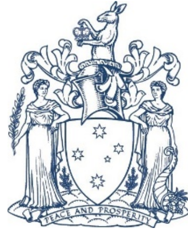

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001502

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	PXO[1]
Date of birth:	1970
Date of death:	16 March 2020
Cause of death:	1(a) Complications of a right superficial femoral artery injury (operated) following a workplace incident
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052

[1] 1 This finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with pseudonyms of randomly generated three letter sequences to protect their identity and to redact identifying information.

INTRODUCTION

1. On 16 March 2020, PXO was 49 years old when he died at the Royal Melbourne Hospital (**RMH**) in Parkville as a result of injuries sustained at a worksite. At the time of his death, PXO lived at an address in Craigieburn, with his family.

2. PXO immigrated from India to Australia in 2016 with his wife, son, and daughter. He was in good health, did not smoke, and played competitive hockey. He had an active social life, and his family was very important to him.[2] PXO's son, OSP, worked for a landscaping company called "Northern Traders" (**NT**), which was owned by XCY. SCE also worked for the company. [3]

THE CORONIAL INVESTIGATION

3. PXO'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.

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. 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.

6. The death of PXO was investigated by the Victorian WorkCover Authority (**WorkSafe**) who compiled a brief of evidence pending the filing of possible offences against parties involved in this matter.[4] This brief was provided to this court and was instrumental in the completion of this finding. I note that WorkSafe did not commence a prosecution against any party in relation to PXO's death due to insufficient evidence.

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[2] WorkSafe Brief, statement of OSP, dated 8 April 2020, page 5.
[3] WorkSafe Brief, statement of OSP dated 8 April 2020, page 1.
[4] Contravention of the *Occupational Health and Safety Act 2004* (Vic), ss 21(1), (2)(a), and (2)(e).

7. This finding draws on the totality of the coronial investigation into the death of PXO including evidence contained in the WorkSafe 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.[5]

8. In considering the issues associated with this finding, I have been mindful of PXO's basic human rights to dignity and wellbeing, as espoused in the Charter of Human Rights and Responsibilities Act 2006, in particular sections 8, 9 and 10.

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

Identity of the deceased

9. On 16 March 2020, PXO, born 1970, was visually identified by his son, OSP.

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

Medical cause of death

11. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 18 March 2020 and provided a written report of her findings dated 25 March 2020.

12. The post-mortem examination revealed a recent incision on the lower abdomen and a large injury on the right upper thigh/groin region showing evidence of medical intervention.

13. Post-mortem computed tomography (**CT**) scans indicated cerebral oedema with mesenteric and lower abdominal wall haemorrhage, an open right groin wound, and bilateral pleural effusions.

14. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

15. Dr Francis provided an opinion that the medical cause of death was '1 (a) Complications of a right superficial femoral artery injury (operated) following a workplace incident'.

[5] 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.

16. I accept Dr Francis' opinion.

Circumstances in which the death occurred

17. In early March 2020, OSP approached XCY and told him that PXO was interested in doing some work. OSP explained that his father was not a qualified carpenter, but that he done some carpentry work in India and had experience in using power tools. During his initial interview with XCY, PXO was told work he would be doing and was verbally instructed in the safe handling of power tools but was instructed not to use them, including the circular saws.[6] PXO was then employed by XCY as a labourer, and began working for NT on about 12 March 2020.[7]

18. NT's work mainly comprised putting in posts and sleepers for garden beds. This involved cutting posts and sleepers to size using a bench saw before cementing them into holes in the ground. Occasionally, the posts would be cut where they had been placed into the ground. Once the posts had been cemented into the ground, a cut was made near the top of the post to indicate where a second sleeper would sit. The top of the post would then be removed using either a Makita battery or cord-powered circular saw.[8]

19. The equipment used at the jobs was supplied by NT.[9] XCY would inspect the equipment used at the jobs himself and kept a supply of spare tools available should equipment be found to be not working correctly.[10]

20. XCY demonstrated to OSP how to use the two saws[11] and ensured that OSP and SCE were proficient in the use of the battery circular saw[12] however XCY instructed OSP not to use the saws whilst he was not at the worksite.[13] OSP stated that XCY gave him verbal instructions at the worksites regarding the job and safety requirements. OSP stated that PXO was told about safety equipment by XCY however he was only present at the sites to assist in retrieving tools and measurements.[14]

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[6] WorkSafe Brief, statement of OSP dated 18 June 2020, page 3.
[7] WorkSafe Brief, statement of OSP dated 18 June 2020, page 3.
[8] WorkSafe Brief, statement of SCE dated 17 March 2020, page 2.
[9] WorkSafe Brief, statement of OSP dated 8 April 2020, page 2.
[10] WorkSafe Brief, statement of OSP dated 20 April 2020, page 1.
[11] WorkSafe Brief, statement of OSP dated 8 April 2020, page 3.
[12] WorkSafe Brief, statement of SCE dated 17 March 2020, page 3.
[13] WorkSafe Brief, statement of OSP dated 8 April 2020, page 2.
[14] WorkSafe Brief, statement of OSP dated 8 April 2020, page 2.

21. On 13 March 2020, NT was contracted to a job in Cobblebank to construct a garden wall. The day passed uneventfully, and the crew planned to return on Monday to complete the job.[15]

22. On 16 March 2020 at about 9.30am, OSP, SCE, and PXO returned to the worksite to complete the wall. XCY planned to attend later that day after retrieving supplies. OSP observed PXO plugging in the electric circular saws and told him not to use it; OSP stated that when he turned around, he heard the saw operating and saw his father cutting into one of the posts. OSP repeated to PXO that he was not to use the saw; his father was adamant that he could do so but eventually stopped.[16]

23. OSP began walking back to his truck however he heard shouting and turned back around to see PXO "jumping on one leg and blood coming from the other leg".[17] OSP told his father to lie down and contacted emergency services before attempting to use his jumper as a tourniquet on PXO's right leg. PXO rapidly became unresponsive, and OSP and SCE began performing cardiopulmonary resuscitation on him.[18]

24. Ambulance Victoria paramedics attended the scene and found PXO to be in cardiac arrest. They applied a tourniquet, packed the wound with a haemostatic dressing, and applied direct pressure to staunch the bleeding. Return of spontaneous circulation (**ROSC**) was achieved at 10.40am. [19]

25. PXO was intubated at the scene and transported to RMH via helicopter. Enroute, he received packed red blood cells (**RBC**) and adrenaline, however he suffered a further cardiac arrest with ROSC achieved again at 11.10am.[20]

26. PXO arrived at RMH at 11.46am and was transferred to the operating theatre where he underwent extra-peritoneal external iliac vessels control, right superficial femoral artery ligation, and a wound washout. He was given further RBC and required an ongoing adrenaline infusion. Other intraoperative issues included metabolic acidosis and coagulopathy.[21]

[15] WorkSafe Brief, statement of OSP dated 8 April 2020, page 3.
[16] WorkSafe Brief, statement of OSP dated 8 April 2020, page 4.
[17] WorkSafe Brief, statement of OSP dated 8 April 2020, page 4.
[18] WorkSafe Brief, statement of OSP dated 8 April 2020, page 4.
[19] The Northern Hospital E-Medical Deposition Form dated 16 March 2020.
[20] The Northern Hospital E-Medical Deposition Form dated 16 March 2020.
[21] The Northern Hospital E-Medical Deposition Form dated 16 March 2020.

27. Following the operation, PXO was moved for a CT scan however his blood pressure dropped, and he developed a distended abdomen. He was transferred to the Intensive Care Unit (**ICU**) where his hypotension was treated with adrenaline and metaraminal.[22] PXO then developed further bleeding and was given additional RBC and inotropic therapy.[23]

28. PXO's brain CT indicated cerebral ischaemia and early loss of grey-white matter differentiation. His abdominal CT showed signs of a possible intra- and extra-peritoneal haematoma and ongoing haemorrhage, likely due to ongoing coagulopathy. The initial plan was for PXO to be returned to theatre for packing and temporary abdominal closure as staff were unable to confirm the suspected futility of resuscitation.[24]

29. Despite aggressive inotropic therapy and volume replacement however, PXO progressively deteriorated during his time in the ICU with persistent hypotension, metabolic acidosis, coagulopathy, and a subsequent large rectal bleed.[25]

30. A consultation was held between consultants from ICU, Trauma, and Vascular Surgery who agreed that, given PXO's prolonged out-of-hospital cardiac arrest, likely hypoxic brain injury, ongoing coagulopathy, peritoneal and gastrointestinal haemorrhage, and multi-organ failure, resuscitation was likely to be futile.[26]

31. A meeting was held with PXO's family where it was explained that he had likely suffered a brain injury which was exacerbated by the ongoing hypotension. Attempts to maintain PXO's status until his wife arrived were unsuccessful, and he passed away at 5.55pm.[27]

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[22] A vasoconstricting medication used to treat hypotension.
[23] The Northern Hospital E-Medical Deposition Form dated 16 March 2020.
[24] The Northern Hospital E-Medical Deposition Form dated 16 March 2020.
[25] The Northern Hospital E-Medical Deposition Form dated 16 March 2020.
[26] The Northern Hospital E-Medical Deposition Form dated 16 March 2020.
[27] The Northern Hospital E-Medical Deposition Form dated 16 March 2020.

WorkSafe Investigation

32. On 16 March 2020 at about 11.45am, WorkSafe Inspectors Abir Elamin and Duncan Hefter attended the incident scene. Inspector Elamin made several observations, including that XCY had not completed any Safe Work Method Statements prior to the crew beginning works and that PXO had not been trained and was not supposed to be handling the power tools. XCY told the Inspectors that new employees are verbally informed of the tasks and that he had demonstrated to PXO how to use the tools required at the job.[28]

33. As a result of his observations and discussions, Inspector Elamin issued three Improvement Notices, including:

    a) NT must provide instruction and training to employees as is necessary when undertaking landscaping works to enable employees to perform their work in a manner that is safe and without risks to health, including through developing documentation for new and existing employees;

    b) NT must provide instruction and training to employees as is necessary on the safe operation of the Makita electrical power saw to enable employees to perform their work in a manner that is safe and without risks to health; and

    c) NT must provide a safe system of work in association with undertaking landscaping works, including undertaking site-specific hazard identification and relevant risk assessments, and to implement relevant control measures.[29]

34. On 8 May 2020, Inspector Elamin conducted a follow up with XCY regarding the Improvement Notices issued on 16 March, during which XCY provided evidence that he had developed procedures and documentation in compliance with the Notices.[30]

35. The electrical circular saw used by PXO at the time of the incident was sent to Makita Australia for examination. The saw was inspected by Steven Draper, National Service Manager for Makita Australia, identified several issues at the time, including:

[28] WorkSafe Brief, statement of Abir Elamin dated 2 June 2020, page 1-3.
[29] WorkSafe Brief, statement of Abir Elamin dated 2 June 2020, page 3-4.
[30] WorkSafe Brief, statement of Abir Elamin dated 2 June 2020, page 5-6.

a) A missing bevel lock bolt and wing nut potentially allowing movement of the blade inside cut;

b) Safety lock off button defeated by a piece of timber stuck in buttonhole, holding the lock off button in position; and

c) Lower Safety Guard not retracting due to jamming of spring on bearing box casting.[31]

36. In his statement of 18 June 2020, OSP stated that the piece of timber identified in the safety lock off button was not present when he used the saw the previous day, and that the button was working correctly.

37. OSP further stated that on the day of the incident, all power tools used by the crew were working correctly, including the retractable safety guards.[32] During an interview with WorkSafe Inspector Michael O'Grady, XCY attested to the fact that he had checked the power tools that morning and had not identified any issues.[33]

38. Extracts from the Owner's Manual relating to the electrical Makita circular saw used by PXO at the time of his death indicate that a pinched, jammed, or misaligned saw blade may result in "kickback", whereby the saw lifts up out of the workpiece and "jumps" back towards the operator, with the potential to harm the operator should such an issue occur.[34]

39. Photos of the cuts performed by PXO immediately prior to the incident and provided by WorkSafe were examined by Philip Blunden, National Accessory & Technical Training Manager for Makita, who noted that it was likely that PXO experienced kickback whilst attempting to change the direction of the saw during the second cut.[35] It is reasonable to conclude that this resulted in the injury to PXO's leg.

[31] WorkSafe Brief, statement of Steven Draper dated 14 April 2020, pages 1-2.
[32] WorkSafe Brief, statement of OSP dated 18 June 2020, pages 5-6.
[33] WorkSafe Brief, record of Interview between WorkSafe Inspector Michael O'Grady and XCY, dated 10 November 2020, page 36.
[34] WorkSafe Brief, statement of Philip Blunden dated 7 April 2020, page 2.
[35] WorkSafe Brief, statement of Philip Blunden dated 7 April 2020, page 4.

COMMENT

40. Having considered all of the evidence, I am satisfied that NT's compliance with the WorkSafe improvement notices indicates that they have taken appropriate action to prevent a similar death from occurring in the future. I am also satisfied that XCY has undertaken appropriate measures to prevent future deaths.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was PXO, born 1970;

    b) the death occurred on 16 March 2020 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052, from complications of a right superficial femoral artery injury (operated) following a workplace incident; and

    c) the death occurred in the circumstances described above.

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

Pursuant to section 73(1A) 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:

TZZ, Senior Next of Kin

Michael O'Grady, WorkSafe

First Constable D. Meredith, Victoria Police, Reporting Member

Signature:

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CORONER SIMON McGREGOR

CORONER

Date: 5 May 2022

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.