Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 48/17

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***John Robert BORRADAILE*** *with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 5-6 December 2017 find the identity of the deceased was* ***John Robert BORRADAILE*** *and that death occurred 4 February 2013 at Royal Perth Hospital as the result of a Neck Injury in the following circumstances:-*

Counsel Appearing:

Ms F Allen assisted the Deputy State Coroner

Mr D Harrop (State Solicitors Office) appeared on behalf of WorkSafe, Department of Mines, Industry Regulation and Safety

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INTRODUCTION

On 4 February 2013 John Robert Borradaile (the deceased) was at his workplace, Penguin International (PI) in Osborne Park, where he assisted in the unloading of a sea container packed with crates of glass sheeting of different sizes. During the process of manoeuvring a tall crate out of the front of the sea container with a forklift and strap, the crate destabilised and toppled to the side.

The deceased had been positioned towards the front of, and alongside, the crate and he was struck by the falling crate. It knocked him to the floor of the container and trapped him. Other employees, including his brother, went to help the deceased but the crate was too heavy to lift enough to release the deceased and a forklift had to be used to lift the crate from the deceased. He was clearly injured although responsive. He was taken by ambulance by Royal Perth Hospital (RPH) but did not survive the day.

The deceased was 26 years of age.

The company owners of PI were prosecuted under sections 19 (1) and 19 (A) (2) of the *Occupational Safety and Health Act 1984* (the Act). One of the owners, Moscou Holdings Pty Ltd, pleaded guilty and was sentenced on 30 November 2015 with respect to those breaches of the Act. The prosecution against the other owner was discontinued by the prosecution. The sections of the Act used by the

prosecution related to the duty of an employer to provide a safe system of work for an employee.

The death of the deceased was a reportable death pursuant to the *Coroners Act 1996* (WA) and it was deemed desirable an inquest be held to clarify the circumstances of the death of the deceased with respect to an enquiry as to whether there needed to be more formal procedures and protocols around the safe handling of heavy glass sheeting.

The evidence at the inquest consisted of the brief of evidence and the oral evidence from a number of the employees present at the time of the unloading of the glass crate. Oral evidence was also provided by the directors of the two company owners comprising PI. This was the first time the family of the deceased had an opportunity to hear evidence from representatives of the employer.

BACKGROUND

The Deceased

The deceased was born on 6 April 1986 in Carlisle, Cumbria, United Kingdom. He was the older of two boys and had an uneventful childhood without any major illness or injury. He had an active lifestyle enjoying football and golf at school, while achieving A levels before leaving school.

Once he left school the deceased worked in sales and held management positions with a number of companies before moving to Western Australia (WA) in September 2012 following a breakdown in his, then, current relationship. He moved to WA to be with the rest of his family who had migrated approximately 6 years earlier. The deceased had visited his family in WA and thoroughly enjoyed the lifestyle.

The deceased's mother reported he initially found it difficult adjusting to life in WA because he had needed to give up a good job and make new friends. However, he eventually settled as he made new friends and started employment at the same company, PI, as his younger brother, Richard. Richard was a qualified glazier and the deceased was employed at PI as a labourer intending to work towards achieving accreditation as a glazier.[1]

Penguin International

PI was located in Collingwood Street, Osborne Park, and was the trading name for a partnership between Moscou Holdings Pty Ltd as the trustee for the Penguin Trust and Rite Angles Pty Ltd as trustee for Rite Angles Unit Trust. The working directors were Mark Moscou for Moscou Holdings Pty Ltd and Rob Brown for Rite Angles Pty Ltd.

Mr Brown had been a contributor of 30% of the capital for PI and in February 2013 was in the process of working out

[1] Ex 1, tab 1, 7 & 13

his resignation from PI. He was present at the PI premises on 4 February 2013 as part of finalising his work time and collecting belongings. Mr Moscou was the working director on the premises on 4 February 2013.[2]

The business of PI was the design, construction, and instillation of glass for use in construction. To enable it to carry out its business PI imported pre-cut glass from China according to the specifications it had provided for its architectural and structural applications. The Chinese manufacturer was provided with specifications for the glass and cut those to order on site in China. Those different sized pieces of glass were then packed in separate crates and the crates loaded into a sea container for transport to PI in Osborne Park.[3] The crates of glass were secured in the sea containers by the use of steel straps, banding and timber chock braces to secure them within the container during transport. Depending upon the requirements for the business, a sea container loaded with crates of glass would arrive in Osborne Park for unpacking between 1-3 times a month.

Once at the Osborne Park premises the sea containers were assessed and then unpacked by which ever employees were present on site at the time there was a need for the container to be unloaded. The precise mechanism for

[2] Transcript of proceedings Magistrates Court of WA – 30.11.2015 and transcript Coroners Court t 6.12.17, p29
[3] t 5.12.17, p27

unloading would differ from container to container depending upon the contents, but generally the sea containers contained crates of various sizes with some smaller crates able to be unpacked manually from the container. The heavier and larger crates needed to be unpacked with the assistance of a forklift able to reach into the container. The crate was secured by means of lifting slings, once it had been freed from its restraining strapping, and hooked onto the forklift jib to be removed.

On occasion the sea container would contain crates of glass too large to be lifted by a forklift jib reaching into the container. These crates needed to be dragged far enough out of the container to be lifted by the slings. These crates were unloaded by employees entering the sea container and freeing a crate by placing a strap around the base of the crate, attached to the forklift. The top front brace would be removed and then the top rear brace, before returning to the front and releasing the bottom front brace. The crate was then dragged forward by the strap until it was far enough out of the container for the slings to be used to lift it on the forklift jib.[4]

[4] Ex 1, tab 7, 6A – t 5.12.17, p44

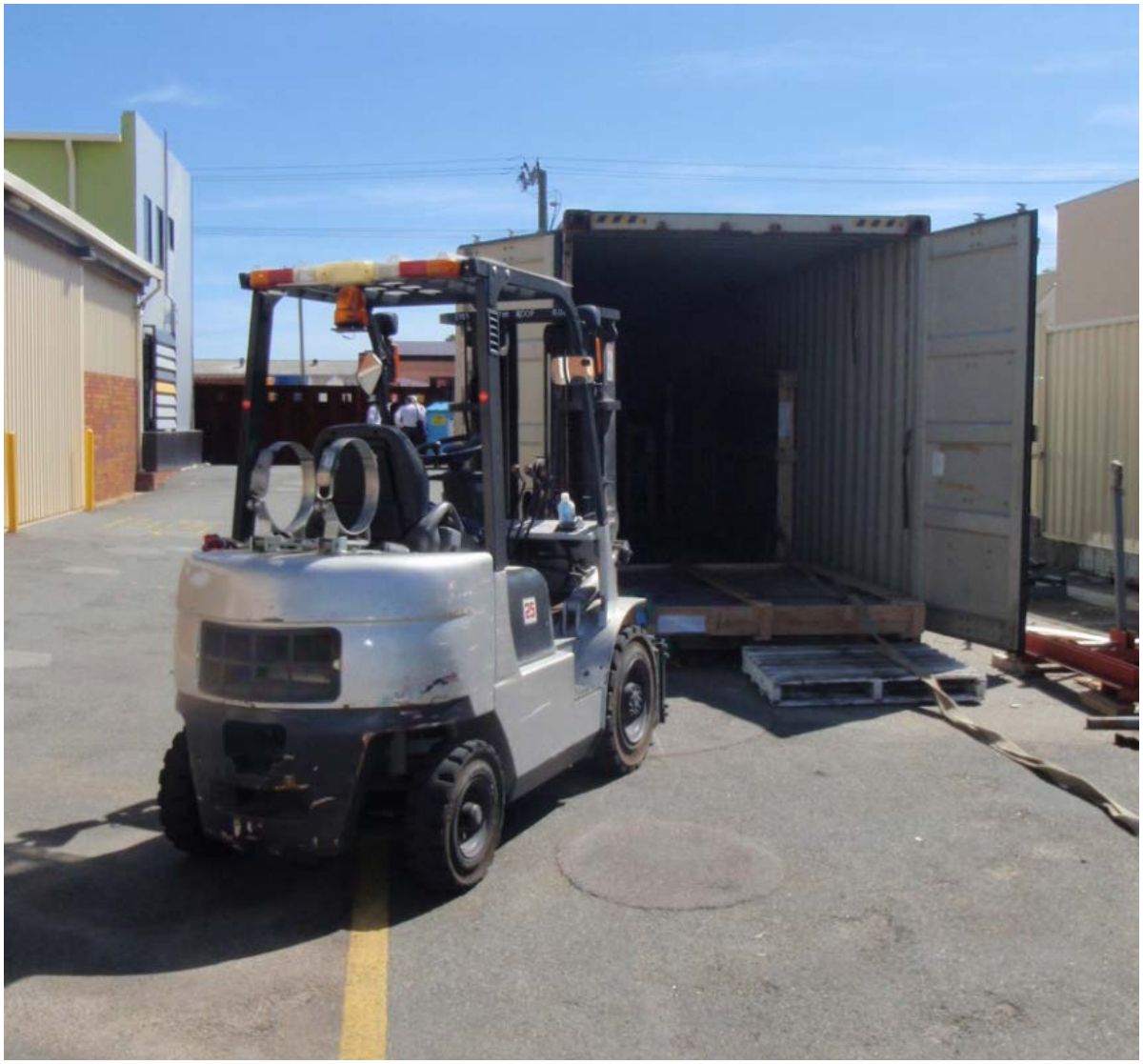

Exhibit 2 – Photograph 1

In theory the guiding of a crate as it was being dragged by the forklift was from behind the crate, as it was dragged forward, in an area out of the "*fall zone*". In practice this was on occasion impracticable and an employee would be in the vicinity of the front of the crate to direct the forklift driver and ensure the crate did not snag as it was dragged forward.[5]

[5] t 5.12.17, p43

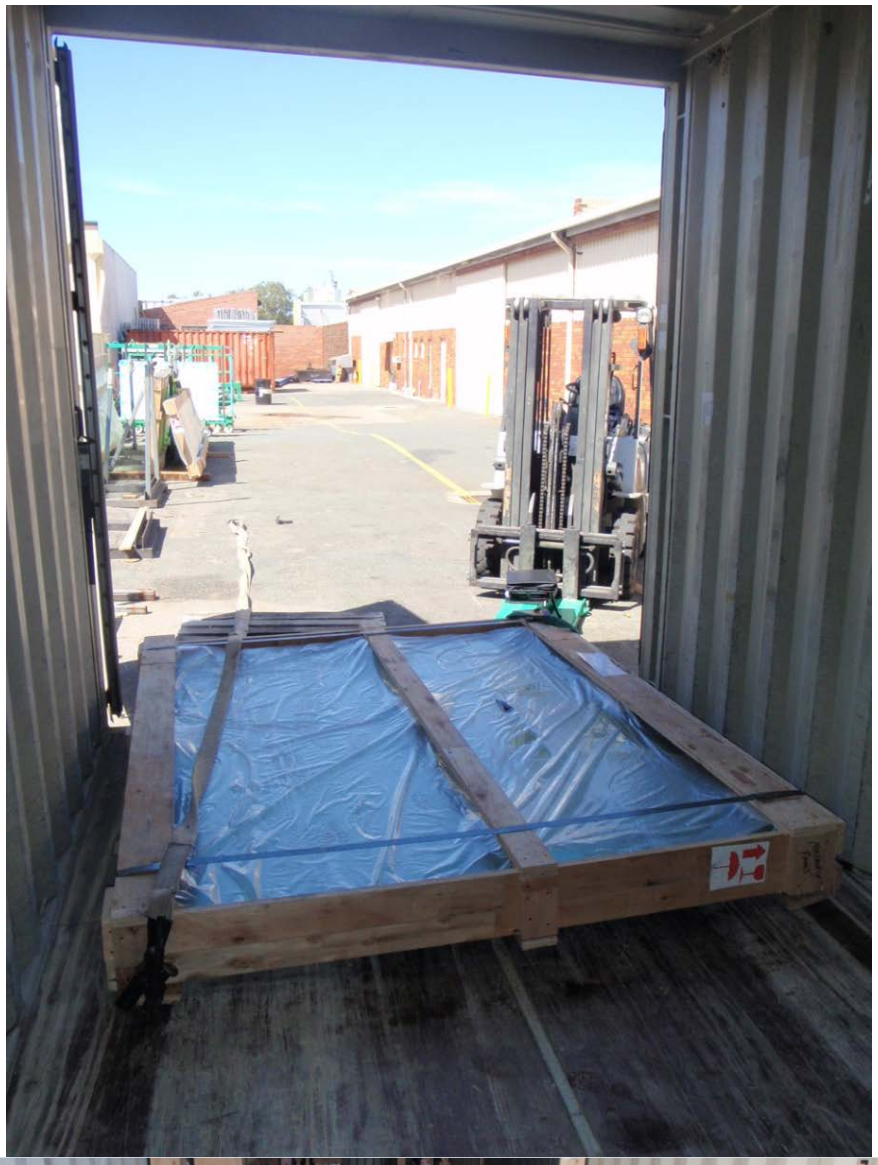

Exhibit 2 – Photograph's 2 & 3

PI instructed its employees to never put their safety at risk by attempting to stop a crate from falling. They were instructed that if a crate was to fall then they were to move out of the way and allow the crate to fall.[6]

There were no written protocols about the methodology, however, workers were trained "*on the job*" and there was always an experienced handler in a team when unloading glass crates became necessary. Generally those employees with forklift tickets were experienced in the work method and would supervise the unloading, however, they were on the forklift and concentrating on the forklift process.[7]

The majority of the employees employed by PI were employed as team leaders once they were reasonably experienced in the work of the company. It would seem this was to give them reasonable award rates once they had gained experience within the company. Newer employees were not employed as team leaders until they had experience with the work of the company.

WorkSafe

WorkSafe is a division within the Department of Mines, Industry Regulation and Safety. It has an executive which reports to the WorkSafe WA Commissioner, a Deputy Director General of the Department of Mines, Industry Regulation and Safety. Part of its function is to formulate

[6] t 5.12.17, p45, 53, 101
[7] Ex 1, tab 6, 7, 8, 9, 10

and implement policies, plans and strategies designed to help ensure there is administrative, research and policy support to the Commission for Occupational Safety and Health, and provide administrative, research and policy support to the Ministerial Advisory Panel responsible for developing recommendations for adopting a national model for work, health and safety laws.[8]

There is a policy and education directorate for WorkSafe which comprise a team concerned with policy and legislation to ensure the above objectives are met.

The aim is for there to be an advisory body supervising and, for the purposes of this matter, implementing compliance with the requirement of the Act, that there be safe systems of work for employees under a duty held by employers.

To enable it to carry out its function WorkSafe has various teams and while the objectives and role of WorkSafe have always been the implementation and advising of safe work practices, the structures under which they have been administered have changed frequently.

The genesis of the current philosophy behind the legislation occurred as the result of a 1972 report which identified short falls in the safety and health legislative frame work in operation at that time and recommended a number of

[8] Ex 1, tab 16

reforms.[9] One of the reforms was to switch responsibility for safety and health in the work place from a regulatory frame work to employers, as duty holders, to provide their employees with safe systems of work.

That resulted in the Act which effectively deregulated the work place, but instead encouraged employers and employees to use their initiative to identify and implement safe systems to carry out the work of their businesses or work places.

The regulations impose an obligation on employers to identify hazards at a work place, make a risk assessment and consider the means by which the risks involved with the systems of work may be reduced and minimised.

Codes of Practice and Guidelines

In respect of some industries and work practices there have been developed, generally by the industry, codes of practice and accepted practices and protocols. While these may be approved they are not the only acceptable way to respond to a hazard. Compliance with a code of practice does not reduce the obligation upon an employer to make an appropriate risk assessment and minimise hazards disclosed by the risk assessment, regardless of compliance with a code of practice or protocol. The codes of practice and protocols are to be taken as guides, but compliance

[9] Robens Report referred to in Ex 1, tab 16 by Charles Mitchell A/Director and Policy Education WorkSafe.

does not remove the duty to provide a safe working environment.

There are currently 35 codes of practice approved by the relevant Minister and they are necessarily broad in scope so as not to prescribe the way a task should be completed or reduce the obligation upon an employer.[10] There is no code of practice concerned with the unloading of glass from sea containers in Western Australia, although there are comparisons for the purposes of this particular case, which is a small and unique area of unloading. There are codes of practice and guidelines promulgated by the equivalent of WorkSafe in NSW.

Where WorkSafe is satisfied there is appropriate guidance material with respect to a specific work practice it may provide guidance notes and links on its website. WorkSafe also produces alerts informing the industry of a specific area of concern which has come to its attention due to serious injury or death arising out of a work environment.

With reference to this particular case there was information available on the internet to assist employers with risk assessment and developing safe practices for the handling of glass, and where information is available, WorkSafe will not generally produce its own. While the legislation in other states may differ from that in WA, that does not

[10] Submission on behalf of WorkSafe 19.02.2018

remove from individual WA employers and employees the necessity to take responsibility for a working environment.

I note some of the information available on the internet currently postdates the date of the deceased's death. I am unaware of the reference material available on the internet prior to the deceased's death in February 2013, but WorkSafe agreed there was nothing produced by them which specifically covered the work undertaken by PI.

4 FEBRUARY 2013

On 4 February 2013 the deceased and his brother, Richard Borradaile, were at the premises of PI in Osborne Park. Mr Borradaile is an accredited glazier and in February 2013 had been working for PI, through the director Mr Brown, for approximately 10 months. He was employed as a team leader and was mentoring the deceased to develop his skills and enable him to take on more lead roles in the jobs allocated to them by PI.[11]

Mr Borradaile saw Roger Dilnot (Mr Dilnot Snr) as his leading supervisor and Mr Dilnot Snr allocated jobs to Mr Borradaile and provided advice on their completion. Mr Borradaile saw Mr Moscou as being in charge of the company and Mr Brown as assisting with administration or physical jobs when necessary.

[11] Ex 1, tab 7

The deceased and his brother were already aware of their allocated work for the day on 4 February 2013 and started working in the factory on their task shortly after 8.30 am. At the time the directors and supervisors were in a meeting and there was a container in the yard which was due to be unloaded that day.

When the deceased and his brother commenced work, the deceased realised his brother would be able to complete that task alone and he told his brother he would go and help the others with unloading the container.[12]

Mr Dilnot Snr's son, Jack Dilnot, and Mark Dodd were already assessing the contents of the container with a view to its unloading. Jack Dilnot is a ticketed forklift driver and Mr Dodd was a glazier employed by PI. Jack Dilnot and Mr Dodd had been directed by Mr Moscou to commence the assessment in preparation for the unloading of the sea container.

Jack Dilnot described the container as approximately 40 feet long and as being half full. He assessed the contents and began to reconcile the crates with the inventory. The deceased and Mr Dodd, who had limited experience with unpacking containers,[13] went into the container with Jack Dilnot and started to separate the crates ready for unloading.

[12] Ex 1, tab 7
[13] Ex 1, tab 9

The sheets of glass of similar size were contained in crates strapped to the side of the container and secured in place with chocks. The deceased and Mr Dodd started to separate the crates with a small jimmy bar and claw hammer to enable to crates to be moved from the container. It was a task the deceased had done before and Jack Dilnot was experienced, as a forklift operator, with the process of unloading crates.[14]

The crates which could be lifted manually were removed by the team and placed on trolleys ready for storage. The medium sized crates were then dragged out by hand and the forklift and slings used to remove them from the container and put them into pallet racks. By that stage there were approximately four or five crates left of the taller, heavier and less stable crates to be removed from the container.[15]

At the time of the incident the deceased had jimmied a crate and separated it from the other similar crates. Mr Dodd was standing behind the deceased supporting the other crates against the side of the container while the deceased and Jack Dilnot placed the strap from the forklift around the base of the crate to enable it to be dragged forward. This was done by the strap being thrown over the crate and

[14] t 5.12.17, p28
[15] Ex 1, tab 8

then "*shuffled*" down to the bottom with enough clearance for the strap to enable the forklift to pull the crate forward.[16]

Jack Dilnot was on the forklift with the strap around the base of the crate. The crate was approximately 2.4 metres wide, 1.9 metres high and 40cm thick with a weight of approximately 1.4 tonnes.[17] Mr Dodd described the crate as taller than the others they had already removed, but not apparently unstable.

The deceased was guiding and directing the crate towards the door of the container while it was being dragged forward to the entrance. According to Mr Dodd the deceased was steadying the crate with his left hand and facing towards the door of the container alongside the crate when it appears to have snagged on the floor of the container.[18]

Jack Dilnot believed the deceased was at the back of the crate standing behind the crate, as the forklift dragged it towards the front of the container.

The crate was a few centimetres out of the container when Mr Dodd, who was holding the other crate to the side of the container, turned to his right and saw the crate begin to fall towards the deceased. Mr Dodd screamed to the deceased.

[16] Ex 1, tab 9
[17] Ex 1, tab 1 pg 2
[18] t 5.12.17, p42, 45

The evidence is consistent that Mr Dodd screamed "No".[19]

Mr Dodd observed the deceased turn and put his hands up against the crate as it fell. This would appear to have been an instinctive reaction in relation to the deceased's positioning alongside the crate, whether it be to protect himself or stop the crate from falling. There was not enough time or space for the deceased to move out of the fall zone, which would have been behind the crate or out of the container, with the limited space available.

The crate fell onto the deceased, scraped his face as he attempted to pull his face away, and the edge of the crate impacted on the base of the deceased's neck and pushed him against the side of the container, dragging him down as it landed. Mr Dodd described the deceased as sitting against the side of the container with the crate on his stomach region and his hands underneath. He was sitting up and conscious.[20]

As a result of Mr Dodd's scream and the noise a number of people on the premises rushed towards the accident site in an attempt to assist.

Shaun Baker, one of the supervisors, was working in the office when Mr Moscou came out and said everybody needed

[19] t 5.12.17, p35, 45
[20] Ex 1, tab 9

to go and see what was happening.[21] As Mr Baker ran out he observed Jack Dilnot unhooking the forklift from the strap and saw the deceased trapped under the crate. He attempted to lift it, but it was too heavy. Jack Dilnot then managed to lift the crate with the forklift and the deceased's brother pulled him from under the crate while Mr Baker telephoned for an ambulance.

Mr Moscou stated the deceased was conscious and responsive at that stage and gave a 'thumbs up' sign to indicate he was still with them.[22] Mr Moscou was clearly distressed when giving this evidence.

An ambulance was called and the deceased was taken to Royal Perth Hospital. The deceased was rushed into the emergency department but unfortunately could not be saved and died shortly thereafter on 4 February 2013.

The police and WorkSafe commenced separate investigations into the circumstances of the deceased's death with the police concentrating on the circumstances with respect to the deceased specifically, while WorkSafe's function was to examine the system of work in place and its relationship to the death of the deceased.

[21] t 6.12.17, p82
[22] t 6.12.17, p103

POST MORTEM REPORT

The post mortem examination of the deceased was undertaken by Dr D Moss, Forensic Pathologist, at the State Mortuary on 6 February 2013.[23]

Dr Moss noted trauma to the neck with extensive abrasions, haemorrhage and lacerations of the muscles and soft tissues of the neck with complete transection of the wind pipe, oesophagus and associated soft tissues. In addition, there were fractures of the cartilage and vertebrae of the neck. There was blood in both chest cavities and the presence of inhaled blood in the upper airways and lungs, with other external injuries to the face, upper limbs and trunk. There was only minor injury to the deceased's lower limbs.

Histology confirmed the presence of blood within the lungs and toxicology only identified drugs consistent with the deceased's treatment once injured. There was no evidence of alcohol or common drugs in the deceased's blood or urine. Neuropathology showed no abnormalities in the brain, but the vertebral column showed abundant paraspinal haemorrhage and haemorrhage between the vertebrae in the lower cervical/upper thoracic vertebral column. There was haemorrhage and disruption of the spinal column at the level of the T6.

[23] Ex 1, tab 3

There was no evidence of natural disease or pathology.

At the conclusion of his examination Dr Moss determined the cause of the deceased's death was neck injury. The extent of the injury was severe.

MANNER AND CAUSE OF DEATH

I am satisfied on the evidence contained within the brief and the oral testimony of witnesses involved in the events of 4 February 2013, the death of the deceased occurred as the result of a neck injury and that neck injury resulted from a work place accident when a crate containing glass fell on him in a confined space.

I find death occurred by way of Accident.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 26 year old male employed as a labourer on the premises of PI in the course of its general business.

As part of its general business sea containers of crates containing customised sheets of glass needed to be unloaded from time to time. There was no written procedure as to how this was to be done, but a system of work had developed over time which involved individual assessment of each container as to the best way to unload

its contents. This was not undertaken as a routine risk assessment with a specific team for each container, but rather a method developed over time with more experienced employees mentoring those new to the task.

I am satisfied PI had viewed information from the internet and sought to adopt that to its circumstances as far as possible. However, it had not provided written protocols or provided employees with Job Safety Analysis (JSA) guidelines.[24]

Generally the crates were removed from the sea containers, from the front to back, using slings attached to the forklift jib to lift and slide crates out of the sea container. For the taller crates this was not possible as there was not enough room for the jib to reach into the sea container and lift a crate. These crates would be progressively freed from their restraints, have a strap worked around their base and be dragged forwards out of the container by a shackle on the rear of the forklift until there was enough of the crate free from the container for the jib and sling and lift method to be used.

Usually the crates were stable enough to be self-supporting, but on occasion the height to width ratio would cause a concern with stability due to the centre of gravity and the risk of a crate becoming destabilised due to the surface over

[24] Ex 1, tab 18

which it was dragged. While the accepted scenario was an unstable crate was to be left to fall to ensure employee safety, there was still a risk with an employee being in the fall zone and not able to move away in time.

Jack Dilnot believed the appropriate place for people to guide the moving crate once it was being dragged by the forklift was from behind and not in the fall zone. The fall zone would depend on the dimensions of the dragged crate. In the instant case Mr Dodd believed the crate had caught on something as it was being dragged which caused it to become destabilised and fall. The location of the deceased and his actions in throwing up his hands would seem to indicate it was an instinctive response to the falling crate and he had no time to do anything further. He was in an extremely vulnerable position.

The company policy was employees should not be in the fall zone once the crate was moving, although it seems to have been accepted that on occasions this was inevitable.

Mr Moscou acknowledged there were occasions when an employee had to be at the front of the crate as it was being dragged out of the container to ensure it did not snag. He did, however, believe the fall zone was obvious and that an employee should not be located in the fall zone once a crate was actually being moved. He believed the appropriate place for that employee was at the front of the crate, but

outside the fall zone. The view of the employees varied as to the necessity for a person to be in the position the deceased was in alongside the moving crate.

There had been a prior incident at the company in 2011 when an employee had injured his hand while unloading a crate of glass from a sea container. On that occasion the employee had been standing in front of a crate which was about chest height, but with a narrow base. He was to the front of the crate, between the crate and the side of the container, with another employee behind, guiding the crate by hand. The injured employee believed he had to guide the crate in case it started to tip and keep it upright.

There had been a person on each side of the crate, guiding it, when the sling slid out of the forklift jib and the crate tipped towards the injured employee. Before he had the opportunity to brace the crate it had fallen and crushed his arm beside the shipping container, grazing his chest as it fell. The employee managed to wriggle free and leave the container before he was pinned down. The crate continued to fall down, flat on the floor of the shipping container. The employee's hand was bruised and he was treated, although he did not attend hospital until the following day with Mr Brown.

This prior incident emphasised there was a hazard with the system in use for the removal of large or heavy crates from

sea containers by the system in use and a lack of reinforcement of the need to avoid the fall zone completely.

The deceased had not been employed by the company at the time of the prior incident and was not as aware of the reality of the danger of a falling crate as those who had been present. Unfortunately, he unconsciously placed himself in a vulnerable position while attempting to assist with unpacking the sea container. Others around him were all concentrating on their specific tasks and missed the opportunity to remind him to place himself out of the fall zone.

At the time the company commenced its business there was little on the internet to assist with safe systems of work for its business, although Mr Bond, on behalf of WorkSafe, indicated the manner of work was not dissimilar from the unloading of stone sheets (for example granite kitchen tops) from containers. Similar principals applied.

Mr Moscou said at that time PI was a very small company and not in a position to make provision for the specialised handling of the big sheets of glass by the use of open top containers as seen with the really big glass importers.[25]

At the time PI started using the sea containers filled in China, Mr Moscou had been much more closely involved

[25] t 6.12.17, p109

with the unloading. He was involved personally and supervised how it was done.[26]

As time evolved it is clear it became more of a routine task, but one which assumed a level of risk assessment not enforced by written protocols or specific toolbox meetings. By February 2013 Mr Moscou believed about 150 containers had been unloaded at the PI premises, but agreed there was no specific training provided.

Mr Brown gave evidence that over time he, on behalf of the company, had looked at different ways of unpacking sea containers which he believed could be safer, but the general consensus of the more experienced employees was not supportive.[27] Mr Brown advised that during his time as an active participant in the day to day business there had been morning meetings to allocate tasks to employees which did not involve a JSA for each container or task or a toolbox meeting at which a JSA would be discussed.[28]

However, it is apparent from the overall evidence the company and employees did consider other methods for the unpacking of the sea containers, none of which were considered reasonable in the circumstances of PI. Mr Bond, on behalf of WorkSafe as one of its inspectors, believed the

[26] t 6.12.17, p101
[27] t 6.12.17, p135
[28] t 6.12.17, p134

basis of the Act was that if a task could not be done safely, then it should not be done.[29]

Mr Moscou said as far as they could PI had regard to what was available on the internet as guidance, but it did not always fit PI's business, nor the premises from which it was operating at that time.[30]

After the death of the deceased, PI employed a safety officer who provided a JSA to employees for use when considering unpacking a new container. Not all employees recalled seeing that JSA, although most of them agreed it was common sense and they were aware of the types of things it contained.[31] All agreed the policy was for an employee to avoid the fall zone.

The difficulty for the deceased was he was a fairly new employee and had not been specifically allocated that task for the day. He was working with his brother, but decided that task did not need his help while the unloading of the container did. He did not have the benefit of a specific written protocol or JSA to refer to remind him of the hazards prior to assisting in the task. While it is common sense to avoid the fall zone, the circumstances in the container with the size of the crate being moved, obviously caused the deceased, in his anxiety to assist where he

[29] t 6.12.17, p179
[30] t 6.12.17, p108-109
[31] Ex 1, tab 18

could, to forget his own safety. The deceased's reaction in throwing up his hands when he saw the crate starting to fall appears to have been entirely instinctive, and in the position in which he was it was inevitable he would be injured.

So while I accept there was a policy in place, those working with the deceased that morning and the deceased himself do not appear to have specifically applied their minds to the risk at the time the crate started to be dragged from the container. There was nothing in place to remind them.

Mr Moscou is now involved in a different company, doing similar work, but from different, more appropriate premises. The new company has employed a glazier with experience from Sydney in similar work, and Mr Moscou believed the system he now uses, and was attempting to use in 2013 is very similar to those used in NSW for which there are guidelines.[32]

Mr Moscou expressed concern there were no traineeships available to provide appropriate training and explained it was his belief there were now more companies in WA doing similar work with little guidance available.[33]

None of that changes WorkSafe's position that the system in use when the deceased died was risky, and there were not enough procedures or protocols in place on behalf of the

[32] t 6.12.17, p109-110
[33] t 6.12.17, p112-113

company to ensure its employees, not only thought about the risks and safety of their work place, but had them reinforced in a manner which was meaningful to when the various tasks were undertaken. This was acknowledged by Mr Moscou on behalf of the company with the original plea of guilty to the WorkSafe prosecution.

WorkSafe does not believe there are a number of other companies undertaking similar work in WA and believes there is already enough information on the internet, admittedly not through the WA WorkSafe site, which provides sufficient guidance for those wishing to undertake the unloading of sea containers in a safe manner. From WorkSafe's perspective and the intent of the legislation, they are not concerned with advice, only assessment of a work environment. They are happy to publish relevant guidelines and alerts on their website and so advise those interested as to unsafe work practices which have resulted in death or injury.

The death of the deceased has emphasised, that while common sense may indicate certain procedures are hazardous, the reality of working in any environment may frequently see the obvious risk overlooked in the will to complete jobs efficiently. It is for this reason it is necessary employees working in risky environments are reminded each time they undertake a hazardous task of the risks involved, especially when it is not a routine task they

complete regularly to a specific pattern. While the circumstances of the death of the deceased may not have been identically reproduced, the incidents of employees being injured by falling or toppling construction works is very real and remains a problem in industry.

For that reason I consider it desirable, despite the fact there is apparently not a broad industry undertaking similar work, that guidelines produced in other states be utilised as part of WorkSafe WA to assist employers in looking for suitable reference material. It does not remove the onus on the employer, and the employee for that matter, to consider the safety of their specific environment. However, it would reinforce the need for conscious reminders each task needs to be appropriately risk assessed each time it is undertaken. The guidelines at exhibit 1, tab 16a and b provide some information as to ways in which injury in the workplace during the unloading of both glass, and/or large crates may be done in the safest possible way.

The deceased, at the time of his death, was new to Australia where he was trying to create a new life for himself, despite having left a very good life in England. He was in Australia to be with his family, pursue a new career and enjoy a new lifestyle. He was working towards that goal with enthusiasm and determination to work hard as part of a team. The deceased was a popular team worker, he was a well-loved brother and son to his family and it was a

devastating event for all concerned, including his co-workers, when his life ended in such a tragic, traumatic and avoidable event.

I recommend;

RECOMMENDATION

WORKSAFE PUBLISH APPROPRIATE GUIDANCE MATERIALS ON ITS WEBSITE SUCH AS THOSE EXHIBITED AT EXHIBIT 1, TAB 16A AND B.

16A NEW SOUTH WALES WORKCOVER HANDLING GLASS SAFELY

16B NEW SOUTH WALES SAFEWORK NSW OCTOBER 2016 GUIDE FOR UNPACKING SHIPPING CONTAINERS.

E F Vicker
Deputy State Coroner
30 April 2018