IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2016 005097

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Audrey Jamieson
Deceased:	Ivica Andrijasevic
Date of birth:	20 March 1962
Date of death:	26 October 2016
Cause of death:	1(a) NECK COMPRESSION
Place of death:	Melbourne Convention Centre, 1 Convention Centre Place, Melbourne, Victoria, 3000

INTRODUCTION

1. On 26 October 2016, Ivica Andrijasevic was 54 years old when he died as a result of the trauma he sustained when he was crushed while operating a Mobile Elevated Work Platform (MEWP), acting in the course of his employment at the Melbourne Convention and Exhibition Centre (MCEC).

2. At the time of his death Mr Andrijasevic lived in Endeavour Hills with his wife, Lucija Andrijasevic with whom he had five children. The family immigrated to Australia from Croatia in about 2012.[1]

Background

3. In 2016 Mr Andrijasevic took up employment as a boilermaker with Stilcon Site Services Pty Ltd (Stilcon SS). On occasion, he shared a work site with his sons, Sasa and Anto, both of whom were also employed by Stilcon SS as riggers.[2]

4. Stilcon Holdings Pty Ltd (Stilcon) was contracted by Probuild Constructions (Aust) Pty Ltd (Probuild) to undertake a construction project at the MCEC. Stilcon subcontracted this work to Stilcon SS which brought Mr Andijasevic to work at the MCEC site on 26 October 2016. The work itself entailed welding operations, installing structural steel reinforcements to precast concrete pedestrian bridges which, as indicated by the evidence, was already in place. Access to the specific bridge on which Mr Andrijasevic was working at the time, was gained by using a MEWP.[3]

5. The MCEC site was serviced by numerous contractors simultaneously, each performing specific duties. On the same day, tradesmen Tomasz Jaworski and Jerry Straka, employed by the Rican Group (RG) were also working at the MCEC site. The evidence indicates that Stilcon subcontracted the RG to perform some of the welding-related duties. More

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[1] Coronial Brief of Evidence [CB], statement of Sasa Andrijasevic who stated that his father worked at 'I&D PTY LTD since 2012' prior to which his father 'lived in Croatia' where he was employed as a 'council property inspector'. It is unclear when in the year 2012 the family arrived in Australia.

[2] CB, statement of Sasa Andrijasevic.

i. A boilermaker is a tradesperson who fabricates metal into boilers or containers intended to hold hot gas or liquid. They also repair and maintain boiler and boiler systems.

ii. A rigger is a tradesperson who specialises in the assistance of manual mechanical advantage of devices comprising a pulley system like motorised cranes, winches and other machinery of a similar nature.

[3] CB, statement of Robert Martin to Victoria Police. Mr Martin was the building supervisor for Probuild.

i. A MEWP is colloquially referred to as a 'boom lift' or 'cherry picker' and also referred to by the acronym, 'EWP' (Elevated Work Platform).

ii. For the purposes of my Finding, in the context of the factual matrix of this matter, a reference to one business entity includes the other entities.

specifically, RG had to install handrails. In the execution of their duties Messrs Jaworski and Straka were required to use a MEWP. According to Mr Jaworski he was briefed by a Stilcon employee and completed the logbook before using the MEWP which was pointed out to him by the employee.[4]

6. Mr Straka stated that he and Mr Jaworski reported for duty at the MCEC site at approximately 8am. There, they were directed by a Stilcon supervisor who explained what work had to be done. Before they commenced their duties, they were required to sign Safe Work Methods Statements (SWMS). According to Mr Straka, he was uncertain which SWMSs were signed but these related to the work he and Mr Jaworski were about to perform. The supervisor then directed them to the specific MEWP that they were to use. Mr Straka then checked that the MEWP was in order and after finding that it was fully operational, he proceeded to sign the logbook and then he discovered that his colleague, Mr Jaworski, had already signed the logbook.[5]

7. Mr Peter Ivaneza was the MCEC site foreman employed by Stilcon SS. According to him, the MEWPs used at the site were owned by Stilcon and were checked every day and while working at the MCEC site, he was not aware that any of the MEWPs were malfunctioning. Mr Ivaneza stated further that 'All the Stilcon crew were inducted onto the site' but he did not know which employees signed the SWMS.[6]

8. According to Sasa, his father was a conscientious tradesperson who fastidiously went about his daily routine in performing his duties, observing safety protocol to the best of his ability. He was well respected by his peers and an acclaimed member of the Croatian community in Melbourne.[7]

9. With about 30 years' experience, Mr Andrijasevic was a 'competent' worker and 'more than capable' of performing the duties assigned to him and held the requisite licencing credentials to operate a MEWP. According to Mr Ivaneza who had witnessed him 'operate booms on

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[4] CB, statement of Thomas Jaworski.

i. The logbook details included the date, time and name of operator.
ii. Mr Jaworski was not certain who the Stilcon employee was who briefed him but the evidence indicates that the Stilcon Site Engineer, Nicholas Jurcic, is usually responsible for performing this task. In this regard, see the statement of Peter Ivaneza.
iii. The logbook entry indicated the specific MEWP—identified as a JLG 460SJ boom-type EWP with the serial number 0300160723.

[5] CB, statement of Jerry Straka. When Mr Straka conducted the 'pre-start check' on the MEWP, he found that 'Everything was working fine'. (sic)

[6] CB, statement of Peter Ivaneza. The evidence indicates that by signing the SWMS, the onus is placed on the employee to bring any malfunction relating to the MEWP to the attention of management staff.

[7] CB, statement of Sasa Andrijasevic

numerous occasions' previously, Mr Andrijasevic did not do anything that would raise 'safety concerns'.[8]

10. Mr Andrijasevic's medical history was largely unremarkable. According to Dr Uday Alhamed of the Stud Road Medical Centre, Mr Adrijasevic's doctor (GP), he did not have any significant health concerns and usually only visited the clinic for 'minor illnesses like flu and to do blood tests'. A condition which impacted his health to some degree, however, was an underactive thyroid gland but this condition was actively managed. In Dr Alhamed's opinion, Mr Andrijasevic did not suffer from any 'chronic' medical conditions or any 'acute' health problems.[9]

THE CORONIAL INVESTIGATION

11. Mr Andrijasevic's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

12. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

13. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Andrijasevic's death. The Coroner's Investigator conducted inquiries on my behalf, including

[8] CB,
i. statement of Peter Ivaneza.
ii. statement of Ymara Jayamanne, Team Leader Licensing Branch, WorkSafe who stated that as at 26 October 2016, the date of his death, Mr Andrijasevic held a Victorian Licence to 'Perform High Risk Work for Boom Elevated Work Platform (WP)'.

[9] CB, statement of Dr Uday Alhamed who had been Mr Andrijasevic's GP since 2012. His last visit to the practice was on 21 May 2016. For his underactive thyroid, he was prescribed thyroxine and his medical records also reflected regular use of aspirin.

taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

15. This finding draws on the totality of the coronial investigation into the death of Ivica Andrijasevic including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[10]

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

Circumstances in which the death occurred

16. On 26 October 2016, Mr Andrijasevic reported for duty at the MCEC at approximately 7am.[11]

17. By agreement between Stilcon SS and Probuild, Mr Andrijasevic commenced his duties for the day 'on loan' to Probuild, tasked to 'weld reo for the pre concrete pour' until approximately 12.30pm. Thereafter, he resumed his duties with Stilcon SS which also entailed welding. According to Mr Ivaneza, Mr Andrijasevic elected to use the 'JLG SJ straight boom'. The evidence indicates that this was the MEWP used by Messrs Jaworski and Straka earlier that day.[12]

18. Mr Andrijasevic was to perform his tasks for Stilcon SS on his own. However, as the site foreman, Mr Ivaneza briefly discussed his duties with him before resuming his own duties. Mr Ivaneza stated that he went 'back to check' on Mr Andrijasevic 'around every 30 minutes' after their discussion and at approximately 2.45pm, the last time that he 'checked on him', he could see him 'welding away' and everything 'appeared normal'.[13]

19. Mr Robert Martin, the Probuild supervisor stated that when he went to check on Mr Andrijasevic, he noticed that the 'boom bucket' was higher than it should have been. On closer

[10] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[11] CB, statement of Peter Ivaneza prepared for Victorian WorkCover Authority. Mr Ivaneza was the site Foreman for Stilcon SS.

[12] CB, statement of Peter Ivaneza. The evidence indicates that the colloquialism 'weld reo' refers to Mr Andrijasevic's assigned duties of welding the steel reinforcements.

[13] CB, statement of Peter Ivaneza

inspection he noticed further that 'a diagonal steel section looked like a seatbelt' over Mr Andrijasevic's shoulder. He then raised the alarm, alerting the site to the emergency.[14]

20. At Approximately 3pm, Mr Ivaneza was alerted by two calls for first aid on the site radio. The next call was a request for an ambulance which raised his suspicion that 'something serious' had happened. After he ensured that the crew he had been working with was safe, he looked over to where Mr Andrijasevic had been working and could only see the base of the MEWP basket on which Mr Andrijasevic had been working. Realising that he could not see him, he hastened to where Mr Andrijasevic was working, climbing the scaffolding to access the MEWP 'basket' which was 'still up in roughly the same position' he last saw it in.[15]

21. As he approached the basket of the MEWP, Mr Ivaneza noticed that a Probuild employee was in the in basket with Mr Andrijasevic.[16] According to Mr Ivaneza, he then rushed down the scaffolding again to 'lower the basket'. After he brought the 'boom down' to a suitable position, he 'helped' the site employees who had congregated at the scene of the incident, to take Mr Andrijasevic 'out from the basket'.[17] (sic)

22. As soon as Mr Andrijasevic was 'helped' out of the 'basket', his colleagues administered cardiopulmonary resuscitation (CPR), one of whom 'used a defibrillator twice' until the paramedics arrived. [18]

23. Upon arrival at the scene, Ambulance Victoria (AV) paramedics were unable to revive Mr Andrijasevic and declared him deceased at the scene.[19]

Identity of the deceased

24. On 26 October 2016, Ivica Andrijasevic, born 20 March 1962, was visually identified by his son, Saśa Andrijasevic who signed a formal Statement of Identification.

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[14] CB, statement of Robert Martin.
[15] CB, statement of Peter Ivaneza.
[16] CB, first statement of Robert Martin, the Probuild Supervisor.
   i. According to Mr Martin, he decided to 'go over to see' how far Mr Andrijasevic had progressed with his assigned tasks when he noticed that the boom bucket was higher than what it should have been and saw that Mr Andrijasevic was 'still standing' but 'looked shorter than normal'.
   ii. Mr Martin identified Mr Ian Williamson, another supervisor as the staff member who 'got into the cherrypicker basket'. (sic)
[17] CB, statement of Peter Ivaneza who stated that about '6 people were around the area by then'.
[18] CB. Statement of Peter Ivaneza. A defibrillator is a device that restores a normal heartbeat by sending an electric pulse or shock to the heart.
[19] CB, Police Report of Death, Form 83. The report contains a reference to the Metropolitan Ambulance Service (MAS) as the service which responded to the emergency call. The MAS became part of AV on 1 July 2008.

25. Identity was not in dispute and required no further investigation.

Medical cause of death

26. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on the body of Ivica Andrijasevic on 28 October 2016, reviewed the scene photographs, the Ambulance Victoria Report and the Police Report of Death, Form 83. Dr Baber provided a written report of her findings dated 30 November 2016.[20]

27. The post-mortem examination revealed abrasions about the face, neck, back and upper limbs. In addition, extensive haemorrhage was observed in the musculature of the neck structures. No natural disease was identified which may have caused or contributed to the death.

28. Toxicological analysis of post-mortem blood samples did not identify the presence of any alcohol or any common drugs or poisons.[21]

29. Dr Baber provided an opinion that the medical cause of death was: 1(a) NECK COMPRESSION.

INVESTIGATIONS

30. I commenced my investigation by attending the scene of the incident on 26 October 2016, arriving on site at approximately 5.30pm after I was advised of the workplace death by Coronial Admissions and Enquiries (CAE) of the VIFM. Upon arrival I noted the position of the MEWP in relation to the deceased.

31. The circumstances surrounding the incident were related to me by Mr Andrijasevic's co-workers who were alerted by an unusual sound. To them, the noise they heard was that of a machine overriding. When they investigated the source of the noise, they noticed that the noise emanated from the MEWP which was in the process of being elevated but was prevented from being fully elevated or extended, obstructed by overhead steel girders.

32. At the time of my inspection at the scene, two inspectors from the Victorian Workcover Authority (WorkSafe) were also at the scene. Inspector Glen Spaulding and Inspector Andrew Slade informed me that their investigation, although in its infancy, identified that there was

[20] CB, Medical Examiner's Report of Dr Yeliena Baber
[21] CB, Toxicology Report of Lillian Roberts, VIFM Forensic Toxicologist.

no employee positioned on the ground as the MEWP was being elevated to guide the operator-- a duty known as 'spotting'. According to them, having someone on the ground 'spotting' is recommended practice on work sites of this nature.[22]

33. Due to the position of the MEWP and what had transpired, the evidence, at that stage, indicated that WorkSafe had to conduct a full risk assessment in relation to the circumstances of Mr Andrijasevic's death as the position of the MEWP indicated that there was an increased risk of injury because Mr Andrijasevic needed additional assistance to manoeuvre the MEWP.

34. Given the nature of the death and the commencement of an investigation by WorkSafe, on 14 December 2016, I directed my coroner's investigator, Senior Constable (SC) David Hughson to compile a Coronial Brief to assist with my own investigation.[23]

WorkSafe Investigation[24]

35. On 26 October 2016, the day of the incident, WorkSafe Inspector Andrew Slade attended the site and commenced the WorkSafe investigation by perusing the Stilcon SWMS which, he noted, did not include any reference to the risks associated with welding work.[25]

36. Pending further investigation, Inspector Slade then advised Probuild to suspend the use of all MEWPs and welding work until the crush hazards and associated risks were identified and discussed with the staff. In addition, he advised Probuild to review all SWMSs for welding work to reflect welding and crush hazards during MEWP operation.

37. Inspector Slade then photographed the scene and seized the following documents for review:

    i. The Probuild "Workplace Induction" for Ivica Andrijasevic';
    ii. The Stilcon SWMS for MEWP operation dated 26 August 2016;
    iii. The Probuild "SWMS Review" of the Stilcon SWMS for MEWP operation dated 29 August 2016;
    iv. The Stilcon SWMS for site arc welding dated 28 August 2016; and
    v. The Probuild "SWMS Review" of the Stilcon SWMS for site arc welding.

[22] CB, statement of Ross Clayton, Senior Investigator, WorkSafe, who was also on site at the time of my inspection.
[23] From 6 September 2018, SC Hughson was assisted by Leading Senior Constable (LSC) Duncan Mackenzie of the Police Coronial Support Unit (PCSU) after I ascertained that WorkSafe had declined to prosecute.
[24] CB, WorkSafe Brief submitted to the Court on 26 February 2018. This Brief was incorporated into the Coronial Brief to the coroner's investigator by my direction.
[25] CB, statement of Andrew Slade who was accompanied by WorkSafe Inspectors Glen Spaulding and Ross Clayton.

38. Inspector Slade also secured the immediate surrounds of the on-site location where the incident occurred as well as the particular MEWP by issuing a non-disturbance notice to Probuild.[26] He documented his observations of 26 October 2016 in his WorkSafe Entry Report and provided a copy to Probuild.[27]

39. On 27 October 2016, Inspector Slade returned to the site to continue his investigation accompanied by fellow WorkSafe Inspector, Andrew Taylor, together with WorkSafe investigators, Damiano Ambrosini and Emir Cihangir. According to Inspector Slade, the object of this visit was to conduct an operational assessment on the MEWP which was operated by Mr Andrijasevic on the previous day, resulting in his injuries and subsequent death. On departure, Inspector Slade issued another non-disturbance notice and a WorkSafe Entry Report. This time, specifically to secure the MEWP.

40. On 27 October 2019, Inspector Andrew Taylor conducted the operational assessment of the MEWP, JLG Model 460J with serial number 0300160723, while it was operated by Nicholas Booth who had been commissioned for this purpose by his employment agent, MC Labour, on behalf of Probuild. Mr Booth was to operate the MEWP to enable Inspector Taylor to conduct an on-site assessment of the operational functions of the MEWP including the switches that controlled its operation. After the on-site inspection, Inspector Taylor secured the MEWP for further inspection, including testing the MEWPs operation at a platform station.[28]

41. On 16 November 2016, having perused the "Workplace Induction" and SWMS documents seized on 26 October 2016, Inspector Slade returned to the Probuild (MCEC) site to ensure that the Stilcon documents had been revised, in line with the requisite WorkSafe standards. Upon further scrutiny and after he was satisfied that the documents had been revised accordingly, Inspector Slade made further recommendations for the SWMS documents to include the use of MEWPs. Specifically, the Stilcon SWMS had to document known hazards in the event of the occurrence of any mechanical defects of MEWP directional switches and, upon failure of the switches, the inherent dangers posed by their malfunction.[29]

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[26] CB, statement of Andrew Slade. Non-disturbance notice V01013502569L/110-01 was handed to Maria Costa, Probuild employee

[27] CB, statement of Andrew Slade. WorkSafe Entry Report V01013502569L was handed also handed to Maria Costa.

[28] CB, statements of Nicholas Booth and Andrew Taylor of the Victorian Workcover Authority, stationed at the Engineering Unit, Specialist Services Division of WorkSafe.

[29] CB, the statement of Andrew Taylor sets out the technical standards adopted by Worksafe in this regard, aligned with legislative injunctions as required by *Occupational Health and Safety Act 2004* (Vic), specifically the Australian Standard A.S. 2550.10—Cranes, Hoists & Winches—Safe Use—Mobile Elevating Work Platforms- 2006.

42. Examining the MEWP on 27 October 2016, Inspector Taylor observed that:

i. The MEWP was not fitted with a Skyguard device which is manufactured by JLG Industries and readily available for purchase. The device fulfils a safety function, decreasing the likelihood of crush injuries by automatically moving the MEWP operator away from an obstruction. According to Inspector Taylor, although the Skyguard was not available when this particular MEWP was manufactured, it was 'possible to retrofit the system for the last 2 years' before the incident;

ii. The original manufacturer's platform levelling override toggle switch had been replaced at some point. The evidence indicates that the MEWP had been repaired previously;

iii. The 'slew lock pin' was disengaged and the electrical supply cable to the movement warning alarm was disconnected;

iv. Impact damage to the left-hand side lower bar used to support the MEWP load which, in industry, is referred to as the "jib";

v. The door to the MEWP platform was faulty—it did not latch due to the damaged door frame; and

vi. The pre-start checks of the base controls appeared to operate correctly.

43. Subsequent tests at the platform station revealed that:

i. Without the engine of the MEWP idling, all controls that were designed to return to the neutral position operated correctly;

ii. The engine started correctly with the operator's foot off the pedal controls without any warning lights illuminating;

iii. With the engine idling, but without engaging the pedal switch, the operator attempted to engage the switches on the MEWP. The operator could not operate the functions switches without operating the pedal switch simultaneously which accorded with manufacturer's specifications;

iv. After operating the pedal switch, all the function switches could be successfully engaged but for the 'jib raise toggle switch' which was designed to return to the neutral position when released but failed to operate in accordance with manufacturer's specifications;

v. The MEWPs 'seven second delay timer' which is designed to prohibit the operation of functions in quick succession, without first disengaging the pedal switch, operated in accordance with the manufacturer's specifications.

44. Having regard to WorkSafe recommendations to the construction industry, consonant with the relevant legislative injunctions, Inspector Taylor focused the WorkSafe investigation on the following:[30]

i. The adequacy of the SWMS and/or policies, procedures and instructions relevant to the use of MEWPs for steel erection works at the MCEC prior to and after the date of the incident;
ii. The deficiencies associated with the operating environment and the operation of the MEWPS at the site;
iii. Any contributing factors to the incident;
iv. The industry practice relating to the operating environment and the operation of the MEWPs at similar construction sites;
v. Identification of any reasonably practicable alternative work practices to those practices undertaken at the site;
vi. The identification of all available risk control measures and the cost of the risk reduction or elimination, specifically relating to crush-type injuries;

45. During his investigation, Inspector Taylor identified a previous incident where WorkSafe had issued an Improvement Notice to Stilcon.[31] According to Inspector Taylor, the incident happened on the 31 March 2016 when Stilcon hired out a 'Snorkel SP 18 boom-type MEWP' which Stilcon owned. This incident resulted in a crush-type injury to another operator who was caught between the ceiling and the MEWP when the switch malfunctioned. Inspector Taylor stated further that the switch 'that was hold to run and designed to return to neutral when released remained in the activated position when released, continuing to raise the platform'.[32] (sic)

46. On 13 May 2016, Inspector Taylor noted that Stilcon had complied with the Improvement Notice by following WorkSafe recommendations in this regard. In addition, Stilcon compiled a 'safety alert' in relation to the 'malfunctioning switch issue'.[33]

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[30] CB, statement of Andrew Taylor who used the following documents to guide his investigation:
i. Victorian Code of Practice- (No.19)—Plant, dated 1 July 1995;
ii. Compliance Code for the Prevention of Falls in General Construction (September 2008);
iii. Australian Standard A.S. 2550.10—Cranes, Hoists & Winches—Safe Use—Mobile Elevating Work Platforms-2006;
iv. WorkSafe Safety Alert-Workers Crushed in EWPs- September 2015.

[31] CB, statement of Andrew Taylor, Improvement Notice number V01013502455L/111-01. Issued by his colleague, Andrew Slade after he created an Entry Report with reference number V01013502455L on 11 April 2016.

[32] CB, statement of Andrew Taylor. The degree of the injury sustained is not clear from the evidence.

[33] CB, statement of Andrew Taylor

47. Inspector Taylor filed a report of his findings dated 29 May 2017 in which he opined that:[34]

i. The jib toggle switch malfunctioned at the time when Mr Andrijasevic operated the MEWP;

ii. The malfunctioning jib toggle may have contributed to the incident because the 'jib continued to raise' beyond 'the point that the operator was expecting';

iii. Stilcon was aware of the risks associated with faulty switches and the importance of maintaining the state of repair of their MEWPs' switches;

iv. Mr Andrijasevic's use of the particular MEWP chosen by himself, may have resulted from the lack of accessibility to an alternative MEWP because of the layout of the site environment;

v. Mr Andrijasevic was left to perform his tasks in isolation from other workers which may have resulted in the degree of injury he sustained. As Stilcon only relied on administrative controls to reduce the risk of their workers sustaining crush-type injuries in addition to the standard safety design features of their MEWPs, the risks of crushing were amplified by Mr Andrijasevic working alone and using a MEWP to perform his duties;

vi. 'Secondary guarding' and/or placing a "spotter" on duty in addition to embracing further 'engineering controls' which existed in the industry at the time may have reduced the risk posed to Mr Andrijasevic.

vii. Due to advances in the construction industry at the time, alternative methods like 'mobile scaffolding, a scissor lift' or acquiring a MEWP already fitted with a 'secondary guarding' feature for the task undertaken by Mr Andrijasevic, could have been attained with relative ease;

48. The evidence indicates that Stilcon was in a position to reduce the risk of injury to its employees, armed with prior knowledge of the safety risks associated with the use of MEWPs and specifically, armed with the knowledge that WorkSafe had previously identified 'faulty switches' on their equipment.

49. Prior knowledge of the inherent dangers posed by construction sites to worker safety and, in particular, the risks associated with the use of MEWPS in the construction industry, is further

[34] CB, Andrew Taylor, Senior Engineer (B.Eng, University of Leeds) "Report on the 26th October 2016 incident at the Melbourne Convention Centre, Melbourne"

supported by WorkSafe regulations issued to employers in the construction industry. The evidence indicates that Stilcon was well-placed to abate the risks associated with MEWPS.[35]

Further assessment of the MEWP

50. At the behest of WorkSafe, the MEWP underwent further mechanical and/or technical assessments by various professionals, skilled in the fields of engineering and technology.

John Hambridge Consulting Report

51. On 28 October 2016, John Hambridge , the Managing Director at John Hambridge Consulting, conducted an examination on the MEWP. Although commissioned to do so by WorkSafe, Mr Hambridge conducted his investigation independently.[36]

52. The scope of Mr Hambridge's investigation was to inspect the MEWP and identify, against a background of industry related practices and relevant codes of conduct, operational faults in relation to its condition. In addition, Mr Hambridge was to consider any maintenance work, or the lack thereof, carried out on the MEWP.

53. Mr Hambridge's investigation identified that;[37]

    i. The fault of the toggle switch and the subsequent uncontrolled movement of the jib in an upward direction was a major concern because, without the knowledge that the switch is faulty, an operator could be 'caught unaware';
    ii. There were discrepancies in the logbook entries with regard to recording the incorrect MEWP serial numbers;
    iii. Logbook entries for the MEWP indicated a lack of a system of checks and balances by management;

54. Having completed his investigation, Mr Hambridge opined that the fault he identified was sufficient to have the 'unit tagged out as unfit for service' and that the 'logbook and document inconsistencies and irregularities are a significant failure of the process of ensuring the safe working capability of the unit'.

[35] CB, statement of Andrew Taylor, as referenced in footnote 28.
[36] CB, statement of John Hambridge who holds an Advanced Diploma in Engineering. John Hambridge Consulting carries on business as consultancy which provides expert witness reports on the integrity and the suitability of plant equipment.
[37] CB, Report of John Hambridge dated 17 November 2016

JLG Industries Report

55. On 22 November 2016, Luke Schubert of JLG Industries (Australia) commenced his investigation of the MEWP, commissioned by WorkSafe.[38]

56. Mr Schubert focused his investigation on the condition of the MEWP and to ascertain whether any reparation work was previously undertaken or required.

57. Mr Schubert's investigation identified that the MEWP's platform control box was severely damaged and that the jib switch itself was worn as it 'remained engaged' whilst performing the JLG-approved 'functional check'. He noted further that the MEWP switches had been previously repaired and fitted with replacement component parts which were not original or JLG-approved.[39]

58. On 8 February 2017, Mr Schubert filed a supplementary report in which he noted that:[40]

    i. The jib lift took 23.5 seconds to elevate fully and 27.55 seconds to return to its normal position;
    ii. With pedal switch depressed and the the jib function switch positioned in the 'jib raise direction', the jib began to rise. However, when the latter switch was disengaged, the jib continued to rise and only came to a halt when the pedal switch was simultaneously disengaged;
    iii. Life expectancy of the switches depended on wear and tear factors including the working environment and the MEWP users;
    iv. When switches do not operate to manufacturer's specifications, the MEWP should be 'removed from service' until such time as appropriate remedial action has been taken; and
    v. To his knowledge, JLG has received reports, via the JLG technical support team, of instances where MEWPs continued to move after the function switches were disengaged.

[38] CB, statement of Luke Schubert, a Technical Services and Engineering Manager at JLG.
[39] CB, Report of Luke Schubert, dated 20 December 2016. Schubert also noted that discrepancies in the logbook, recording incorrect MEWP serial numbers. The MEWPs service book records were illegible, incomplete and contained the records of another MEWP.

[40] CB, Supplementary Report of Luke Schubert. WorkSafe requested the Supplementary Report on 18 January 2017 to address further concerns raised by their investigation.

AMAT Materials Engineering Report

59. On 22 June 2017, Barry Gartner, Director at AMAT Materials Engineering Pty Ltd commenced his investigation on the MEWP's jib lift switch. His investigation comprised a comparative analysis of the jib switch removed from the MEWP, identified as a Parcola Electra 3231-7E switch, and new switch which met JLG specifications. [41]

60. Mr Gartner's investigation revealed that:[42]

    i. The faulty jig toggle switch resulted from wear and tear due to long term use.
    ii. Water seepage as a result of a worn seal or washer contributed to the formation of a 'white deposit' forming on the electrical contacts of the component part;
    iii. The particular jib switch was a substitute or replacement switch and contrary to the Box Mechanical Services Pty Ltd (BMS) Job Report No 03651, it was not replaced two weeks prior to the incident which caused the injury to Mr Andrijasevic. According to Mr Gartner, the BMS Job Report was in respect of another MEWP and not the MEWP which caused the injuries when it failed to operate correctly;
    iv. The replacement switches were not suited to the particular MEWP under investigation;[43]
    v. The internal contact surfaces within the base of the jib toggle switch component and the springs which are lubricated during the manufacture process had lost its lubrication over time which resulted in wear on the copper contact points in the component itelf. According to Mr Gartner, this type of 'wear' has 'occurred over a relatively long period of operation', resulting in 'intermittent mechanical fault'. Simply put, the switch became 'stuck' intermittently.

61. On 22 August 2017, following the outcome of Mr Gartner's investigation, WorkSafe conducted further enquiries. BMS records indicated that the switch which was faulty and was not operating at all, had been replaced on 28 November 2015 with a switch of the same or similar functionality, obtained from a supplier. This replacement switch was identified by the

[41] CB, Statement of Barry Gartner BEng (Metallurgical), Materials Engineer.
[42] CB, Report of Barry Gartner, *The Examination of a faulty jib lift switch from a boom type mobile elevated work platform* dated 2 August 2017.. The evidence indicates that Stilcon claimed to have serviced or replaced the component part within a two-week period prior to the incident. The BMS Job Report was dated 10 October 2016.
[43] The switch was not a JLG-approved switch.

code, or number, APTS 1169. Furthermore, the BMS records indicated that BMS had been carrying out maintenance work on this particular MEWP since November 2012.

62. BMS records indicated further that the platform control panel basket level switch was replaced again with an APTS 1169 switch on 10 October 2016 after it was found that it did not operate in accordance with the manufacturer's specifications.

63. The BMS records did not contain any reference to a Parola Electra switch and they were unaware that one had been fitted.

64. Consequently, Mr Gartner was commissioned to conduct further testing of the switch to determine its suitability, amongst other things. Mr Gartner subsequently analysed samples of the debris from the worn 'switch rocker plates' found within the component by examining the debris through a Geotrack International Scanning Electron Microscope (SEM). From his observations, Mr Gartner concluded that:[44]

    i. The electroplated silver coating of the copper plate was worn away, exposing the copper;
    ii. The debris was an amalgam or blend of predominantly copper and silver;
    iii. The presence of zinc can be attributed to zinc corrosion due to the seepage of water into the component via the broken seal; and
    iv. The domed caps on the springs of the toggle of the jib switch slide onto the springs. By comparison, in the JLG equivalent switch, the caps are fixed or 'captive' on the springs. The evidence indicates that the JLG caps are more secure than the caps found on the MEWP's jib switch.

65. Having considered his own investigations, in conjunction with viewing a video clip of the 27 October 2016, recording the 'jib lift switch sticking in the 'RAISE' position, Mr Gartner opined that the mechanical failure of the jib switch on 26 October 2016 'would probably be the result of the wear of the switch's rocker plate and of the mating black caps on the return springs'.[45]

66. In order to clarify the discrepancy with regard to the origin of or particular "brand" of the switch examined by Mr Gartner, WorkSafe investigator, Damiano Ambrosini, after making

[44] CB, Supplementary Report of Barry Gartner dated 23 August 2017.
[45] CB,
    i. Supplementary Report of Barry Gartner.
    ii. Statement of Damiano Ambrosini, WorkSafe Investigator who recorded the video-clip.

the necessary enquiries, ascertained that the supplier from whom BMS sourced MEWP component replacement parts, supplies both "brands".

67. The evidence indicates that the replacement switch may not have been suited to its intended purpose, in the context of the site environs and continuous use, without regular servicing.

68. On 22 February 2018, having completed their extensive investigations, WorkSafe informed the Court that the 'Victorian WorkCover Authority did not commence a prosecution against any party' and cited 'insufficient evidence' as the reason for their decision.[46]

69. Having reviewed the voluminous WorkSafe Brief and having considered that WorkSafe declined to prosecute due to 'insufficient evidence' which, by implication, is consonant with the requisite standard of proof at criminal law, *beyond reasonable doubt*, I considered my own function, purpose and duty in the context of the Coronial Jurisdiction.

70. By contrast, the standard of proof for coronial findings of fact is the civil standard of proof, *on the balance of probabilities*, with the *Briginshaw* gloss or explication. [47]

Purpose of a Coronial Investigation

71. The purpose of a coronial investigation of a *reportable death*[48] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[49] For coronial purposes, *death* includes suspected death.[50]

72. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined

[46] CB, Letter from the Victorian WorkCover Authority to the Court dated 22 February 2018.

[47] Briginshaw v Briginshaw *(1938) 60 C.L.R. 336 esp at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*

[48] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act).

[49] Section 67(1).

[50] See the definition of "death" in section 3 of the Act.

to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[51]

73. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[52] Coroners are empowered to report to the Attorney-General in relation to a death; 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 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.[53] These are effectively the vehicles by which the coroner's prevention role can be advanced.[54]

74. It is important to emphasise that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[55]

75. Against this background, I interrogated whether Stilcon SS had adopted any preventative or restorative measures in response to Mr Andrijasevic's death. Moreover, in my endeavour to elicit an explanation of any such preventative or restorative measures taken, I invited Stilcon SS to provide evidence in this regard for my consideration. In addition, I invited Stilcon SS to put forward any other matters appertaining to the preventative and restorative measures which they intended to execute after Mr Andrijasevic's death, to advance my investigation.[56]

76. On 5 December 2018, Colin Almond of HWL Ebsworth Lawyers, on behalf of Stilcon SS, advised the Court that his client found the questions raised 'somewhat problematic'. According to Mr Almond, it would be difficult for his client to respond to 'circumstances where there were no eye witnesses' (sic) to the events that led to the death of Mr Andrijasevic.

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[51] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[52] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[53] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[54] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[55] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

[56] Coronial File [CF], Letter from the Court to Stilcon SS dated 22 October 2018.

Mr Almond advised the Court further that WorkSafe has 'determined that evidence does not exist to support charges being laid' against his client.[57]

77. Mr Almond enclosed the following documents for my perusal:

    i. Stilcon Site Training Register as at 17 October 2018;
    ii. The SWMS dated 9 June 2016 for the site where the incident that led to the death of Mr Andrijasevic occurred;
    iii. The 'current SWMS dated 7 September 2018 and 3 October 2018';[58] and
    iv. Examples of Stilcon SS 'Verification of Competency Cards'. [59]

78. Mr Almond advanced his opinion that, despite the fact that WorkSafe had not proffered any criminal charges, his client had 'taken further steps to improve its workplace practices' including competency assessments to operate MEWPs every three years.

Further Investigation

79. I considered the content of Mr Almond's letter and the supporting documents in the context of my investigation to date and in the context of the Coronial Brief of Evidence. In this regard, closer scrutiny of the relevant documents revealed that the SWMS dated 9 June 2016, did not identify the risk of crushing when using a MEWP.[60]

80. In a similar vein, I considered the import of Mr Almond's contention that the SWMS documents dated 7 September 2018 and 3 October 2018 respectively, demonstrated Stilcon SS's commitment to a safer work environment by being site specific. Although these documents provide greater detail and information about the risks of crushing injuries, they did not relate to the site at which Mr Andrijasevic sustained his fatal injuries. I do, however, commend the initiative taken by Stilcon SS in this regard as it indicates, in general terms, their commitment to ensuring a safer working environment in future. Similarly, I commend the preventative measures taken by Stilcon SS by proactively implementing a process whereby employee competence to operate a MEWP is assessed every three years.

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[57] CF, Letter from Colin Almond
[58] CF, Letter from Colin Almond according to whom these SWMSs demonstrated that his client now adopted a 'more comprehensive and site-specific SWMS' for use at its work sites.
[59] CF, Letter from Colin Almond. Three examples were provided.
[60] CB,
    i. Similarly, in a more recent version of the SWMS, dated 26 August 2016, crushing risks are not identified.
    ii. The statement of Peter Inanveza confirms that the risk of crushing was not identified by either SWMS.

81. Having considered the evidence in conjunction with the response of Stilcon SS, I sought the input of all the interested parties to advance my investigation. To this end, on 13 March 2019, I determined to list the matter for a Mentions Hearing.

82. On 4 July 2019, the interested parties were notified accordingly and invited to provide written submissions for my consideration before the Mentions Hearing.

83. On 5 August 2019, Mr Ian Hill of Corrs Chambers Westgarth on behalf of Probuild, made written submissions prior to the Mentions Hearing. The salient points of these submissions were as follows:

    i. Only one of the defects identified might be connected with the death, being the potential defect in the jib switch which resulted in it not always returning to neutral;
    ii. If the defect was operative at the time of the incident, it still required Mr Andrijasevic to keep his foot on the foot switch in order to move the EWP;
    iii. It is far from clear that the defect was involved in the circumstances of the death and there is no evidentiary basis to pursue the matter further to establish whether it was or not;
    iv. Stilcon had systems in place requiring pre-start checks to be done. Mr Schubert was unable to suggest any other methos of identifying problems with the jib switch;
    v. Those who had used the equipment immediately before Mr Andrijasevic had not detected any problems; and
    vi. The problems only appeared intermittently during the post-incident testing.

84. Probuild submitted further that the facts of this matter do not warrant a public hearing as the cause of death is easily ascertainable and the coronial brief provided enough information upon which to make findings of fact or to comment on matters of systemic deficiency.[61]

Mentions Hearing

85. Having considered the body of evidence at this stage of my investigation, I determined that the scope of the Mentions Hearing was to address the following issues in relation to the death:

    i. The identified defects and faults of the MEWP;
    ii. The practices and procedures of maintain the MEWP;

[61] On 13 March 2019, the Coronial Brief was released to the interested parties by my Direction.

iii. The practices and procedures of workers using a MEWP including but not limited to those working by themselves; and

iv. The limitations of the SWMS at the time of the incident.

86. On 13 August 2019, at the Mentions Hearing, I was assisted by Leading Senior Constable Duncan McKenzie of the Police Coronial Support Unit (PCSU). Mr R O'Neill appeared on behalf of Probuild, Ms A Upton appeared on behalf of Stilcon and Ms N Hodgson appeared on behalf of the Victorian WorkCover Authority (WorkSafe).

87. At the Mentions Hearing, I reiterated my duties as a coroner. In the context of this matter and given the extent of my investigation at this juncture, I had to satisfy myself of employer adherence to appropriate worksite health and safety practices. In addition, I had to be satisfied that the restorative and preventative measures implemented by the employer after the incident sufficed.[62]

88. Standing by the submissions made prior to the Mentions Hearing, Probuild sought to emphasise that, absent a direct reference to crush-type injuries in the SWMS, such injuries are to be inferred from the context of the document itself. As such, the risk was appropriately identified in the SWMS and hence 'the failure to refer to the specific type of injury could not be seen as a causative aspect of this incident'.[63]

89. Probuild submitted further that in light of the extensive investigation, adducing oral evidence would not advance my investigation.[64]

90. Stilcon's oral submissions centred on the role that WorkSafe played in the investigation. In summary, Stilcon differentiated WorkSafe's dual role—an enforcement function and an inspectorate function. According to Stilcon, these roles are distinguished by the outcome of each process. The former usually culminated in a criminal prosecution and the latter culminated in issuing Improvement Notices.[65]

91. Stilcon sought to emphasise the distinct nature of these 'parallel' processes by impressing upon me that even though WorkSafe declined to prosecute, Stilcon was issued with

[62] CF, Transcript of Mentions Hearing, pages 11-12.
[63] CF, Transcript of Mentions Hearing, pages 15-16.
[64] CF, Transcript of Mentions Hearing, page 17.
[65] CF, Transcript of Mentions Hearing, pages 18-19. The Court did not receive written submissions from Stilcon prior to the Mentions Hearing.

Improvement Notices which have been complied with resulting in changes to the SWMS and as such, no further action or investigation would be required.[66]

92. Having heard Ms Upton on behalf of Stilcon, I drew attention to the scope of the Mentions Hearing and in particular, the adaptations to the workplace practices and procedures in respect of any restorative and preventative measures, envisaged by my investigation, implemented after the incident. I afforded Stilcon an opportunity to address my concerns by inviting them to provide written submissions after the Mentions Hearing.[67]

93. WorkSafe did not make any oral submissions.[68]

94. At the conclusion of the proceedings, having considered the extent of my investigation at this juncture including the extensive nature of the evidence contained in the Coronial Brief and the written submissions in relation thereto, I determined that this matter need not proceed to Inquest and communicated my intention to finalise the matter by means of an In-Chambers Finding to the parties, pending receipt of Stilcon's written submissions.

95. On 4 October 2019, Stilcon provided the Court with written submissions summarised as follows:[69]

    i. Stilcon acknowledged that the SWMS dated 26 August 2016 did not refer to the risk of crushing injuries when operating a MEWP;
    ii. Stilcon denied that the risks associated with 'crushing' injuries were not considered and referred the Court to an ancillary SMWS for the activity "Erect steelwork for the Multi-level Carpark' dated 9 June 2016. According to Stilcon, employees were instructed to orientate themselves with surrounding hazards;
    iii. At the time of the incident, Stilcon was committed to maintaining their MEWPs;
    iv. After the incident, Stilcon continues to maintain its MEWPs in accordance with manufacturer's specifications;
    v. The MEWP operated by Mr Andrijasevic was fitted with engineering controls to reduce the risk of crush-type injuries. A further safety feature fitted to the MEWP was the isolating foot switch;
    vi. After the incident, Stilcon adapted its SWMS to specifically include the risk of crushing;

[66] CF, Transcript of Mentions Hearing, page 19
[67] CF, Transcript of Mentions Hearing, page 20.
[68] CF, Transcript of Mentions Hearing.
[69] CF, Submissions by Colin Almond, HWL Ebsworth Lawyers on behalf of Stilcon Holdings Pty Ltd

vii. Employees are regularly reminded of risks and inherent worksite hazards by convening 'regular tool box meetings'; and

viii. Although Stilcon has discharged 'its legal obligations' by complying with WorkSafe regulations, they acknowledge that 'there is always room for improvement' and they continue to train their staff 'in regard to the safe manner in which they are to carry out their work'.

96. Having perused the written submissions made by the interested parties in relation to the evidence contained in the Coronial Brief, I considered my investigation to have been completed and resolved to finalise the matter without a public hearing. The body of evidence in conjunction with the oral and written submissions had obviated the need to refer this matter to oral evidence and, as such, I was able to discharge my duties as a coroner.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. Although WorkSafe declined to prosecute, their extensive investigation into the circumstances surrounding Mr Andrijasevic's death, replete with independent expert reports, represented a complete summation of the factual matrix of this matter. I acknowledge the commendable effort by WorkSafe in this regard.

2. Having considered the content of the WorkSafe Brief of Evidence (WSB) in the context of my own purpose, function and investigation, I am satisfied that the WorkSafe investigation meets the statutory obligations which characterise my duty as a coroner. Accordingly, I have incorporated the WSB into my Coronial Brief of Evidence.

3. I have considered the submissions made by the interested parties on the evidence contained in the Coronial Brief of Evidence in the context of the standard of proof applicable in the Coronial Jurisdiction and I am satisfied that the weight of the available evidence indicates that Mr Andrijasevic's death was preventable.

4. I turn now to examine those submissions in the circumstances of Mr Andrijasevic's death as revealed by my investigation.

Submissions by Probuild

5. That Mr Andrijasevic's death was untimely and tragic is incontrovertible on the available evidence.

6. The state of repair of the MEWP and the functionality of its control switches was a salient feature of my investigation. Similarly, the output of the WorkSafe investigation was centred on the malfunction of the switches which controlled the vertical movement of the MEWP. The jib switch was defective in that it did not return to the neutral position which resulted in the vertical extension of the MEWP even after the switch was disengaged. Both Inspector Taylor and Inspector Slade were of the opinion that the faulty jib switch caused the malfunction of the MEWP which ultimately contributed to the injuries sustained by Mr Andrijasevic. The submissions from Probuild do not take into account the time the MEWP takes to extend fully. In light of Mr Schubert's investigation, the evidence indicates that Mr Andrijasevic may not have been able to respond to the impending danger in good time after he disengaged the jib switch. Likewise, the evidence indicates that in all probability, Mr Andrijasevic may have been unable to remove his foot from the pedal switch or the 'dead man switch' which operated in tandem with the jib switch, required to move the MEWP.

7. Probuild's contention that 'it is far from clear that the defect was involved in the circumstances of the death' is misplaced. The weight of the available evidence indicates the contrary. Mr Hambridge's investigation identified that the 'fault of the toggle switch and the subsequent uncontrolled movement of the jib in an upward direction is of major concern'. Mr Hambridge identified the possibility that that Mr Andrijasevic's failure to detect the fault could have contributed to the incident. Furthermore, subsequent testing of the MEWP by WorkSafe in the days that followed the incident and in particular the reports by Mr Gartner and the evidence of Mr Schubert, supports the probability that the malfunction of the switch contributed to the incident.

8. The probability that the malfunction of the switch contributed to the incident is supported further by the number of times that the switch was repaired or replaced, viewed against the background of a prior incident on 31 March 2016, where the malfunction of a MEWP switch resulted in injury.

9. Despite Mr Schubert's inability to suggest 'any other method of identifying problems with the jib switch', Inspector Slade made meaningful suggestions in this regard in the context of operating MEWPs including when, where and how pre-start checks are to be conducted.

10. Furthermore, Probuild submitted that Messrs Straka and Jaworski failed to detect any problems with the MEWP thereby implying that the MEWP was functioning soundly. Although correctly stated merely because they did not report a malfunction, the veracity of the submission does not accord with the available evidence. The fact that they did not detect a fault cannot be taken as indicative that the fault did not exist at the time when they tested the unit, viewed in the context of the evidence as a whole. It is particularly noteworthy that the motion alarm was found to have been disconnected and that the control assembly box was found to have been severely damaged. Similarly, it is noteworthy that the logbook records have been obscured by illegible entries with references to, *inter alia*, other MEWPs. In contradistinction to the submission, the evidence indicates that Messrs Straka and Jaworski should have noted these defects, but they did not.

11. Mr Hambridge identified that the switch failed intermittently. While this appears to corroborate the contention that Messrs Straka and Jaworski did not detect any malfunction, it more compellingly supports the probability that the malfunction remained undetected by Mr Andrijasevic until the MEWP was in operation and when the switch failed to disengage, it was too late for him to avoid the danger which resulted in his fatal injuries.

12. On the available evidence, the degree of wear on the MEWP's control switches cannot be reconciled with the submission that 'Stilcon's procedure required that faulty equipment was to be marked out until repairs were done' and the further submission that there 'was 'extensive evidence' that this procedure was being followed with the particular MEWP at the time of the incident. In this regard, the evidence of Mr Hambridge 'indicates a culture of carelessness' in that the intermittent failure of the toggle switch remained undetected and the motion alarm was disconnected. Mr Hambridge also found that the MEWP's serial number was not accurately reflected in the relevant logbook and the logbook records did not reflect 'faults and issues' as they were detected. More strikingly, the logbook did not reflect a system of regular supervisory control by 'cross-checking' entries related to the MEWPs. Having considered the evidence of Mr Hambridge in the context of the Coronial Brief, I am satisfied that his conclusions can be reconciled with the body of evidence contained in the Coronial Brief.

13. I am satisfied that Stilcon's implementation of a system of using safety observers or 'spotters' on an ongoing basis in response to the incident, is a proactive measure aimed at preventing similar incidents in future. I acknowledge and commend the preventative and restorative measures adopted by Stilcon in this regard. However, I find the lack of relevant administrative control measures such as work procedures, staff training, emergency procedures and supervision particularly concerning in light of the September 2015 WorkSafe Safety Alert (WSA).

14. The WSA highlights the importance of using 'spotters' and where it is not possible to use 'spotters', it recommends substitution methods when using a MEWP, scissor lift or the like. The incident occurred approximately one year after WorkSafe published the WSA which indicates that at the time of the incident, Stilcon did not comply with the WorkSafe recommendations as evidenced by the SWMS dated 29 August 2016.

Submissions by Stilcon

15. Principally, Stilcon conceded that the SWMS- Operate Elevated Work Platforms of 29 August 2016 did not emphatically reflect the risk of crushing injuries but added that risks associated with crushing are implied in the SWMS dated 29 August 2016 by virtue of the fact that a previous SWMS, dated 9 June 2016, identified the risk. Stilcon submitted that the risks of crushing had been considered and had been a factor taken into account when that SWMS was compiled. I acknowledge the concession made by Stilcon but, with regard to the contention that the risks associated with crushing have been incorporated into the SWMS of 29 August 2016 by reference to an earlier SWMS, I noted that the latter, the SWMS of 9 June 2016, was applicable to the whole work site and was generic in its terms. It listed crushing risks for multiple hazards including welding work using a MEWP with a welding mask but does not reflect any inherent risks in operating a MEWP with defective control switches, *per se*. In my view, the SWMS of 9 June 2016, which refers to associated dangers in respect of the erection of steelwork is not specific enough to extend to the operation of MEWPs.

16. Stilcon submitted further that at the time of Mr Andrijasevic's death as well as after his death, their MEWPs were maintained in accordance with manufacturer's standards and specifications. I acknowledge that Stilcon has a plan for regular servicing of their equipment in place but, as the evidence indicates, contingency plans for *ad hoc* reparations as and when faults arise are not monitored closely enough. In this regard, the evidence indicates poor communication and a poorly developed system of checks and balances characterised by a lack

of adequate supervisory control. Allied to this is the evidence of WorkSafe having issued an Improvement Notice on 31 March 2016 after a user suffered injuries in circumstances not dissimilar to the factual matrix of this matter. The degree of wear on the MEWP's component parts including the switch controls is also indicative of a lack of attention to the MEWP maintenance or servicing needs. I am not satisfied, on the available evidence, that Stilcon's maintenance regime in relation to their MEWPs is adequate.

17. Stilcon's contention that, at the time of the incident, their MEWPs were fitted with 'engineering controls', in line with recommendations set out in the WorkSafe Victoria Safety Alert dated September 2015 is misplaced. According to Stilcon, their MEWPs were fitted with isolator switches which returned to the neutral position coupled with a further isolating pedal switch. In this regard the evidence indicates that Stilcon had either misinterpreted or misunderstood the term 'engineering controls'. Inspector Taylor explained that the term refers to 'secondary guarding controls' available for purchase and installation on existing MEWPs, like the 'Skyguard' product. It entails an aftersales modification to a MEWP including pressure sensing devices and proximity sensing devices and the like. The evidence does not indicate that any of these devices were installed at the time of the incident.

18. I am, however, satisfied that after the incident, Stilcon had taken a proactive approach by revising their SWMS documents to specifically include crushing risks. I commend the preventative measures taken in this regard.

19. I acknowledge and accept that there were no eyewitnesses to the incident and that WorkSafe declined to prosecute. However, on the available evidence and guided by the standard of proof applicable to my jurisdiction, I am of the view that, at the time of the incident, neither Probuild nor Stilcon had implemented adequate preventative measures to secure the safety of Mr Andrijasevic or any employee in the circumstances of this matter, operating a MEWP.

Prevention opportunities

20. In concluding my investigation and focusing on my prevention role, I considered the prescripts of WorkSafe's publication, Industry Standard for the Safe Use of Elevating Work Platforms (The Standard), published in April 2021. Having scrutinised this document, I noted that WorkSafe compiled The Standard in response to the high number of deaths in Victorian workplaces involving MEWPs – ten deaths over a ten-year period.

21. Having considered the evidence as a whole in conjunction with The Standard, in order to fulfil my statutory obligation to prevent similar deaths in future, I identified five specific preventative measures. In finalising my investigation, I compared these preventative measures against the content of The Standard to determine whether WorkSafe had previously addressed the pertinent issues.

22. The first preventative measure I identified was the need for every operator using a MEWP to perform mandatory pre-start operational checks as opposed a singular daily operational check. I noted that in Part 6 of The Standard, WorkSafe advised that a pre-start operational check should occur before each shift or first daily use of the MEWP. I acknowledge the foresight expressed in The Standard and commend the advice given by WorkSafe. However, the language of The Standard is not obligatory in this regard. I have determined, therefore, that my first Recommendation is appropriate in the circumstances.

23. The second preventative measure I identified was that all operators must be directed to test directional switch controls before each use of a MEWP on an ongoing basis and throughout the day. Part 6 of The Standard specifies that pre-start operational checks should include a check of the MEWP's ground and platform controls. However, The Standard does not include any direction about checks that might need to be conducted more often than this. I have determined, therefore, that my second Recommendation is appropriate in the circumstances.

24. The third preventative measure I identified was the necessity for supervisors to have oversight of MEWP operators' pre-start operational checks and associated logbooks. Specifically, guided by the evidence, it is my considered view that it is crucial for supervisors to observe the operators' pre-start operational checks. In addition, the supervisor should:

    i. Countersign and date each logbook entry recording a check by the operator after that operator has made and signed an entry; and
    ii. Conduct regular, perhaps weekly, audits of the pre-start operational checks and maintain accurate audit records.

    In my review of Part 6 of The Standard, I noted that all advice regarding pre-start operational checks is directed at the MEWP operator without reference to the important role that supervisors ought to play in reinforcing and reviewing these vital safety checks. I have determined, therefore, that my third Recommendation is appropriate in the circumstances.

25. The fourth preventative measure I identified was the need for all employees to attend regular mandatory training sessions which may be incorporated in other safety initiatives such as toolbox meetings, site inductions and the like, to create an ongoing awareness of construction site risks with particular reference to crushing risks associated with operating a MEWP. In this regard, I noted that Part 2.1 of The Standard does address initial training requirements. It fails to address the issue of ongoing training, however. I have determined, therefore, that my fourth Recommendation is appropriate in the circumstances.

26. In the circumstances of this matter, and leading on from my previous comment, I considered that the need for all employees to attend mandatory training sessions on how to maintain accurate and proper records and how to record logbook entries which reflect observed faults or defects accurately. I note that under Part 2.1 in The Standard, WorkSafe considered that the content of MEWP operator training should include "prestart (pre-operational) inspection". I acknowledge this foresight and commend the action taken by the WorkSafe in this regard. I have determined, therefore, that any Recommendation in relation to this aspect would be inappropriate. Nevertheless, I implore WorkSafe to reflect upon whether any more specific instruction would be required to prevent similar deaths in future.

27. I am aware that The Standard draws heavily upon the Australian Standard AS 2550.10-2006, titled Cranes, hoists and winches - Safe use - Part 10: Mobile elevating work platforms. Consequently, I have also reviewed the AS 2550.10-2006 as part of my investigation and considered whether I should direct specific recommendations to Standards Australia about the prevention measures outlined above. In light of the fact that the Australian Standard AS 2550.10-2006 has not been updated since April 2009 and its current status, "Pending Revision", implies that the document, either wholly or in part, has become obsolete and requires updating to retain its status as an Australian Standard, I have determined that to formulate a Recommendation in this regard directed at Standards Australia may be to no purpose. Instead, I have determined that my fifth Recommendation is appropriate in the circumstances.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. In the interests of public health and safety and preventing like deaths, I recommend that the Victorian WorkCover Authority revise Part 6 of its Industry Standard for the Safe Use of Elevating Work Platforms to require mandatory pre-start operational checks of MEWPs.

2. In the interests of public health and safety and preventing like deaths, I recommend that the Victorian WorkCover Authority review Part 6 of the Industry Standard for the Safe Use of Elevating Work Platforms to consider which elements of the MEWP inspection should be undertaken more regularly than only before the start of each shift or first daily use. The evidence in this matter supports a view that the testing of directional switch controls should occur throughout the day whenever there is a new incident or episode of MEWP operation. I adopt this view.

3. In the interests of public health and safety and preventing like deaths, I recommend that the Victorian WorkCover Authority review Part 6 of the Industry Standard for the Safe Use of Elevating Work Platforms to consider the role of the supervisor in the inspection process. At present, the inspection process described in the Industry Standard addresses only the MEWP operator's role, and the example of a pre-operational inspection checklist does not include any supervisor input. The Victorian WorkCover Authority must consider the need for supervisors to countersign logbook entries completed by operators, and the need for supervisors to conduct weekly audits of logbooks to ensure the maintenance of complete and accurate.

4. In the interests of public health and safety and preventing like deaths, I recommend that the Victorian WorkCover Authority review Part 2.1 of the Industry Standard for the Safe Use of Elevating Work Platforms to consider recommendations about ongoing training and the regular reinforcement of safety messages.

5. In the interests of public health and safety and preventing like deaths, I recommend that Standards Australia engage the appropriate experts to review AS 2550.10-2006. I recommend that the review includes a consideration of the circumstances in which Ivica Andrijasevic died, and my Findings regarding his untimely and preventable death.

FINDINGS AND CONCLUSION

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explication.[70] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

2. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Ivica Andrijasevic, born 20 March 1962;

   b) the death occurred on 26 October 2016 at Melbourne Convention Centre, 1 Convention Centre Place, Melbourne, Victoria, 3000.

   c) I accept and adopt Dr Baber's opinion and I find that Ivica Andrijasevic died from neck compression; and

3. I find further that Ivica Andrijasevic's death was the unintended consequence of his deployment of a faulty or malfunctioning control mechanism of the Mobile Elevated Work Platform lift on which he was working by himself, unaided by a safety observer or 'spotter' and while not knowing that the control mechanism was faulty or intermittently faulty.

4. AND, having considered all the circumstances, I find that the repeated failure by operators of that particular Mobile Elevated Work Platform to detect and report existing faults or defects whilst conducting daily pre-start and operational checks and the lack of supervisory control at the Melbourne Convention and Exhibition Centre construction site represented an opportunity lost to prevent the death and as such, that failure to detect and report existing faults or defects contributed to the events that led to Ivica Andrijasevic's injuries and death. As such, I find that Ivica Andrijasevic's death which occurred whilst acting in the course and scope of his employment was preventable.

[70] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

I convey my sincere condolences to Ivica Andrijasevic's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Lucija Andrijasevic

Steve Jacobs, Wisewould Mahony Lawyers (on behalf of the Victorian WorkCover Authority)

John Tuck, Corrs Chamber Westgarth (on behalf of Probuild Constructions (Australia) Pty Ltd

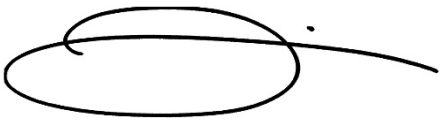
Stilcon Holdings Pty Ltd

Standards Australia

Senior Constable David Hughson, Coroner's Investigator

Leading Senior Constable Duncan McKenzie, Police Coronial Support Unit

Signature:



AUDREY JAMIESON

CORONER

Date: 24 March 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.