IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000482

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Matthew Duncan Gordge
Date of birth:	7 December 1982
Date of death:	26 January 2020
Cause of death:	1(a) Traumatic asphyxia
Place of death:	64 Dawson Street, Brunswick, Victoria, 3056

INTRODUCTION

1. On 26 January 2020, Matthew Duncan Gordge was 37 years old when he died from injuries sustained in a workplace incident. At the time of his death, Mr Gordge lived in Footscray. He was separated from his wife, Frida Enegren, but they remained in regular contact.

THE CORONIAL INVESTIGATION

2. Mr Gordge'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.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Gordge's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths. WorkSafe Victoria (**WorkSafe**) also conducted an investigation and provided a copy of the hand-up brief (**the WorkSafe brief**) prepared in contemplation of proceedings in the Magistrates' Court of Victoria against Damian Blundell. I note that no such proceedings eventuated.

7. This finding draws on the totality of the coronial investigation into Mr Gordge's death including evidence contained in the coronial brief and the WorkSafe brief. While 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.[1]

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

Circumstances in which the death occurred

8. In late January 2020, Mr Gordge's friend Damian Blundell, a handyman by trade, secured repair and maintenance work at Transit Dance in Brunswick through one of its directors, Edward Malek. The work included painting the bathrooms on the ground floor, and painting the glass of windows near the ceiling.[2]

9. Discussions took place between Mr Blundell and Mr Malek in relation to using a scissor lift for the windows, after which Mr Blundell hired a scissor-type mobile elevated work platform (**MEWP**), from All Star Access Hire at Mr Malek's expense. At approximately 6.50am on 24 January 2020, Mr Blundell attended the studio to accept delivery of the MEWP.[3]

10. The four-wheeled MEWP in question was an electrically powered "*slab type*" manufactured on 30 February 2016 by Dingli Australia. Its platform, along with personnel, equipment and materials, could be elevated to a height of eight metres via the scissor mechanism. The MEWP could also be driven in a backwards and forwards motion, with two wheels used for steering in the desired direction.[4]

11. At approximately 8.00am on 25 January 2020, Mr Gordge and Mr Blundell commenced work at the studio. In his statement to police, Mr Blundell explained that he and Mr Gordge were going to work together on a trial basis for this work as they were both dissatisfied with their previous employment and wanted to "*see if these sort of contracts would be viable for the both of us in future*". For this particular contract, they had not agreed on what Mr Gordge would be paid as they planned to discuss this once the work was complete. According to

---

[1] 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.

[2] Statement of Damian Blundell dated 30 January 2020.

[3] Statement of Damian Blundell dated 30 January 2020.

[4] Statement of Andrew Taylor dated 30 July 2020.

Mr Blundell, Mr Gordge advised he was able to drive a scissor lift and they agreed that he would work on painting the windows near the ceiling. They finished work on the first day at approximately 3.30pm and went their separate ways.[5]

12. At approximately 8.30am on 26 January 2020, Mr Blundell commenced working downstairs in the bathroom while Mr Gordge ascended in the MEWP to work on the windows. Throughout the morning, they played music on a portable speaker placed near the MEWP and Mr Blundell recalled that Mr Gordge appeared to be in good spirits. According to Mr Blundell, the bathroom doors "*swing outwards*" and prevented him from seeing out into the studio.[6]

13. At approximately 2.00pm, Mr Blundell was inside the bathroom when he noticed that the music had stopped and he could hear a beeping sound coming from the MEWP. He called out to Mr Gordge but there was no response. As Mr Blundell entered the studio, he observed Mr Gordge leaning over on the MEWP platform, which was raised approximately four metres from the ground. He called out again but Mr Gordge did not respond. Mr Blundell then realised that Mr Gordge's face was swollen and he was pinned between a roof beam and the MEWP safety barrier,[7] with the MEWP's "*control stick near his stomach area*".[8]

14. Mr Blundell immediately ran to the MEWP and tried to engage the emergency release, while using the hands-free function on his phone to contact emergency services. After several attempts to move the keys and pull the release lever, he was finally able to free Mr Gordge. Mr Blundell then climbed into the MEWP platform and commenced cardiopulmonary resuscitation (**CPR**) under instruction from the operator.[9]

15. Victoria Police, Ambulance Victoria paramedics and members from the Metropolitan Fire Brigade arrived a short time later and continued CPR. Responding paramedics were unable to revive Mr Gordge and pronounced him deceased.

16. WorkSafe inspectors attended shortly after and issued a non-disturbance notice to Mr Malek pursuant to section 110 of the *Occupational Health and Safety Act 2004* with respect to the MEWP. Mr Malek removed the key to the MEWP[10] and Ivan Curak, service manager from All Star Access, attended the site to move and secure the MEWP until inspectors could attend

---

[5] Statement of Damian Blundell dated 30 January 2020.
[6] Statement of Damian Blundell dated 30 January 2020.
[7] Statement of Damian Blundell dated 30 January 2020.
[8] Statement of Detective Senior Constable Jaideep Kochhar dated 11 April 2020.
[9] Statement of Damian Blundell dated 30 January 2020.
[10] WorkSafe Victoria Entry Report dated 26 January 2020; WorkSafe Non-Disturbance Notice dated 26 January 2020.

for further examination. Prior to moving the MEWP, Mr Curak tested its controls to ensure they were in working order.[11]

17. Police subsequently viewed closed-circuit television (**CCTV**) footage of the incident and determined that it was consistent with the circumstances as recounted by Mr Blundell; however, it did not depict the precise location where Mr Gordge was pinned between the MEWP railing and roof support structure.[12]

Identity of the deceased

18. On 29 January 2020, Anthony Gordge visually identified the deceased as his son, Matthew Duncan Gordge, born 7 December 1982.

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

Medical cause of death

20. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 30 January 2020 and provided a written report of her findings dated 25 April 2020.

21. At autopsy, Dr Glengarry identified several injuries consistent with traumatic (or crush) asphyxia, namely an external injury pattern consistent with the MEWP railings, congestion to the face and neck, deep bruising to the chest wall and lungs, and fractured ribs.

22. Toxicological analysis of post-mortem samples identified a blood alcohol concentration of 0.02g/100mL and 0.03g/100mL in blood and vitreous humour, respectively. No common drugs or poisons were detected.

23. Dr Glengarry provided an opinion that the medical cause of death was 1(a) Traumatic asphyxia.

24. I accept Dr Glengarry's opinion.

[11] Statement of Renae Skropeta dated 21 May 2020.

[12] Statement of Detective Senior Constable Jaideep Kochhar dated 11 April 2020; Statement of Rhys Jones dated 14 August 2020.

FURTHER INVESTIGATION

25. WorkSafe conducted an investigation pursuant to the *Occupational Health and Safety Act 2004*, which involved investigators conducting site visits, taking several photographs of the structures and surrounding area, gathering relevant documents, and obtaining witness statements.

Mr Gordge's industry experience and qualifications

26. During the course of the investigation, WorkSafe obtained a statement from Carla Smith, a friend of Mr Gordge, whom he first met approximately 10 years prior to his death. Ms Smith recalled that he worked at her café for approximately six years and that he worked as a "*gardener or landscaper*" between shifts at the café. After scaling back his hours at the café, Mr Gordge eventually left her employment but remained in contact. According to Ms Smith, he engaged in other odd jobs in the years that followed but "*really got the bug for building work*" in around 2014 to 2015 when he assisted a "*proper builder*" in converting a Nissen hut.[13]

27. Mr Gordge conducted other work with the builder from the hut conversion and in 2017, he did some painting work with Daniel Reynolds. Ms Smith recalled that Mr Gordge also worked for a business that produced "*festival props and sets*". The work subsequently reduced "*when the construction phase was done*" and he later assisted someone with painting work.[14]

28. Between May 2018 and March 2019, Mr Gordge worked with Mr Reynolds in his residential maintenance business. Mr Reynolds advised that during the course of Mr Gordge's employment, he did not use an Elevated Work Platform (**EWP**) and he was unaware of Mr Gordge's experience in using EWPs. When required to work at height, Mr Reynolds arranged for scaffolding to be erected as he considered it "*safer than using either a ladder system or an EWP*". Mr Gordge's last job with Mr Reynolds involved the use of a scaffold to work at a residence at a height of "*about 6 metres or a bit more to the gutter line*".[15]

---

[13] Statement of Carla Smith dated 27 February 2020.
[14] Statement of Carla Smith dated 27 February 2020.
[15] Statement of Daniel Reynolds dated 2 March 2020.

29. According to Ms Smith, Mr Gordge did not hold any formal trade qualifications throughout this period. In December 2019, however, Mr Gordge proudly informed her that he had obtained his construction white card. Although she did not recall speaking to Mr Gordge about his experience with MEWPs, Ms Smith was of the opinion that the white card was his "*first training card*" for construction work.[16]

30. Between November 2019 and January 2020, Mr Blundell worked as a subcontractor with Nikolaos Lakiotis of Thes Painting Pty Ltd. At Mr Blundell's recommendation, Mr Lakiotis employed Mr Gordge on a subcontractor basis between approximately 30 December 2019 and 21 January 2020. In his statement to WorkSafe, Mr Lakiotis explained that they were engaged for painting works at ground level, occasionally with a step ladder but they were not required to use an EWP. Mr Lakiotis recalled that Mr Blundell mentioned having "*some sort of licence for using machines, elevators*" but he did not enquire further as EWPs were not required for this project. After completing the project, Mr Lakiotis did not re-engage Mr Blundell nor Mr Gordge.[17]

31. The WorkSafe Licensing Branch subsequently confirmed that at the time of his death, Mr Gordge held a valid Construction Induction Card, issued 20 December 2019. Notwithstanding he did not hold a High Risk Work Licence at the time of his death, such a licence is not required for the operation of scissor lift EWPs.[18] It was also confirmed that Mr Gordge first registered for an Australian Business Number (**ABN**) as a sole trader on 15 February 2010.[19]

Transit Dance project

32. A statement was obtained from Mr Malek, in which he advised that Transit Dance moved from Kensington to the Dawson Street studio in 2018. Originally a derelict industrial site, Mr Malek advised that they conducted renovations before formally opening the studio in September 2018. In the years that followed, ongoing maintenance work was conducted and future work was also planned for the studio. Mr Malek advised that the studio generally

---

[16] Statement of Carla Smith dated 27 February 2020.

[17] Statement of Nikolaos Lakiotis dated 3 June 2020.

[18] Pinnacle Safety and Training, Statement of Attainment for Matthew Gordge dated 17 December 2019; Letter from Fiona Seal to Rhys Jones dated 29 January 2020; Statement of Rhys Jones dated 14 August 2020.

[19] Australian Taxation Office, Australian Business Register extract for Mr Matthew Duncan Gordge, trading as Matt Gordge.

operated between 4.30pm and 8.30pm on weekdays, but was open for private tuition and high school students during the day.[20]

33. Mr Malek and Mr Blundell first met on 21 November 2019, at which time Mr Blundell commenced leasing a storage space attached to the studio for his creative endeavours. Over time, Mr Malek became aware that Mr Blundell was a painter by trade and engaged him as a contractor for works in two studios on the easternmost side of the building by way of a verbal contract. Mr Blundell conducted the work over the Christmas/New Year period and the bulk of the work was completed by 6 January 2020.[21]

34. Mr Malek was satisfied with the initial works and entered into the second contract with Mr Blundell for painting the bathrooms near a breakout area. Mr Malek indicated that if the work were completed by the weekend of 25 January 2020, he would engage Mr Blundell for further work. According to Mr Malek, at around the time Mr Blundell was painting the bathroom, he approached Mr Blundell about blacking out a row of windows between the roof of the breakout area and the roof of the gymnasium and studios. Mr Malek suggested that the windows be painted from the outside, however Mr Blundell advised that the slope of the roof rendered this approach "*impossible*" and suggested that they be painted from the inside with the assistance of a scissor lift.[22]

35. Mr Malek advised WorkSafe that he had been told by Mr Blundell that he possessed a "*ticket*" for using a scissor lift; however, Mr Malek did not see nor request to see such a ticket. He added that Mr Blundell did not mention using a Safe Work Method Statement for the MEWP or for working at heights, and Mr Malek was not aware of any paperwork required for the MEWP hire.[23]

36. When Mr Malek attended the studio on the morning of 25 January 2020, he observed Mr Blundell painting the bathroom and two people on the MEWP, who were applying black paint to the windows. The two men were not known to Mr Malek, however I am satisfied that one of the men was Mr Gordge.[24] He estimated that the windows they were painting at this time were approximately six metres from the floor, and that the MEWP platform was "*higher than the lowest part of the roof structures that run East-West across the breakout area*".

[20] Statement of Edward Malek dated 11 February 2020.
[21] Statement of Edward Malek dated 11 February 2020.
[22] Statement of Edward Malek dated 11 February 2020.
[23] Statement of Edward Malek dated 11 February 2020.
[24] The investigation has not revealed the identity of any other person present, as Mr Malek asserted. During the course of the WorkSafe investigation, Mr Malek indicated he did not want to view photographs of Mr Gordge from the incident to confirm his identity.

Mr Malek watched the MEWP operation "*off and on*" for approximately 30 minutes and observed them manoeuvre the MEWP "*up and down so that they avoided the beams and other parts of the roof structure with the MEWP*".[25]

37. When Mr Malek attended the studio the following morning, Mr Blundell was again in the bathroom and Mr Gordge was in the MEWP in a position elevated above the lowest parts of the roof structure. While Mr Malek acknowledged that he "*did not pay him much attention*", he considered that Mr Gordge was using the MEWP "*competently*" as he moved it in a "*straight line*" and Mr Malek did not observe any "*jerky*" or "*excessive movements*". Mr Malek left the studio at approximately 11.00am.[26]

38. WorkSafe inspectors attended Transit Dance on 29 January 2020, at which time Mr Malek detailed the extent of the project, the process by which Mr Blundell was engaged as a contractor, and the studio layout. Inspectors observed the horizontal row of windows that formed part of the painting project, which extended partway along the side of the large hall. It was noted that there was no wall between the large hall and gym area, however a vertical wall extending upwards towards the gutter line of the hall roof was observed at the point it met with the gym roof.[27] The row of windows were estimated to be approximately 8 metres from the floor and they could not be accessed by any permanent fixture.[28]

39. Discussions took place between the lead WorkSafe investigator, Inspector Rhys Jones, and Tim Bowers, a director of All Star Access, with respect to the provision of training in the use of EWPs in conjunction with their hire. Mr Bowers advised that training in the use of EWPs could be provided at All Star Access premises through Go Workplace Training (**GWPT**), a registered training organisation (**RTO**). The relevant course, an Elevating Work Platform Association of Australia (**EWPA**) Yellow/Gold Card, involved training in the use of MEWPs to any height.[29]

[25] Statement of Edward Malek dated 11 February 2020.
[26] Statement of Edward Malek dated 11 February 2020.
[27] Statement of Rhys Jones dated 14 August 2020.
[28] Statement of Andrew Taylor dated 30 July 2020.
[29] Statement of Rhys Jones dated 14 August 2020; Go Workplace Training – Training Services Guide 2020-2021, All Star Access Hire.

40. Inspector Jones was later advised by representatives of GWPT that it was considered the preferred supplier of training in the use of EWPs to customers of All Star Access; however, All Star Access had not given an undertaking to GWPT with respect to ascertaining a customer's EWP training status before entering into a hire agreement.[30]

41. Inspector Jones reattended All Star Access on 3 June 2020 and met with Rankin Sionamale, the driver who delivered the relevant MEWP to Transit Dance. Although Mr Sionamale did not have an independent recollection of the delivery, he and other drivers who delivered EWPs would sometimes unload them from the truck and place them "*on the street outside premises or in a nearby carpark*". On this day, Inspector Jones confirmed with another director of All Star Access that their delivery drivers did not provide instructions to recipients on the use of EWPs.[31]

42. Further enquiries were made with the EWPA, who confirmed that neither Mr Blundell nor Mr Gordge had undertaken training in "*RIIHAN301E, Operate Elevating Work Platform*" with an RTO associated with EWPA. This does not exclude the possibility that either of them may have completed training with another RTO or received sufficient on-the-job instruction on the use of EWPs.[32]

Examination of the MEWP

43. On 30 January 2020, Andrew Taylor, Senior Engineer from Victoria WorkCover Authority, attended Transit Dance to conduct an examination and functional assessment of the Dingli scissor lift. Mr Taylor was assisted in the examination by Peter Wenn of Wenn Wilkinson & Associates, Technical Director Engineering of EWPA and Chairman of the Australian Standards Committee concerning cranes, hoists, and winches on mobile elevating work platforms.

44. As noted in his report to WorkSafe, Mr Taylor considered that the platform's maximum elevated height of eight metres was sufficient for Mr Gordge to stand and reach the windows at Transit Dance. Having measured the platform and EWP itself, Mr Taylor was satisfied that the MEWP was sufficiently narrow to fit between the lowermost horizontal spacings of the roof truss, which measured approximately 3.5 metres at a height of 6.95 metres.[33]

---

[30] Statement of Rhys Jones dated 14 August 2020.
[31] Statement of Rhys Jones dated 14 August 2020.
[32] Statement of Rhys Jones dated 14 August 2020.
[33] Statement of Andrew Taylor dated 30 July 2020.

45. Mr Taylor observed that the MEWP's platform controls, which were connected to the MEWP by a flexible cable, included a joystick fitted with a function enable switch. He noted that such a feature is present on all MEWPs, occasionally in the form of a foot pedal. In order to manoeuvre or elevate the MEWP, the trigger on the joystick must be engaged, and this functioned correctly at the time of the examination. Mr Taylor commented that the function enable switch, together with barriers at each side of the controls set below the guardrail height, prevents accidental operation of the MEWP and is known as 'primary' guarding.[34]

46. Mr Taylor measured the top of the joystick at 32mm below the control guard, below the 50mm prescribed by Standards Australia[35] to prevent the operator inadvertently leaning on the controls while carrying out tasks on the platform. He considered, however, that this minor height difference was not a contributing factor in the incident as the risk was mitigated by the presence of the function enable switch to the underside of the joystick. Mr Taylor otherwise observed that the 1065mm distance between the platform floor and top of the handrail was compliant with the Australian Standards.[36]

47. When the elevation function was engaged, the platform raised at a speed of 220mm per second at full speed. Mr Taylor noted that when the joystick was released, the raise/lower movement ceased and the joystick appropriately returned to neutral. Similarly, the raise/lower switch located on the ground-based controls returned to neutral upon its release.

48. The ground controls, used to lower the platform of an MEWP if the platform controls fail, included an emergency stop button to turn off and isolate the MEWP, preventing all powered movements. An emergency lowering handle was located to the right-hand side of the ground controls.[37]

49. Mr Taylor inspected the MEWP's steering, elevation and travel functions and was satisfied that there were no mechanical faults or failures that would have caused or contributed to Mr Gordge's death. He noted that the MEWP travel and elevation functions could only be used in isolation and not at the same time. With respect to the MEWP's emergency mechanisms, Mr Taylor did not observe any issues with the emergency stop button or horn upon the platform controls, or emergency lowering handle, reversing alarm or flashing lights located at the ground controls and base.

---

[34] Statement of Andrew Taylor dated 30 July 2020.
[35] AS/NZS 148.10:2011 Cranes, hoists and winches, Part 10: Mobile elevating work platforms, Clause 2.6.4.
[36] Statement of Andrew Taylor dated 30 July 2020.
[37] Statement of Andrew Taylor dated 30 July 2020.

50. Mr Taylor could not identify an entry in the logbook to confirm whether or not MEWP pre-start checks were conducted by either Mr Blundell or Mr Gordge prior to using the MEWP. Notwithstanding, after completing his inspection and having liaised with All Star Access in relation to the MEWP's inspection and service history, Mr Taylor considered the MEWP was safe to operate.[38] He concluded that equipment malfunction could be excluded as a contributing factor in the incident.[39]

Operation of the MEWP immediately prior to death

51. Mr Taylor also viewed the relevant CCTV footage to provide an opinion on the appropriateness or otherwise of Mr Gordge's use of the MEWP operation immediately prior to the incident. Although the platform remained out of view, Mr Taylor identified from the base unit, scissor stack and shadows that the MEWP's final movement was the elevation of its platform.

52. Mr Taylor observed that approximately four minutes prior to Mr Blundell's attendance, Mr Gordge manoeuvred the MEWP away from the wall while remaining on the elevated platform. After straightening the wheels, he lowered the platform for approximately five seconds before driving forward slightly and then turning slightly left towards the wall. Mr Gordge then raised the platform one last time, towards the roof trusses for approximately two seconds. Mr Taylor estimated that the platform raised approximately 200 millimetres in this time.

53. Although Mr Taylor could not identify Mr Gordge in the CCTV footage, he was conscious of the position in which Mr Gordge was located by Mr Blundell, leaning over the platform control panel and guardrail. As the final movement of the MEWP evidently pinned Mr Gordge between the guardrail and roof trusses, Mr Taylor posited that as the platform raised, he may have been operating the controls while "*ducking down*" over the guardrails in order to narrowly clear the roof truss.[40]

---

[38] WorkSafe brief, Statement of Scott Mans dated 28 July 2020; EWP Logbook for Dingli brand electric scissor lift (model S0812E, serial AU160317-3) dated 22 November 2016; Hazard & Risk Assessment Sheet, Scissor lifts Electric Slab Unit 2616, dated February 2019; Scissor Maintenance & Safety Checklist, last conducted 23 January 2020 at All Star Access workshop, no issues identified.

[39] Statement of Andrew Taylor dated 30 July 2020.

[40] Statement of Andrew Taylor dated 30 July 2020.

54. Mr Taylor considered that Mr Gordge's risk of crush injury could have been reduced by lowering the platform further before travelling underneath the roof trusses, allowing him to remain standing when operating the controls. He explained that had Mr Gordge been in a standing position, he may have had sufficient time to take evasive action or release the controls to stop the MEWPs movements before coming into contact with the roof trusses.[41]

Expert opinion – Eliminating or reducing risk of crush injury while using EWPs

55. Mr Taylor was also engaged by WorkSafe to provide an expert opinion in the matter. He was asked to comment on matters specific to the circumstances of Mr Gordge's death, including his observations after visiting Transit Dance, industry practices with respect to EWP use at the time of the incident, and the training/qualifications required by Mr Gordge and Mr Blundell.

56. More generally, Mr Taylor was also asked to provide an opinion on industry-wide safe practices regarding the use of EWPs, occupational health and safety legislative provisions relating to scissor lifts, and any proposed structural improvements or developments to health and safety risk protocol regarding EWPs.

<u>Crushing hazard and risks</u>

57. Crushing hazards can exist in environments where EWPs are operated in close proximity to overhead and adjacent structures. When a task being undertaken from the EWP results in the requirement of the EWP to move and operate in close proximity to overhead or adjacent structures, the risk of crushing exists. Risks of crushing can eventuate due to several reasons:

    a) Poor or unsafe operation of the EWP by the operator;

    b) Unintended operation of the EWP (e.g. the operator selects the wrong control or moves the MEWP in the wrong direction due to unfamiliarity with the controls);

    c) Lack of situational awareness by the operator when operating the EWP (e.g. looking at ground-based hazards or the controls, and not towards structures above or adjacent to them that they might be moving towards);

    d) EWP malfunction;

[41] Statement of Andrew Taylor dated 30 July 2020.

e) Unstable or undulating ground conditions upon which the EWP is traversing;

f) Lack of or poor communication between operator and any passengers.[42]

58. The risk is heightened should the operator or any passengers lean over, or place any limbs over the guard railing around the platform, as the person(s) can become trapped and crushed between the metal guardrails and the overhead or adjacent structure.[43]

59. A crushing injury suffered by an operator of a EWP can result in sustained involuntary operation of the controls. This is when, due to the body being crushed over the controls, the controls are held by the body in the operating position therefore resulting in the plant continuing to attempt to operate or push the plant further against the obstruction. When the operator's neck or back is crushed in these ways, it generally also causes the injured person to suffer asphyxia.[44]

60. Mr Taylor identified that a crushing hazard existed at the workplace located at 64 Dawson Street, Brunswick on 26th January 2020 and the risk was high as, to reach the windows to be painted, the platform of the MEWP needed to pass under, and be raised between the steel roof trusses.[45]

61. Mr Taylor noted that with the MEWP positioned at right angles to the roof trusses and located centrally, it would leave approximately 0.5 metres of clear space at each end of the MEWP between the MEWP and the roof trusses. When approximately 12 (top and bottom panes) of the small square windows were painted, the MEWP needed to be repositioned to reach the next set of windows to be painted. Due to the metal lower chords of the truss being in the path of the raised MEWP, the MEWP was required to be lowered beneath the height of the roof truss and then the MEWP driven, or travelled, under and past the truss prior to the platform being raised again to reach the next set of windows. These MEWP manoeuvres needed to be repeated several times, not only to reach subsequent sets of windows but also to return to the windows to apply further coats of paint.[46]

---

[42] Statement of Andrew Taylor dated 30 July 2020.
[43] Statement of Andrew Taylor dated 30 July 2020.
[44] Statement of Andrew Taylor dated 30 July 2020.
[45] Statement of Andrew Taylor dated 30 July 2020.
[46] Statement of Andrew Taylor dated 30 July 2020.

62. Mr Taylor observed that the lack of contrast between the grey roof trusses and the concrete floor and metal roof, together with a low level of lighting, decreased the visibility of the trusses and would heighten the likelihood of a crushing risk eventuating.[47]

63. Mr Taylor concluded that the circumstances in which Mr Gordge was operating the MEWP gave rise to risk of a crushing injury. Specifically, if an operator leans over the controls or guardrails and the MEWP is raised into a structure above the operator, the potential for serious and permanent injuries existed including that of death through asphyxiation.[48]

Measures to eliminate or reduce risk

64. Mr Taylor identified possible solutions for the elimination or reduction of crushing risks in the circumstances of the operation of the MEWP:

Alternative work practices

65. Mr Taylor considered the alternative option of painting the windows of the studio from the outside by gaining access to the roof of the gymnasium. He considered that this option would have eliminated the crushing risks posed through the use of a MEWP but would also have introduced greater falls risks. He therefore concluded that this option would not be recommended.[49]

Secondary Guarding

66. Mr Taylor considered the engineering control capable of being applied to EWPs to reduce the risk of crushing injury which is known in the industry as 'secondary guarding'. Secondary guarding does not eliminate the risk of crushing when operating EWPs but may reduce the likelihood or the severity of injury sustained.[50] At the time of the incident, Mr Taylor noted that the availability of the secondary guarding risk control measures for scissor-type EWPs were at a level that it would not have been reasonably practicable for them to be present on an MEWP at the incident workplace. This is due to the measures being newly introduced to industry and in small numbers and therefore availability.[51]

---

[47] Statement of Andrew Taylor dated 30 July 2020.
[48] Statement of Andrew Taylor dated 30 July 2020.
[49] Statement of Andrew Taylor dated 30 July 2020.
[50] Statement of Andrew Taylor dated 30 July 2020.
[51] Statement of Andrew Taylor dated 30 July 2020.

67. Mr Taylor referred to recent developments in secondary guarding technology. Since Mr Gordge's death, he noted that more manufacturers and third party suppliers are providing secondary guarding devices for scissor-type EWPs devices. He observed that the most popular device is a third party (EQSS) supplied solution called 'Overwatch'. Overwatch utilises a LIDAR (Light Detection And Ranging) sensor to monitor the operator's position and will stop the operation of the MEWP if it detects movement of the operator that may indicate a crushing potential. Importantly, the barrier to entry for Overwatch is quite low. The cost is under $1000 and can be installed by the purchaser in around 20 to 30 minutes. The supplier has had approval from all major MEWP manufacturers to fit the device to 'their' MEWPs.[52]

Operator training

68. Mr Taylor noted that there is no legislative requirement for the operator of a scissor-type EWP to hold a high risk work licence under the *Occupational Health and Safety Regulations 2017*. However, there are many providers of training courses that operators can attend to learn how to operate EWPs safely and to also be assessed on their competency in operating them. The most common training scheme in use in the industry is that of 'yellow card' training which was developed and is administered by the Elevating Work Platform Association of Australia (**EWPA**). The course content includes hazard identification and controls relating to the risk of crushing. Over the last 17 years, over 400,000 operators have been trained. Upon successful completion of the course a user is issued with a physical yellow card that can be used to demonstrate competency to employers.[53] Although not a prescriptive legal requirement, it is common in industry.

69. Based on the statement of Mr Blundell, the competency of Mr Gordge appears to have been based on the acceptance of a verbal assurance that he could operate one.[54]

Supervision - Spotter /safety observer

70. Mr Taylor considered that the level of supervision required of a scissor-type EWP being operated by a single person will depend upon the outcome of a hazard identification/risk assessment process. A hazard identification and risk assessment process should be undertaken at the job planning stage. Should hazards exist, such as overhead structures or overhead powerlines that could be reached by the EWP, then there should be close supervision of the

---

[52] Statement of Andrew Taylor dated 30 July 2020.
[53] Statement of Andrew Taylor dated 30 July 2020.
[54] Statement of Andrew Taylor dated 30 July 2020.

activity, ideally with a ground-based person, or spotter, with line-of-sight to the EWP while it is operated. The ground-based person assists the operator in directing the movements of the EWP and can take emergency response actions should the operator become incapacitated or trapped. The ground-based person will have been trained in the emergency retrieval controls of the specific MEWP in use at the workplace.[55]

Operator Manual

71. Mr Taylor noted that the operator's manual that was supplied with the MEWP provides instructions for the safe use of the MEWP which include that:

    a) only trained and authorized personnel shall be permitted to operate this machine;

    b) Crushing hazard - Use common sense and planning when operating the machine with the controller from the ground. Maintain safe distances between the operator, the machine and fixed objects;

    c) Collision hazard - Check the work area for overhead obstructions or other possible hazards;

    d) Workplace inspection - Be aware of and avoid the following hazardous situations: Overhead obstructions and high voltage conductors.[56]

Two person task

72. Mr Taylor considered that another administrative control that could have been deployed at the incident scene was to use two persons in the MEWP to perform the painting. The Dingli S012-E MEWP was designed to carry two persons, and by having two persons in the platform one person can operate the MEWP and one can guide the operator in the movements of the platform and advise the operator of any hazards. However, Mr Taylor noted that incidents have occurred in the past due to poor communication between persons present on the platform of the MEWP. Both persons need to be aware of the hazards and the non-operator aware of the imminent movements of the platform via the operator. Therefore, he considered that this method would increase the risk exposure time and increase the numbers of persons exposed to the hazards and would therefore not be recommended as a risk control measure.[57]

[55] Statement of Andrew Taylor dated 30 July 2020.
[56] Statement of Andrew Taylor dated 30 July 2020.
[57] Statement of Andrew Taylor dated 30 July 2020.

Safe system of work – Ideal safe operation of scissor-type MEWP

73. Mr Taylor concluded that a reasonably practicable safe system of work for the use of scissor-type EWPs with a single occupant/operator would include undertaking a hazard identification and risk assessment process at the planning stage of the job. Further, it would include a trained and competent operator who was familiar with the operation and controls of the specific EWP in use. This person would be assisted by a ground-based person who is trained in the emergency descent controls of the EWP. The EWP would be provided in a safe and maintained condition and the operator would carry out a pre-start check to confirm that the MEWP operated as designed and was safe to operate.[58]

74. The ground-based safety observer would maintain line-of-sight to the operating EWP to assist and direct the EWP operator in manoeuvring the EWP into the required position for the task. The ground-based safety observer would also be available to take prompt action by lowering the platform of the EWP using the emergency lowering controls should the operator become incapacitated or trapped. This system of work would be supported by and clearly laid out in a safe work method statement and emergency procedures that would be read, understood and adhered to by persons involved in the task prior to the task commencing.[59]

Professional relationship between Mr Blundell and Mr Gordge

75. Mr Taylor drew particular attention to the duties owed by an employer pursuant to section 21 of the *Occupational Health and Safety Act 2004*, with respect to providing their employees with a safe work environment free from health risks.[60]

76. During the course of the investigation, Mr Blundell appropriately engaged with WorkSafe with respect to providing documentation relating to his own registration and qualifications, and clarifying his professional dealings with Mr Gordge.

77. Mr Blundell advised that his engagement with Mr Gordge was by verbal agreement only, and that he approached Mr Gordge to complete the work on the windows as his own medical circumstances prohibited him from working at heights. At the time he engaged Mr Gordge, they each operated in their capacity as sole traders, with their own ABNs. Mr Blundell

[58] Statement of Andrew Taylor dated 30 July 2020.
[59] Statement of Andrew Taylor dated 30 July 2020.
[60] Statement of Andrew Taylor dated 30 July 2020.

confirmed that as Mr Gordge held his own construction 'tickets', he did not arrange site-specific training with respect to the work at Transit Dance.[61]

78. With respect to records relating to the identification of occupational health and safety hazards and/or risks that were undertaken prior to work being conducted by Mr Blundell upon the MEWP, Mr Blundell advised that he arranged the MEWP hire and delivery on behalf of Transit Dance, but its use did not require "*specific training or tickets*". No Safe Work Method Statements (**SWMS**) were conducted for the project. He added that there was no form of induction process via the hire company and the MEWP was to be used by Transit Dance for other maintenance works once the windows were complete.[62]

79. WorkSafe subsequently examined bank statements from Mr Gordge and Mr Blundell and confirmed that they each received payment from Mr Lakiotis for their respective work in early January, but that no payments were made from Mr Blundell to Mr Gordge in connection with the Transit Dance project.[63] Mr Blundell explained that he and Mr Gordge did not reach any formal agreement as to payment for the project, nor were any recent payments made as Mr Blundell anticipated that he would receive an invoice from Mr Gordge upon completion of the work.[64]

80. Having completed a thorough analysis of their professional relationship, the Victorian WorkCover Authority ultimately considered there was insufficient evidence to establish that Mr Blundell was Mr Gordge's employer at the time of the incident. It was also considered that there was insufficient evidence to establish that at the time of the incident, Mr Blundell was responsible for the management and control of risks associated with Mr Gordge's use of the MEWP.

81. WorkSafe subsequently advised the Court on 22 November 2021 that a decision was made not to commence prosecution against Mr Blundell in connection with Mr Gordge's death.

---

[61] WorkSafe brief, Exhibit 27 – Response from Mr Blundell to WorkSafe request for documents.

[62] WorkSafe brief, Exhibit 27 – Response from Mr Blundell to WorkSafe request for documents.

[63] Commonwealth Bank transaction statement for Matthew Duncan Gordge from 2 July 2019 to 4 February 2020; National Australia Bank transaction statements for Mr DF Blundell from 5 October 2019 to 5 December 2019, and 6 December 2019 to 5 February 2020.

[64] WorkSafe brief, Exhibit 27 – Response from Mr Blundell to WorkSafe request for documents.

WORKSAFE INDUSTRY STANDARD

82. Since Mr Gordge's death, WorkSafe have published the *Industry Standard – Elevating work platforms* dated April 2021. The Industry Standard provides practical advice on the safe use and maintenance of MEWPs. It includes provision for the following:

    a) Training & competency – Information, instruction, training or supervision must be provided to those involved wit the operation of EWPs, prior to the undertaking of the task. In relation to scissor-type EWPs, training should comprise of structured, nationally recognised training that includes assessments overseen by a suitably trained assessor to ensure that the operator has achieved the required level of competency and proof of competency should be available. There is also provision for the content of the training which includes hazard management.

    b) Hazards – use of secondary guarding is recommended where a crushing hazard is identified. The secondary guarding may include physical barriers, pressure sensing devices or proximity sensing devices.

    c) The platform of EWPs should be lowered when travelling to another location, as the stability of the raised EWP is heavily reliant upon the ground conditions and the absence of hazards

    d) Safety observers – Operators should never operate an EWP alone. A safety observer should be appointed to warn the operator(s) of hazards and ensure prompt action to rescue operator(s). The safety observer needs to have line-of-sight to the operator, should be trained in the operation of and the emergency procedures for that specific EWP and should not leave the area until the EWP is lowered to a stowed position and the operator has alighted from the platform.

CONCLUSION

83. As noted above, my role is to establish the facts of Mr Gordge's death, not to cast blame or determine criminal or civil liability. My other role is to help prevent deaths by promoting public health and safety through comments and recommendations if appropriate.

84. The investigation did not reveal the extent of Mr Gordge's experience working at heights or with an MEWP of the kind employed at Transit Dance, nor his advice to Mr Blundell to that effect. Further, there is no evidence that All Star Access confirmed the competency of

Mr Gordge, or anyone else, to operate the MEWP. I am therefore unable to definitively conclude whether or not Mr Gordge was performing work outside of his training and experience.

85. While the investigation has not identified the precise circumstances that led to Mr Gordge becoming pinned between the MEWP rail and roofing structure, I am satisfied that it was occasioned by, at least in part, Mr Gordge having failed to ensure sufficient clearance between the MEWP barrier and roof trusses.

86. I note that Mr Gordge's post-mortem blood alcohol concentration was below the threshold for fully licensed motorists, however I am unable to exclude the possibility that it may have had an impact on his judgment and reaction time in the circumstances.

FINDINGS

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

    a) the identity of the deceased was Matthew Duncan Gordge, born 7 December 1982;

    b) the death occurred on 26 January 2020 at 64 Dawson Street, Brunswick, Victoria, 3056, from traumatic asphyxia; and

    c) the death occurred in the circumstances described above.

COMMENTS

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

88. A number of measures have been identified in this finding which may have prevented Mr Gordge's death, including the use of secondary guarding, safety observers, and appropriate training and planning to identify hazards and respond to emergencies. I consider that these measures have now been specifically addressed and incorporated into the *WorkSafe Industry Standard – Elevating work platforms* dated April 2021. However, given the relatively low cost identified by Mr Taylor of retrofitting EWPs with secondary guarding technology, I am of the view that consideration should be given by WorkSafe to mandating the use of such technology on all EWPs, regardless of whether there has been any subjective assessment that their particular use could give rise to a crushing injury.

89. It will be of critical importance for WorkSafe to monitor the impact of the Industry Standard on the behaviour of those in the industry who operate EWPs so that its effectiveness can be assessed and amended if necessary, or whether consideration needs to be given to the implementation of more prescriptive and robust measures in the form of legislative amendment.

90. While the training of operators is covered in the *WorkSafe Industry Standard – Elevating work platforms*, the circumstances of Mr Gordge's death highlight the uncertainty that can arise in relation to the identity of the person who will ultimately operate an EWP and whether they have in fact received adequate and appropriate training. I consider that one way to reduce this uncertainty would be to require those who engage in the business of hiring EWPs to the industry to confirm the competency and/or training of the prospective operator before approving any contract.[65]

RECOMMENDATIONS

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

(i) WorkSafe Victoria consider the viability of including a provision in the *Industry Standard – Elevating work platforms* that requires all EMPs to be fitted with secondary guarding technology.

I convey my sincere condolences to Mr Gordge'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.

[65] I note that there is no employment relationship between a company that hires EWPs and their customers which may limit the regulatory reach of WorkSafe in the circumstances

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

Frida Enegren, Senior Next of Kin

WorkSafe Victoria

Constable Jaideep Kochhar, Coroner's Investigator

Signature:

____

Coroner David Ryan

Date : 05 August 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.