IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002895

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Paul John Hinton
Date of birth:	17 April 1969
Date of death:	30 May 2023
Cause of death:	Blunt force head trauma
Place of death:	9 English Avenue, Scoresby Victoria 3179

INTRODUCTION

1. Paul John Hinton was 54 years old when he died from injuries sustained when he was crushed by a vehicle he was repairing on 30 May 2023. Mr Hinton was a qualified mechanic who lived in New Zealand and flew to Melbourne a few days prior to his death.

2. Mr Hinton worked in the automotive industry for more than 30 years, commencing as a technician in the Royal New Zealand Air Force. He worked on the Asia Pacific rally circuit where he was in charge of drivers, and for International Motorsports as an automotive technician. He also worked in Australian mines where he regularly serviced and repaired trucks. Most recently, Mr Hinton worked at St Lukes Tyre and Mechanical in New Zealand, where he performed vehicle checks, repairs, procured parts and invoiced customers. One of Mr Hinton's former friends and colleagues, Sharn Connor, recalled that Mr Hinton was "*always conscious of possible hazards and finding ways to limit risks*". Mr Connor stated he "*never saw him go under any vehicle that posed a safety risk*".

THE CORONIAL INVESTIGATION

3. Mr Hinton'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. Senior Constable (SC) Lachlan Connelly acted as the Coronial Investigator for the investigation of Mr Hinton's death. SC Connelly conducted inquiries on my behalf and compiled a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Paul John Hinton 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.[1]

PRELUDE

8. In April or May 2023, Mr Hinton chanced upon an old acquaintance, David Bennett, at an automotive event in New Zealand. Mr Hinton had completed some work for Mr Bennett a few years earlier, assembling spray-painting booths. During their conversation, Mr Hinton asked Mr Bennett if he had any work opportunities for him.

9. Mr Bennett stated he had a job for Mr Hinton in September or October 2023. Mr Hinton was interested in this job but said he might not be immediately available as he had plans to move to Queenstown. Mr Bennett suggested a small task for Mr Hinton, repairing the brake line on his daughter's BMW, and Mr Hinton accepted the opportunity.

10. In early May 2023, Mr Bennett informed Mr Hinton that he was planning to travel to Adelaide for work later in that month. Mr Hinton noted that the rugby State of Origin competition was due to be held that same week and suggested that they could attend together. Mr Hinton and Mr Bennett agreed and planned their trip to Adelaide.

11. During their trip to Adelaide, Mr Bennett mentioned that he had a Ford Territory (**the Ford / the vehicle**) located at his rental address in Scoresby, Victoria. A mechanic had performed a roadworthy test on the vehicle, and Mr Bennett was planning to sell it 'as is', however Mr Hinton suggested he could complete the required work so that it could be sold with a roadworthy certificate.

12. Mr Hinton flew into Melbourne late on 27 May 2023. As Mr Bennett was not due to fly in for another day, he organised a spare key for Mr Hinton to access the Scoresby property. Mr Bennett arrived in Melbourne on 28 May 2023 and when he arrived at the Scoresby property, Mr Hinton informed him that he had purchased a new jack to work on the vehicle. Mr Hinton also explained that he had already completed some work to the front of the vehicle.

---

[1] 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.

The list of jobs remaining included the front suspension linkages and front and rear suspension bushes. That evening, they both stayed up late watching Formula One racing.

13. On 29 May 2023, Mr Hinton and Mr Bennett went shopping together to purchase two socket sets and some parts for the vehicle. Mr Bennett explained that they did not need to purchase anything else as he had a range of tools and safety equipment at the Scoresby address. This equipment included mechanical jacks and axle stands.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

14. On 30 May 2023, Mr Hinton and Mr Bennett had coffee together in the morning. Mr Hinton then went to work on the Ford, while Mr Bennett remained inside for the majority of the morning, working on his computer. At about midday, Mr Bennett checked on Mr Hinton and asked if he wanted to accompany him to collect a drive shaft for the vehicle. Mr Hinton declined and stated that he preferred to stay and continue working.

15. Mr Bennett recalled that at the time he left the premises, the vehicle's front wheels were still attached, and the rear wheels had been removed. The front of the vehicle was inside the garage, while the rear of the vehicle protruded from the garage into the driveway. The front wheels appeared to be touching the ground, while the rear of the car was supported by mechanical jacks. Mr Bennett previously showed Mr Hinton some pieces of wood and steel that could be used as wheel chocks. Mr Bennett stated that he did not pay particular attention at that time as Mr Hinton was an experienced and qualified mechanic.

16. Mr Bennett was away from the property for 30 to 60 minutes. When he returned, he approached the vehicle and discovered Mr Hinton's body pinned underneath.

17. Mr Bennett immediately called Triple Zero and while he was on the phone, he tried to lift the vehicle off Mr Hinton's body. He saw that the floor jack was under the rear of the vehicle and that it was fully extended. He moved the floor jack to a point near Mr Hinton's chest and tried to lift the vehicle, but after pumping the jack for a short time he realised that he would not be able to do so. Mr Bennett checked for a pulse and noticed that Mr Hinton felt cold to the touch.

18. Emergency services arrived on scene a short time later and paramedics confirmed that Mr Hinton was deceased.

19. Fire Rescue Victoria (**FRV**) members assessed the scene and provided an opinion in relation to how the incident had occurred. FRV noted that, prior to working on the Territory, Mr Hinton

had removed the rear wheels and lifted the vehicle up with jacks that were placed near the rear axles. The vehicle's front wheels remained in place and were touching the ground. The driveway where Mr Hinton was working had a very slight slop down from the garage. The front wheels that were touching the ground were not chocked. Therefore, while Mr Hinton worked on the vehicle, it rolled slightly, which caused it to fall off the jacks and collapse on top of him.

20. Police did not identify any suspicious circumstances or evidence of third-party intervention in connection with Mr Hinton's death.

Identity of the deceased

21. On 30 May 2023, Paul John Hinton, born 17 April 1969, was visually identified by his friend, David Bennett.

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

Medical cause of death

23. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an examination on 31 May 2023 and provided a written report of his findings dated 10 July 2023.

24. The post-mortem examination revealed findings consistent with the reported history. There was evidence of injury to the left side of the head in keeping with a heavy object such as a vehicle coming to rest on the body.

25. Examination of the post-mortem CT scan revealed a fractured right parietal bone with pneumocranium, no intracranial haemorrhage, calcific coronary artery disease and no pneumothorax.

26. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

27. Dr Lynch provided an opinion that the medical cause of death was *1(a) Blunt force head trauma.*

28. I accept Dr Lynch's opinion.

CPU REVIEW

29. I referred this case to the Coroner's Prevention Unit (**CPU**)[2] to establish how many people have died across Australia in the previous 10 years after being crushed while working under motor vehicles in a domestic setting.

30. The CPU used two separate data sources to identify deaths nationally. The inclusion criteria across both data sources were as follows:

    a) The death was reported to a coroner between 1 January 2014 and 24 April 2024.

    b) The death was unintentional.

    c) The death was caused by the person being crushed while working under a vehicle because of a failure in a car jack, ramp, block or other analogous method used to raise the vehicle off ground level.

    d) The death occurred in a domestic setting, not in the context of paid work at a commercial premises.

Sources of data

National Coronial Information System (NCIS) data extract

31. The CPU requested NCIS analysts to provide a report containing nationwide data on deaths meeting the above criteria. NCIS is a searchable database of Australian coronial investigations from 2000 onwards. The central limitation of the NCIS is that it only includes closed cases where information about the mechanism of death was coded in the NCIS. There are delays in all jurisdictions between the date the case is closed and the date when the information is coded into NCIS. These delays mean that relevant deaths in recent years may be missed by NCIS searches if those searches rely on the coded data (as was the case here).

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

Coroners Court of Victoria surveillance database search

32. For Victorian deaths, the CPU supplemented the NCIS results with a search of the Court's surveillance database, which contains coded information on all Victorian deaths reported to the coroner since 2000. The central limitation of this database is that the data relies on coders correctly using certain death classification codes in relevant deaths. There is always a possibility of human error in death coding and classification in these circumstances, and as such the CPU could not confirm with complete certainty that all relevant cases were identified.

Relevant cases

33. The CPU identified 70 deaths nationwide between 1 January 2014 and 24 April 2024. Among these deaths, 21 occurred in Victoria while 49 occurred in other Australian states or territories. The annual number of cases in Victoria ranged from zero to three. There was no obvious trend in the numbers over time. Of the 70 deaths, 69 were males.

34. On average, there were two to three deaths each year in Victoria and six to seven deaths nationally caused by people being crushed while working under vehicles in domestic settings. The number has remained relatively steady over the past decade and involved men over a large range of ages.

35. Victorian coroners who have recently considered similar deaths have focused on community education as a key strategy aimed at reducing deaths in similar circumstances. In Coroner Jamieson's finding into the death of Maurice Matthews,[3] her Honour recommended:

    a) *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 focusing on the safety in DIY motor vehicle maintenance and repairs.*

    b) *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.*

36. In response, WorkSafe Victoria advised that it has met with the Australian Competition and Consumer Commission (**ACCC**) and has agreed to liaise with the ACCC regarding potential

[3] Finding into death without inquest – Maurice Matthews (COR 2021 3523).

opportunities to amplify and reinforce DIY vehicle maintenance and repair safety awareness messaging.

37. The ACCC advised in response that in addition to the safety information published on the ACCC Product Safety website, other activities have included:

    a) A campaign in 2019 which focused on DIY vehicle maintenance safety, supported by two videos.

    b) Regular seasonal social media messaging, which includes warnings about working under vehicles supported by a jack, and safe use advice.

    c) Amplification of messaging developed by the Consumer Education Network, an Australian Consumer Law regulator network which includes the ACCC and state and territory consumer protection regulators. This has included '*Safe Summer/Be Summer Safe*' and other seasonal content which incorporates DIY vehicle maintenance safety advice.

38. The ACCC advised that it will liaise with WorkSafe Victoria regarding potential opportunities to amplify and reinforce DIY vehicle maintenance and repair safety awareness messaging.

39. I commend this work but note that it is vitally important that safety messaging of this kind remains current and is delivered through a wide variety of media.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Paul John Hinton, born 17 April 1969;

    b) the death occurred on 30 May 2023 at 9 English Avenue Scoresby Victoria 3179, from blunt force head trauma; and

    c) the death occurred in the circumstances described above.

ACKNOWLEDGEMENTS

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

I thank the Coronial Investigator and those assisting for their work in this investigation.

ORDERS & DIRECTIONS

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:

Diane Hinton-Watt, Senior Next of Kin

Australian Competition and Consumer Commission

WorkSafe Victoria

Senior Constable Lachlan Connelly, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 30 June 2026

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.