

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 2390/01

Inquest into the Death of GREGORY PRICE

Delivered On: 16 March 2010
Delivered At: County Court, Melbourne
Hearing Dates: 16, 17, 18 November 2009
Findings of: Coroner Parkinson

Representation: Mr A. Palmer appeared on behalf
of Victorian WorkCover Authority

Mr G. Casement appeared on behalf of Mr Anthony Wines,
Mr Mark Radobuljac, Mr Mark Spiteri, Mr Jason Kendray,
Mr Robert Andrew.

Mr T. Bourke appeared on behalf of Vaughan Constructions
Pty Ltd and Mr Marco Sciarra, Mr Glen Stanton,
Mr Leslie Holland, Mr Mathew Vaughan

Mr J. Gettschall appeared on behalf of Mr Joseph Nugara

Place of death: Swan Drive, Derrimut, Victoria 3030

SCAU: Leading Senior Constable Gregory McFarlane
assisting the Coroner



FORM 37

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Section 67 of the Coroners Act 2008

Court reference: 2390/01

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: PRICE
First name: GREGORY
Address: Lot 1, Loch Street, Yarragon

AND having held an inquest in relation to this death on 16, 17, 18 and 19 November 2009

At: Melbourne
Find: that the identity of the deceased was GREGORY JOHN PRICE
And: that death occurred on 2nd August, 2001
At Swan Drive, Derrimut, Victoria 3030

from

1a. MULTIPLE INJURIES SUSTAINED IN INDUSTRIAL ACCIDENT

in the following circumstances:

1. Mr Gregory Price was 46 years of age at the time of his death. He was married to Kerry and was the father of four children, Paula, Janine, Dee-Ann and Trevor. He was employed as a Foreman - Carpenter by Precedent Constructions Pty Ltd. Mr Price's death occurred on 2 August 2001. It is unacceptable that such a long period has been allowed to pass between Mr Price's death and this inquest.¹ This matter involves the death of a man at his workplace and it is in the public interest, notwithstanding the time lapse, that there be a public inquiry into the circumstances of the death, with consideration of any safety issues which may arise with a view

¹ A committal hearing occurred on 12 - 15 May 2003. On the 8 July 2004 the DPP entered a Nolle Prosequere and on 23 August 2004 all charges were withdrawn. I am not in a position to comment upon the subsequent delay. Once seized of the case I conducted directions hearings on 29 July 2009 and 1 September 2009 and the inquest was listed for hearing 16 to 19 November 2009.

to avoidance of any further deaths. The family is also entitled to have some understanding about what occurred and what caused their husband and father's death. The inquest was conducted pursuant to the provisions of the *Coroners Act 1985*. Pursuant to s7 of Schedule 1 of the *Coroners Act 2008* ("the Act") the findings of the inquest are deemed to be finding made under 67 of the Act.

2. A number of witnesses made application to be excused from giving evidence in the proceedings on the grounds that their evidence may expose them to prosecution for an indictable offence pursuant to s21 and 25 of the *Occupational Health and Safety Act (Vic) 1985*. Mr Anthony Wines, Mr Joseph Nugara, Mr Mathew Vaughan, Mr Robert Andrew, Mr Marco Sciarra and Mr Glen Stanton were excused from giving evidence. Mr Jason Kendray, Mr Mark Spiteri and Mr Mark Rabobuljac were required to give evidence, however, were excused from answering particular questions which may have exposed them to such prosecution.

Background

3. Precedent was a contracting firm which installed pre-form insulation panels for factory walls and ceilings. Its directors were Mr Wines and Mr Nugara. Mr Nugara also had an operational role as foreman. Mr Price, Mr Kendray, Mr Spiteri, Mr Andrew and Mr Rabobuljac were employed by Precedent in various roles in installation of the panels. The principal contractor on the site was Vaughan Constructions Pty Ltd ("Vaughan"). Vaughan employed Mr Glen Stanton as Site Manager and Mr Marco Sciarra as Occupational Health and Safety Representative.

4. Vaughan engaged Precedent to install panels at a construction site at Derrimut Road, Derrimut. The project involved the installation of pre-fabricated form insulation panels at a cold storage facility construction site at Derrimut. The building under construction was a combination of concrete panel and sandwich panel construction. The panels, described as sandwich panels, are comprised of polystyrene sandwiched between colorbond metal sheeting. Two sections of the north-west side of the building were being constructed as cold storage rooms from the sandwich panels. The area measured 16 metres by 16 metres and had a solid and level concrete floor. The south and west sides of the room had been completed and the incident happened during the erection of panels on the east side of the building. At the time of the incident approximately 250 panels had been installed at the site. The panel sizes being installed on 2 August, were 10 metres high and weighed approximately 120 kilograms each.

5. The panels were described as larger than usual and as a result an additional elevated work platform or scissor lift ("EWP"), had been hired to assist in the installation. An elevated work platform consists of two parts, the carrier or chassis and the elevating superstructure. They include self-propelled scissor lifts. They are utilised for work at a height where an operator works from within the confines of an extending platform.

6. The EWP on this occasion was a Genie GS 3264, Serial Number GS46-43512. It was manufactured in 2001. The maximum platform height of the machine was 9.8 metres with a maximum weight capacity of 318 kg. The EWP came with operating instructions. They were contained in a box located on the platform of the EWP where the operator stood. The manuals in various formats contain express instructions both written and diagrammatic against tying anything to the rails of the EWP.

7. A Work Method Statement (Exhibit 12) and a Job Safety Analysis (Exhibit 20) had been prepared for the job by Precedent and provided to the principal, Vaughan, but was not located at the site.

The Work Process for installation of the panels

8. Although Mr Andrews was excused from giving evidence in the proceedings, I have been assisted by his statements dated 13 August 2001 and 29 August 2001 (exhibits 26 and 27) in establishing the order and mechanism of work. He described the work process as:

"A panel is laid on the floor of the factory with its base as close as possible to the line of the wall. The top of the panel is placed on a roller attachment on the front tynes of the forklift. The forklift is then driven forward slowly and the tynes raised so that the panel is raised to a vertical (upright) position. A scissor lift is positioned as close as possible to the factory wall and along side the position where the panel will stand. A rope is looped around the top of the panel leading back to the basket of the scissor lift and loosely tied to the hand rail. The scissor lift is set at about the height of the panel so that the worker in the lift can secure the panel to the building framework. Usually the scissor lift operator is just under the height of the roof. As the panel is raised into position, the rope slack is put into the scissor lift basket. The rope loop at the top of the panel is then used by the scissor operator to help steady the panel once it is vertical. The rope is not used to pull the panel up. The scissor operator then steadies the panel with his hands while other workers at the base of the panel attach lifting equipment to the base of the panel to place it into a steel channel. During the raising process there are two workers at the bottom outside of the panel to ensure that the base does not slide and prevent it from being raised. Once the panel is vertical the scissor is moved across so that the bottom of the panel can be slotted into the channel and the panel itself fixed into the framework. The process takes about 15 to 20 minutes to complete. Precedent has a written work method statement for panel installation. The method is used regardless of the height of the panels, except that we would not use a rope for very short panels."

9. Mr Trevor Price, the son of the deceased who himself had been employed on panel installation by Precedent, gave evidence to assist the Coroner as to the manner in which the work was undertaken as witnesses who were employed on the site on the day of the incident were unable to assist in that regard. His evidence was that the work generally involved the use of a rope to assist in steadying the panel being lifted into position and that the rope was tied to the rail of the EWP to prevent it (the rope) from falling to the ground, so that it was easily recovered for the next task. He was also able to assist in describing the role of the forklift in the work process. He stated at pages 281 to 283 of the transcript:

"In relation to the reversing of the forklift at what point would the tines be lowered?---So that generally, um, the tine - the forklift driver would reverse back maybe a metre or two and drop the tines because you've got the two base members - base operators at the base, underneath the fork tines; so if you lowered it straight away it would probably be on the - maybe hit the guys so you would normally move back a metre or two and drop the tines.

You said you've got a light forklift license?---Yes.

How long ago did you get that?---Um, I think 2003.

Do you recall any of your training that you received when you were obtaining that license?---Yes.

Can you recall what instructions you were given in relation to moving the forklift around with the tines in the extended position?---Yes, if there's no load on the - on the tines, the tines are to be lowered at the safest point, so in this process if you were to sit stagnant and drop them down it's not the safest point so you shouldn't be dropping them down there but basically they'd tell you to drop the tines so that - because you don't have a visual and everything on the floor is all about visuals. I don't want to go to it too much but basically when you're driving the fork you're instructed to keep your eyes forward because you've got two mirrors either side and they are actually very visual as far as what is behind you so what you want to do is drop the tines so that you can see - have a full visual of everything around you and then if your tines basically are meant to be at the axle height of the front wheels, which means that there is nothing higher than the top of the fork, which means you don't have to now look up, you only have to look around, um, yeah.

So if the tines are in the extended position would it obscure your view of the top of the scissor lift and the worker in the scissor lift?---Um, before moving, it wouldn't - it wouldn't make a difference, so when - when the panel is in the inverted position and the forklift is sitting there stagnant, the fork - the tines being in the raised position wouldn't change the visual, it would probably give you a better visual of what is happening right in front of you and you'll be able to see up to - you would basically look through the forklift

groove to see the scissor lift. Once you start reversing backwards then it would start obscuring your view.

Would it be possible that the tines could obscure the driver's view of the rope if it had become caught?---On reversing backwards, yes.

Yes. So at the back of the reversing manoeuvre wouldn't be the safest place to lower the tines?---Pardon?

When you've finished the reversing manoeuvre ready for the next sheet, that wouldn't be the safest point to lower the tines? They should have been lowered prior to the complete reversal, is that - - -?---Correct.

Perhaps I will rephrase that. The safest method you say is to move back two metres away from the workers, lower the tines and then reverse?---The safest - the safest point is the earliest point possible to lower the tines, is the safest point."

What occurred on 2 August 2001

10. On 2 August, Mr Price commenced work at 7am and together with other employees set up the equipment including the elevated work platform and the forklift. The employees working with Mr Price were, Mr Kendray, Mr Radobuljac, Mr Spiteri and Mr Andrew. Mr Price was operating the EWP and Mr Radobuljac and Mr Spiteri were working on the ground steadying and lifting the panels into position. Mr Andrew was operating the forklift and Mr Kendray was working elsewhere inside the building. The first panel was erected at 8.30am. The incident occurred shortly after the fourth panel for the morning had been raised to the vertical position. Mr Price was in the elevated work platform when it fell to the ground. Mr Price sustained critical injuries and died at the scene.

11. Mr Andrew's account of the incident is as follows:

"The fourth panel for the morning had been raised to the vertical position and I saw Greg Price, the scissor lift operator, holding the panel with both hands. He yelled out that he had control of the panel and so I began backing the forklift away. I had backed away about 10 to 12 metres in position for the next panel when I heard somebody scream. I stopped the forklift and turned around quickly. I saw the scissor lift and the panel falling towards me. The scissor lift fell onto a pack of panels and the panel fell onto the side of the forklift causing it to spin over onto the other side and then it fell onto the scissor lift".

12. Mr Andrew also stated that he observed that the rope leading from the scissor lift basket to the top of the panel was draped over the roller attachment on the front of the fork between the bracket and the roller. He was unable to say how the rope became caught on the forklift.

13. Mr Radobuljak was located on the outside of the panel on the far side to the forklift and EWP. His evidence was that he was on the outside of the panel and he could not see what was occurring on the floor where the forklift and scissor lift were located. Mr Spiteri was also located on the outside of the panel. Mr Spiteri described in his statement having heard a yell and observing the panel and the EWP fall to the ground. He then ran outside of the building to avoid being hit by the panel and EWP. The recollection of both of these witnesses was limited and their evidence in some respects contradicted earlier statements they had made. This may partly be explained by the significant period of time which has elapsed. Their evidence was of limited assistance in determining the manner in which the incident occurred.

14. WorkSafe inspectors attended the scene and gave evidence as to their observations at the scene and their investigations into the incident. Evidence was taken from now retired Senior Inspector Mr James Arnott, Senior Inspector Mr Andrew Gildea and Senior Inspector Ms Rebecca Hills. The statement of Inspector Mr Noel Baker, (Exhibit 8) provided scene observations as follows:

"From the opening at the north end, Mr Baker observed an extended Elevated Work platform (scissor lift) lying on its side on the concrete slab inside the building. A sandwich panel (refrigeration panel) was lying on the slab on the right hand side beside the fallen scissor lift. A forklift truck fitted with a roller attachment on the tines was positioned to the right of the panel at the working platform end of the scissor lift. The tines were raised about 3 to 4 metres off the ground. Mr Price was lying on the concrete floor approximately 1 metre past the platform of the collapsed scissor lift. There was a fibre rope hanging from the right hand side of the roller attachment and I observed this was between the roller and the frame, I also observed the rope going under the panel and one end was secured to the handrail of the scissor lift."

15. Mr Arnott described:

"the EWP was lying on its side in a fully extended position the distance from the base of the machine to the work platform was 9.8 metres, the distance from the base of the machine to the east wall under construction was 1540 millimetres. The distance of the base of the EWP from the south wall was 4.42 metres. The work platform had been pulled from its mountings to the scissor mechanism and the guardrails of the work platform were damaged."

The Prohibition in the manuals against ropes

16. There are issues with stability of EWP's which arise from the height of the equipment and its relatively small base. This is the reason why the instruction manuals associated with the equipment urge that there be thorough instruction in operation and that the accompanying manuals be read. The manuals which were located in proximity to the fallen EWP contained prohibition against tying anything to the rail of the EWP. They had apparently been contained in a plastic box which had been attached to the platform. These documents are contained in Exhibit 11. Relevantly they are:

- Using Elevated Work Platforms Safely at pages 15 to 17 provided: Never try to lift loads by attaching wires, cables or similar items to the platform.
- Manual of Responsibilities of Self-Propelled Elevating Work Platforms at page 10 provides: Entanglement - Care should be taken to prevent rope, electric cords, and hoses, etc. from becoming entangled on the aerial platform.
- Safety Manual For Operators and Mechanics at page 32 provided: Warning - Never attach wire, cable or similar items to the platform, should they tangle or catch on a fixed object, the machine could tip over.

17. In addition there was a single page document (Exhibit 24) - Hazard Identification and Risk Assessment for the use of EWP produced by Western Access Pty Ltd, the owner and hirer of the EWP which stated a risk of the plant tipping or rolling over and a risk of entanglement.

18. These warnings as to risk are clearly stated and drawn in the instructions. They were not read and were not heeded and nor was there a more general assessment of the possible work site risks associated with the EWP, taking into account the particular use to which the equipment was being put and the working in close proximity to the forklift. The failure to comply with the warnings against attaching rope or to the EWP contributed to the death.

The operation of forklift and involvement in the work process

19. Mr Andrews was operating the forklift. He was reversing the forklift when the incident occurred. The forklift tynes were raised when he reversed. The evidence is that good practice is to lower the tynes after the load has been delivered and prior to reversing. However the evidence is that tynes are sometimes raised for a short period after their load has been delivered. That may have been the case here. He did not see that the rope was caught in the roller mechanism as he reversed. This may have been as a result of the tynes not being lowered. However, it is also possible that lowering the tynes might have also caused a drag on the rope sufficient enough to also pull over the EWP.

20. There is no evidence to suggest that Mr Andrews was not safely operating the forklift, by excessive speed or lack of attention. I am satisfied that the involvement of the forklift was problematic because of the rope, the size of the panels being placed and the absence of a lookout to ensure all was clear.

21. Work Safe inspectors and the authors of the draft reports agree that the likely mechanism of entanglement was that the rope end which was usually pulled up into the platform of the EWP by the operator, remained dangling outside the platform or fell out of the platform. It was then caught between the forklift and the bearing housing mechanism. (Associate Professor Rechnitzer page 15. 15 and Associate Professor Kunnell page 18. 8.2).

22. The rope was attached to the EWP rail. As the forklift reversed, the rope became taut. The rope did not give way to pressure and the EWP was pulled over. It does not appear that the load of the panel itself was borne by the rope or was the cause of the tip-over.

23. It is clear from the forklift process description given by Mr Trevor Price, that because of the safety implications for other employees located in proximity to the forklift, it was not always an option to immediately lower the tynes prior to reversing and that the most appropriate timing was dependant upon the location from time to time of those employees. From the point of view of those on the ground it appears that the lowering of the tynes occurred consistent with those requirements. The issue of the overhead works, was not in consideration because it had not been factored into the risk analysis.

WorkSafe investigators evidence as to the safety of the work process

24. I was much assisted in this proceeding by the evidence of the WorkSafe inspectors, Ms Rebecca Hills, Mr Andrew Gildea and Mr James Arnott. I have also had regard to the statements of then Senior Inspector Mr Noel Baker. The WorkSafe investigation material was made available to the Coroner. Mr Arnott, now retired, was an inspector for 15 years. He has extensive training and qualification in occupational health and safety and qualifications in the construction industry, together with many years of experience in industry, as did Mr Baker. Mr Gildea's evidence was that the use of a rope was not a safe work practice and that a rope should never be tied to an elevated work platform because of the real risk of snagging. Ms Hills' evidence was that on her attendances at the site prior to the incident she had not observed the rope being used or panels being placed into position. Her evidence was that had she observed this process, she would have investigated why the rope was being used and the potential risks associated with its use. However she expressed the opinion that the use of a rope was unsafe because of the risk of entanglement and other risks such as tripping.

25. Mr Arnott described his approach to occupational health and safety in the workplace and the particular process being utilised at the site when he said:

"I think it was inherently unsafe. The idea of Occupational Health and Safety is you don't calculate the odds, you identify the hazard and identify the risk and then if you can't eliminate it and you work in a hierarchy control to reduce it as far as possible".

26. He observed that:

"It is a principle of occupational health and safety that once a risk is identified you prevent it or you do as much as you can to lower the risk. You don't just say, 'Well, it's a fairly low risk, we'll forget about it'. And in relation to Mr Retchner's report, I agree in what he says that it was an unsafe work practice and also that it shouldn't be continued but I would disagree with his premise that it wasn't foreseeable. I think it was very foreseeable and these written information booklets that were on the machine clearly say it was foreseeable".

27. Mr Arnott expressed the view that the accident happened because the rope was tied to the platform and it became entangled in the forklift and it pulled it over. He expressed the opinion that the work process was unsafe.

28. Mr Arnott adopted a practical approach to workplace safety. His evidence was that the system of work was unsafe because it failed to comply with the operational procedures in relation to the use of EWP's and it did not comply with the work method statement proposed to the principal contractor, Vaughan. There was no identification of a fundamental feature of the work process, that is the use of the rope. He also observed that the work method failed to provide for any remedial mechanism or procedure to ensure that the rope was bucketed or made safe. In light of the use of a rope, there should have been a lookout on ground in relation to possible rope entanglement and there was not.

29. The evidence of the inspectors was that they concluded the process utilised by the company was an unsafe system of work. They concluded that the existence of a rope tied to a railing of the scissor lift was of itself unsafe. The fact that the rope was not bucketed (coiled into a bucket or bin in the scissor lift) added to the risk associated with the process. Their evidence was that even if the rope was not being used to lift the panels into position and therefore not weight bearing, it was a dangerous process to have a rope affixed to the elevated work platform because of the risk of the rope tangling and pulling over the scissor lift. I accept this evidence.

30. The work process involved the reversing of a forklift in proximity to an EWP. A rope was being used and no one had turned their mind to the very real possibility of the rope becoming entangled and the EWP platform tipping over. This had not been considered because there had not been a proper analysis of the job safety.

The Draft Reports of Engineering Experts

31. Two draft reports (Exhibits 29) were provided to the Coroner by the Office of Public Prosecutions. ("OPP") These reports had been considered by the OPP for the purpose of evaluating issues such as foreseeability in a criminal liability context. The status of these reports is unclear. They are apparently draft reports and it does not appear that they were exhibited in any civil or criminal proceeding. The authors were not called in this inquest and I note that the documents hold the status of draft reports and were created for another purpose. The parties agreed that it was unnecessary to call either author to give evidence, however the reports were exhibited and pressed by some parties as providing some technical assistance in this case and therefore it is appropriate that I address those aspects briefly.

32. Dr Kuhnell's draft report is an analysis of foreseeability. This is undertaken on a statistical analysis of the number of fatal incidents involving EWP's and the probability of an incident such as that which occurred in this case. The report concluded that the incident, was not reasonably foreseeable. That report characterises the degree of foreseeability, by reference to the statistical likelihood of such an incident occurring. This analysis may be of assistance in the context of civil or criminal litigation however I have not been assisted by this approach in this coronial investigation. Dr Rechnitzer's report took issue with the validity of the statistical analysis, however that is not a debate which I am inclined to determine in this proceeding. Dr Rechnitzer's observations in relation to the work method are of some assistance as they are relevant to the issue of the Work process analysis and the Job Safety Analysis of which the Work Safe inspectors were critical.

"In regard to the work method it is apparent that safer systems could be developed. The usual impetus for the development of safer systems arises from risk assessments, safety incident, efficiency improvements, new technology etc. In regard to whether precedent work method was as safe as practicable, the answer to this depends on whether sufficient risk was apparent with the existing method, which required addressing. If the method used was considered safe then no changes would be pursued. In the latter circumstance, the method of work would be regarded as safe as practical. However had the risk with the rope been sufficiently identified then other practical work methods could have been developed."

33. Dr Rechnitzer observed that there is an issue of safety which requires attention if a person has died during the work process and concluded:

"I disagree with Dr Kuhnell's probability calculations, as they are guestimates and are not based upon any empirical or other evidence. I disagree that the work method is as safe as practical, in that, in light of the fatal incident a preventable hazard has been clearly identified as regards the use of the rope. Although the significance of this hazard may not have been fully foreseeable in the context of the operational environment and the apparently safe work experience, the risk is clearly foreseeable now. It is not acceptable in my opinion for a work practice to continue with a known serious injury risk hazard, when alternative methods can be developed to eliminate such a risk".

34. Whilst these draft reports discuss foreseeable risk by reference to statistical analysis and past practice and experience, it seems to me that debate is to some extent academic in a context where the death occurred after instructions for operation had been ignored and a fulsome analysis of the potential for risk had not been undertaken.

35. In this case the manuals of instruction in relation to the piece of equipment expressly identify the fixing or tying of a rope as a safety hazard. The work method statement provided by the contractor to Vaughan did not declare or refer to the use of rope to steady or assist in the placement of panels at all and certainly not by being tied to the railing of the elevated work platform.

Safety oversight at the site

36. There was inadequate safety oversight on the site by the contractor, Precedent. This arose because of inadequate induction of employees and insufficient regard for the application of safe operating procedures in utilising either the elevated work platform or forklifts in the installation of the panels.

37. It is clear from the evidence, including the witness statements, that nobody read the equipment operating instruction manuals. The work method statement and job safety analysis were not even present on the site and they were not read, nor required to be read, by the employees.

38. Whilst the evidence is that a walk-through of site and oral description of the work process was given to some employees, exactly what that description involved and to whom it was given is unclear. Mr Arnott observed that there is no point in having a work method statement if it is not on site and available to those who are employed there. In his opinion, a walk through of the site is helpful, but both are required.

39. Had the operation manuals been read and the work method statement and Job safety analysis developed and considered with the employees, an analysis of the safety of using the rope and associated risks would have been more likely undertaken.

40. It is apparent from the statements that the rope system was in general use by Precedent and their employees. Mr Glen Stanton, of Vaughan, stated (Exhibit 16) that he did not know that a rope was being used and had he known he would have intervened. There is no evidence of his sighting the use of the rope and the work method statement was silent on this matter. Whilst it must be accepted that neither Vaughan, nor its managers, had actual knowledge of the use of the rope, it is reasonable to expect that the company through its managers and supervisors ought to have observed that the process was being undertaken on their worksite. Mr Stanton's statement was that had he observed the use of rope, he would have stopped it immediately as he regarded it as unsafe.

Adequacy of the Work Plan and Job Safety Analysis

41. I agree with Mr Arnott's evidence that occupational health and safety is not a numerical statistical risk process. It is requiring of a carefully considered analysis of the work to be performed, prior to the work commencing. This means a consideration of what risks may arise and how such risks may be ameliorated. Mr Arnott's evidence was that the Work Method Statement should include all procedures for undertaking the work. The use of the rope was in his opinion a significant part of the work process and should have been included. He and other inspectors were critical of the work method statement as not properly defining the job being done and was silent in relation to a number of matters. Workers who were using the EWP had not been required to read and had not on the evidence, read the Operation and Safety Manual for the equipment.

42. I am satisfied that each of the Work Method Statement and the Job Safety analysis documents were inadequate to describe how the work was performed and the associated safety considerations. The work plan and JSA did not identify the particular aspects of the work, nor the particular safety considerations which applied to those processes. There was no reference to the rope being used and therefore no consideration at all of any potential safety risk of that work process.

43. I am satisfied that had it been considered, it would have been obvious that a rope overhanging in a workplace where forklifts were being operated in close proximity, might end up being caught up in the forklift. Mr Stanton said as much in his statement. Whilst many of the witnesses agreed with this proposition as a matter of hindsight, I do not accept that it is merely a matter of hindsight as none of the fundamental analysis had been undertaken. The possibility of tip-over of the elevated work platform is not so hard to anticipate if the rope is tied to the elevated work platform against the specific equipment operating instructions.

44. I find that a failure the contractor, Precedent and the operator himself, to properly analyse, consider and comply with the operating instructions for the EWP was a contributing factor to the death.

45. I find that the failure by the contractor, Precedent and its Managers, to complete a comprehensive Work Method Statement and Job Safety Analysis resulted in the risk associated with the use of the rope not being identified and remedial measures not being implemented. I find this contributed to the death.

46. I find that the failure by the contractor Precedent and its Managers, to complete a comprehensive Work Method Statement and Job Safety Analysis resulted in the risk associated with the use of the rope and EWP in proximity to a Forklift, not being identified and remedial measures not being implemented. I find this contributed to the death.

Possible Safety interventions involving the continuing use of rope

47. One proposal is that if a rope is to be utilised, then it should be one with a lanyard type safety release. The difficulty with this proposal arises from the prohibition against tying anything to EWP rails, the inherent instability of that equipment and that tip over pressure and adequacy of release response required may vary from site to site and equipment to equipment. There is also the danger that operators may assume that as a rope is expressly allowed to be used, it may be also used to lift weight.

48. An arrangement involving the storing or bucketing of the rope in a receptacle in the base of the EWP retains the same potential for the rope to be loose or overhang if it is not placed in the bucket by the operator or for some reason is pulled out of the bucket.

49. A further suggestion was the placement of mesh around rails of the EWP. This may be helpful to prevent other items falling out of the bucket, particularly when working overhead, however, if a rope is tied to the rails and not fully gathered in, the entanglement danger remains.

COMMENTS:

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. The evidence is that a new contractor was engaged to complete the panel installation task and that the work process was then undertaken with additional employees, 5 in the crew, two EWP's with wider bases and no rope was utilised. I have been unable to establish what the current industry practice is in relation to installation of pre form panels. If the use of a rope in the process continues to be utilised as part of the method of installation it is unsafe and should be prohibited.
2. I was informed during the course of the inquest that there is no legislative requirement that work method statements or job safety analysis be undertaken and provided on a construction site. The legislature should consider legislating for this requirement and the detail to be contained therein. It appears that in so far as a contractor is required to provide such information to a principal it appears to be very much a matter of discretion as to what is included in the statement.
3. It is imperative that the detail of the work method is also analysed from an occupational health and safety point of view and not only from the perspective of the most efficient manner of performing the work. It is important that this is discussed with the employees actually doing the work. Otherwise, as was the case in this matter serious potential risks may be overlooked.
4. Although it would seem to be stating the obvious, operating instructions for plant and equipment should be read by employees operating the equipment.
5. I have been provided with the WorkSafe Victoria's manual in relation to Safe Operation of Forklifts and a publication entitled "A guidebook of Industrial Traffic Management and Forklift Safety dated April 2003 produced by the Accident Research Centre at Monash University an initiative funded by WorkSafe. The contents of that paper discuss the fitting of onboard camera systems which they describe as having been developed as a result of the trend towards increased mast heights. The onboard camera allows the operator to see the proximity of the forklift tynes and load pockets and are often mounted on the lift carriage just below the tynes or within the tynes themselves. In the absence of a lookout, this is an appropriate modification in circumstances where forklifts and Elevated Work Platforms are being utilised in close proximity and where direct visual contact is obscured.

6. In this matter charges for indictable offences were laid which were ultimately discharged at Committal or made the subject of Nolle Prosequere by the Director of Public Prosecutions in 2004. It appears that the issues in this inquest to some extent traverse those matters and in those circumstances I make no notification to the Director of Public Prosecutions pursuant to S69(2) of the Coroners Act 2008.

RECOMMENDATIONS:

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. That no rope or line of any type be affixed, attached or tied to any elevated work platform when the Elevated Work Platform is in use.
2. That all Elevated Work Platforms have warning stickers located in a prominent position on railings prohibiting the affixing, attaching or tying of any type of rope or line.
3. That a Work Method Statement and a Job Safety Analysis be required prior to commencement of any construction work and that they describe in detail the manner in which the work is being performed, the identification of risks and a description of the risk elimination or reduction measures to be adopted.
4. That the operating instructions in relation to the safe operation of the plant and equipment being used on a construction site be expressly referred to in the Work Method Statement and the Job Safety Analysis.
5. That the Work Method Statement and Job Safety Analysis be legislatively required to be located at the site where the work is to be performed and that it be read by or to each employee prior to their commencing work on the site.
6. That where a Forklift and Elevated Work Platform are operating in close proximity in the installation of pre-form panels, that there be a lookout appointed, or camera device fitted to ensure distance and separation of equipment.

7. In addition to the Interested Parties, I direct that a copy of finding to:

The Minister responsible for WorkCover -

The Honourable Tim Holding Minister for Finance;
WorkSafe Victoria;

Construction Forestry Mining and Engineering Union;

Master Builders Association of Victoria;

Australian Industry Group;

Victorian Trades Hall Council;

The Elevating Work Platform Association of Australia.

Signature:


The seal of the Coroners Court of Victoria is circular. It features a central coat of arms with a shield, a crown on top, and two figures holding a shield. The text "Coroners Court" is written in a curve at the top, and "of Victoria" is written in a curve at the bottom.

Kim M.W. Parkinson
Coroner

Date: 16th March 2010