IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 6974

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Mr ST
Date of birth:	10 July 1986
Date of death:	21 December 2019
Cause of death:	1(a) Crush injury to the head
Place of death:	190 Palmer Road, Sunbury, Victoria

INTRODUCTION

1. Mr ST was a 33-year-old man who lived in Sunbury with his wife, Mrs DE, and their son at the time of his death.

2. On 21 December 2019, Mr ST suffered fatal injuries while working on a car at home.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr ST's death was reported to the Coroner as it appears to have resulted, directly or indirectly, from an accident or injury, and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

5. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers.

6. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

IDENTITY

7. On 21 December 2019, Mrs DE visually identified her husband, Mr ST, born 10 July 1986.

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

[1] This is 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.

BACKGROUND

9. Mr ST was employed as a service technician and was an avid car enthusiast. He often worked on cars at home and was very safety conscious when it came to his equipment.[2]

10. In her statement to police, Mrs DE commented that her husband only purchased high quality equipment and although she worried about his safety, he had never suffered any injuries while working on his cars.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On the evening of 20 December 2019, Mr ST and Mrs DE stayed overnight at the home of Mrs DE's parents in Bendigo. Between approximately 9.30am and 10.00am on 21 December 2019, Mr ST returned home to work on his Land Rover while his wife remained with her parents.[3] According to Mrs DE, her husband planned to remove the "*whole front of the engine*"[4] in order to "*change the timing belts and work on the turbo*".[5]

12. At approximately 1.00pm, Mrs DE left Bendigo with her son. While driving home, she tried to contact her husband on the phone but he did not answer. Mrs DE arrived home at approximately 3.00pm and as she drove towards the carport, she observed her husband on his back on the ground, his head underneath the right-hand side of the Land Rover. As a trained nurse, Mrs DE formed the opinion that her husband was deceased.[6]

13. Mrs DE immediately contacted emergency services while she drove to the home of her neighbour, Mr KL, arriving at approximately 3.50pm.[7] When she arrived at her neighbour's home, she alerted him, his wife and son, who followed her home to assist.[8] When they arrived back at Mrs DE's home, Mr KL used a nearby hydraulic jack, which was approximately one metre from the car, to lift the car enough to pull Mr ST by his feet out from underneath the car.[9]

14. Mr KL commenced chest compressions, but was unable to find a pulse and Mr ST was cold to the touch. Ambulance Victoria paramedics and Victoria Police members arrived a short

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[2] Coronial brief, Statement of Mrs DE dated 24 January 2020, 2.
[3] Coronial brief, Statement of Mrs DE dated 21 December 2019, 1.
[4] Coronial brief, Statement of Mrs DE dated 24 January 2020, 2.
[5] Coronial brief, Statement of Mrs DE dated 21 December 2019, 1.
[6] Coronial brief, Statement of Mrs DE dated 30 January 2020, 1.
[7] Coronial brief, Statement of Mr KL dated 21 December 2019, .
[8] Coronial brief, Statement of Mrs DE dated 30 January 2020, 2.
[9] Coronial brief, Statement of Mr KL dated 21 December 2019, 1.

time later. Paramedics were unable to find signs of life and declared Mr ST deceased at 4.07pm.[10]

15. Responding police members inspected the car and equipment and observed that a jack stand with 3000kg capacity was lying on its side underneath the chassis.[11] The car's bonnet was open and various engine parts were laying on the ground next to the vehicle, along with several tools.[12] The front driver's wheel had also been removed and was resting on the ground nearby.[13]

16. On closer inspection of the jack stand, police members observed dirt marks upon two of its four feet, which indicated the jack had "*sunk into the dirt*", causing it to buckle under the weight of the car. Police members ultimately considered the "*unsuitable*" ground surface upon which the car was placed on the jack contributed to the accident. Police members observed warning labels upon the jack stand that outlined the safety precautions to be taken when in use. A prominent warning cautioned that the jack stand should only be used in pairs and on "*hard level surfaces (e.g. concrete)*".

17. Victoria Police did not identify any suspicious circumstances or third party involvement as part of their investigation.[14]

CAUSE OF DEATH

18. On 23 December 2019, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 27 December 2019. In that report, Dr Baber concluded that a reasonable cause of death was '*Crush injury to the head*'.

19. Dr Baber consulted a post-mortem computed tomography (CT) scan, which revealed a traumatic crush fracture in the form of a "*depressed right temporoparietal skull fracture*".

20. Toxicological analysis identified the presence of dextromethorphan,[15] but did not detect alcohol or other common drugs or poisons.

21. I accept Dr Baber's opinion as to cause of death.

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[10] Coronial brief, Appendices, Verification of Death Form.
[11] Coronial brief, Statement of Leading Senior Constable Raelene Conway dated 27 January 2020, 1.
[12] Coronial brief, Statement of Acting Detective Sergeant Glenn Palmer dated 22 December 2019, 2.
[13] Coronial brief, Statement of Senior Constable David Attard dated 30 January 2020, 2.
[14] Coronial brief, Statement of Acting Detective Sergeant Glenn Palmer dated 22 December 2019, 3.
[15] Methorphan is a synthetic analogue of codeine available as dextromethorphan, used in cough syrups, tablets, and capsules for its anti-tussive effects.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

22. The tragic accident which resulted in Mr ST's death demonstrates the ongoing need for ensuring vigilance and safety when undertaking mechanical work in a residential setting, particularly without the assistance of another person.

23. As part of my investigation, I requested information about Victorian deaths occurring in similar circumstances between 2014 and 2019.

24. Data from the National Coronial Information Centre identified 11 people, including Mr ST, who died after being crushed whilst performing maintenance under a vehicle. The deceased included 10 males and one female, ranging in age from 21 to 80. Three had used ramps to raise the vehicle, two had used jacks, and one had used a brick or stand in association with other mechanisms to raise the vehicle. In six deaths, the incidents occurred at home and the cause of death involved a crushing injury or asphyxiation.

25. This Court has made several comments and recommendations with the aim of reducing the number of preventable deaths resulting from crush injuries in the setting of do-it-yourself vehicle maintenance/repairs.

26. In September 2016, following the recommendation of Coroner Audrey Jamieson,[16] the Australian Competition and Consumer Commission (ACCC) undertook to review the effectiveness of its 2011 campaign through Product Safety Australia that focused on DIY vehicle safety, and considered further activities to highlight its campaign.

27. The resources involved in the campaign included an informative flyer, a short safety film on YouTube, postcards, and a competition which encouraged the sharing of safety information. Her Honour also recommended that WorkSafe Victoria evaluate its role in raising awareness of important safety precautions for people engaging in DIY motor vehicle repairs.

[16] *Finding into death without inquest into the death of Lloyd Douglas Hill*, dated 12 September 2016.

28. In November 2018, Coroner Michelle Hodgson made recommendations in connection with a death in similar circumstances.[17] Her Honour noted that the rate of deaths in the setting of DIY vehicle maintenance had reduced since the launch of the 2011 campaign, but that deaths in these circumstances were continuing to occur.

29. Her Honour recommended that the ACCC undertake a further review of its campaign, particularly the 'Safe Summer' campaign throughout the summer of 2016 and 2017. In collaboration with WorkSafe Victoria, this campaign amplified the message of DIY vehicle safety via workplace safety channels, and a new brochure/factsheet was generated for distribution.

30. Her Honour also made a recommendation that WorkSafe Victoria review its continuing role with the ACCC in raising awareness of DIY vehicle safety and associated safety precautions.

31. In response to Her Honour's recommendations, WorkSafe acknowledged its ongoing involvement with the ACCC's campaigns on this topic, and that WorkSafe social media channels would be utilised to promote messages of safety precautions.

32. In its response, the ACCC noted its 2018 'Safe Summer' campaign which ran from 10 to 21 December 2018 involved the '*publication of a unique web page as well as a range of supporting social media posts*'. The social media posts reportedly focused on specific vehicle jacks and support stands.

33. Mr ST's death is not only a tragic example of the dangers involved in DIY vehicle repairs and maintenance, but his death was preventable. I note that a relevant factor for consideration is the ultimate responsibility of the equipment user to ensure safe use. The investigation has not revealed precisely how the jack supporting Mr ST's vehicle ultimately failed however it appears it was used on an unstable or unsuitable surface.

[17] *Finding into death without inquest into the death of Timothy Aghan*, dated 5 November 2018.

Recommendations

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

34. With the aim of preventing injuries and deaths in similar circumstances, I recommend that the ACCC consider renewing its national 'Safe Summer' campaign with a view to including DIY motor vehicle repairs and maintenance, and review its strategies for disseminating information involved in the campaign.

35. I also recommend that WorkSafe Victoria consider once again collaborating with the ACCC in its campaign to promote safety precautions for DIY vehicle maintenance.

FINDINGS AND CONCLUSION

36. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Mr ST, born 10 July 1986, died on 21 December 2019 at 190 Palmer Road, Sunbury, Victoria, from a crush injury to the head in the circumstances described above.

37. I convey my sincere condolences to Mr ST's family for their loss.

38. I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

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

Mrs DE, senior next of kin.

Senior Constable David Attard, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 18 September 2020