IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 5335/08

REDACTED FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JOHN OLLE, Coroner having investigated the death of TS

without holding an inquest:

find that the identity of the deceased was TS

born on 26 December, 1937

and the death occurred on 27 October 2008

at Caulfield Hospital, 260 Kooyong Road, Caulfield, Victoria 3162

from: 1a. ASPIRATION PNEUMONIA
II. HYPOXIC BRAIN INJURY IN A SETTING OF A MAN INVOLVED IN A WORKPLACE INCIDENT

Pursuant to Section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. TS was aged 70 years at the time of his death. He lived in Murrumbeena.

2. The circumstances of TS's death have been fully addressed in the coronial brief. I note the brief contains a detailed WorkSafe report of its investigation.

Incident Summary

3. TS was a painter and decorator. He and his son, worked in the family business.

4. On 22 May 2008 TS was painting an interior wall of a newly constructed factory in East Bentleigh, Victoria. He used a scissor lift to elevate himself to the desired working height.
In mid afternoon, TS's son noticed his father's head was pinned between the railing of the scissor lift and the factory ceiling. He used an extension ladder to reach the platform and lowered the scissor lift. On closer inspection, it was apparent TS had suffered extensive crush injuries to the neck.

5. Ambulance personnel stabilised TS, and transferred him to the Alfred Hospital. He was admitted to Intensive Care, where he remained in a vegetative state for three weeks. He was transferred to a rehabilitative care unit where he died on 27 October 2008.

Background and Training

6. TS was a vastly experienced painter and decorator. He gained formal qualifications in Greece. He had owned the family painting business prior to his son. He had extensive experience using Mobile Elevating Work Platforms ('MEWP') including scissor lifts. He had not undertaken formal training. TS had used this particular scissor lift on two to three earlier occasions.
He was in good health, although he took medication for high cholesterol and high blood pressure.

The work site and contractual arrangements

7. The factory site was owned by *SJO Pty Ltd.* Jim Vais, the Managing Director was a friend of both men.

8. *JT Building Construction Pty Ltd* was engaged by Mr Vais to project manage construction of the factory. Mr Vais separately engaged TS son's business to complete the painting work.

9. Exterior painting commenced in February 2008. They returned in May 2008 to complete the interior. At which time construction was complete. The site manager attended periodically to oversee the remaining trade work.

10. The scissor lifts were already on site, having been hired by *JT Building Construction Pty Ltd.* Following WorkSafe Victoria investigations, no charges were laid against any party.

The scissor lift

11. The scissor lift ('the lift') was a Haulotte Type Compact 8 model and was relatively new. Testing of the lift was undertaken following the incident and no faults were detected.
Movement is controlled from both a panel in the bucket and a control panel at ground level. A toggle switch is used to elevate and lower the platform, and move it forward and backward. A dead man switch and protective bar are positioned over the joy stick to ensure that inadvertent operation of the joy stick does not occur.

12. The lift had been hired from *Monash Hire Group Pty Ltd.* A number of contractors (electricians, plumbers and carpenters) had used the lift whilst working at the factory.[5]

Job Safety Analysis and risk assessment procedures

[5] See statement of Jim Tzouvelis, pages 2-3 of 5.

13. Mr Vais explained both TS and his son underwent a site induction when they first attended the factory in February 2008.

14. According to TS's son:

> *"Neither my father nor I documented any toolbox meetings or did any written Job Safety Analysis or similar such things in relation to our work at SJO Pty Ltd or any other job. Every job we did was pretty much the same, and we both knew that we had to use a scissor lift or scaffold to paint at height and we were both conscious of that safety factor."*[6]

Expert opinion

15. WorkSafe Victoria engaged the services of Mr Daryl Lord, a safety consultant. Mr Lord concluded that the specific model scissor lift was a suitable and appropriate model for the work task performed.

16. He considered TS had a degree of competency in the operation of MEWPs. He found no supportive evidence to suggest that the risk of being crushed between the scissor lift rails and the overhead structure would have been reasonably foreseeable. Mr Lord further stated that it was the operator's responsibility to check whether any obstructions overhead were present.

Scissor lift safety concerns

17. At my request the Coroners Prevention Unit (CPU)[7] :

- reviewed the circumstances of this tragic incident; and
- identified previous deaths involving the use of scissor lifts and similar MEWPs; and
- examined the relevant safety measures applicable to their use including general safety advice and operator training requirements.

Overview

18. MEWPs such as scissor lifts are promoted as a falls control measure because they provide a robust platform on which to work at a height. Their use is reportedly increasing as they become cheaper to hire and purchase, and technological advances permit them to be used more broadly.
MEWPs have been associated with deaths, injuries and adverse events through a range of mechanisms including:

- operators falling from the platform;
- plant tipping over;

[6] See statement of TS's son, page 5 of 8.
[7] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and to provide them with professional assistance on issues pertaining to public heath and safety.

- operators being crushed between the platform and overhead structures or other static objects; and
- through contact with overhead powerlines.

Previous reported fatalities

Victoria and Australia

19. There were three deaths involving the use of MEWPs in Victoria in 2011. These included:

- a plumber who was electrocuted after coming into contact with an overhead powerline whilst in a raised scissor lift;
- a contractor engaged by an asbestos removal company was crushed between an overhead structure and the platform of a boom lift; and
- a tree stump removalist who fell from the elevated bucket of a cherry picker.

20. Between 1 January 2000 and 31 December 2010 six deaths were directly caused by a MEWP. Three Victorian deaths occurred in circumstances similar to TS. Namely, being pinned between the work platform of the MEWP and a fixed overhead structure.

21. A search on the National Coroners Information System (NCIS) and news reports identified six interstate deaths, including one incident where the operator was crushed between an overhead structure and the work platform.

International reports

22. The United States' Fatality Assessment and Control Evaluation program (FACE) of the National Institute for Occupational Safety and Health ("OH&S") reported four deaths in which a scissor lift operator had been pinned between the scissor lift and a wall or overhead structure.

23. According to a safety alert issued in the United Kingdom, three workers died in a three-month period after being crushed between structures and the MEWP they were operating. Investigations revealed that each incident could have been contributed by, amongst other factors, an untrained operator, an operator unfamiliar with the assigned MEWP, and lack of supervision.

Stakeholder advice

24. Advice was sought from the following key stakeholders to assist the coronial investigation:

- Bernardus Kiekebosch, Managing Director of Haulotte Australia.
- Mr Stephen Marsland, General Manager of Monash Hire Group Pty Ltd.
- Philip Newby, Executive Director of the Elevating Work Platform Association of Australia (EWPA).

25. Information was sought on relevant technological advancements to control for the hazard of overhead obstructions (i.e. sensor alarms and warnings of overhead structures); current training requirements; plant risk assessment procedures and general views towards improving safety.

26. The following was apparent:

- There are two relevant Australian Standards that cover the design and safe use of MEWPs:
  - o AS 1418.10 Cranes, Hoists and Winches: Part 10 Elevating Work Platforms (Design of MEWP).
  - o AS 2550.10 Cranes, Hoists and Winches: Part 10 Mobile Elevating Work Platforms (Safe use).

- The applicable Australian Standards are considered to be equal to or superior to international standards. Mr Kiekebosch advised that proximity sensor systems are available for self-propelled boom-type MEWPs used in the aircraft industry. When scissor lifts are used however they generally move up vertically and much of the work is done above the platform. Give this, side sensors would serve little purpose and overhead sensing would be impractical.

- Both the operator's manual and AS.2550.10 mentions the need to carry out a hazard risk assessment of the job site, taking particular note of any overhead obstructions.[8] According to Mr Marsland, hire companies may supply a hazard risk assessment which accompanies a MEWP, although this does not always occur.

- All persons operating a boom-type EWP where the boom extends to a height of 11 metres or more must hold a high risk work licence. This is in line with the *National Standard for Licensing Persons Performing High Risk Work* (2006) and reflected in Victoria's OH&S legislation. A high risk work licence includes a photograph of the individual and is valid for a period of five years. This requirement does not apply to scissor lifts.

- There is an industry recognised EWPA "Yellow Card" training program that covers the safe operation of all MEWPs and is offered by Accredited Trainers of the EWPA. The Yellow Card provides a means for employers to meet their duty of care requirements. The training program is based on AS2550.10.

- Mr Kiekebosch emphasised that there was no substitute for proper training and that Australia has been a world leader in this regard. Mr Marsland suggested a change in the current legislation to require a licence for the operation of all MEWPs, regardless of height and size.
- Mr Newby however did not consider the expansion of the national licensing requirement to include all MEWPs was appropriate or feasible, noting that compliance with basic OH&S duties appears to be the key issue.

[8] For example: Clause 4.12 - *Proximity hazards* states that consideration shall be given to the presence of proximity hazards including nearby structures or fixed hazards, including the risk of elevating or travelling into overhead structures.

- Mr Newby noted that publications were available on the EWPA website on ways to minimise the risk of crushing.

27. Comment was sought from WorkSafe Victoria with respect to a number of potential recommendations arising from this investigation, including the expansion of the National Standard to include scissor lifts in the licensing scheme. WorkSafe advised that there was no current proposal to expand the scope of the National Standard. States and territories agreed on the high risk licence scheme as part of the national harmonisation of OH&S legislation in preparation for the 2012 introduction. With respect to Job Safety Analysis (JSA) worksheets, WorkSafe noted that a duty-holder should commence preparing a JSA or Safe Work Method Statement prior to the selection and hiring of plant to ensure that it is indeed appropriate for the required task.

Conclusions

28. The available evidence supports the conclusion that operator error was the immediate cause of this incident. The death of TS was not an isolated event. In 2011 alone three workers have been fatally injured whilst operating an MEWP.

29. Mr Lord considered TS competent in the operation of an MEWP. He found no evidence to suggest that the risk of being crushed would have been reasonably foreseeable. However, past incidents identify overhead structures is tragically real and but one of several hazards associated with the use of MEWPs.

30. In the absence of suitable engineering solutions to minimise the risk of a person being crushed, operator training is critical. The national licensing standard currently applies only to boom-type EWPs extending more than 11 metres. However, the *OH&S Act* 2004 places a duty on employers to ensure that an employee receives sufficient training, information and instruction to undertake a work task safely and without risk.

31. The relevant Australian Standard further notes that an MEWP operator must be competent (whether through training, qualifications, experience or both). Had TS completed formal training in the safe use of scissor lifts, he would have greater appreciation of the overhead hazard, and the tragic outcome may have been averted.

RECOMMENDATIONS:

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

Recommendation 1

That Safe Work Australia expand the National Standard for Licensing Persons Performing High Risk Work to require operators of a broader range of mobile elevating work platforms, such as scissor lifts, to hold a high risk work licence.

Recommendation 2

That the Elevating Work Platform Association of Australia take necessary initiatives to ensure that plant hire companies stress to hirers of the hazards associated with operating elevating work platforms, and the vital importance of plant-specific operator training to reduce the risk of injury during use.

Recommendation 3

That WorkSafe Victoria conduct an education campaign, targeting employers to ensure their workers obtain training in the operation of Mobile Elevating Work Platforms for plant such as scissor lifts, which do not currently require a high risk work licence. The Yellow Card training program for example is one such avenue available to acquire training.

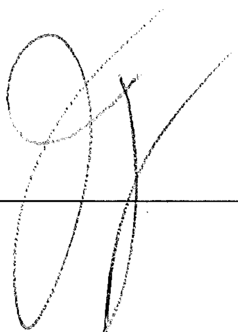
Finding

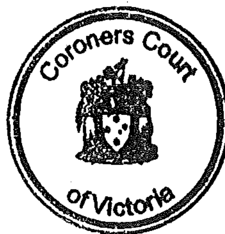
I find the cause of death of TS to be aspiration pneumonia and hypoxic brain injury in a setting of a man involved in a work place incident.

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

The family of TS
Investigating Member
Interested parties

Signature:





JOHN OLLE
CORONER
6 March 2012