IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 4278

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of LLOYD DOUGLAS HILL

without holding an inquest:
find that the identity of the deceased was LLOYD DOUGLAS HILL
born 31 January 1989
and the death occurred on 22 or 23 August 2015
at 1811 Barwon Heads Road, Connewarre Victoria 3227
from:

1 (a) MECHANICAL ASPHYXIA (CHEST CRUSHED BY CAR)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Lloyd Douglas Hill was 26 years of age at the time of his death. He worked as a builder and carpenter, and also in farm maintenance. Mr Hill usually lived with his girlfriend, Emma Smith at her family's property near Cobden. However, he would regularly visit his parents' home; a rural property in Connewarre.

2. At around 7.00pm on 22 August 2015, Mr Hill had dinner at his parents' home. Mr Hill subsequently walked 100m to the large rear shed on their rural property, to work on his 1975 Holden utility vehicle. At around 9.00pm, Mr Hill's father Trevor heard the vehicle start up and drive out the driveway; it returned at approximately 9.30pm. Mr Hill's parents went to bed later in the evening, believing that he was still working on his vehicle.

3. At approximately 1.30am on 23 August 2015, Mr Hill's father Trevor walked into the kitchen area of the house. Trevor noticed that the lights to the rear shed were still on and walked out to check on Mr Hill. Upon arriving at the shed, Trevor located Mr Hill lying underneath the vehicle, with his legs protruding from the rear. Mr Hill's chest was trapped underneath a metal storage box, which formed part of the undercarriage of the utility. Trevor called out to his son, but received no response. He then jacked up the right side of the vehicle, before pulling Mr Hill out from underneath and commencing cardiopulmonary resuscitation (CPR). Trevor ran back towards the house and called out to his wife, Sharon, and they contacted emergency services. Ambulance paramedics arrived at 1.59am, but were unable to find signs of life. Mr Hill was declared deceased at 2.04am on 23 August 2015. Police attended shortly afterwards.

INVESTIGATIONS

Forensic Pathology investigation

4. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Mr Hill, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury. Toxicological analysis of post mortem blood did not detect alcohol, common drugs or poisons. Dr Lynch ascribed the cause of Mr Hill's death to mechanical asphyxia, in circumstances where his chest was crushed by a car.

Police investigation

5. Upon attending the Connewarre premises after Mr Hill's death, Victoria Police did not find any signs of third party involvement. Police observed that the vehicle had been reversed up two homemade timber ramps, enabling Mr Hill to perform work underneath. The front wheels were not 'chocked up' or braced in any way, and the vehicle was in 'park' gear. The handbrake was not engaged.

6. It appeared to attending police that Mr Hill had lowered himself down onto his back on a mechanic's trolley, and rolled underneath the vehicle from the rear. Mr Hill then unbolted the rear-differential of the vehicle using a spanner, and detached the driveshaft. Once this came loose, it effectively put the vehicle in neutral gear from park, and caused the vehicle to roll

forward down the ramps. Police surmised that this motion pinned Mr Hill between the trolley he was lying on, and the large metal box underneath the vehicle.

7. Leading Senior Constable (LSC) Andrew Sherry, the nominated coroner's investigator,[1] conducted an investigation of the circumstances surrounding Mr Hill's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, a statement made by Mr Hill's father Trevor Hill.

8. Trevor Hill reported that his son was two weeks off being fully qualified as a registered builder. Mr Hill was a car enthusiast; he enjoyed working on cars and would attend car shows and drive friends around in his Holden utility.

Coroners Prevention Unit investigation

9. Following my receipt of the coronial brief, I asked the Coroners Prevention Unit (CPU)[2] to review the circumstances of Mr Hill's death and provide information regarding the number of deaths involving people working on cars.

10. Between 1 January 2000 and 30 June 2016, 28 Victorian deaths were identified in which a motor vehicle had rolled from ramps or stands, causing fatal injuries to an individual working underneath. All of the deceased persons were male, and ranged in age from 18 to 81 years.

11. The CPU reviewed photographs of the homemade vehicle ramps used by Mr Hill. It was identified that the ramps did not have a flat or recessed top section to prevent a vehicle from rolling back, but were angled up to the top. It was also noted that Mr Hill did not have the wheels chocked to prevent the vehicle rolling off the ramps, and while the vehicle transmission was placed in 'park', the handbrake was not engaged.

12. It was identified that in the past, the Australian Competition and Consumer Commission (ACCC) has published safety messaging targeting people attempting 'do-it-yourself' (DIY) tasks, such as working beneath motor vehicles. Through Product Safety Australia, the ACCC

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[1] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

[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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

issued bans and recalls for different vehicle jack types, which did not meet the Australian Standard (AS/NZS: 2693) for vehicle jacks, or did not meet the requirements under the product safety standard under the *Trade Practices Act 1974 – Consumer Protection Notice 1 of 2010.* In 2011, the ACCC published a research project entitled 'Do-it-yourself (DIY) vehicle maintenance' and identified a number of risk management strategies, including:

- Making warning labels more prominent so they could not be missed;
- Placing safety information prominently alongside equipment specifications, such as lifting capacity, would ensure ease of finding and reading messaging;
- Radio advertisements all day Saturday and mainly afternoons on Sunday (the periods the project found when D-I-Y tasks are mainly attempted);
- Internet and social media ('how to' videos found on YouTube could have safety messaging incorporated).

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Deaths from 'do-it-yourself' (DIY) tasks present a major challenge for this Court and safety agencies. The circumstances of these deaths often involve individual factors such as misusing equipment, instituting improvised methods, or inaccurately perceiving or becoming complacent about the associated risks. The deaths of 28 Victorians since 1 January 2000, however, are indicative of a devastating problem in our community, in need of a coordinated and effective response.

2. On 7 March 2008, following my investigation into the death of Gregory Heppell,[3] I commented that 'deaths occurring in the domestic setting associated with DIY activities are an example of matters that generally fall outside the domain of a Minister or statutory authority' and suggested that WorkSafe Victoria may be able to play a role in the DIY domestic area.

[3] COR 2006 4089.

3. In the investigation into the death of Yakov Marmer,[4] Coroner John Olle noted that the ACCC had undertaken an extensive national safety campaign for the safe use of vehicle jacks. His Honour added that 'while this is to be commended, such a campaign, to be truly effective, requires it to reach those in the community who undertake DIY vehicle maintenance. I strongly encourage the ACCC, as the national product safety regulator, to ensure that the 'Don't be a Jackass with Jacks' campaign is reaching this key group who persist in unsafe vehicle maintenance practices'.

4. I commend the national DIY vehicle safety campaign which was launched by Product Safety Australia on 1 September 2011. The campaign involved the ACCC working with state and territory fair trading agencies to raise awareness about people's safety when doing DIY mechanic work.[5] The joint initiative aimed to help curb deaths and serious injuries associated with working under a car. The campaign involved a range of resources including postcards; a competition encouraging the sharing of safety information; a short YouTube safety film; and an informative safety flyer 'Working under a Vehicle'.

5. I note that of the 28 Victorian deaths identified by the CPU involving DIY maintenance underneath cars since 1 January 2000, five of those deaths occurred from 2011 onwards. While the relationship between the launch of the ACCC's DIY vehicle safety campaign and the apparent decrease in the rate of associated deaths cannot be confirmed, it is an encouraging sign of the value of raising safety awareness amongst the community.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With the aim of preventing injuries and like deaths, **I recommend** that the Australian Competition and Consumer Commission review the effectiveness of the outcomes and reach of its national DIY vehicle safety campaign and consider further activities, such as, but not limited to, weekend radio advertisements to further highlight associated safety issues.

2. AND **I further recommend** that WorkSafe Victoria review its role in raising awareness amongst the Victorian community of important safety precautions for people engaging in 'do-it-yourself' motor vehicle repairs.

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[4] COR 2010 1330.

[5] See: https://www.productsafety.gov.au/news/dont-be-a-jackass-with-jacks; https://www.productsafety.gov.au/news/under-your-car-diy-vehicle-maintenance accessed on 9 September 2016.

FINDINGS

The investigation has evinced the considerable dangers associated with 'do-it-yourself' car repairs, and the recurring deaths across the wider Victorian community. The positive impact of safety awareness campaigns cannot be underestimated, and the death of Mr Hill will hopefully serve as a reminder of the importance of appreciating the inherent risks involved in untrained persons repairing heavy machinery.

The evidence indicates that Mr Hill failed to take important safety precautions while working on his vehicle, such as using a ramp without a flat or recessed top section; chocking the wheels to prevent them from rolling; and engaging the handbrake. I find that Mr Hill died in circumstances which were both tragic and preventable.

I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that Lloyd Douglas Hill died from mechanical asphyxia, in circumstances where his chest was crushed by a car.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:

Mr Trevor and Mrs Sharon Hill

Ms Emma Smith

Australian Competition and Consumer Commission

Victorian WorkCover Authority (WorkSafe Victoria)

Leading Senior Constable Andrew Sherry

Signature:

AUDREY JAMIESON

CORONER

Date: **12 September 2016**