IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003523

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Maurice Wayne Matthews
Date of birth:	23 October 1950
Date of death:	05 July 2021
Cause of death:	1(a) Mechanical asphyxia from being crushed under car
Place of death:	861 Macclesfield Road, Yellingbo, Victoria, 3139

INTRODUCTION

1. On 05 July 2021, Maurice Wayne Matthews was 70 years old when he died while working on a vehicle. At the time of his death, Maurice lived in The Patch with his wife, Heather.

2. Maurice and Heather had been married for 26 years. He was a much-loved father, step-father to Heather's children, and grandfather.[1]

3. Maurice loved to travel, have dinner with his family and help those around him. His friends and family were his life and he would lend a hand to anyone; he was always approachable and willing to assist. He was always happy, and a pleasure to be around.[2]

4. Maurice was a retired diesel mechanic with a wealth of experience in the field, having worked in mechanics all his life. He was 'extremely handy', often fixing vehicle mechanical issues or things around the home. He was described as a 'jack of all trades'. He was extremely cautious, took the utmost care while working and did not take shortcuts.[3]

5. Maurice's medical history included coronary artery disease for which he had a coronary artery bypass graft in 2017, glaucoma and obstructive sleep apnoea. He reported depression in 2018 for which he was prescribed sertraline to good effect.[4] He was otherwise very fit and healthy.[5]

THE CORONIAL INVESTIGATION

6. Maurice'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.

7. 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.

[1] CB, Statement of Heather Matthews, dated 21 January 2022.
[2] CB, Statement of Heather Matthews, dated 21 January 2022; Statement of Peter Sanders, dated 30 December 2021.
[3] Ibid.
[4] CB, Statement of Dr Alexandra Romete, dated 21 January 2022.
[5] CB, Statement of Heather Matthews, dated 21 January 2022.

8. 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Maurice's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Maurice Wayne Matthews including evidence contained in the coronial brief. Whilst 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.[6]

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

Circumstances in which the death occurred

11. At around 9am on 5 July 2021, Maurice attended at his step-son Peter and daughter-in-law Jenny's house to work on a vehicle Peter owned. At around 11am, Jenny spoke to Maurice who was working underneath the vehicle. He told Jenny he was okay and was his 'normal, happy self'. Jenny then left to go shopping.[7]

12. At around 3pm, Jenny returned and checked on Maurice. He did not respond when she yelled his name, so she grabbed his leg. When he did not respond, she ran to her neighbours who were standing at the fence and called emergency services.[8]

13. Emergency services arrived at the scene shortly thereafter, though sadly Maurice was unable to be revived.

14. Police observed a rope tied from the front bull bar of the vehicle to the nearby carport post. A jack appeared to have been set up at the pinch points on the right side of the vehicle. The

[6] 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.
[7] CB, Statement of Jenny Sanders, dated 7 January 2022.
[8] Ibid.

carport was on a rocky and sloped section of the ground, and the jack was now leaning slightly to the right on an uneven section of gravel, causing the front of the vehicle to dip downwards.[9]

15. Initial enquiries determined that the jack had become unstable on the rocky and sloped terrain and slid, causing the front of the vehicle to shift.[10]

Identity of the deceased

16. On 5 July 2021, Maurice Wayne Matthews, born 23 October 1950, was visually identified by his daughter-in-law, Jennifer Sanders, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Brian David Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Maurice Matthews on 6 July 2021. Dr Beer reviewed the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of his findings dated 27 July 2021.

19. The external examination was unremarkable, with findings in keeping with the clinical history and known circumstances. The CT scan showed buckle rib fractures indicative of anterior compressive force.

20. Toxicological analysis of post mortem blood samples identified the presence of sertraline (~ 0.1mg/L) and metoprolol (~ 0.4mg/L).

21. Dr Beer provided an opinion that the medical cause of death was 1 (a) MECHANICAL ASPHYXIA FROM BEING CRUSHED UNDER CAR.

FURTHER INVESTIGATION

22. With a view to identifying pertinent prevention opportunities, I asked the Coroners Prevention Unit (**CPU**) [11] to provide me with data on deaths occurring in similar circumstances, that is, during the course of working underneath a vehicle.

[9] CB, Statement of Acting Sergeant Gavin Rhodes, dated 29 January 2022.
[10] Ibid.
[11] 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.

23. The CPU identified 25 deaths in Victoria between 1 January 2010 and 12 October 2021, where the deceased was working under a vehicle and the mechanism used to raise the vehicle failed, causing them to be crushed. All deceased were male, with their ages ranging from 18 to 75.

24. Victorian Coroners have made a number of comments and recommendations aimed at reducing preventable deaths resulting from at-home vehicle maintenance. Most recently, Coroner Caitlin English (as she then was), made recommendations in connection with the death of Daniel Mladenoski[12], who died after the vehicle he was working beneath fell on him. Investigating officers considered the unsuitable ground surface upon which the car was placed on the jack contributed to the accident.

25. Her Honour made the following recommendations:

    i. 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.

    ii. I also recommend that WorkSafe Victoria once again considered collaborating with the ACCC in its campaigns to promote safety precautions for DIY vehicle maintenance.

26. Whilst Maurice was a retired diesel mechanic and therefore had the appropriate technical knowledge to repair a vehicle, the fact remains that doing so at home is an inherently dangerous activity that carries the risk of death, and these preventable deaths continue to occur. As such, I will make similar recommendations to those noted above.

RECOMMENDATIONS

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

(i) With the aim of preventing like deaths and promoting public health and safety, I recommend that the ACCC consider renewing or creating a new educational campaign focussing on the safety in DIY motor vehicle maintenance and repairs.

The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[12] COR 2019 006974, *Finding into death without Inquest,* dated 18 September 2020.

(ii) With the aim of preventing like deaths and promoting public health and safety, I recommend that WorkSafe Victoria consider again collaborating with the ACCC in its campaigns to promote safe DIY vehicle maintenance.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Maurice Wayne Matthews, born 23 October 1950;

   b) the death occurred on 05 July 2021 at 861 Macclesfield Road, Yellingbo, Victoria, 3139;

   c) I accept and adopt the medical cause of death as ascribed by Dr Brian David Beer and I find that Maurice Wayne Matthews died from mechanical asphyxia due to being crushed by a vehicle he was working beneath, in circumstances where I find his death was preventable.

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

Pursuant to section 73(1B) 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:

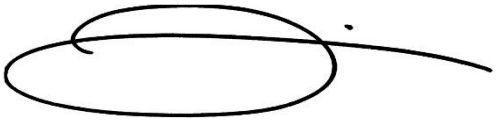
Heather Matthews, Senior Next of Kin

Australian Competition and Consumer Commission

WorkSafe Victoria

Senior Constable Daniel Ryan, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 6 March 2024

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.