OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Irene Clare Leach**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR926/06(0)
DELIVERED ON:	15 September 2009
DELIVERED AT:	Cairns
HEARING DATE(s):	6 October 2008, 24 November 2008
FINDINGS OF:	Coroner Black
CATCHWORDS:	CORONERS: Inquest – waterlifts, standards, installation, safety audits, registration with Workplace Health and Safety authorities

REPRESENTATION:

Counsel assisting:	Mr Dean Morzone
Mr Nicolls	Mr Kevin McCreanor

Coroner's findings and decision

These are my findings in relation to the death of Irene Clare Leach. The findings seek to explain how the death occurred and consider whether any changes to policies or practises could reduce the likelihood of deaths occurring in similar circumstances in the future.

The *Coroners Act 2003* provides that when an inquest is held into a death, the Coroner's findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The Coroner has jurisdiction to inquire into the cause and circumstances of a reportable death. If possible, he or she is required to find, where the death in fact happened, the identity of the deceased, when, where and how the death occurred and what caused the person to die.

There has been considerable litigation concerning the extent of a Coroner's jurisdiction to inquire into the circumstances of a death and it seems to me to be appropriate that I say something about the general nature of inquests for the benefit of the deceased's family and for completeness.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:

> *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the Prosecutor accuses and the accused defends. The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires. The focus is on discovering what happened; not on ascribing guilt, attributing blame or apportioning liability.*
>
> *The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a Coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.*
>
> *A Coroner must not include in the findings, or any comments or recommendations or statements that a person is or may be guilty of an offence or civilly liable for something. However, if as a result of considering the information gathered during an inquest a Coroner reasonably suspects that a person may be guilty of a criminal offence, a Coroner must refer the information to the appropriate prosecuting authority."*

It is important to note that proceedings in a Coroner's Court are not bound by the rules of evidence pursuant to section 37 of the Act. Because section 37 of the Act provides that a court may inform itself in any way it considers appropriate, that does not mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a Coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt; an inquiry rather than a trial. A Coroner should apply the civil standard of proof, namely the balance of probabilities, to the approach (referred to as the Briggenshaw sliding scale) is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trial of fact to be sufficiently satisfied that has been proven to the civil standard.

It is also clear that a Coroner is obliged to comply with the rules of natural justice and act judicially. This means that no finding adverse to the interests of any party may be made without that party first being given a right to be heard in opposition to that finding. As Annetts v McCann makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

Introduction

Irene Clare Leach was born on the 27th of June 1912 and was thus aged 94 years at the date of her passing. She used a walking frame and was not particularly mobile. Some time in the 1990s a waterlift was installed to enable her, in her advanced years, to ascend and descend between the ground floor and the first level of her long-time home at 76 Martyn Street, Parramatta Park, Cairns. The deceased's three sons, Mark, Brian and Kevin, apparently each contributed about $1000 towards the lift's manufacture and installation.

When the lift was sited on the ground, its roof was level with and formed part of the first floor area. Some time in the afternoon of the 17th of March 2006 between about 3.15pm and 5.30pm, Mrs Leach stepped on the roof of the waterlift, which was positioned on the ground floor level. She was aided in the movement, it seems, by use of her walking frame. According to her son Mark, leading up to the accident his mother had become frailer and suffered from memory loss.

Mrs Leach operated the control rod which caused the lift car to ascend from the ground to the first floor. Mrs Leach remained on the roof of the car and, being unable to stop its rise, was pinned between the roof of the lift, her walking frame and the ceiling of the house. She was found by her son Mark Leach at about 5.30pm that day. He observed that his mother was slumped over her walking frame, with her neck area wedged between the frame and the ceiling. She was deceased and was subsequently declared so at the scene.

A postmortem examination conducted by a forensic pathologist, Dr David Williams, established that the death was caused by compression of the neck. The postmortem also established that Mrs Leach had suffered other significant injuries, including fractures to both sides of the front of the chest. A coronial inquiry was commenced.

The Investigation

From a comprehensive technical report prepared by a Workplace Health and Safety inspector, Mr Chris Parr, it has been established that the waterlift installed in Mrs Leach's premises was of a simple construction. There were two guides to which the car of the lift was attached, and two lifting cylinders located at the sides of the guides which provided the force to lift the car. There were two control valves. The upper valve, a single position (on and off),

controlled the flow of water from the water supply. The lower valve had two positions. In an open position, water drained from the cylinders causing the lift to descend. In a closed position, water was supplied to the cylinders causing the lift to rise. The mechanism was operated by a connection rod to a lower valve on the first floor, which enabled the drainage of water from the system allowing the lift to descend. At the rear of the lift car was a control rod which, when opened, allowed water to enter the cylinder providing force to a piston, which in turn to a ram rod, providing lift.

Mr Coggins, who is a principal investigator with the Department of Workplace Health and Safety, conducted an inspection of the lift. He found that a certain amount of force was required to operate the lift control bar. It was Mr Coggins' conclusion that Mrs Leach would've had to use both hands to operate the lift's mechanism. Once in motion, a similar application of force would be required to stall or stop it. It seems that Mrs Leach did not possess the necessary strength.

A further technical report from Workplace Health and Safety chief safety engineer, Mr Thomas Herron, suggests that the lift design and installation largely ignored relevant safety standards. In particular, there was no risk control measures in place exposing all operators of the lift and those in close proximity to it, to a high risk of injury. It is Mr Herron's view that this risk could have been eliminated had the lift complied with relevant regulations, mandatory design approval and inspection procedures that were in force at the time. It is apparent that the inadequacies in the mechanism had a direct causal relationship to the death of Mrs Leach.

Although Mrs Leach's grandson, Jeffrey, declined to provide a formal statement for the purposes of this inquest, he disclosed to an investigating officer, Detective Sergeant Clarke that his grandmother had had earlier difficulties with the lift, including a time when he had found her stuck on the top of it. He also reported an incident when a cat owned by the deceased had been killed through the lift's operation. There is corroborative evidence to this effect from statements given by the deceased's other two sons, Mark and Brian.

About a week before the incident under investigation, Mrs Leach's home carer was made aware of the problems with the lift. She observed the control rod mechanisms to be immovable, despite her application of considerable force - more force, it seems, than could have been applied by the deceased. Some days later she noted the lift to be apparently operational again. There is no evidence that the lift had undergone any repairs in the intervening time.

It has been established that Mrs Leach was fully aware of recent problems and dangers associated with this mechanism, but persisted or attempted to persist in its use. Perhaps this was attributable to mild age related Alzheimer's disease, as identified by Dr Williams.

There is a substantial body of evidence that suggests the lift was installed by Mr Alfred Nicolls, who resides at 4 Trinidad Close, Trinity Park. Some details of the installation have been recorded in the deceased's notebook suggesting a Nick Nicolls was the manufacturer/installer. There is also some evidence from the deceased's son Mark of a Mick Nicolls providing some maintenance to the system in late 2004.

During the course of investigations for these coronial proceedings, a search under the authority of a warrant was conducted on Mr Alfred Nicolls' residence

at Trinity Park. Evidence of the manufacture and supply of like lifts was found. Mr Nicolls declined to take part in an interview. Accordingly, there is no evidence directly linking Nicolls with the manufacture and installation of the lift installed in Mrs Leach's home. Additionally, there is conjecture as to when the lift was actually installed. Mark Leach opines that it was installed four to five years prior to his moving with his mother in about 1998.

According to Inspector Parr of Workplace Health and Safety, the lift had numerous defects and deviated from Design Guide No 910404 (Disabled Person's Private Residence Lift) and from other recognisable Australian Standards 1735.17 (1995) (Lifts for people with limited mobility - Restricted use - Water-drive). In particular, Mr Parr's inspection identified there was no lift well, no front door to the lift and the general engineering of the mechanism was poor.

Design Guide 910404 was published in 2005 and required the lift design and plan be registered. There is no evidence of any such registration. In addition, although the residence of the deceased would normally be classified as a workplace, the fact that the lift was classified as high risk plant, as defined under a schedule of the Workplace Health and Safety Act of 1995, a home then became and was classified as a relevant place as defined under Schedule 3 of the Act.

Design Guide No 910404 evolved from previous versions authorised by the chief inspector of machinery under the provisions of the Inspection Machinery Act. This Act was repealed when the Workplace Health and Safety Act of 1989 was proclaimed. A regulation passed in the Workplace Health and Safety Act in 1993 provided that, "If the plant is a lift for use by a disabled person in a private residence, the plant must comply with Design Guide No 910404." The regulation came into operation on the 30th of April 1993.

As mentioned previously, the installation date of the lift has not been determined. If the lift was installed prior to that date, that is the 30th of April 1993, there was no specific design guide for waterlifts applicable in Queensland if installed in a private residence. In his report to the Coroner Inspector Dean Coggins expressed this view:

> *"Unless it can be determined with a high degree of certainty when the lift was designed, manufactured and installed, it cannot be determined whether obligations under the 1989 or the 1995 Act continue to exist."*

It is worth noting that in 1986, the Standards Association of Australia published AS1735 Australian Standards 1735 in relation to design guides for lifts. Part 12 of the standard dealt with facilities for persons with disabilities. In clause 1.2 thereof it was particularly provided: A standard does not apply to lifts in sole occupancy - private dwellings. It is also relevant to note that even if the Design Guide 910404 was applicable it contained the following clause:

> *"It is the **owner's**," my emphasis, "responsibility to ensure that a lift is maintained in a safe operational condition."*

A Design Guide sets out the design criteria that must be complied with. Waterlifts in private residences, being a Design Guide, it does not set out detailed requirements for maintenance. Effective maintenance would obviously be required to ensure safe operation conditions of the waterlift and the statement merely serves as a prompt for designers who use the guide to

include maintenance provisions in the owner's manual.

It is clear that the manufacturer/installer was not the only person who serviced or made alterations to the lift following its installation. For example, Mr Brian Leach, apparently in recognition of the difficulties encountered by his mother in operating the lift handle, when attending the premises from out of town considered an alteration to the mechanism but abandoned that because of lack of tools. On another occasion he adjusted the tension of the lever arms to ensure that the lift descended properly. It is impossible to conclude that whatever these repairs or maintenances involved, there was no impact on the operational status of the lift, thus it cannot be concluded with any degree of certainty that the actions of any individual, whether by manufacture, installation or maintenance of the lift mechanism, contributed to Mrs Leach's death.

It is open for me to find that at the time of her death, Mrs Leach suffered from a confusion of her mind and that she inadvertently activated the lift to ascend rather than descend. Either through her frail physical condition or confused mind she was unable to operate the mechanism that would have reversed the situation.

Findings required by s45

I find that Irene Clare Leach died on the 17th of March 2006 at 76 Martyn Street, Parramatta Park, Cairns.

Mrs Leach was aged 94 years at the time of her death.

A postmortem examination report discloses, and I certify the cause of death as compression of the neck.

S46 Comments and recommendations

In 1995 a new Australian Standard was enacted, AS 17.35 Part 17 - Lifts for People with Limited Mobility - Restricted use - water-drive.

All new waterlifts after the enactment of that provision would have to comply with the Australian Standard.

I am informed that waterlifts of this nature were once required to be registered under the provisions of the Workplace Health and Safety legislation. It is my understanding that such registration was without fee. The requirement for such registration has ceased. In my view it would be in the public interest and would benefit the safety of aged, infirmed persons to require that waterlifts of the nature discussed in these proceedings be again required to be registered with the Workplace Health and Safety authorities.

A further recommendation would be that these devices be subjected to a regular, if not annual audit by appropriately qualified persons to ensure the continued compliance with the Australian Standard and Design Guide.

A significant period of time has passed since Mrs Leach's death. It seems unjust that a person who has lived so long and seen so much of life should be taken from her family in this undignified way. Hopefully these proceedings may bring home to all concerned the reasons for standards and design guides that are to provide a safe environment.

I am indebted to counsel assisting the Coroner, Mr Dean Morzone, and

counsel for Mr Nicolls, Mr Kevin McCreanor, for their most cogent and helpful submissions.

I extend my sympathy and the sympathy of my staff to all the family and friends of Mrs Leach.

Coroner Black
Cairns
15 September 2009