IN THE CORONERS COURT
OF VICTORIA
AT SHEPPARTON

Court Reference: COR 2013 003878

FINDING INTO DEATH WITHOUT INQUEST

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

I, Stella Maria Stuthridge, Coroner, having investigated the death of Robert Leslie Davis

without holding an inquest:

find that the identity of the deceased was Robert Leslie Davis

born on 28 February 1948

and the death occurred on 1 September 2013

at Ashwin Road, Macs Cove Victoria 3723

from:

1a MULTIPLE INJURIES SUSTAINED IN A FALL FROM A HEIGHT

Pursuant to section 67(1) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances**:

Mr Robert Leslie Davis was aged 65 years at the time of his death and he lived in Riverwood, NSW. Mr Davis worked most of his life in the plumbing industry and was well regarded. He enjoyed the outdoors including boating, fishing, camping, hunting and cooking.

Mr Davis was a type 2 diabetic, had cardiomyopthy, high blood pressure and an irregular heart beat. He was on blood thinning medication and medication for pain relief. He weighed around 140 kilograms and was morbidly obese.

His family noticed that Mr Davis was getting a little more unstable on his feet as he was getting older. Although they hadn't witnessed him falling they would see him occasionally have a little trip but he would stay upright. Because of this his son would usually tell him not to walk around without anyone being with him as he wanted him to be safe in case he tripped and fell.

On Thursday 29 August, Mr Davis left home and travelled to Mac's Cove to go dear hunting. Mr Davis had been hunting at Mac's Cove several times before, often with his son. He normally didn't walk whilst hunting and would usually sit behind deer blinds to save him from walking in the steep terrain.

Mr Davis went hunting with his son on Friday 30 August. When his son was leaving that evening Mr Davis told him "I'm going to go for a walk in the morning and I'll probably leave about lunch time."

Early the next morning Mr Davis went hunting with three associates. They separated with Mr Davis walking through steep, rocky and difficult terrain. At about 9.30am, Mr Davis stumbled and fell down a gully hurting his ankle. Mr Davis was unable to walk and believed his ankle was broken. Attempts were made by Mr Davis and his associates to walk out of the area. Due to the location being so steep and at least one kilometer from a track with vehicle access it was decided to contact emergency services.

Emergency services attended the scene with Ambulance members stabilising Mr Davis and providing medication for his pain. Options for extraction of Mr Davis were considered and it was decided that the most appropriate method would be via a rescue helicopter.

At 11.43am, a Hems 5 rescue helicopter arrived and a Flight Paramedic was winched down and took over responsibility for Mr Davis' treatment. He was moved via a stretcher to a more appropriate location to extract him and vegetation was removed. It was deemed by Hems 5 members that an extraction using a stretcher was unsuitable due to the large amount of vegetation and that the strop harness should be used. Mr Davis was placed in the harness and provided with instructions regarding the winching process.

At 12.36pm a 'two person' winch was conducted with the Flight Paramedic and it took around 65 second for the pair to approach the skids of the helicopter. Mr Davis then began to panic or struggle and possibly lost consciousness. The Flight Paramedic struggled to hold Mr Davis' arms down and he was observed to begin to slip from the harness. The helicopter pilot lowered the helicopter by ten feet to decrease the distance to the ground if someone fell. The Paramdic and the Winch Operator attempted to pull Mr Davis, who was limp, into the helicopter. While both struggled to hold Mr Davis he slipped out of the strop harness falling approximately 70 to 80 feet to the ground. He could not be revived.

The Victoria Police investigating member attended the scene and interviewed witnesses. Their investigation concluded that equipment malfunction of the strop harness played no part in the death. It identified factors that may have contributed to the death as the type of harness used, time taken during the winching procedure and Mr Davis' weight and pre-existing medical conditions.

A physical examination of Mr Davis was performed by Dr Kate Strachan from the Victorian Institute of Forensic Medicine who reported the cause of death as multiple injuries sustained in a fall from a height. The examination showed an enlarged heart and multiple fractures. Toxicology analysis showed the presence of codeine, metclopramide and paracetamol at therapeutic levels. Morphine was detected at 0.1mg/L with no ethanol or common drugs and poisons identified. Dr Strachan noted that it was not possible at the examination to determine what may have caused an unresponsive episode while he was in the hoist, or whether this event would have been potentially life threatening in the absence of injuries sustained in the fall from the helicopter.

An opinion was obtained from Dr Alan Garner, a specialist in retrieval medicine, on the medical factors that may have contributed to the death. Dr Garner stated that a critical safety factor is that a person in the single strop harness must maintain their arms against their body as it is possible to slip out of the strop. Dr Garner's opinion is that "...the overwhelming likelihood is that Mr Davis lost consciousness due to the effect on his respiratory and cardiac function from use of a single strop technique resulting in thoracic compression and vascular collapse. This was significantly exacerbated by his underlying comorbidities of morbid obesity and congestic cardiac failure which would have both amplified the compressive effect and reduced his ability to compensate for the predictable physiological changes associated with this rescue technique."

An investigation was undertaken by the Australian Transport Safety Bureau, which found that the use of a rescue strop, without employing the integral hypothermic strap, was not suitable for the patient's size and medical condition, and following their loss of consciousness contributed to the patient falling from the strop. The safety issue they identified was that the "…operator had limited guidance for rescue personnel regarding the selection of the most appropriate rescue equipment, and the conditions when various types of equipment should be considered."

Ambulance Victoria (AV) provided a statement advising that they have used the rescue strop for almost 30 years without any incident prior to 31 August 2013. Since the incident AV has implemented a Risk Reduction Action Plan including the introduction and use of the Air Rescue Vest. The Air Rescue Systems Air Life Rescue Vest provides the benefits of full body capture as well as the speed of the rescue strop. The Vest has a reinforced neck structure providing head stabilisation and vertical support even for an unconscious victim.

I find that Mr Robert Leslie Davis died as a result of multiple injuries sustained in a fall from a height.

COMMENTS

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

Ambulance Victoria acknowledge that winching is a procedure that has a substantial element of risk to the helicopter crew, paramedics and patients. They will use learnings from this incident as an opporunity to review all procedures and processes to improve safety on an ongoing basis.

Pursuant to rule 64(3), I order that the following be published on the internet:

Finding into death without inquest for Mr Robert Leslie Davis.

Signature:

Stella Maria Stuthridge

Coroner

Date: 4 September 2015