FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 2613/08

Inquest into the Death of ANTHONY RIMANICH

Delivered On:	30 August, 2010
Delivered At:	Melbourne
Hearing Dates:	6 May, 2010
Findings of:	CORONER KIM PARKINSON
Representation:	Ms E Watson for Victorian WorkSafe, Victoria Mr J Goetz for Road Signs and Marking Supplies Pty Ltd (trading as RMS Road Management Solutions)
Place of death:	Royal Melbourne Hospital, Royal Parade, Parkville 3052
PCSU:	Senior Constable Kelly Ramsay, assisting the coroner

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Court reference: 2613/08

In the Coroners Court of Victoria at Melbourne
I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname:	RIMANICH
First name:	ANTHONY
Address:	56 Fulton Road, Blackburn South, Victoria 3130

AND having held an inquest in relation to this death on 6 May, 2010
at Melbourne
find that the identity of the deceased was ANTHONY RIMANICH
and death occurred on 18th June, 2008

at Royal Melbourne Hospital, Royal Parade, Parkville, Victoria 3052

from

1a. COMPLICATIONS ARISING FROM BLUNT FORCE TRAUMA TO THE HEAD (CONSISTENT WITH A FALL)

in the following circumstances:

1. Mr Anthony Rinaldo Rimanich was born on 21 June, 1948 and was 59 years of age at the time of his death. He is survived by his wife, Mrs Livinia Rimanich and his daughter, Mrs Tania Brecht. He was employed as a Storeman/Factory worker by Road Signs and Markings Pty Ltd; trading as Road Management Solutions.

Background

2. Road Management Solutions is a firm which supplies pre-form safety signs and barriers for use in traffic and pedestrian management. It operates out of premises at 81 Norcal Road, Nunawading. Mr Rimanich commenced employment with the company on 15 July 2007. His job was to laminate and cut road signs and his responsibilities included such matters as stock counting and picking. He was described as a good honest and reliable worker who was conscious of occupational health and safety issues and an advocate of working safely.

3. On 3 June 2008, Mr Rimanich sustained a head injury at work and was located semi - conscious on the floor of the factory. He was transported to the Royal Melbourne Hospital where an emergency craniectomy was performed. On 4 June, 2008 he underwent further neurosurgery. His condition failed to improve and on 11 June 2008, in consultation with family members, a decision was taken to provide palliative care. Mr Rimanich died on 18 June, 2008.

4. An autopsy was conducted by Dr Malcolm Dodd, a Senior Forensic Pathologist of the Victorian Institute of Forensic Medicine. Dr Dodd reported Mr Rimanich died as a result of complications arising from blunt force trauma to the head (consistent with a fall). He commented: *"Internal examination of the cranium disclosed residual subdural haemorrhage and haemorrhage/maceration of the inferior surfaces of the frontal poles in keeping with a contre coup type injury. The complications of blunt force trauma are manifest as extensive bronchopneumonia and generalised hypoxic changes within vital organs."*

The events on the day of the incident

5. On 3 June 2008 Mr Rimanich together with Mr Alan Oates were engaged in a stock counting exercise of flat storage on shelving of pre-constructed road signage. The purpose of the count was to establish availability of ready supplies. The count was being conducted in an area which is fitted with shelving.

6. Mr Rimanich was working counting the sheets and Mr Oates was recording the count. In his statement Mr Oates said he was located at a work bench some 4 to 5 metres away tallying the count being provided by Mr Rimanich. Mr Oates stated that after some count, Mr Rimanich went silent and Mr Oates, who had his back to Mr Rimanich, looked around to observe him unconscious lying on his back on the floor.

7. An investigation into the circumstances of the incident was undertaken by WorkSafe Investigator Mark William Watkins. Mr Watkins gave evidence in the proceedings and described the racking system. "*The racking system upon which the injured person was alleged to have fallen from measured 3.250 metres high and consisted of 3 storage bays wide that measured 2.650 metres wide. This racking system contained a number of shelves positioned at various levels from 600mm to 2.4 metres high. The racking supported timber pallets that carried flat sheet metal products*".

8. Mr Oates stated that the racking system was of four levels from ground up to 3 metres high. The height at which Mr Rimanich was working according to witnesses, including Inspector Watkins, did not require him to climb onto the racking or shelving to identify the numbers of panels. The panels being counted were at a height of approximately 1 metre from the ground level on the third shelf. The photographs of the scene reveal a shelving system which having

regard to Mr Rimanich's height, would have enabled him to count stock at the shelf in question, without the need for attaining further height. The evidence is that there was sufficient equipment available at the premises to attain additional height if required including mobile ladders and forklift with attachments.

9. The actual cause and manner of the fall is unclear. It is possible Mr Rimanich tripped or stumbled at floor height, however the floor surface was examined by the investigators and described as a flat concrete floor of good surface finish. It is more likely that he fell from the edge of the shelving upon which he had been standing or balancing whilst counting the stock. Whilst the witnesses denied that anyone ever climbed onto the framing and stated that it had been expressly prohibited and was known to be prohibited, there are scuff marks in photos which may suggest that people had climbed the framing on some occasions. Whilst there are some indications of footmarks on panels and cross beams, they have been excluded as being those of Mr Rimanich, by reference to the size of the shoe imprints. The injuries he sustained are consistent with him having falling backwards and suffering injury as a result of his head impacting the concrete floor.

10. The fact of the scuff marks and the evidence of Mr Georg Siologa Tafu that Mr Rimanich had been known to "tell people off for climbing on the racks, suggests that there was such a practice occurring from time to time, although the supervisor, Mr Skinner, had not observed this occurring.

11. The evidence is that the workplace had adequate provision for lifting and climbing equipment and that lifting and laddering equipment was available. It does not appear, having regard to the evidence of Mr Skinner, that there were time imperatives, which would have caused Mr Rimanich to forego the use of that equipment and take a speedier alternative on the day of the incident. There is no evidence that such an approach would in fact have been quicker. Mr Skinner's description of the panels being counted and the photographs of the shelving and panels, satisfies me that they were observable and able to be counted from a standing height.

Safety oversight at the site

12. There is no evidence to suggest that safety oversight at the site was inadequate. The company occupational health and safety policies and work process directions required that any stock picking or count taking place over shoulder height should involve the use of ladder equipment. The evidence is that induction training was provided in safe work practices with all employees, although not specifically addressing any prohibition against climbing the racks. Mr Rimanich was described by his co-workers as a safety conscious employee.

Conclusion

13. It is unclear how it was that Mr Rimanich came to fall to the ground and sustain the significant head injuries. The pathologist has reported that the injuries are consistent with a fall and there is no evidence to suggest that the injury was sustained in any other manner. There is no evidence that a natural medical event, such as a cardiac incident, preceded the fall. I am satisfied that it is likely that the fall occurred as a result of Mr Rimanich losing his footing or balance and falling from the shelving unit where he was balancing. Whilst the height at which he was likely to be balancing was not great, the fall onto concrete ground was sufficient to cause significant head injury and brain trauma.

14. I find that Mr Anthony Rimanich died on 18 June 2008 and that the cause of his death was complications arising from blunt force trauma to the head arising from a fall.

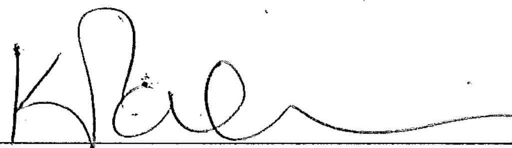
COMMENTS:
Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. I note that the WorkSafe investigators and the company have considered the occupational health and safety framework and instructions within which the company worked. An improvement notice which was issued to the company in relation to signage and training in relation to stock inspection and removal was acted upon. In particular additional signage was erected in relation to standing and climbing on racks and storage areas, this was also expressed in the work process manual and tool box meetings were held to discuss the issue. All site induction within the company now includes express instructions as to this matter.

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

1. Having regard to the steps taken by the company as outlined above, I make no recommendations in this matter. I direct that a copy of this finding be provided to the interested parties.

Signature:



Kim M.W. Parkinson
Coroner
Date: 30th August 2010