Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 39 /17

I, Sarah Helen Linton, Coroner, having investigated the death of ***Reef Jason Bruce KITE*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***23 October 2017*** *find that the identity of the deceased person was* ***Reef Jason Bruce KITE*** *and that death occurred on* ***13 October 2015*** *at* ***Princess Margaret Hospital*** *as a result of* ***crush asphyxia*** *in the following circumstances:*

Counsel Appearing:

Sgt L Houisaux assisting the Coroner.

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INTRODUCTION

1. Reef Kite died on 13 October 2015 at Princess Margaret Hospital. He was an active, healthy one year (21 month) old boy until that day. Sadly, Reef was crushed by a chest of drawers that fell on him at his home. Despite emergency medical treatment, he could not be saved. This inquest has been held with the support of Reef's mother, who hopes that a public inquiry into Reef's death might save another family from experiencing the same trauma that Reef's family have experienced since that day.

2. I held an inquest at the Perth Coroner's Court on 23 October 2017.

3. The documentary evidence comprised a comprehensive report of the death prepared by the Western Australia Police.[1] The author of the report, Senior Constable Fiona Thorp, was called as a witness at the inquest.

4. In addition, oral evidence was heard from:

   - Senior Constable Stephen Barnes, a forensic officer with the WA Police forensic field operations unit, who examined the chest of drawers;
   - Mr Scott Phillips, the Chief Executive Officer of Kidsafe Western Australia; and
   - Reef's mother, Skye Quartermaine.

5. The inquest focused primarily on issues of safety relating to children's furniture, particularly unstable chests of drawers, and the options available to minimise the risk of harm to children in the future.

EVENTS ON 13 OCTOBER 2015

6. Reef was born on 16 December 2013. For the last three months of his life Reef lived with his mother and his older half-brother and brother in a rental property in Perth, following his parents' separation. Prior to that he had lived with his parents and siblings in a different house.[2]

7. Reef was healthy at birth and had never been diagnosed with any illness or health conditions during his short life. Reef began to walk at 10 months of age, so by October 2015 he was steady on his feet and easily able to get about on his own. Reef was an active little boy and would usually have a sleep from about 11.00 am to 3.00 pm. After his sleep he would usually get up and play in his room until his mother came and got him.[3]

8. On Tuesday, 13 October 2015, Reef woke up at about 8.00 am. During the morning he had breakfast and watched cartoons at home, cuddling up with his mother and brothers on the sofa. At 11.30 am Reef was put to bed in his bedroom so that he could have his daytime nap. Reef's bed was a toddler

[1] Exhibit 1.
[2] T 6.
[3] T 6; Exhibit 1, Tabs 2, 4 and 15.

sized single bed with a sideguard, which he was able to get in and out of without assistance.[4]

9. Also in Reef's room was a chest of drawers that had been purchased three months earlier from a discount furniture store. It was already assembled at the time of purchase. The chest of drawers was situated on the opposite side of the room to Reef's bed. Reef's clothes were stored inside the drawers. The chest of drawers was not fixed to the wall but appeared to his mother to be stable on the carpeted bedroom floor. As far as Reef's mother was aware neither Reef nor his brothers had ever climbed any of the cabinets or chests of drawers in the house in the past.[5]

10. At about midday Reef's mother checked on Reef in his bedroom and found he was asleep but that he had taken off his nappy and bedlinen and soiled the walls before he went to sleep. She cleaned up the mess and placed a new nappy on him before putting him back to bed. Reef didn't wake up during this process and she left him in his room to continue sleeping. Reef's brothers then also went down for their naps in the main bedroom.[6]

11. Reef's mother checked on Reef at 1.30 pm, at which time Reef was still sleeping. With all the children asleep, Reef's mother took a moment to sit on the couch by herself and she then dozed off on the couch for a while.[7]

12. Reef's mother awoke between 2.45 pm and 3.00 pm. She checked on Reef's brothers in the main bedroom and noted they were still sleeping. She then went to check on Reef. Usually after Reef woke up from his nap he would stay in his room playing and she would hear that he was awake.[8]

13. When Reef's mother opened his bedroom door she saw that the tallboy chest of drawers had tipped over and that Reef was trapped underneath the drawers, some of which had fallen open and were pressing onto his chest. He appeared to be lying on his side. She thought his head was clear of the chest of drawers but it was possibly lying in part on a rocking horse that was also in the room.[9]

14. Reef's mother immediately lifted the chest of drawers up and pulled Reef out. She saw that he was cold and limp and had marks on the left side of his face near his temple, possibly from where a drawer had hit him. She also noted Reef did not have a nappy on.[10]

15. The chest of drawers fell over again after Reef's mother pulled him out from underneath it. She did not attempt to right it again but instead Reef's mother ran with Reef to her landlord's house at the rear of her property to seek help. When she arrived at her landlord's house Reef was still limp and cold in her arms. With the help of her landlord, they commenced cardiopulmonary resuscitation and rang for an ambulance to attend. Reef

[4] Exhibit 1, Tabs 2 4 and 9.
[5] Exhibit 1, Tabs 2, 4 , 9 and 13.
[6] Exhibit 1, Tabs 2 and 4.
[7] Exhibit 1, Tabs 2 and 4.
[8] T 6; Exhibit 1, Tabs 2 and 4.
[9] T 7; Exhibit 1, Tabs 9, 13 and 15.
[10] Exhibit 1, Tabs 9, 13 and 15.

showed no response to their CPR efforts while they waited for the ambulance.

16. St John Ambulance received the call at 2.49 pm and their ambulance officers arrived at the scene at 2.56 pm, only 7 minutes later. They continued resuscitation efforts while they drove Reef to Princess Margaret Hospital. They handed over to PMH staff at 3.22 pm.[11]

17. PMH doctors continued resuscitation attempts, including several doses of adrenaline, but Reef did not respond and CPR was eventually stopped and he was declared life extinct at 3.34 pm.[12]

CAUSE OF DEATH

18. On 13, 14 and 15 October 2015 a Forensic Pathologist, Dr Gerard Cadden, conducted a post mortem examination of Reef. He appeared clean and well-nourished and had a general appearance in keeping with his stated age. External superficial imprint markings were seen on the face, as well as some markings to the rest of the body. Internally, fine petechiae were noted over the cheek surfaces of the face. Congestive change in respect to the internal aspect of the body was also evident, including the heart and brain. No internal injury or congenital disease was identified.[13]

19. At the conclusion of his post mortem examination, and following receipt of the results of all ongoing investigations, Dr Cadden formed the opinion that the cause of death was crush asphyxia.[14]

20. I accept and adopt the conclusion of Dr Cadden as to the cause of death.

THE CHEST OF DRAWERS

21. Police officers at the Coronial Investigation Unit were advised of Reef's death shortly afterwards and they commenced an investigation into his death, including a forensic investigation at his home, with specific attention paid to the chest of drawers.[15]

22. The chest of drawers that fell on Reef was a six drawer tall chest, which measured 1270 mm high x 1050 mm wide x 450 mm deep. It had four full width drawers on the bottom and two half drawers on the top row. It had full extension metal drawer runners. It was made of pine material. The drawers were purchased by Reef's mother earlier in 2015 from a furniture store in Western Australia.

23. There are apparatus available to secure some furniture to the wall, such as some models of bookcases and wardrobes, some of which are sold with the

[11] Exhibit 1, Tabs 14 and 16.
[12] T 5; Exhibit 1, Tabs 6 and 14.
[13] Exhibit 1, Tab 7.
[14] Exhibit 1, Tab 7.
[15] Exhibit 1, Tabs 2 and 4.

furniture. However, the Victoria tallboy drawer chest involved in this case was not sold with such apparatus and did not come with safety or warning instructions.[16]

24. Reef's mother gave evidence at the inquest to explain that she was, nevertheless, aware of the benefits of securing such furniture to the wall but the chest of drawers was not bolted to the wall because she had not been given permission by her landlord to do so.[17] She also believed it to be relatively stable.[18]

25. When forensic police officers, including Senior Constable Barnes, went to Reef's home on 14 October 2015 they entered Reef's bedroom and found the chest of drawers tipped over and lying on the floor. They lifted the chest of drawers back upright but it immediately began to tip back over again. Having observed this, the officers decided to do some tests on its stability. Testing by the officers from the Forensic Crime Scene Unit revealed the chest of drawers tipped with ease when minimal force was applied. As the momentum of the chest of drawers increased, the drawers came out on the metal runners, causing the chest to fall forward heavily.[19] Senior Constable Barnes agreed it was almost like a domino effect, in the sense that after one drawer came out, all the others quickly followed.[20]

26. Senior Constable Barnes indicated that the forensic officers at the scene were very surprised at how easily the drawers came out and the chest toppled over, as well as how easy it was to topple the chest of drawers over even with the drawers in the closed position. The chest of drawers itself was also very heavy, requiring two men to lift it. Noting those features, Senior Constable Barnes gave evidence that once the drawers started falling forward, it would be very difficult for an adult to stop the chest from tipping over, and impossible for a young child.[21]

27. Reef's mother gave evidence that she thought the weight of the chest of drawers was an advantage, as it made it more stable. Sadly, as she pointed out in her evidence, the video made by the forensic officers after Reef's death showed how wrong her assumption had been.[22]

28. It is unclear from the evidence obtained during the coronial investigation whether the chest of drawers fell forward because Reef pulled out the drawers to look into them or because he used the drawers as steps or if he simply began to climb up the chest and it toppled over. Any of these actions may cause disruption in the weight or distribution of the chest of drawers, causing it to become unstable and fall forward. Although the exact circumstances are unknown, I am satisfied that after waking up from his nap, while playing in his bedroom Reef came in contact with the chest of drawers, which toppled forward onto him. The weight of the chest of drawers resulted in crush asphyxia, which caused his death.

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[16] Exhibit 1, Tab 27.
[17] T 22.
[18] T 24.
[19] T 12 – 13; Exhibit 1, Tabs 4, 10, 11 and 12.
[20] T 13.
[21] T 13 - 14.
[22] T 24.

29. I find that the manner of death was by way of accident.

GENERAL SAFETY RISK OF UNFIXED FURNITURE

30. Pursuant to s 25(2) of the *Coroners Act 1996* (WA), I may comment on any matter connected with Reef's death, including public safety.

31. As part of her investigation, Senior Constable Thorp conducted some inquiry into previous deaths of children in similar circumstances. She found that in 2014 two similar deaths of small children occurred in the United States of America involving the IKEA MALM model of drawers. The US Safety Watchdog raised concerns about safety issues following the deaths and wall mounting kits were made available to consumers, including for retrospective fitting, by IKEA.[23] Senior Constable Thorp also identified a similar death to Reef's involving a two year old child in the United Kingdom, which was reported in January 2016. In that case, again, a chest of drawers had fallen on the child in the family home.[24]

32. Sadly, when I recently conducted a brief internet search, just to see if any further updates were available, I noted reports that more children internationally have reportedly died as a result of being crushed by chests of drawers, which has led to the international recall of some furniture items such as the MALM drawers, as well as further reminders of the need to secure such furniture items to the wall.[25]

National Safety Initiatives

33. Research was undertaken on behalf of the Australian Competition and Consumer Commission (ACCC) in 2015 on consumer awareness of furniture stability risks and prevention. The research was undertaken to inform a consumer education campaign aimed at parents and child carers. The research focussed particularly on the dangers of common furniture in homes with children under the age of five and involved an online survey of people with children under five years old. The research found that young children tend to climb on furniture such as freestanding bookcases, wardrobes and sideboards, which can be a safety hazard as the weight of a small child can cause the piece of furniture to topple over. The report writers observed that several hundred children are injured this way each year; some, like Reef, fatally.[26]

34. The result of the ACCC commissioned research was that the majority of parents are aware of the risks posed to young children by falling furniture and one quarter of parents have experienced an incident of falling furniture. The research found that parents generally want to know the types of furniture that are most involved when children are injured and how to attach brackets or anchors. It was concluded that the best way this could be

[23] T 8.
[24] T 8.
[25] http://www.news.com.au/lifestyle/home/interiors/ikea-recalls-17-million-chests-after-eight-children-die-from-falling-furniture/news-story/c32b437219155b7c906c0fd050b178e9.
[26] Exhibit 1, Tab 17 and Tab 21.

communicated was through pamphlets provided with the furniture, but it was noted that chests of drawers were the most likely pieces not to have instructions or equipment provided when purchased.[27]

35. The ACCC promotes discouraging children from climbing on furniture, moving unstable furniture from places where children play, securing tall furniture to a wall using anchors or angle braces and placing locking devices on drawers to prevent them being used as steps or ladders. Informed by the research about consumer awareness of these issues, the ACCC embarked on a campaign comprised of targeted posts via social media, including advertisements and Facebook and Twitter feeds and a furniture safety video was also released online. In addition a blog post was created for major parenting forums titled "Toppling Furniture: Anchor it and protect a child."[28] The blog post is available on the Product Safety Website and includes the following safety tips:

> **Buy safe**
>
> - Purchase low-set furniture or furniture with sturdy, stable and broad bases.
> - Look for furniture that comes with safety information or equipment for anchoring it to the walls.
> - Test the furniture in the shop – make sure it is stable. For example, pull out top drawers of a chest of drawers and apply a little pressure to see how stable it is; make sure the drawers do not fall out easily.
>
> **Use safe**
>
> - Attach, mount, bolt or otherwise secure furniture to walls and floors.
> - Do not put heavy items on top shelves of bookcases.
> - Place televisions at the back of cabinets or secure them to the wall.
> - Discourage small children from climbing on furniture.
> - Do not put tempting items such as favourite toys on top of furniture that encourage children to climb up and reach.
> - Do not place unstable furniture near where children play.
> - Put locking devices on all drawers to prevent children opening them and using them as steps.

[27] Exhibit 1, Tab 17, p. 4.
[28] https://www.productsafety.gov.au/news/toppling-furniture-anchor-it-and-protect-a-child.

36. In June 2016 the ACCC distributed an information sheet to over 3500 furniture suppliers and retailers across Australia alerting them to the risks of toppling furniture and highlighting the importance of educating consumers about the use of wall anchors to minimise the potential danger of injury or death.[29] In 2017 the ACCC continues to work to improve the safety of furniture, with a renewed focus on engaging with manufacturers and retailers, as well as state and territory agencies and internationally.[30]

37. There is evidence that the National Retail Association (NRA) has actively cooperated with the ACCC, noting that they have developed a voluntary Best Practice Industry Guide. The guide, titled "Best practice guide for FURNITURE AND TELEVISION TIP-OVER PREVENTION" was issued in April 2017 and is available as a free download on the NRA website.[31] The guide specifies best practice for freestanding televisions and certain furniture items, including chests of drawers over 500 mm tall, and encourages stakeholders to implement strategies focussed on product design to maximise stability, supplying suitable anchor devices with furniture and also including consumer advice about how to safely install them.

Western Australian Safety Initiatives

38. Mr Scott Phillips gave evidence on behalf of Kidsafe WA, an independent not-for-profit organisation dedicated to promoting safety and preventing childhood injuries and accidents in Western Australia.[32] Mr Phillips explained in his evidence that the organisation exists to inform the community and to reduce the burden of unintended or accidental injuries to, and deaths of, children.[33] Mr Phillips noted that 27 children a year still die in such circumstances in Western Australia, which puts a large burden on those families as well as the wider community.[34] Many of these deaths are preventable.[35]

39. Mr Phillips gave evidence that Kidsafe has spent considerable time recently looking at product safety, given new technologies that mass produce. Together with other regulatory bodies such as the ACCC, WA Consumer Protection, the Department of Health, the University of Western Australian and the Poisons Information Centre, Kidsafe has formed a group called the WA Product Advocacy Network. The WA Product Advocacy Network's aim is to make sure that they are informing the community about product safety in what can be "a really busy environment."[36] This year, after noticing a trend in children dying from 'furniture tip-over', the group commissioned a report into this area of furniture-related injuries in children. Information was provided by Princess Margaret Hospital, which is the only tertiary paediatric

[29] Exhibit 1, Tab 21.
[30] Exhibit 1, Tab 21.
[31] https://www.nra.net.au/wp-content/uploads/2015/06/NRA-furniture-and-TV-tip-over-best-practice-guide.pdf.
[32] Exhibit 1, Tab 20, p. 1.
[33] T 16.
[34] T 16 - 17.
[35] Exhibit 1, Tab 20, p. 1.
[36] T 17.

centre in Western Australia, although children are treated in other metropolitan and regional facilities.[37]

40. The report found that there were 271 furniture-related injuries in children in the five year period up to December 2016 (which would include Reef's death). Of those incidents, 148 involved furniture tip-overs. The majority of children involved were under three years of age and it was equally distributed between boys and girls. The number one piece of furniture involved was a chest of drawers, and the second most common was TV cabinets. Perhaps given the statistically higher involvement of chests of drawers, half of the incidents occurred in the child's bedroom. Mr Phillips commented that the common practice of putting toys and TV's on top of chests of drawers in children's bedrooms was thought to contribute to an attraction to climbing drawers.[38]

41. The group then considered "What can we do as a community?" to reduce the number of these incidents?[39] One of the answers has been to work with retailers to try to make the safety information about securing furniture available at the point of sale or fixed within the packaging.[40]

42. The next part of the Advocacy Network's plan is to educate the public.[41] They use education across all of their networks in many different formats, including everything from social media to antenatal classes to presentations for playgroups and schoolgroups. They attempt to cover as many groups as possible, including expectant parents, current parents and grandparents, all of whom are likely to have young children regularly in their home.[42] The key tenet is, of course, close direct supervision. However, accepting that direct supervision is not always achievable when at home, the message is about making the environment safe for our children.[43] This includes information about choosing stable furniture, securing furniture, as well as where to place it in the house and not putting items attractive to children on top of it.[44] Finally, there is an emphasis on teaching children about the dangers of climbing furniture.[45]

43. For the purpose of this inquest, various Western Australia based furniture companies, such as Fantastic Furniture, Super Amart and Impressions Furniture provided information to the Court about how they have taken steps to provide safety warnings (via physical warnings on furniture and sales documentation as well as through staff communication to customers) and anchoring or 'tip' kits to customers purchasing furniture at risk of toppling. The particular supplier of the chest of drawers involved in Reef's death also provided information to the Court, noting that although the specific product does not come with anchoring equipment or a safety warning, they have initiated a training programme to inform all staff of the

[37] T 17; Exhibit 1, Tab 29.
[38] T 17; Exhibit 1, Tab 29.
[39] T 17.
[40] T 17 – 18; Exhibit 1, Tab 29, p.6.
[41] T 18 – 19.
[42] T 19.
[43] T 19.
[44] T 18 – 19.
[45] Exhibit 1, Tab 29, p.6.

dangers that 'tallboy's can pose to children if not secured, so that this information can be communicated to customers, and they have also contacted all of their suppliers to request their assistance with placing warning labels on their products and to provide the necessary hardware for securing them to the wall, to resolve this issue.

44. Mr Phillips acknowledged that in many areas retail are very responsive to the safety message and they assist with the education component and suppliers have changed some products (such as TV footings) and provide fixings such as straps and brackets with the products.[46] It is heartening to see that the child safety message promoted by the WA Product Advocacy Network is being heard and taken seriously by the retail industry in this State.

45. There are also Australian Standards for domestic furniture that relate to determination of stability of freestanding chests of drawers. The objective of this Standard is to assist in reducing the probability of the identified furniture items tipping and causing injury to users, particularly children. Climbing is assumed to take place on the face of the furniture, which may feature common foot or handholds (such as drawers). However, it should be noted that even furniture items that pass the Standard's test methods may still tip in certain circumstances.[47]

46. Mr Phillips advised that as part of the safety network Kidsafe WA sits on the product safety standards committees and is aware that they are reviewing safety standards. However, Mr Phillips also noted that as technology increases and products come onto the market quickly, including people buying products from overseas online, it is difficult to regulate. Instead, the primary emphasis is on caregiver education so that people make the right choices about what they buy and how they install it.[48]

47. As noted above, children under 5 years of age are most at risk of suffering serious, and even fatal, injuries from falling furniture. Acknowledging that constant parental supervision is not always realistic given these types of furniture are often used in children's bedrooms or playrooms, anchoring such insecure and unstable household furniture to the wall is recommended. Other preventive options include selecting safer furniture that has broad and stable bases rather than legs, placing locking devices on the drawers to stop them being pulled out by children and not placing toys or other desirable items on top of furniture, to lessen the attraction.[49]

48. General discouragement of children from climbing on furniture is also recommended.[50] Reef's mother gave evidence that she is personally aware of parents being complacent because their children don't climb. She wished to emphasise that Reef was not known to climb furniture in the past, and yet this happened to him.[51]

[46] T 21.
[47] T 8.
[48] T 20.
[49] Exhibit 1, Tab 29.
[50] T 9.
[51] T 23.

Rental Properties

49. I noted during the inquest that there can be an issue for tenants obtaining permission to fix furniture to walls, which Reef's mother indicated had been a problem for her in this case.[52] Mr Phillips acknowledged this problem and advised that as part of the education plan, the Advocacy Network has arranged for Consumer Protection to put out some instructions to landlords to emphasise that landlords have a responsibility to ensure that rental premises are safe to live in, and encouraging them to give tenants permission to anchor furniture in a bid to protect children. As noted on the website, "A hole in a wall can be patched or repaired at the end of a rental agreement, but a child's life cannot be replaced."[53] It also notes that if the rental property is rented furnished, the landlord should secure any furniture that may pose a hazard.[54] The Consumer Protection website includes a link to the ACCC Product Safety Australia website article on toppling furniture, as described above.

50. Nevertheless, the difficulty remains that under the current legislation governing residential tenancies, landlords are entitled to decline consent to a tenant affixing any fixture and remove any fixture that a tenant has affixed to the rental premises without the landlord's consent.[55] I note that depending upon the terms of the residential tenancy agreement, the *Residential Tenancies Act 1987* (WA) provides that the lessor shall not unreasonably withhold such consent, although that obviously leaves open the question of what is unreasonable.

51. Given the importance of this issue, I recommend that the State government give consideration to amending the *Residential Tenancies Act*.

RECOMMENDATION

I recommend that the State government give consideration to amending the *Residential Tenancies Act 1987* to ensure that a residential tenancy agreement cannot preclude a tenant from affixing a fixture, if the fixture relates to anchoring a television or item of furniture to a wall for the purposes of child safety. Rather, the Act should provide that for those specific fixtures, such an item may be affixed with the lessor's consent (and the lessor shall not unreasonably withhold such consent).

[52] T 22.
[53] https://www.commerce.wa.gov.au/consumer-protection/home-safety-rental-preoperties, p. 5/7.
[54] https://www.commerce.wa.gov.au/consumer-protection/home-safety-rental-preoperties, p. 5/7.
[55] *Residential Tenancies Act 1987* (WA), s 47.

CONCLUSION

52. Reef died as a result of a tragic accident involving a chest of drawers in his room. His death was preventable. It is important for other parents to know that Reef's death was not an isolated incident and other children have died in similar fashion.

53. There are steps that can be taken by parents to prevent a similar tragedy occurring in their own home, and it is particularly important that parents with children under five years of age make an assessment of the safety risks of furniture in their home and seek information as to what steps they can take to make that furniture child safe. Some of the options have been discussed in this finding, but there are always new things being learnt and new innovations, which makes the internet a useful tool for parents who can access the websites of relevant agencies such as Kidsafe (www.kidsafewa.com.au) and Product Safety Australia (www.productsafety.gov.au).

54. It is hoped by Reef's parents that the publicity surrounding Reef's death will help to prevent similar deaths. One way this may be done is to raise the awareness of landlords to the real safety issues that arise with some common household furniture items and the need for them to be flexible in their approach to tenants' requests to secure some items to walls in a rental property. Hopefully, the publicity surrounding this inquest, and potentially consideration by the Legislature of the recommendation I have made, may go some way to achieve this aim.

S H Linton
Coroner
24 November 2017