



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

(These findings have been de-identified in relation to the names of friends and others by direction of the Coroner)

I, Olivia McTaggart, Coroner, having investigated the death of Margaret Mary Lore

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

- a) The identity of the deceased is Margaret Mary Lore;
- b) Margaret died in the circumstances set out below;
- c) The cause of death was traumatic head injuries; and
- d) Margaret died on 28 January 2017 at Blackmans Bay, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Margaret's death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; police and witness affidavits; medical records and reports; forensic evidence; and information from the Kingborough Council.

Margaret Mary Lore, known as "Maggie", was born on 1 October 1999 and was aged 17 years at her death. She was a school student. She is the only child to Leaf Hazel Lore and Daniel Michael Lore, and has a step-brother. The family lived together in Richmond until Maggie's parents separated in 2008. Subsequently, her mother and step-brother moved to Ballina, New South Wales. In late 2013 Maggie moved to Ballina to live with her mother and stayed there until Easter 2015 when she returned to live with her father in Richmond.

Upon returning to Tasmania Maggie attended MacKillop Catholic College and then Guilford Young College. She was healthy and active. She participated in various activities including netball, dancing and yoga. She was very artistic and enjoyed poetry.

On the evening of 27 January 2017, Maggie spent the night at her house with friend A. The following morning they both used cannabis. Friend A left the address about midday.

At about 4.30pm Maggie's father dropped her off in Hobart City where she did some shopping. She was then collected by friend A and friend B. They drove to the home of friend C in Kingston.

Between 6.00pm and 6.30pm Maggie and friend C were picked up by friend D and friend E and they all went to Domino's Pizza in Kingston where they had dinner. They then caught a bus back into the city.

Whilst in the city, Maggie found out via Facebook about a party at friend F's house at Kingston. To get to the party, Maggie was collected from the city by friend G and friend B. They arrived at the party at about 9.00pm.

Friend F had invited approximately 85 people to the party. His mother, Ms M, had instructed a limit of 35 guests and she expected only that number to attend. In fact, the evidence indicates that over 100 people attended at the party. There were three adults supervising, including Ms M. Steps were taken by Ms M to ensure that alcohol was limited in type and quantity, as well as requiring permission notes from parents of children under 18 years. However, as more persons arrived, the supervising adults were unable to adequately monitor the alcohol brought in or the permission notes. At that point Ms M contemplated calling the police to control the party.

As it transpired, police had received a complaint from neighbours about the noise from the party and that a number of youths were on the street drinking. About 10.30pm police officers attended the residence and closed down the party.

Some of Maggie's school friends were at the party. They have provided affidavits for the investigation. From these affidavits I can find that Maggie was drinking vodka and coke from a cup and had a 700ml bottle of vodka. It is unknown where or how Maggie came into possession of the bottle of vodka. There were varying accounts of Maggie's sobriety, which included that she was '*not drunk at all*', '*happy drunk*' and '*pretty drunk*'.

Various witnesses in the investigation have stated that at the party Maggie was asking around for anyone who had a 'bong' (a smoking device for cannabis) that she could use. No witnesses were identified as actually seeing Maggie smoking cannabis.

Upon the party being closed by police, Maggie left the address and travelled to McDonald's, Kingston, with a number of young people. From there they drove down to the blowhole area at Blackmans Bay, located next to Talone Road. The blowhole itself is a geological feature situated near Blackmans Bay beach and the cliffs adjacent to the beach. The beach, blowhole and cliff area are frequented by people for leisure, recreational and access purposes. Relevant to this investigation, Talone Road runs for approximately 700 metres parallel and close to the cliff face.

On the way to the blowhole Maggie produced cannabis and showed it to friend A. At 11.00pm Maggie and her group (of nine others) arrived at the blowhole in three separate cars. Maggie had never been to the blowhole before and was unfamiliar with the area. The evidence clearly indicates that at this time she was very drunk, likely having consumed approximately one half of the 700ml bottle of vodka between 9.00pm and 11.00pm. Most of the other members of the group had not consumed large amounts of alcohol and were not as intoxicated as Maggie.

The area is not well lit with no street lighting and there was no moon that night. A number of people in the group climbed the sturdy wire mesh fence between the street and the cliff edge and gathered on either side of the fence line. Maggie also decided to climb the fence at the cliff edge. She was unfamiliar with the area and used a mobile phone torch in one hand to light her way from where she was sitting in the car to the cliff. She stepped onto a horizontal coppers log vehicle barrier close to the fence and then climbed over the 1.4 metre high fence line. Immediately to her right the fence height was only 1.0 metre but she was likely to have been unaware of this. The ground on the other side of the fence line at the point of her climb is uneven with a slight downward gradient. The distance from the fence to the cliff edge is approximately 2.7 metres. Maggie landed awkwardly and her momentum caused her to fall towards the cliff edge and then over it. The drop to the bottom of the cliff onto rocks is approximately 20 metres. Maggie landed 1.5 metres out from the cliff edge onto the rocks below.

Friend A scaled the cliff edge and was the first to reach Maggie. A number of others either stayed at the top or went south towards a small track and made their way back along the cliff face and water's edge where they met up with friend A and Maggie.

Friend A and others in the group administered first aid which consisted of trying to maintain Maggie's airway and placing her on her side. Emergency services were contacted. Paramedics attended, assessed Maggie and determined that she was deceased. Police officers attended, secured the area and commenced an investigation.

Due to the dangerous location, police were unable to remove Maggie and so arrangements were made for her extraction by helicopter at daylight. Police remained at the location until the helicopter left with Maggie's body.

An autopsy was performed by Dr Donald Ritchey, forensic pathologist, at the Hobart mortuary. Dr Ritchey concluded that Maggie died as a result of traumatic head injuries. I accept Dr Ritchey's opinion as to cause of death.

Toxicological testing of Maggie's blood showed very high levels of alcohol (0.154 grams of alcohol per 100ml of blood) and the presence of cannabis. Both the cannabis and high alcohol level, in combination, would have greatly impaired her intellectual performance, judgment, coordination and balance.

If Maggie was not as intoxicated, she may not have chosen to climb the fence, or at least at the point in the fence line which she did. If she had not consumed as much alcohol, she may not have fallen from the edge. Her decision to hold the phone in one hand may also have limited her ability to steady herself.

The evidence in this comprehensive investigation satisfies me that Maggie's death was a tragic accident and that there are no suspicious circumstances surrounding it. Further, it is evident that her decision to scale the cliff fence was made by herself without any direct pressure placed upon her by the other members of the group.

I am satisfied that Maggie did not consume alcohol before arriving at the party. The fact that the party was inadequately supervised at that time due to the unexpectedly large number of people arriving may have created the environment in which she could consume that alcohol. Additionally, she may not have been in the Blackmans Bay area, had it not been for attending the party in Kingston. Nevertheless, it appears that she voluntarily purchased the bottle of vodka and, unwisely, decided to drink a large quantity in a short period of time. At the party itself, Maggie did not necessarily appear to be highly intoxicated.

The particular events that occurred shortly after the party leading to Maggie's death could not have been foreseen. In this regard, the blowhole area was located about 5 kilometres away from the party venue and it appeared to be a spontaneous decision of the group to drive there. It is therefore not appropriate to make criticism of any person involved in the circumstances surrounding Maggie's death. I simply observe that those responsible for hosting parties involving young persons drinking alcohol should make every effort to ensure that alcohol consumption is strictly regulated, bearing in mind that those in a very intoxicated state may later engage in dangerous or risk-taking behaviour.

Sadly, Maggie's tragic death serves as a reminder of the dangers of mixing alcohol and illicit drugs and, in particular, of young people doing so in public places.

Comments:

In this investigation, I have been provided with documentation from the Kingborough Council and Department of Primary Industries, Parks, Water and Environment which outlines information concerning the land around the blowhole and adjacent cliff face at the end of Talone Road.

The historical review by the Office of the Surveyor General reveals that the area of land in question is likely vested in a private estate and not actually owned by the Council or the Crown. However, there is no indication in the evidence for the coronial investigation that any private owner has asserted rights over this portion of land. To the contrary, it is clear that the Council has taken responsibility for the management and maintenance of the area over many years. This management includes installation of concrete pathways and steps, interpretation signage, road, fencing and park benches. It would seem that, for all purposes, the area has been treated as Council land and used as a public reserve, recreational area and access way.

Although statistics pertaining to use of the area are not provided, it is clear that the area is heavily used, particularly the walking track along the cliff face from Blowhole Road to Talone Road. The cliffs themselves are also a popular spot for abseiling, and there is an informal path that has been well used on the coastal side of the fence for cliff jumping and abseiling launches.

The fence along the cliff face in the area varies in height from 900 mm to 1.5 metres. The fence is constructed from chain mesh and was installed over 30 years ago. The fence is sturdy, in reasonable condition, and provides an obvious barrier between the walking path and the cliff face.

There are two warnings concerning the area, both of which are at the Blowhole Road end. One sign is attached to a tree located at the end of the beach where the track leads to Blowhole Road. This sign reads: "*Sections of this foreshore are extremely dangerous*". The other sign is an interpretation panel (regarding the geology of the area) at the entrance to the lower part of the reserve from Blowhole Road. It includes in very small red writing the words: "*Caution. Please stay behind the fence. This is an actively eroding site*". Both signs do not appear to be adequate warning of the dangers of the high cliff face and the need to remain behind the fence line. For this potentially hazardous area that is frequently used by youths and other members of the public both day and night, prominent and clearly-worded warning signs should be erected at both ends of the reserve and other spots on the reserve most frequently used.

Having commented upon the apparent inadequacy of the signage, I am satisfied that adequate signage would not have altered Maggie's decision to climb the fence in the circumstances I have described. Appropriate signage, however, may deter others from dangerous behaviour near the cliff face.

There are no street lights at the end of Talone Road in the area where the group, including Maggie, were present. In his report to me, the investigating officer expressed the view that a single street light installed in this area would provide lighting to the track, as well as serve a safety and security function. It appears that there may be some reluctance on the part of the Council to install lighting at this spot on the grounds that it might encourage young persons to congregate in the area. I question the validity of this view. However, it is not appropriate to make a recommendation regarding lighting the area without having the benefit of all available evidence. I am not able to determine whether, had the area been lit by a street light, it would have made any difference to Maggie's actions that evening. There is a chance that it may have done so by removing the need for her to hold her phone torch and by revealing the proximity of the cliff edge.

An interrogation of coronial records reveals that there have been no other deaths, at least in recent times, from the cliff top in accidental circumstances. I do not have evidence regarding the occurrence of any non-fatal injuries as a result of accidental falls from the cliffs.

The Council, in its report, stated that: "*The matter is complicated in so much as Council does not own or formally manage the site, although clearly has undertaken maintenance in the area. However, before considering recommendations for formally taking over the management of the land and investigating the need for improved infrastructure in the area, it would be prudent to await the findings from the Coronial enquiry.*"

With respect to the Council, the issue, at least from a public safety perspective, does not appear complicated. Whether or not the Council was aware of the likely private ownership of the land before the advice from the Office of the Surveyor General on 3 April 2017, it has clearly taken responsibility for management of the site for many years without apparent impediment.

Coronial recommendations, and responses to them, are very important in the prevention of deaths and public safety. However, it should be emphasised that the evidence required to be considered by the coroner in any one investigation is likely to involve many other issues associated with the death and the coroner may not deem it appropriate to deal with matters that others expect to be included in the scope of the investigation. Furthermore, the caseload of the Coronial Division is very large and, regrettably, delays may occur in the finalisation of any matter. Finally, in respect of issues of safety, an organisation is often privy to much more information than the coroner has obtained in the investigation and is therefore best placed to respond efficiently and effectively to important issues arising from the death.

Therefore, where an organisation, agency or other body is obliged to assess and respond to adverse events within the remit of its own functions and powers, it should do so in a timely way and without feeling constrained by the need to await the coronial findings. This does not mean that coronial recommendations ultimately made should not be considered and, if appropriate, responded to.

Independently of any coronial investigation, a Council's function under the *Local Government Act 1993* includes providing for the health, safety, and welfare of the community. After Maggie's death, I would have expected the Council to commence a timely examination and assessment of safety in the area concerned, having regard to information held, advice from specialised personnel, and policy and resourcing issues. The result of that process should be a fully reasoned and documented decision on relevant matters of management and safety of the area, including the desirability of changes to ownership of the land, and enhanced barriers, signage and lighting. As that process has not been undertaken, it is appropriate to recommend that it be done.

Recommendations

I **recommend** that the Kingborough City Council undertakes or initiates a comprehensive assessment of management and safety of the public area comprising the blowhole and the cliff face area from Blackmans Bay beach to its end point on Talone Road; such assessment to include consideration of changes to the title of the land, and enhanced barriers, signage, lighting, seating and installation of CCTV systems.

I further **recommend** that the Kingborough City Council gives consideration to recommendations from the assessment and, if it deems that action is required, devises

a plan and schedule to undertake that action.

Conclusion

I extend my appreciation to investigating officer Constable Steven Bomford for his high quality and thorough investigation and report.

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

Dated: 26 February 2019 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner

