IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002573

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Sanel Mujezinovic
Date of birth:	23 December 1980
Date of death:	17 May 2021
Cause of death:	1a: Multiple injuries sustained in a workplace incident
Place of death:	Cahill Street & Gratz Street St Albans Victoria 3021

INTRODUCTION

1. On 17 May 2021, Sanel Mujezinovic was 40 years old when he died during the course of his employment, having been struck by a large piece of equipment that catastrophically failed. At the time of his death, Sanel lived in Bundoora with his partner Leisa.

2. Sanel is survived by his son, Levi, with his ex-partner Brighid.

3. Sanel was a concreter by trade and had worked in the industry for over 20 years. At the time of his death, he was employed as a concrete pump operator for Prisbel Concrete Pumping Pty Ltd (**Prisbel**) and had done so for approximately five years. His supervisor, Damon Papadopoulos, stated that Sanel was one of the *top 10* concrete pump operators in Melbourne.

4. According to Brighid, Sanel was extremely safety conscious. He would not hesitate to turn down a job if it was unsafe and was known to visit work sites during the night prior to attending a job to check whether the site was safe. Sanel had been present when a colleague, Thomas Kelly, was killed having been struck by a concrete boom in 2009[1].

Prisbel

5. At the time of Sanel's death, Prisbel had five concrete pumping trucks, each operated by a driver who was licensed and qualified to do so.

6. Each concrete pumping truck underwent daily, monthly and yearly inspections. The daily and monthly inspections were in the form of a checklist completed by the pump operator. The yearly inspection was conducted by a "competent person" (an engineer). I will discuss the yearly inspection requirements further below.

THE CORONIAL INVESTIGATION

7. Sanel'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.

8. 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

[1] Coroners Court of Victoria case number COR 2009 004900 refers.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. 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.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Sanel's death. The Coronial 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.

11. This finding draws on the totality of the coronial investigation into the death of Sanel Mujezinovic including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

12. Prisbel were contracted by ProCon Civil Melbourne to pour concrete for a laneway at a townhouse development in St Albans.

13. At around 6:30am on 17 May 2021, Sanel attended at the job site at McKechnie Street. He was operating a concrete pumping truck, being a Nissan diesel truck equipped with a 32 metre Schwing GMBH concrete boom pump, model KVM32/28-125. The concrete pump had been manufactured in 1990 and was purchased by Prisbel in April 2010.

[2] 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.

Photo of pumping truck taken during 2018 annual inspection.

14. Sanel's role was to control the rate of concrete being poured by using a remote control that moved the boom and guided the concrete to the correct position. Other workers on site levelled the concrete as he did so.

15. The job required around 70 cubic metres of concrete, which was expected to take around five hours to pour. He was the only concrete pumper working. He began pumping the concrete at around 7:30am.

16. At around 11:34am, Sanel was pumping the last load of concrete. He stood in the concrete slab, underneath the extended boom. Suddenly, the boom collapsed, striking Sanel to the back of the head and causing him to fall face first into the concrete.

17. Other workers at the scene immediately rendered assistance to Sanel and called Triple Zero. Sadly, Sanel was declared deceased at the scene by attending paramedics.

Identity of the deceased

18. On 17 May 2021, Sanel Mujezinovic, born 23 December 1980, was visually identified by his supervisor Damon Papadopoulos, who completed a Statement of Identification.

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

Medical cause of death

20. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Sanel Mujezinovic on 18 May

2021. Dr Archer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log and scene photographs and provided a written report of her findings dated 22 July 2021.

21. Examination of the post mortem CT scan showed a right occipital fracture with pneumocephalus (air around the brain). There were several fractures including of the right mid fibula, multiple rib fractures and the vertebral bodies of the 12th thoracic and 3rd lumbar vertebrae. There was right pneumothorax and traumatic pneumatoceles.

22. The external examination showed an abrasion of the chest, and a laceration to the back of the head.

23. Dr Archer commented that the injuries were of a nature that would have caused rapid unconsciousness and death. The injuries were indicative of an incident involving significant force.

24. Toxicological analysis of post mortem blood and urine samples identified the presence of methylamphetamine and metabolites, cocaine metabolites, MDMA, cannabis metabolites, olanzapine and paracetamol.

25. Dr Archer provided an opinion that the medical cause of death was 1(a) MULTIPLE INJURIES SUSTAINED IN A WORKPLACE INCIDENT.

FURTHER INVESTIGATIONS

Investigation by WorkSafe Victoria

26. Following Sanel's death, WorkSafe Victoria (**WorkSafe**) conducted an independent investigation into the incident.

27. The investigation identified that the boom's collapse was due to a metal fatigue crack in the king post. The king post is an internal component of the turret assembly at the base of the concrete boom, which connects the boom to the truck. The king post is a steel cylinder that

holds the boom upright and enables the boom to rotate (or slew), supporting its weight as concrete is pumped through the boom.

Photo of the snapped king post taken following its collapse.

Expert opinions

28. Subject matter expert, investigation engineer Barry Gartner, opined that the fatigue cracking probably took several years to develop before a crack had initiated. He considered that the presence of the fatigue cracking would have been detectable possibly months before the final fracture, and the slow propagation primary fatigue crack zones may have been detectable for a year or more. However, the ability to detect those primary cracks would require accessibility to the king post.

29. The concrete pump was subject to annual inspections. None of those inspections involved the disassembly of the unit to enable the inspection of the king post. The concrete pump was 20 years old when it was acquired by Prisbel in 2010. In accordance with Australian Standard AS2550.15-1994, it should have been subject to a 'major inspection' that included the pump being stripped down to enable non-destructive testing of core components including the king post. No 'major inspection' had ever been conducted.

30. Expert engineer John Hambridge was asked by WorkSafe to provide an opinion on the failure mechanism leading to the incident. He provided an opinion that *given the age, the*

indeterminate origins of the unit and the unknown usage or hours worked this unit should have had the column (king post) removed and inspected.

Outcome of investigation

31. A prosecution was commenced against Prisbel who subsequently pleaded guilty to a single charge of failing to provide a safe work environment under sections 21(1) and (2)(a) of the *Occupational Health and Safety Act 2004.* On 21 May 2025, Prisbel was convicted in the Magistrates' Court of Victoria and fined $50,000.

32. Following the prosecution, the Court was provided with a copy of the WorkSafe brief of evidence.

Coronial investigation

33. It was apparent that had the concrete pump been subject to a thorough 'strip down' inspection, the fatigue cracking may have been identified and the fatal incident averted.

34. Coronial Investigator Senior Constable (**S/C**) Jonathan Tipas compiled a coronial brief of evidence. In his summary of the incident, he concluded the following:

> *The Coronial Investigator recommends a review of the current Codes of Practices and Australian Standards in relation to concrete moving equipment and a suggestion that equipment either at a certain age or hour metre be subject to yearly inspections that MUST include a full strip down and examination of internal components as previously required in the AS 2550.15-1994.*

Inspection requirements

35. Australian Standard 2550.15-1994, "Cranes - Safe use - Part 15: Concrete Placing equipment" (**1994 Standard**), referred to by S/C Tipas, required the following:

> ***8.3 MAINTENANCE, INSPECTION AND RECORDS***
>
> *The requirements of the maintenance, inspection and assessment for the continued service of concrete placing equipment shall be in accordance with AS 2550.1 and conducted in accordance with the following hierarchy:*
>
> *(a) Pre-operational inspection.*
>
> *(b) Routine maintenance inspections.*
>
> *(c) Annual inspections.*

(d) Assessment of suitability for continued service.

36. Subsection (d), assessment of suitability for continued service, requires *major inspection by a competent person, after a maximum of six years of service and at intervals thereafter as recommended by the competent person. The purpose of the inspection is to assess the suitability of the equipment for continued service.*

37. What constitutes a 'major inspection' is later clarified and includes *the stripping of critical components of the concrete placing equipment so as to allow a complete and thorough inspection.*

38. Australian Standard 2550.15-2019, "Cranes, hoists and winches - Safe use - Part 15: Concrete Placing equipment" (**2019 Standard**) was published on 21 January 2019, replacing the 1994 Standard.

39. The 2019 Standard requires:

> ***6.4.1 General***
>
> *The requirements for inspection, assessment and maintenance for continued service of concrete placing equipment shall be conducted in accordance with the following:*
>
> *(a) Pre-operational inspections (each use).*
>
> *(b) Routine inspections and maintenance (monthly).*
>
> *(c) Periodic inspections.*

40. As this excerpt shows, the annual inspection and the assessment of suitability for continued service (often referred to as the major inspection) in the 1994 Standard have now been rolled into a single periodic inspection in the 2019 Standard. Periodic inspections are required to be carried out at intervals specified in section 6.4.4.2 of the 2019 Standard, which are determined by the age of the equipment. For example, equipment up to five years old shall be inspected once every 1000 operating hours but not less than once per year; and equipment more than ten years old shall be inspected once every 250 operating hours but not less than once per year. Defining periodic inspections by a combination of operating hours and time period is somewhat complex, which might be the reason why people (including witnesses in the WorkSafe investigation) refer to the periodic inspection under the 2019 Standard as an annual or yearly inspection when technically it is not.

41. Section 6.4.4.1 sets out the requirements for a periodic inspection and includes:

Completing the periodic inspection report (see Appendix B) of all critical components and systems, and as required, examination of the condition of the components and equipment with regard to the formation of cracks, damage, wear, corrosion and other changes. Where required, critical components and elements of the equipment will need to be disassembled for thorough examination, including Non-Destructive Testing (NDT) as directed by a competent person.

42. In short, the 1994 Standard required a major/strip down inspection when conducting an assessment of suitability for continued service, whereas such an inspection is only required under the 2019 Standard <u>if directed by a competent person.</u> Effectively, the competent person now has broad discretion to determine the maintenance program for pumping equipment.

<u>Inspection of Prisbel's concrete pump</u>

43. Until 2019, Prisbel engaged Transport Certification Services to conduct inspections of their concrete pumping trucks, including that involved in the fatal incident. Managing Director Jarrod Thompson confirmed that his firm had only undertaken annual inspections, and that Prisbel had not requested they perform major inspections or strip down inspections.

44. It is unclear why Prisbel did not conduct major inspections of their concrete pumping trucks. It is clear they knew of the requirement. A Plant Hazard and Risk Assessment Worksheet for the truck in question, completed on 7 May 2021, ten days prior to the fatal incident, listed *yearly and 6 yearly major inspections are performed according to manufacturer's recommendations* as a control currently in place to prevent crush or trap hazards.

45. From 2019, inspections were conducted by Andrew Baigent of Andrew Baigent Consulting Engineers. Dr Baigent issued two Annual Inspection Certificates, dated 21 October 2019 and 24 October 2020.

46. My investigation focussed on the inspections conducted by Dr Baigent, given their proximity to the fatal incident. As there was no statement from Dr Baigent in either the coronial or WorkSafe briefs of evidence, the Court sought statements so as to understand:

    a) The nature of the inspections undertaken;

    b) How Dr Baigent determined that no major inspection was required on either occasion; and

c) Whether it would be possible to tell if the king post cylinder was cracked, through an external inspection.

47. Dr Baigent provided a statement dated 25 August 2025, and a subsequent statement dated 3 January 2026.

Nature of the inspections

48. Dr Baigent advised that he carried out a visual in-person inspection of the concrete placing boom before issuing the Annual Inspection Certificates dated 21 October 2019 and 24 October 2020. On each occasion, the inspection included, *inter alia*:

a) Visual inspection of the unit to determine no damage was present.

b) A functional test of the unit, which included folding and unfolding the boom, slewing (rotating) the boom and luffing (raising and lowering) the boom.

c) Visual inspection of welds, boom pivot points and brackets.

d) Visual inspection of boom rest points, concrete receival hopper and other components.

e) Inspection of log book and previous inspection reports.

Inspection of the king post cylinder

49. Dr Baigent stated:

> *From my observations that the king post was not exhibiting any excessive movement, and from my examination confirming that the visible welds around the king post were satisfactory, I concluded that the king post was structurally satisfactory. Certainly, if there were issues associated with excessive movement or weld deterioration, I would have requested that the unit be taken to a workshop and that the boom be removed so that a further detailed examination of the king post could be carried out. This is precisely the course of action I prescribe when these issues are observed.*

50. He further stated that *a competent person would only require the king post to be removed if excessive of visible weld deterioration was present.*

51. He reiterated this by stating:

In my now more than 30 years of experience with truck-mounted concrete placing booms with king posts, I am unaware of any other failures around the world similar to the failure which occurred in this incident. Therefore, provided that the king post was not exhibiting excessive movement and taking into consideration that the manufacturer does not require the king post to be removed for periodic examination, I would not require the king post to be removed from the chassis.

Was it possible to identify the cracked king post cylinder?

52. Dr Baigent stated that he would not be able to identity a cracked king post cylinder from an external visual inspection. He explained:

> *Unless the king post was not exhibiting excessive deformation, I would be confident that the king post was satisfactory and would not require an external in-person inspection. However, in should be noted that if there were concerns with the structural integrity of the king post, an external in-person inspection by a competent person might not discover that any cracking was present. In my view, non-destructive testing by a NATA registered material testing expert would be required to determine whether the king post was free of any cracking.*

53. Having read Dr Baigent's statement, I sought to clarify his answer as to whether it was possible to identify the cracked king post cylinder on the basis of the inspection and tests he conducted on 24 October 2020.

54. Dr Baigent clarified that it would not be possible to determine that the king post cylinder was structurally unsatisfactory on the basis of the inspection and tests carried out prior to his issuing of an Annual Inspection Certificate. Based on his observations and function testing, given there was no indication of damage, it was reasonable to assume the king post was satisfactory.

55. Dr Baigent explained the difference between an Annual Inspection Certificate and Major Inspection Certificate, stating:

> *In order to issue a Major Inspection Certificate, the Competent Person supervising the inspection would need to be satisfied that the king post was structurally satisfactory. Therefore, despite the manufacturer not requiring the king post to be removed at any time during the service life of the unit, the Competent Person should have it removed so that the bushes and slewing teeth could be visually examined. By removing the king post from*

the chassis, there would then be the opportunity to visually examine it also. From my experience, I have never observed any cracking in a king post once it had been removed from the chassis at the time of a Major Inspection.

56. Based on his experience with metallurgy and metal fatigue, Dr Baigent considered:

> *[…] it is very likely that the king post for this particular concrete placing boom was not structurally satisfactory when I issued my Annual Inspection Certificate on 24 October 2020. However, based on the standard procedures associated with the observations and testing required for the issuing of an Annual Inspection Certificate, it gave the outward appearance that it was satisfactory. Indeed, there was no evidence of excessive movement or any other issue associated with the king post which would have given me the slightest indication that it was cracked and nearing the end of its service life.*
>
> *There was also no requirement for the king post to be removed at the time of me issuing the Annual Inspection Certificate. As I have discussed above, I would have expected that the king post would have been removed, and inspected and tested, at the time of the Major Inspection. It is unlikely, in my opinion, that the cracking of the king post could have developed to the catastrophic level that it did in the time following its last Major Inspection. Therefore, it is my opinion that the king post was almost certainly exhibiting some sign of cracking at the time of the Major Inspection.*

57. In providing this detailed explanation, Dr Baigent appeared to be under the impression that a Major Inspection had been carried out on the boom some time in the past. However, as already noted, the WorkSafe Investigation established that no such Major Inspection had been conducted in the time Prisbel owned the boom.

58. I note that Dr Baigent conducted inspections on an annual basis. Both Annual Inspection Certificates issued included the notation *"The next annual inspection is due in twelve months from the date of this certificate."*

59. This appears to be at odds with the requirements in the 2019 Standard, which replaced annual inspections with periodic inspections. The periodic inspection requirements are based primarily on hours of operation. The concrete placing boom involved in this incident was more than 10 years old, so it was required to undergo periodic inspection every 250 hours but not less than once per year.

60. The reason I determined not to pursue this line of investigation is that it is not known how many hours per year the concrete pump was operating. The pump's hour meter registering hours of operation was malfunctioning during 2019 and 2020 and did not record operational hours. WorkSafe expert John Hambridge noted that the hour metre reading recorded on Dr Baigent's two Annual Inspection Certificates was the same: 12878 hours. In the absence of clear evidence about the hours of operation time, I cannot establish whether the concrete pump was being operated for more than 250 hours per year and therefore should have required more frequent periodic inspections.

ADDITIONAL INQUIRIES

61. I am very grateful for Dr Baigent's assistance in this matter. His detailed explanation of the inspections he undertook, which revealed no signs that the king post was cracking and at risk of catastrophic collapse, brought into sharp relief the issues surrounding Sanel's death.

62. In particular, Dr Baigent's statements highlight a 'Catch 22' of sorts in the practical application of the 2019 Standard, which was the relevant Australian Standard in place to guide safety inspections of concrete placing equipment when Dr Baigent conducted his periodic inspections of the concrete boom in both October 2019 and October 2020.

63. Under the 2019 Standard, as already explained above, the distinction (in the 1994 Standard) between annual inspections and major inspections was removed and replaced by a single requirement for a periodic inspection conducted at least once per year (or more often depending on operating hours and the age of the equipment). In undertaking a periodic inspection, a competent person can direct for the equipment to be disassembled for thorough examination of internal components such as the king post (akin to the major inspection in the 1994 Standard), but there is no requirement for strip-down and disassembly to inspect internal components other than at the competent person's direction.

64. In this case, Dr Baigent as the competent person (and as a highly experienced engineer) conducted the periodic inspections and did not direct for the concrete pump to be disassembled and the king post to be examined because it was not showing any signs that this was required. However, the fatigue cracking that resulted in the catastrophic failure could only have been detected for certain if the concrete pump was disassembled. As Dr Baigent explained:

> *All structures which suffer a catastrophic failure are able to sustain load until their strength deteriorates through fatigue or other structural deterioration, resulting in*

instantaneous collapse. Therefore, while the structure can give the appearance that it is structurally satisfactory, failure can unexpectedly occur.

65. The 2019 Standard thus would appear to support a circular logic of sorts – the king post's integrity can be compromised through fatigue cracking without showing any outward signs of compromise, and therefore disassembly is required to test whether the king post is compromised, however disassembly is only directed by the competent person if the periodic inspection reveals outward signs the king post integrity may be compromised – which might mitigate against the 2019 Standard's purpose of ensuring concrete placing equipment is operated in a safe manner.

66. My criticism here is not directed at Dr Baigent, who on all the evidence before me conducted his October 2019 and October 2020 inspections of the concrete boom consistently with the requirements of the 2019 Standard. Rather, my criticism is directed at the 2019 Standard itself, which may not be up to the task of uncovering issues with critical internal components such as the king post before they catastrophically fail.

67. In reviewing the WorkSafe brief for the Prisbel prosecution, I noted that several witnesses discussed the differences in inspection requirements between the 1994 and 2019 Standards in Victoria, and some witnesses mentioned that certain jurisdictions (namely New South Wales, Queensland and Western Australia) may have requirements for major strip down inspections, additional to the inspection requirements described in the 2019 Standard.

68. In concluding my investigation, I directed the Coroners Prevention Unit[3] contact the workplace safety regulators in New South Wales, Queensland and Western Australia, on my behalf, to check whether their strip down requirements for inspecting concrete pouring equipment equipment were in fact different to what is required in the 2019 Standard.

69. I was pleased to receive a response from Tim Hulme, Assistant State Inspector for Engineering at SafeWork NSW. Mr Hulme confirmed that in NSW the inspection requirements for concrete placing booms are those described in the 2019 Standard.

70. I was pleased to receive a response from Shahid Khan, Senior Inspector Engineer in the WorkSafe Division of the Western Australia Department of Local Government, Industry

[3] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

Regulation and Safety. Mr Khan provided a link to the WorkSafe Western Australia concrete pumping web page[4] which describes maintenance, inspection and testing requirements that appear to be consistent with the 2019 Standard.

71. Finally, I was pleased to receive a response from Stuart Davis, the Chief Adviser (Construction Engineering) in the Engineering Unit at Workplace Health and Safety Queensland. Mr Davis explained that under the Workplace Health and Safety Queensland *Concrete Pumping Code of Practice 2019* there is still a requirement for a major inspection to be carried out every six years. The *Code of Practice* specifies:

> *The major inspection is to be a comprehensive inspection that includes dismantling all high stress areas and components subject to wear, unless considered unnecessary by the certifying engineer, including those areas that normally cannot be readily accessed during periodical inspections.*[5]

72. As dismantling equipment is not mandated to occur during the major inspection (it can be skipped if "considered unnecessary by the certifying engineer", noting the "certifying engineer" appears to be the equivalent of the competent person in the 2019 Standard), the Concrete Pumping Code of Practice 2019 appears to be very similar to the 2019 Standard. However, an important difference is that the *Code of Practice* provides very clear guidance on the circumstances under which dismantling the plant may not be required:

> *Under limited circumstances where the plant has had minimal use and has no adverse effects from its storage (e.g. has been stored indoors), the certifying engineer overseeing the major inspection may decide not to dismantle parts of the plant. When making this decision the certifying engineer is to base the decision on factors including the following:*
>
> - *the design life of the plant, where this is available for the manufacturer*
> - *a function test and load test to verify the unit is operating in accordance with manufacturer's specifications and all limits are functioning (e.g. boom rest, stowage, slew, boom fold/unfold)*
> - *the certifying engineer has a comprehensive knowledge of the specific make and model of plant - such that the engineer is aware of where cracks and wear are likely*

[4] https://www.worksafe.wa.gov.au/concrete-pumping.
[5] Workplace Health and Safety Queensland, *Concrete Pumping Code of Practice 2019, PN12522, p.48 <https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0019/18127/concrete-pumping-cop-2019.pdf>*.

to occur and uses this knowledge to decide which parts of the plant do not require dismantling. This should be backed up by documentary evidence (e.g. previous case studies including photographs)

- *documentation on the working history of the plant that details the operating frequency and duration. This information should be derived from detailed log books and maintenance records kept for the life of the plant and not be based on statements from the boom owner that the boom has had minimal use (note: some of the more sophisticated units may be fitted with data loggers that can supply some of the use information)*

- *tolerance checking of critical connections (i.e. those where failure of the connection could result in collapse or overturning of the plant) to check these are within the manufacturer's specifications. Where the manufacturer specifies quantitative tolerances, the tolerances should be measured quantitatively and recorded within the inspection report.*

- *visual verification and/or testing, by the certifying engineer, that the plant is in good condition, after the plant has been cleaned, outriggers deployed, and the boom unfolded. This visual inspection should identify the absence of cracks, corrosion and damage to the plant. Where cracks exist and corrosion (other than surface corrosion) exist, it would be difficult for the certifying engineer to justify not dismantling the unit*

- *in the case of mobile concrete placing booms, the absence of damage or metal fatigue on the plant from road travel (i.e. even though a limited quantity of concrete has been pumped the unit may be showing signs of wear and damage from road travel – this may apply more to units operated in rural locations)*

- *any information from the boom manufacturer that may affect the decision on whether the unit is dismantled (e.g Has there been a safety recall on the unit that highlights failure and/or increased wear of critical components?)*

- *verifiable documentary evidence that a particular part of the plant has been dismantled and re-assembled to an acceptable standard recently (refer section "When can the engineer decide not to dismantle a component" above)*

- *full documented history of any minor or major repairs and modifications that have been carried on the concrete placing boom or support structure (photographic evidence and repair method statements should remain with plant for future reference).*

Where the certifying engineer has determined that dismantling of the plant is unnecessary, inspection criteria should be developed by the engineer that includes any conditions associated with the ongoing safe use of the unit. For example, the engineer may specify more frequent inspection intervals or may state that the unit requires dismantling within a period of less than six years.

73. Furthermore, upon finalising the major inspection, a comprehensive inspection report must be completed which includes:

Where the certifying engineer has made the decision not to dismantle the plant, or parts of the plant, the engineer is to document a comprehensive rationale for his or her decision that includes a discussion of the factors included in, but not limited to, the section "Circumstances under which dismantling of the plant may not be required".

74. This guidance appears to be far superior to anything contained in the 2019 Standard.

75. Mr Davis also directed my attention to a similar incident which occurred in North Queensland in 2022 where a king post failure caused the collapse of a concrete placing boom, fortunately only causing property damage.

76. Knowing that the king post failure that caused Sanel's death was not a unique event (albeit very rare) lends extra impetus to my considering what might be done to ensure that similar events to not occur again in Victoria.

COMMENTS

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

1. Sanel Mujezinovic died from injuries sustained when struck by a concrete placing boom that collapsed in a workplace incident. The boom's catastrophic collapse resulted from fatigue cracking that developed and propagated through the boom's king post over a long period of time, likely a number of years.

2. To detect the fatigue cracking that resulted in the boom collapse, a strip-down inspection involving disassembly of the boom's base (the turret) would have been required to access and test the king post. There is no evidence that any such strip-down inspection ever occurred during the 30-year life of the concrete boom.

3. In my investigation I did not focus on the historical reasons why no strip-down inspection was conducted, noting that WorkSafe prosecuted Prisbel - the company who had owned the concrete pump since 2010 - for failing to provide a safe work environment, one aspect of which was not having ever disassembled the unit to inspect the king post.

4. Rather, I focused on the approximately 18 months leading up to the fatal incident, when Dr Andrew Baigent conducted two periodic inspections of the concrete pump (in October 2019 and October 2020) under the auspices of the 2019 Standard, at the same time that the fatigue cracks were developing and spreading. I sought to understand what those inspections revealed, and whether they presented an opportunity to identify the king post's fatigue cracking before the catastrophic - and tragically fatal - collapse.

5. Dr Baigent explained there were no signs during his periodic inspection - which involved visual inspection and functional testing of the equipment - that the king post might be compromised by fatigue cracking or otherwise. Therefore, he did not believe there was any need for a strip-down inspection and he did not direct that it occur.

6. Under the 2019 Standard, a strip-down or disassembly to inspect critical components of the pump (such as the king post) during a periodic inspection is not required unless directed by a competent person. Dr Baigent was a competent person empowered to conduct the periodic inspections and determine that a strip-down inspection was not required.

7. Considering the results of Dr Baigent's periodic inspections in the context of the 2019 Standard, I was concerned that the 2019 Standard may have supported a circular argument militating against strip-down inspection: the king post cracking could only have been detected through a strip-down inspection, but there were no outward signs of king post cracking to indicate a strip-down might be required, so Dr Baigent did not direct that a strip-down inspection occur.

8. I am further concerned that there may be other concrete pumps in operation across Victoria with king posts in the process of cracking but not showing any outward signs of compromise. Under the current periodic inspection requirements in the 2019 Standard, these too could

catastrophically fail without a competent person ever requiring them to undergo strip-down or disassembly to inspect crucial internal components.

9. I have concluded that the periodic inspection requirements described in the 2019 Standard, where a strip-down inspection is only conducted at the direction of a competent period, may not be up to the task of ensuring Victoria's concrete pumping fleet is safe.

10. In my deliberations about what might need to be done to address this safety issue, I considered whether the 2019 Standard might need to be amended. However, the process for amending an Australian Standard is rather involved and can take some time, so rather than making a recommendation to this effect, I instead determined simply to distribute this finding to Standards Australia for information and for any action they see fit.

11. Regulation at the state level, potentially by introducing strip-down inspection requirements in Victoria additional to those set out in the 2019 Standard, would appear to be a more direct pathway to addressing the safety issue I identified. In this respect, I note with approval the existence of the Workplace Health and Safety Queensland *Concrete Pumping Code of Practice 2019*, which sets out a requirement in Queensland for major inspection of concrete pumps every six years and is explicit about the limited circumstances under which dismantling of the equipment may not be deemed necessary (and the comprehensive documentation required when determining not to dismantle the equipment).

12. I consider the Queensland approach to be a sensible one. While there is still a level of discretion on the part of the certifying engineer or 'competent person', the onus is for equipment to be dismantled for comprehensive checks during a major inspection unless a detailed justification can be provided for not doing so. The result of this should be that crucial internal components such as king posts are inspected and tested more often than would otherwise occur if the 2019 Standard alone was applicable.

13. Victoria has an *Industry Standard: Concrete Pumping* that WorkSafe Victoria published in April 2004. It has not been revised since the 2019 Standard was released. The process of revising and updating the *Industry Standard: Concrete Pumping*, could provide the impetus to consider additional strip-down requirements for concrete pumps operated in Victoria.

14. I am also gravely concerned about the issue of the malfunctioning hour meter on the concrete pump across two inspections, when hours of operation is one of the primary criterion

determining inspection schedules under the 2019 Standard. I intend to make a recommendation to address this.

RECOMMENDATIONS

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

(i) In the interests of preventing like deaths and promoting public health and safety, I recommend that WorkSafe Victoria revise and update the *Concrete Pumping Industry Standard* 2004, to reflect the contents of Australian Standard 2550.15-2019, "Cranes, hoists and winches - Safe use - Part 15: Concrete Placing equipment" (2019 Standard).

(ii) In the process of revising and updating the *Concrete Pumping Industry Standard* 2004, I recommend that WorkSafe Victoria give consideration to introducing more stringent requirements for strip-down inspection of concrete pumps (whether within the Industry Standard or by issuing a Compliance Code, Code of Practice or other industry guidance document) to improve identification of issues with internal components before they cause catastrophic malfunction and death.

(iii) In the interests of preventing like deaths and promoting public health and safety, I recommend that WorkSafe Victoria introduce a regulatory requirement that the hour meter on concrete pumping equipment must be in good working order, and that it would be contrary to the regulatory requirement to operate the equipment where the hour meter is faulty.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Sanel Mujezinovic, born 23 December 1980;

   b) the death occurred on 17 May 2021 at Cahill Street and Gratz Street, St Albans, Victoria 3021;

   c) I accept and adopt the medical cause of death ascribed by Dr Melanie Archer and I find that Sanel Mujezinovic died from multiple injuries sustained in a workplace incident, where he was struck by a concrete placing boom;

2. AND, on the evidence available to me, I find that Sanel Mujezinovic died at his workplace, while acting in the course of his employment, in circumstances that may have been prevented had a strip-down inspection occurred.

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

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

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

Leisa Palmer, Senior Next of Kin

Brighid Murphy

WorkSafe Victoria

WorkSafe Western Australia

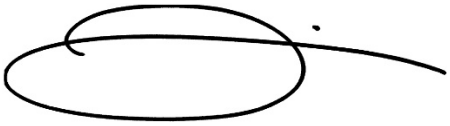
SafeWork New South Wales

Workplace Health and Safety Queensland

Standards Australia

Senior Constable Jonathan Tipas, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 22 January 2026

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.