CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Dennis Cavanagh
Hearing dates:	2 March 2017
Date of findings:	2 March 2017
Place of findings:	State Coroners Court, Glebe
Findings of:	**Magistrate Teresa O'Sullivan, Deputy State Coroner**
Catchwords:	CORONIAL LAW – Cause and manner of death Cause of death unascertained
File number:	2015/270129
Representation:	**Sergeant Durand Welsh, Sergeant Assisting**
Findings:	**Identity of deceased**: The deceased person was Dennis Cavanagh **Date of death**: Mr Cavanagh died on 14 September 2015 **Place of death**: He died at Wheelbarrow Ridge Road, Colo Heights, NSW **Manner of death:** Mr Cavanagh died when he lost control of the back hoe he was driving and jumped or fell off it **Cause of death:** The cause of his death was not able to be determined

Table of Contents

The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Dennis Cavanagh.

REASONS FOR DECISION

Introduction:

This inquest concerns the death of Dennis Cavanagh. Mr Cavanagh was last seen alive at about 3:30 p.m. on the 14 September 2015. He was travelling east on Wheelbarrow Ridge Road from Putty Road. The witness saw Mr Cavanagh driving a backhoe in the same direction as he was travelling on the north side of the road. Mr Cavanagh was on the left hand side, half on the road and half in the dirt. The witness describes the backhoe to be travelling "slowly." [1]

At about 3.45pm on 14 September 2015, another witness, who was driving east along Wheelbarrow Road, located Mr Cavanagh on the roadway lying face down and he did not appear to be breathing. Intensive care paramedics attended the scene and sadly, Mr Cavanagh was pronounced deceased at 4:16 p.m.

The Inquest:

The purpose of the coronial jurisdiction, according to law, is to make formal findings as to the following five aspects of a death:

- the identity of the person
- the date of their death
- the place of their death
- the manner of their death
- the cause of their death.

Guided by these five aspects, an inquest investigates the facts and circumstances of a death, places them on the public record, and in certain cases will examine changes that could be made to prevent similar deaths in the future.

Accordingly, section 27(1)(d) of the Coroner's Act 2009 legislates that an inquest "is required to be held...if it appears to the coroner concerned that the manner and cause of the person's death have not been sufficiently disclosed".

In this case, the manner and cause of death have not been sufficiently disclosed. As such, an inquest is mandatory on these narrow issues.

[1] Statement of Stuart ROBERTS paragraph 3

Section 81 (1) of the Coroners Act 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings. These are my brief findings in relation to the death of Dennis Cavanagh.

The Evidence:

Background:

Dennis Cavanagh was born on the 21 June 1944. He was 71 years old at the time of his death on the 14 September 2015. The deceased has two children, Vanessa CAVANAGH and Dennis CAVANAGH Jnr., from his relationship with Theresa French. Theresa, Vanessa, Dennis Junior and their Aunty Euphemia all attended this inquest.

For over forty years the deceased resided in the Colo Heights area, and at the time of his death he resided at 2963 Putty Rd, Colo. He was a well-known member of the community and a former member of the local Rural Fire Service. Previously, he was a plant operator for Roads and Maritime, and he has an extensive history of using heavy machinery and other plant machinery.

The backhoe:

At about 900 a.m. on 14 September 2015, the deceased contacted via telephone Anthony SHORTEN, a close friend, to request the use of Mr SHORTEN's backhoe. Mr SHORTEN told the deceased that the brakes were "not that flash". The deceased responded: "I've driven backhoes all my life, I'll just put the bucket down. It will be fine."[2]

Mr SHORTEN states that he then said to Mr CAVANAGH, "Look, I'd rather not." Mr SHORTEN then describes Mr CAVANAGH as "putting the pressure on" and saying it was an urgent job and that he needed it as soon as possible.

Around lunchtime, the deceased attended SHORTEN's residence. Mr SHORTEN filled up the backhoe with forty litres of fuel and went over the backhoe with Mr CAVANAGH, in Mr SHORTEN's words, "...showing him the controls." Mr CAVANAGH test drove it down the driveway and afterwards said everything was okay. Mr SHORTEN advised Mr CAVANAGH to take it easy going down a section of roadway referred to colloquially as the dipper. Mr CAVANAGH said that he would make sure he would be in low gear and that the only problem would be the dipper and going across Putty Rd to his house.

[2] Statement of Anthony Shorten paragraph 4

Senior Constable DAVENPORT from the Engineering Investigation Unit conducted an inspection of the backhoe at the police holding yard in Chipping Norton on the 15 September 2015. He concluded that the main service brakes were not working properly and that the handbrake was not working at all.

The backhoe is a 6.5 tonne JCB. It has a rear bucket and a front bucket. It has a NSW registration plate, MSX500, attached to the cab. Police inquiries reveal that the registration plate was cancelled on the 31 August 1986 and has not since been re-registered.

In May 2013 via eBay, Anthony SHORTEN purchased the backhoe unregistered for $5499 from a Matt TUMOUR of Llandilo. Mr SHORTEN never intended to register it as it was for use on his private property. In his statement, Mr SHORTEN says, "It was in the same condition as when I bought it." [3]

About half an hour after Mr CAVANAGH collected the backhoe, SHORTEN travelled to a location opposite the Mr CAVANAGH's residence on Putty Road for an unrelated matter and sighted him operating the backhoe on his property.

About 3:30 p.m. on the 14 September 2015, Stuart ROBERTS was travelling east on Wheelbarrow Ridge Road from Putty Road. ROBERTS encountered Mr CAVANAGH driving the backhoe in the same direction as him on the north side of the road. Mr CAVANAGH was on the left hand side, half on the road and half in the dirt. ROBERTS says that the backhoe was travelling "slowly." [4]

At the time, Mr CAVANAGH was atop a crest. Past where Mr CAVANAGH was seen, Wheelbarrow Rd descends the crest and then ascends another incline. [5]

The fatal incident:

The final resting place of Mr CAVANAGH was located about 100 metres past the point where ROBERTS last saw him. Gouge marks on the bitumen suggest Mr CAVANAGH got approximately halfway up the second incline when the backhoe began to roll backwards. The gouge marks are believed to be the result of Mr CAVANAGH lowering the backhoe's bucket in an attempt to brake. The backhoe came to rest in bushland on the south side of Wheelbarrow Rd.

It appears from the road damage and the last sighted location of Mr CAVANAGH that the backhoe rolled backwards in a south-westerly direction, crossing over the double white centre lines as it did so. At some stage Mr CAVANAGH has been

[3] Statement of Anthony Shorten paragraph 5
[4] Statement of Stuart ROBERTS paragraph 3
[5] Statement of Emma COLE Pg 8

ejected or has jumped from the cab. Witness John Riley, who was driving east along Wheelbarrow Road, located Mr CAVANAGH on the roadway around 3:45 p.m.

Mr RILEY states Mr CAVANAGH was lying face down and did not appear to be breathing. Mr RILEY yelled a couple of times at Mr CAVANAGH, with no response. Mr RILEY could not check Mr CAVANAGH due to a hip condition that prevented him bending down.

Intensive care paramedics Mathew MOORE and Wayne BARRY attended the scene at about 4:09 p.m. The paramedics rolled Mr CAVANAGH over and Wayne BARRY noticed a laceration to Mr CAVANAGH's forehead. Mr CAVANAGH was not breathing and had no pulse. Wayne BARRY confirmed with a cardiac monitor that Mr CAVANAGH's heart was not beating. No CPR was conducted and Wayne BARRY pronounced Mr CAVANAGH deceased at 4:16 p.m.

The Autopsy:

The post-mortem could not ascertain the cause of death. Pathologist Dr Jordan BUTLER could not rule out positional asphyxia, especially given what was described in the autopsy as Mr CAVANAGH's morbid obesity. Positional asphyxia would be dependent somewhat on the position of the body on the roadway. Mr RILEY's statement and associated knowledge of Mr CAVANAGH's initial position on the roadway was not known at the time of the post-mortem. Dr BUTLER was subsequently provided with the statement of Mr Riley, indicating Mr CAVANAGH's position, but could not conclusively say that the cause of death was positional asphyxia.

Mr CAVANAGH had a laceration to the forehead but no associated haemorrhage. There was no definite intracranial injury. However, Dr BUTLER stated, "Certain brain injuries may not be identifiable if death occurred quickly...and cannot be completely excluded."

Dr BUTLER could also not exclude an unidentified concurrent event or illness (e.g., acute myocardial infarction) that increased his susceptibility to hypoxia nor could he exclude the possibility of positional asphyxia.

Mr CAVANAGH's medical records were obtained from Mt Druitt Aboriginal Medical Service, but these could not assist Dr BUTLER in finding a definitive cause of death.

The toxicology report revealed that the only detected substances were salicylic acid and telmisartan within therapeutic levels. Salicylic acid is used for skin and wart treatment, and telmisartan is used in the management of hypertension. Alcohol and other common drugs of abuse were not detected.

Dr Pokorny's evidence:

The only witness to give oral evidence at this inquest was forensic pathologist Dr POKORNY. She was the supervising pathologist for the autopsy on Mr CAVANAGH.

Dr Pokorny thought that there were three possible causes of death:

1. Positional asphyxia
2. Blunt force head injury
3. A concurrent natural event that increased Mr Cavanagh's susceptibility to hypoxia.

Ultimately she was not able to what caused Mr Cavanagh's death.

Manner of death:

As to the manner of Mr Cavanagh's death, I find, on balance, that he lost control of the back hoe he was driving and jumped or fell off it.

In closing, I would like to thank the officer in charge of this investigation, Constable Cole. I would also like to thank Sergeant Assisting, Sergeant Durand Welsh, for his very helpful submissions.

Finally, I would like to acknowledge Mr Cavanagh's family who attended this inquest. I am sorry that we are not able to determine what actually caused Dennis's death.

At times an inquest can be a bit cold and technical and I am aware of how hard that must be for the family who are sitting listening. I would like them to know that I am also acutely aware that at the heart of this inquest is the incredibly sad fact that they have lost a loved one. Dennis Cavanagh was obviously a vibrant and active man and part of a family and community that loved him very much. His death must have been a terrible shock and I offer my sincere condolences.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Dennis Cavanagh

Date of death

Mr Cavanagh died on 14 September 2015

Place of death

He died at Wheelbarrow Ridge Road, Colo Heights, NSW

Cause of death

The cause of his death was not able to be determined

Manner of death

Mr Cavanagh died when he lost control of the backhoe he was driving and jumped or fell off it

I close this inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner

Date 2 March 2017