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 C

Find That:

a) The identity of the deceased is Mr C;

b) Mr C died in the circumstances described in this finding;

c) Mr C died on 30 September 2014 in southern Tasmania

d) Mr C died as a result of traumatic asphyxia that occurred when he was crushed under a motor vehicle that he was working on; and

e) Mr C was born in Tasmania and was aged 39 years at the time of his death; Mr C was a single man whose occupation at the date of death was an unemployed mechanic.

Background:

Mr C was born in Tasmania and was aged 39 years at the date of his death. At the time of his death he was living in a caravan at his brother's home.

Circumstance Surrounding the Death:

At 1:20pm on 30 September 2014, Mr C was working on his white Kia Pregio van in the driveway of his brother's home. Neighbours heard him calling for help and went outside to investigate. A neighbour, Ms L, spoke to him and he asked her for help and to get the van off him. It was apparent that Mr C was trapped under the driver's side of the van with his legs sticking out from underneath it. Ms L called 000 for assistance and then got help from other neighbours. However, Mr C had stopped talking and moving. Ms L and another neighour used a car jack from Ms L's residence to jack the vehicle up on the front driver's side. They are to be commended for their efforts.

Police and ambulance officers attended. CPR was commenced on Mr C. He was seen to have redness and bruising on the right side of his abdomen. CPR was continued by police

for 43 minutes but ultimately was unsuccessful and at 2:19pm as a result of advice from ambulance officers all resuscitation attempts were ceased. The efforts of Senior Constable Newbury and Senior Constable Remess as well as ambulance personnel in the extended CPR efforts are to be commended.

After formal identification Mr C's body was transported to the mortuary at the Royal Hobart Hospital by mortuary ambulance. At the hospital Dr Donald Ritchey, forensic pathologist, carried out an autopsy. As a consequence of that autopsy, Dr Ritchie expressed the opinion that the cause of Mr C's death was traumatic asphyxia. I accept this opinion.

It was apparent from the investigation conducted at the time by police that Mr C had been working on the van and was in the process of removing the gearbox from the vehicle. Located under the van was a trolley jack. It is apparent that Mr C was working under the vehicle when it was supported by the trolley jack and some home-made car ramps which belong to his brother. The vehicle was in neutral but the hand brake was applied.

A pair of steel home-made vehicle ramps were observed under the vehicle. One ramp was found in a position in front of the passenger's side front tyre but it was not touching the tyre or wheel. The other ramp was approximately 1 metre in front of the driver's side tyre and was seen to be upside down.

A small 'scissor' jack (in addition to the trolley jack) was noticed to be extended in front of the front driver's side wheel resting upon a paving brick. The van was supported on this jack and the other three wheels. This jack was identified as that used by the neighbours to get the vehicle off Mr C.

Tests conducted on the trolley jack showed that it appeared to be working correctly.

I am satisfied on the basis of the material provided to me as a consequence of the investigation into Mr C's death that he was crushed to death when the vehicle he was working under had become dislodged from home-made ramps. A review of the evidence indicates that the vehicle under which Mr C was working appears to have rolled off the ramps because the back wheels had not been chocked after the vehicle was placed on ramps at the front of it. This is an extremely dangerous practice.

Comments and Recommendations:

I am quite satisfied that if Mr C had been working under a vehicle which was properly supported then he would not have died.

Section 28 (2) of the *Coroners Act* 1995 provides:

> "*A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate*."

This is the second occasion in less than 12 months that a man has been crushed to death whilst working under an inappropriately supported vehicle. As recently as April of this year I recommended in relation to a very similar death "that no person at any time work underneath a car or any piece of machinery supported only by a trolley jack" (Mr T, 2015 TASCD 090). I repeat that recommendation.

I commented that working underneath any vehicle that is not properly supported is an inherently dangerous and very likely fatal practice.

In conclusion, I convey my sincere condolences to the family of Mr C.

Dated: 1 July 2015 at Hobart in the state of Tasmania.

Simon Cooper
CORONER