



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Raymond Henry Millington

**Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that**

- a) The identity of the deceased is Raymond Henry Millington;
- b) Mr Millington died as a result of being crushed while working under a bus in the circumstances set out in this finding;
- c) Mr Millington's cause of death was chest and neck injuries and mechanical asphyxia; and
- d) Mr Millington died on 2 September 2021 at Bagdad, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mr Millington's death. The evidence includes:

- Tasmania Police Report of Death to the Coroner;
- Affidavits verifying identification and life extinct;
- An opinion of the forensic pathologist regarding cause of death;
- Toxicology report of Forensic Science Services Tasmania;
- Tasmanian Health Service and Greenpoint Medical Centre records for Mr Millington;
- Affidavit of Anne Millington, wife of Mr Millington;
- Affidavit of Ruth Millington, former daughter-in-law of Mr Millington;
- Affidavit of Leslie Axelsen, mechanic who was scheduled to work on the bus with Mr Millington;
- Affidavit and photographs of an officer of Forensic Services; and
- WorkSafe Tasmania investigation file.

## **Background**

Raymond Henry Millington was born on 1 August 1950 and was 71 years of age at his death. He had been married for 42 years to Anne Millington and together, they have three children. Mr Millington was in reasonable health for his age and there is no evidence that a medical condition or conditions contributed to his accidental death.

Mr and Mrs Millington had owned and operated the business Millington Coaches since 1984. The business, operating several passenger buses, was predominantly conducted from their family home in Bagdad as well as a bus depot in Claremont. At the time of his death, Mr Millington was semi-retired, having reduced his driving hours by employing another driver.

Mr Millington was not a trained mechanic but had worked on engines all his life. He was actively involved in the routine inspection, mechanical maintenance and up-keep of the fleet of passenger vehicles. He held competencies, issued by the Bus Association of Victoria, for inspection of various mechanical systems and components, performing safety and roadworthiness inspections and carrying out diagnostic procedures associated with passenger vehicles.

Over the years, he undertook various repairs on his buses in conjunction with a qualified and experienced mechanic. The Bagdad property of Mr and Mrs Millington was used as a workshop to service the buses.

## **Circumstances surrounding death**

On 28 August 2021, Mr Millington was driving his 2006 Hyundai New Cosmos Commercial Passenger Vehicle (“the bus”) when he encountered issues with the gearbox. He managed to drive the bus back to his property at Bagdad, where he parked the front of the bus towards the workshop entrance.

On 29 August 2021 Mr Millington attempted to turn the bus around by reversing it but could not activate reverse gear. As a consequence, the bus was left facing towards the workshop. The evidence suggests that Mr Millington had been attempting to turn the bus around in order to reverse the rear of the bus over the service pit in the workshop. In this way, he could more easily access the undercarriage of the bus to work on it.

On 1 September 2021, Mr Millington spoke with Leslie Axelsen, a mechanic with AutoFix Services Tasmania, about the issues with the gearbox. Mr Axelsen had been retained by Mr and Mrs Millington as their primary mechanic for a period of 25 years. During the telephone conversation, Mr Millington told Mr Axelsen that the gearbox in the bus was stuck in either

first or second gear, and he could not reverse the bus. Mr Millington and Mr Axelsen made a plan to remove the gearbox and rebuild it. This work was scheduled for 6 September 2021. However, Mr Millington told Mr Axelsen he would “*start loosening a few nuts and bolts*” before this date.

On the evening of 1 September 2021, Mr Millington told his wife that he planned to start removing the gearbox from the bus the following day, in preparation for Mr Axelsen to commence the gearbox rebuild. It was not envisaged by Mr Axelsen that Mr Millington would attempt to remove the gearbox by himself before the date scheduled for the work.

At 8.20am on 2 September 2021, Mrs Millington left Mr Millington at home with their granddaughter. Mr Millington was scheduled to drop their granddaughter off at Bagdad Primary School that morning and pick her up that afternoon. Mrs Millington had several appointments that day and did not plan on returning home until later in the afternoon.

Mr Millington returned home in the morning after dropping his granddaughter to school. Mrs Millington tried to reach Mr Millington by phone between 1.00pm and 3.30pm, but he did not return any of her calls. Mrs Millington was not concerned for his welfare at this time.

At 3.55pm Ms Ruth Millington (“Ruth”),<sup>1</sup> received a call from Bagdad Primary School advising that Mr Millington had not collected his granddaughter (and her daughter) from school. Ruth notified Christopher Millington (her former husband and son of Mr and Mrs Millington) of the phone call from the school. Ruth then travelled to Mr Millington’s home to check on him.

When Ruth arrived and yelled out for Mr Millington, she received no reply. She then made her way to the rear of the property where she saw the bus parked near the workshop and saw that Mr Millington’s legs were protruding from underneath the bus and not moving. On closer inspection, Ruth formed the view that the bus had fallen on top of Mr Millington. Shortly after 4.00pm she called Ambulance Tasmania to attend and also notified Christopher of what she had discovered.

Mr Brad Finlayson, family friend of the Millingtons, was called by Christopher and requested to come to the property. Upon arrival, Mr Finlayson checked Mr Millington and found that he was unresponsive and did not have a pulse.

At 4.21pm Senior Constable Paul Hyland and Ambulance Tasmania paramedics arrived at the scene followed shortly by members of the Tasmanian Fire Service. Mr Millington was

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<sup>1</sup> Mr and Mrs Millington’s former daughter-in-law.

declared deceased by paramedics at the scene. An investigation into Mr Millington's death was opened by Tasmania Police and WorkSafe Tasmania.

### **Investigation into the cause of the accident**

#### *Cause of death*

An autopsy was conducted by experienced forensic pathologist, Dr Christopher Lawrence, who found that Mr Millington had sustained rib fractures and chest compression. Accepting the opinion of Dr Lawrence, I find that Mr Millington died as a result of mechanical asphyxia due to being crushed while he was working under the bus. Toxicological analysis of Mr Millington's post-mortem blood sample revealed only the presence of his prescribed medication, which I am satisfied did not contribute to his death.

#### *Condition of the bus at the time of Mr Millington's death*

The 2006 Hyundai New Cosmos Commercial Passenger Vehicle had been owned by Mr and Mrs Millington for approximately six and a half years. Both were aware that the bus had some previous gearbox issues. On 16 August 2021 an issue arose with the gear selector forks which was able to be fixed by Mr Axelsen. An issue with the selector forks occurred again on 25 August 2021 and was the issue that Mr Axelsen was scheduled to fix on 6 September 2021 by rebuilding the gearbox.

#### *Observations of the scene and the bus*

When he was discovered, Mr Millington was situated underneath the bus with the engine bay door raised. He was positioned on his back and with his legs protruding from underneath the bus. Senior Constable Hyland, investigating officer, assessed that there was limited space between the ground and the undercarriage of the bus for a person to work and move. He also noticed that the tail shaft had been removed and was pinning Mr Millington's right arm to the ground.

The scene photographs taken by a Forensic Services officer show that Mr Millington had used various combinations of wooden sleepers stacked on top of each other wedged underneath the rear skid plates to level the bus. However, these timber sleepers did not significantly raise the height of the bus to create additional space underneath for Mr Millington to work.

The wing mirrors of the bus were resting against the roller door and the bus had caused a slight impression to the roller door. I find that this was an indication that the bus had moved forward a small distance from its original position

An inspection of the bus was conducted by Mr Paul Buckley, Safety and Compliance Officer with the National Heavy Vehicle Regulator. During his inspection of the bus, he noted the park brake lever was found in the 'on' position. The park brake on this model of bus is an air-over- cable operation. In his affidavit, Mr Buckley explained:

*“With the tail shaft removed there is no mechanical connection from the park brake mechanism to the rear road wheels. With this type of park brake system, the vehicle is free to move in any direction if the tail shaft is removed regardless of the position of the park brake lever or mechanical components.”*

Upon the evidence, I find that Mr Millington activated the park brake prior to working under the bus. However, at the point when Mr Millington removed the tail shaft from the rear of the bus the park brake mechanism disengaged from the rear wheels of the vehicle, allowing the wheels to rotate freely.

I find that, upon the park brake disengaging, the bus rolled a small distance towards the workshop crushing Mr Millington between the undercarriage of the bus and the ground. In such a position, he was unable to breathe and, sadly, died.

Significantly, Mr Millington did not implement the simple measure of applying chocks to the wheels of the bus to prevent it from moving before he started to work underneath it. This was particularly poor practice in light of the fact that he intended to remove the tail shaft, which would render the park brake non-operational.

Further, the bus was situated on a slight downward, uneven slope towards the workshop which likely contributed to it rolling forward and crushing Mr Millington.

There was also insufficient space between the ground and the undercarriage of the bus for Mr Millington to safely work and move. This contributed to his death. He was not working in a service pit and was not using a hoist or other equipment to properly elevate the rear of the bus. I note that it was the intention of Mr Axelsen to elevate the rear of the bus for the date of the scheduled work.

Finally, the removal and replacement of the gearbox was scheduled to take place at the direction of a properly qualified and experienced mechanic within one week of this incident. Unfortunately, Mr Millington exercised poor judgement in commencing the work alone and without sufficient safety measures to protect himself against the risks.

## Comments

Mr Millington died at his 'workplace' of unnatural causes. As such, his death would ordinarily be required to be the subject of a public inquest pursuant to section 24 of the *Coroners Act 1995* ("the Act"). However, I have received a representation from the senior next of kin, Mrs Anne Millington, under section 26A(2) of the Act, that she does not seek an inquest be held. Additionally, I am satisfied that not holding an inquest, under section 26A(3) of the Act, is not contrary to the public interest. I have therefore decided not to do so.

Mr Millington's death highlights the danger of performing mechanical maintenance underneath vehicles that have not been properly stabilised or chocked. It also highlights that caution should be exercised before deciding to work underneath vehicles where the work is not safely within the competency of the person intending to perform it.

In such cases, WorkSafe provides the following cautions for persons intending to perform work underneath vehicles:

1. **Risk assessment:** It is critical that prior to undertaking any work that a risk assessment is prepared. Risk assessments should identify the hazards that may be encountered when undertaking the work as well as identifying any controls that are to be implemented in order to reduce the risk of injury or harm. Hazards should be assessed in terms of their likelihood of causing harm as well as the consequences should the likelihood be realised. Controls identified should seek to mitigate either likelihood or consequence or both.
2. **Ensure that vehicles are adequately secured prior to commencing work:** The use of wheel chocks or equivalent methods to prevent inadvertent physical movement of a vehicle whilst a person is working under the vehicle must be applied. The unplanned movement of a vehicle represents a significant hazard that is easily mitigated with the use of wheel chocks. Relying on mechanical or other engineering controls may mitigate the risk of vehicle movement. However, should these systems fail, and vehicle movement occurs, consequences can be catastrophic.
3. **Understanding engineering systems and their risks:** Workers must have a good understanding of the work that they are undertaking, particularly when it relates to complex mechanical systems. They must be in possession of adequate information, training, and instruction to enable an awareness of the risks that may be encountered. In this way, appropriate controls can be applied to minimise the likelihood of injury or harm.

I extend my appreciation to Senior Constable Paul Hyland and WorkSafe Senior Investigator Kylie Walker for their respective investigations and reports.

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

I convey my sincere condolences to the family and loved ones of Mr Millington.

**Dated:** 23 November 2023 at Hobart in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**