

FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the Coroners Act 2008

Court reference: 2919/07

In the Coroners Court of Victoria at Melbourne

I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname: MULVANEY
First name: DAVID
Address: 13 Barron Court, Dandenong, Victoria 3175

without holding an inquest:

find that the identity of the deceased was DAVID MARIO MULVANEY
and death occurred on 28th July, 2007

at Alfred Hospital, Commercial Road, Melbourne, Victoria 3004

from

- 1a. 85% BURNS
- 1b. EXPLOSION

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and Mr Mulvaney was not immediately before he died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. David Mulvaney was aged 58 years at the time of his death. He lived at 13 Barron Court, Dandenong.

The Explosion

2. The coronial brief has fully addressed the circumstances of death of Mr Mulvaney.
3. Mr Mulvaney was employed to clean and prepare metal for powder coating. Solvents and thinners used in the process were stored in 200 litre metal drums. Once empty, the drums were stored at work, apparently difficult to dispose of.

4. With his employer's permission, Mr Mulvaney had taken an empty drum home. On the 28th July, 2007, whilst cutting the drum in his shed, an explosion occurred.
5. Mr Mulvaney was transported to The Alfred Hospital where he died later that day.

Coroners Prevention Unit

6. At my request, the Coroners Prevention Unit (CPU)¹ undertook a review of similar cases to ascertain the extent of information (in particular, warnings) available on the risks of cutting drums in Victoria, and other jurisdictions.
7. CPU research revealed that New South Wales and Queensland have issued specific warnings about the dangers of cutting fuel drums or empty containers. Copies of warning attached to this finding.

In Victoria

8. WorkSafe Victoria published a "modifying and reusing empty drums" safety sheet in October 2008, which advises against welding, cutting or grinding drums to the risk of explosion caused by exposure to a heat source or sparks (attached). The safety sheet also covers issues involving drum modification and risks of lifting modified drums using cranes or hoists.
9. The safety sheet does not specifically focus on the risks of cutting fuel drums or empty containers. A potential to cloud the prevention message is thus created.
10. WorkSafe Victoria has also issued an incident report in October 2006 of an explosion caused by welding an empty steel drum. The incident resulted in life threatening injuries to the worker.

Key Communication Messages

11. Drums used as containers to deliver fuel, solvents, thinners or other highly flammable substances to industries are often reused or recycled for other uses. Drums are cut by using angle grinders, plasma cutters and oxy-acetylene. Death and serious injuries have occurred following an exploding drum in the process of being cut.

¹ The CLS is part of the Coroners Prevention Unit (CPU) established in 2008 to strengthen the prevention role of the Coroner. The CPU assists the Coroner in formulating prevention recommendations and in monitoring and evaluating the effectiveness of recommendations. The role of CLS is to assist the Coroner's investigation of deaths occurring in a healthcare setting. CLS is staffed with practising Physicians and Nurses independent of the health professions or institutions involved. They draw on their joint medical, nursing and research experience to evaluate the clinical management and care provided, and to identify areas of improvement so that similar deaths may be avoided in the future.

- Flammable residue or vapours may remain in a drum, which when exposed to a heat source, friction or static electricity, may ignite and explode.
- Cleaning the drum may not of itself be sufficient to remove any flammable material or purge any remaining vapours.
- Cutting or welding drums, which have contained flammable or toxic substances is an extremely hazardous task to undertake.
- Proper safeguards must be followed i.e. ascertain the prior contents of the drum to identify hazardous material, remove all bungs (plugs) to allow any vapours to escape, clean the drum with water and detergent to remove hazardous material. Used drums displaying dangerous goods labels should always be treated as though they are full of product.

Post Mortem Medical Examination

12. On 31st July, 2007, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination only on the body of David Mulvaney.

Dr Burke found the cause of death to be 85% Burns and Explosion.

13. Dr Burke commented:

"A Section 29 Objection to Autopsy was issued by the deceased's next of kin.

The documents in the Coroners's file indicate David Mulvaney was a fifty eight year old man who, on the 28th day of July 2007 was angle grinding an empty 44 gallon drum which had contained either thinners or prepsol. Mr Mulvaney was engulfed in flames which had spread throughout the garage. He screamed for help. His wife and neighbours came to his aid. Mr Mulvaney was taken by ambulance to the Alfred Hospital where full thickness burns to 85% of his body were diagnosed. The injuries were deemed not survivable. Palliative care was instituted in the intensive care unit and Mr Mulvaney died later that day at 1630 hours.

Without a full post mortem examination, one may be unable to address medico-legal issues that could arise at a later date.

In the absence of a full post mortem examination, and in these circumstances, a reasonable cause of death would appear to be 1(a) 85% Burns and 1(b) Explosion."

RECOMMENDATION

1. WorkSafe Victoria consider creating a specific warning, similar to the warnings of New South Wales and Queensland which specifically warn us about the dangers of cutting fuel drums or empty containers.

Finding

I find the cause of death of David Mario Mulvaney to be 85% Burns and Explosion.

Signature:

John Olle
Coroner

10th May, 2011



15. In relation to whether bacterial tracheitis was a possible cause of death, he stated, "there are no features to persuade me that bacterial tracheitis was a likely possibility."

16. He concluded that Aliyra-Rose's death was "unexpected, unpredictable and cannot be primarily attributed to croup". He finally advised that there were "no preventable factors in her death related to her medical care."

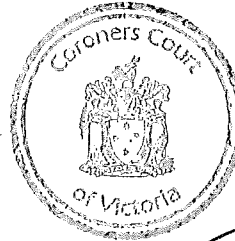
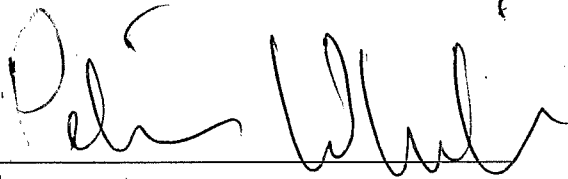
Finding

17. I find that the care and management of Dr Mikhael, the family GP was of a high standard.

18. I find that despite the incorrect diagnosis of bronchiolitis by Dr Yu at the Sunshine Hospital, it did not contribute to the death of Aliyra-Rose.

19. I accept the conclusion of Dr Parsons in relation to the cause of death and find that Aliyra-Rose died on 25 June 2007 as a result of *Category II Sudden Infant Death Syndrome (SIDS)*.

Signature:



Peter White
Coroner
Date: 24th October, 2011

DISTRIBUTION:
Thurley Family
Dr Toma-Mikheal
Sunshine Hospital
Royal Childrens Hospital