MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to S.57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of Mr B

Find that:

a) The identity of the deceased is Mr B;
b) Mr B died in the circumstances set out below;
c) Mr B died as a result of hypoxic/ischaemic brain damage due to crush injury of chest and abdomen;
d) Mr B died in October 2013 at Launceston General Hospital, Charles Street Launceston in Tasmania; and
e) Mr B was born in Launceston, Tasmania and was aged 39 years at the date of his death; he was separated from his wife and employed as a mechanic.

Decision not to hold an inquest:

Section 24 of the *Coroners Act 1995* relevantly provides:

> 24. (1) Subject to section 25, a coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Tasmania or it appears to the coroner that the death, or the cause of death, occurred in Tasmania or that the deceased ordinarily resided in Tasmania at the time of death and –
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> (ea) the deceased died at, or as a result of an accident or injury that occurred at, his or her place of work and the coroner is not satisfied that the death was due to natural causes.

This provision is subject to section 26A of the Act. That section provides that a coroner may decide not to hold an inquest in relation to a workplace death if the senior next of kin requests it and the coroner is "satisfied that it would not be contrary to the public interest or the interests of justice if the inquest were not held".

In this case a request has been made by the senior next of kin that there be no inquest. In the circumstances I am satisfied that it would not be contrary to the public interest or the interests of justice not to hold an inquest. I am satisfied as to these matters because the death the subject of the investigation has been comprehensively investigated by both Tasmania Police and WorkSafe Tasmania.

In addition, I consider that the circumstances of the death do not require an inquest to be heard in public because it is very clear how the accident occurred. Finally, in my view it is unnecessary to hold a public inquest to convey to the wider community the lessons to be learned from this tragic death.

Introduction:

Mr B was born in Launceston in 1973. He was the son of IJ and GB. Mr B had three brothers and a sister. Mr B was married but separated at the time of his death. He and his wife had three sons together.

Mr B was by training a mechanic and by all accounts a very good one. According to his brother, Mr B worked at a number of different places before starting work at a small family-run mechanical workshop in Launceston. At the time of the accident which ultimately claimed Mr B's life it was managed by NC. NC's son was the head mechanic in the workshop. In addition to Mr B, six (6) other men were employed in the workshop. One of those men was Mr B's brother.

Circumstances Surrounding the Death:

At about 2:30pm on 30 August 2013 Mr B began a routine service of a Toro Z597 motor mower. That mower, including an after-market skid plate which had been fitted to it, weighed approximately 700 kg. Part of the service necessitated Mr B working underneath the mower. Mr B was working alone carrying out the service, something that was quite normal. Other co-workers were in the general vicinity in the workshop.

A comprehensive investigation by WorkSafe Tasmania and Tasmania Police (under the *Coroners Act 1995*) allows me to make the following findings. Mr B used a trolley jack to raise the rear of the mower to a height sufficient to enable him to fit underneath it as he needed to access the underside of the mower. Under the mower is a sump plug which drains oil from the sump (a normal part of any mechanical service). However, Mr B did not utilise jack stands to support the mower before he got under it.

Jack stands were available in the workshop. The investigation revealed that it is standard safety practice that after any machine is raised on a jack, jack stands are placed under a secure part of the raised machine and then the jack lowered so that the stands (and not the jack) take the weight and secure the load.

There were at least five jack stands within the vicinity of the area where Mr B was carrying out the service. The investigation identified that two stands were within very easy reach (that is to say within 3 metres).

The investigation also revealed that although there is no formal documentation of risk assessment and the like, all employees at the mechanical workshop had been instructed to never get under any piece of machinery unless it was supported by jack stands.

The fact that the weight of the mower was not supported by jack stands meant that getting underneath it was inherently dangerous. Worse, because the trolley jack was used by Mr B to lift one side of the mower it was unstable and not properly balanced.

It seems clear, and I find, that as Mr B used a spanner to undo the sump plug, as a precursor to draining oil from the sump and replacing it with fresh oil, the force that he applied was sufficient to move the unbalanced and unsupported mower off the trolley jack. As a consequence, the mower fell on to Mr B who was lying underneath it, pinning him to the concrete floor of the workshop.

Mr B's brother and a co-worker seem to have been the first people to have noticed that Mr B was trapped underneath the mower. Using the jack Mr B had been using they lifted the mower off him and pulled him out from underneath it. A "000" call was made immediately (Ambulance Service records reveal that the call was made at 3.02pm). CPR was commenced by some of Mr B's co-workers immediately. A Tasmania Fire Service crew was very close by and also responded, arriving before the ambulance. Fire fighters took over CPR for eight to ten minutes before the arrival of the ambulance. Paramedics administered drugs while fire fighters continued performing CPR.

Mr B was rushed to the Launceston General Hospital where he was immediately admitted to intensive care in a critical and unstable condition. After investigation by medical staff at the hospital it became clear that Mr B had suffered significant internal injuries. Mr B did not recover from those injuries and passed away in the presence of his family in October 2013.

The fact of Mr B's death was referred to the Coroners' office for investigation. After formal identification an autopsy was carried out on Mr B's body by Dr Christopher Hamilton Lawrence, the State Forensic Pathologist. Dr Lawrence expressed the opinion that Mr B died as a result of hypoxic/ischaemic brain damage due to crush injury of the chest and abdomen following being trapped under the mower. In plain English this means that Mr B could not breathe while he was crushed underneath the mower. I accept this opinion. No toxicological investigations were carried out because of the effluxion of time between the accident which caused Mr B's death and his actual death, which meant that no meaningful information would result from such analysis to assist in the investigation of Mr B's death.

In conclusion I am satisfied that the death of Mr B occurred in the circumstances outlined in this finding.

Comments and Recommendations:

The accident which caused Mr B's death was wholly avoidable. If he had utilised jack stands to support the weight of the mower underneath which he was working the accident would not have occurred as it did.

Unfortunately, I have had occasion twice already this year to comment on the inherent danger associated with working under any piece of machinery not properly supported by jack stands (see Mr T [2015] TASCD 90; Mr C [2015] TASCD 187). That it is necessary for the warning to be repeated for a third time in less than a year is a cause for genuine concern.

I warn in the strongest possible terms that no person should work under any vehicle or piece of machinery supported only by a trolley jack. Jack stands must be used to properly and safely support the weight of any piece of machinery or vehicle under which a person is working. A failure to properly use jack stands is inherently dangerous and can and will lead to death, as this case illustrates.

In concluding, I convey my sincere condolences to the family of Mr B.

Dated: 26 October 2015 at Hobart Coroners Court in the State of Tasmania.

Simon Cooper
CORONER