MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Kevin Howard Weber

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Kevin Howard Weber;

b) Mr Kevin Howard Weber died as a result of a head injury from a fall sustained on 21 February 2018;

c) Mr Weber's cause of death was a subdural haematoma; and

d) Mr Weber died on 12 March 2018 at Hobart in Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Weber's death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; police and witness affidavits; CCTV footage; correspondence from the Glamorgan Spring Bay Council; and medical records.

Mr Weber was born on 5 March 1952 and was aged 66 years. He lived in Triabunna with his partner, Irene Nicolay.

On 21 February 2018 Mr Weber and Ms Nicolay went for a walk in the vicinity of the marina at Triabunna. They proceeded to walk up a set of four steps from the car park onto a grassed area at the Seafarers' Memorial. As Mr Weber reached the top of the steps he lost his balance and fell about one metre backwards onto the concrete of the car park, striking his head.

Mr Weber initially lost consciousness but regained it with a period of confusion. He was able to walk to the ambulance that was summoned. During transport from the location of his fall to the Royal Hobart Hospital Mr Weber became neurologically unresponsive.

At the hospital a CT scan revealed a large right sided subdural haematoma for which he underwent an urgent craniotomy and evacuation of the haematoma. His post-operative course was complicated by elevated intracranial pressure. He remained neurologically unresponsive. Ventilator support was withdrawn on 11 March 2018 and he died the following morning, 19 days after his fall and injury.

Comments and Recommendations

One issue raised by the unfortunate death of Mr Weber was the absence of a hand rail next to the set of steps from which he fell. Mr Weber's fall was captured on CCTV footage from the area. From examining that footage, it is not clear whether the existence of a hand rail would have prevented Mr Weber's fall. It is possible, however, that he may have used it to stabilse himself.

In helpful correspondence from the Glamorgan Spring Bay Council received in this investigation the General Manager of the Council indicated that the steps in question do not legally require railings and are compliant with current regulations, being below one metre in height. I accept this is the case. The General Manager indicated that the Council has nevertheless decided to install a "mid-rail" on the steps given that they are in high use by members of the public.

The circumstances of Mr Kevin Weber's death are not such as to require me to make any recommendations pursuant to Section 28 of the Coroners Act 1995.

I convey my sincere condolences to the family and loved ones of Mr Weber.

Dated: 26 July 2018 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner