IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002230

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Jing Hui Chen
Date of birth:	14 December 1973
Date of death:	28 April 2023
Cause of death:	1(a) Traumatic head injury sustained in a fall
Place of death:	Royal Melbourne Hotel, 629 Bourke Street, Melbourne, Victoria, 3000
Keywords:	Workplace safety, WorkSafe investigation, fall from height, head injury

INTRODUCTION

1. On 28 April 2023, Jing Hui Chen ('Jackie') was 49 years old when he died from injuries he sustained in a fall from the roof of his work vehicle. At the time of his death, Jackie lived at 98 Pleasant Road, Templestowe Lower, Victoria, 3107 with his wife and children.

2. Jackie was raised in China, where he completed high school and obtained his air conditioning licences and certificates. Although he had known his wife since high school, her family migrated to Australia in 1992, so it was not until she returned for a holiday that they became a couple. They were married in 1999 and Jackie migrated to Australia in 2000.[1]

3. Jackie gained Australian permanent residency in 2005 and his air conditioning business continued to thrive in Melbourne.[2]

4. Aside from experiencing some back pain that he attributed to his years of heavy lifting, he was a fit, healthy and happy man who enjoyed going out for meals with family, friends and business associates.[3]

THE CORONIAL INVESTIGATION

5. Jackie's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* ('the Act'). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

[1] Statement of Belinda Chen, Coronial Brief.
[2] Ibid.
[3] Ibid. See also Report of Dr Wai Cheung-Yap, Coronial Brief.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Jackie's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating police and WorkSafe officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Jing Hui Chen including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

10. In considering the issues associated with this finding, I have been mindful of Jackie's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

11. On 19 April 2023, Jackie had lunch in Doncaster with a colleague, Jingyuan Hu ('Jack'). Jack had just collected one of the work vans, a white Volkswagen Crafter van, from the Volkswagen dealership in Doncaster where it had been left for repairs. After lunch, Jackie went to another worksite and Jack drove the van back to Jackie's factory at 645 Waterdale Road, West Heidelberg. Jack reversed the van through the open roller door at the front of the factory into a parking bay in order to reload all the usual tools that had been removed prior to the van being taken for maintenance.[5]

12. Jackie returned to the factory later that afternoon.[6] Jack and Jackie worked together to remove two large plastic tubes that were attached to either side of the van's roof rack and shortened them to improve their functionality. These tubes were attached to the van with metal clips and were used to transport smaller plastic and metal tubing to job sites. The tubes were fitted with screw-on caps so that their contents did not fall out in transit.[7]

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[4] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[5] Statement of Jack Hu, Coronial Brief.

[6] Statement of Andrew Croft, Coronial Brief.

[7] Statement of Jack Hu, Coronial Brief.

13. The roof rack for this van was fitted with rollers above the rear doors. The purpose of the roller was to make it easier to load heavier items such as ladders up onto the roof rack. After they had shortened the tubes, Jackie and his colleague rested them against the rollers, then slid the tubes over the rollers up onto the roof. The rear doors of the van remained open, with a ladder positioned in the middle of the doors, which Jackie and his colleague used to climb back up on to the roof, intending to secure the tubes back in their usual position on either side of the roof rack.[8]

14. During this manoeuvre, neither man was wearing a harness. They were able to stand upright on the van's roof due to the height of the factory's ceiling.[9]

15. By about 6:00pm, the tubes had been secured back in place on the roof of the van, but Jackie decided to add a few extra screws to better secure the tube caps.To that end he climbed back up the ladder by himself and asked Jack to check the ground around the van and pick up any loose screws that might puncture tyres.[10]

16. Jack commenced his task and was about 2 metres away from the passenger side rear quarter panel of the van, looking for loose screws on the floor, when CCTV footage from the factory shows that Jackie moved towards the rear of the van's roof, adjusted his feet as though he was going to crouch down at the rear passenger side corner, when his right foot slipped from the roof of the van causing him to lose his balance and fall to the concrete factory floor, striking his head as he landed. [11]

17. I note that at this point on the vehicle, Jackie's foot would have been quite close to the rollers described above, and some inadvertent contact with those rollers, which were also quite close to the ladder, may have been the cause of his loss of balance, though I cannot be certain of that.

18. Jack did not actually see Jackie fall, but heard the noise and immediately ran to render assistance. Blood was already coming from Jackie's right ear. [12] The manager working in the office nearby also heard the noise and came straight out to help. Jack called 000, and the

[8] Ibid.
[9] Statement of Tim Kohler and Exhibit 8, Coronial Brief.
[10] Statement of Jack Hu, Coronial Brief.
[11] Statement of Tim Kohler and Exhibit 8, Coronial Brief.
[12] Statement of Jack Hu, Coronial Brief.

manager moved the van out of the way so as to facilitate easier ambulance access. Jackie was moaning but not articulating distinct words.[13]

19. Paramedics promptly conveyed Jackie to the Royal Melbourne Hospital for emergency treatment,[14] but sadly he could not be revived, and after nine days in hospital he passed away in the Intensive Care Unit at 6:37pm on 28 April 2023.

WorkSafe Investigation

20. WorkSafe investigators attended the scene but did not pursue a criminal investigation because Jackie was the only licensed 'employee' within his business, the rest being subcontractors, and clearly this arrangement would not be continuing.[15] The investigation established that whilst the factory office contained standard blank Safe Working Method Statements, and these were supplied to contractors to complete, no records were located to verify that had actually occurred. The ongoing management engaged adequately with new safety and training procedures relating to working at heights and better record-keeping, and I am satisfied that no further prevention opportunities need to be explored within the remit of this death investigation.[16]

Identity of the deceased

21. On 28 April 2023, Jing Hui Chen, born 14 December 1973, was visually identified by their wife, Belinda Chen. Identity is not in dispute and requires no further investigation.

Medical cause of death

22. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an external examination on 1 May 2023 and provided a written report of his findings dated 2 May 2023.

23. The post-mortem examination revealed a significant head injury consistent with the fall history provided. No other independent cause of death was identified.

[13] Statement of Andrew Croft, Coronial Brief.
[14] Exhibits 3 & 4, Consolidated Patient Care Record, Ambulance Victoria, Coronial Brief.
[15] Letter to Court from Alex Hillgrove, 19 December 2023, and Inspection Report by Joseph Barcellona, 5 May 2023, both of WorkSafe, Coronial Brief.
[16] Inspection Reports by Joseph Barcellona, 14 June and 18 July 2023, both of WorkSafe, Coronial Brief.

24. Toxicological analysis of blood samples was not ordered because Jackie's extensive hospital treatment following his fall masked all other potential insights that might have been gained.

25. Dr de Boer provided an opinion that the medical cause of death was 1 (a) traumatic head injury sustained in a fall, and I accept his opinion.

FINDINGS AND CONCLUSION

26. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[17] Adverse findings or comments against individuals in their professional capacity are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

27. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Jing Hui Chen, born 14 December 1973;

    b) the death occurred on 28 April 2023 at Royal Melbourne Hotel, 629 Bourke Street, Melbourne, Victoria, 3000, from traumatic head injury sustained in a fall; and

    c) the death occurred in the circumstances described above.

28. Having considered all of the evidence, I find that Jing Hui Chen contributed to his own death by working at heights without following the industry standard practices identified during the WorkSafe inspections cited above.

I convey my sincere condolences to Jackie's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

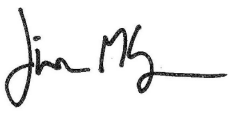
[17] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

Belinda Chen, Senior Next of Kin

Scott Newlan, TG Legal & Technology on behalf of WorkSafe Victoria

Leading Senior Constable Jill Walker, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 04 September 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.