CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 5th, 6th and 7th days of November 2012 and the 14th day of May 2013, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Sophie Ann Schulz.

The said Court finds that Sophie Ann Schulz aged 18 months, late of 18 Golden Way, Nuriootpa, South Australia died at Fravira Clinic, 431 Magill Road, St Morris, South Australia on the 17th day of June 2009 as a result of head injuries. The said Court finds that the circumstances of her death were as follows:

1. Cause of death and reason for Inquest

1.1. Sophie Ann Schulz who was born on 6 December 2007 and was therefore 18 months of age when she died on Wednesday 17 June 2009, was accidentally killed when she was trapped in the hydraulic mechanism of a massage table as the table was being lowered.

1.2. A post-mortem examination was conducted in respect of Sophie by Dr Neil Langlois who is a forensic pathologist at Forensic Science South Australia. In his post-mortem report[1] Dr Langlois describes Sophie's cause of death as head injuries. I do not need to set out Dr Langlois' findings in detail except to say that in his opinion the injuries were compatible with a crush type force. The other salient feature of Dr Langlois' findings is that in his opinion death occurred instantly which I take to mean that there was no period of survival following the crushing application of force to Sophie's head. This is significant for a number of reasons, not the least of which is that Sophie did not suffer notwithstanding that it took some little time for her head to be freed

[1] Exhibit C3a

from the mechanism in question; efforts to free the child's head were hampered because the massage table could not be raised once the child's head had become trapped in the lowering and raising mechanism. Thus the inability to raise the massage table and free the child's head immediately upon its entrapment, a circumstance that would not have been foreseeable, did not in any way contribute to Sophie's death. I add here that the reason for that failure was not identified in the evidence with complete clarity.

1.3. I accept Dr Langlois' evidence in its entirety. I find that the cause of Sophie's death was head injuries. I find that the injuries were due to a crushing force. I find that Sophie died instantly upon the application of that force.

1.4. Sophie's death occurred at the Fravira Clinic (the clinic) at St Morris. The clinic provides a number of health related services including massage. Sophie's mother, Mrs Justine Schulz, had undergone a massage at the hands of one of the clinic's therapists. The massage had taken place on the massage table in question. During the course of this massage Mrs Schulz's children, Sophie and her son Regan who was 4 years of age at the time, were present in the room and playing. No person who had the sole task of directly supervising the two children was in the room. When the table was lowered by the therapist, Sophie's head was trapped in the moving mechanism beneath the table. At some point she had moved to a position under the table and had done so unnoticed. In the course of her mother's evidence at Inquest, Sophie was described as a busy, very curious and very playful little girl who enjoyed interacting with her older brother. She enjoyed exploring the world and playing. She was already very mobile. She could climb up onto things such as a chair or a table. She had been walking since just before her first birthday. She could run without tripping. She could move quite quickly on her feet. The post-mortem report reveals that Sophie's weight was within the 75th to 90th percentile and her height was in the 90th percentile. She therefore appears to have been a relatively large child for her age. On the day in question there was nothing out of the ordinary about Sophie's activity and demeanour. It was all in keeping with that to be expected of an active toddler.

1.5. In this Inquest I examined the circumstances in which Sophie came to be trapped within the moving mechanism of the massage table as it was being lowered by the massage therapist towards the end of her mother's therapy. I also examined the issue as to whether this event could and should have been prevented. I also examined the issue as to how such an event might be prevented in the future.

2. The Fravira Clinic

2.1. The clinic is situated at 431 Magill Road, St Morris. It has been at that location for 20 years. The proprietor of the clinic is Ms Elvira Brunt who describes herself as a 'circulatory specialist'. Ms Brunt gave evidence in the Inquest. She told the Court that the general field of endeavour in which she specialised was medicine[2]. Ms Brunt stated that she had a medical degree which had been conferred upon her in what used to be Yugoslavia. She undertook her internship in Adelaide. She told the Court that the Australian authorities did not recognise her specialisation and so she was not allowed to display her qualifications. She has never practised as a medical practitioner in the strict sense[3]. I am not completely certain as to the nature of the therapy that Ms Brunt performs except that in her witness statement[4] she describes it as *'redirecting blood flow through manipulative massage of the stomach area'*. Conventional massage therapy is provided by a number of therapists at the clinic. Ms Brunt personally provides the more specialised form of massage. The clinic has a number of treatment rooms in which there are massage tables. One of those rooms is described as an 'emergency room'. It has one massage table in it. There is also storage in the room for various items including toys. The room is situated opposite a reception area and office. The room space is open at one end. The open end of the room is separated from the reception area by a partition. The evidence is that there was no line of sight available from the reception area or from the office to the location within the emergency room at which the massage table was situated. It was in this room that Sophie Schulz died.

2.2. Among the services provided by the clinic was a full body massage performed by one of the massage therapists followed by a stomach manipulation performed by Ms Brunt herself. Ms Brunt would not usually be present for the conventional component of this therapy but would be called in at the conclusion of the massage to perform her own therapy. For this purpose the massage table that had originally been set at a height that was suitable for the purposes of the conventional massage would be lowered by the therapist to a level that was more suited to Ms Brunt's particular therapy. The patient would remain on the table as it was being lowered. I shall describe the massage table in more detail presently.

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[2] Transcript, page 240
[3] Transcript, page 241
[4] Exhibit C25

2.3. The evidence would suggest that the business of the clinic was brisk. Although patient appointments were made, it was uncommon for appointments to run on time with the result that on occasions patients would be required to wait for extended periods. This uncertainty appears to have had the consequence that patients would bring their children, sometimes toddlers, to the clinic. In her evidence Ms Brunt eschewed the suggestion that small children were encouraged to be brought to the clinic. She gave the Court the distinct impression that she would have much preferred it if children did not attend[5]. However, it is clear that the presence of small children at the clinic was at the very least tolerated to the point where a culture developed that while a patient's massage was taking place, the patient's child or children would be looked after by another waiting patient. As well, staff at reception could keep an eye on children who were in the emergency room while a parent's massage was there taking place, although as seen earlier, there was no direct line of sight between the reception area to the massage table within that room. As a measure of the tolerance if not encouragement in respect of the presence of children at the clinic, there was a dedicated 'kid's room' as depicted on a floor plan of the clinic[6]. In addition, toys were made available for children and some of these were stored in cupboards in the emergency room. In any event on the occasion in question there was no restriction on the presence of Mrs Schulz's two children in the emergency room while her therapy was taking place.

3. <u>The massage table</u>

3.1. The table in question is an Athlegen Powerlift massage table. The table is Australian designed and manufactured by Athlegen Pty Limited. The massage table incorporates twin parallel lifting arms that achieve constant horizontal positioning of the tabletop regardless of the set height. An electric linear actuator provides the lift power. Operation of the table is through a floor mounted pneumatic rocker pedal that is activated by the operator's foot. The rocker pedal works on the principle of a billow expanding or compressing to produce corresponding vacuum or pressure in a pneumatic hose. The pedal must be held pressed for the duration of any desired table height adjustment either up or down. The connection at the operative end of the pneumatic hose is to a pressure sensitive electric switch mounted internally within the

[5] Transcript, pages 260-261
[6] Exhibit C18d

linear actuating casing. It is possible for the pneumatic hose and the switch to become disconnected thereby rendering the foot pedal inoperative.

3.2. During the process of lowering the massage table, a gap that exists between the metal underside of the tabletop and the uppermost of the metal struts that lift the table, becomes progressively compressed. At the table's highest point the gap would be wide enough to admit a person's head. At its lowest point there is no gap as the metal components sit flush. It is within this gap that Sophie Schulz's head became entrapped resulting in the fatal crushing injuries. During the process of lowering the table, the forces exerted are considerable. In the opinion of a chartered engineer, an experiment that was conducted following these events and in which a ball was placed in the relevant gap demonstrated that the force involved would be sufficient to crack a human skull[7]. A different question, of course, is whether these forces would have been obvious to the lay operator.

3.3. Ms Brunt told the Court that the width of the tabletops supplied to her clinic were wider than standard. One of the reasons, if not the principal reason for this, was to prevent patients hands and arms dangling over the side of the table during therapy and to prevent a person's limb from becoming entrapped in the table's lowering mechanism. The extra width of the table ensured that the patient's arms could be adequately accommodated on the table alongside the patient's upper body. It was thus foreseeable, and indeed foreseen, that the lowering of the table could have potentially dangerous consequences if a person's body part became entrapped in the lowering mechanism.

3.4. The working mechanism of the massage table was exposed to view. There were no covers or guards preventing access to or sight of the working mechanism.

3.5. Situated on the working mechanism was a small plate that bore in capital letters the word 'CAUTION', and among other things warned a person to 'keep clear of moving parts when operating table'. It has to be said that this plate was not of a significant size, nor situated in a prominent and inevitably seen location on the mechanism.

3.6. The table came with a manual in which there was a section entitled "D. Safety Reminders". Under this heading it was stated "1. Your table has a number of moving

[7] Evidence of Mr Kenneth Sumpter, Transcript, page 164

parts. Do not make adjustments to your table without making sure your client is clear of all moving parts".

3.7. Regardless of the existence of the warning plate and manual, no reasonable adult who had seen the mechanism of the table in operation could have failed to be impressed by the potential danger presented by that mechanism.

4. The circumstances of Sophie Schulz's death

4.1. Sophie's mother, Justine Schulz, had been a patient of the clinic since approximately 1996. Mrs Schulz gave evidence in the Inquest. She told the Court that she attended at the clinic perhaps four times per year on average. There was no particular ailment for which Mrs Schulz sought treatment at the clinic, but she attended for massage therapy and alternate therapy.

4.2. On the day in question Mrs Schulz had an appointment for 10:45am. She arrived at about that time with her children Sophie and Regan. She waited a little over an hour for her appointment. The appointment was carried out in the emergency room. Mrs Schulz and her children waited there for approximately 15 minutes before the therapist entered the room. On this occasion the therapist was Ms Mira Maric who was a masseur at the clinic. Ms Maric had been employed at the clinic in that capacity for about 11 years. She had obtained a qualification as a masseur through a TAFE course. As explained in Ms Maric's statement[8] she usually massaged people for about half an hour before Ms Brunt, whom she described as the 'Circulatory Specialist', entered the room and took over. Ms Maric's statement suggests that the emergency room was selected for Mrs Schulz's therapy because the room contained toys for her two children to play with. One of those toys was a 'Magna Doodle'. Mrs Schulz explained that they had one of these at home which belonged to Regan. Sophie had shown a particular interest in Regan's toy, and during the course of the massage she was playing with the one that was available at the clinic.

4.3. Other than Mrs Schulz, Ms Maric and the two children, no person was within the room during the course of the massage. Specifically, there was no person present whose task it was to supervise the children or their activities. Of course, Ms Maric

[8] Exhibit C22

had sight of the children and would have had a better view of them than Mrs Schulz who was lying on the table at all material times.

4.4. It was customary for patients of the clinic to bring a sheet and towel. The sheet was draped over the massage table before the commencement of the massage. How far such a sheet would drape over the sides of the table at its highest level would obviously depend on the size of the sheet, but it is not inconceivable that the space under the covered table may have constituted an inviting and interesting place for a small child to climb into. Mrs Schulz told the Court that she brought with her a single bed sheet that would hang part of the way down on either side.

4.5. Mrs Schulz told the Court that during the massage she could see her children 'to a certain extent'[9] but that the main contact that she had with her children was verbal. The first part of the treatment involved Mrs Schulz's lying on her stomach. After a period of time she turned over to lie on her back. For part of that time she was therefore looking at the ceiling but from time to time she would focus her attention on Regan or Sophie and would talk to make sure they were playing nicely. Sophie was playing with the Magna Doodle and Mrs Schulz would occasionally look up and visibly see them playing on the floor at the end of the room nearest the partition. On several occasions she spoke to Regan and asked whether he and his sister were alright. Mrs Schulz recalled that she was having a conversation with the therapist about the toy and the fact that it would make a good Christmas present for Sophie. At that stage she was lying on her back and then felt the table being lowered. As it was being lowered she heard Sophie make a noise. Sophie had become wedged in the hydraulic mechanism of the table.

4.6. In her oral evidence before the Court, Mrs Schulz said that on previous occasions when the table had been raised or lowered during treatment she had not been told by the therapist in advance that the table was going to be raised or lowered[10]. It was not put to Mrs Schulz that on the occasion in question Ms Maric had indicated to Mrs Schulz in advance that the massage table would be lowered. Nevertheless, Mrs Schulz does not appear to have been taken by surprise by the lowering of the massage table. It is also clear that she did not anticipate Sophie being under the table at any stage as it was being lowered. She did not take any action to ensure that both of her

[9] Transcript, page 78
[10] Transcript, page 82

children were clear of the table as it was being lowered. I am sure that it did not occur to her to do so. As to this, in my view Mrs Schulz was entitled to rely on the vigilance of the person operating the table. Mrs Schulz suggested in her evidence that in any event '*it happened all very fast*'[11].

4.7. Ms Maric was the only other adult eyewitness to the event. She told the Court that for the most part she was positioned in the approximate 1 metre gap between the massage table and the wall opposite the cupboards where the toys were situated. At other times she was at the head of the table. From either position Ms Maric had an unobstructed view of the room and therefore of both children. However, there obviously would have been a limited ability for her to see either under the table or the area the near far side of the massage table should one of the children have ventured to either location unnoticed.

4.8. In her oral evidence Ms Maric told the Court that her general practice was to warn a patient who was lying on a massage table that she was going to move the table. She told the Court that she massaged Mrs Schulz for approximately 20 to 30 minutes during which period the children were playing in the room. Sophie was playing with the Magna Doodle. According to her statement to police Ms Maric said that she was checking on the children throughout the massage to make sure they were safe and out of the way. She was aware that Mrs Schulz would talk to the children from time to time and in particular about sharing the Magna Doodle. At one point Mrs Schulz rolled over on to her back. The children were still playing. Ms Maric herself then became engaged in conversation about the toy with Mrs Schulz. Ms Maric described what then happened:

> 'From what I remember it wasn't all that long after that because at one minute I remember they were playing there and then I said to Justine that I'm going to lower the table as we always had practised doing and then as I was lowering the table, it was this sudden like a cry - noise and I looked across and I couldn't see the little girl. Because that noise made me to lift the sheet and I could see that she was in there.' [12]

Ms Maric stated that when she looked across the room before commencing to lower the table *'both children were there'* but that in the very short time while her attention was on Ms Schulz the child must have moved under the table[13]. In essence what Ms

[11] Transcript, page 87
[12] Transcript, page 107
[13] Transcript, page 141

Maric was saying is that when she lowered the table she had in her mind an image of both children being at a location away from the table[14].

4.9. In her oral evidence a number of significant matters were established through Ms Maric. I find:

i) Ms Maric was never aware of Sophie being under the table[15]'

ii) Sophie was at no point near Ms Maric's side of the table[16];

iii) When Ms Maric operated the table she had been standing on the side of the table that was nearest the wall[17]. This would have meant that she had an unobstructed view of the room save and except for the space underneath the table and the space immediately to the other side of and at the ends of the table;

iv) When Ms Maric lowered the table she intended to lower it to its lowest point[18]. The mechanism of the table would thus, but for Sophie's entrapment, have ultimately been compressed to the point where there would not have been any space between the mechanism and the underside of the table itself. Thus the placement of any object in that space as it was being compressed would inevitably have resulted in the entrapment and possible crushing of that object. The lowering of the table to its lowest level should thus have been seen as presenting itself as a situation of danger to any person who might venture close to the table as it was being lowered;

v) That during the entirety of the period during which the massage table was being lowered until it stopped due to Sophie's entrapment, Ms Maric could not have been watching Sophie or have otherwise been aware of her exact location.

vi) If Sophie's head was already in the space between the mechanism and the underside of the table at the instant the table commenced being lowered, Ms Maric was unaware of that fact. Accordingly, on this scenario it would follow that Ms Maric did not ensure that Sophie and Regan were clear of the table before she commenced lowering the table.

[14] Transcript, page 142
[15] Transcript, page 108
[16] Transcript, page 109
[17] Transcript, page 109
[18] Transcript, page 121

vii) Alternatively, if Sophie placed her head in that space at a time after the table commenced being lowered, Ms Maric was also unaware of that fact. It would in this scenario therefore follow that she did not maintain her view of the child as the table was being lowered. It would also follow that Ms Maric did not ensure that the children remained clear of the table as it was being lowered.

viii) Ms Maric did not maintain the necessary degree of vigilance towards the children as she lowered the table.

4.10. It is not necessary to describe the efforts that were made to dislodge Sophie. Her dislodgement was not immediate as the mechanism of the table could not be raised. I have already mentioned the fact the failure to raise the table and to immediately dislodge Sophie from the mechanism had no impact on her death.

5. Was Sophie Schulz's entrapment foreseeable?

5.1. Mrs Schulz told the Inquest that no warning had ever been given to her by any staff members at the clinic as to the risk that might have been presented to children. She did not perceive any danger that might have been presented to children within the treatment room[19]. Nothing was ever said to her specifically about dangers associated with the tables[20]. She was not deterred from bringing her children to appointments[21]. She also told the Court that she had not taken much notice of the mechanisms involved in the movement of the massage table. If she had been told anything about the dangers presented by the tables she would not have taken her children to appointments.

5.2. As far as supervision of her children was concerned, the only level of supervision that she would have regarded as naturally to be expected from the therapist would have involved alerting her to the fact that her child had left the room[22]. She agreed with Ms Abbey, counsel for Ms Maric, that her purpose in attending the clinic was for a massage and not for childcare[23]. However, Mrs Schulz did say that she would have assumed that any person operating equipment in the room would have been under a duty of care to operate it correctly. She assumed that when it came to operating any

[19] Transcript, page 76
[20] Transcript, page 76
[21] Transcript, page 74
[22] Transcript, page 81
[23] Transcript, page 88

equipment, the staff of the clinic were the experts in this regard as they were the people who knew how the machinery worked.

5.3. Mrs Schulz was never warned about putting her hands near the workings of the massage table and she did not see any warning sign that a person should be mindful of the mechanics of the table.

5.4. It is clear and I so find that Mrs Schulz had no appreciation of the danger presented by the raising and lowering mechanism of the table. It seems plain that prior to this event it never occurred to her that either of her children could become entrapped in that mechanism.

5.5. In her oral evidence Ms Maric eschewed the suggestion that she was employed to provide childcare. Nevertheless she stated that as a matter of commonsense she always looked out for children. When asked by counsel assisting, Ms Cacas, as to whether she had been taught to check under the table before she raised or lowered it, Ms Maric answered:

> 'We were always told to look out for - which we always did for whatever was happening in the rooms.' [24]

When pressed for an answer that was responsive to counsel assisting's question, Ms Maric stated that they had not been specifically told to look under the table but that they should be '*looking out for generally what was happening in the room*'[25]. Eventually she stated in evidence that they were not given instructions to look under the table[26]. Ms Maric did say at one point in her evidence that they did their best always to make sure that there was nothing close, meaning close to the table[27]. Ms Maric denied that anyone, including Ms Brunt, had ever said specifically that there was a need to ensure that patients kept their limbs clear of the moving parts of the table – she said that the patients were always on top of the table. Ms Maric did not recall having her attention drawn to any written material that cautioned the user of the table in respect of moving parts. In particular the instruction manual for the massage table which set out certain 'Safety Reminders' including that one should not make adjustments to the table without making sure the patient was clear of all moving parts, was not seen by her. As well, the plate fixed to the machinery itself that cautioned a

[24] Transcript, page 130
[25] Transcript, page 130
[26] Transcript, pages 130-131
[27] Transcript, page 133

person to keep clear of moving parts when operating the table was not drawn to her attention.

5.6. Ms Maric stated that it was her normal practice to ensure that no person was in the vicinity of the table before it was lowered. However, she stated that she was never given any specific instruction by anyone at the premises not to lower the table unless she could see where children were located.

5.7. Ms Brunt told the Court that the massage tables in question had been installed approximately 7 to 8 years ago because she was concerned about the welfare of the backs of the masseurs. The normal Athlegen massage table was narrower than those that she ultimately settled on. Ms Brunt told the Court:

> '… I was concerned that I could wrap my hands around it and almost touch the mechanism underneath and I thought somebody could jamb their finger. So, I requested that they be made wider and stronger because I had patients that are not very well and sometimes lose balance and need to be turned. So, the width was beneficial for the safety of them being able to be turned.' [28]

She told the Court that her only other concern in respect of the massage tables related to power sockets. No-one from the supplier or manufacturer had indicated that there had ever been any serious injury associated with their tables. Indeed she told the Court that the Athlegen representative had said that he thought that Ms Brunt was being overly cautious.

5.8. Ms Brunt also told the Court that all of her staff, including Ms Maric, had been instructed to move the beds minimally and only when absolutely necessary. She instructed them to leave the table at its lowest level when not in use and to lower it to that level prior to her coming into the room to deliver her own therapy. She instructed staff to ensure patients kept their hands to their sides. She also instructed them to tap the patient and inform the patient every time that they were going to lift or lower the table[29].

5.9. As far as persons approaching the table was concerned, Ms Brunt said that anybody who ventured close to the table would be removed[30].

[28] Transcript, page 222
[29] Transcript, page 225
[30] Transcript, page 226

5.10. Ms Brunt acknowledged that although there had been no written risk assessment created in relation to the use of the massage tables, she believed that she had carried out a process of identifying any of its possible associated hazards[31]. However, she said that she never imagined the possibility that something of the kind that ultimately happened to Sophie would ever occur. Accordingly, at no stage did she specifically instruct staff to ensure that a child did not get under the table, although she clearly remembered constantly instructing staff not to let the children near the table. She conceded, however, that this instruction had more to do with the possibility of electrocution[32].

5.11. In her evidence Ms Brunt dealt with the issue concerning the cautionary label on the machinery as well as the material within the operator's manual. In respect of the cautionary plate on the machinery itself,[33] Ms Brunt said that she had not seen that even though she had cleaned the underside of the table. Nevertheless, she said that she had given directions to her staff to keep clear of the moving parts when operating the table. Similar cautionary advice in the manual was also in her words 'absolutely' passed on to her staff[34]. Ms Brunt opines that communicating verbally with her staff was more precise than showing them any written material[35].

5.12. When specifically asked about the question of foreseeability, this exchange took place between Ms Brunt's counsel and herself:

> 'Q. I just want to ask you finally, if you had been told that a child could get under the bed or if anyone had foreseen that a child could get under the bed in that way, what further steps would you have taken.
>
> A. I don't believe I could foresee it. I mean it was just such a freakish accident. I don't really think there was anything more that I could do other than what I've put in place now.' [36]

5.13. Ms Brunt on more than one occasion in her evidence was at pains to point out that she had not perceived any possibility that a child could get his or head crushed in the mechanism in question. She said it simply never occurred to her. She did acknowledge that quite obviously an injury would be caused to a person if a person

[31] Transcript, page 230
[32] Transcript, pages 230-231
[33] Exhibit C13a, page 6
[34] Transcript, page 233
[35] Transcript, page 234
[36] Transcript, page 235

had a body part trapped within the mechanism, but she simply did not foresee this occurring. She said:

> '… It just never occurred to me that anyone would be allowed to crawl under the bed …'[37]

But she then went on to say that they were careful to disconnect the electricity to the machinery when situated at its highest level, and when cleaning underneath they were careful '*to ensure that we didn't get ourselves trapped*'[38].

5.14. In answer to me, Ms Brunt acknowledged that there was no direct instruction given to her staff not to allow small children to be in a treatment room unless they were supervised by someone other than the patient. Instead, they had been instructed to attempt to find someone to hold or occupy a child, including patients waiting in the waiting room. Ms Brunt said that she had since established that on that particular day the appointment schedule had unusually been running on time and there had been no-one suitable to look after the children[39]. This is contradicted by Mrs Schulz who said that she had to wait about an hour for her appointment. However, the discrepancy is of no consequence as it is clear that the presence of the children in the room on this particular occasion was accepted by all concerned.

5.15. Ms Brunt also said that she believed that staff would warn patients when something was about to occur.

5.16. As far as a patient's appreciation of risk was concerned, Ms Brunt could not recall any circumstances where the patient themselves would not be on the table when it was raised or lowered. However, she thought that most patients may have seen it raised or lowered at some stage and that one could see the mechanism when one walked into the room. Ms Brunt suggested that a parent whose task it was to watch a child in a room would have been in a position to assess the risk posed by the moving machinery[40]. As seen, however, Mrs Schulz said that she had not taken much notice of the mechanism of the table. It was not unreasonable for her not to have done so. I accept her evidence as to that. In any event staff in the premises and indeed Ms Brunt herself, would be in the best position of all to be able to assess and appreciate the risk

[37] Transcript, page 253
[38] Transcript, page 253
[39] Transcript, page 257
[40] Transcript, page 265

involved in the moving mechanism. Ms Brunt as much acknowledged this when she said '*well any mechanical object has a risk factor*'[41].

5.17. Ms Brunt also acknowledged that given the practice whereby the table would be moved to its lowest point before she entered the room to perform her treatment, this meant that in the case of a patient who had a young child present the table would be lowered in the child's presence[42]. However, she pointed out that there was a standing instruction that a child was not to go anywhere near the table and that the staff were expected to police that instruction[43].

5.18. Ms Brunt also pointed out that the parent bore some responsibility to watch over their own child.

5.19. In my view the conclusion is inescapable that a small child, totally naïve to the nuances of moving machinery, could be foreseen as having a tendency to be attracted towards machinery such as this. A child of 18 months of age would be completely oblivious to the dangers posed by the machinery. One only has to contemplate an 18 month old child alone in a room with this machinery in operation to appreciate how dangerous a situation that would be. One does not have to have the benefit of 20/20 hindsight to state such an obvious proposition. To my mind it was foreseeable to staff who worked in the premises, and in particular to those who operated the machinery and saw it working on a daily basis, that a child might be attracted to and place a body part in the moving machinery. Given the accepted presence of a small child in the room, the only sure way that this could have been prevented would have been for constant vigilance and sight of the child to be maintained for the whole of the duration of any lowering operation. Clearly that did not take place in this case. The ultimate responsibility for ensuring that the massage table was lowered safely was manifestly that of its operator, in this case Ms Maric. In my view anyone operating such machinery had a very clear obligation to ensure that any person in the room was not only accounted for, but was not in any way near the table as the lowering operation occurred.

5.20. It is not the point to say there was no child-minding responsibility adhering to Ms Maric's duties. Regardless of whether there was any general duty to control the

[41] Transcript, page 265
[42] Transcript, page 269
[43] Transcript, page 269

behaviour of children or to account for their whereabouts at any given point in time, there was certainly an obligation to ensure that this machinery was operated safely so that it did not entrap any person in its mechanism. The machinery should not have been operated unless every person in the room was accounted for and no-one was near the machine.

6. Conclusions

6.1. I make the following findings.

1) Sophie Ann Schulz died on 17 June 2009 as a result of head injuries;

2) Sophie met her death when her head was entrapped in the lowering mechanism of a massage table situated at the Fravira Clinic, 431 Magill Road, St Morris;

3) Sophie's death was instantaneous upon the application of the crushing force that was applied by the lowering mechanism of the massage table;

4) Sophie's head was entrapped in the lowering mechanism of the massage table as it was being lowered by Ms Maric, a massage therapist at Fravira Clinic. It is not possible to determine precisely when it was that Sophie moved to a position under the massage table. It is possible that she moved to that position at a time prior to Ms Maric commencing to lower the table. It is also possible that at a time after Ms Maric commenced lowering the table, Sophie moved to that position and placed her head in the location where it would soon become entrapped. In either case Sophie moved to that position unnoticed either by her mother, Mrs Justine Schulz, or by Ms Mira Maric, the therapist. Her moving to that position was also unnoticed by any other staff member including any such member who may have been present at the reception area of the clinic;

5) It was Ms Maric's duty and responsibility to ensure that at all times as the table was being lowered that any person was clear of the working mechanism of the table, and in particular to ensure that the whereabouts of Mrs Schulz's children were accounted for and that both were in a safe location relative to the table;

6) Ms Maric did not ensure that both of Mrs Schulz's children were clear of the working mechanism of the table while it was being lowered. She also did not

ensure that the exact location of both children relative to the table was accounted for as she lowered the table;

7) No direct instruction was given to staff of the Fravira Clinic that children should only be allowed in a treatment room unless under supervision;

8) No direct instruction was given to staff of the Fravira Clinic that children should not be allowed to venture under massage tables, and the reason for such a prohibition was not explained. However, it is plain that as a matter of common sense no child should have been so permitted. Such an instruction should not have been required as the need to prevent a child from venturing under a table should have been self evident;

9) Mrs Justine Schulz did not have any appreciation of the fact that her daughter, Sophie, had moved to a position underneath the table. Mrs Schulz did not perceive any danger that might have been presented to children within the treatment room. She had not taken notice of the mechanism involved in the movement of the massage table. In any event Mrs Schulz was entitled to assume that the operator of the massage table would only operate the table with appropriate care and vigilance;

10) It was understood among the staff of Fravira Clinic, or ought to have been understood by the individual staff members, that the mechanism of the massage table could entrap a person's body part within that mechanism. I find that both Ms Maric and Ms Brunt understood this at a time prior to the incident in question. I find that it was foreseeable to both Ms Maric and Ms Brunt that a small child who was not being constantly watched could move to a position underneath the table and become entrapped in the mechanism.

11) Sophie Schulz's death would have been prevented if (i) small children were not permitted within treatment rooms, and probably would have been prevented if (ii) management of Fravira Clinic had insisted that small children who were present in a treatment room be supervised by an adult who was a person other than those participating in the treatment, and may have been prevented if (iii) staff had been regularly reminded verbally and in writing to ensure small children did not venture under massage tables at any time, especially when the table was being lowered.

7. Recommendations

7.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

7.2. During the course of the Inquest evidence was given from two sources concerning the desirability and feasibility of installing guards on the sides of massage tables that exposed lowering mechanisms and where the mechanism might be hazardous to a person.

7.3. Mr Peter Stevens is a person who services Athlegen machines. Mr Stevens gave evidence in the Inquest. He serviced the machine in question on a number of occasions prior to these events. He was of the belief that given the fact that the tables are not necessarily at a consistent height at all times, it would not be feasible to install guards on their sides. On the other hand, Mr Kenneth Sumpter, an engineer who examined the machine and gave evidence at the Inquest, regarded guards not only as a matter of feasible implementation, but that in his view they are essential. He expressed surprise that massage tables of this type were not protected in any way. He pointed out that in an industrial scenario relevant standards dictate that such protective means would be mandatory. There is no general Australian Standard in relation to the guarding of the working mechanism of massage tables. The Court would point out that not only are clients and patients possibly susceptible to the dangers presented by these tables, but workers employed at any institution at which they are deployed might also be at risk. I prefer the evidence of Mr Sumpter, the engineer, on the issue of guards. To my mind there is a strong case that research should be undertaken to establish whether it would be appropriate and feasible for guards to be configured and installed in respect of massage tables of this kind. I propose to recommend accordingly.

7.4. There is one further matter that should be mentioned in this regard and that is that this does not appear to have been the only incident involving a death caused by the moving parts of a massage table. It has been recorded that in June 2011 in the United States an incident very similar to the one under discussion occurred and that it also

involved an 18 year month old child. Although such incidents are rare, it cannot be said that they are unheard of.

7.5. Tendered to the Court were the affidavit, statements and accompanying material of Ms Alana Hale who at the material time was a Senior Inspector in the Investigation Team of SafeWork SA[44]. Among this material were two prohibition notices that were issued by SafeWork SA and served upon the management of the Fravira Clinic on 18 June 2009[45]. The first of these notices mandates the clinic not to operate massage tables until such time as a hazard identification and risk assessment in line with Occupational Health, Safety and Welfare legislation has been undertaken and appropriate control measures have been put in place. The second notice mandates the clinic not to allow young children in the massage area until such time as a hazard identification and risk assessment in line with Occupational Health, Safety and Welfare legislation has been undertaken and appropriate control measures have been put in place.

7.6. The response from Fravira Clinic consisted of the provision of a hazard and risk assessment dated 21 June 2009[46] that described the implementation of measures that include massage tables being locked in the lowest position and being disconnected from power when children are present in any treatment room. In addition, when children are present in treatment rooms they must be under the control of an adult or, if age appropriate, placed in a playpen prior to their parent commencing their treatment. In addition, the response included the establishment of a procedure whereby staff must ensure that no person is in the vicinity of the table prior to or during the table's adjustment.

7.7. A SafeWork SA 'SAFEGUARD', issued in May 2012, deals with the hazard presented by treatment tables or beds with power assisted lifting mechanisms[47]. The Safeguard was sent by way of pro forma letter to a number of entities that utilise the particular machine in question. This Safeguard describes a number of recommended strategies that include advice that moving parts of appliances should be positioned or enclosed to prevent access by any person so as to prevent injury, that there is a need

[44] Exhibits C15 to C15n
[45] Exhibit C15i
[46] Exhibit C15e
[47] Exhibit C24a, RLH3

for operators to check below the table top and to ensure that children are not in the vicinity of the table or bed and that there is a need for adequate training to be given to operators and employees on how the appliance works.

7.8. The Court is of the view that the experience of this case would strongly suggest the only certain method by which such an incident could be prevented in the future would be not to permit children to be present in a room where such equipment resides or to have an age appropriate child constrained within the room by means of a playpen. Otherwise the safety of a small child depends largely upon the vigilance and patience of a supervising adult, a matter that may be inconsistently applied in practice.

7.9. As indicated earlier in these findings, the reason the child's head could not be released upon its entrapment was due to the inability of the operator to raise the table by means of the foot pedal. Mr Sumpter in his evidence suggested that there were a number of possibilities in this regard including the possibility that the tube that connects the foot pedal to the electrical actuator had become trapped between the child and the frame, or that the end of the tube connected to the actuator had become dislodged during the course of the incident or in the efforts to free the entrapped child. That latter scenario seems unlikely as efforts to free Sophie only commenced after it had been established that the massage table could not be raised by means of the foot pedal. The precise reason has not been established with any degree of certainty, but as indicated earlier it had no bearing on the outcome. In the course of the Inquest I invited Mr Golding, who appeared for and on behalf of SafeWork SA, to have the failure of the table to be raised to be drawn to the attention of the manufacturer, Athlegen.

7.10. I make the following <u>recommendations</u>:

1) That these findings be drawn to the attention of Standards Australia and that Standards Australia consider researching and implementing a Standard whereby massage tables with exposed lowering mechanisms should be required to have guards attached in order to prevent accidental access by a person to the working mechanism;

2) That SafeWork SA issue a further Safeguard to the effect that children in no circumstances should a child be present within a room in which a massage table

of this kind resides, except in the case of an age appropriate child who can be accommodated within a playpen.

7.11. Finally, it should be noted that much of the time that has elapsed since the event with which this Inquest is concerned included the period of two years immediately following the event, during which period a prosecution pursuant to the Occupational Health, Safety and Welfare Act 1986 was being considered. A complaint alleging a breach of that Act was not laid in the Magistrates Court until 16 June 2011 which, having regard to the two year limitation period for the laying of complaints for summary offences, was the last day on which this complaint could be laid. In due course the prosecution was withdrawn.

7.12. It is difficult for a coronial Inquest to be conducted while a prosecution is either being considered or once instituted has not been concluded. Section 21(2) of the Coroners Act 2003 states that where a person has been charged in criminal proceedings with causing the event that is, or is to be, the subject of an inquest, this Court may not commence or proceed further with the inquest until the criminal proceedings have been disposed of, withdrawn or permanently stayed. While this provision did not operate in this case as the charge laid did not relate to an offence that had as its core element Sophie's death, difficulties in conducting a coronial Inquest can nevertheless still occur due to the fact that while a prosecution is being considered or remains extant, material witnesses may well seek to invoke the privilege against self incrimination, thereby frustrating the effectiveness of coronial proceedings. In the opinion of the Court this can give rise to unsatisfying consequences. The desirability of conducting a public inquiry into accidents such as these, and the frustrations occasioned by delay in the prosecutorial process, has been the subject of coronial comment in this jurisdiction in the past. I refer to the findings of the State Coroner Mr Mark Johns in the matter of the death of Daniel Nicholas MADELEY[48] and commend the suggestions for reform that were made at paragraph 12.4 therein.

7.13. For my own part I would add the following. There appears to be no sensible reason why, as in another Australian jurisdiction[49], there ought not be a legislative regime whereby a witness in coronial proceedings can be compelled to truthfully answer questions notwithstanding that the answers might incriminate him or her in respect of

[48] Inquest 14/2010
[49] Coroners Act (NSW) 2009, section 61

an offence, but on the understanding that they will be issued a certificate or other type of assurance that the evidence that they give will not be used in any subsequent court proceedings. This very valuable investigative tool is not available to the coronial jurisdiction in South Australia and its absence in many instances may either act to the detriment of the integrity of coronial proceedings or renders them futile. I draw this issue to the attention of the Attorney-General for his consideration.

Key Words: Crush Injury; Massage Table; Hydraulic Mechanism

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 14th day of May, 2013.

Deputy State Coroner

Inquest Number 22/2012 (0986/2009)