Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 22/19

I, Sarah Helen Linton, Coroner, having investigated the death of ***Sean MORGAN-SMITH*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***27 May 2019*** *find that the identity of the deceased person was* ***Sean MORGAN-SMITH*** *and that death occurred on* ***24 June 2015*** *at* ***Fiona Stanley Hospital*** *as a result of* ***abdominal injuries*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Mr N John (State Solicitor's Office) appearing for the Department of Mines, Industry, Regulation and Safety (specifically including WorkSafe).
Mr A Dinelli (Australian Government Solicitors) appearing for Comcare.

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INTRODUCTION

1. Mr Sean Morgan-Smith worked as a postal worker for Australia Post. On the morning of Wednesday, 24 June 2015, Mr Morgan-Smith was delivering mail in the Huntingdale area while riding his Australia Post Honda motorcycle. The motorcycle was fitted with high visibility panniers and a flag and Mr Morgan-Smith was wearing his uniform and an appropriate motorcycle helmet.

2. On the same morning, Mr David Bonifazi was driving a front end loader to perform site works on a vacant block in Elkington Pass in Huntingdale. This required him to reverse out across the footpath and into the roadway regularly. Mr Bonifazi was working on the site on his own and there were no barriers on the footpath, nor any warning signs to alert people travelling on the footpath to his activities. The front end loader did, however, emit a loud beeping noise when it was reversing.

3. Shortly after 10.00 am Mr Morgan-Smith drove up the roadway on Elkington Pass before moving onto the northern footpath to deliver mail into letter boxes at homes near the vacant block where Mr Bonifazi was working. After delivering the mail, Mr Morgan-Smith attempted to drive his motorcycle along the footpath behind where Mr Bonifazi was working. As Mr Morgan-Smith passed behind the front end loader, Mr Bonifazi reversed backwards onto the footpath and struck Mr Morgan-Smith's motorcycle, knocking him to the ground.

4. Mr Bonifazi reversed forward and then got out of his front end loader and came to help Mr Morgan-Smith. Other people in the area also came to assist. When it became apparent that Mr Morgan-Smith was injured, Mr Bonifazi rang emergency services and asked for an ambulance to attend.

5. St John Ambulance received the call at 10.15 am and an ambulance was directed to attend as a Priority 1. The ambulance arrived at the scene at 10.23 am.[1] At the time the first ambulance crew arrived Mr Morgan-Smith was unconscious but had no obvious injury. Mr Morgan-Smith suffered a cardiac arrest in the presence of the ambulance crew and CPR was commenced. He was conveyed by ambulance to Fiona Stanley Hospital and handed over to hospital staff at 11.15 am. Further resuscitation efforts were continued at the hospital, but sadly Mr Morgan-Smith could not be resuscitated. A post-mortem examination found he died as a result of abdominal injuries.

6. An investigation by police officers from the Major Crash Investigation Section found there was no reasonable explanation for Mr Bonifazi having failed to see Mr Morgan-Smith behind him when reversing, other than he failed to keep a proper lookout. Mr Bonifazi was charged by police with the offence of dangerous driving causing death in relation to the death of Mr Morgan-Smith. However, the charge was later discontinued by the Office of the Director of Public Prosecutions on the basis it was considered there was no reasonable prospects of conviction.

[1] Exhibit 1, Tab 20.

7. The investigating police officers also noted that Mr Bonifazi appeared to have failed to comply with occupational health and safety requirements by not blocking access to the site, nor displaying any warning signs on the footpath and road adjacent to the building site. The incident was brought to the attention of WorkSafe investigators by the WA Police, but WorkSafe declined to investigate the matter on the basis that Mr Morgan-Smith was employed by Australia Post and therefore came within the Commonwealth's jurisdiction, which is regulated by Comcare. However, this failed to acknowledge that the actions of Mr Bonifazi came within the jurisdiction of WorkSafe. No regulatory authority has taken any enforcement action or issued any guidance notes or similar as a result of Mr Morgan-Smith's death.

8. Initially, some information was also provided to this Court of potential concerns raised on behalf of the then Road Safety Commissioner. After a change in leadership, the Road Safety Commission later withdrew the submission as it did not accord with the current practice or views of the Road Safety Commission.

9. I gave consideration to the issues of work safety and risks highlighted by Mr Morgan-Smith's death, and some uncertainty as to how he came into contact with the front end loader, and I determined that it was desirable to hold an inquest. Mr Morgan's Smith's widow, Bethany Morgan-Smith, was informed of my decision to hold an inquest and she supported this decision. Mrs Morgan-Smith raised a number of areas of concern in relation to her husband's death and the investigations that followed. I have attempted to address them, where possible and relevant to the scope of the inquest, in this finding.

10. I held an inquest at the Perth Coroner's Court on 27 May 2019. Following the inquest some additional relevant information, and a number of submissions on behalf of the parties, were filed with the Court. I have taken into account that information and the submissions in reaching my findings.

BACKGROUND

11. Mr Morgan-Smith was born Sean Braime in Hull in the United Kingdom. On 14 February 2004 he married Bethany Smith and that year he changed his name to Sean Morgan-Smith. The couple had two young sons. In 2011 they moved as a family from the United Kingdom to Perth, Western Australia.[2]

12. Mr Morgan-Smith had joined the Royal Navy after finishing high school and remained in the navy until he was medically discharged due to knee damage, at the age of 46 years. After moving to Australia, Mr Morgan-Smith obtained employment with Australia Post as a postal delivery worker in February 2015.[3] In his spare time, Mr Morgan-Smith was very active in sports, such as golf, cycling and motorcycling, and he also acted as a soccer referee and

[2] Exhibit 1, Tab 7.
[3] Exhibit 1, Tab 7.

trained other referees. He had no major health issues other than the knee injury, which had led to his naval discharge.[4]

EVENTS ON 24 JUNE 2015

13. Mr Bonifazi consented to participate in a formal interview with police officers on the morning of the crash and also gave evidence at the inquest, so much of the events of the day comes from his account, although there are also some other witness accounts and objective evidence that I have taken into account and also considered in testing the reliability of Mr Bonifazi's recollection.

14. Mr Bonifazi confirmed he was employed by West Coast Site Works as a front end loader operator and had been sent to create a sand pad on the vacant block at 21 Elkington Pass in Huntingdale. Mr Bonifazi indicated he had a 'toolbox' meeting in-house with the supervisors and other staff and then conducted a job safety audit (JSA) on site with a supervisor at the time the front end loader was delivered to the site.[5]

15. Mr Bonifazi gave evidence the JSA involved considering potential hazards such as visibility to the site, weather, and vehicle and pedestrian traffic. Mr Bonifazi gave evidence the hazards identified were thought to be minimal because the job site was at the end of a no-through road and the footpath also ended there. Mr Bonifazi accepted there was still a possibility of some pedestrian traffic, but believed there would be limited risk to pedestrians as he had excellent, nearly 360° external vision when operating the machine, so he would be able to observe any approaching pedestrian. Mr Bonifazi indicated the only blind spots were below the tyres and a slight blind spot behind the front end loader where the motor was situated.[6] Mr Bonifazi also suggested that the risk for pedestrians was reduced because his front end loader was fitted with flashing beacons and reverse beepers, which would alert approaching pedestrians to his moving vehicle.[7]

16. The job commenced on 23 June 2015 and Mr Bonifazi worked at the site for one full day and had begun work for the second day when the incident occurred. His activities on the site involved moving sand around. To do so, he would constantly reverse the front end loader off the site, across the footpath and verge and onto the road. He confirmed he had not put in place any pedestrian or traffic warning or calming measures at the building site and at no stage did he have another person there to act as lookout while he was performing his duties.[8] Mr Bonifazi indicated he might have taken such measures in a higher traffic area, such as in a school zone, but he didn't deem it necessary at this worksite.[9] Mr Bonifazi agreed that it was his responsibility to implement such measures if he felt the job required it.[10]

[4] Exhibit 1, Tab 7.
[5] T 8, 11.
[6] T 9 – 11.
[7] T 11.
[8] T 12; Exhibit 1, Tab 6, p. 6 and Tab 14.
[9] T 12.
[10] T 13 – 14.

17. Mr Bonifazi acknowledged that while working on the site he had seen some pedestrians but did not believe they had used the footpath adjacent to his worksite.[11] It was put to Mr Bonifazi that the CCTV footage does show two or three pedestrians approaching his worksite and passing through the sandy area to the other side of Elkington Pass and he indicated he did not remember seeing those people.[12]

18. On this particular day, Mr Bonifazi had started work on the site that morning and had been moving sand from one side to the other. He was working alone. He had reversed onto the footpath and road on several occasions, which can be seen on the CCTV footage. Mr Bonifazi said that when he was reversing back he would always check his two side mirrors and the centre mirrors, which show anything next to the machine, then look over his shoulder and proceed to reverse.[13] There are no reversing cameras or sensors on the front-end loader to assist him in this process.[14]

19. Mr Bonifazi acknowledged when speaking to police that he was aware postal workers operate on the footpath and he had also seen people walking their dogs in the area. He noted it was a dead-end street and the site he was working on was at the end of the street. He claimed he had not had to hold up work at any stage to let anyone pass by.[15]

20. After working for about two and a half hours, Mr Bonifazi began to reverse from the site toward the road again. Prior to reversing, Mr Bonifazi said he did his usual visual checks, which involved checking the surroundings, then he engaged reverse in the machine (which activated the reverse beeper). Mr Bonifazi said he then looked again before beginning to reverse.[16] Mr Bonifazi mentioned that he looked with his own eyes out the windows to the right and left and then also used his mirrors to check the area. The only blind spot within the mirrors was directly behind the machine, at effectively ground level, due to the height of the machine.[17] Mr Bonifazi was asked if there was anything that would obstruct his view of the footpath, and he mentioned only a site toilet further up, but said "you could plain as Jane see straight down"[18] the footpath.

21. Mr Bonifazi began to reverse and estimated he had reversed about half a metre backwards, approaching the footpath, when he heard something. He stopped reversing, applied the handbrake and looked over his shoulder while still in the front end loader and saw a motorcycle on the ground lying on top of a person. Mr Bonifazi claimed not to have felt anything and only heard some sort of sound, although it was slight.[19] He told police he had not seen

[11] T 11.
[12] T 12.
[13] Exhibit 1, Tab 6, p. 6 and Tab 14.
[14] Exhibit 1, Tab 14.
[15] Exhibit 1, Tab 14, pp. 37 – 38.
[16] T 16.
[17] T 17 - 18.
[18] T 19.
[19] Exhibit 1, Tab 14, pp. 31 – 32.

Mr Morgan-Smith prior to this stage, despite looking down the street before reversing.[20]

22. It was put to Mr Bonifazi that in the CCTV footage his front-end loader is seen to rise up and down, as if going over a bump, which could be inferred to be when he hit Mr Morgan-Smith and drove over his motorcycle. Mr Bonifazi did not accept this proposition and when pressed further as to what else could have caused this movement, he indicated he could not recall it occurring, although he was shown the CCTV footage of the event. He indicated that his memory had definitely been affected by the events but he believed he would not have forgotten running over Mr Morgan-Smith, if that had indeed occurred.[21]

23. I note from my viewing of it, the CCTV footage shows the front end loader appears to rise up slightly when it is reversing back, around the time Mr Morgan-Smith is struck and it then moves forward and again rises up as it moves forward, before coming to a stop.[22] The obvious conclusion is that this movement is caused by the impact with Mr Morgan-Smith. Mr Bonifazi did agree in questioning that it was possible that the left rear tyre of the front-end loader made contact with the right side of the motorcycle, but he did not think it was possible that the front-end loader had driven over a tyre of the motorcycle.[23]

24. Mr Bonifazi said after becoming aware the motorcycle was behind him, he checked the person was not under the front end loader's tyres, then left the handbrake on and got out. He did not say he moved forward in the police interview, but did say in his evidence in court that he pulled forward after seeing the motorcycle at the back of his machine.[24] The movement forward is consistent with the CCTV footage and a crash investigator also concluded that the tyre imprints showed the front end loader had moved forward post impact.[25]

25. Mr Bonifazi claimed when he was reversing he had simply taken his foot of the brake and not accelerated. It is an automatic vehicle, so it will move if the foot is not on the brake. He estimated his speed was less than one kilometre per hour in his police interview.[26] It does not appear this slow on the CCTV footage that I have viewed, although I am certainly not suggesting he was moving at high speed. The police crash investigator concluded the evidence suggested the front-end loader was travelling at a low speed at impact, and I accept that.[27]

26. Mr Bonifazi said he got out of the cab of the front-end loader and approached Mr Morgan-Smith.[28] He was lying on the side of the road and the motorcycle was lying on top of him and still running. It appeared to

[20] T 19; Exhibit 1, Tab 14, pp. 46 - 47.
[21] T 22 – 24.
[22] Exhibit 1, Tab 9.
[23] T 24 - 25.
[24] T 15; Exhibit 1, Tab 6, p. 6 and Tab 14.
[25] Exhibit 1, Tab 21.
[26] Exhibit 1, Tab 14, pp. 48 – 49.
[27] Exhibit 1, Tab 21.
[28] Exhibit 1, Tab 6, p. 6 and Tab 14.

Mr Bonifazi the motorcycle had tipped over sideways, with the front handlebars still facing towards the no-through road.[29] Trying to reconstruct events, Mr Bonifazi thought the motorcycle had hit the back bumper of the front-end loader, which had caused it to fall over sideways.[30]

27. Mr Bonifazi said the motorcycle engine stalled, so he did not have to turn it off.[31] He pulled the motorcycle off Mr Morgan-Smith and flipped it onto its other side. This was consistent with evidence at the scene reviewed by a crash investigator.[32] Mr Morgan-Smith was conscious at this time but in pain. He told Mr Bonifazi his name was Sean. Mr Bonifazi told police that Mr Morgan-Smith took off his own helmet. Mr Bonifazi spoke to Mr Morgan-Smith and asked him if he wanted him to call an ambulance. Mr Morgan-Smith said he did, so Mr Bonifazi used his work telephone to call emergency services and request an ambulance.[33] When Mr Bonifazi rang emergency services, it was recorded that he said that the postman's motorbike had been clipped by his machinery.[34]

28. It is apparent Mr Morgan-Smith was able to tell Mr Bonifazi his age while Mr Bonifazi was on the telephone to emergency services.[35] However, from about this time Mr Bonifazi recalled Mr Morgan-Smith began screaming out in pain and was unable to answer Mr Bonifazi's questions about where the pain was coming from. After a time Mr Morgan-Smith went quiet and appeared to be going into shock. Mr Bonifazi said this prompted him to call emergency services again and ask them to hurry up and send the ambulance as it appeared Mr Morgan-Smith was going into shock and was still breathing but no longer alert.[36] Mr Bonifazi also rang his employer to advise what had occurred.[37]

29. Around this time a lady walking her dog, Ms Philippa Lyons, had come across the scene. She told police she had heard some loud beeping then it stopped suddenly and at the same time she heard the sound of a man shouting, then everything went quiet. Ms Lyons continued walking forward and saw a postman, Mr Morgan-Smith, lying on the ground next to the footpath and mail scattered everywhere. Mr Bonifazi was talking on his telephone. Ms Lyons approached to see if she could help. Mr Bonifazi said he was on the telephone to emergency services so she turned her attention to Mr Morgan-Smith. He was conscious and said he was having trouble breathing. He was able to speak but it was obvious he was in pain and had an injury around his left eye. Mr Morgan-Smith asked Ms Lyons to call his wife and gave her his mobile telephone and told her the pin code to unlock it. She tried to call Mrs Morgan-Smith, who did not answer, so she then left a voicemail message.[38]

[29] T 25.
[30] T 25.
[31] T 27.
[32] Exhibit 1, Tab 15 and Tab 21.
[33] Exhibit 1, Tab 14, pp. 33 – 34.
[34] Exhibit 1, Tab 15.
[35] Exhibit 1, Tab 15, p.1.
[36] Exhibit 1, Tab 14.
[37] Exhibit 1, Tab 14.
[38] Exhibit 1, Tab 16.

30. Ms Lyons stayed with Mr Morgan-Smith and held his hand and tried to reassure him while waiting for the ambulance to arrive. A neighbour, Mr Raveenthran Raman Kutty, had also come to assist. Mr Raman Kutty lived next door to the vacant block where Mr Bonifazi was working. He had seen the front end loader and heard it beeping when reversing the day before and again the following day. Mr Raman Kutty had heard when the loader stopped beeping around 10.10 am and was told by a workman that there had been an accident, so he went to see if he could help. He recognised Mr Morgan-Smith as his local postman, whom he had spoken to a few days earlier.[39]

31. Mr Morgan-Smith complained he couldn't breathe so they tried to undo some of his clothing. Mr Morgan-Smith's eyes began to glaze over and he stopped talking but he was still breathing. They tried to put him into the recovery position and shortly afterwards an ambulance arrived and the ambulance officers took over caring for Mr Morgan-Smith. On arrival, the ambulance officers found Mr Morgan-Smith to be unconscious and not alert. The only obvious external injury was around his left eye. As his airway was unprotected they tried to assist his breathing. At 10.46 am Mr Morgan-Smith went into cardiac arrest and CPR was commenced.[40]

32. Ms Lyons spoke to Mr Bonifazi, who was now in the company of his work supervisor. She overheard Mr Bonifazi tell the ambulance officer that he thought his front end loader had only been moving at about 2 km/hr and he was glad Mr Morgan-Smith had not gone under his wheels. She also overhead Mr Bonifazi tell his supervisor that he had had to drag Mr Morgan-Smith out from under his motorcycle. These statements were consistent with Mr Bonifazi's later interview with police.[41]

33. The first attending ambulance officers recorded in their patient care record that Mr Bonifazi had also alleged that Mr Morgan-Smith had "tried to dart along the footpath to beat [him]."[42] Mr Bonifazi couldn't specifically remember saying this to the ambulance officers, but he agreed it was a possible explanation for what occurred, although he did not see Mr Morgan-Smith attempting to do so.[43] Mr Bonifazi's lights and reversing beepers were working, so Mr Bonifazi believed this should have alerted Mr Morgan-Smith that there was a hazard and he should exercise caution.[44]

34. Nevertheless, Mr Bonifazi agreed the responsibility was on him to stop his vehicle, if he had seen Mr Morgan-Smith approaching.[45] The problem was, he did not see him. Mr Bonifazi was asked if he could explain why he hadn't seen Mr Morgan-Smith, and he said he thought it must have been due to Mr Morgan-Smith coming up "so quick."[46] There is no objective evidence as to the speed at which Mr Morgan-Smith was travelling as he approached the site. There is CCTV footage of him travelling up the road prior to moving on

[39] Exhibit 1, Tab 17.
[40] Exhibit 1, Tab 20.
[41] Exhibit 1, Tab 16.
[42] Exhibit 1, Tab 20.
[43] T 30.
[44] T 31.
[45] T 31.
[46] T 30.

to the footpath to deliver mail, but it does not show the moments before impact and the police crash investigator could not estimate the motorcycle's speed at impact.[47]

CAUSE OF DEATH

35. Mr Morgan-Smith was taken to Fiona Stanley Hospital as a Priority 1.[48] Sadly, despite further intensive resuscitation efforts, he could not be revived and his death was confirmed at the hospital by a Consultant Emergency Physician at 11.34 am.[49]

36. On 26 June 2015 a Forensic Pathologist, Dr Jodie White, performed a post mortem examination on the body of Mr Morgan-Smith. The examination showed a large haemoperitoneum (blood in the abdominal cavity) in association with extensive tearing and disruption of the omentum and small bowel mesentery. There were scattered soft tissue injuries and a bony injury to the left hand. There were also injuries consistent with resuscitation efforts.[50] Toxicology analysis detected no alcohol or drugs.[51]

37. At the conclusion of the examination, Dr White formed the opinion the cause of death was abdominal injuries. I accept and adopt the opinion of Dr White as to the cause of death.

38. Mrs Morgan-Smith raised a concern that there was possibly a delay from the time of the incident and the first call to emergency services, which was logged at 10.15 am. Mrs Morgan-Smith relies on the time given on the CCTV footage to identify the delay until this call as being in the order of 7 minutes, although the times on the CCTV footage have not been confirmed as accurate so there is a limit to how much they can be relied upon. In addition, it appears from the patient care record, that the time the ambulance arrived was perhaps 4 minutes earlier, as there is a note that due to the incomplete road and poor mapping, one ambulance officer left the vehicle to go and assess Mr Morgan-Smith while the other ambulance officer drove the ambulance to a different spot for better access, which took approximately 4 minutes.[52]

39. In any event, after making enquiries with Dr White, I am satisfied that a difference of even as much as seven minutes in making the first call would not have made a difference to the outcome for Mr Morgan-Smith, given the extent of his internal injuries, which were severe and would likely to have been very difficult to surgically repair, even with immediate medical attention.[53] Sadly, the severe crush type injuries sustained by Mr Morgan-Smith were so serious that he was unlikely to survive them.

[47] Exhibit 1, Tab 21.
[48] Exhibit 1, Tab 20.
[49] Exhibit 1, Tab 2.
[50] Exhibit 1, Tab 4.
[51] Exhibit 1, Tab 5.
[52] Exhibit 1, Tab 20.
[53] Email correspondence with Dr White, dated 10 September 2019.

POLICE INVESTIGATION

40. As noted above, Mr Bonifazi was interviewed by police as part of a Major Crash investigation. Mr Bonifazi was also breathalysed after the incident and his breath sample detected no alcohol. This was also the case for Mr Morgan-Smith.[54]

41. It was confirmed Mr Bonifazi had an appropriate licence qualification to drive the front end loader and had held his ticket for six or seven years.[55]

42. In terms of his employment, Mr Morgan-Smith had undergone an induction programme, including motorcycle training and assessment, when he commenced his employment with Australia Post.[56] He also held proper qualifications to ride the motorcycle provided by his employer.

43. Both the front end loader and the Australia Post Honda motorcycle were examined by a qualified mechanic and vehicle examiner from the Police Vehicle Investigations Unit. The examiner detected minor defects in the front end loader and none in the motorcycle.[57]

44. It was noted that the motorcycle was fitted with right and left hand panniers constructed of high visibility reflective material and a triangular flag, also constructed of high visibility material, was mounted on a pole approximately 1.5 m long. The pole was fixed to the rear of the motorcycle.[58] These items made the motorcycle highly visible. Mr Morgan-Smith was also wearing reflective clothing and a white helmet.[59]

45. As noted above, CCTV footage from neighbouring houses and tyre imprints indicate the front-end loader had been moved forward post the impact with Mr Morgan-Smith's motorcycle.[60]

46. A tyre imprint from the left rear wheel of the front-end loader was found under the Honda motorcycle when lifted.[61] Sand adhering to the exposed left side of the motorcycle, and disturbed ground, indicated that the motorcycle had been rolled over from its left side to its right side post impact. There was impact damage to the right side of the motorcycle, towards the centre and rear. Yellow 'paint like' material was present on the top of the pannier framing.[62] This is significant as the front-end loader was yellow.[63] Underneath the left rear of the front end loader were recent scrape and scuff markings and white 'paint like' material.[64]

[54] Exhibit 1, Tab 6, p. 8.
[55] Exhibit 1, Tab 14, p. 38.
[56] Exhibit 1, Tab 19.
[57] Exhibit 1, Tab 6, p. 4.
[58] Exhibit 1, Tab 6, p. 4.
[59] Exhibit 1, Tab 6, p. 7.
[60] Exhibit 1, Tab 6, p. 3.
[61] Exhibit 1, Tab 6, p. 3 and Tab 21.
[62] Exhibit 1, Tab 6, p. 3.
[63] Exhibit 1, Tab 21.
[64] Exhibit 1, Tab 21.

47. The police crash investigator looked at the front end loader and believed it had good 360° visibility from the driver's position.[65]Major crash investigators found no obvious obstructions to vision present on the footpath, with good visibility along the section of carriageway and footpath on the immediate approach to the site where the crash occurred. It was a sunny and dry day and the area was well-lit by sunlight.[66]

48. The area where the incident occurred was adjacent to a vacant residential block at 21 Elkington Pass (where Mr Bonifazi was working). Elkington Pass had been split into two streets, separated by a sandy area with wooden bollards. It was clear the road for vehicles terminated next to the vacant residential block at 21 Elkington Pass and the concrete footpath also ended, but there was a pedestrian track worn into the dirt that ran from the end of the footpath at 21 Elkington Pass through to the continuation of the roadway on the other side of the bollards.

49. Senior Constable Adrian Callaghan, a qualified crash investigator, produced an Initial Collision Assessment Report and concluded the front end loader was reversing out of the western side of the vacant block and starting to cross the footpath when it collided with the Honda motorcycle ridden by Mr Morgan-Smith. The motorcycle was travelling on the footpath, heading in a northerly direction. As noted above, the evidence suggested the front end loader was travelling at low speed when it made contact with the right side of the motorcycle.[67]

50. The area where Mr Morgan-Smith was struck, on the footpath and verge, is classified as a road for the purposes of the *Road Traffic Act 1974* (WA).[68] As a postman, Mr Morgan-Smith was permitted to ride on footpaths at a maximum speed of 10 km/hr while delivering mail, provided that the footpath was not more than 100m from his next delivery point and that he took adequate precautions to avoid colliding with, endangering or obstructing any person or vehicle on the path.[69] The police investigators

[65] Exhibit 1, Tab 6, p. 3 and Tab 21.
[66] Exhibit 1, Tab 6, p. 4.
[67] Exhibit 1, Tab 6, p. 4.
[68] Section 4, *Road Traffic (Administration) Act 2008* (WA).
[69] Section 253(h)(i, ii, iii) *Road Traffic Code 2000* (WA).

concluded Mr Morgan-Smith was legally entitled to ride on the footpath under specified conditions, with which he appeared to be compliant.

51. The investigating police could not identify any reasonable explanation for why Mr Bonifazi did not see Mr Morgan-Smith, apart from him failing to look down the footpath before reversing. The evidence indicated Mr Morgan-Smith had ridden from the road onto the footpath and then traversed a 30m section of footpath to reach the point where he was struck. There was nothing to obstruct Mr Bonifazi's view of anything up to 50m along the footpath on the immediate approach to the crash site.[70] A re-creation by police shows Mr Morgan-Smith, dressed as he was and on his motorcycle, would have been highly visible as he approached.[71]

52. As for Mr Morgan-Smith's decision to drive behind the front-end loader, based upon the CCTV footage, the police investigators found there is an indication that Mr Bonifazi momentarily stopped on the site before reversing back into Mr Morgan-Smith. It was felt Mr Morgan-Smith could have quite reasonably have believed that Mr Bonifazi had stopped on the site as he had seen Mr Morgan-Smith and was allowing him to make safe progress past

[70] Exhibit 1, Tab 6, p. 7.
[71] Exhibit 1, Tab 13, p. 5.

along the footpath.[72] Sadly, this was not the case and Mr Bonifazi reversed into him.

53. At the conclusion of the police investigation, police officers charged Mr Bonifazi with the offence of dangerous driving causing death.[73] A brief of evidence was compiled and submitted to the Office of the Director of Public Prosecutions (ODPP), which has the carriage of this charge as it is can only be dealt with on indictment. Following a case conference between ODPP prosecutors and the investigating officer, Detective Senior Constable Bushby, the ODPP prosecutors indicated that they felt there were no reasonable prospects of conviction and the prosecution against Mr Bonifazi was discontinued.[74] This information was not communicated by the WA Police or ODPP to WorkSafe/Comcare staff, but they appear to have found out through their own inquiries.

54. It is not my role as a coroner to apportion criminal responsibility, and I am prohibited from framing a finding or comment in such a way as to appear to suggest that a person is guilty of any offence. Therefore, it is not my role to comment on the decision of the ODPP to discontinue the prosecution. What I can say, however, is that I agree with the investigating police officers' position that there was nothing in the evidence they obtained to suggest that the conduct of Mr Morgan-Smith in any way absolved Mr Bonifazi from his responsibility to keep a proper lookout for members of the public using the footpath. The re-creation shows he would have been highly visible coming up the path, and Mr Bonifazi's evidence, as I've summarised earlier, was that he believed there was nothing to obstruct his view. It is difficult to understand how he could have missed seeing Mr Morgan-Smith approaching.

55. I did not find Mr Bonifazi to be a truthful and reliable witness as to the events. However, there is limited other evidence available upon which to reach conclusions about what happened.

56. Mrs Morgan-Smith has raised her concerns that he minimised his conduct even immediately after the event, when speaking to the emergency services staff and witnesses, which may have affected his medical treatment. Having read the Patient Care Records, I am satisfied that the ambulance officers treated the matter seriously and any minimisation of events by Mr Bonifazi was unlikely to affected their approach to Mr Morgan-Smith's emergency care.

57. It was apparent from his evidence that Mr Bonifazi made an assumption that if his lights and reversing beepers were operating, people approaching would know to keep out of his way, but that is a dangerous assumption to make in such circumstances. Mr Morgan-Smith clearly assumed he could safely pass behind the front-end loader, but as he reached the back of the front-end loader, in the acknowledged blind spot, Mr Bonifazi reversed and struck the motorcycle while it was on the footpath. I accept Mr Bonifazi did not see the motorcycle before he hit it, but I also consider the responsibility was on him to put in place measures to ensure people could not enter the blind spot.

[72] Exhibit 1, Tab 6, p. 8.
[73] Pursuant to s 59(1)(b) *Road Traffic Act*.
[74] Exhibit 1, Tab 6, p. 9.

58. This leads to the WorkSafe and Comcare role, from a State and Commonwealth perspective, in regulating safe work practices when there is large plant and machinery and members of the public coming into contact.

COMCARE AND WORKSAFE INVESTIGATIONS

59. Mr Morgan-Smith was working as a postal delivery officer and riding his postal delivery motorcycle at the relevant time. He was in the process of transiting from a previous mail drop off to his next delivery address when he rode along the footpath parallel to Elkington Pass and collided with the front end loader.[75]

60. The Commonwealth work health and safety regulator Comcare is responsible for monitoring and ensuring compliance with the Commonwealth work health and safety laws, which are contained within the *Work Health Safety Act 2011* (Cth) and associated regulations. As Australia Post is a Commonwealth agency, Comcare's regulatory powers were enlivened when Mr Morgan-Smith was killed during the course of conducting his duties as an Australia Post worker. Comcare conducted an investigation into the death of Mr Morgan-Smith and assessed Australia Post's compliance with the Act and regulations.[76]

61. The focus of the investigation was whether Australia Post provided a safe workplace, as well as the conduct of Mr Morgan-Smith as an Australia Post employee. In addition, the conduct of third parties, including West Coast Site Works and Mr Bonifazi, was considered as they had management or control of plant at the workplace of Mr Morgan-Smith or were a person at the workplace (on the basis that Mr Morgan-Smith's motorcycle was, in effect, his Australia Post workplace at the time).[77] Mr Cliff Montgomery, who was employed as inspector for Comcare at the relevant time, conducted the inquiry.

62. Mr Montgomery indicated that he gathered information from Australia Post on their policies and procedures on training, as well as the specific training Mr Morgan-Smith received as part of his employment.[78] The information obtained on the training appeared satisfactory and raised no concerns. The equipment used by Mr Morgan-Smith, such as the motorcycle and his clothing and helmet, was also considered, and Mr Montgomery indicated that everything appeared to be in order and again raised no concerns.[79] The motorcycle was found by police vehicle investigators to be appropriately licensed and well-maintained.

63. Mr Montgomery noted that Australia Post has included in its national toolbox talks the topic of awareness to motorcycle postal delivery officers conducting work near construction sites and reversing vehicles and raised a

[75] Exhibit 2, Tab 1, p. 1.
[76] Exhibit 2, Tab 1, p. 1.
[77] Exhibit 1, Tab 1, p. 1.
[78] T 64.
[79] T 64 – 65.

number of campaigns for ongoing public awareness. Mr Montgomery concurred with the organisation's response and expressed the opinion the organisation should continue to encourage workers to be vigilant.[80]

64. Mr Montgomery obtained from Australia Post a breakdown of what is the organisation's expectations for how Mr Morgan-Smith conducted his work, and found no issues of concern. He held the appropriate motorcycle licence for his work requirements. The investigation did not find any faults or failures on the part of Mr Morgan-Smith in carrying out his duties, which included a duty to take reasonable care for his own health and safety, although it was noted that there was little information available about what Mr Morgan-Smith was doing at the precise time of the motorcycle crash. Nevertheless, the inquiry did not find Mr Morgan-Smith had engaged in any contributory behaviour.[81]

65. Mr Montgomery's investigation concluded that West Coast Site Works had ensured, as far as is reasonably practicable, that the plant (namely the front-end loader itself) was without risks to the health and safety of any person.[82] Mr Montgomery also noted the advice from West Coast Site Works that they had engaged an OH&S specialist to review their practices, which indicated a desire by the organisation to improve their safety culture. Their voluntary actions negated any need to issue an improvement notice.[83]

66. As part of his investigation, Mr Montgomery had attended the worksite after the incident and did not observe any formal exclusion zone or barrier system to protect workers, others and the general public from exposure to the front end loader being operated by Mr Bonifazi. Access to the site was not restricted and there was no spotter or supervisor in attendance, despite these options being available on the West Coast Site Works JSA form. Mr Bonifazi declined to speak to Mr Montgomery on legal advice, but did provide written information in response to a formal request.[84]

67. The only adverse conclusion the Comcare investigation reached was in relation to the conduct of Mr Bonifazi. The investigation found that as the driver of the front end loader, Mr Bonifazi failed to comply with his duty under s 29 of the Act, by not taking reasonable care that his acts or omissions did not adversely affect the health and safety of other persons.[85] Mr Montgomery concluded that there should have been some sort of warning process or something in place to separate the work that was occurring, namely Mr Bonifazi's site work activity, and the general public, including anyone that might be on the footpath, riding or otherwise.[86]

68. However, the investigation was not considered to have revealed sufficient evidence to support any prosecution by Comcare against Mr Bonifazi. Furthermore, it was noted that at that time Mr Bonifazi was facing a Western Australian criminal charge of dangerous driving occasioning death (although

[80] Exhibit 2, Tab 1, p. 4.
[81] T 65 – 66; Exhibit 2, Tab 1, pp. 1 -4.
[82] T 69; Exhibit 2, Tab 1, p. 2.
[83] Exhibit 2, Tab
[84] Exhibit 2, Tab 1, p. 3.
[85] Exhibit 2, Tab 1, p. 2.
[86] T 67.

as noted above, this was later discontinued by the State). Mr Montgomery did not recommend any enforcement action be taken by Comcare against Mr Bonifazi as it was considered that it was not in the public interest given the criminal charge he was then facing.[87]

69. It was recorded in the Comcare investigation report that the front end loader was being operated at the time of the incident by Mr Bonifazi in what would be defined as High Risk Construction Work under the *Occupational Health and Safety Regulations 1996* (WA), regulation 3.137. It was suggested that there may have been breaches by Mr Bonifazi and his employer within that legislation.[88]

70. Mr Montgomery suggested that there could have been a method for separating the works occurring at the site and the public, through as a minimum, a barrier arrangement, and then possibly the use of a spotter when the loader was moving over the footpath.[89] These types of suggestions were consistent with the information provided by the WA Department of Mines, Industry, Regulation and Safety through Worksafe on the commerce website regarding construction work and the public. On the relevant website, it indicates that the movement of plant and equipment "to, around and on construction sites creates hazards." Relevant to this matter, the suggestions made are that the public can be isolated by the following measures:[90]

- *Enclosure of construction site via fencing;*
- *Display of warning signs/lights;*
- *Arrange for a controller to redirect traffic/people;*
- *Provide a temporary by-pass for traffic/people;*
- *Erection of barriers around work area;*
- *Use of spotters working with the plant*

71. Paperwork seized by police investigators included a Site Specific Contract Agreement between the owners of the building site, and West Coast Site Works, Mr Bonifazi's employer. It also included the Job Safety Analysis signed by Mr Bonifazi. Both documents mention the potential use of cones, signs or barriers to protect others on the site and members of the public.[91]

72. Counsel Assisting contacted legal counsel at WorkSafe on 5 June 2018 to clarify the status of any WorkSafe investigation into the death of Mr Morgan-Smith. A prompt reply was received by email that same day indicating that Mr Chris Kirwin, who is employed in the Directorate of WorkSafe as the Director WorkSafe Industrial and Regional, had advised that because Mr Morgan-Smith was employed directly by Australia Post, who fall within the Commonwealth's jurisdiction, WorkSafe did not investigate the incident.[92]

[87] T 67; Exhibit 2, Tab 1, p. 5.
[88] Exhibit 2, Tab 1, p.4.
[89] T 70 – 71.
[90] Exhibit 2, Tab 1 and Tab 1B: http://www.commerce.wa.gov.au/worksafe/construction-work-and-public.
[91] Exhibit 1, Tab 6, p. 5.
[92] Exhibit 1, Tab 8.

73. Mr Kirwin is a long-term WorkSafe employee and has been in his current role, or its equivalent, since 2006. Mr Kirwin also has past experience working for Comcare and in the private sector.[93] On 24 June 2015 a WorkSafe call centre member hand-delivered to Mr Kirwin notification of a call from the WA Police regarding the incident involving Mr Morgan-Smith. The WorkSafe call centre member had apparently advised the WA Police caller that they should contact Comcare, as Mr Morgan-Smith was a Commonwealth employee.[94] Mr Kirwin also made contact with his equivalent at Comcare, Mr Tony Sutcliffe. Mr Sutcliffe advised he was already aware of the incident and Comcare staff were on their way to the incident site.[95] Mr Kirwin decided that WorkSafe inspectors would not attend the incident site to investigate at that time as the WA Police and Comcare were already investigating, although he said he was willing to reassess this position at a later time if required.[96]

74. On 1 July 2015 Detective Senior Constable Bushby from the Major Crash Investigation Section contacted WorkSafe in relation to Mr Morgan-Smith's death and advised that the incident that led to his death had occurred in the vicinity of a building site. Mr Kirwin gave consideration to the matter and notified Detective Senior Constable Bushby on 10 July 2015 that he remained of the view that WA Police were well suited to investigate the incident, given it occurred on a footpath, which is deemed to be part of a 'road'.[97] At that time Mr Kirwin was viewing it from the perspective of it being a road traffic crash between two vehicles on a roadway, rather than a worksite.[98] Mr Kirwin later acknowledged that the piece of equipment (namely the front end loader) can be a work site in its own right, but he wasn't thinking in those terms at the time.[99]

75. On 13 August 2015 Mr Morgan-Smith's widow contacted WorkSafe and spoke to Mr Kirwin. This was the first contact between Mr Morgan-Smith's family and WorkSafe as WorkSafe had not commenced an investigation. Mr Kirwin directed Mrs Morgan-Smith to Comcare and the WA Police. Mr Kirwin also emailed Mrs Morgan-Smith that day to provide some links to documents, including the WorkSafe document "When your partner or family member dies in a work related accident."[100]

76. On 4 September 2015 Mr Kirwin attended a meeting with Mr Sutcliffe from Comcare and representatives from Australia Post at Comcare offices. The meeting was in relation to Australia Post workers operating on footpaths generally. Mr Kirwin indicated that he was advised at the meeting that Comcare's investigation was progressing and it was not raised at that time that WorkSafe might need to consider conducting its own investigation. Mr Kirwin said he felt comfortable that Comcare were investigating and was happy with the level of information he had received. Mr Kirwin acknowledged

[93] Exhibit 2, Tab 8.
[94] Exhibit 2, Tab 8.
[95] Exhibit 2, Tab 8.
[96] Exhibit 2, Tab 8 [17] – [20].
[97] Exhibit 1, Tab 8 [23] – [29].
[98] T 76; Exhibit 2, Tab 8, Attachment C.
[99] T 77.
[100] Exhibit 2, Tab 8 [32].

there was the possibility of conducting a dual investigation but did not consider it at the time.[101]

77. However, not long after, another employee within Mr Kirwin's Department did raise this issue. On 12 October 2015, Principal Inspector Nathan Fry from the Manufacturing, Transport and Service Industries Directorate emailed Mr Kirwin raising concerns as to WorkSafe not having investigated the incident thus far. Having learnt from past experience, Mr Fry rather presciently suggested that the situation might arise that the police could drop their charges, leaving WorkSafe in a difficult situation having delayed their investigation. Further, Mr Fry noted that the jurisdiction over the earthmoving business and loader driver would more likely fall within the State jurisdiction, so there was a real possibility that Comcare might direct the investigation into them to WorkSafe at a later stage.[102]

78. At that time Mr Kirwin had become aware that Mr Bonifazi had been charged by police with causing the death of Mr Morgan-Smith, so he responded to Principal Inspector Fry on the basis that he was concerned about the potential for double jeopardy to arise and was also awaiting the outcome of the Comcare investigation.[103] Mr Kirwin followed up with Mr Sutcliffe at Comcare that day to ask about the progress of their investigation. At that stage, the investigation was still ongoing and Comcare was considering their legal position on jurisdiction as well. Mr Fry still expressed some concern about the delay in WorkSafe commencing an investigation, and suggested it was a "risky strategy"[104] to wait, but left it with Mr Kirwin.

79. Mr Kirwin agreed at the inquest that, in hindsight, he might have taken a different path and followed Mr Fry's advice, but at the time he decided to leave the matter with Comcare and the WA Police.[105]

80. The Comcare investigation concluded on 5 February 2016 and as noted above, no actions were taken. Sometime after, Mr Kirwin made enquiries with Mr Sutcliffe as to WorkSafe obtaining material from the Comcare investigation. He followed up these enquiries in early April 2016. On 7 April 2016 Mr Sutcliffe confirmed that Comcare had investigated and Mr Kirwin understood from their conversation that Comcare did not have jurisdiction to take enforcement against the business or operator of the front end loader, although this is somewhat different to the evidence of Inspector Montgomery.

81. Mr Kirwin stated that this information led him to reassess the need for WorkSafe to investigate. On 8 April 2016 Mr Kirwin contacted Detective Senior Constable Bushby to enquire about the progress of the police investigation. Detective Senior Constable Bushby responded on 13 April 2016 to the effect that the WA Police had determined that the primary causes of the incident were the absence of signage or blocking of the footpath to prevent its use while the loader was reversing over it and the failure of the driver of the front end loader to keep a proper lookout while

[101] T 79 - 80; Exhibit 2, Tab 8.
[102] Exhibit 2, Tab 8, Attachment D.
[103] Exhibit 2, Tab 8 [35] – [36].
[104] T 80.
[105] T 81 – 82.

reversing.[106] WorkSafe was then advised on 18 April 2016 that the criminal charge laid against Mr Bonifazi had been dismissed in the Magistrates Court.[107]

82. Mr Kirwin stated the absence of the potential for enforcement outcomes from Comcare or the WA Police prompted him to seek more material from Comcare and the police "to determine whether WorkSafe should consider enforcement action."[108] Mr Kirwin recorded the incident as an 'investigation' in WorkSafe's computer system on 21 April 2016 but he did not mark it as a 'fatality/major investigation', although he concedes this was an error, and had some ramifications later for how the matter was closed off.[109]

83. The request for documentation from the WA Police was re-directed to the State Coroner and on 22 April 2016 the post mortem report and toxicology report were provided, but the State Coroner's Office indicated they were still waiting to receive the police report. Mr Kirwin made some other enquiries on 22 April 2016, including contacting the City of Gosnells to request details of the building permit and any traffic management plans for 21 Elkington Pass. Mr Kirwin received a building permit only, and he indicated he had not been expecting there to have been a permit to close the footpath as he assumed the driver of the front-end loader would only access the footpath when entering and leaving the site and conduct their work within the site. He also believed they would not reverse across the footpath if practicable and assumed they would adopt a practice of pointing the back-end of the loader onto the block, rather than the road, when working near the property boundary.[110] This was what Mr Kirwin understood was usual practice, based on his experience at WorkSafe.[111]

84. Mr Kirwin attended an address on 27 April 2016 where a front end loader was being operated by West Coast Site Works. He observed the site was fenced with temporary fencing while the loader was levelling the block and the loader drove forwards out of the site when leaving. It appeared to Mr Kirwin that this showed a change in the method of working had been implemented following Mr Morgan-Smith's death.[112]

85. Mr Kirwin received some documentation from Comcare not long after, including Inspector Montgomery's report. He became aware that Mr Bonifazi had declined to be interviewed as part of the Comcare investigation but for various reasons he decide not to attempt to interview Mr Bonifazi.[113]

86. There were some delays in the State Coroner's Office providing information to Mr Kirwin, which required him to follow-up his request a number of times, but eventually Mr Kirwin received a package of documents on 8 May 2017.[114] It would appear Mr Kirwin did not receive a copy of the CCTV

[106] Exhibit 2, Tab 8 [48] – [49].
[107] T 83; Exhibit 2, Tab 8 [51].
[108] Exhibit 2, Tab 8 [54].
[109] Exhibit 2, Tab 8 [55] – [57].
[110] T 84; Exhibit 2, Tab 8 [61] – [67].
[111] T 85.
[112] Exhibit 2, Tab 8 [68] – [69].
[113] Exhibit 2, Tab 8 [72] – [78].
[114] Exhibit 2, Tab 8 [82] – [86].

footage, the interview with Mr Bonifazi and the police report, as he only viewed these items for the first time shortly before the inquest.[115]

87. On 14 September 2017 Mr Kirwin spoke to Mr Joseph Martino, the operator of West Coast Site Works, and confirmed that it is not his practice to obtain local government permits to close footpaths.[116]

88. Sometime between 14 September 2017 and 14 October 2017 Mr Kirwin reviewed all of the material he had obtained and concluded that there were no reasonable prospects of conviction of Mr Martino (as the business owner of West Coast Site Works) nor Mr Bonifazi (as the driver of the front end loader) for an offence under the *Occupational Health and Safety Act* causative of the death of Mr Morgan-Smith. Mr Kirwin stated he had regard to factors including:

- the relative visibility of the site;
- the reversing alarm on the loader;
- the relatively low objective risk, looking prospectively, of a person being unable to avoid the loader; and
- the general absence of an expectation that the footpath would have been closed to traffic in those circumstances.[117]

89. Mr Kirwin decided that the WorkSafe investigation file would be closed on 14 October 2017. This should have involved sign off by the WorkSafe Commissioner given how the investigation had been run, but this did not occur and the omission was not identified due to the way the case had been opened.[118] Mr Kirwin advised that since that time a separate Directorate of Investigations has been created, with all serious matters going before the Director of Investigations, who would review this type of decision-making. Further, in December 2018 an independent WorkSafe Commissioner was appointed by the Minister and any serious WorkSafe investigation that is intended to be closed off must go before the Commissioner before it is finalised. These changes create additional safeguards to avoid the problem that arose in this case.[119]

90. Mr Kirwin advised this Court that, in retrospect, he accepts that he should have ensured that WorkSafe actively investigated the matter at an earlier stage. He said in evidence that "it was a mistake not to employ assets on day one."[120] In particular, Mr Kirwin acknowledged that, as pointed out by Principal Inspector Fry, he had now realised it was unlikely that Comcare would have had enforcement jurisdiction over West Coast Site Works or Mr Bonifazi. Mr Kirwin was open and frank in his admission and accepted responsibility for the outcome of the matter and for the ways the outcome was likely to have affected the family of Mr Morgan-Smith.[121]

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[115] T 87.
[116] Exhibit 2, Tab 8 [87].
[117] Exhibit 2, Tab 8 [88] – [89].
[118] Exhibit 2, Tab 8 [90].
[119] T 97 – 98.
[120] T 84.
[121] Exhibit 2, Tab 8 [95] – [96].

91. Mr Kirwin also acknowledged that if the WorkSafe investigation had commenced at an earlier stage, it might have led to a different outcome in terms of a WorkSafe prosecution being commenced.[122] There is nothing that can be done about this now, as the statute of limitation period has expired.

92. Mr Morgan-Smith's widow had commented in a letter to the Coroner about her feeling that there had not been clear and open communication with WorkSafe. Another benefit of WorkSafe commencing an investigation at an earlier stage would have been the improved communication it would have brought with Mr Morgan-Smith's next of kin, as I understand there would have been a more pro-active approach by WorkSafe to notify family and keep them informed. Instead, Mrs Morgan-Smith was left to make the first contact in this case.

93. In March 2019 Mr Kirwin met with the WorkSafe Commissioner and representatives of Comcare to discuss various matters, including the need for more collaboration and communication between Comcare and WorkSafe in relation to matters such as proactive regulation, prevailing workplace issues, joint inspections, joint training. Relevantly to this matter, they also discussed an emphasis on protocols for dealing with matters involving potential jurisdictional cross-over, in addition to the existing Memorandum of Understanding between the authorities.[123] Mr Kirwin advised that the implementation of the harmonised Work Health and Safety legislation in Western Australia is anticipated to further facilitate information-sharing between WorkSafe and, relevantly, Comcare.[124] I understand that legislation is still to be enacted.

94. It was submitted on behalf of Comcare that ultimately, in this case, it was appropriate that WorkSafe undertake the relevant investigation into the conduct of Mr Bonifazi as Comcare's jurisdiction was only enlivened because of Mr Morgan-Smith's employment, whereas the focus of the investigation really became the conduct of Mr Bonifazi and his employer West Coast Site Works. In those circumstances, although technically Comcare could take action, it was appropriate that WorkSafe discharge the duty to investigate under the relevant WA Act.[125] Comcare was not best placed to regulate the kind of conduct that was being scrutinised, as the general site work operations that were being undertaken are the type of works that usually fall within the domain of WorkSafe. As counsel for Comcare put it, "the conducting of a construction on a residential site is in the heart"[126] of WorkSafe's jurisdiction.

95. Counsel appearing on behalf of WorkSafe, as part of the Department, accepted this was the case and that WorkSafe was the appropriate regulator in this case, given the focus was the conduct of Mr Bonifazi and West Coast Site Works, and WorkSafe should have commenced an investigation at an early stage.[127]

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[122] T 102, 108.
[123] Exhibit 2, Tab 8 [107] – [108].
[124] T 106 - 107; Exhibit 2, Tab 8 [109].
[125] T 111.
[126] T 119
[127] T 124.

96. Information was provided by Comcare that in 2018 Comcare initiated the development of a memorandum of understanding with the WA Police for co-ordination, co-operation and information sharing between the organisations. Unfortunately, despite some attempts to reach agreement, in February 2019 negotiations broke down and the WA Police advised Comcare that it was not in favour of the memorandum of understanding. Comcare has indicated it remains committed to engaging with the WA Police on a case-by-case basis. Comcare has also developed an internal protocol whereby, upon becoming aware of WA Police involvement in matters of concern to Comcare, Comcare inspectors will contact the WA Police and if they are also investigating the relevant inquest, Comcare will write to the WA Police advising it is undertaking an inspection or investigation and ask that they inform Comcare of any significant developments in its investigation (such as the commencing or discontinuing of a prosecution). The internal protocol is not limited to the WA Police, but instead requires Comcare inspectors to communicate with law enforcement agencies in all states and territories in which relevant incidents occur, in the absence of a MOU or Communications Protocol between Comcare and the agency.[128]

97. Comcare does not have a protocol or agreement in place with WorkSafe WA whereby Comcare will formally indicate if it has formed the view that an investigation may more appropriately be dealt with by WorkSafe. Comcare has indicated in submissions that it considers it would be of utility for Comcare and WorkSafe to develop such a protocol or agreement but at present, in the absence of such a formal process, Comcare has indicated it intends to engage with WorkSafe by exchanging written correspondence in relation to any investigation where parallel duties under the respective Acts may arise.[129] The advantage of putting such discussions in writing, is there is less prospect of the kind of miscommunication that appears to have arisen in this case.

98. I am satisfied from the evidence heard, and the additional information provided, that Comcare and Worksafe WA are conscious of the need to work co-operatively, and communicate effectively, on cross-jurisdictional matters and to also ensure they receive information from the WA Police where relevant.

99. I am also satisfied that WorkSafe has put into place better processes to ensure that a serious case such as this will be investigated at an early stage, and there are safeguards in place to ensure that no investigation is concluded without a number of senior people being satisfied that there is no scope/public interest in initiating enforcement action and/or prosecution.

100. Mrs Morgan-Smith has expressed her concern that she would not want another death to occur in similar circumstances when it could be prevented by learning lessons from the death of her husband. While Mr Kirwin has acknowledged that an earlier investigation could potentially have achieved more in terms of prosecution and enforcement that is no longer possible,

[128] Comcare's Written Submissions in Response to Issues Raised by the Coroner, filed 17 June 2019 and additional email correspondence dated 2 September 2019.
[129] Comcare's Written Submissions in Response to Issues Raised by the Coroner, filed 17 June 2019.

there is certainly nothing to prevent WorkSafe from focusing its energies on continuing to educate people on the risks involved in these kinds of activities, and providing information that encourages safe work practices. With this in mind, I have summarised below the evidence of the various witnesses as to what lessons can, and have, been learnt from this tragic event.

MANNER OF DEATH

101. If there had been a successful prosecution by the police, WorkSafe or Comcare in relation to this matter, the manner of death would be guided by that outcome. However, as the police charges were discontinued, and neither WorkSafe nor Comcare proceeded with any charges, this does not apply.

102. In the circumstances, I therefore find that the death occurred by way of accident.

PUBLIC SAFETY AT RESIDENTIAL CONSTRUCTION SITES

103. This inquest clearly raised concerns about public safety at construction sites and the need for reduction of hazards in this environment, particularly in terms of reducing interaction with pedestrians near these sites.

104. Mr Bonifazi was asked at the inquest whether, in hindsight, he felt a spotter might have been useful at this site. Mr Bonifazi agreed that spotters can be useful, and indeed are necessary, at some heavy traffic sites, but in his opinion there was insufficient traffic at the Elkington Pass site to have justified the use of a spotter.[130] Mr Bonifazi was also asked about whether the use of witches' cones on the footpath might have been helpful, but he expressed the opinion that they "don't achieve much" as in his experience, people still take the path they want to, despite witches' hats being put in place.[131] Mr Bonifazi also suggested that the flashing lights and reversing beepers on the front-end loader were more likely to be alert pedestrians to the hazard than any barrier on the footpath.[132] During his evidence, Mr Bonifazi did not volunteer any suggestions for how a similar incident could be avoided in the future. Mr Bonifazi had been told there might be an adverse comment made about his conduct, so he may have been reluctant to volunteer too much outside the scope of the facts, as he recalled them. Further, I note he no longer works as a front-end loader driver.[133]

105. Mr Joseph Martino is the owner of West Coast Hire Works and the employer of Mr Bonifazi at the time. Mr Martino was more willing to offer up some suggestions and solutions than Mr Bonifazi.

[130] T 28.
[131] T 29.
[132] T 12.
[133] T 13.

106. Mr Martino has experience operating the same type of front-end loader driven by Mr Bonifazi and he agreed with Mr Bonifazi that there is pretty good vision all the way around the loader from the cabin, other than directly behind the engine at the rear.[134] This blind spot would mean the driver would not be able to see someone standing right behind the engine.[135]

107. Mr Martino agreed that it was accepted by his business that using a front-end loader in a residential area created a risk for pedestrians and a JSA was used for each job to assess the risk. Mr Martino advised that most of their sites are in new residential areas, many of which don't have footpaths, which reduces the risk to some degree. However, in a case such as Elkington Pass, where there was a footpath, it was up to the operator to assess the hazards on site. Mr Martino did suggest that the fact the footpath ended at the site might have reduced the risk that people would walk by the site, but accepted people might still be passing through on occasion.[136] Mr Martino suggested that normal practice where a front-end loader was crossing the footpath would be to put out witches' cones. He noted that on most of their sites, the work would then be contained within the site for the most part, but if the front-end loader was crossing the footpath regularly, then a spotter would be put in place.[137] Mr Martino indicated this was the practice of his business currently, as well as at the time of the incident.[138]

108. Mr Martino was not involved in the toolbox meeting nor the JSA conducted on site for this job. Mr Martino did, however, have an opportunity to view the CCTV footage of the work on the Elkington Pass site on 24 June 2015 and he expressed the opinion that having seen the front-end loader crossing over the footpath on at least two occasions, with the benefit of hindsight in his opinion a spotter should have been used. However, he could see how an assumption might have been made at the time that no vehicles would be coming past the site, given it was a no-through road and the footpath ended.[139]

109. After Mr Morgan-Smith's death, on his own initiative, Mr Martino arranged for an Occupational Health and Safety Consultant to come in to West Coast Site Works and perform an audit to check the business' compliance. This resulted in some changes to practices being made. Sometime later, Mr Martino employed another OH&S Consultant to review the matter again and procedures were further revised and safe work method statements put in place for this type of situation. Under the business procedures at present, it is recommended that a spotter should still be used in these circumstances, although as noted above, much of their work is confined within the site and does not carry the same risk. However, Mr Martino noted that he has seen a lot of other sites where similar work is performed by other earthmoving companies and no spotter is in use. Mr Martino gave evidence that his business can only control their own worksites but feels that in the building industry a lot more could be done as there are many different

[134] T 33.
[135] T 34 - 35.
[136] T 35 - 36.
[137] T 36 – 37, 44.
[138] T 37.
[139] T 37

trades doing deliveries and other activities that involve crossing the footpath regularly.[140]

110. Mr Martino expressed the opinion that in his specific industry, namely earthmoving and site works, WorkSafe could do more to improve the safety of their work practices.[141]

111. Mr Martino provided information at the inquest about other steps his business has taken to reduce risk at worksites where there is a vehicle working near a footpath. They have made up signs to affix to witches' hats to alert pedestrians to the danger presented by earthmoving machinery operating nearby.[142]

112. Mr Martino suggested that in the new residential subdivisions, where there are a lot of tradespeople working on new construction, it might be prudent for similar signs to be put permanently in place to warn people to be cautious due to the possible hazards in the area.[143]

113. Mr Martino also explained they have a new system of safe work method statements and pre-site assessments that has replaced the previous practices.[144]

[140] T 38 - 40.
[141] T 46.
[142] Exhibit 4.
[143] T 44.
[144] T 45 – 46; Exhibit 4.

114. Mr Shane Asmus, the Chief Engineer for the City of Gosnells, gave evidence about the council's procedures for road closures in the context of building and site works. Mr Asmus indicated that road closures are not uncommon, but closure of a footpath would be a very rare requirement for a residential building site. However, as part of the building licence, a temporary crossing permit must be lodged, which requires the builder to comply with a number of conditions to keep the road reserves safe and limit damage to the infrastructure. It specifically requires the applicant not to "create any danger or obstruction to persons using the thoroughfare or path."[145] Such an application was made for the builder of the residence at 21 Elkington Pass.[146]

115. Mr Asmus suggested that the practice adopted by Mr Martino's business of a sign warning pedestrians to beware, would be common in such a case, and depending upon the amount of traversing of the footpath, a spotter might be considered appropriate, but the council does not dictate what is done and does not supervise or conduct site inspections until the work is finished, unless a complaint is received.[147]

116. Mr Brendon Wiseman is the Road Safety Policy Manager for Main Roads Western Australia. Mr Wiseman explained that the Commissioner for Main Roads has authority under the *Road Traffic Code 2000* (WA) for signage for temporary traffic management at worksites on the public road network. This authority is usually delegated to the local council, in this case the City of Gosnells. Mr Wiseman confirmed his understanding, similar to the police view, that the footpath outside the site at Elkington Pass formed part of the road reserve. As such, any work requiring traversing of the footpath may have required a traffic management plan to ensure the safety of road and footpath users. An alternative would have been to close the footpath, although similarly to Mr Asmus, Mr Wiseman indicated this would be very unusual.[148]

117. Mr Wiseman explained at the inquest that the traffic guidance scheme could have been as simple as some devices and witches' hats, with the additional possibility of the use of a spotter, although Mr Wiseman noted the relevant provision says a look-out person or spotter may be dispensed with if the work will not take longer than 10 seconds and approaching traffic can be seen for a distance away equal to 20 seconds of travel time. This would seem to indicate that the situation where the footpath is only traversed at the start of the day and the end of the day, to access the site, would not require a spotter. However, where the footpath is being continually traversed during the day, a spotter might be required.[149]

118. Mr Kirwin agreed that with the benefit of hindsight, there were a number of measures that could have been utilised to protect the public from the activities of the loader:[150]

[145] Exhibit 2, Tab 4.
[146] Exhibit 2, Tab 4.
[147] T 50 - 52.
[148] T 56 – 57; Exhibit 2, Tab 2.
[149] T 60 - 61.
[150] T 87.

- The block could have been fenced with a longer boundary and gate, with the gate closed once the loader has entered the site and the loader could then work within the fence, thus not exposing the public to the operations of the loader;
- A spotter could have been utilised; and
- The footpath and/or road could have been closed and marked off with water filled barriers to direct pedestrians to a different route.

Of these steps, Mr Kirwin suggested the fencing of the boundary was the simplest and best option to control the hazard.[151]

119. However, even at the time, Mr Kirwin commented that it was well within Mr Bonifazi's capacity, separate to putting up barriers or closing the footpath or anything of that level, to operate in a different way and work within the boundaries of the block, and to ensure he did not reverse across the footpath and did not point the rear of the loader to the public near the property boundary.[152] Mr Kirwin considered that if Mr Bonifazi could not do this, and did have to continually reverse across the footpath, then he should have put in place a traffic management plan and obtained a permit from the council as he had created a risk to pedestrians on the footpath.[153]

120. Consistent with Mr Kirwin's evidence, the WA Commission for Occupational Safety and Health issued a guidance note in February 2014 under the *Occupational Safety and Health Act* titled the "Safe movement of vehicles at workplaces."[154] The note identifies that:[155]

> *Reversing, loading, unloading and pedestrian movement are the activities most frequently linked with workplace vehicle accidents.*

121. This is intended to provide general advice and guidance to employers and employees and suppliers at workplaces to help them identify hazards. The onus remains on the duty holder to identify their site specific hazards and put effective safeguards in place.[156]

122. A safety alert had been issued by WorkSafe in 2015, titled 'Vehicles and mobile plant causing deaths at workplaces' after a similar event where a bobcat doing landscaping reversed over a person in a public park, resulting in their death. It provided general advice about powered mobile plant interacting with people as Mr Kirwin noted that people interfacing with machinery is a regular problem, with reversing a particular risk as there are blind spots and dangerous shadows. He noted that of course it is the person who usually comes off second best, so it is best to separate the people from the machinery.[157] WorkSafe also issued a media release on 3 September 2015 referring to a number of incidents involving mobile plant and

[151] T 87.
[152] T 84 – 86.
[153] T 89 - 90.
[154] Exhibit 2, Tab 7.
[155] T 89; Exhibit 2, Tab 7, p. 5.
[156] T 91.
[157] T 92 - 93.

pedestrians and noting that in all the incidents the bottom line was a lack of management of the movement and speed of vehicles and "a lack of segregation of pedestrians and vehicles."[158]

123. Mr Kirwin gave evidence that, acknowledging the issue is ongoing, in more recent times WorkSafe has published further material in the form of guidance material and media released as well as having regular contact to disseminate material through the Housing Industry Association and the Master Builders Association and the Civil Contractors Association, who all have members doing this kind of work. Further, Mr Kirwin has met with the Road Safety Commission and the WA Local Government Association (WALGA) with a view to considering what more can be done to reduce the risks on residential streets for this kind of work.[159]

124. Mr Kirwin suggested that layered into all of this, one option might be for me to recommend that local government should make it a requirement in issuing a building permit that the site be fenced before starting work. This is what often occurs on building sites in the CBD, where the risk to high level of pedestrian traffic is more openly acknowledged and site fencing is required as part of the building permit.[160] Mr Kirwin noted that it would add an additional cost but suggested that it is simply the cost of doing business safely.[161]

125. Mr Kirwin believed a trial was being undertaken by one of the local councils to require a fence to be installed as part of the issuing of all residential building permits.[162] However, further inquiry with WALGA found that the proposal had never got beyond the early stages and no such trial had been undertaken. The information provided by WALGA also indicated it is still not currently a common requirement in the building permit application process.[163] However, it was noted that in September 2015 the City of Stirling Council resolved that the City of Stirling adopt the Main Roads Western Australia Guidelines titled 'Provisions for all path users at roadworks sites in built up areas' as standard practice for maintaining a safe environment for pedestrians and to provide advice to persons intending to carry out works of the requirement to maintain a safe environment for pedestrians and monitor compliance with the same.

126. In summary, there seems to be a general agreement amongst the witnesses that the practice of having large plant or machinery reversing into areas accessible by pedestrians is undesirable and should be actively prevented, or supervised when it occurs. Mr Martino has taken active steps within his own business to try to decrease the risk to some degree, by creating additional signage to warn pedestrians, as well as improving the job safety audit process before work commences and trying to ensure that all works are done within the site as much as possible.

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158 *"Warning on vehicle movements after multiple incidents,"* Media Release, Worksafe WA, 3 September 2015.
159 T 94.
160 T 94 – 96.
161 T 95.
162 T 96.
163 Email correspondence to Counsel Assisting from Mr Mal Shervill, Policy Officer Road Safety, WALGA dated 28 May 2019.

127. Other witnesses agreed that these types of measures are helpful, and likely to be more practical than wide scale footpath and road closures. Mr Kirwin, on behalf of WorkSafe, also strongly supported consideration of local councils making it a requirement of a residential building permit that the site be fenced to protect the public from the activities on site. It was acknowledged that this would increase building costs, although no information was provided to me as to how much the average cost would be. Without more information, I am reluctant to make a recommendation that it be mandatory, as I assume this cost would ultimately be borne by the homeowner. However, in my view it is definitely a matter that is worth some consideration by local councils. Therefore, I encourage WorkSafe to re-engage with WALGA and the Road Safety Commission to consider whether this type of proposal is practical and economically viable.

128. In the meantime, other simple solutions such as working within site as much as possible and limited reversing out of the site, and putting up warning signs and witches' hats, should be actively promoted by WorkSafe, although I accept the ultimate duty and responsibility rests on the individuals carrying out these activities.

CONCLUSION

129. Mr Morgan-Smith was killed while carrying out his job as an Australia Post delivery worker. Anyone who has ever seen an Australia Post worker out delivering the mail would be aware of the many hazards they continually face, such as uncontrolled dogs and cars reversing out of driveways. The evidence indicates Mr Morgan-Smith had been trained to identify hazards and was appropriately attired and equipped to be highly visible to others, in order to reduce the risk to himself when carrying out his duties.

130. Similarly, the hazards of operating heavy plant and equipment on worksites where there is the possibility of coming into contact with the public, particularly when reversing, was well known at the time of Mr Morgan-Smith's death and various organisations had tried to educate those in the building industry to be alert to the dangers and put safety measures in place.

131. Despite these risks being known, on 24 June 2015 Mr Morgan-Smith was struck and killed by Mr Bonifazi's reversing front-end loader while Mr Morgan-Smith was delivering mail and Mr Bonifazi was conducting site works. Although some initial charges were laid by police, they were discontinued by the ODPP and no prosecution was instituted by either the Commonwealth or State work health and safety regulators. The evidence indicates some of the reasoning for the regulators not proceeding was due to the understanding there were State criminal charges underway. When it became known those charges would not proceed, it did prompt some further review by WorkSafe, but no prosecution or enforcement action was commenced.

132. I can understand the frustration and sadness of Mrs Morgan-Smith at how these investigations into her husband's sudden death proceeded and stalled.

The consultation process was limited and she has spent considerable time on her own trying to piece together and understand what occurred. Mrs Morgan-Smith accepts that poor decisions may have been made by both men on the day, but has concerns about Mr Bonifazi's lack of willingness to give a full and honest account of events. Sadly, even after a full coronial inquest, there remains facts that we do not know.

133. What is known following this inquest is that there are real and obvious dangers whenever large pieces of machinery are in operation near pedestrians. These risks are well known and there are simple measures that can be put into place to try to reduce those risks. I am hopeful that this inquest will remind those in the building industry of the tragic consequences that can occur when proper care and regard for the safety of others is not taken. WorkSafe WA is well positioned to further transmit that message to industry members and the general public, and I encourage that organisation to continue to do so.

S H Linton
Coroner
23 September 2019