



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Desmond Keith McConnon

Find pursuant to section 28 of the *Coroners Act 1995* that

- (a) The identity of the deceased is Desmond Keith McConnon;
- (b) Mr McConnon died when he suffered multiple injuries as a consequence of a fall from a 3m height of a tree;
- (c) The cause of Mr McConnon's death was hypovolemic shock;
- (d) Mr McConnon died at the Royal Hobart Hospital, Hobart in Tasmania on 24 October 2015; and
- (e) Mr McConnon was born in Tasmania, Australia on 8 July 1947 and was 68 years of age at the time of his death; he was a gardener and married.

In making these findings I have had regard to the material obtained as a consequence of the investigation into Mr McConnon's death carried out pursuant to the Coroners Act 1995. That information provided to me included a comprehensive police subject report from the investigating officer, a report of death to coroner, affidavits dealing with life extinct and identification of Mr McConnon, an affidavit of Dr Donald McGillivray Ritchey the forensic pathologist who performed an external examination of Mr McConnon's body, results of toxicological analysis and affidavits from investigating officers, Mr McConnon's widow and Mr McConnon's friend Mr Marcus Swan.

I am satisfied to the requisite legal standard that Mr McConnon died in the Royal Hobart Hospital as a consequence of hypovolemic shock caused by serious multiple injuries he sustained when whilst assisting Mr Swan to trim branches from a tree at Mr Swan's home he slipped and fell approximately 3 m from the tree hitting a metal barbecue on the way to the ground. It is clear after the fall he was awake, oriented able to communicate with Mr Swan and medical personnel. He was transported by ambulance to the Royal Hobart Hospital. There whilst he was being evaluated he

suffered cardiac arrest. Notwithstanding aggressive resuscitation attempts at the hospital Mr McConnon died of his injuries roughly 30 minutes after his arrival.

I note that the evidence is that ordinarily Mr McConnon was careful and cautious and in recent years at least had essentially ceased working at heights altogether.

Unfortunately it is clear that he was not using safety equipment at all. It is equally clear that had Mr McConnon been wearing a harness then he would not have fallen and suffered the injuries which killed him.

Comments and Recommendations

The circumstances of Mr McConnon's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I do however **comment** that this is yet another entirely avoidable death caused by the fall of an older male whilst working at height. I urge all those working at height to ensure that the appropriate precautions are taken to prevent accidents of the type occurring which very sadly claimed Mr McConnon's life.

I convey my sincere condolences to Mr McConnon's family and loved ones.

Dated 31 October 2016 at Hobart in the State of Tasmania.

Simon Cooper
Coroner