IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000330

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Darren Jeffrey Lamb
Date of birth:	9 November 1977
Date of death:	17 January 2022
Cause of death:	1a: Chest injuries sustained in a workplace incident (forklift driver)
Place of death:	Conroy Removals, 25 Fowler Road Dandenong, Victoria
Keywords:	Workplace death – Crushing injury – Forklift driver

INTRODUCTION

1. On 17 January 2022, Darren Jeffrey Lamb (**Darren**) was 44 years old when he died from injuries sustained in a workplace incident in which 20-foot shipping container fell on the cabin of the forklift he was operating. Darren had been employed as a high-risk forklift driver at Conroy Removals Pty Ltd in Dandenong South since March 2021.

2. At the time of his death, Darren lived in Koo Wee Rup with his wife, Charlene Lamb (**Charlene**) and their 7 children Jake (20), Jayde (16), Leyon (13), Nevada (7), Willow (5), Aspen (3) and Billie (1). Jame was working with his father at the same workplace on the day he died.

THE CORONIAL INVESTIGATION

3. Darren'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.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. 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.

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

7. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths. The Victorian WorkCover Authority (**WorkSafe**) also conducted an investigation and provided a copy of the hand-up brief (**the**

WorkSafe brief) prepared in contemplation of proceedings in the Magistrates' Court of Victoria against Conroy Removals. I note that no such proceedings eventuated.

8. On 7 February 2025, the Coroners Court of Victoria received a request from Charlene, requesting that an inquest be held into her husband's death pursuant to section 52(5) of the Act.[1] On 30 June 2025, then Coroner John Olle determined that it was not necessary to hold an inquest.[2]

9. In July 2025, I assumed carriage of the investigation into Darren's death from Coroner Olle for the purpose of considering the final direction of the case and making findings.

10. This finding draws on the totality of the coronial investigation into the death of Darren Jeffrey Lamb including evidence contained in the coronial and WorkSafe briefs. I have reviewed all the material, however, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

11. These findings are made without disturbing Coroner Olle's decision relating to the decision not to hold an inquest. However, I have reviewed all of the material afresh, knowing the family concerns and now make these findings of fact. Importantly, in the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

12. At approximately 5.00am on 17 January 2022, Darren arrived at work to commence his shift. Shortly after his arrival at work, Darren had a morning meeting with his manager, Stephen Pritchett (**Stephen**) to discuss the day's work.

13. At approximately 5.46am, Darren commenced his working day. Darren's job was to operate a Hyundai 130D-7E model forklift to move shipping containers. His task that day was to unstack a 20-foot shipping container with a gross weight of approximately 3850kg.

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1 Form 26, Request for Inquest into Death dated 7 February 2025.
2 Form 28, Decision by Coroner whether an Inquest will be held into Death dated 30 June 2025.
3 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.

14. At approximately 6.45am, when another employee, Shaquille Davies (**Shaquille**), arrived at work, he noticed one shipping container suspended at an angle and immediately informed Stephen who was still in the site office. By this time, the branch manager, Michael Morgan (**Michael**), had also arrived at work and heard Shaquille report his observation. According to Shaquille, he observed the container suspended at an angle, and he knew that it was not sitting correctly. At the time, he said he did not, however, see the forklift, only the top of the container.

15. Stephen, Shaquille, and Michael then rushed to where Darren had been working and discovered that the container was resting on top of the forklift's cabin. When they called out to Darren, he did not respond. Michael immediately alerted the emergency services.

16. At approximately 7.00am, Ambulance Victoria paramedics arrived. However, due to the precarious position of the container on the roof of the cabin, it was deemed unsafe for responding paramedics to venture any closer to the forklift and were therefore unable to reach Darren. However, according to Stephen, he could see Darren in the cabin of the forklift, but he "*wasn't moving*".

17. After Conroy Removals sourced a crane service to remove the container from the top of the forklift, paramedics were able to access Darren but were unable to revive him and pronounced him deceased at 10.48am.

Identity of the deceased

18. On 17 January 2022, Darren Jeffrey Lamb, born 9 November 1977, was visually identified by his manager, Stephen Pritchett.

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 autopsy on 21 January 2022 and provided a written report of her findings dated 17 May 2022.

21. The post-mortem examination revealed crushing injuries of chest. Dr Archer reviewed a post-mortem computed tomography (**CT**) scan, which revealed multiple rib fractures on both sides of the chest. Dr Archer did not identify any evidence of significant natural disease that could have contributed to death.

22. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

23. Dr Archer provided an opinion that the medical cause of death was '*1(a) Chest injuries sustained in a workplace incident (forklift driver)*'.

WORKSAFE INVESTIGATION

24. WorkSafe conducted an investigation into the incident pursuant to the *Occupational Health and Safety Act 2004* (**the OH&S Act**), which involved investigators conducting site visits and gathering relevant documentary evidence. The WorkSafe investigation was further informed by the observations of Victoria Police, witness statements and other material obtained during the course of the concurrent police investigation.

25. A review of the closed-circuit television (**CCTV**) footage at the Conroy Removals site depicts Darren driving the Hyundai 130D-7E model forklift to his scheduled work location at 6.07am. The CCTV footage then depicts the mast of the forklift wavering as Darren reversed the forklift. The mast is then observed to significantly tilt backwards, causing the shipping container to fall on the roof of the forklift cabin, crushing the cabin with Darren inside.

26. None of the other employees present heard or witnessed the incident at the Conroy Removals worksite.

27. The WorkSafe Engineering Unit (**WEU**) subsequently commenced an investigation into the incident which resulted in Darren's death.

28. The WEU investigation revealed that the specific cause of the mechanical failure in the forklift driven by Darren was that "*the bolts that assist in retaining the mast in the mast mounting hooks had failed*". The investigation further revealed that the design of the mast attachment was likely to have been the main contributing factor to the incident, as opposed to a failure of the bolts in isolation.

29. WorkSafe's Principal Engineer Andrew Taylor (**Mr Taylor**) was engaged to consider the operation of this Hyundai 130D-7E model forklift and forklifts more generally, with a view to identifying any available prevention opportunities arising from the circumstances in which the fatal incident occurred.

30. Routine service and maintenance of the Hyundai forklift was conducted by Biondo Forklifts, from whom Conroy Removals had hired the forklift. The relevant maintenance receipts obtained by WorkSafe indicate that the standards of maintenance were "*required to comply with the "Original Manufactures (sic) Specifications and/or the relevant Australian Standards*",[4] which was itself consistent with the Conroy Removals Work Health and Safety practices with respect to minimum standards for inspection and maintenance of plant, in particular maintenance schedules.[5]

31. In his statement of 4 April 2024, Mr Taylor cautioned that the current Australian Standard (*AS 2359-2013, Powered industrial trucks – Part 2: Operations*) advises operators to follow the manufacturer's recommendations with respect to the servicing of forklifts,[6] which he considered do not provide sufficient guidance on: the frequency of inspections; critical components for inspection that may not have been sufficiently considered by the manufacturer; nor any guidance as to what should be identified during an inspection and the means by which it can be identified.

32. According to Mr Taylor, to his knowledge, many forklift owners operated their forklifts without conducting proactive, preventative inspections and routine maintenance on them. Mr Taylor explained that when undertaking maintenance work on forklifts, many owners, mechanics, and service agents often prioritise the inspection and maintenance of mechanical components over structural components.

33. In his review of the manufacturer's proposed maintenance schedule, Mr Taylor noted that the prescribed routine inspections for cranes, hoists and winches differ considerably from those prescribed for forklifts, particularly with regard to forklift structural components which are critical to the forklift's optimal and safe operation. Consequently, Mr Taylor opined that the forklift manufacturer's prescribed maintenance schedule may be inadequate in this regard. He attributed this oversight in the manufacturer's prescribed maintenance schedule to the lack of guidance in the Australian Standards.

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[4] WorkSafe Brief, Exhibit 28, Biondo Forklifts maintenance receipts.

[5] WorkSafe Brief, Exhibit 20, Conroy Removals, 'Work Health and Safety Manual V2 06/12/2016', Form 24.1 Plant Identification Register & Maintenance Schedule: "*All inspection and maintenance records will as a minimum standard comply with the Manufacturers recommendations or relevant Australian Standards where appropriate.*"

[6] Clauses 6.2.1 and 6.5.

34. According to Mr Taylor, Australian Standards prescribe the different types of maintenance procedures which ought to be conducted on cranes, hoists and winches, including the focus, manner and frequency of inspections. By contrast, however, these prescribed measures are absent from the 'safe use' suite of Australian Standards which aim to guide the prescribed maintenance specifications for forklifts.

35. Mr Taylor advised that the Hyundai forklift driven by Darren has a fixing arrangement similar to only two brands of forklifts used in Victorian workplaces, Hyundai and Hyster, (including in a small number of older, larger machines). He described the risk of similar incidents occurring with other brands of forklifts as negligible, noting other brands utilise "*mast connection designs with bolts that are not in the direct load path*".

36. Mr Taylor proposed that the WEU consult with manufacturers of relevant Hyundai and Hyster forklifts to ensure manuals for forklifts with mast attachments of the same or similar design are revised to incorporate the removal and testing of bolts at a certain frequency. He noted that such an undertaking would provide an opportunity to confirm any ongoing supply of forklifts with a similar design to the one driven by Darren. Further, Mr Taylor highlighted the potential for WorkSafe to identify previously supplied forklifts and require the manufacturers to communicate the need for changes in their inspection and maintenance to affected customers and workplaces.

37. WorkSafe subsequently wrote to the Court on 14 March 2025 to advise that it had met with representatives of HFA Distributors (Hyundai) and Adapt-A-Lift Group (Hyster) to discuss the incident. Neither organisation was able to identify similar incidents or significant findings from service records. However, WorkSafe advised that these discussions had prompted the organisations to alert affected customers and service technicians to the issues since identified in similarly designed forklifts with respect to the mast mounting hooks, and to recommend that they conduct regular checks of the bolts.

38. Further, Hyundai were reported to have affixed stickers to the masts of the Hyundai 130D-7E model forklifts as a visual prompt to alert operators to the issues identified and took steps to ensure that such alerts are applied to the masts of all similar Hyundai forklifts sold in Australia.

CONCLUSION

39. Whilst I acknowledge the initiative taken by WorkSafe with representatives of Hyundai and Hyster, these alerts and interim measures do little to address the real and immediate risk of inadequate inspection and maintenance of forklifts outside of the particular manufacturers identified herein or forklifts of a particular design.

40. Given the evidence of the WEU, particularly Mr Taylor's contribution to the coronial investigation, it is evident that the lack of prescribed measures in the 'safe use' suite of the Australian Standards guiding the prescribed maintenance specifications for forklifts, presents a potential prevention opportunity in the field of forklift maintenance and testing practices.

41. Mr Taylor also observed that there is a tendency for inspections to concentrate on mechanical rather than structural components, and suggested that this limited focus may have been influenced by the absence of prescriptive specifications for the inspection and maintenance of forklifts.

42. This is particularly troubling given that structural and mechanical defects in equipment can present differently and carry different safety risks. Where progressive symptoms of mechanical issues may be identified by reduced performance in the operation of equipment, structural defects may remain latent until identified by way of targeted inspection. These risks underscore the importance of prescriptive maintenance specifications that clearly identify the categories of defects capable of detection and the appropriate method for their detection, so that the scope and quality of inspection and maintenance are not left to individual judgment or variations in practice.

43. In light of the WorkSafe findings regarding the failure of the mast mounting hooks, together with the absence of prescribed measures in the Australian Standards and the consequent omission in the prescribed maintenance specifications, I am satisfied that the weight of the available evidence supports a conclusion that Darren's death was preventable in the circumstances.

44. Having regard to my statutory obligation to contribute to a reduction in the number of preventable deaths in Victoria, I am satisfied that any risk of similar incidents occurring may be mitigated by the introduction of maintenance specifications applicable to forklifts in the Australian Standards. Further, I note that such maintenance specifications are already observed for hoists, cranes and winches, and provide a guide to forklift manufacturers in compiling their maintenance schedules in respect of these components.

45. For completeness, I note that the investigation reviewed the Conroy Forklift procedures. The issue arises as to whether these procedures could ever be sufficient in the context of inadequate maintenance specifications. I further note that the relevant Conroy policy requires that only certified and authorised employees are to operate forklifts.[7] Darren's qualifications and Notice of Assessment were obtained by WorkSafe, which confirmed that Darren successfully obtained the appropriate High Risk/Forklift licence certification on 11 August 2021.[8]

FINDINGS

46. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explication. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.[9]

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

    a) the identity of the deceased was Darren Jeffrey Lamb, born 9 November 1977;

    b) the death occurred on 17 January 2022 at Conroy Removals, 25 Fowler Road, Dandenong, Victoria, from chest injuries sustained in a workplace incident while in which Darren was driving a forklift; and

    c) the death occurred in the circumstances described above.

48. Having considered the available evidence, I am satisfied that Darren's death was a tragic accident arising from his operation of a faulty or malfunctioning forklift in the course and scope of his employment.

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[7] WorkSafe Brief, Exhibit 19, Conroy Removals Pty Ltd 'Forklift Policy'.

[8] WorkSafe Brief, Exhibit 1, Statement of Attainment ('Licence to operate a forklift truck') and Notice of Assessment ('Licence to perform high risk work') dated 11 August 2021.

[9] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

49. Further, I am satisfied that the weight of the available evidence supports a conclusion that the relevant forklift used by Darren was not routinely inspected for specific mechanical and structural defects such as those that Mr Taylor indicates ought to have been, but were not, outlined in the relevant Australian Standard. Whilst the evidence indicates that Conroy engaged Biondo Forklifts, from whom Conroy Removals had hired the forklift to undertake the maintenance, it is clear that they were maintaining the forklift to an incomplete or lower standard than was warranted. Accordingly, I find that Darren's death was preventable in the circumstances.

50. If the inspection guidelines are more fulsome in regard to the relevant standards, and the forklifts inspected for these defects, it is possible that future fatal incidents could be averted.

RECOMMENDATIONS

51. In the interests of public health and safety and with the aim of preventing like deaths, I make the following recommendations pursuant to section 72(2) of the Act:

    (i) That Standards Australia amend AS*2359.2:2013—Powered industrial trucks—Part 2*: *Operations* to incorporate more detailed inspection requirements and establish mandatory inspection frequencies;

    (ii) That the Victorian WorkCover Authority amend the *Occupational Health and Safety Regulations 2017 (Vic)* to include 'forklifts' or 'industrial trucks' in Regulation 10 to impose a requirement to keep records of inspection and maintenance carried out on the plant and to the relevant standards; and

    (iii) That the Victorian WorkCover Authority implement a safety communication campaign to ensure all owners, operators and hire companies are alerted to additional inspection and maintenance obligations for forklifts arising from amendments to AS*2359.2:2013—Powered industrial trucks—Part 2*: *Operations* and Regulation 10 of the *Occupational Health and Safety Regulations 2017 (Vic)*.

I convey my sincere condolences to Darren's family and work colleagues 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:

Charlene Lamb, Senior Next of Kin

Victorian WorkCover Authority

Standards Australia

Detective Senior Constable Imogen Carmel, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 23 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.