IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 001272

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Jack Andrew Peter Stewart
Date of birth:	29 September 1996
Date of death:	5 March 2026
Cause of death:	Neck compression
Place of death:	Coles Echuca Darling Street & Hare Street Echuca Victoria
Keywords:	Charity bins – safety – design - asphyxia

INTRODUCTION

1. On 5 March 2026, Jack Andrew Peter Stewart was 29 years old when he was found deceased in Echuca. He is survived by his mother, Misty Barber, and his siblings, Tsarnic, Bindhi and Daron. He is warmly remembered for his gentle and generous nature and is deeply mourned by his family.

BACKGROUND

2. Jack grew up in the Echuca/Moama area where he attended school.

3. Jack's father passed away suddenly when Jack was 19 years old. Misty recalled that the death had a significant and devastating impact on Jack. Following his father's death, Jack began using illicit drugs, including methylamphetamine. He was also diagnosed with drug-induced schizophrenia. Misty recalled that Jack's behaviour became erratic and threatening which required her to reluctantly obtain an Intervention Order for the protection of the family.

4. Following this time, Jack experienced a period homelessness before engaging in a rehabilitation program. He was then provided stable accommodation by Ms Barbara Kerr and her family for which Misty is deeply grateful.

THE CORONIAL INVESTIGATION

5. Jack'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.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Jack's death. The Coronial Investigator conducted inquiries on my behalf, including obtaining statements and evidence from witnesses – such as family, first responders and the forensic pathologist.

9. On 29 March 2026, Jack's mother submitted to the Court a request for an inquest to be held into her son's death.

10. On 27 May 2026, I determined that it was not necessary to hold an inquest into Jack's death.

11. This finding draws on the totality of the coronial investigation into Jack's death. While 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]

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

Circumstances in which the death occurred

12. CCTV footage disclosed that on 5 March 2026 at 4.00am, Jack rode his BMX bicycle on the footpath along Hare Street, adjacent to the Coles carpark in Echuca. He then turned left into Darling Street and stopped shortly afterwards in front to two charity bins which were situated at the edge of the carpark. He then sifted through some loose items that had been placed at the rear of the bins before he moved around to their front. His further movements are not able to be seen in the footage as they are obscured by the charity bins.

13. On 5 March 2026 at around 4.00am, a storeman employed at Coles Echuca heard what he thought were voices coming from the carpark area while he was unloading items at the loading dock. The loading dock is located on Darling Street. He walked over to a window overlooking the carpark but could not see anything so he returned to work.

14. At around 5.00am, a local resident was driving east along Darling Street when she observed a person hanging out of a charity bin which was located along the footpath adjacent to the Coles carpark. She subsequently contacted emergency services and notified Victoria Police.

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

15. At around 5.03am, Victoria Police arrived at the scene and observed that Jack was trapped head-first in the opening chute of one of the charity bins. He was unresponsive and they were unable to extract him from the bin. Ambulance Victoria and the Country Fire Authority arrived shortly afterwards. Specialist equipment was used by fire fighters to remove Jack from the bin and he was pronounced deceased by paramedics at 5.32am.

16. Police located Jack's BMX bicycle at the scene which they suspect Jack had used to gain access to the bin chute.

17. There were two donation bins located on Darling Street adjacent to the Coles car park in Echuca at the time of Jack's death. They were placed and managed by SCR Group. The bins were easily visible from Darling Street in a reasonably well-lit area. They were removed from the location the day after the incident.

18. The donation bins were designed with a tamper-resistant door mechanism with a "rolling chute". Donated items are placed into a metal trough/chute and only deposited into the base of the bin once the trough/chute is rotated approximately 90 degrees by lifting a handle on the door. Each of the bins displayed clear signage on the trough/chute stating: *Danger. Do Not Enter Hub. Entering this hub can cause serious bodily harm*.

Identity of the deceased

19. On 10 March 2026, Jack Andrew Peter Stewart, born 29 September 1996, was visually identified by his mother, Misty Barber.

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

Medical cause of death

21. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an external examination and reviewed a post-mortem computed tomography scan (**CT**), producing a report of his findings dated 12 March 2026.

22. Dr Bedford noted areas of injury involving the anterior neck in keeping with pressure on the neck from the bin door. He noted that the pressure would lead to blockage of the airways and the vessels to the brain.

23. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine and cannabis.

24. Dr Bedford provided an opinion that the medical cause of death was *1(a) Neck compression*.

25. I accept Dr Bedford's opinion.

FAMILY CONCERNS

26. Jack's mother has expressed concern to the Court in relation to the unsafe design of charity bins and the location of the particular charity bins at Coles Echuca.

CPU REVIEW

Other cases

27. I referred the circumstances of Jack's case to the Coroners Prevention Unit (CPU) for advice.[2] They searched the National Coronial Information System and identified five deaths between 1 July 2000 and 31 March 2026 where the deceased was found entrapped within the chute mechanism of a charity bin. No recommendations were made in these cases. There have also been a number of cases recorded in North America.

Design

28. The CPU noted that the National Association of Charitable Recycling Organisations Ltd (trading as Charitable Recycling Australia)[3] has established a voluntary Code of Practice setting out standards for the design, management and servicing of charitable donation bins.[4] Relevantly, the Code provides as follows:

> ***3. Bin Design***
>
> *It is important that bins are designed to minimise the potential for a person to enter through the donation chute, a practice that can result in serious injury or risk of death. In addition to the requirements for bin placement outlined in item 4.1 below, charity bin operators should*

[2] 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.

[3] National Association of Charitable Recycling Organisations Ltd is the peak body representing charitable recycling organisations throughput Australia.

[4] https:www.charitablereuse.org.au/wp-content/uploads/2020/08/Charitable-Donation-Bins_Voluntary-Code-of-Practice-2020-1.pdf.

ensure that, where used, swing chutes are sufficiently highly placed and narrow to prevent entry.

4.1 Placement and Security

Bin placement is largely a matter for charitable bin operators to negotiate with landlords, including local governments and businesses. Bin placement should take into consideration a range of factors to ensure they do not detract from the amenity and appearance of the site, and do not increase the risk of illegal dumping. In general, the following types of sites have been found to be successful:

- *Highly visible sites with good lighting, regular foot traffic and security cameras, or*
- *Sites that can be secured outside business hours – such as churches, community centres or businesses, or*
- *Sites that can be actively managed and monitored by local government workers or security guards – such as transfer stations, shopping centre grounds, or carparks*.

Research

29. In a 2020 academic paper on deaths associated with donation bins, the researchers outlined the circumstances and postmortem findings of five such deaths that occurred in British Columbia and Ontario between 2009 and 2019.[5] The paper noted the proliferation of charity bins across Canada of varying designs and observed that individuals in low socioeconomic situations may seek access to the bins for either shelter or to obtain items for personal use or resale.

30. Amphetamines were present in all five cases; in two cases the deceased also tested positive for opioid drugs, and one case was also positive for the stimulant drug cocaine. The researchers proposed that the use of recreational stimulant drugs may be an enabling factor for individuals to overcome the physical and exertional challenges of squeezing into a donation bin opening.

31. The paper considers the design of charity bins including those which have been installed with a "rolling chute" mechanism. It is noted that, as a deterrent against theft, the mechanism includes a trough/chute which forms an inner door when the outer door is opened by a person

[5] Hickey T et al, *"Deaths Associated with Community Donation Bins: A Ten-Year Retrospective Review Describing Five Cases in British Columbia and Ontario"*, Academic Forensic Pathology, 10(1), 2020, pp.47–55.

to deposit items in the trough/chute. The mechanism is designed to restrict direct access to the bin. However, the authors noted that *"a motivated individual may contort their body to squeeze through the narrow passageway over the rotating chute. Injury can result by forcing one's head, neck and upper body through the narrow opening between the chute opening and the door frame and/or ceiling of the bin. Furthermore, there is manual upward force into the area of the upper body and neck during the process of trying to enter the bin, as the lower body and legs continue to depress the lever mechanism"*. The result is that the neck/upper body can become trapped between the lip of the inner door of the chute and the frame and/or ceiling of the bin. The weight of the person's lower body and legs on the inside of the outer door of the chute creates a force on the neck which leads to asphyxia.

32. The researchers considered three options to prevent similar deaths:

a) Warning labels – one of the deaths in their study had a warning label and as such, it is unclear if such warning labels will sufficiently reduce injury and/or death.

b) Location of bins – placing the bins in areas of greater visibility with increased foot traffic may be one harm reduction approach. Alternatively, given that these deaths appear to be more likely occur at night, placing bins in areas that can be locked off during the evening (eg. rolling the bins into a secured garage or shed) may improve safety.

c) Design – this was considered the optimal solution to preventing injury and/or death. All the deaths in the study were associated with the rolling chute or the mailbox style bins. Establishing what constitutes a safe bin design and developing a baseline standard for bin safety was undertaken via a collaborative effort by individuals and organizations. Through this process, two primary changes to existing bin designs (mailbox and rolling chute styles) were identified with the goal to reduce/eliminate the potential for harm. The mailbox style bin was made safer by disengaging the metal mechanism that caused the inner door to close when the outer door was opened. The rolling chute style bins were made safer by retrofitting a metal insert to better restrict potential access to the small bin opening. An example of this change is shown in a video produced by a bin manufacturer (https://vimeo.com/310162178).

FINDINGS AND CONCLUSION

33. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Jack Andrew Peter Stewart, born 29 September 1996;

    b) the death occurred on 5 March 2026 at Coles Echuca, Darling Street & Hare Street Echuca, Victoria, from neck compression; and

    c) the death occurred in the circumstances described above.

34. Having considered all of the circumstances, I am satisfied that Jack's death was a tragic accident.

COMMENTS

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

35. Charity bins are situated in many locations around Victoria. They provide an accessible means for the public to donate unwanted items which may be of value and use to those in need. The "rolling chute" design is common in charity bins. But its design presents a serious risk to those who might seek to retrieve items from within the bin from through the chute.
36. The charity bin in this case was clearly marked with a sign which warned against the dangers of entering the chute. Nevertheless, the public location of the bin provided an opportunity for people in need and whose desperate circumstances (in this case also associated with illicit drug use) might motivate them to run the risk of attempting to retrieve items from inside the bin.

RECOMMENDATIONS

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

> The Director of Consumer Affairs Victoria give consideration to the preparation of a proposal to Standards Australia for the development of a standard for the safe design of charity bins.

I convey my sincere condolences to Jack's family for their loss.

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:

Misty Barber, Senior Next of Kin

Senior Constable Brenton Shiells, Coronial Investigator

Signature:

Coroner David Ryan

Date: 27 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.