IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 000755

REDACTED FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of LG
without holding an inquest:
find that the identity of the deceased was LG
born on 8 April 2007,
and that the death occurred on 23 February 2010
at Moorooduc Victoria 3933
from:

1 (a) TRAUMATIC ASPHYXIA.

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. LG was aged 2 years and 10 months at the time of her death. She lived with her parents and her 5-year-old brother and was a happy, healthy and active child.

2. On the evening of Tuesday 23 February 2010, LG's parents were at home with their children, as well as a friend of the couple who was staying with the family for a short time. LG was put to bed at about 8.00pm. She slept in a single bed in her own room. Her father turned her light off, left her door ajar and put her brother to bed shortly afterwards.

3. LG's father then busied himself in the study before joining his wife and their friend to watch TV in the lounge. At about 10.00pm he decided to go to bed, and he and his wife checked on the children, going into their son's room first.

4. When they went into LG's room, they saw that the chest of drawers at the foot of her bed was leaning over against the bed. They turned on the light and saw that LG was stuck between the foot of the bed and the chest of drawers, which had apparently tipped over onto her.

5. Her parents placed LG on the floor and then her father and their friend performed CPR whilst LG's mother rang 000. Ambulance officers arrived a short time later and continued CPR until about 10.40pm when they confirmed that, tragically, LG had passed away.

6. Police attended the home and investigated the circumstances surrounding LG's death. They concluded that LG had probably climbed up the chest of drawers to reach ornaments on top of them that she liked holding, and that the drawers had overbalanced and tipped over pinning her against the foot of her bed and suffocating her. The police provided the brief of evidence, including scene photographs, on which this finding is largely based.

7. An external examination of LG's body was performed by Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (VIFM). Dr Lynch reviewed the circumstances as reported by the police to the coroner and post-mortem CT scanning of the whole body (PMCT) and provided a written report of his findings. Dr Lynch ascribed *traumatic asphyxia* as a reasonable cause of death, in the absence of performing a full post-mortem, and advised that there was no evidence of any injuries to suggest non-accidental injury. He noted the results of post-mortem toxicological analysis that did not reveal the presence of any common drugs or poisons in post-mortem samples taken from LG.

8. I find that LG's death was caused by traumatic asphyxia.

Further investigation

9. As part of the coronial investigation of LG's death, I asked that the Coroners Prevention Unit (CPU) provide advice regarding:

- The number and details of previous deaths of children involving the tip-over of furniture or appliances; and
- The use, awareness and adoption of the Australian Standards for domestic furniture (AS/NZS 4935:2009) in the Australian furniture industry.

Their advice is attached to this finding as **Appendix A**.

COMMENTS

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

1. The CPU identified 13 deaths of children under the age of 16 resulting from furniture tipping over on the child. The average age of those children was one year and 11 months old. The item of furniture most commonly involved in the deaths, were chests of drawers.

2. The number of injuries that result from furniture tip-overs is not well reported in Victoria. Data from Queensland suggests that approximately 180 children under 5-years of age present to Queensland hospitals each year with injuries sustained in furniture tip-over.

3. The Western Australian Coroner's Court has held two inquests into such deaths. The first inquests presided over by State Coroner Hope was held in 2000, and resulted in recommendations for furniture stability standards, and improved labelling of compliant furniture.[1] In the finding from the second inquest, Deputy State Coroner Vicker concluded that a mandatory standard that covered all issues pertaining to furniture was unworkable, and that item specific information provided by retailer would be a more appropriate way to alert parents to the risks of furniture tip-over.[2]

4. Since the release of these findings, an Australian Standard for domestic furniture stability has been released and is currently being assessed by the Australian Competition and Consumer Commission (ACCC) to determine whether it is appropriate to make the standard mandatory. I understand that the ACCC is more inclined to undertake a safety campaign, than to declare a mandatory standard.

5. Safety information is currently available to parents in various forms. However, there have been concerns expressed about whether that information is widely distributed enough to be effective. The information is produced by both State and Commonwealth consumer affairs agencies and community organisations.

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[1] Brayden Opie – Inquest reference number 30/2000.

[2] Adrian Stonehouse – Inquest reference number 23/2007.

RECOMMENDATIONS

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

1. That the ACCC give due consideration to the voluntary Australian Standard Domestic furniture – freestanding chests of drawers, wardrobes and bookshelves/bookcases (AS/NZS4935:2009) for the introduction of a mandatory standard under the Australian Consumer Law.

2. Further, and in the alternative, in the event that the ACCC determines that AS/NZS 4935:2009 is not appropriate to be applied as a mandatory standard, **I recommend** that the ACCC consider alternative product safety measures to reduce the risk of furniture/appliance tip-over.

3. While there is existing safety information regarding domestic furniture and the risk of tip-over, it is primarily available on the internet. I endorse the Deputy State Coroner of Western Australia's conclusion that, information that is only available online, would mainly be accessed by those already attuned to infant safety, rather than raising awareness amongst parents and carers generally. I also endorse Deputy State Coroner Vicker's observation that retailers could do much more to alert consumers to the potential for apparently stable items to become unstable.

4. **I therefore recommend** that the ACCC consider the mandatory labelling of safety information for furniture and appliances that pose a tip-over risk to children, and/or mandatory provision of safety information by retailers regarding tip-over risks at the point of sale of these products. Examples of safety labels are contained within the voluntary Australian Standard AS/NZS 4935:2009.

5. More intensive efforts could be made to enhance community awareness of tip-over risks to children, and practical measures that can be taken to reduce those risks. **I recommend** that the ACCC develop a public awareness campaign, aimed at the parents and carers of young children, with the goal of raising awareness of the risks of furniture tip-overs. The Western Australian tip-over campaign involved collaboration between the State government and child-safety groups, and such collaboration in this case would also be appropriate.

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

The family of LG
Ms Ruth MacKay, General Manager, Product Safety Branch, ACCC
Dr Claire Noone, Executive Director, Consumer Affairs Victoria
Ms Patrizia Torelli, CEO, Australian Furniture Association Inc

Mr Gerry Murray, CEO, Furnishing Industry Association of Australia (Queensland)

Mr Peter McCutcheon, Chair, Furntech

Mr Robert Caulfield, President, Kidsafe Victoria Inc

Professor Christine Kilpatrick, CEO, Royal Children's Hospital

Mr Richard Bolt, Secretary, Department of Education and Early Childhood Development

Leading Senior Constable Greg Kraus, Mornington Police Station.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **27 September 2013**

APPENDIX A - Furniture tip-overs involving a child

1. The CPU identified 13 deaths of people under 16 years of age due to tip-overs of furniture or appliances in Australia from 1 January 2000 to October 2011. The median age of the deceased was 1 year and 11 months old, and the main activities that the children were undertaking prior to their deaths were climbing the furniture or playing on or near the furniture. The main types of furniture and appliances involved were sets of drawers, televisions and wardrobes.

2. The incidence of injuries related to furniture tip-overs is not well reported in Victoria. The Monash University Accident Research Centre (MUARC) has published injury data for furniture-related injuries in children, and incidence of TV tip-overs, but not specifically about furniture tip-overs.

3. The USA Consumer Product Safety Commission (CPSC) analysed the number of children who had been treated in emergency departments as a result of injuries sustained from the tip-over or instability of appliances, furniture or televisions in the period from 1990-2007. They estimated that 264,200 children aged 17 years or younger presented to an emergency department in the study period, approximately 14,700 per year and found the average age of the injured child was 2 years. There were an estimated 300 deaths during the same period, with the majority occurring in those aged under three years when they were climbing on the furniture.

4. In Australia, the Queensland Injury Surveillance Unit (QISU) analysed the number of children under the age of five years who presented to a participating emergency department following a furniture-related event between 1999 and 2008. 288 of the total 449 presentations were related to a tip-over event, and at least 8.6 per cent of the tip-over events resulted from children climbing on the furniture.

5. JTR Quality Furniture, owned and managed by Mr Russell Silver, constructed the chest of drawers that was in LG's bedroom. Mr Silver provided evidence with respect to the construction of the drawers. JTR supplied furniture to several suppliers, including Deaco Furniture in Mornington, where Mr and Mrs Goding bought the chest of drawers. Mr Silver had over 20 years experience in the furniture-manufacturing industry and was not aware of any design standard to be complied with in the manufacture of tall boys or chests of drawers. Mr Silver stated that, for as long as he has worked in the industry, designs of tall boys have been the same with only slight variations in moulding shapes and sizes of units, drawers and depths of units. Mr Silver closed his business in November 2009.

6. The CPU also identified two findings from the Western Australian Coroners Court where a coroner made recommendations in relation to deaths of children due to tip-overs of furniture or appliances. The first of these findings was made in relation to the death of Brayden Opie in 1999.[3] State Coroner Hope recommended that:

> 1. *The Furnishing Industry Association of Australia and Furntech[4], the Australian Furnishing and Research Institute, extend and promote the Furnishing Quality Program[5] so as to provide swing tags for showroom display of storage furniture when such furniture complies with appropriate safety standards and particularly standards relating to stability of the furniture.*
> 2. *That an Australian Standard be developed for storage furniture and particularly for chests of drawers which is:*
>   a. *relatively short and easy to read;*
>   b. *relatively inexpensive for purchase by manufacturers and retailers; and*
>   c. *which focuses on important safety issues.*
> 3. *That consideration be given to making adherence to safety features of a standard relating to storage furniture mandatory (as has occurred in relation to cots sold in Australia since 1 July, 1998, AS/NZS 2172 Cots for Household Use).*

7. The second finding was in relation to the death of Adrian Stonehouse in 2007.[6] Deputy State Coroner Vicker concluded that a mandatory and standard 'rules for all approach to domestic furniture' is impractical because of the huge variations in household furniture and the multitude of factors that affect the item's stability including use and weight distribution. Deputy State Coroner Vicker opined that community awareness was very important, as 'a consumer not following advice is one thing. A consumer not knowing what can be done is another' and recommended:

> *That the Department of Consumer and Employment Protection Retail and Services Branch work with:-*
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> *i. retail groups to encourage their manufacturers to provide specific safety advice with respect to individual items of furniture, and*
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> *ii. consumer groups to put pressure on retailers to be aware of safety issues and ensure manufactures indicate safe options for domestic furniture use.*

8. Following State Coroner Hope's recommendation, the Western Australian Department of Commerce, Consumer Protection Division (WACPD) released some educational material and then formed the Joint Technical Committee Commercial/Domestic Furniture. This committee was made up of a number of bodies with an interest in the furniture industry, and Standards Australia. The committee developed the Australian/New Zealand Standard Domestic Furniture – Freestanding

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[3] Brayden Opie – Inquest reference number 30/2000.

[4] Furntech is the trade name for the Australian Furnishing Development and Research Institute (AFDRI), a not-for-profit organisation that tests furniture and develops standards.

[5] Research conducted by the CPU indicates that this program is inactive. It may have been replaced by Furntech's Blue Tick Program.

[6] Adrian Stonehouse – Inquest reference number 23/2007.

chest of drawers, wardrobes and bookshelves/bookcases – determination of stability (AS/NZS 4935:2009). This voluntary standard was published in November 2009.

9. The Australian Standard is based on an American standard ASTM F2057-04 and covers any wardrobe, bookcase or chests of drawers that are over 500mm tall. A chest of drawers includes any chest that contains one or more drawers or extendible items. The test for drawers requires that every drawer is opened two-thirds of its full extension length and the tester looks for tipping or fracturing of the unit. All of the drawers are then closed. Each drawer is then tested separately by having a 29-kilogram weight placed in it.

10. Apart from minor fittings, furniture items that fracture and cannot accept full application of the test mass or force will be deemed to have failed the requirements of the standard. Furniture items that tip over or are only prevented from tipping by an extendible element will also be deemed to have failed the standard. The standard requires that a National Association of Testing Authorities (NATA) Australia accredited laboratory perform the test procedures. It also requires durable warning labels and swing tags to be attached to the furniture which warn of the risk of tip-over, and strongly recommends that devices (anchors) for attaching the furniture to a wall be included with the furniture.

11. After the standard was published, it was immediately referred to the Australian Competition and Consumer Commission (ACCC)[7] for consideration to be made a mandatory standard. The WACPD informed the CPU that prior to our inquiry it was their understanding that the ACCC had not acted upon that referral, and was unlikely to make the standard mandatory. The ACCC informed the CPU that if it decided not to make the standard mandatory, it would consider a major safety campaign, which could address the concerns about TV tip-overs and would cover furniture already in homes as well as newly manufactured furniture.

12. The CPU sought the views of the Australian Furnishing Association Inc.[8] on whether it would support a mandatory standard and the feasibility of complying with the Australian Standard if it were mandatory. The CEO of the Association stated that it had submitted letters to the ACCC

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[7] In January 2011, the Australian Consumer Law (ACL) came into effect. The ACL harmonised state and territory consumer affairs legislation and divided power between the state and Commonwealth agencies. The Minister for the ACCC has sole responsibility for making mandatory standards under the *Competition and Consumer Act 2010* (Cth). Mandatory standards are only used when evidence indicates a risk of serious injury, illness or death associated with a product. There are currently no mandatory standards for domestic furniture stability. The ACCC is currently considering whether to make the Australian Standard Domestic furniture – freestanding chests of drawers, wardrobes and bookshelves/bookcases (AS/NZS4935:2009) mandatory.

[8] Formerly the Australian Furniture Industry Association (Victoria and Tasmania). The Association now also represents Western Australia.

in 2011, asking for the standard to become mandatory and reaffirmed that position, given the tragic deaths of a number of children. The Association did, however, have concerns about how the standard would be enforced, given the broad range of products on the marked that would be caught by the standard and the many importers who bring relevant products into Australia.

13. Furntech, a not-for-profit organisation that tests furniture and develops standards, is the only certified tester for this standard listed on the NATA website, and confirmed that it had not tested any furniture to this standard as at 19 October 2011. There seems to be little voluntary compliance with the furniture standard.

14. The state and Commonwealth consumer protection agencies have published some awareness and guidance material about the risk of furniture and TV tip-overs, and there are common key messages between the jurisdictions and are widely available on the agencies' websites. The key messages are:

- prefer furniture with a stable base over furniture with legs
- test the furniture in the shop
- put the item in a low risk area of the house
- secure the item to the wall
- lock any drawers
- match your TV and stand size and consider anchoring the TV
- don't place items that are attractive to children on top of the furniture
- keep electrical cords out of the reach of children
- place any heavy items on the furniture as far back on the furniture as possible
- discourage your child from climbing on the furniture.

Western Australia has worked with Kidsafe to release its information. The Queensland Fair Trading Office has released a video on its website that details the prevention measures and the ACCC has included that video on its product safety website.

15. The American CPSC has undertaken a safety campaign about furniture tip-overs, which has a social networking focus but also included media releases, a poster, a brochure and a video.