IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 1069

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**Jacob Austin KERMEEN**
Delivered on:	26 September 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	25, 26 and 27 June 2018
Findings of:	**IAIN TRELOAR WEST, ACTING STATE CORONER**
Coroner's Assistant:	Ms S. Mileska
Representation:	Mr D. Lucas appeared on behalf of R.S. Connell and Sons Pty Ltd Ms F. Ellis appeared on behalf of WorkSafe Victoria

THE PURPOSE OF A CORONIAL INVESTIGATION

1. Mr Kermeen's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria, and appeared to be unnatural and unexpected.[1]

2. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

3. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

4. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

5. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate to be considered relevant to the death.

6. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the '*prevention*' role.

7. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

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[1] Section 4 *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*
[3] See Preamble and s 67, *Coroners Act 2008.*
[4] *Keown v Khan* (1999) 1 VR 69.

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

8. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

9. This finding is based on the entirety of the investigation material comprising the coronial brief of evidence, including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, other than documents tendered through Counsel (including Counsel Assisting), and written submissions of Counsel following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into the death of Mr Kermeen. I do not propose to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and where otherwise appropriate.

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

Identity of the Deceased, pursuant to section 67(1) (a) of the Act

10. On 4 March 2015, Mr Neil Kermeen identified the deceased to be Jacob Austin Kermeen, born 5 September 1995.

11. Identity is not in dispute and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

12. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine performed an autopsy on Mr Kermeen and provided a written report of her findings. Post

[5] (1938) 60 CLR 336.

mortem CT scan showed pelvic fractures, bilateral rib fractures, a right pneumothorax and subcutaneous emphysema. There was no evidence of significant head injury. Severe facial congestion was present with patchy petechial type haemorrhages throughout the head, neck and chest. There were bilateral haemothoraces with patchy alveolar haemorrhage throughout the left lung. Pelvic fractures were also identified. There was no evidence of significant natural disease. Toxicological analysis revealed the presence of nordiazepam, oxazepam, temazepam, methylamphetamine, amphetamine and prior cannabis use.

13. Dr Francis attributed the cause of death to be;

1a) TRAUMATIC ASPHYXIA AND MULTIPLE INJURIES SUSTAINED IN A WORKPLACE INCIDENT

14. Mechanical asphyxia occurs when the body is positioned in such a way that the person's airway is compromised (positional asphyxia) or when enough pressure is placed on the person's chest or abdomen that respiration is impossible (traumatic asphyxia). Often there may be a combination of these mechanisms. In cases of traumatic asphyxia, the nonspecific signs of asphyxia (congestion, petechiae etc.) are prominent during the post mortem examination.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

The initial investigation into the death of Mr Kermeen was undertaken by Detective Senior Constable Brendan Fontana, who prepared the inquest brief **(IB).** In addition, Inspector Stacey De Luca from WorkSafe Victoria completed an investigation into the matter and prepared a WorkSafe brief **(WB)** which was also provided to the Court. Having considered both briefs of evidence, the circumstances of the death are outlined below.

15. Jacob Kermeen was a 19-year-old man who resided in Bentleigh. He is survived by his parents, Ms Jo Kermeen and Mr Neil Kermeen.

16. On 3 February 2011, Mr Kermeen commenced work for his father's company, Rangedale Drainage and Civil Services as a labourer and excavator operator. During this time, he obtained various qualifications including a Trenching and Shoring Ticket. He was trained in his role by a senior experienced employee and was required to upgrade or refresh his training frequently. He worked around trenches and shafts during his employment, and

would often work as part of a three man crew, with one in the trench performing the work, one on the side of the trench supervising the works and handing down equipment, and the other using machinery such as an excavator.[6] Mr Neil Kermeen stated that all the civil construction staff at Rangedale are trained in trenching and shoring, regardless of whether they actually perform that role. This is so '*they are aware of what is required and acceptable and are able to determine when things go wrong.*'[7]

17. In August 2013, Mr Kermeen obtained employment with R.S. Connell & Sons Pty Ltd **(R.S. Connell)**, a pipe laying civil construction company where he worked as a labourer/pipe layer. On 4 March 2015, R.S. Connell were subcontracted by Sandridge Roads to work on an estate, Brinalee, in Cranbourne. Mr Kermeen was working as part of a three man crew with Mr Wayne Vincent and Mr Aaron Young to excavate into a live sewer and lay new pipes throughout the estate. Mr Vincent was the excavator operator, Mr Young was the 'toppie'-that is, the person at the top of the trench who assists the excavator operator and Mr Kermeen was the pipe layer.

18. According to Mr Young, the normal process was that Mr Vincent would perform a 'cut' using a 600cm wide bucket which he used to excavate the dirt to a depth of 3 metres. A smaller bucket would then be used to dig some dirt from the bottom of the trench so that the trench shield was able to sit on it. Chains would then be put on the excavator in order to connect them to the trench shield which was then lowered into the trench. Once the shield was in place, Mr Kermeen would get into the trench and commence laying pipe. He would then place 'bedding' down, being 7mm of crushed rock, spread in accordance with a laser, and Mr Young would pass him pipe to connect with the pipe already in the trench.[8]

19. According to Mr Young, the trio worked solidly until 12pm before they stopped for lunch. After lunch, they changed the direction of the pipe so they had to do a new manhole to get the laser properly aligned. The manhole was 2.4 x 2.4 metres in excavation. Once the manhole was completed, Mr Vincent started to excavate and put in a new shield for the pipe. He did one cut and put a new shield in and Mr Kermeen entered within the shield with aid of a ladder. Mr Vincent started to do another cut. Mr Young stated,

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[6] IB pg. 1-2
[7] IB pg. 2
[8] IB pg. 31-32

'Wayne was nearly down to the 3 metre depth. I was standing at ground level near the manhole, preparing the next bit of pipe to pass down to Jake. All our equipment was on one side of the trench. Wayne was dumping dirt on the other side so as not to get near us with the machine. The dumped dirt was within two metres of the trench he was cutting. I had walked near to the trench to get ready to put the chains on for the next shield. Wayne had just dumped a bucket full of dirt out and was moving the bucket back into position when the trench wall collapsed from the other side of me. I looked for Jake but noticed he was not in the trench shield.'[9]

Mr Young stated that he was not sure why Mr Kermeen stepped out of the trench shield that day. He stated, *'in all my time working with him, he had never done that before...He didn't say why he walked out of the shield, he just did it. He had his trench shoring ticket and knew not to go into an unprotected trench.'*[10]

20. Mr Vincent's account is as follows; at approximately 2pm, Mr Kermeen was laying the sewerage pipe in the shielded area of the trench. Mr Vincent came in with the bucket of the machine to trim the base of the trench. He lifted the boom of the excavator out of the trench and the bucket was full. He slewed to his right and emptied the bucket before moving back into position directly above the trench. As he was coming back into the position with the excavator, he observed Mr Kermeen out of the shield and in the unprotected zone which he was digging in.[11] He yelled out to him to get back into the shield but the left hand side of the trench wall collapsed, totally engulfing Mr Kermeen beneath it.

21. Mr Vincent began digging with the excavator in an area two metres in front of where he had last seen Mr Kermeen. Once he could see Mr Kermeen's helmet, he began to dig another metre closer to him. At this point in time, Mr Young jumped into the trench with a shovel and commenced digging. Mr Vincent continued to reach past Mr Kermeen towards the trench shield area and pushed dirt away from him with the bucket of the excavator. He continued doing this until he couldn't continue with the excavator for fear of causing injury to Mr Kermeen.

22. Mr Young called for an ambulance and for a number of other workers from Sandridge Roads who were working on the site, approximately 200 metres away, who came over to

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[9] IB pg. 32
[10] IB pg. 34
[11] IB pg. 26

assist. These were Mr Marcus Lia, Mr Kevin Spencer and Mr Bobby Hill. Mr Spencer and Mr Hill joined Mr Vincent in the digging. Mr Hill could see that Mr Kermeen was unresponsive, had blood around his ear and Mr Vincent could not locate a pulse.[12]

23. The County Fire Authority **(CFA)** arrived along with paramedics and police. For safety reasons they requested Mr Vincent to get out of the trench but he refused to do so and continued to dig for some time. Mr Vincent stated that nobody else got into the trench at this point due to the potential danger.[13] The CFA advised Senior Constable Chris Clarke that given the instability of the trench walls, recovering Mr Kermeen's body would be delayed until a specialist Melbourne Fire Brigade unit arrived.[14] Mr Kermeen was not showing any signs of life but due to safety issues with the trench, his body was only recovered at 9.30pm. He was subsequently declared deceased.

24. Based on the WorkSafe investigation, R.S. Connell pleaded guilty to two charges under s.21(1) (2)(a) and 23(1) of the *Occupational Health and Safety Act 2004* (Vic) on 31 March 2017. They were fined $25,000 without conviction, together with costs of $8,000.

The inquest:

25. On 11 September 2017, Mr Neil Kermeen wrote to the Court outlining his concerns at discrepancies in evidence between the inquest brief and the WorkSafe brief. In particular, he queried whether Mr Vincent and Mr Young were actually on site at the time of the trench collapse.

26. Despite Mr Vincent and Mr Young's statement insisting that they were, evidence from Paramedic Glenn Stevens indicated that a young Caucasian male at the scene stated to him; '*we didn't see him [Jake] for about 20 minutes...thought he had gone off for a smoke...walked over to the trench and saw it had caved in.*'[15] Paramedic Shannon Davey also stated that a young Caucasian male had stated to her '*we had gone for smoko...Jake had gone missing...we went back to the trench and noticed it collapsed and started digging and called 000...Jake was supposed to be in the shield...we have had to tell Jake 5 or 6 times to get back in the shield.*'[16] WorkSafe Inspector Colin Skinner also remarked that Mr Vincent

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[12] IB pg. 14
[13] IB pg. 28
[14] IB pg. 36
[15] Statement of Glenn Stevens pg. 2 of WB
[16] Statement of Shannon Davey pg. 2 of the WB

had stated to him that Jake had been missing for about 30 minutes when they noticed the trench had collapsed.[17] This information is in direct contrast with the statements of Mr Vincent and Mr Young.

27. As such, the focus of the inquest was narrowed to that particular issue. The safety standards employed by R.S. Connell were already dealt with by the WorkSafe investigation and I do not need to make further comments in respect of that.

28. The following witnesses were called to give evidence at the inquest;

(a) Mr Neil Kermeen

(b) Mr Aaron Young

(c) Mr Wayne Vincent

(d) Mr Scott Barton

(e) Mr Rohan Cottle

(f) Senior Investigator Stacey De Luca

(g) Mr Colin Skinner

(h) Paramedic Glen Stevens

(i) Paramedic Shannon Davey

Evidence and Findings:

29. It is not my intention to reiterate from the transcript, the evidence of the various witnesses. What is clear from the evidence is that laying of sewer pipes can be performed from within the confines of the trench shield, but what remains unclear, is why Mr Kermeen left the protection of the shield immediately prior to the collapse. Following recovery of Mr Kermeen[18] there were no fines or bedding located at the base of the trench, hence it appears he could not have been engaged in levelling activity, preparatory to receiving another pipe.

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[17] Statement of Colin Skinner pg. 4 of the WB
[18] Exhibit 12, page 11

30. While this question remains unanswered, the weight of evidence satisfies me that he had not been abandoned by his fellow workers at the time the incident occurred. I accept the evidence of Mr Young, that he and Mr Kermeen could continue or finish to lay pipes[19] in the absence of Mr Vincent, where there was a trench shield in situ, however, in the absence of both the excavator and 'toppie', there would be nothing for the pipe layer working alone to do.[20]

31. It is difficult to reconcile the inconsistencies that appear in various statements forming the IB and those obtained by the WorkSafe investigator. However, I have had the benefit of seeing Mr Young and Mr Vincent give their evidence and be examined in relation to it. I find that all three were working together when the trench collapsed.

32. The opposing versions as to what happened at the time of the collapse must be considered in the light of the unexpected nature of the incident, the trauma associated with the attempted recovery and the fact that not all attendees at the site directly witnessed the incident.

Preventative Measures:

33. There are policies and procedures in place through legislation, regulations and work practices addressing protection and safety of workers in trench work-places. Since the tragic death of Mr Kermeen, R.S. Connell have added a further safeguard to their work practice, by providing a magnetic chain to be attached to the end of the shield as a reminder not to step outside of it. The chain is not designed as a barrier, but as a reminder and when the next shield is placed, it is removed and attached to the new shield and so on as each is placed along the length of the trench.

Conclusions:

34. The identity of the deceased was Jacob Austin Kermeen, born 5 September 1995.

35. The death occurred on 4 March 2015 at Brindalee Estate, Linsell Boulevard/Tangemere Way Cranbourne East, 3977 Victoria from traumatic asphyxia and multiple injuries sustained in a workplace incident.

36. The death occurred in the circumstances described above.

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[19] T 111.17-29
[20] T 111.26-31

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

Mr Neil Kermeen

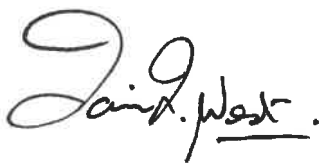
Detective Senior Constable Brendan Fontana, Greater Dandenong CIU

Mr Michael Connell, R.S Connell & Sons

Mr David Lucas, McDonald Murholme Lawyers

Inspector Stacey De Luca, WorkSafe Victoria

Signature:



IAIN WEST
ACTING STATE CORONER
Date: **26 September 2018**