.

b) From 1 July 2022 the requirement to report slips, trips and falls of a passenger was removed. Instead, if a slip, trip or fall occurred and resulted in serious injury or fatality, this was reportable under the requirement to notify the ONRSR of serious injuries and fatalities. Between 1 July 2022 and 30 June 2025 there were 26 serious injuries and fatalities reported relating to slip, trip or fall occurrences on Victorian light rail; an average of eight or nine per year.

45. Dr Pelham explained that the change in reporting requirements was due to implementation of the National Rail Safety Data Strategy 2018-2022. She noted:

> *Notwithstanding the removal of slips, trips and falls from being notifiable occurrences under the RSNL, rail transport operators are still expected to monitor such occurrences and address any resulting safety risks and issues under the RSNL safety duty to manage safety, so far as is reasonably practicable.*

46. One question that interested me but on which Dr Pelham was unable to assist, related to the ages of passengers in reported slips, trips and falls. I was curious as to whether these non-fatal injuries (like the deaths) were primarily in older age groups. Dr Pelham explained that this information on age is not always collected by ONRSR.

Victorian Injury Surveillance Unit assistance

47. At the same time the CPU was corresponding with the ONRSR, I also directed them to contact the Victorian Injury Surveillance Unit (**VISU**) to find out what insights they might have into tram fall-related injuries. VISU, housed within Monash University, holds multiple de-identified injury datasets that are incredibly useful for understanding the magnitude of public health issues in Victoria. Many coroners have sought assistance from VISU as part of their investigations, and I gratefully acknowledge their efforts to assist me in this instance.

48. In response to the CPU's query, VISU data analyst Dr Jane Hayman (**Dr Hayman**) collated the annual number of non-fatal admissions to Victorian hospitals due to falls on trams,

covering the period FY2020-21 to FY2024-25. The formal description of the data Dr Hayman collated was, community injuries among "*Occupant of streetcar injured by fall in streetcar (excludes falls while boarding/alighting)*".

49. Dr Hayman reported there were 129 relevant hospitalisations during the period, being an average of approximately 26 hospitalisations per year. Dr Hayman further reported that people aged under 60 years accounted for 21.8% of hospitalisations, while those aged 60 years and over accounted for 78.2% of hospitalisations. This is consistent with the six Victorian coronial cases of people who died after falls while passengers on trams; all were aged over 60 years.

Injury data and prevention

50. Both the VISU and ONRSR data highlighted that deaths are only a small part of the overall burden of injury associated with falls in trams. For me, this strengthened the rationale for considering whether there might be any prevention opportunities relating to Garry's death, particularly given we have an ageing population and therefore potentially more elderly people using public transport such as trams in the future.

51. The discrepancy between the VISU data (which showed on average 26 hospitalisations per year following falls on trams) and the ONRSR data (which showed on average eight or nine slip, trip or fall occurrences on Victorian light rail each year causing fatalities or serious injuries) is notable, and its reasons are unclear. The ONRSR guideline titled *Notifiable Occurrence Reporting Requirements* (dated 10 January 2022) does not have a definition of serious injury, so one possible explanation is that perhaps not all injuries resulting in hospitalisation are serious injuries as understood by tram operators and are not all reported. Another possibility is that presentation to hospital may occur some time after the fall, and so if the tram operator is not aware of the seriousness of the fall at the time they may not know to report it.

52. Whatever the reason, I have directed for this finding to be provided to the ONRSR so that if they wish, they can look into whether they are appropriately notified about all relevant slip, trip or fall occurrences on Victorian light rail each year causing fatalities or serious injuries. I am certain that accurate and complete data is key to the ONRSR's important work in promoting and improving national rail safety and ensuring the safety of the community.

Dr Luke Valenza's PhD thesis

53. In my further research into preventing injuries on trams, I came across multiple references to a Monash University PhD thesis titled *Passenger Falls on Trams* submitted by Luke Valenza (now **Dr Valenza**) in 2020. Librarian Kathryn Rough at the Victorian Institute of Forensic Medicine contacted Monash University's library on my behalf to obtain a copy of the thesis; I thank both Kathryn and Monash University for this assistance.

54. I do not intend to provide a detailed overview of Dr Valenza's work, which involved several components. In brief, Dr Valenza examined passenger falls on Melbourne's tram network, focusing in particular on the factors that may influence a fall. He undertook a comprehensive literature review and analysed information from a number of sources including hospitalisation data and actual footage of falls on trams. He found that:

> *[…] falls were more frequently associated with acceleration and deceleration, vulnerable passengers (older and disabled), the location on board the tram, not holding onto support aids and impacting hard surfaces within the tram.*[7]

55. Dr Valenza consulted with experts and the tram network operator (his research was supported by Yarra Trams) to develop and evaluate potential design solutions to reduce falls and injuries on board trams, focusing particularly on how the interior of trams might be redesigned to achieve this result. He discussed the potential design solutions with an expert panel, refined them, and then tested two of the interventions.

56. The interventions he tested were: (i) LEDs in grab handles and support rails within the tram to alert passengers of accelerations and to increase the visibility of these supports; and (ii) installation of patterns and prints on the floor of the tram to lead passengers into safer areas of the tram. He concluded from the tests that the LED grab handles were a promising intervention, but that the use of patterns and prints on the floor did not encourage passenger movement through the tram or increase the adoption of a safer stance when standing.

57. In his discussion, he wrote:

> *[…] further research is recommended to develop methods for reducing falls from accelerations. This project proposes that it would be beneficial to develop a profile of accelerations, decelerations and jerk for tram routes, which could help coordinate when the LEDs embedded in the rails should flash. This could warn*

7 Valenza L, *Passenger Falls on Trams*, PhD Thesis, Caulfield: Monash University, p.68.

passengers just before they were most likely to experience jerk and remind them to hold on or brace.[8]

58. I considered that Dr Valenza's PhD thesis comprised a thorough, high-quality body of research. Noting that Yarra Trams was the industry sponsor for his project, I have assumed that Yarra Trams is fully aware of his findings and recommendations. Further to this point, I was heartened to read of Dr Valenza's experience that during the course of his thesis, Yarra Trams introduced a number of new safety interventions on trams, including interventions Dr Valenza had been exploring in his work.

Correspondence with Yarra Trams

59. After reviewing Luke Valenza's PhD thesis together with the VISU and ONRSR data, to round out my investigation, I asked the CPU to look into whether there might be any falls prevention initiatives on other tram networks around Australia which might be relevant to Victoria. The CPU undertook desktop research and provided me information about two such initiatives on the **G: Link Gold Coast Light Rail** in Queensland.

60. The first initiative was that passengers using the G: Link Gold Coast Light Rail can 'touch on' at tram stops before boarding the tram, which potentially allows them to find seats or supports faster and reduces the risk of falls on trams. Given the available evidence indicates that Garry's fall occurred after he 'touched on' his Myki but before he could find a support to hold, the CPU highlighted this as potentially relevant for consideration in Victoria.

61. The second initiative was that there are blue boarding assistance squares at tram stop platforms on the G: Link Gold Coast Light Rail. When the blue button is used to open the tram door, the driver is alerted that the passenger may need additional time to find a seat. This again would appear to be relevant to the circumstances of Garry's death.

62. The CPU also drew my attention to Yarra Trams' strong record of tram safety initiatives, including particularly its multiple public awareness campaigns. Noting that the recent Victorian deaths following falls on trams were all among people aged over 60 years, and most tram fall-related hospitalisations in the VISU data were also in older age groups, the CPU queried whether perhaps a targeted safety education campaign for older passengers might be indicated.

8 Valenza L, *Passenger Falls on Trams*, PhD Thesis, Caulfield: Monash University, p.134.

63. I directed the CPU to write to Yarra Trams about these three sets of initiatives, to find out the Yarra Trams view on each. I was thankful to receive a considered response from Joe Le, who is Yarra Trams' Chief Health, Safety & Sustainability Officer.

64. Joe Le indicated that the first two interventions, the ability to 'touch on' before boarding and the implementation of a boarding assistance alert system, have both been considered by Yarra Trams and the Department of Transport. He explained that while both interventions may be technically possible to implement, they would require detailed assessments because Melbourne's tram network is very different to the light rail on the Gold Coast, meaning that any attempt to retrofit these interventions in Melbourne would present a range of challenges. He indicated that while Yarra Trams cannot support either intervention at present, they are open to consideration in future.

65. Regarding the idea of a targeted safety campaign, Joe Le confirmed that work on such a campaign is currently underway:

> *The campaign aims to reinforce key protective behaviours - encouraging passengers to remain seated where possible, to hold on while standing or moving through the tram, and to delay standing or walking until the tram has come to a complete stop. The campaign would use clear, simple messaging and highly visible cues to prompt these behaviours, recognising that many falls among older passengers are associated with not holding supports, moving within the vehicle, or responding to sudden braking events.*

66. I consider such a campaign (which complements previous safety campaign undertaken by Yarra Trams)[9] to be commendable.

9 In 2018, Yarra Trams produced a campaign called "This is how we tram", aimed at reducing falls and serious injuries to passengers 60 years and over. The campaign encouraged passengers to think of safety behaviours such as holding on while 'touching on' - ICON Agency, 'This is how we tram 60+ safety campaign', <https://iconagency.com.au/work/yarra-trams-seniors-behaviour-change-campaign>, accessed 15 April 2026.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Garry William Ledger, born 12 April 1947;

    b) the death occurred on 20 September 2025 at The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004, from *1(a) complications of acute renal impairment in the setting of pelvic and lumbar fracture sustained in a fall in a man with idiopathic cardiomyopathy*; and

    c) the death occurred in the circumstances described above.

68. Having considered all of the circumstances, I am satisfied Garry died just over three weeks after a fall on a tram in St Kilda, Melbourne, when he was focused on 'touching on' his Myki and had not had the opportunity to hold any support on the tram before it commenced moving. While Garry had a significant burden of natural disease, including renal impairment and cardiomyopathy, it was his fall on the tram and resultant serious injuries, including pelvic and vertebral fractures, that precipitated his deterioration and ultimate death.

69. Having reviewed the incident report provided by Yarra Trams, I am satisfied that the response to Garry's fall was appropriate and that, while there was the possibility for Garry's care to have been escalated sooner, '000' was called as soon as the seriousness of his condition was realised. There is no evidence before me that the tram being operated by a learner driver at the time of the incident had any bearing on the outcome; the driver reported accelerating slowly and was supervised by an experienced driver at the time of the incident.

70. I consider that the care Garry received at The Alfred Hospital was reasonable, appropriate and compassionate, and that, when he was found unresponsive on 20 September 2025, staff responded appropriately and promptly. However, sadly, and despite significant resuscitation attempts extending for almost one hour, Garry's life could not be saved.

71. Given these circumstances, I have not identified any direct prevention opportunities. However, Garry's death brings into view a range of prevention opportunities that I now turn to make comment upon.

COMMENTS

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

72. I am very concerned about the number of deaths and injuries among older Victorians following falls on trams. Public transport in Victoria, and the extensive network of trams in Melbourne, provide a crucial way for older people to get out and about, in circumstances where they may no longer be driving a car, and where they are subsequently reliant on public transport to get from 'A' to 'B'. Older people feeling safe to use trams is critical to their ongoing social connection, their ability to participate meaningfully in life in our community, to attend appointments, and to avoid physical and social isolation. Notably, certain of these factors also correlate with the needs of other key groups in our community with particular accessibility requirements, such as those living with disability.

73. For tourists, as Garry was, the Melbourne tram network is an attractive and easy way to see the city for people who are visiting the city on holiday. Such tourists may be unfamiliar with riding on Melbourne trams and/or unaware of the risk of falls that is inherent in travelling on a vehicle that is frequently stopping and starting to let people on and off.

74. It is clear to me Yarra Trams is very aware of these issues and deeply engaged in efforts to make tram travel as safe as possible for older Victorians, and for those visiting from other places. It is also clear that any significant changes to the way trams operate in Melbourne (such as by touching on points being before one boards the tram, or boarding assistance squares) will require a detailed assessment, and likely, significant investment.

75. However, I make comment that, in addition to the public awareness campaigns that Yarra Trams has deployed to help reduce the risk of falls, <u>any future upgrades of the tram system should include consideration of key safety features featured in other jurisdictions</u>, such as Sydney and the Gold Coast. A means by which to 'touch on' <u>before</u> one boards a tram is an example of an initiative that would increase the safety of passengers, because they are not focused on completing this task when a tram is, or is about to be, in motion, as Garry was. Ensuring there is a 'stop' button in close range to the priority passenger seats is another strategy. Such simple changes have the potential to save lives and prevent serious injury.

76. Therefore, while I commend Yarra Trams and Transport Victoria for the existing approach to passenger safety, I would urge both entities to consider additional safety measures in the future to help our elderly population navigate tram travel safely, and with confidence. In an ageing population, this issue will only become more and more pressing in future years, and keeping our older population safe, connected and confident to use public transport is critical to respecting their human rights, dignity and value to our broader community.

ORDERS AND DIRECTIONS

I order that a copy of this finding be published on the Coroners Court website in accordance with the Rules.

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

Gerlinde Ledger, Senior Next of Kin

Bayside Health Alfred

Yarra Trams

Transport Victoria

Office of the National Rail Safety Regulator

Transport Accident Commission

Senior Constable Nicholas Ervin, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 25 August 2026

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.