QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non- inquest findings into the death of Vaughn Ross McManus at Roaring Meg Falls Wujal Wujal**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	28 March 2019
FILE NO(s):	2017/4400
FINDINGS OF:	Nerida Wilson, Northern Coroner
CATCHWORDS:	Roaring Meg Falls; accidental slip and fall; alcohol and drug toxicity; Kuku Yalanji; Wujal Wujal; traditional owners; indigenous; aboriginal; culturally sensitive site; signage; mobile and satellite telephone coverage; telecommunication signal; police recovery operations from waterfall; rescue helicopter; Emergency Services Queensland; retrieval helicopter

Contents

Background

1. On 1 October 2017 Vaughn Ross McManus, a 31 year old man, and his fiancé [referred to as "Ms D"] travelled from Mossman to the location of the Roaring Meg Falls located at Wujal Wujal, approximately 245 kilometres north of Cairns, via Cape Tribulation and the Bloomfield Track. They arrived at the falls around 4:00pm.

2. Mr McManus travelled from Mossman to Roaring Meg via the 'CREB' track (described as a steep rough track linking the Daintree to Wujal Wujal). The drive took approximately 4 hours. The couple parked at the Roaring Meg Falls.

3. Mr McManus and Ms D followed the walking track along the riverbank to the top of the falls, and ventured out across the rocks. While the couple stood on a rock in the middle of the stream at the very top of the falls, Mr McManus's dog 'Bud' lost his footing, Mr McManus reacted, and in his efforts to reach for the dog he slipped and fell over the edge of the falls (an estimated fall of 20 metres to the base).

4. Ms D climbed to the bottom of the falls and saw Mr McManus floating face up. He was not moving so she jumped in the water and grabbed him and held him and saw that he was not responsive. She could see blood coming from his head, ear and mouth. He was not breathing. She attempted CPR and could feel that his ribs were broken.

5. The dog was hurt and could not walk. Ms D could not carry or lift the dog, or Mr McManus. She moved Mr McManus to the waters edge to secure his body ensuring he would not float away. Ms D returned to the top of the falls and located her phone. She did not have mobile coverage. She could not locate the keys to Mr McManus's utility so she again climbed down to the base of the falls to see if they were located with him. She could not find the keys (She did not realise Mr McManus had placed them on the tyre of his ute).

6. Ms D returned to the vehicle but could not access the vehicle without the keys. She then walked for an estimated one hour or more along the CREB track where she located an emergency phone at a Ranger Base and she contacted Triple 0 sometime between 5.30pm and 6.00pm. An emergency response was activated via the Wujal Wujal police.

7. The Roaring Meg Falls are about a one hour drive from Wujal Wujal, along China Camp Road (a difficult dirt road). The police arrived on scene by 7:30pm.

The recovery operation

8. The recovery efforts led by local police stationed at Wujal Wujal, Sergeant Tome and Acting Sergeant Melandri were delayed due to the onset of nightfall and the location of Mr McManus's body.

9. In order to obtain access to the base of the falls police were required to tether themselves to a large tree via a rope to create an anchor point in order to facilitate a safer crossing. Due to the terrain and conditions the only way to facilitate the recovery of Mr McManus's body was by rescue helicopter the following day.

Autopsy report summary and interpretation

10. Dr Paull Botterill, Senior Staff Specialist Forensic Pathologist performed a post mortem examination at the Cairns Hospital on 5 October 2017 and concluded:

    According to the Police Form 1, this 31 year old man, with a past history of migraines and blackouts, was believed to have slipped while standing in shallow water at the top of Roaring Meg Falls, near Wujal Wujal, on the afternoon of 1 October 2017. He was observed to fall some 20 metres to the base of the falls, landing on rocks. He was unresponsive to resuscitative efforts.

    The pattern of distribution of injuries would be consistent with a fall onto rocks.

    In my opinion, at the time of autopsy, the cause of death was most probably multiple injuries sustained in a fall from height but the possible contribution of concurrent alcohol and/or other drug toxicity were difficult to completely exclude at the time of autopsy examination.

    Testing for drugs and poisons showed the presence of an illicit stimulant (methylamphetamine and metabolite) at a blood level in the reported potentially lethal range).

    Blood alcohol level was 92 mg/1 00 mL (i.e. a blood alcohol of 0.09 in road traffic terms). Although such a level may result in a degree of impairment of rapid and extremely complex motor skills, the level is not sufficiently high to result in death of itself but, as stimulant intoxication, may be associated with behavioural changes which may have impacted upon circumstances leading to the death.

11. The Forensic Pathologist noted the cause of death as: Multiple Injuries; (as a result a fall from height, with multiple drug toxicity (methylamphetamine, alcohol) significantly contributing to death.

12. I accept the conclusions of the forensic pathologist.

Queensland Police Investigation Report

13. I have regard to the investigation report prepared by the Investigating Officer Acting Sergeant J Melandri regarding this death. I have extracted below, relevant aspects of the Form 1 Report of Death to a Coroner:

Investigating Officers opinion regarding cause of incident

14. *Mr McManus has of his own accord approached the falls standing close to the edge without considering the possibility of danger. Mr McManus had not previously attended the site and was unaware of previous tragedies at that location. A lack of local knowledge of the area coupled with the desire to obtain a closer view has led to an increased danger resulting in death*.

15. *The surface on which the deceased had been standing prior to the incident the area was naturally slippery and it was the investigating officer's opinion that Mr McManus did not remain at a safe distance from the falls*.

16. I accept those conclusions.

QPS issues and recommendations by Investigating Officer

17. *There exists only two signs located at the car park / camping area of the falls however despite this, it is the officers belief that despite previous reports of this nature from similar tragedies under similar circumstances there appears to be a lack of adequate signage at the entrance to the walking track leading to the falls. Neither is there any further signage located at the falls itself reminding visitors of the dangers of standing close to fast flowing waters. There exists a plaque erected and viewable along the walking tract dedicated to a past victim (Heike Theil) who also lost her life under similar circumstances in 2013.*

18. *There is no viewing platform to satisfy the curious nor are there barriers to prevent dangerous access the falls. Difficulty exists in building or erecting such barriers at the location as during the wet season such barriers would be subject to flooding and therefore would be submerged and possibly underwater and/or washed away completely due to the force of the flow of water prevalent during this season.*

19. *Being traditional and sacred land, this could also raise sensitive issues as it would increase traffic to the site which holds cultural significance to the traditional owners and elders of the land. To a lesser extent, the environmental impact of erecting viewing platform would also prove a point of contention with regards to this area as it would no doubt be debated by some that it would detract from the beauty of the area.*

20. *However, the investigating officer continues to hold strongly the view that the absence of any telecommunication signal in this area, coupled with the long and arduous journey along the four-wheel drive access only road with the nearest emergency assistance located some great distance from the area, necessitates the presence of, at the very least some kind of safety barrier. In addition to this, further clearly marked and viewable signage to deter tourists, visitors and the like from approaching closely and/or conducting dangerous behaviour likely to cause injury and/or death to any persons is essential*.

21. *Additionally, police communications via radio and cell phone in this area are unavailable. CB signal exists, however only proves useful when traffic exists along the track. For this reason, being the absence of available reliable communication with emergency services in the event of a like incident, it should be made clear by way of additional clear and visible signage that the area is potentially unsafe and visitors must exercise extreme caution.*

22. *Police satellite phone coverage is the only semi-reliable form of communication. However, a lack of mobility of the device due to hard wiring into the police vehicle creates a deficiency in communication requirements necessary during an initial search and subsequent operations be they Search and Rescue, or in this case, retrieval of the deceased. Absence from the vehicle means absence from communication as is also often the case for tourists and visitors to the area.*

23. *For this reason, a remote telephone station such as is present further along the CREB track as provided by Telstra would provide a way of urgent communication. One such station is also provided in a nearby property close to Wujal Wujal. Although such device would not prevent a tragedy from occurring, it would shorten the response time considerably as any person in distress would be able to contact emergency services allowing personnel to be mobilised in a more timely fashion*.

The coronial investigation

24. I personally attended the site and formed a view that the concerns raised by Acting Sergeant Melandri (above) were valid, taking into account his extensive local knowledge and experience. Acting Sergeant Melandri also investigated the 2013 death of tourist Heike Theil in similar circumstances, in the same location.

25. The following concerns arise from my coronial investigation:

- Inadequacy of warning signs regarding the dangers at Roaring Meg Falls;
- Inadequacy of signage alerting visitors to the culturally sensitive nature of the area;
- The lack of communication services (either mobile phone service or access to a satellite phone) sufficiently proximate to the Roaring Meg Falls to provide emergency communication in the event of accident, emergency and rescue and recovery operations; and
- The need to raise public awareness amongst non-indigenous people about cultural issues of significance to the Kuku Yalanji people, including the traditional owners preference for visitors to speak with local police, or traditional owners, prior to attending the site of Roaring Meg Falls.

26. So that proper consideration might be given to addressing these concerns, and issues raised in these findings, I intend to provide a copy of these findings to:

- Douglas Shire Council;
- Department of Environment and Science;
- Telstra Corp;
- Department of Communications;
- Department of Indigenous Affairs (Prime Minister and Cabinet);
- Cape York Land Council;
- Queensland Police Service; and
- Qld Air Services and Medical Rescue (510)

27. I encourage and trust that an interagency collaboration, or roundtable, in consultation with the Kuku Yalanji people, will result in improvements and outcomes that may prevent such deaths from happening again in the future, and / or optimise the emergency response.

28. I encourage the relevant authorities to whom I am providing a copy of these findings, to consult with the traditional owners and the Wujal Wujal community when considering how to:

a) inform non-indigenous visitors of the potential risks when entering into the area of the falls and;
b) raise awareness about the cultural significance of the area, before visitors come on to Kuku Yalanji country.

Acknowledgements

29. To assist my understanding of the local environment and the cultural issues touching on this matter, I was afforded the great privilege of being personally guided onto country by a group of traditional women owners. I take this opportunity to pay my respects to the most senior female Kuku Yalanji elders, Doreen Ball and Kathleen Walker.

30. During my escorted visit I was moved by the reverence the women displayed, for their land, for Mr McManus, for Ms D, for Mr McManus's family, and for the Wujal Wujal police officers including Acting Sergeant Melandri, whom they greatly respect (due to his long service to the community and recovery efforts for two deaths within a period of 4 years at Roaring Meg). This death caused a significant disruption to the community of Wujal Wujal.

31. I thank the Kuku Yalanji elders and traditional owners for providing their consent to publish these findings in the hope that it may raise public awareness about the dangers of walking in and around the Roaring Meg Falls. The Kuku Yalanji desire for the general public to respect the culturally sensitive nature of the area, and the wishes of the traditional owners of the land.

32. In formulating these findings I have been assisted by the comprehensive investigation report prepared by Investigating Officer, Acting Sergeant John Melandri. The report is of the highest quality and he is to be commended for his investigation and the role he played in the recovery of Mr McManus's body.

33. Acting Sergeant Melandri and Sergeant Tome placed themselves in peril when assisting the emergency helicopter crew by lowering to the base of the falls tethered to a tree so as to guide Mr McManus' body to a place in the river where he could be winched by harness to the helicopter overhead.

34. Acting Sergeant Melandri was also instrumental in the search and recovery of Heike Thiel a tourist who fell and from the falls in 2013, also sustaining fatal injuries.

35. Acting Sergeant Melandri's courage and humility is not unnoticed amongst the community of Wujal Wujal where he has served for 7 years. The community conveyed to me their concern for Acting Sergeant Melandri's personal safety when undertaking such high risk recovery operations.

36. Indeed all front line responders, including the Qld Government Rescue 510 helicopter crew are placed at risk when effecting rescue and recovery operations in such circumstances, notwithstanding their great skill.

Conclusions

37. I find there are no suspicious circumstances surrounding the death of Vaughn Ross McManus.

38. I find that Vaughn Ross McManus died from fatal injuries consistent with a fall from height sustained when he accidently slipped and fell at the Roaring Meg Falls whilst under the influence of methylamphetamine and alcohol.

39. I offer my condolences to Ms D who was valiant in her efforts to seek assistance for her fiancée, and in very difficult and unfamiliar terrain and fading light, managed to locate a satellite phone after hiking for over one hour to raise the alarm, all the while knowing Mr McManus was deceased. The tragic events of that day will no doubt change her life forever.

40. I offer my sincerest condolences to the family of Vaughn McManus for their tragic loss. Mr McManus was a much loved son and brother.

41. The McManus family have provided their permission to publish these findings in the hope that the issues as identified herein will raise public awareness and prevent similar deaths from occurring in the future.

42. I do not intend to hold an Inquest into this matter.

43. I direct that these findings be published on the Coroners Court of Queensland website.

44. I close the coronial investigation.

Findings required by s. 45

Identity of the deceased –	Vaughn Ross McManus
How he died –	I find that Vaughn Ross McManus died from fatal injuries consistent with a fall from height sustained when he accidently slipped and fell at the Roaring Meg Falls whilst under the influence of methylamphetamine and alcohol
Place of death –	Roaring Meg Falls, China Camp Road, Dawnvale QLD
Date of death –	1 October 2017
Cause of death –	1(a) Multiple injuries 1(b) Fall from height 2 Multiple drug toxicity (methylamphetamine, alcohol)

Nerida Wilson
Northern Coroner
28 March 2019