

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2012 2229

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

I, AUDREY JAMIESON, Coroner having investigated the death of NORMAN ROBERT ALDOUS

without holding an inquest:

find that the identity of the deceased was NORMAN ROBERT ALDOUS  
born 13 March 1948  
and the death occurred on 13 June 2012  
at 21-25 Coora Rd, Oakleigh South VIC 3167

**from:**

- 1 (a) CRANIAL FRACTURE AND INTRACRANIAL HAEMORRHAGE
- 1 (b) BLUNT FORCE TRAUMA TO THE HEAD
- 1 (c) FALL FROM A HEIGHT

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Norman Robert Aldous was 64 years of age at the time of his death. He lived at in Wheelers Hill with his wife Suzette. Mr Aldous was a labourer, and had worked extensively in grounds keeping and sports facilities. For approximately three years, he had been working as a casual labourer for Bifalco Pty Ltd, trading as Carnegie Smart Hire, which was owned by Mr Henricus Otten, a friend of Mr Aldous' from Rotary.
2. Just after 9.00am on 13 June 2012, Mr Aldous was located lying on the concrete floor of a factory at 21-25 Coora Rd, Oakleigh South. He was lying approximately four to five metres

beneath an open unprotected area of the roof structure, and it was unclear how long he had been there. Emergency services were called, and ambulance paramedics arrived at 9.13am. Unable to locate a pulse, the paramedics assessed Mr Aldous' cardiac rhythm as asystole and subsequently declared Mr Aldous to be deceased. A CFA Emergency Medical Response crew then arrived, followed shortly afterwards by police and Victorian WorkCover Authority employees.

## **INVESTIGATIONS**

### *Forensic pathology investigation*

3. Dr Malcolm Dodd, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a full post mortem examination on the body of Mr Aldous, reviewed a post mortem CT scan and referred to the Victoria Police Report of Death, Form 83. Dr Dodd made an incidental finding of a pyloric ulcer on a background of gastritis, and focal infiltrating adenocarcinoma originating from the area of ulceration and inflammation.
4. Toxicological analysis of post mortem blood did not detect any alcohol, common drugs or poisons, except for paracetamol.
5. On the evidence available to him, Dr Dodd reported to the Coroner that the cause of Mr Aldous' death was cranial fracture and intracranial haemorrhage secondary to a blunt force trauma to the head, as a result of a fall from height.

### *Police investigation*

6. The circumstances of Mr Aldous' death have been the subject of investigation by Victoria Police on my behalf. Police located roofing screws with Mr Aldous, as well as with his vehicle.
7. Police obtained statements from Mr Aldous' wife Suzette Aldous, Ambulance Paramedic Andrew Nash and a letter from General Practitioner Dr Penelope Martin. Police also accessed WorkCover Authority statements provided by Henricus Otten, owner of Melbourne Commercial Steel Roofing Pty Ltd Nikolaus Panagis, and Roofing Plumbers Jimmy Cardalini, David Wilson and Terry Muller.
8. Dr Martin wrote in a letter dated 17 September 2012 that Mr Aldous had been in excellent health, and had well controlled hypertension and hyperlipidemia.
9. Mr Otten reported that Bifalco Pty Ltd is a general equipment hire business. The factory at 21-25 Coora Road Oakleigh South had been purchased by a superannuation fund operated by Mr Otten, with the plan being to move his business operations to this site. The building required a new roof and new walls, as well as the removal of asbestos. Most of the work was being

completed by external contractors, including Melbourne Commercial Steel Roofing Pty Ltd, but Mr Otten asked Mr Aldous to assist on 12 and 13 June 2012. Mr Otten said that Mr Aldous' role was to remove old nails and clean up lengths of timber that had been removed from the factory, so it could be reused on the roof.

10. In the course of their investigation, police learned that on 12 June 2012, Mr Aldous had been working up on the roof with Mr Otten, without fall protection in place such as harnesses. They were putting timber up into the gutters which run at the bottom of the sky lights on the roof. This work took up most of the day, until they ran out of clean timber at 5.00pm. There was still more timber at the site to be cleaned, that needed to be put on the roof as well.
11. Mr Otten said that he asked Mr Aldous to return to the site on 13 June 2012, to clean up more of the timber so it could be used for the roof. It was agreed that Mr Aldous would only do half a day. Mr Otten said that he was not on site that morning, and as far as he knew, Mr Aldous would not be up on the roof, as he had just been asked to clean up some timber. Mr Otten said that he had not wanted him to go on the roof, and he had planned to do it himself with another employee later in the day.
12. There was no other evidence available as to what duties Mr Otten asked Mr Aldous to undertake on 13 June 2012, and Mr Aldous' fall was not witnessed.
13. There was a corner of the roof that had not been completed because there was machinery bolted to the floor of the factory area and it could not be accessed by the elevated work platform or scaffold to do the roofing above. This was the area where Mr Aldous fell. Mr Cardalini added that there was hand railing in this area, which would have stopped Mr Aldous from falling forwards. While he did not observe the accident, Mr Cardalini thought that Mr Aldous would have fallen backwards.
14. Mr Cardalini said that as far as he knew, there were no Job Safety Analysis (JSA) or Safe Work Method Statements (SWMS) with this job; nor a formal induction to the site. Mr Muller said on his arrival to the site, he was told that the Melbourne Commercial Steel Roofing's JSA and SWMS had been given to Mr Otten. However, Mr Muller did not see them. Mr Panagis said that there was a SWMS for these works and a copy had been given to Mr Otten.

#### *Worksafe Investigation*

15. As Mr Aldous' death occurred in the course of his employment, the Victorian WorkCover Authority (or WorkSafe) conducted an investigation into the circumstances of his death.

16. Inspector Stephen Thornely attended the accident site at approximately 10.00am on 13 June 2012. Mr Thornely observed that it had not been ensured so far as reasonable practicable that the roofing works were being performed in a manner which was safe and without risks to health. There was no visible access tower or other safe means of accessing the roof.
17. WorkSafe Investigators Russell Tomlin and David Steer attended at approximately 10.15am on 13 June 2012 and observed that there were no fall protection measures in place in the area above the location the deceased was situated.
18. A Prohibition Notice was issued dated 13 June 2012, under section 112(1) of the Occupational Health and Safety Act 2004.
19. On 19 June 2012, Inspector Rachel Baker and Group Leader Mark Drury attended the site to make further enquiries. It was agreed that further roofing activities would not be recommenced prior to a follow up visit to ensure safe systems of work had been implemented. A number of expectations were discussed, including that safe access to work areas be provided and falls prevention measures be implemented.
20. As part of the WorkSafe investigation, Mr Tomlin issued directions to Bifalco Pty Ltd; Monash City Council; ATS Australasian Technical Services Pty Ltd (asbestos removalists); Trustee for the Otten Family Trust; and Melbourne Commercial Steel Roofing Pty Ltd, under section 100(1) of the Occupational Health and Safety Act 2004, to produce a number of documents.
21. On 17 July 2012, Ms Baker attended the site and spoke with Mr Otten. During this visit, Ms Baker was informed that a safety management plan had been formulated and implemented at the workplace, and that there were plans for staff to undertake formal occupational health and safety training in the near future. Discussions were had with a representative from Melbourne Commercial Steel Roofing, including in relation to safe work methods to be adopted on commencement of roofing activities.
22. When Ms Baker and Mr Thornely returned to the site on 18 September 2012, roofing works had been completed. Discussions were held regarding fall prevention measures used, which included guard railing and harness systems. Mr Thornely assessed that the immediate risk relating to the previously issued Prohibition Notice had been remedied.
23. Ultimately, WorkSafe recommended no charges under the Occupational Health and Safety Act 2004, against any party involved in the investigation.

## COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

### *Coroners Prevention Unit Investigation*

1. The Coroners Prevention Unit (CPU)<sup>1</sup> also investigated the circumstances of Mr Aldous' death on my behalf, in particular in relation to any other similar deaths of people in workplaces after falling from height.
2. The CPU identified that between January 2000 and 30 November 2015, 53 other people had died from a fall from height at the workplace. The most deaths were recorded in the 55 to 64 year age group, of which Mr Aldous belonged. Of the 53 deaths, eight related to people who had been working on roofs.

### *WorkSafe Victoria – Falls Publications and Campaigns*

3. In his statement, WorkSafe Investigator Mr Tomlin reported that publications relevant to falls from height are voluminous, and include but are not limited to the following WorkSafe publications:
  - a. Basic Steps to Preventing Falls from Heights, 1<sup>st</sup> Edition, June 2005
  - b. New Laws For Working at Heights Apply from 31 March 2004
  - c. Compliance Code: Prevention of falls in general construction, 1<sup>st</sup> Edition, 18 September 2008
  - d. A handbook for the construction regulations, Working safely in the general construction industry, 1<sup>st</sup> Edition, February 2008
4. I note that the publications referred to by Mr Tomlin are all from some time ago. Through further perusal of the WorkSafe website I have also identified the availability of the following publications:
  - a. Your health and safety guide to falls prevention, 1<sup>st</sup> Edition, November 2007
  - b. Preventing falls at work – Information Sheet, June 2007

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<sup>1</sup> The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

- c. Fall protection for roof work – Information Sheet, April 2011
5. I note the value of WorkSafe’s publications and the benefit of making information about the hazards of falls from heights at workplaces more widely available.

## RECOMMENDATIONS

1. With the aim of enhancing workplace safety and minimising harms, I recommend that WorkSafe Victoria consider releasing an updated and comprehensive publication relating to both preventing and increasing awareness of the associated dangers of falls from height at the workplace.

## FINDINGS

I find that Mr Aldous died at his workplace in circumstances that were hazardous and largely preventable. On the evidence available to me, I am unable to determine what Mr Aldous was doing on the roof, or what he had been instructed to do on 13 June 2012. I note that Mr Aldous had been engaged in roof work with employer and site owner Mr Otten the previous day, without fall protection in place such as harnesses.

I accept and adopt the medical cause of death as identified by Dr Malcolm Dodd and find that Norman Robert Aldous died from a cranial fracture and intracranial haemorrhage secondary to a blunt force trauma to the head, as a result of a fall from height at his workplace.

Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

Mrs Suzette Aldous

Mr Russell Tomlin, WorkSafe Investigations Division

Dr Penelope Martin, General Practitioner

Bifalco Pty Ltd

Senior Constable Wesley Bryant

Signature:

A handwritten signature in blue ink, consisting of a large loop followed by a horizontal stroke and a short vertical stroke.

AUDREY JAMIESON  
CORONER

Date: **21 March 2016**

