IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2009 4900

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 THOMAS ANTHONY KELLY

without holding an inquest:

find that the identity of the deceased was THOMAS ANTHONY KELLY

born 4 October 1963

and the death occurred on 15 October 2009

at Pentridge Village, Corner of Pentridge Boulevard and Stockade Avenue Coburg Victoria 3058

from:

1 (a) HEAD INJURY

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

1. Mr Thomas Anthony Kelly was 46 years of age at the time of his death. He lived in Greensborough with his wife Nada and their two sons. Mr Kelly was a concreter and was sub-contracted by Bushy Park Concreting Pty Ltd (Bushy Park).

2. On 15 October 2009, Mr Kelly was working at the Pentridge Village site, a multi-level building construction at the intersection of Pentridge Boulevard and Stockade Avenue, Coburg. The site was operated by West Homes Australia Pty Ltd (West Homes) who had contracted with Bushy Park, who had in turn contracted with Improved Concrete Pumping Services Pty Ltd (ICPS) to provide a truck mounted concrete pump at the worksite.

3. On 15 October 2009, Mr Kelly was working on a job with a number of other concreters, to concrete the second level of the building site. Due to the height of the second level, the concrete pumping truck, with a hydraulic concrete placing boom, was required to pump the concrete from the ground level to the second level.

4. At approximately 11.00am, as the job was nearly completed, Mr Kelly was performing height checks in the concrete. At this time the concrete pumping truck, owned and operated by ICPS, moved; the outrigger support on the passenger side of the pumper sunk into the ground and caused the front end of the pumper to tip. The passenger side of the pumper tipped onto the ground, lifting the driver's side off the ground and causing the large boom on the pumper to tip into the concrete being poured on the second level. As the boom toppled forward, Mr Kelly was struck by the boom arm to the back of his head.

5. Work colleagues came to the aid of Mr Kelly, lifted the boom off him and called emergency services. Mr Kelly was moved out of the wet concrete area and onto a dry piece of concrete for first aid. Metropolitan Fire Brigade members attended the scene, followed soon after by ambulance paramedics who arrived at 11.16am. Cardiopulmonary resuscitation was initiated. Mobile Intensive Care Ambulance (MICA) paramedics also attended and found Mr Kelly to be unconscious, pulseless, with an unrecordable blood pressure and non-breathing. Full resuscitative measures were continued for over 30 minutes. Mr Kelly was declared deceased after paramedics discontinued resuscitation attempts at 11.56am. Police officers and Victorian WorkCover Authority (WorkSafe) employees also attended the scene.

INVESTIGATIONS

Forensic pathology investigation

6. The Deputy Director at the Victorian Institute of Forensic Medicine, Associate Professor David Ranson, conducted an external examination upon the body of Mr Kelly, reviewed a post mortem CT scan and referred to the Victoria Police Report of Death, Form 83. Associate Professor Ranson noted that the post mortem CT scan showed evidence of major trauma of a type that would be expected to be fatal. Toxicological analysis of post mortem blood did not identify any alcohol or common drugs or poisons. On the evidence available to him, Associate Professor Ranson ascribed the cause of Mr Kelly's death to a head injury.

Police investigation

7. The circumstances of Mr Kelly's death have been the subject of investigation by Victoria Police on my behalf. The police investigation did not identify evidence of third party involvement. Statements were obtained from Mr Kelly's wife, Nada Kelly, MICA Paramedic Ivano Forte and MICA Clinical Support Officer Gary Becker.

8. Mrs Kelly stated that her husband was self-employed as a concreter, and would contract himself out to jobs. Mrs Kelly said that her older son and a family friend had told her after her husband's death that he had said to them that he expected somebody to get hurt at the Pentridge Village site. Mrs Kelly said that Mr Kelly had never told her that he felt unsafe at work, but that even if he had felt unsafe, he would not have wanted to worry her. Another friend told Mrs Kelly that he had spoken to Mr Kelly the day before his death, and that he had described the site as wet and muddy, with lots of rubbish on it. Mr Kelly had told this friend that the job had been cancelled three days in a row and that pressure was mounting to get the job done.

WorkSafe Investigation

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

10. On 12 October 2011, WorkSafe charged West Homes with one charge against section 21(1) and 21(2)(a)[1] and in the alternative, one charge against section 23[2] of the *Occupational Health and Safety Act 2004* ('the Act'). ICPS were charged with one charge against section 23 of the Act. A committal hearing was listed, however WorkSafe withdrew prosecution on 1 August 2012,[3] and subsequently informed the Coroners Court of their withdrawal by letter dated 20 November 2012, which accompanied the WorkSafe brief.

11. In response to a request for further details regarding the discontinued proceedings, WorkSafe indicated by letter to the Court dated 5 February 2013, that upon further review of the case, charges had been withdrawn against West Homes because it was determined that there was insufficient evidence to establish any breaches of the Act. Charges were withdrawn against ICPS on public interest grounds according to WorkSafe. No further explanation was provided in

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[1] Duties of employer to employees (failure to provide, so far as is reasonably practicable, working environment that is safe and without risks to health).

[2] Duties of employer to other persons (failure to ensure persons not exposed to risk).

[3] I note that copies of the court extracts contained in the WorkSafe brief suggest that charges were withdrawn against each party on 2 August 2012.

this letter regarding the withdrawal of charges, aside from reference to WorkSafe's general prosecution guidelines.

12. In the process of their investigation, WorkSafe obtained statements from ICPS Concrete Pump Operator Paul Gatto, Concrete Agitator (truck) Drivers for Hanson Construction Materials Robert Cappola, Mark Livock, Peter King, Antonio Puopolo and Russell Wilson, Bushy Park Concreting sub-contractors Livio Forlano and Clinton Knight, Bushy Park supervisor Steven Mrnjavac, and WorkSafe staff: Inspector Cameron Ellis, Inspector Matthew Gipp, Senior Investigators (and Inspectors) James Chasser, Anthony Byrne and Peter Collins. WorkSafe also obtained expert opinions from Civil Engineer Reginald Hobbs and Manager of Geotechnical Engineering's concrete pumping and spraying division Danilo Dugina.

13. Livio Forlano reported that he is self-employed as a concreting sub-contractor. On 15 October 2009, Mr Kelly was engaged as concreter by Mr Forlano, who had been engaged by Bushy Park to supply about eight concreters for the job that day. Mr Kelly had worked as a concreter at the Pentridge Village site approximately eight times prior to this date.

14. ICPS Concrete Pump Operator Paul Gatto reported that the concrete pumping truck used on 15 October 2009 was a heavy rigid Daf truck with a Sermac pump. It weighs 42.5 tonnes and is approximately 15 metres long. The boom reaches approximately 48 metres with a hose attachment to take the concrete about another 30 metres. Mr Gatto did a daily check list on the truck that morning and had not found anything to be wrong. Upon arriving at the Pentridge Village site at about 6.00am, Mr Gatto spoke to the foreman, who showed him where to set up. Mr Gatto assessed the designated ground and asked the foreman if there were any pipes underneath. The foreman replied there were none. Mr Gatto noted that the ground was soft; it had been raining prior to their arrival. He told the foreman that the ground was soft and asked again if there was anything under the ground. The foreman said there was not.

15. Mr Gatto drove the truck into position and put all four stabiliser legs out, with the timbers down. Mr Gatto and a colleague put large three metre long, six inch thick timber planks down where the legs were to drop down. They then put a rubber pad down on top of the timbers, and the legs of the truck were lowered onto the pads. Mr Gatto then used levers to lift the truck until it was level.

16. Mr Gatto then walked up to the top of the slab and used a remote control to put the boom on top of the slab. When the boom was in position, the hose operator held the hose, and Mr Gatto would stand where he could see the truck. Mr Gatto said it was usual practice to have someone

from the company in charge of the site to back trucks onto the pumper, but when there is nobody available, the truck drivers do it or he and his colleagues do. Mr Gatto said that for this job, he could not see the hose operator from where the truck was positioned; he needed to remain up the top so that he could watch the hose operator and the truck at the same time. Mr Gatto said that a number of times he had to ask the concreters to move out of the way of the boom. Bushy Park Concreting sub-contractor Clinton Knight reported that both Mr Gatto and the hose operator did not leave the deck on level two where the concreters were working over the course of the morning.

17. Mr Forlano reported that on this day, there were at least ten concreters working on the suspended slab, and that they were all sub-contracted to Bushy Park. The concreters had a number of different tasks, including screeding (pulling the concrete back with a screed to make it level), setting the height using a trowel and staff, and using the trowel or helicopter machine to finish off and give the concrete a smooth finish. The area of the concrete slab was large; over 1000 square metres.

18. Concrete Agitator Driver Robert Cappola stated that the morning had light showers coming through and it was a little bit muddy and slippery, but not enough to bog the trucks and the ground was flat. Mr Cappola and other truck drivers were backing up to the hopper with guidance from each other, taking turns to start loading the hopper when the previous driver had finished unloading.

19. Mr Cappola noted that there was no spotter on this day. He noted that at some jobs, they have a spotter to guide the truck drivers back into the pump. Concrete Agitator Driver Mark Livock similarly noted his surprise that there was not a spotter at the site; he was annoyed that the drivers had to assist each other to back into the hopper pump for loading. Mr Cappola said he did not see any of the pump operators who owned the pump, as they were obviously operating the pump from the suspended slab, with a remote control. Concrete Agitator Driver Peter King assumed that both of the concrete pumper operators were up where the slab was being poured, and stated that nine times out of ten, the operators are there to guide you on to the pumper.

20. Mr King discharged his truck's load of concrete into the hopper of the pumper, and before finishing, guided Mr Livock's truck back to the pump. While he was discharging, Mr King thought he saw the back of the concrete pumper move. He then saw the rear bumper of his truck start to twist, and was not sure what was happening. The whole back of the pump truck then began to raise and Mr King ran out of the way.

21. Mr Livock reported that he was waiting for Mr King's truck to finish unloading into the pump, when he heard some funny noises coming out of the pump. Mr Livock noticed the pump start to move, and jumped backwards. The pump clipped Mr Livock's truck and hooked up onto Mr King's truck, lifting it off the ground.

22. Mr Forlano said there had been nothing unusual about how the pour was going, or about how everyone was working on the day. Mr Gatto said that they were pumping away as normal when in a split second, the boom came down. Mr Gatto was standing near the guard rail at the edge of the slab. The hose operator let go of the hose and ran as it came down. Mr Gatto saw the boom hit Mr Kelly, knocking him down into the wet concrete. Mr Forlano said that Mr Kelly was lying in the concrete under the pump hose.

23. WorkSafe Inspector Cameron Ellis attended the Pentridge Village site at approximately 12.30pm on 15 October 2009, and met with Michael Bonnici, the site foreman.

24. On his arrival at the site, Senior Investigator James Chasser observed the rear of the Daf 85.430 pumping truck was still in the air, and the left front support arm or outrigger, appeared to have sunk into the soil. Senior Investigator Anthony Byrne observed that the rear passenger outrigger had slid off the timber supports and a support pad could be seen nearby. Senior Investigator Chasser noted that a mark could be seen on the top timber of the support system, where the support pad of the outrigger appeared to have slid off the timber before sinking into the ground. The rear left outrigger had slid off the timber supports and a plastic support pad could be seen nearby. The outriggers on the right or driver's side of the truck were in the air, with their support pads and timber support systems still in position.

25. Senior Investigator Chasser also noted that the hole where the left front outrigger had sunk was excavated to a depth of approximately 1200mm and approximately 1.0 metre square. Building rubble appeared in the top 300-400mm of the soil and a cast iron pipe was noted at this depth. The soil below that point appeared natural. Another cast iron pipe was found at approximately 1200mm depth. The soil in the south west corner of the excavated hole appeared to be damp. It was not determined what the cast iron pipes were and it was speculated that they may have been remnants from the old Pentridge jail.

Expert Reports Provided to WorkSafe

<u>Introduction</u>

26. Civil Engineer Reginald Hobbs and Manager of Geotechnical Engineering's concrete pumping and spraying division Danilo Dugina provided separate expert reports to WorkSafe. Mr Hobbs'

report concluded that the sudden displacement of the concrete placing boom, which struck Mr Kelly, was caused by the outrigger/stabiliser pad on the passenger side of the truck mounted concrete pump/placing boom penetrating the ground. Mr Dugina emphasised that the likelihood of a hazard or risk eventuating was high given the ground conditions being unknown and untested, and the lack of monitoring of the stability of the boom pump.

Assessment of Weight Bearing Capacity and Ground Conditions

27. Mr Dugina opined that the stability of the ground should have been assessed and adequate measures should have been taken to ensure safe support of the stabilisers, especially given the very large size of the boom involved.

28. In particular, Mr Dugina stated that a 'solid, level' area should have been provided by West Homes, as they had control of the site as the principal contractor.[4] Mr Dugina added that due to the very large size of the boom pump and the stabiliser load, West Homes, Bushy Park and ICPS should have had the set up area tested or assessed by an engineer. Mr Dugina stated that the ICPS operator Mr Gatto should not have set up without knowing the ground bearing pressure.[5] Mr Dugina also considered that West Homes, as the principal contractor should have conducted a careful investigation to ensure that the concrete placing equipment was positioned over adequately compacted ground.[6]

29. Mr Hobbs considered that the requirement of Clause 4.3 of the WorkSafe Industry Standard, that the pump set-up should be clear of inadequately compacted or soft ground was not observed, as the unit was set up on uncontrolled fill.

30. Mr Hobbs noted that as any pipe found in the hole that had been excavated at the location of the relevant outrigger was of a relatively small diameter, collapse or deformation of such a pipe was not likely to have caused the outrigger to penetrate the ground to the extent it did. Furthermore, Mr Hobbs would regard the possible presence of old water, sewer and drainage pipes to be highly likely in the area of any old building. A further risk was that any such pipe charged with water could be leaking and detrimentally affecting the ground conditions in the area of such a pipe. Mr Hobbs regarded this to be a possible hazard that deserved to be investigated as part of a considered evaluation of the ground conditions in the area where it was proposed to operate the concrete pump, or any item of large plant.

[4] As per: Clause 4.2(a) Australian Standard AS 2550.15-1994: Cranes – Safe Use – Concrete Placing Equipment

[5] As per: Clause 4.2(c) Australian Standard AS 2550.15-1994: Cranes – Safe Use – Concrete Placing Equipment

[6] As per Clause 4.2(d) Australian Standard AS 2550.15-1994: Cranes – Safe Use – Concrete Placing Equipment

31. The WorkSafe Industry Standard for Concrete Pumping dated April 2004 requires that the Principal Contractor should 'select the most suitable location for the pump set-up, including... an accessible reasonably level area with a firm base, able to support the loaded working pump and any delivery trucks'[7] and the concrete pumping contractor should 'after consulting with the other involved contractors... ensure the most suitable location for the pump set-up is selected, including... a firm base, able to support the fully loaded working pump and any delivery trucks'.[8] These provisions did not appear to have been adhered to.

Packing Under Outrigger Pads

32. Mr Hobbs' calculations of possible maximum bearing pressures on the ground surface at each outrigger/stabiliser location led to his conclusion that none of the outrigger/stabiliser pads were provided with adequate packing or engineered 'bog mats' to safely spread the loads to the ground.[9] In assessing this, Mr Hobbs had regard for such ground being of unknown capacity at the time, and containing uncontrolled fill and silty clays of limited bearing capacity as described in geotechnical engineering reports provided to WorkSafe by West Homes.

33. Indeed, geotechnical assessment of the ground performed subsequent to the incident provided a recommendation that the safe bearing capacity of the ground for operation of mobile cranes is 200kPa. Mr Hobbs' calculations indicated that all four of the outrigger / stabiliser pads of the crane did not have adequate packing under the pads to disperse the loads to achieve this bearing pressure.

34. Mr Hobbs determined that the packing under the critical outrigger / stabiliser pads was comprised of loose pieces of timber with at least the upper layer (and probably) of these being of 'softwood' contrary to the recommendations of Clause 4.5 of the WorkSafe Industry Standard. The size and construction of the packing under the outrigger/stabiliser pads was not suitable to cater for possible lateral displacement of the truck mounted concrete pump and placing boom. Mr Hobbs was not able to determine whether the outrigger/stabiliser pad penetrated the ground by 'sliding off' or by otherwise displacing the timber packing under it, or had been subject to lateral displacement arising from vibration of the pump and had moved off the packing and then penetrated the ground. Mr Hobbs opined that it is of no consequence

[7] Clause 3.2, WorkSafe Industry Standard for Concrete Pumping, April 2004

[8] Clause 3.3, WorkSafe Industry Standard for Concrete Pumping, April 2004

[9] This indicated a lack of compliance with the requirement of Clause 4.5 of the WorkSafe Industry Standard that 'adequate packing of sufficient strength and load bearing area is available for the outrigger stabiliser pads. Packing may include engineered bog mats or suitable timbers.'

which of these occurred as the packing was inadequate to disperse the load in any case and presented a hazard.

35. The requirement of Clause 4.2(c) of the Australian Standard AS2550.15-1994: Cranes – Safe Use, Part 15 - that 'the operator shall ensure that the allowable bearing pressure of the ground is not exceeded by the loading on any outrigger / stabiliser pad and shall place, if necessary, suitable packing under the outrigger / stabiliser pads…' was also not observed. Mr Dugina added that it should have been known from the operator's manual, the Sermac Handbook that this particular boom pump should not be set up on natural ground and the size of the blocking to be used, if allowed, by the handbook should be of a minimum standard.[10] This was an omission by ICPS.

36. Mr Hobbs considered that West Homes, ICPS and Bushy Park were the parties who should have been responsible for observing the provisions relating to packing at the outrigger / stabiliser pads in the WorkSafe Industry Standard, Australian Standard AS 2550.15 and the Sermac Handbook.

37. Mr Dugina agreed that West Homes also breached the Industry Standard by not providing stable ground, engineered blocking under stabilisers or engineered bog mats, so as to reduce or eliminate the risk of subsidence of the stabiliser. Mr Dugina considered that the very large Sermac concrete boom pump should only have been set up on known, stable, ground conditions, adequate blocking or engineered bog mats.

38. Mr Hobbs' review of ICPS' 'Job Safety Analysis Work Sheet', signed by Mr Gatto and West Homes' 'Site Induction' sheet both dated 15 October 2009, indicated that particular attention was not given to the outrigger/stabiliser loads likely to be imposed by such a large unit or the capacity of the ground to support those loads. Mr Dugina similarly opined that the generic Job Safety Analysis used by ICPS did not provide sufficient emphasis on specific site based risks. Mr Dugina added that there was also a failure to observe the Sermac Handbook recommendations for stabiliser support by ICPS.

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[10] Mr Dugina also noted that in the Sermac operators handbook on page 62, 2.5.2 there is a warning to constantly check the stability of the machine on the resting surface when it is in operation. Mr Dugina doubted that the driver's cabin end stabilisers/outriggers would have always been visible from the position of Mr Gatto on level two of the building.

Working Under the Boom

39. Mr Hobbs noted that Mr Kelly was stated to have been working under the boom, contrary to the requirements of Clause 4.2(f) of Part 15, Concrete Placing Equipment: AS2550.15-1994 that there should be exclusion zones enforced under such equipment.

Lack of Operators and Spotters

40. Mr Hobbs concluded that the absence of an experienced concrete 'acceptor', concrete pump operator, 'safety observer', 'spotter' or 'traffic controller' at the pump hopper gave rise to hazards in relation to concrete truck drivers having to perform this task, in relation to the risk of a person being struck by a truck, unsatisfactory concrete possibly being able to enter the pump and also the risk of concrete that was not to specification being placed in the building structure. While not the primary cause of the incident, these hazards were contrary to 'Guidance Notes' issued by WorkSafe Victoria[11] and applicable Australian Standards.[12]

41. Mr Dugina noted that a traffic controller should have been used to back the concrete trucks up to the pump.[13] This was a breach of the Industry Standard by West Homes and Bushy Park. Mr Dugina also noted that placing an operator on the pump as well as the boom, to monitor the stability and pumping characteristics, could have reduced or eliminated risks relating to inter alia the stabiliser sinking and causing the boom to move downwards and/or sideways;[14] and failure to detect any diminishing boom pump stability at an earlier juncture. This was a failure of the Industry Standard by ICPS and West Homes.[15] Mr Dugina noted that having no one to guide the concrete truck back contravenes the WorkSafe guidance note of 21 March 2001, the purpose of which is to provide guidance on the safe reversal of concrete trucks onto concrete pumps. Mr Dugina also pointed out that the WorkSafe Industry Standard 5.4 requires a worker

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[11] A WorkSafe Victoria 'Guidance Note' dated March 2001 refers to the hazards of concrete trucks reversing to pumps. It suggests that 'wherever possible, the principal contractor and the pumping contractor should plan the concrete pour and schedule deliveries to avoid the need for two trucks to discharge concrete simultaneously…' It also recommends that a 'safety observer' be used to control truck movement and that '… if the safety observer is not available to assist concrete trucks reversing, then only one truck is to be unloaded at a time…'

[12] Clause 4.2(i) of AS2550.15-1994 provides that 'if more than one truck is required to approach the hopper at any one time, a spotter or traffic controller should be on hand to safely direct the movement of the trucks. No person shall stand between the reversing truck and the hopper.'

[13] Mr Dugina stated it was industry practice that this duty belongs to the principal contractor.

[14] Mr Dugina noted that it was industry practice that this duty belongs to the pump operator.

[15] Mr Dugina also noted that it contradicted the Australian Standards AS 2550-15 Part 15 Section 4.2(i) that states if more than one truck is required to approach the hopper at any one time, a spotter or traffic controller should be on hand to safely direct the movement of the trucks. No person shall stand between the reversing truck and the hopper. It is industry practice that this duty belongs to the principal contractor.

to be positioned at the hopper to operate the emergency systems and to control the discharge process. This worker could also monitor the stability of the boom pump.

42. Mr Dugina also stated that as there was no operator on the pump doing a visual inspection of its stability, it is quite possible that the pump and boom had been moving gently forward over the course of the job. In addition, the monitoring of the pump and the boom's stability and pumping characteristics should have been undertaken, especially given the concern raised regarding ground conditions stated to have been raised by Mr Gatto when he arrived on site. Mr Dugina opined that this was a failure by ICPS to observe requirements of the Industry Standard, which requires that outriggers/stabilisers shall be periodically checked for settlement or undue movement.[16] However, Mr Dugina stated that West Homes should have also been vigilant of the manner in which the equipment was being operated.

43. Mr Hobbs agreed that if an experienced concrete pump operator had been stationed at the point of discharge, rather than being located on an upper level of the building, then any signs of issues with settlement of outrigger/stabiliser pads, or lateral displacement of the pump may have been noticed. This may have provided an opportunity to cease pumping and warn personnel to move away before any significant displacement of the unit had taken place.

44. Mr Dugina opined that constant monitoring of the boom's stability must be adhered to, and that this can only be achieved by the operator being on the pump at all times, allowing constant monitoring of the boom's stability and the pumping operation. Mr Dugina also considered that concrete trucks should always be backed up by a competent person if one truck is being discharged, and by dedicated traffic control if two trucks are discharging or at the hopper together. Mr Dugina was concerned that Mr Gatto had questioned the ground conditions, set up there, and then failed to monitor the stability of the boom pump.

Mention Hearing on 29 August 2014

45. On 29 August 2014, a Mention Hearing was held, primarily so as to inform interested parties that a Form 45 application for access to coronial documents had been received by the Court, and to allow them to be heard on this matter. The Form 45 application had been received from Slater and Gordon on behalf of the Construction, Forestry, Mining and Energy Union (CFMEU),[17]

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[16] Specifically, Mr Dugina noted that it is a requirement of the operator to monitor the stability of the boom pump. AS2550.15-1994, 7.5(g) states, outriggers/stabilisers shall be periodically checked for settlement or undue movement, and (h) the operator should carry out periodic visual checks of the equipment.

[17] The Court received this application on 15 August 2014.

who sought access to the coronial brief as well as any documents relating to the decision of the Victorian WorkCover Authority to withdraw charges under 'the Act' against West Homes. Reasons cited for this application were related to the inclusion of circumstances surrounding this incident in the Royal Commission into Trade Union and Governance Corruption ('the Royal Commission').[18] Parties that were legally represented at the hearing were Mrs Kelly, West Homes, the Victorian WorkCover Authority ('the VWA'), and the CFMEU.

46. Mr Guy Gilbert, on behalf of the CFMEU emphasised that the union's interest in this matter, relates to a concern that the circumstances surrounding Mr Kelly's death were inherently dangerous and occur on a daily basis across Victoria. Mr Gilbert related that the Pentridge Village site had been selected by the Royal Commission for investigation. In essence, the CFMEU sought to demonstrate that its entry and role in occupational health and safety issues at the site, following Mr Kelly's death, were warranted. Mr Gilbert suggested that the withdrawal by the VWA of its charges against West Homes and ICPS created an impression that there were no occupational health and safety issues at the site. The CFMEU sought to dispel this perception, inter alia by accessing documents and statements that demonstrated what occurred before, during and after 15 October 2009.

47. Mr Gilbert added that should my investigation in this matter proceed to an Inquest, the CFMEU would seek to be an interested party, to represent the employees' perspective in relation to occupational health and safety issues that arose at the site. I noted that in general terms, a union would not always be an interested party in an industrial death. They may have an interest but they do not always seek leave. Mr Gilbert submitted that an interested party can have a broader role, to be able to pursue the interests of its members in terms of a critical issue that affects them on a day to day basis. Mr Trevor Wraight, on behalf of the VWA noted that many of the CFMEU's issues raised by Mr Gilbert seem to be broader issues that would be covered by the Royal Commission. Mr Wraight suggested that the wider issues on the large site at Pentridge Village did not pertain to the coronial investigation.

48. At the Mention Hearing, I noted that as the charges were withdrawn by the VWA, I considered proceeding to an Inquest in this matter. However, I noted that there now seemed to be some overlap with my investigation and that of the Royal Commission. Mr Gilbert observed that the Royal Commission's terms of reference were not focussing upon industry standards, or

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[18] At the Mention Hearing it was raised that a second Form 45 application was received from Ligeti Partners, on behalf of West Homes to assist with civil proceedings involving claims for damages made by Mrs Kelly. The Court received this application on 11 June 2014.

occupational health and safety. Rather, the Royal Commission was responding to the way the CFMEU entered the site and dealt with employers. However, I considered that the findings of the Royal Commission could be influential in the sense of how broad my own investigation would be, or whether certain findings or recommendations from the Royal Commission may help to contain my own investigation.

49. Following the Mention Hearing, the Court received correspondence from the Royal Commission's General Counsel Bill Steenson on 10 September 2014. Mr Steenson advised that the Commissioner John Dyson Heydon AC QC did not intend to make substantive inquiries into, or findings about the cause of, or circumstances leading to, Mr Kelly's death. However, Mr Steenson did state that the Commissioner had conducted a public hearing in Melbourne on 8 July 2014, in relation to the conduct of the CFMEU and its officers towards representatives of Pentridge Village and West Homes. The Commissioner planned to conduct a further public hearing on 17 September 2014 regarding this matter and had received from the CFMEU a number of unsigned witness statements in response to the evidence provided by directors of Pentridge Village and West Homes on 8 July 2014. The CFMEU witnesses had raised concerns about the incident resulting in the death of Mr Kelly, and the occupational health and safety standards at the site around the time of his death. It was anticipated that CFMEU would seek to cross examine the directors of Pentridge Village and West Homes about occupational health and safety standards at the Pentridge Village site.

50. I considered that material relevant to my investigation might emerge at the Royal Commission. As a result, parties were informed by letter dated 10 September 2014, that I had decided to suspend my investigation until I had reviewed the Royal Commission's findings and recommendations.

Royal Commission into Trade Union and Governance Corruption

51. In a witness statement provided to the Royal Commission, Leigh Chiavaroli, Director of Pentridge Village, and former director of West Homes, acknowledged that the site was not flawless from a safety perspective, and that there were some safety incidents on site: 'the site was not free from defect with respect to safety'.[19] Mr Chiavaroli also stated that immediately after the death of Mr Kelly, West Homes and Pentridge Village had reviewed its safety processes and procedures.

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[19] Witness Statement from Leigh Adrian Chiavaroli, dated 7 July 2014, pge 20

52. The transcript from the Royal Commission's public hearing on 17 September 2014 included reference by Counsel for the CFMEU, John Agius SC, to a lack of clarity regarding the circumstances in which the VWA determined not to proceed with the prosecution against West Homes. Mr Agius SC spoke of there being no way to test the general statement that the decision not to prosecute was a result of 'insufficient evidence' and whether or not the prosecution was aborted because of 'some technical defence'.[20]

53. I note that Mr Agius SC submitted at the hearing that WorkCover had issued over 40 notices in respect of faults that it found at the Pentridge Village site following its inspection after the death of Mr Kelly.[21] In his witness statement, Mr Chiavaroli had noted that West Homes was issued with a number of improvement and prohibition notices by VWA and had complied with all of them, and where required, remedied the matters in the notices.

54. The Commissioner handed his Interim Report to the Governor General on 15 December 2014, and it was tabled in Parliament on 19 December 2014. 'The Pentridge Village Site' was included as a case study in Volume 2 of the Interim Report.[22]

55. The outline of the findings, included that 'the circumstances surrounding and the causes of that fatality are not within the Terms of Reference' of the Royal Commission.[23] Furthermore, it was noted that as a coronial inquiry was on foot, it was not appropriate to deal further with the cause and circumstances surrounding Mr Kelly's death.

56. However, I do note that the Interim Report did cover discussions between a CFMEU representative and a director of Pentridge Village in January and March 2009. These discussions included a suggestion by the CFMEU representative that Pentridge Village needed help from the CFMEU to look after the workers on site. It was noted that an occupational health and safety consultant had been engaged to conduct audits on the site since October 2000, and a full time occupational health and safety officer had been employed at Pentridge Village. Between an occupational health and safety site inspection on 16 March 2009, in which the CFMEU representative said to the Pentridge Village director that everything was okay, and 15 October

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[20] Public Hearing Pentridge Village / Andrew Zaf, Royal Commission into Trade Union Governance and Corruption Transcript, 17 September 2014, @ pge 7

[21] Public Hearing Pentridge Village / Andrew Zaf, Royal Commission into Trade Union Governance and Corruption Transcript, 17 September 2014, @ pges 6-7

[22] Chapter 8.10, 'The Pentridge Village Site', Interim Report, Royal Commission into Trade Union and Governance Corruption, pge 1527

[23] Interim Report, Royal Commission into Trade Union and Governance Corruption, pge 1532

2009, there were no more phone calls or visits from the CFMEU. It was also noted that during a meeting on the day of the incident, the CFMEU representative criticised the occupational health and safety staff that West Homes had engaged on the Pentridge site.

57. The Royal Commission into Trade Union and Governance Corruption, via amended Letters Patent dated 30 October 2014, had a revised final report date of 31 December 2015. The final report did not make reference to the Pentridge Village site or the circumstances surrounding Mr Kelly's death.

Mention Hearing on 25 May 2016

58. I held a second Mention Hearing on 25 May 2016, in order to advance my conclusion in this matter following the delivery of the Royal Commission's final report and enable any outstanding issues to be raised. In the interests of natural justice, I also sought to raise adverse comments that I was planning to make in relation to the circumstances surrounding Mr Kelly's death. Parties that were legally represented at this hearing were Mrs Kelly, the VWA, and the CFMEU.

59. A request was made on behalf of the CFMEU to access the relevant ICPS Job Safety Analysis as well as the expert reports of Mr Hobbs and Mr Dugina. VWA opposed the release of these documents through the coronial jurisdiction and requested that the CFMEU instead be advised to direct a Freedom of Information request to them. The CFMEU also sought to make submissions in relation to material within the WorkSafe brief. I noted that the CFMEU did not have interested party status, and that the issues raised, for example the lack of specificity used in Job Safety Analyses, appeared to span beyond the scope of my investigation. I determined not to release the documents prior to the delivery of this Finding. I also advised that I was equipped with sufficient information to finalise my investigation.

60. A request was made on behalf of Mr Kelly's family to adjourn the coronial investigation in light of the fact that four civil proceedings were on foot. I was told that the family sought to know the outcome of mediation set for June 2016, before deciding whether or not to formally request an Inquest. I advised that the role of the Coroner is not to tie in with civil claims, and I did not consider it appropriate to delay my investigation any further. However, I did convey that I would consider the application for adjournment. Following the Mention Hearing I determined to proceed with finalising my investigation, as I was not convinced that suspending the matter to await the outcome of civil mediation was appropriate in the circumstances.

COMMENTS

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

1. It is regrettable that so much time has passed between Mr Kelly's death on 15 October 2009, and the delivery of this Finding. As Mr Kelly's death was the subject of investigations by Victoria Police and WorkSafe, and considered in a Royal Commission, it was appropriate to await the outcomes of these matters prior to finalising my coronial investigation.
2. It is not the role of the Coroner to conduct a wide-ranging, broad investigation that goes beyond matters that pertain to the relevant death.[24] To the extent that the CFMEU detailed extensive occupational health and safety issues with the Pentridge Village site at the Royal Commission, including the more than 40 WorkSafe notices issued regarding faults on site, and problems with employees responsible for occupational health and safety, these issues speak to broader concerns that pertain to matters beyond the scope of my investigation. While Mr Agius SC did raise the concern of to what extent were the two nominated health and safety representatives on site responsible for not raising known pump truck dangers with the pump truck driver, I view that these issues can be dealt with through recourse to more systemic failures relating to the use of the equipment, as opposed to the conduct of individuals. Issues raised by the CFMEU at the Mention Hearing on 29 August 2014, in relation to the wider misuse of concrete pumping trucks across Victoria, can be considered in reference to the equipment in the instant matter. In addition, I consider that issues raised at the Mention Hearing on 25 May 2016, in relation to Job Safety Analyses, qualifications of spotters, and issues with concrete pumps contacting with overhead power lines in the absence of a spotter, are beyond the scope of my investigation.
3. Moreover, while I remain unclear as to the specific reasons that prompted WorkSafe to withdraw its charges against West Homes and ICPS in August 2012, I would not expect that taking this matter to Inquest would enlighten me with respect to why the prosecution was so abruptly halted. Given the passage of time since Mr Kelly's death, the evidence before me is sufficiently comprehensive to connote that significant problems existed in the usage of the Daf 85.430 concrete pumping truck.

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[24] In *Harmsworth v State Coroner* [1989] VR 989 at 996, it was held that 'the power to comment, arises as a consequence of the obligation to make findings… It is not free-ranging. It must be comment 'on any matter connected with the death'. The powers to comment and also to make recommendations… are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings.'

4. With a weight of 42.5 tonnes, and with a boom reaching approximately 48 metres, it was reasonable to expect that appropriate occupational health and safety measures would be observed in relation to the concrete pumping truck. It remains unclear to me why such a large piece of plant was permitted to operate on ground conditions that were unknown and untested. As a result, none of the outrigger/stabiliser pads were provided with adequate packing or engineered 'bog mats' to safely spread the load of the concrete pumping truck to the ground. This was a large oversight, in the context of the size of the plant and the large number of workers operating in close vicinity. I note that ICPS' Job Safety Analysis and West Homes' Site Induction both failed to place specific emphasis on site based risks including outrigger/stabiliser loads likely to be imposed by such a large unit, or the capacity of the ground to support those loads.

5. In addition, the absence of a traffic controller, concrete pump operator, or spotter located proximate to the concrete pumping truck gave rise to a number of hazards. Leaving aside the issues relating to traffic control and the safety of truck drivers delivering the concrete to the pumping truck, the lack of an operator meant that opportunities were missed to prevent the incident. Placing an operator on the pump as well as the boom, to monitor the stability and pumping characteristics, could have reduced or eliminated the risks relating to the passenger side stabiliser sinking and causing the truck to tip and the boom to move, by providing an opportunity to detect any instability and intervene at an earlier junction.

6. By letter dated 5 February 2013, WorkSafe advised the Court of preventative measures that had been implemented in relation to concrete pumping and specifically, following Mr Kelly's death. Prior to the incident, WorkSafe had released its Industry Standard for Concrete Pumping in April 2004. In 2006, WorkSafe undertook a concrete pump project where 108 pumps were audited for compliance with occupational health and safety requirements. In 2010, a local initiative was instigated after WorkSafe received information that a number of defective concrete pumps were being used in the Pakenham/ Cranbourne area. Specifically, in response to Mr Kelly's death, WorkSafe issued a media release highlighting the risk associated with the use of concrete pumping units, which led to a related article in 'The Age' newspaper. While these initiatives are commendable, I note that more than a decade has passed since the 2004 release of the Industry Standard and that a renewed and proactive promotion of the dangers inherent to the use of these plant is warranted.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. Unfortunately, I am unable to direct recommendations to the relevant interested parties Bushy Park Concreting Pty Ltd, Improved Concrete Pumping Services Pty Ltd, or West Homes Pty Ltd because I have been informed that since Mr Kelly's death they have each been placed in liquidation.[25] If this were not their current legal status, I would have recommended they each implement a policy that where the use of a concrete pumping truck is anticipated, a trained 'spotter' always be available to assist in the direct vicinity of the truck, if they have not already done so. Nevertheless, this does not detract from the need for improved legislation and regulation relating to the use of appropriate staffing, or availability of a 'trained spotter' on construction sites.

2. In the Finding into Death Without Inquest following the investigation into the workplace death of Gregory Andrews,[26] delivered on 20 April 2016, I recommended that the Minister for Finance, who is also responsible for WorkSafe, the Hon Robin Scott MP, consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter to sections 27, 29 and 30 of the *Occupational Health and Safety Act 2004*, in relation to the use of plant. Mr Kelly's death in the absence of a proximate spotter again emphasises this deficiency in workplace safety and **I reiterate the following recommendations** I made in the Finding into Death Without Inquest in the matter of Gregory Andrews:

    a. In the interests of emphasising the importance of avoiding the unsafe understaffing of heavy machinery, **I recommend** that the Minister for Finance, who is also responsible for WorkSafe, the Hon Robin Scott MP, consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 27 of the *Occupational Health and Safety Act 2004*, which requires

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[25] I note that as per notices published by Australian Securities and Investment Commission, Bushy Park Concreting Pty Ltd and Improved Concrete Pumping Services Pty Ltd have been placed in liquidation. See: https://insolvencynotices.asic.gov.au/browsesearch-notices?appointment=All¬icepurpose=All&companyname=bushy%20park%20concreting%20pty%20ltd¬icestate=All&archvd=0 and https://insolvencynotices.asic.gov.au/browsesearch-notices?appointment=All¬icepurpose=All&companyname=Improved%20Concrete%20Pumping%20Services¬icestate=All&archvd=0 accessed 16 June 2016. I also note that the Beton Pumping Group's website states that it acquired Improved Concrete Pumping Services Melbourne Pty Ltd in November 2014. See: http://www.betonpumping.com.au/about-beton.html accessed 16 June 2016. I further note conversations held between Paul Pratt, Ligetti Partners and the Court on 16 June 2016 in relation to West Homes Pty Ltd. Mr Pratt advised the Court that West Homes Pty Ltd had been placed in liquidation.

[26] COR 2009 4550

that 'a person who designs plant who knows... that the plant... is to be used at a workplace must' inter alia 'give adequate information to each person to whom the designer gives the design... concerning -... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was designed.'

b. **And I further recommend** that the Minister for Finance, who is also responsible for WorkSafe, the Hon Robin Scott MP, consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 29 of the *Occupational Health and Safety Act 2004*, which requires that 'a person who manufactures plant who knows... that the plant... is to be used at a workplace must' inter alia 'give adequate information to each person to whom the manufacturer provides the plant... concerning -... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was manufactured.'

c. **And I further recommend** that the Minister for Finance, who is also responsible for WorkSafe, the Hon Robin Scott MP, consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 30 of the *Occupational Health and Safety Act 2004*, which requires that 'a person who supplies plant who knows... that the plant... is to be used at a workplace... must' inter alia 'give adequate information to each person to whom the supplier supplies the plant... concerning -... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was designed, manufactured or supplied.'

3. With the aim of increasing awareness about the dangers of working with heavy hydraulic machinery, **I recommend** that WorkSafe issue Safety Alerts on a regular and periodic basis, and not only in response to a fatality; on the dangers of operating concrete pumping trucks, including recommendations that a spotter always be available.

FINDINGS

The circumstances of Mr Kelly's death serve as a tragic reminder of the inherent dangers associated with the use of large pieces of plant, and the importance of observing and adhering to extensive occupational health and safety protocols in relation to their operation.

I have been unable to identify a single isolated factor that has contributed to the relevant events and circumstances. Rather, the lack of a spotter proximate to the concrete pumping truck; unknown and untested ground conditions; inadequate packing or engineered bog mats for outrigger/stabiliser pads; and the fact that Mr Kelly appears to have been working under the boom in what should have been an exclusion zone, have all existed in an unsatisfactory and pervasive culture of permitting unnecessary risk and unsafe conditions that ultimately led to Mr Kelly's death.

It is not the role of the Coroner to lay or apportion blame, but to make findings of fact. Having identified systemic problems that are consistent with a culture of failing to adhere to appropriate standards, such findings are sufficient to discharge my statutory obligations.

On the evidence available to me, I find that Mr Kelly died at his workplace, while acting in the course of his employment, in circumstances that were largely preventable.

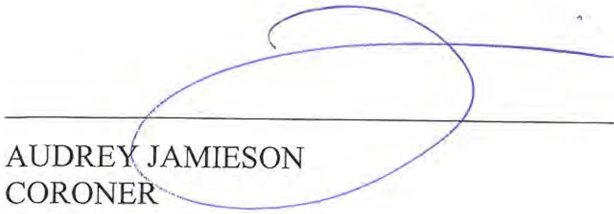
I accept and adopt the medical cause of death as identified by Associate Professor David Ranson and find that Thomas Anthony Kelly died from a head injury.

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 Nada Kelly
Mrs Karen Lucev
Defteros Lawyers on behalf of Nada Kelly
Mr Paul Pratt, Ligetti Partners on behalf of West Homes Australia Pty Ltd
Beton Pumping Group, acquirers of Improved Concrete Pumping Services Pty Ltd
Ms Mai Pham, Victorian WorkCover Authority (WorkSafe)
Mr Marcus Clayton, Slater & Gordon Lawyers, on behalf of the Construction, Forestry, Mining and Energy Union
Ms Catherine Belcher, Herbert Geer (now Thomson Geer) on behalf of WorkSafe
Mr Paul Ricco, Wisewould Mahony Lawyers, on behalf of WorkSafe
Mr Steven Matheson, Transport Accident Commission
Sergeant Julie MacDonald

Signature:



AUDREY JAMIESON
CORONER

Date: **16 June 2016**