



CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION: Non-Inquest findings into the deaths of Ashley Pangana MORRIS, 2016/4191 and Humbereto Ferreira LEITE, 2016/4194

TITLE OF COURT: Coroners Court of Queensland

JURISDICTION: BRISBANE

FILE NO(s): 2016/4191 and 2016/4194

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FINDINGS OF: Donald MacKenzie, Coroner

CATCHWORDS: Coroners: Inquest, Work, Health and Safety Fatalities, Reckless practices by contractor, two workers crushed by overhead concrete slabs lowered into a pit; Inadequate safety strategies in place; Mental Health Court ruling contractor permanently unfit to plead to manslaughter charge.

REPRESENTATION:

COUNSEL ASSISTING: Mr Patrick McCafferty KC & Ms Karen Dodds

***WARNING: These Findings contain still images (Not graphic) from the police investigation report*.**

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Introduction

1. On Thursday, 6 October 2016, a tragic workplace incident occurred at the Eagle Farm Racecourse (“the racecourse”) in Ascot resulting in the deaths of the deceased, Mr Ashley Pangana Morris, aged 34, and Mr Humberto Leite, aged 55 years. Mr Morris and Mr Leite suffered fatal injuries while assisting with the erection of concrete wall panels that made up a foul water pit at the racecourse.
2. The racecourse is owned by Brisbane Racing Club Limited (“BRC”). At the time of the tragic incident, the racecourse was in the process of redevelopment. That process commenced on 14 March 2016 when BRC appointed Criscon Pty Ltd (Criscon) as principal contractor and gave possession of the site to the company. At the time of their deaths, Mr Morris and Mr Leite were working as subcontractors for a company known as Construction Building Technologies Pty Ltd (“CBT”), under the direct supervision of Mr Claudio D’Alessandro who had day to day operation and management of CBT.
3. It appears that Mr D’Alessandro was engaged and paid directly by Criscon to design and construct in-ground waste tanks into which effluent from newly constructed horse stables flowed. It would be later pumped out and transported away. He came up with a concrete design for the water tanks using precast concrete panels. There were five panels to be used, four walls and a roof, with a concrete slab to be poured as a base. Each separate panel wall weighed between approximately 9 to 11 tonnes and was 5 x 5 metres in size.
4. On the day they died, Mr Leite and Mr Morris were working with Mr D’Alessandro and a crane operator, Mr Collin Young. Mr Young was employed by, or subcontracted to, a separate company, Equipment and Lifting Solutions Pty Ltd (“ELS”), to operate the crane. The men were tasked with installing four concrete pre-cast walls proximate to the settling tanks which were below ground. This was not the first occasion the men had undertaken this task. The two deceased were inside the pit to position the pre-cast concrete panels against the walls as they were lowered by the crane.
5. Fundamental to the safety of Mr Morris and Mr Leite in the pit was the bracing of the panels against the walls so that they did not fall inwards crushing them. As it transpired, three sides, the north, east and south sides, were first installed, and connected with metal brace beams. This was under Mr D’Alessandro’s direction. Critically the panels were not laterally restrained, rather they were braced to another adjacent panel at the top by Mr D’Alessandro. Both Mr Morris and Mr Leite remained in the hole in which the structure was being erected. Remaining in the hole at this stage meant that there was no means by which either could exit if required to do so urgently.

6. As the crane was in the process of lowering the fourth panel, on the western side, the three other sides buckled as the bracing failed. It was likely that the fourth panel contacted the other panels with enough force to cause the bracings to fail. The north and south walls fell outwards. The east wall fell forwards but both Mr Leite and Mr Morris were able to get on top of it once it had fallen. However, because of the bracing the northern wall had retracted, it fell into the pit crushing Mr Leite and Mr Morris and, effectively, killing them both instantly.
7. In short, Mr D'Alessandro's work system did not comply with the Queensland Tilt-up and Pre-cast Construction Code of Practice 2003 and was unsafe for the following reasons:
 - There was no escape route for the two workers in the event of panel collapse - they were working in a pit and were surrounded by concrete panels.
 - The bracing which only consisted of a diagonal brace from the top edge of one panel to the next, was structurally inadequate for the loading applied during the erection of the panels.
 - The panels were provided with either no, or negligible, lateral restraint along their bottom edges.
 - The force applied by the fourth panel to the erected panels, was substantial due to movement of the swinging load, and the likely need to line up the edges of the fourth panel with the two adjacent panels.
 - The flooring was uneven with the bottom edges of the three inserted panels neither braced to the floor nor firmly seated (on gravel not concrete and reinforcement steel protruding).
8. At autopsy both men were found to be in reasonably good health prior to their deaths which was caused by:
 - 1 (a). *Multiple injuries; due to, or as a consequence of:*
 - 1 (b) *Concrete Wall collapse*
9. Following the tragic deaths of Mr Morris and Mr Leite, the incident was investigated by Workplace Health Safety Queensland ("WHSQ"), a department within the Office of Industrial Relations, and the Queensland Police Service.
10. In 2019, Criscon was prosecuted, by WHSQ, for two offences of breaching section 32 of the *Work Health and Safety Act 2011*. The company pleaded

guilty to the offences and was fined \$405,000. On appeal that fine was increased to \$625,000 and a conviction was recorded.¹

11. After the incident on Thursday 6 October 2016, a PACE alert was initiated with the Australian Federal Police (“AFP”) to detain Mr D’Alessandro if he attempted to leave the country. At approximately 09.45 hours on Tuesday 15 November 2016, Mr D’Alessandro was detained by Australian Border Force at the Brisbane International Airport while attempting to board a Philippine Airlines flight to Manila. He was arrested at the International Airport by an officer from the Queensland Police Service (“QPS”) and conveyed Boondall Police Station for questioning. After seeking advice from his lawyer Mr Michael Purcell, Mr D’Alessandro exercised his lawful right to silence. He had purchased his flight ticket to the Philippines the night before on Monday 14 November 2016.
12. On 16 November 2016, Mr D’Alessandro was subsequently conveyed to the Brisbane City Watchhouse. He was charged with two counts of *Manslaughter*, under sections, 310 of the *Queensland Criminal Code*, in relation to the two deaths of Mr Morris and Mr Leite and one charge of *Reckless conduct* under section 31 of the *Work Health and Safety Act 2011* (WHS Act). He appeared in the Magistrates Court at Brisbane that day and was granted bail. On 4 April 2019, after multiple adjournments and multiple new lawyers, Mr D’Alessandro was committed for trial from the Magistrates Court at Brisbane to the Supreme Court at Brisbane on two counts of manslaughter. An indictment was presented on 20 August 2019 and multiple adjournments followed.
13. On or about 19 December 2019, Mr D’Alessandro suffered a stroke. The matter was ultimately referred to the Mental Health Court. On 15 December 2022, Mr D’Alessandro was found to be permanently unfit for trial and the criminal proceedings were discontinued in the Supreme Court at Brisbane in early 2023. Also, by operation of section 122(a) of the *Mental Health Act 2016*, the prosecution against him under the WHS Act was also discontinued.
14. Charges under the WHS Act against the director of Criscon, Clemente Crisci, and Collin Young (the crane operator) were discontinued on 20 July 2018. Charges under the WHS Act against the site manager, Michael Crisci, were also discontinued on 18 December 2020.
15. It must be remembered that COVID-19 considerations caused lengthy delays from 2020 to 2023. A coronial Inquest cannot take place until criminal charges relating to a death against an individual are finalised. This Court encountered a number of difficulties in undertaking an investigation into this death from 2023. Substantial records dating back to 2016 outside the scope of the criminal prosecution had to be located by

¹ *Reynolds v Criscon Pty Ltd* [2019] QDC – please also note Annexure 1: the sentencing Magistrate’s remarks at first instance

QPS and WHS officers, Mr Leite's partner, Ms Paula Fonseca-Leite became uncontactable, incorrect information was given to the court that Mr D'Alessandro was back working on industrial projects which had to be investigated and Counsel Assisting had to provide a comprehensive advice to me. It was not until mid-2025 that I was able to be properly briefed.

16. Understandably though, the families of the deceased were frustrated at the delays and disappointed that Mr D'Alessandro would not be prosecuted. Mr Morris's partner, Ms Luisa Wilson wrote to this court stating:

"Everything that hasn't happened over my partner and his colleague's death is absolutely devastating for myself and our families.

It's disgusting for the magistrates court to allow every court mention to be passed on to the next.

This was over years, then the man who Was negligent on manslaughter charges, well the murderer! Had a stroke so it went to mental health courts not Supreme courts to be held responsible for his actions. Everything was then just thrown out of the court system!

Just a terrible outcome for us, with no explanations or any knowledge of what had happened that terrible Day. I want to swear so bad in this message.

I want to request an inquest to the Coroner, so please let me know when this can be held.

Luisa Wilson"

17. The decision of whether an Inquest is to be held is a matter for the assigned Coroner. They are extremely resource intensive and are best utilised where there are issues of disputed facts. In this case the facts are effectively not in dispute but the egregious behaviour of Mr D'Alessandro and others can be enlightened for the general public through this non-inquest publish findings.

The Coronial Jurisdiction and Non-Inquest Findings

18. A coroner's powers of investigation are supported by a number of specific powers under the Coroners Act (Qld) (the Act"). Pursuant to s11 of the Act, a Coroner may investigate the suspected death of a person if directed to by the State Coroner, and the State Coroner suspects that the person is dead, and their death was a reportable death. Section 45(2) of the Act provides:

“A coroner who is investigating a death or suspected death must, if possible, find –

- (a) who the deceased person is; and*
- (b) how the person died; and*
- (c) when the person died; and*
- (d) where the person died, and in particular whether the person died in Queensland; and*
- (e) what caused the person to die.”*

19. The focus is on discovering what happened, not on ascribing guilt, attributing blame, or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act prohibits findings being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence (s45(5)).
20. This Court, pursuant to Section 3 (d)(ii) of the Act has the object of commenting on matters related to “the administration of justice”, it is improper for an inferior Court created by statute, such as the Coroners Court of Queensland, which is not of higher jurisdiction in the appellant hierarchy, to review an order of a another Court of equal or superior jurisdiction such as the Supreme, District and Magistrates Courts of Queensland. Further, I must not include in any Findings any statement that a person is, or may be, (a) guilty of an offence or (b) civilly liable for something. As a matter of good public policy, it is undesirable for a judicial or jury verdict to be reviewed by a Coroner whose role is primarily a therapeutic one where the standard of proof is on the balance of probabilities.² However, a Coroner retains a “residual investigatory function” beyond a review of a previous court’s decision within the above-mentioned constraints.³
21. Section 37(i) of the Act provides that “*the Coroners Court is not bound by the rules of evidence but may inform itself in any way it considers appropriate*”. This flexibility has been explained as a consequence of being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial. However, the rules of evidence and the cornerstone of relevance should not be disregarded and in all cases the evidence relied upon must be logically or rationally probative of the fact to be determined.⁴
22. As stated earlier, a Coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the

² *Domaszewicz v State Coroner* (2004) 11 VR 237 at [81] and *Rolfe v Territory Coroner* [2023] NTCA 8 [53].

³ *Mirror newspapers v Waller* (1985) 1 NSWLR 1 at [16].

⁴ See Evatt, J in *R v War Pensions Entitlement Appeal Tribunal; Ex parte Bott* (1933) 50 CLR 228 at 256; Lockhart J in *Pearce v Button* (1986) 65 ALR 83, at 97; *Lillywhite v Chief Executive Liquor Licensing Division* [2008] QCA 88 at [34]; *Priest v West* [2012] VSCA 327 at [14] (Coroners Court matter) and *Epeabaka v MIMA* (1997) 150 ALR 397 at 400.

Briginshaw sliding scale is applicable.⁵ This means that the more significant the issue to be determined, the more serious a factual allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.⁶ It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.⁷ This means no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As the High Court made clear in *Annetts v McCann*⁸ this includes making submissions against Findings damaging to a person's reputation.

23. After considering the material obtained during the coronial investigation, I consider I have, without the necessity of an Inquest sufficient information to make the necessary findings required by s 45(2) of the Act in relation to the deaths of Mr Morris and Mr Leite. The investigations into their deaths was substantial. Workplace Health Safety Queensland ("WHSQ"), a department within the Office of Industrial Relations, and the Queensland Police Service ("QPS"). As a result, Criscon was prosecuted, by WHSQ, for two offences of breaching section 32 of the *Work Health and Safety Act 2011*. The company pleaded guilty to the offences and was fined \$405,000. On appeal that fine was increased to \$625,000.⁹
24. Mr D'Alessandro was charged with two counts of *Manslaughter*, on the basis of criminal negligence under sections, 300, 303 and 310 of the *Criminal Code Act 1899* and one count of *Reckless conduct* under section 31 of the *Work Health and Safety Act 2011* (WHS Act). There was an extensive investigation and brief of evidence involves thousands of pages of evidence.
25. Pursuant to Section 28 of the Act, I may hold an Inquest if it is in the public interest to do so. By s. 28(2) of the Act, in deciding whether it is in the public interest to hold an inquest, the coroner may consider:
 - (a) *the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and*
 - (b) *any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.*

⁵ *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

⁶ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

⁷ *Harmsworth v State Coroner* [1989] VR 989 at 994; Freckelton I., "Inquest Law" in The Inquest Handbook, Selby H., Federation Press, 1998 at p 13

⁸ (1990) 65 ALJR 167 at 168

⁹ *Reynolds v Criscon Pty Ltd* [2019] QDC 252 (<https://archive.sclqld.org.au/qjudgment/2019/QDC19-252.pdf>).

26. Relevantly, the *State Coroner's Guidelines 2013* (Qld) (which include a very broad range of considerations: *Davis v Ryan, State Coroner* [2019] QCA 282 at [5]) provide:

(a) *That Coroners should carefully assess the extent of investigation warranted by the circumstances of each death so finite coronial resources are applied strategically, with any temptation to assume the death is from a predetermined cause to be resisted until the cause of death and the circumstances of it have been established (para 7.2);*

(b) *That "how the person died" refers to "by what means and in what circumstances the death occurred"; it is broader than the medical cause of death (para 8.3);*

(c) *The factors for consideration when assessing whether an inquest should be held include, but are not limited to:*

- *Can all the findings required by s 45(2) be made without an inquest?*
- *Are chambers findings sufficient? If not, why not?*
- *Is an inquest likely to assist?*
- *Is there such uncertainty or conflict of evidence so as to justify the use of the judicial forensic process?*
- *Are there suspicious circumstances that have not been resolved or resulted in criminal charges? (para 9.2); and*

(d) *That where family members believed someone is criminally responsible for the death and no charges have been made, inquests are commonly requested; and that unless a Coroner can demonstrate the suspicions are baseless, the request will usually be granted (para 9.2)."*

27. On 7 April 2025, by email, Mr Morris' partner, Ms Luisa Wilson, requested that the deaths of Mr Morris and Mr Leite be investigated by way of an inquest due to the discontinuation of the criminal proceedings, and a failure to have the circumstances of the deaths properly examined and explained. To date, no response has been received from Mr Leite's spouse, Ms Paula Fonseca-Leite, following correspondence sent on 31 March 2025 regarding the proposed publication of non-inquest findings.

28. Unfortunately, any Inquest in this matter would take place some ten years after the death being investigated. Recently, the High Court of Australia in *Willmot v The State of Queensland* [2023] HCA 102 (13 November 2024) confirmed the difficulties of assessing evidence of witnesses after the lengthy effluxion of time between an event and the recalling of it in court. The plurality said: "Human memory is "fallible for a variety of reasons, and ordinarily the degree of fallibility increases with the passage of time". A number of factors affect such delayed evidence:

- (i) The effluxion of time;
 - (ii) The physical and emotional trauma of the event being recalled;
 - (iii) Potential exposure to other differing accounts of the event;
 - (iv) Intoxication at the time of the event; and
 - (v) Personal factors: aging, poor general health, anxiety and nervousness, effects of medication and cultural/language barriers
29. More importantly, the reality is that there are essentially no real conflicts within the evidence and the effluxion of time has diminished the value of any forensic techniques such as cross-examination. It is clear that both deceased died as a result of Mr D'Alessandro's actions or inactions. He caused the death of both men, but I cannot, and will not, find that he was criminally or civilly responsible. I will spell out the evidence discovered by QPS and WHS investigators. Hopefully, these findings will allow the deceased's families and the general- public to draw their own conclusions.

The Fatal Incident on 6 October 2016

30. Both Mr Leite and Mr Morris died at Eagle Farm Racecourse in Ascot on 6 October 2016. The racecourse is owned by Brisbane Racing Club Limited ("BRC"). It was in the process of some redevelopment. That process commenced on 14 March 2016 when BRC appointed Criscon Pty Ltd (Criscon) as principal contractor and gave possession of the site to the company.
31. The relationship between BRC and Criscon was contractual: the two entities executed a "contract for design and construct" on 14 March 2016. Clemente Crisci was the director of Criscon. The site manager was Mr Michael Crisci. At the time of their deaths Mr Leite and Mr Morris were working as labouring subcontractors for a company known as Construction Building Technologies Pty Ltd (CBT), under the direct supervision of Mr Claudio D'Alessandro.
32. As part of the redevelopment, a series of horse stables were constructed. This included the establishment of in-ground waste tanks whereby waste from the horse stables would be transported into a series of settling tanks and the balance waste pumped into disposal trucks. In essence, the waste tank construction component was an inground foul water tank. Its design was a concrete structure to be installed just below the ground surface to collect storm water and run off from the stables.
33. The concrete design for the water tanks contemplated using precast concrete panels. There were five panels to be used, four walls and a

covering roof, with a concrete slab to be poured as a base. Each separate panel wall weighed between approximately 9 to 11 tonne and was 5 x 5 metres in size.

34. It was D'Alessandro who likely had some role in sourcing the pre-cast walls. He did not have a written contract with Criscon but rather, it would appear, had some form of verbal agreement with the company.
35. At some point during the investigations undertaken by WHSQ, Criscon suggested that Mr D'Alessandro was in fact engaged by (and therefore a subcontractor of) a company known as Landfill Logistics Qld Pty Ltd ("Landfill Logistics"). However, this assertion does not appear to be complete or accurate. There was no formal contract in place between Mr D'Alessandro and Landfill Logistics. The assertion is also inconsistent with some of the communications passing between Mr Michael Crisci and Mr D'Alessandro, the fact that Mr D'Alessandro was paid directly by Criscon, and further, Mr D'Alessandro issued the safe work method statement directly to Criscon.
36. Mr D'Alessandro's "hands were all over" the sinking of water tanks at Eagle Farm Racecourse. The verbal agreements (and whatever terms they were) appear to have contemplated Mr D'Alessandro not only supplying the pre-cast walls but having, at least, substantial input into their design and fabrication. This includes the hire of the crane, organisation of labour, the planned bracing systems required to secure the panels both during installation and in final position.
37. In relation to the design, Mr D'Alessandro initially approached an engineering firm, Engineering Design Global Enterprises Pty Ltd t/a Edge Consulting Engineers, who provided plans for the walls. Another firm, Calibre Consulting (Qld) Pty Ltd, also produced some form of plans. It appears, though, that Mr D'Alessandro, using these plans designed the panels himself.
38. He had some experience in creating and erecting walls using precast panels but not appropriate engineering qualifications. It appears, almost certainly, that Mr D'Alessandro, and others under his direction, and probably the deceased, constructed the panels. Whatever plans existed (and whomever prepared them) the adequacy of their design, including the panel design drawings, the bracing systems (temporary and final), and whether they were certified by an appropriately qualified engineer, they were unsatisfactory.
39. On Thursday, 6 October 2016, Mr Morris and Mr Leite were working with Mr D'Alessandro and another worker, Mr Collin Young (now deceased). Mr Young was a crane operator employed by, or a subcontractor to, a separate company, Equipment and Lifting Solutions Pty Ltd (ELS), to operate the crane required for the project. The crane used was a Liebherr mobile crane. ELS has supplied the relevant safe work method statement for crane component of the construction.

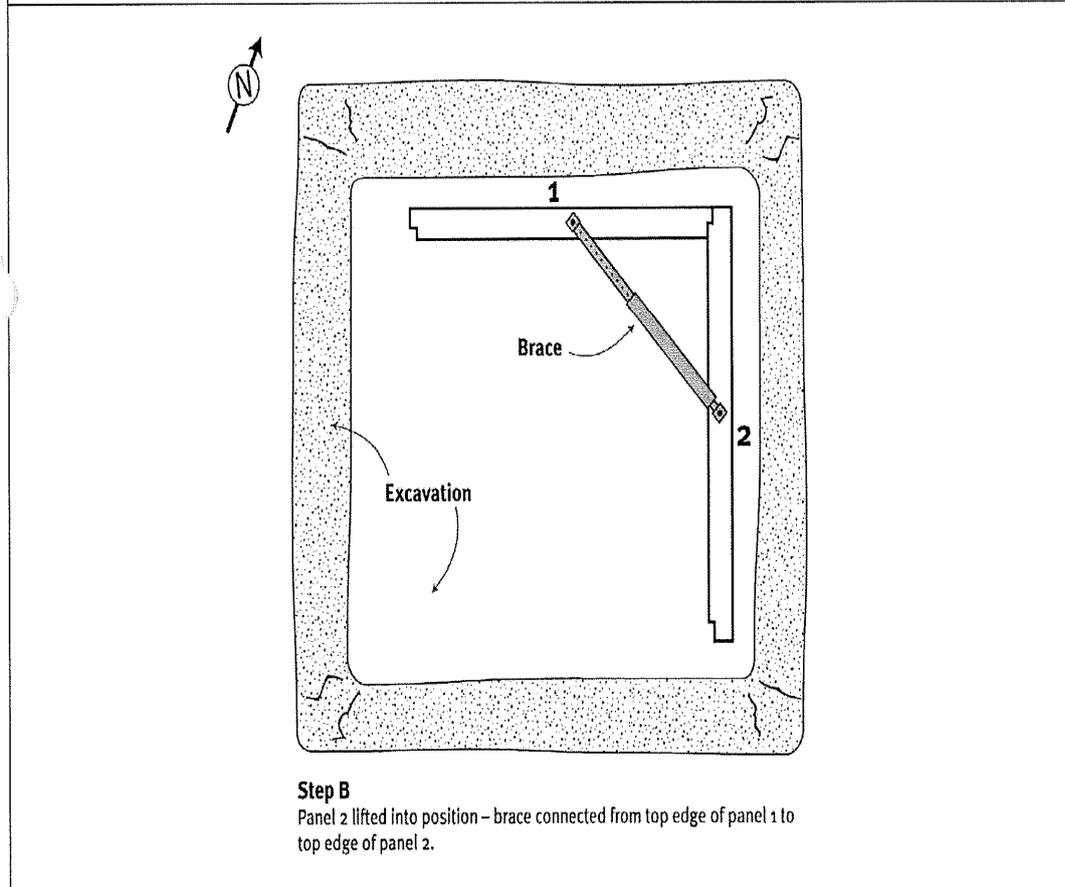
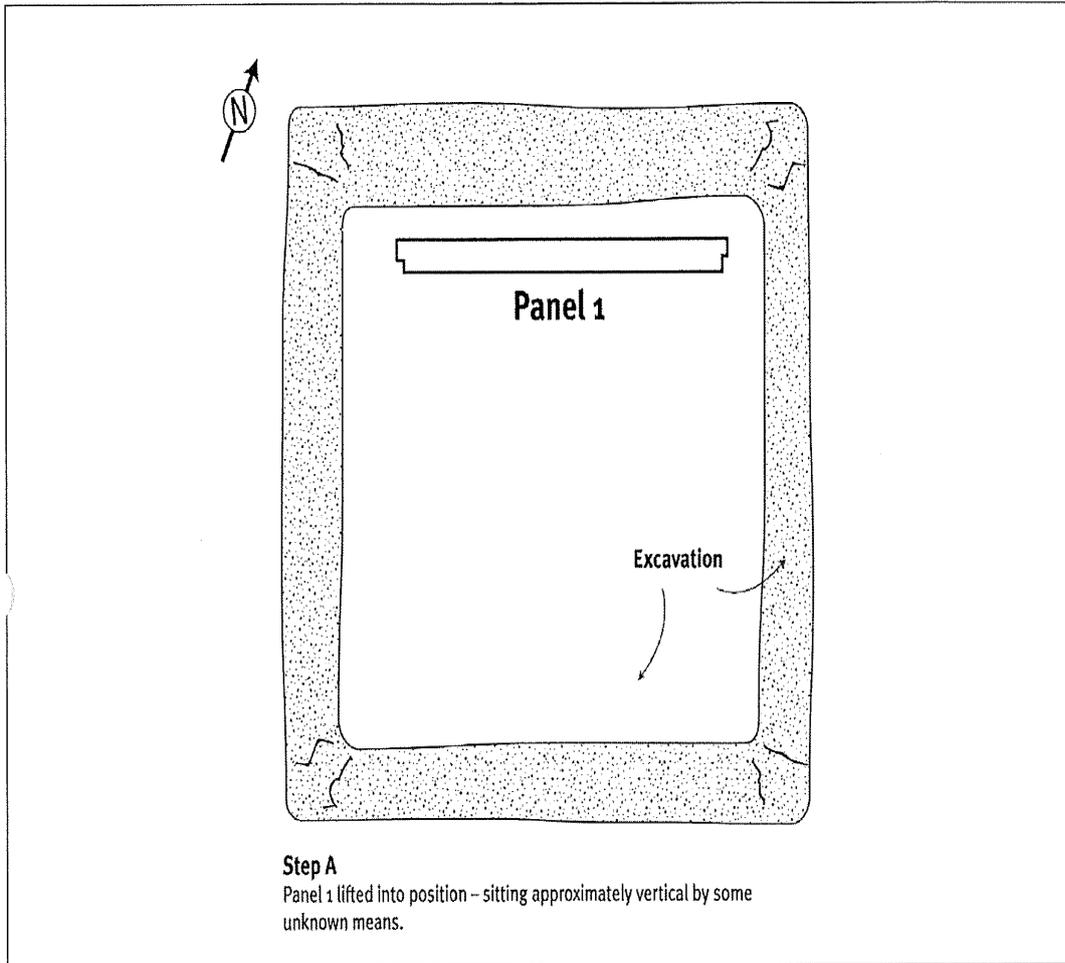
40. Mr Morris and Mr Leite were tasked with installing four concrete pre-cast walls proximate to the settling tanks which were below ground. This was not the first occasion the men had undertaken this task. Approximately a week before, on 30 September 2016, Mr Morris and Mr Leite had successfully constructed a tank using the same method and without incident.¹⁰
41. The second tank was to be constructed in a pit adjacent to the first tank previously installed. The same methodology, including the crane and crane operator, was used. The construction process involved the crane lowering the pre-cast concrete panels into the pit. While each panel was lowered into the pit the two workers were inside the pit. Their task was to assist the positioning of each panel and to put packing under the lower edge of each panel.
42. The panels were lifted by, by crane, with a device known as clutches. These are connected by steel cables to a sheave. The clutches are then connected by chains to the crane hook block. The clutches, steel cables and sheaves were supplied by Mr D'Alessandro.
43. The method of work adopted by Mr D'Alessandro involved the use of bracing that consisted of a diagonal brace from the top edge of one panel to the next adjacent panel rather than them each being laterally restrained. This system also required workers to enter the excavation pit while the panels were being lowered into position.
44. Mr D'Alessandro directed where the panels were to be placed. Specifically, a hole in which the walls were to be placed was dug and Mr D'Alessandro directed when the panel was to be lowered. Initially, the panel was lowered so that some of the weight of the panel was taken on the ground and the balance tension on the cable. The panels remained in this position while Mr Morris and Mr Leite braced the panel, likely, with Mr D'Alessandro's assistance or under his direction.
45. There is some evidence (from Mr Jamie Wolski, a machinery operator) also involved in the project) which suggests that Mr Morris informed Mr D'Alessandro that the panels were not going to fit into pads or that the pads were in the wrong location in response to which Mr D'Alessandro apparently instructed Mr Morris to *"...just put them in the gravel, they weren't required to sit on concrete pads."*
46. During the erection process, three wall panels, the north, east and south sides, were progressively lifted into the excavated pit using the mobile crane and were attached to each other using metal brace beams that were connected between the top edges of the panels. This was likely undertaken by Mr Morris, Mr Leite, and Mr D'Alessandro, but under Mr

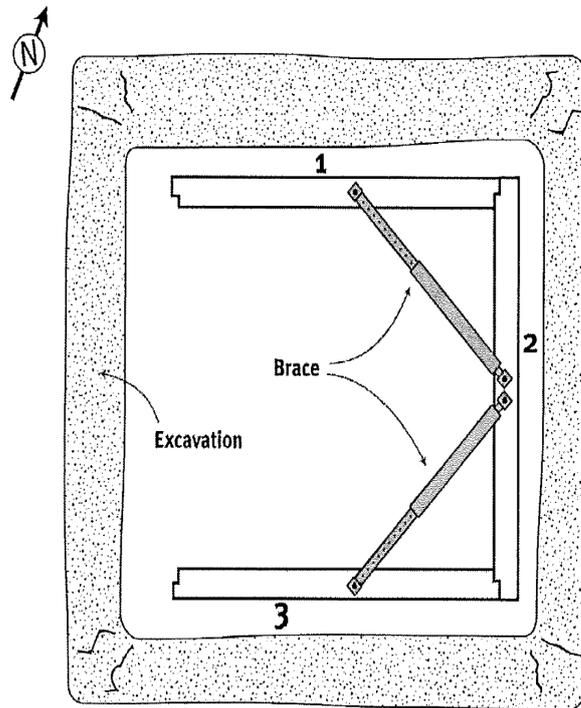
¹⁰ This work formed the basis of the first contravention of section 32 of the *Work Health and Safety Act 2011* upon which Criscon was successfully prosecuted.

D'Alessandro's direction.

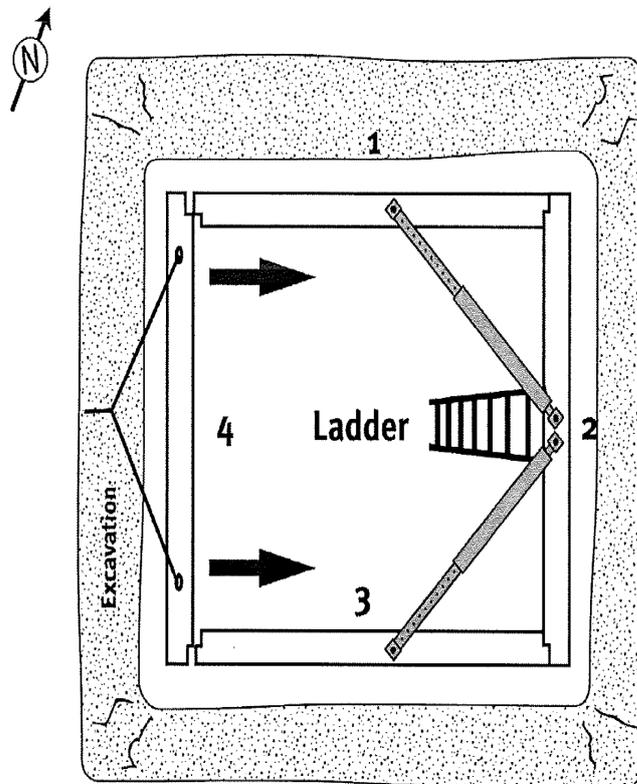
47. The fourth panel, the western side, was braced by Mr D'Alessandro, while Mr Morris and Mr Leite remained in the hole in which the structure was being erected. Remaining in the hole at this stage meant that there was no means by which either could exit if required to do so urgently. This fourth panel was then lowered into the excavation pit so that its vertical edges could be butted up against the edges of the first and third panels. At this stage of the work activity, both Mr Morris and Mr Leite were located either inside the excavation, on the ground, on a ladder, or on top of the panels.
48. The crane was in the process of lowering the final piece, on the western side, when the three other sides began to buckle. The north and south walls fell outwards. The east wall fell forwards and both Mr Morris and Mr Leite were able to get on top of the wall once it had fallen. However, because of the bracing, the northern wall retracted and landed on top of Mr Morris and Mr Leite crushing the pair and, likely, killing them both instantly.
49. From WHSQ's assessment of the incident, it was considered likely that the fourth panel contacted the other panels with enough force to cause one or more of the braces to panel connections to catastrophically fail. With the braces no longer ensuring the panels remained vertical, the panels became unstable. An unsuccessful attempt appears to have been made by Mr Morris and Mr Leite to vacate the pit using the ladder scaling the walls and they were both fatally crushed by the panels, instantly.
50. The following diagram which was Annexure 2 to the WHSQ Final Report graphically outlines this tragedy in steps "A" to "F":

Appendix 2 – Diagrams showing likely sequence of events associated with the incident

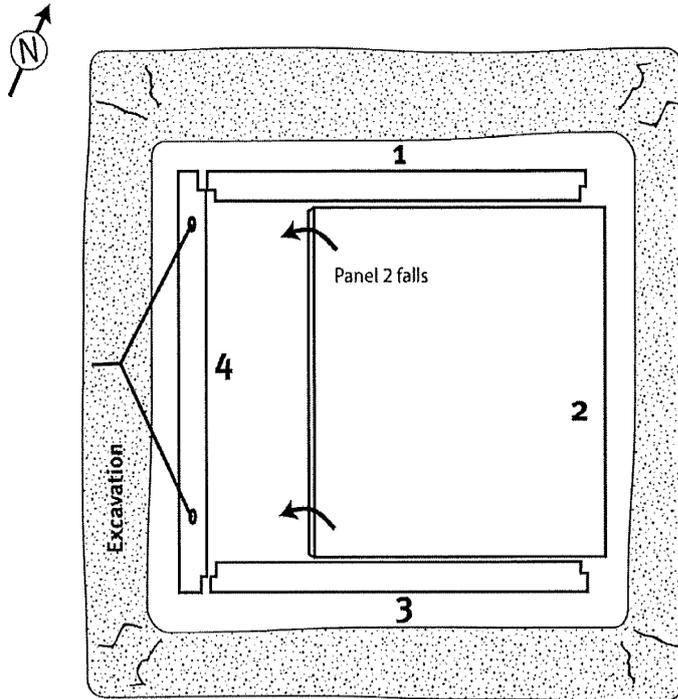




Step C
 Panel 3 lifted into position – brace connected from top edge of panel 2 to top edge of panel 3.

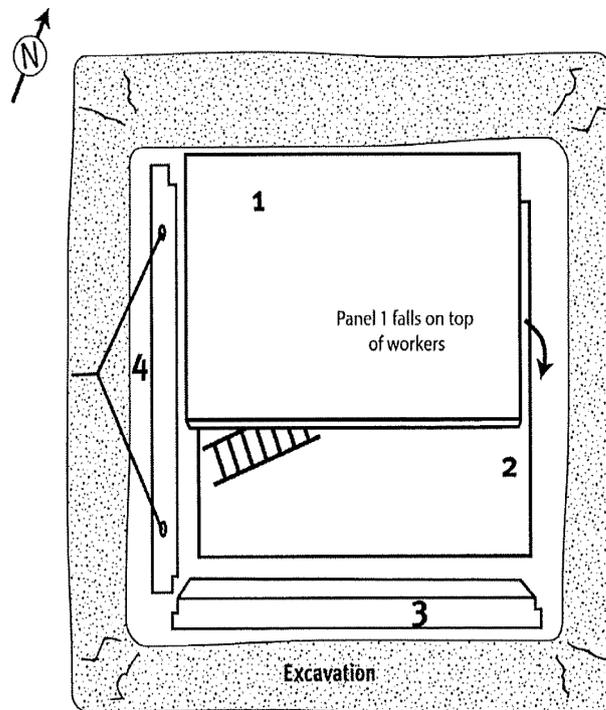


Step D
 Panel 4 lifted into trench. Attempt to line its edges up with panels 1 and 3. Forces from panel 4 cause one or more brace connections to fail. Workers attempt to escape with ladder up panel 2.



Step E

Panel 2 falls into the excavation. Ladder and workers flicked off. Workers and ladder end up on top of panel 2 when it falls flat.



Step F

Workers are on top of panel 2. Panel 1 becomes unstable and falls on top of them. Panel 3 remains leaning against the excavation wall. Panel 4 remains near vertical on the crane hook.

Autopsy Reports

51. On 10 October 2016, both of the deceased's bodies were the subject of full internal autopsies. This included a full examination of the internal organs of the bodies, an external examination of the bodies, postmortem CT scan imaging, toxicological examination of the deceaseds' postmortem blood samples, and review of medical records and history. Both autopsies were limited due to the extensive crush injuries to both deceased men.

52. A summary of the autopsy report for Mr Morris is:

“CT SCANS showed extensive injuries. They included bilateral temporal bone and basal skull fractures, transection of the vertebral column between the cervical and thoracic segments, and multiple rib, sternum, scapula, pelvic bone and femoral fractures.

EXTERNAL POST-MORTEM EXAMINATION showed a man with multiple injuries including extensive trauma to lower abdomen, pelvis and both thighs associated with exposure of soft tissues, inner organs and bones.

INTERNAL POST-MORTEM EXAMINATION confirmed the injuries seen on CT scans. It additionally demonstrated transection of the proximal descending aorta, contusions of the lungs, and laceration of the heart and liver.

HISTOLOGY of sampled organs showed red cell extravasation consistent with acute trauma. No significant natural disease was identified. Specifically, coronary arteries, myocardium and liver showed no significant abnormality.”

53. (No alcohol or drugs were detected on toxicological testing of Mr Morris's postmortem blood and urine samples).

54. A summary of the autopsy report for Mr Leite:

“EXTERNAL POST MORTEM EXAMINATION showed a man with numerous abrasions, bruises and lacerations to the head, limbs and torso. Blood was draining from the nose and ears, consistent with underlying skull fractures. There were palpable facial, rib and pelvic fractures.

A FULL INTERNAL POST MORTEM EXAMINATION showed extensive injuries including:

- Extensive comminuted skull fractures involving the cranial vault and base of skull.*
- Facial fractures.*

- Extensive rib fractures with distortion of the rib cage, consistent with lateral compression.
- Thoracic spinal fractures.
- Extensive pelvic fractures.
- Lacerations to the pericardium, heart, lungs, kidneys, liver and spleen.
- Tearing of the mesentery and intestine with perianal laceration and extrusion of the bowel.

CT SCANS confirmed the internal findings. The features were consistent with a compressive force being applied to the lateral aspect of the body.

HISTOLOGY showed slightly more significant atherosclerosis of one of the coronary arteries than could be appreciated by the naked eye and some mild emphysematous changes in the lungs.

TOXICOLOGICAL ANALYSIS was performed on post-mortem samples. Testing of chest cavity blood detected quinine (an antimalarial drug which has some other medical uses), meloxicam (a non-steroidal anti-inflammatory) and an ingredient of cannabis. Chest cavity blood is not an ideal specimen and the levels detected may not be an accurate reflection of the actual levels in the blood at the time of death.

However, due to the injuries sustained, peripheral blood was not able to be obtained. No alcohol was detected in blood or vitreous humour, however a small amount was present in the urine, indicative of recent alcohol consumption, which has been metabolised. Minute THC traces (.008 mg/Litre) were noted in Mr Leite's indicating prior use but there would have been no intoxicating effect at the time of death."

55. On 8 and 9 December 2016, both of the experienced forensic pathologists, unremarkably determined that the cause of death was:

1 (a). Multiple injuries; due to, or as a consequence of:

1 (b) Concrete Wall collapse

56. I so find.

Workplace Health and Safety Queensland's Investigation

57. Work Health and Safety Queensland produced an extensive 50-page expert report on the cause of this concrete wall collapse. It reviewed thousands of documents and was thorough, readable, and damning in its assessment of worker safety at the foul water pit being constructed at the racecourse on 6 October 2016. The report stated definitively: " ... *the overall work system implemented to construct the pit was fundamentally*

unsafe and ignored basic safety principles commonly used for the erection of both tilt-up and pre-cast concrete wall panels”.

58. Because the report is so comprehensive, I cite its conclusions verbatim and them as part of the findings in this coronial investigation. The conclusions of the author of this report, Mr Stuart Davis, were:

“Conclusions

Incident cause

59. *This incident has highlighted the consequences of failing to implement a safe system of work to construct the foul water pit. Both Ashley MORRIS and Humberto LEITE were fatally injured due to the absence of a safe system of work.*
60. *In the Author's opinion, the overall work system implemented to construct the pit was fundamentally unsafe and ignored basic safety principles commonly used for the erection of both tilt-up and pre-cast concrete wall panels. MORRIS and LEITE were required to work inside the pit where there was no escape route for either of the workers. In the event of the wall panels becoming unstable and falling, there was negligible, if any, likelihood of either worker being able to survive. Irrespective of how safe or unsafe other aspects of the work system were, the fact that there was no escape route for the workers is a key flaw of the work system.*
61. *The temporary bracing system used was unsafe in that the braces provided inadequate restraint for the panels due to their angle, their method of securing, and their position on the top edge of the panels. The bracing used on wall panels in the stable area, adjacent to the pit, with braces extending from the wall panels to deadmen embedded in the ground, would have been far more effective. Cast in ferrules, or at least holes drilled in the panel faces prior to erection, could have allowed the brace feet to be attached to the panel faces and this would have improved panel stability.*
62. *The lack of restraint at the bottom of the panels also contributed to the instability of the panels, allowing the panels to move, resulting in failure of one or more of the brace to panel connections. Without lower lateral restraint, the lower panel edges were free to "kick out" as a result of the erection loads. There appears to have been little, if any consideration, of how lateral movement of the bottom of the panels could have been minimised.*
63. *The bracing method used was inadequate for the erection loads applied. In the Author's opinion, the most significant erection*

loads were applied by the suspended panels due to natural sway of the load and the motion of the mobile crane. At the time of the incident, the fourth and final panel needed to be butted with the two perpendicular panels. Exacerbating this issue was the likelihood that the fourth panel was suspended at an angle, due to the location of the panel lifting inserts. With heavy loads the momentum and energy of a swinging load will be high, even though the load is moving at a relatively slow speed.

- 64. In the Author's opinion, to line up the fourth panel with the edges of the two perpendicular panels, the mobile crane applied lateral loading to the structure and this was transferred to the braces and their connections.*
- 65. In addition to inadequate bracing, the work system required workers to work in close proximity to the panels both to attach the braces and to level the panels. The levelling of the panels required workers to install packers, either timber or plastic shims or a combination of both, under the lower edges of the panels. This activity was made more difficult by the protruding re-enforcement bar on the inside lower edges of each of the wall panels. Complicating the task further was the fact that the panels were not sitting on a firm level surface, but rather on gravel that was prone to movement. The absence of a level concrete slab or strip footing under each wall panel increased the likelihood of the panels falling. Although four circular concrete footings had been provided on the floor of the excavation, these were in the wrong location and could provide little if any assistance to the workers.*
- 66. An additional item that merits comment is that workers were required to drill holes in the top edges of the panels, during the erection process, so that the insert anchors could be installed to anchor the braces to the panels. The time that workers were located around unstable panels and exposed to the risk from panel collapse was therefore increased. Instead of drilling holes during the panel erection, cast-in ferrules could have been installed during panel construction or holes could have been drilled when the panels were on the ground prior to being erected. However, it should be noted that with the steel re-enforcement protruding from the inside faces of the panels, holes could only be drilled on the inside faces of the panels. This would, in turn, only permit brace connections with braces on the inside of the pit which is not ideal (see "Alternative systems of work" for further detail in Annexure 2).*

Comparison with the Tilt-up and Pre-cast Construction Code of Practice 2003

67. *The erection of the foul water pit falls within the scope of the Tilt-up and Pre-cast Construction Code of Practice 2003. This Code is well known within the Queensland construction industry and provides practical guidance on safe systems to avoid concrete elements becoming unstable, falling and striking people. The work system used to construct the foul water pit ignored key parts of the Code including the need to provide:*
- *Documentation relating to safe systems of work and safe panel design including panel design drawings, bracing systems and professional engineering certification.*
 - *Adequate temporary bracing for concrete wall panels including a minimum of two braces per panel that have been engineer designed.*
 - *Effective lateral restraint and safe means of support at the bottom edges of the panels.*
68. *In the Author's opinion, this incident and the associated loss of life, would not have occurred if the Code had been complied with.*

Mobile crane set up

69. *A function test on the Liebherr Model L TM 1100 mobile crane being used at the time of the incident did not show any faults or safety concerns relating to the crane's operation and there were no obvious visual defects identified. However, the crane was fitted with inadequate counterweight to carry out the entire lift in compliance with the crane's load chart. The crane was fitted with a 2.5 tonne counterweight and is estimated as being overloaded by approximately 15 percent. Further to this it is likely that the crane operator had typed in an incorrect input into the crane's computer - instead of providing the counterweight input of 2.5 tonne, he has inputted 6.1 tonne.*
70. *It is the Author's opinion that the quantity of timbers under the northwest outrigger pad should have been greater so that gaps between timbers would be minimised. This would have helped to distribute the load transferred from the crane to the ground. Notwithstanding the above comments, the crane did not overturn as a result of the loads being lifted, nor did any of the outrigger timbers show signs of sinking into the ground. While the crane should have been used in compliance with the crane manufacturer's instructions and not overloaded, the crane's set up did not make any significant contribution to the incident.*

Engineer drawings

71. *Four drawings provided to the Author relate directly to the design of the foul water pit, two prepared by Calibre Consulting (QLD) Pty Ltd and two prepared by Edge Consulting Engineers. The drawings do not specify safe systems of work to construct the concrete pit nor do they include details of lifting or bracing inserts. The drawings deal with the design of the final pit showing details of panel dimensions, concrete and re-enforcement, and cut outs for pipes.*
72. *A key difference between the drawings prepared by Calibre Consulting and Edge Consulting is the base dimension details of the pit. The Calibre Consulting drawings show a larger concrete slab than the base dimensions of the approximate cube. The drawings show the base slab as extending 250 mm outside of the external dimensions of the pit walls. In the Author's opinion, having a larger base slab in the pit is far better than the actual system that was to be used (i.e. pouring the base in-situ after the wall panels are erected). With a larger slab, that is flat and level, a much superior surface would be provided to stand the wall panels on, than that actually provided (i.e. gravel, where the panels are more likely to fall over).*
73. *The Edge Consulting drawings do not include a bottom slab that is larger than the base dimensions of the completed pit. It is reasonable to conclude the pit designer considers the base is to be poured after installation of the wall panels. Cast-in ferrules near to the base of each wall panel are shown and it is likely that the designer's intention was that the external re-enforcement bar would be screwed into the panels after the panels were placed in the excavation. The external re-enforcement bar could then be tied to any re-enforcement steel at the base of the pit prior to pouring the concrete slab. This would make installation of the panels easier, without steel bar protruding from the panels. Inspection of the wall panels following the incident shows that the protruding re-enforcement was not removable (i.e. could not be screwed in and out) but had been cast into the panels during their construction prior to transport to the area of the pit.*
74. *Notwithstanding the provision for the cast-in ferrules and the provision to add the protruding bars after the lift, it is the Author's opinion that the design of the pit shown in Edge Consulting drawings would be difficult to construct. However, the provision of the cast-in ferrules to facilitate the later addition of the protruding re-enforcement bar suggests that the designer had at least some knowledge and input into the way the panels were to be erected. This conclusion is further*

supported by the provision of a gravel strip under the pit walls on both of the Edge Consulting drawings. In the Author's opinion, a gravel strip would increase the risk of the panels falling during their erection and concrete strip footings would provide a safer alternative that reduced the risk of the panels falling.

Alternative systems of work

75. *This incident highlights the result of allowing workers to work in a dangerous work zone and providing inadequate bracing of concrete wall panels*
76. *It is the Author's opinion that the safest alternative would be to provide braces and their associated footings on the outside of the pit. To provide external braces and to remove the need for worker(s) to be located in the pit the use of packers or shims to level the panels needs to be removed. One work system that removes the need for workers from the pit includes the following steps (refer Diagrams 5,6 and 7 in "Discussion"):*
- *Pouring a concrete slab, of adequate strength and depth, at the base of the pit that is larger than the base dimensions of the final structure and includes rectangular recesses that the wall panels can be slotted into.*
 - *Providing a total of eight concrete footings (i.e. deadmen) on the outside of the pit, so that there are two footings for each of the four walls to be erected.*
 - *Providing the wall panels with edge lifters so that they hang vertically and attaching two braces per panel prior to lifting.*
 - *Progressively lifting panels into the excavation and attaching both braces on each panel to the concrete footings on the outside of each-of the panels. The edges of each panel can be aligned with adjacent panels using the screw adjustment on the brace.*
77. *Following this system of work highlighted above would have avoided this incident."*

Failures to comply with Industry Codes of Practice

59. As stated in the conclusions above, WHSQ's investigation¹¹ revealed that there was significant non-compliance with the *Tilt-up and Pre-cast*

¹¹ Exhibit F1 - Technical Report on Concrete Panel Collapse at Eagle Farm Racecourse at pp. 1-2.

Construction Code of Practice 2003 (Code); and the work system adopted by Mr D'Alessandro was unsafe for the following reasons:

- There was no escape route for the two workers in the event of panel collapse. They were working in a pit and were surrounded by concrete panels.
- The bracing, consisting of a diagonal brace from the top edge of one panel to the next, was structurally inadequate for the loading applied during the erection of the panels.
- The panels were provided with either no, or negligible, lateral restraint along their bottom edges.
- The force applied by the fourth panel to the erected panels, was substantial due to movement of the swinging load, and the likely need to line up the edges of the fourth panel with the two adjacent panels.
- The work system had additional flaws that both increased the forces applied to the panel and required workers to be located in a high-risk zone.
- Workers being required to place packing under the bottom edges of the panels.
- The panels having a quantity of re-enforcement steel protruding at right angles from the bottom edge towards the centre of the pit.
- The absence of a level concrete slab or strip footing under each wall panel.

60. In addition, WHSQ Investigation found that the work system did not comply with the *Tilt-up and Pre-cast Construction Code of Practice 2003 (Code)* in the following key areas:

- Documentation relating to safe systems of work and safe panel design including panel design drawings, bracing systems, and professional engineering certification:
 - o There were no drawings for erections of the panels (as required by Section 4.2 of the Code). These drawings would include details on how the panels are to be placed and secured into position (including bracing details).
 - o There were no drawings or documented specifications showing the type, position, method of fixing and installation angle of panel braces (as required by Section 5, 2nd dot point of the Code).

- There was no design certification by a Professional Engineer for the panel temporary support system and erection loads. According to the Code, this certification would include a Professional Engineer's certification statement and signature on the drawings or on a certification letter cross-referencing the relevant drawings (Section 9.1 of the Code).
- There was no documented lift plan including a site plan where the crane was to be set up and locations where the panels were to be lifted from, and to (as required by Section 12.1 of the Code).
- The work system used required workers, involved in the erection of panels, to be located in a position where they could be struck in the event of a panel falling over. The Code states that this should be avoided (Section 13.1 of the Code).
- Minimal or no lateral restraint was provided at the bottom edge of the panels. The Code indicates that dowel pins should be fitted into the bottom edge of the panels or into the footings prior to lowering (Section 14.1, 7th dot point of the Code).
- Adequate temporary bracing for concrete wall panels including a minimum of two braces per panel that were engineer designed:
 - There was only one brace per panel (albeit an inadequate one), when the Code states a minimum of two braces per panel should be used (Section 5, 10th dot point of the Code).¹²
- Effective lateral restraint and safe means of support at the bottom edges of the panels.
 - It is likely that the levelling shims were at least 80mm in some places including the height of the timber packing and plastic shims. The Code states, "*Levelling shims should not exceed 40mm height (this will assist in maintaining panel stability)*" (Section 14.1, 9th dot point of the Code).

61. The work system also failed to comply with the *Mobile Crane Code of Practice 2006* in the following areas:

- Section 13.1.3: Crane operator must always exercise proper diligence and operate the crane safely. If the crane operator has reason to believe that a lift may be dangerous or unsafe, the operator must refuse to proceed until the relevant risks have been confirmed.

¹² As a matter of completeness, it is noted that in January 2013, Mr D'Alessandro was the PCBU ("person conducting a business or undertaking" at a workplace where he had management and control of the installation of concrete tilt-up panels. WHSQ identified that single bracing was being used at this workplace in non-compliance with the *Tilt-Up and Pre-Cast Construction Code of Practice 2003* (Exhibits > OIR – Other Material > OIR Final Report and Letter; and CCMS #11292192). On 3 January 2013, Mr D'Alessandro was advised by WHSQ that the use of one brace during the installation of concrete panels did not comply with the Code.

- Section 13.2.3: Control measures to minimise risk of injury from unsecured and dropped loads. No exclusion zones were established around the mobile crane and adjoining areas to prevent persons from entering the area.

62. In fairness, WHSQ also identified that the mobile crane being used at the time of the incident was overloaded by approximately 15 percent during lifting one of the wall panels, “but this had negligible, if any, effect on the incident”.
63. Critically, WHSQ ultimately concluded, and I accept this as a Finding, that the incident, and the associated loss of life, would not have occurred had there been compliance with these Codes.

Prosecution Of Mr D’Alessandro

64. After the incident on Thursday 6 October 2016, a PACE alert was initiated with the Australian Federal Police (AFP) to detain Mr D’Alessandro if he attempted to leave the country. At approximately 09.45 hours on Tuesday 15 November 2016, Mr D’Alessandro was detained by Australian Border Force at the Brisbane International Airport while attempting to board a Philippine Airlines flight to Manila. He was arrested at the International Airport by Senior Constable Christian Troeger and conveyed Boondall Police Station for questioning. After seeking advice from his lawyer, Mr Michael Purcell, Mr D’Alessandro exercised his lawful right to silence. He had purchased his flight ticket to the Philippines the Monday night before (14 November 2016).
65. On 16 November 2016, Mr D’Alessandro was subsequently conveyed to the Brisbane City Watchhouse. He was charged with two counts of *Manslaughter*, under section 310 of the *Queensland Criminal Code*, in relation to the two deaths of Mr Morris and Mr Leite and one charge of *Reckless conduct* under section 31 of the *Work Health and Safety Act 2011* (WHS Act). He appeared in the Magistrates Court at Brisbane that day and was granted bail. On 4 April 2019, after multiple adjournments and multiple new lawyers, Mr D’Alessandro was committed for trial from the Magistrates Court at Brisbane to the Supreme Court at Brisbane on two counts of manslaughter. An indictment was presented on 20 August 2019 and multiple adjournments followed.

QPS Investigation

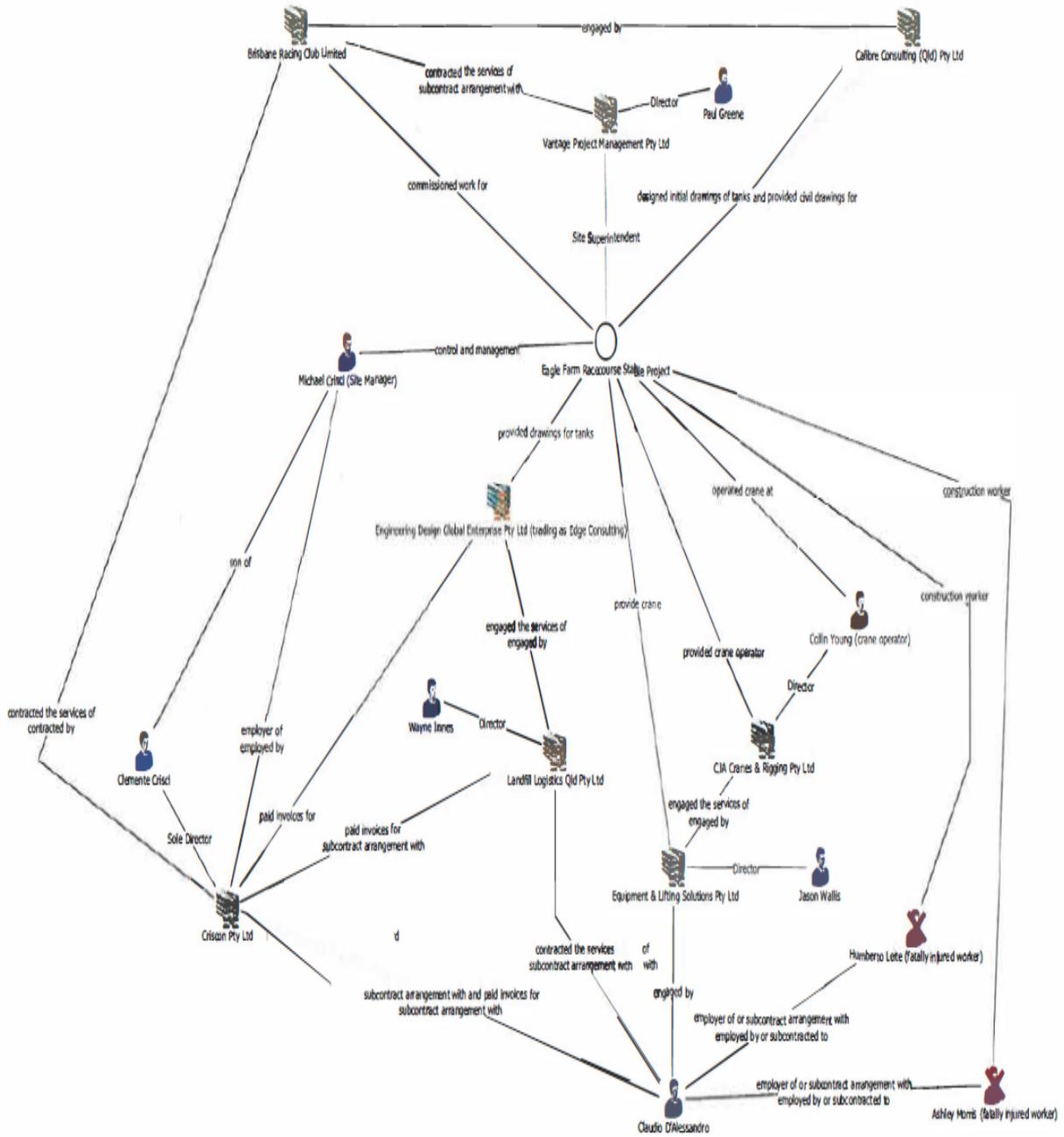
66. QPS investigators were “on scene” very quickly after this incident occurred and commenced investigations immediately in tandem with

WHSQ investigators. They also undertook an extensive investigation called "*OPERATION OSCAR GLEYSOL*" and produced a thorough 300-page report aligning with the WHSQ report. Numerous witnesses were interviewed, photographs and television footage obtained, and background checks undertaken.

67. They eventually created an Association Link Chart" which charted the links between the various dramatis personae stemming from their relationships with Mr D'Alessandro:

OPERATION OSCAR GLEYSOL

Association Link Chart



Current as at 18/01/2017

In-Confidence

Prepared by MARTIN J3811
State Intelligence Bondoff

Witness Statements

68. The following are extracts from the QPS investigation report which are helpful summaries of the evidence of important witnesses in this investigation:

Witness:	Statement Summary
Senior Constable Christian TROEGER Brisbane FCU	Senior QPS was the investigating officer in relation to this matter and compiled the QPS brief of evidence
Constable Tom MORT Hendra Station	This witness was the First Response Officer to the scene.
Collin YOUNG Crane Operator	<p>This witness operates as a sub-contractor to Equipment and Lifting Solutions and has been in the mobile crane industry for 20 years. On 6 October 2016 the witness received a text from the dispatcher that he was required to attend the Eagle Farm Racecourse to lift panel for a drainage overflow tank.</p> <p>The witness stated he had previously completed a drainage overflow tank at the same site on 30 September 2016.</p> <p>SWMS for the job were supplied by ELS and placed in the cabin of the crane on the morning of the first job.</p> <p>The witness has known D’ALESSANDRO through other jobs over the years however, this was the first time he had worked with him. The witness stated the first tank job went smoothly. At this job he had his own dogman who was an ELS employee.</p> <p>The second tank job on 06/10/16. The witness arrived on site at about 10am.</p> <p>The witness describes how the panels for the tank are lifted and fitted as well as D’ALESSANDRO’s instructions for installation to him and the two deceased workers.</p> <p>The witness was present when the panels collapsed trapping the two deceased workers.</p> <p>The witness can describe the bracing used at the time of installation.</p>
John WILSON WH&SQ Investigator	Principal WPH&S Inspector – compiled the WHSQ Expert Review Report and brief of evidence
Stuart DAVIS WH&SQ Investigator	WPH&S Engineer. Compiled technical report dated 24 January 2017
Darryl MORRISON Geo-tech Engineer	Analysis of earth composition within pit and surrounds

Trevor Matthew KING
Concreter/Steel Fixer/Form
Worker

This witness started work at the Brisbane Racing Club June/July 2016 as a sub-contractor for D'ALESSANDRO to fabricate and install upright concrete panels for stables.

Paragraph 16-18 the witness describes the fabrication process of a concrete panel.

Paragraph 19-20 the witness describes how the panels are moved around the site.

Paragraph 22 the witness recalls an incident where props were removed before welded or bolted and as a result D'ALESSANDRO had to sack a worker.

Paragraph 23 the witness describes the term "live props" used by D'ALESSANDRO to save money.

Paragraph 24-26 the witness describes the lifting process. D'ALESSANDRO directed workers to complete unsafe practices to save time installing the panels for the stables.

Paragraph 30-37 the witness states when he was directed to fabricate panels for first of two tanks. Describes how there were no engineering plans for the panels and the plans were D'ALESSANDRO's. No ferrules or lifters were accounted for in D'ALESSANDRO's plans.

Paragraph 38-40 the witness states D'ALESSANDRO attempts to move the panels himself using the crane and nearly topples the crane.

Paragraph 49-52 the witness states how the first tank was propped and that during the installation the two deceased were working inside the tank under D'ALESSANDRO's direction.

Paragraph 54 the witness has to enter the tank to complete steel work whilst the tank was not correctly propped or welded. Felt unsafe.

Paragraph 60-61 First tank is completed. Witness was concerned for his safety as D'ALESSANDRO used the crane to lift the concrete kibble.

Paragraph 63-67 Witness states they start on tank 2. There were issues with the depth of the pit. D'ALESSANDRO told the witness and deceased to "make it work".

Paragraph 72 The witness is advised at 4:45am on 06/10/16 not required for work that day.

	Paragraph 75 The witness's phone conversation with D'ALLESANDRO.
Trevor Matthew KING Addendum Concreter/Steel Fixer/Form Worker	This witness completed an addendum statement in regard to examining two work diaries owned by D'ALESSANDRO. Witness states he only ever saw 8 pages out of the smaller diary and appears unchanged. He had seen D'ALESSANDRO in possession of both diaries.
Nathan William BURNS Concreter	<p>This witness is a sub-contractor and known D'ALESSANDRO since 2006. The witness has worked for D'ALESSANDRO on and off since that time in precast concrete/tilt panels. He has known the deceased (Mr MORRIS) since April 2016 and deceased (Mr LEITE) 2 months prior to the incident.</p> <p>Commenced work at Eagle Farm Racecourse June 2016.</p> <p>Paragraph 5 witness states D'ALESSANDRO known to cut corners.</p> <p>Paragraph 10-12 the witness describes how to fabricate the panels. The witness was only part of the fabrication work not the installation.</p> <p>Paragraph 16-20 the witness states when the panels for the two tanks were constructed and that no ferrules or lifters were drawn into the designs.</p> <p>Paragraph 22 the witness returns from days off to find tank 1 panels are already in the pit. Describes the bracing.</p> <p>Paragraph 23-24 the witness describes how the panels should be braced.</p> <p>Paragraph 25-30 witness refuses to get into tank to complete steel work. States different processes of the tank completion were being completed all at once rather than step by step as required.</p> <p>Paragraph 34 the witness is required to make the concrete pads for tank 2.</p> <p>Paragraph 35-39 the witness is told advised by D'ALESSANDRO not to come to work on 06/10/16. Conversation between witness and D'ALESSANDRO after incident.</p>
Jamie Scott WOLSKI Machinery Operator	This witness is qualified to operate excavators, bobcats, rollers, trucks, scrapers, graders and other miscellaneous machinery.

	<p>The witness had known D'ALESSANDRO for approximately a month through the Eagle Farm Racecourse job.</p> <p>FKG completed the preliminary works at the Racecourse before being overtaken by Criscon in March 2016.</p> <p>The witness then began work for Landfill Logistics.</p> <p>This witness observed the fabrication and erection of pre-fabricated panel at the site for stables.</p> <p>In September 2016 Michael CRISCI introduced the witness to D'ALESSANDRO. The witness was to liaise with D'ALESSANDRO as to drainage penetrations for prefab panels for two water settling tanks.</p> <p>The witness identified numerous issues of concern with the installation of water tank 1 (see paragraph 12).</p> <p>The witness became involved in second water tank (the incident tank). The witness became concerned again over the transportation of the panels (see paragraph 13).</p> <p>The witness observed the excavated pit where the second water tank was to be installed on 5 October. He saw that there were no dead men drilled or poured before or after the concrete levelling pads were poured in each corner. The prefab panels did not have ferrules cast into the slab.</p> <p>On 6 Oct the witness transported the panels to the pit location at the request of Michael CRISCI.</p> <p>The witness stayed for the installation of the first panel. The witness then recalls a conversation between Mr LEITE and Mr MORRIS over the bracing of the first panel (see paragraph 19-22).</p> <p>It was identified by Mr LEITE and Mr MORRIS that the levelling pads were in the wrong location. Mr MORRIS told this to D'ALESSANDRO and D'ALESSANDRO told them to put the panel on the gravel (see paragraph 25-26). PVC packers were used to level the panel.</p> <p>The witness was called away by Michael CRISCI and returned approx. an hour later and saw the second panel installed. The second panel was connected to the first panel by an Acrow prop horizontal on a 45-degree angle on the top edges of the panel.</p>
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	<p>D'ALESSANDRO was seen tightening a 'true' bold through the flange of the Acrow prop.</p> <p>The witness saw timber supporting panel two (see paragraph 29). The witness was called away again.</p> <p>The witness was on the other side of the creek from the pit 30 minutes later when he saw the third panel in and the fourth being attempted to be put in place. The fourth panel was taking nearly two hours to install. The witness did not see the incident. Only heard screams.</p>
<p>Thien NGUYEN CBT Employee</p>	<p>The witness had been working for CBT since 2015 and has only known D'ALESSANDRO for that time. Job description included concreting and patching.</p> <p>Commenced work at Eagle Farm in May 2016 with D'ALESSANDRO. Completed the concreting, form work and bracing to prop tilt panels for new stables. Filled the holes ones the bracing was taken away walls were welded.</p> <p>The witness was standing at the side of the pit when the fourth panel was being lowered. Saw both Mr LEITE and Mr MORRIS inside the pit when the final wall was being installed. Mr LEITE and Mr MORRIS started to climb out using a ladder. The witness did not see the walls collapse however heard banging and looked back to see two walls fallen over. Mr LEITE and Mr MORRIS had been crushed by the fallen panels.</p>
<p>Binh Thanh VO CST Employee</p>	<p>The witness had been working for CGT for 4 years and has known D'ALESSANDRO only for that time. Job description is installing and making concrete panels. The witness has never been involved in or seen D'ALESSANDRO involved in the installation or assisted in the installation of underground water tanks or structures.</p> <p>Commencing a job D'ALESSANDRO is given an engineering report on how the concrete pillars are to be constructed. D'ALESSANDRO is responsible for ensuring the pillars are poured to the requirements of the engineer.</p> <p>D'ALESSANDRO sub-contracted the witness to the Eagle Farm job around April 2016. The witness describes how to install a panel using props attached to a 'dead man'.</p> <p>The witness was not in the area when the water tank collapsed on the 6 October and cannot give any insight on how the water tank was being installed.</p>

<p>Paul Gregory HICKEY CST Employee</p>	<p>This witness knew the deceased Mr LEITE for 15 years and the deceased Mr MORRIS for 3 months prior to the incident. The witness has known D'ALESSANDRO for 14 years. He had worked for him 14 years ago when D'ALESSANDRO had his company, Sach. The witness had only started working for D'ALESSANDRO (CBT) again for three months prior to the incident.</p> <p>The witness's job description was to patch panels that were already erected and secured at the Eagle Farm Racecourse. He no involvement in the construction or installation of the panels.</p> <p>The witness was not working in the area of where the water tank collapsed on 6 October. The witness was notified by another CBT employee about the collapse. Attended the scene and saw Mr MORRIS's head sticking out from underneath the collapsed panel.</p>
<p>John Michael KELLY Plumber/gasfitter/drainer</p>	<p>This witness is a plumber specialising in commercial plumbing work. In September 2016 the witness was approached to assist with civil drainage and water mains for the infield development at Eagle Farm Racecourse.</p> <p>The witness was sub-contracting for Landfill Logistics. The job included the installation of storm water mains and foul water drainage lines.</p> <p>Paragraph 9-10 the witness describes what 'foul water' drainage is and what they are made of.</p> <p>The witness first met D'ALESSANDRO on site when he was requested to dig the holes for the tanks. First pit hole was dug September 2016.</p> <p>Paragraph 12-13 describes how the 1st pit was dug.</p> <p>Paragraph 14 the witness was advised by D'ALESSANDRO that there would be no welding completed on the 2nd tank.</p> <p>Paragraph 15-19 describes procedures completed on pit 1 after excavation.</p> <p>Paragraph 20-24 two weeks after the first pit was dug out the second pit was commenced by the witness.</p> <p>The witness had regular contact with Mr MORRIS and Mr LEITE during the excavation.</p>
<p>Christopher Jerome WILSON Boiler Maker</p>	<p>Commenced work at Eagle Farm in August 2016. Knew Mr MORRIS and Mr LEITE. Job was to weld panel brackets on the stables as well the plates on</p>

	<p>tank 1 and tank 2. The witness was welding the plates on tank 1 while Mr MORRIS was inside the tank.</p>
<p>Chad Michael LARKIN Excavator Operator</p>	<p>Excavated both pits. Nil deadman piers or footings excavated, flat bottom only. Bucketed 300mm crusher dust over entirety of base of pit upon completion. Cannot provide specifics but from his position 50metres to the south on the day of the incident, LARKIN could tell that the installation of the panels was not running as smoothly as the initial pit the week before.</p>
<p>Luisa Michelle WILSON Partner of Ashley Paul Pengana MORRIS</p>	<p>This witness is the defacto of the deceased Mr MORRIS. Met D'ALESSANDRO for the first time at Mr LEITE's funeral on 14 October 2016 however had previously spoken to him on the phone on 10 October 2016.</p> <p>D'ALESSANDRO was Mr MORRIS's boss and had worked for him prior to the Eagle Farm Racecourse job.</p> <p>Paragraph 9. A conversation occurred between the witness and Mr MORRIS about having to "dodgy up" levelling pads.</p> <p>Paragraph 14-30 is the conversation recalled by the witness between D'ALESSANDRO and the witness.</p>
<p>Timothy Michael PETERS Structural Engineer</p>	<p>Structural and Civil Engineers for Edge Consulting and were engaged directly by Landfill Logistics in relation to the redesign of stormwater tanks at Eagle Farm. Original design was completed by Calibre Consulting. The witness can produce these plans.</p> <p>The witness can produce the plans he completed for tank 1 and tank 2. These plans did not include lifting, propping and handling details for panel as it was normal practice that the information would be provided by specialised panel consultants during the drawing process.</p> <p>The witness had received information that Hayden SANDERS from Edge Consulting had inspected the panels prior the pour.</p> <p>On 10 October 2016 the witness met with D'ALESSANDRO and discussed bracing and lifting.</p> <p>The witness has worked on three projects prior with D'ALESSANDRO. The witness on those occasions had to caution D'ALESSANDRO in relation to shop details and certification temporary works.</p>
<p>Lewis Stephen William BARRY Graduate Structural Engineer</p>	<p>This witness works for Edge Consulting and duties include carrying out site inspections, concrete and steel design.</p>

	The witness inspected the steel on the base slab of the settling tank 1 on 4 October 2016. The witness can produce his report of the inspection.
Blake Cameron ALLAN Structural Engineer	This witness is a minor shareholder of Edge Consulting. The witness knows D'ALESSANDRO through a previous project in 2014. This witness has had to caution D'ALESSANDRO on unsafe construction practices. This witness can describe how their business is engaged by clients.
Hayden SANDERS Engineer Edge Consulting	Inspected steel in precast panels prior to being poured. Witness had numerous safety concerns with the deft. on previous jobs and raised them with management.
Dave WHIMPEY Brisbane Racing Club Chief Executive Officer	Witness gave brief statement re history of works and contractual arrangements.
Ian Edward RANDALL WPH&S Officer BRC	This witness is the WPH& S advisor for Brisbane Racing Club and had been employed by them since 29 September 2016. Did not see incident. This witness can produce the SWMS and checklist for Onsite Erection of Concrete Panels and documents.
Joelle Sue Ann BROWN Forensic Investigative Computer Analyst	This witness examined a diary belonging to D'ALESSANDRO. Report confirmed pages removed from diary and could refer to impressions found on subsequent pages.
Ryan BAKER QBCC Senior Licence Entitlement Officer	QBCC Licencing officer. Preliminary investigations appear to indicate Mr D'Alessandro was required to, and did not, hold a specific occupational plumbing and drainage licence with the QBCC to conduct the subject works in Pit 2.
Darren McGEE Expert pre cast panel installer.	Attended scene 7 /10/16 and under video form SOC gave expert opinion on how installation should have taken place. Arranged by WPH&S (Tony SHEEHAN)
Brendan TECARR Expert crane assessor	Attended scene, audio interview with John WILSON WPH&S. Identified issues with crane however believed not contributory.
Dr Nadine FORDE Medical Practitioner	Conducted autopsy on Mr LEITE's body
Dr Andrej KEDZIORA Medical Practitioner	Conducted autopsy on Mr MORRIS's body

Photographs

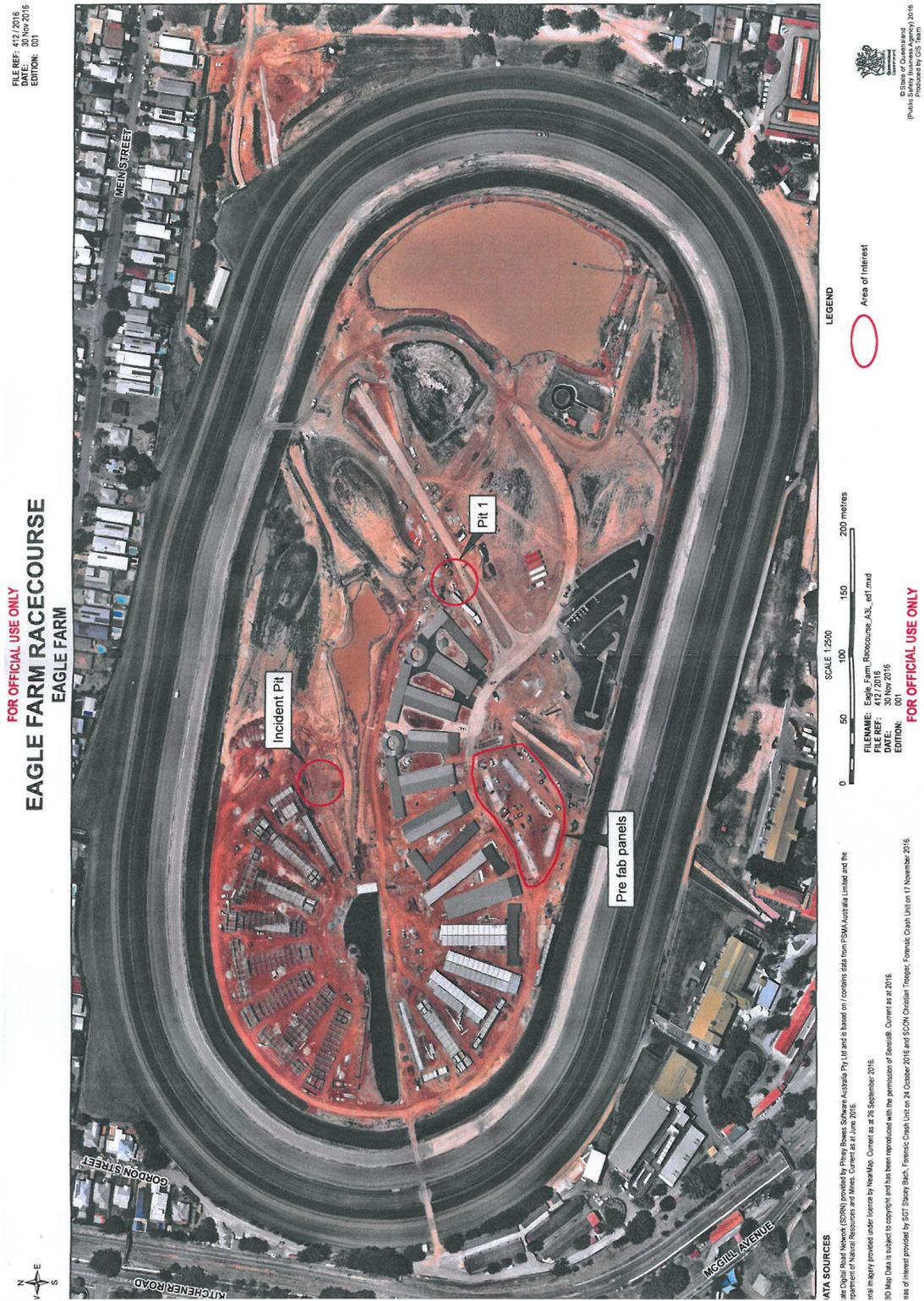


Image 1: Aerial photograph of Eagle Farm Racecourse taken 30 November 2016 and orientated north

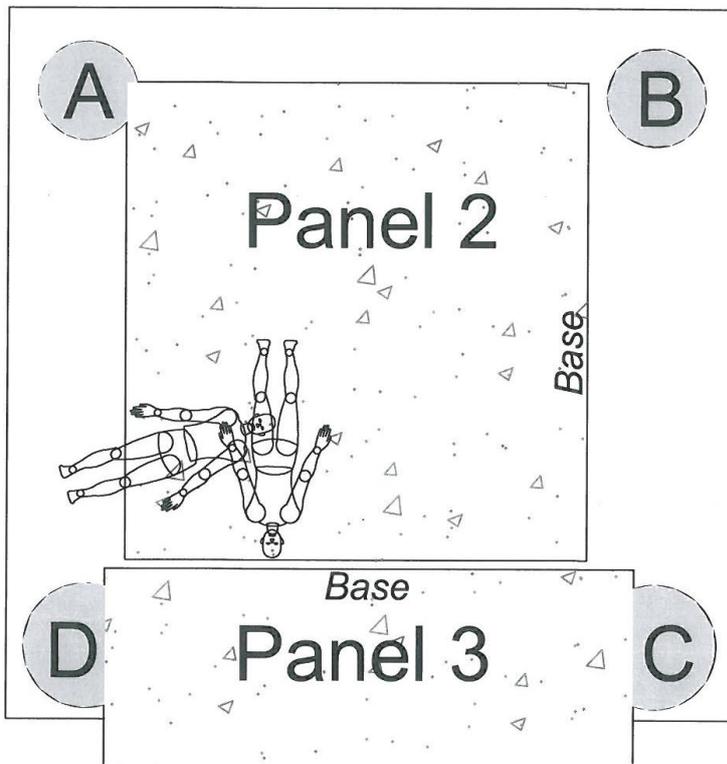


Image 2: A photograph taken of Tank 1 as successfully constructed by Mr D'Alessandro's team on 30 September 2016. This was the result hoped to have been achieved on 6 October 2016.



Pit Plan

Eagle Farm Race Course Redevelopment
Foul Water Drainage Settling Tank Site



Prepared by
Christian TROEGER
Senior Constable 10704
Brisbane Forensic Crash Unit
Incident date: 6/10/2016
Mapped: 7/10/2016
QP1601876532



Scale 1:50

Image 3: A plan and photograph of the pit following the extraction of the deceaseds' bodies. The photograph does not accurately depict the pit prior to the fatalities occurring because items and ground fill was removed in the extraction process.

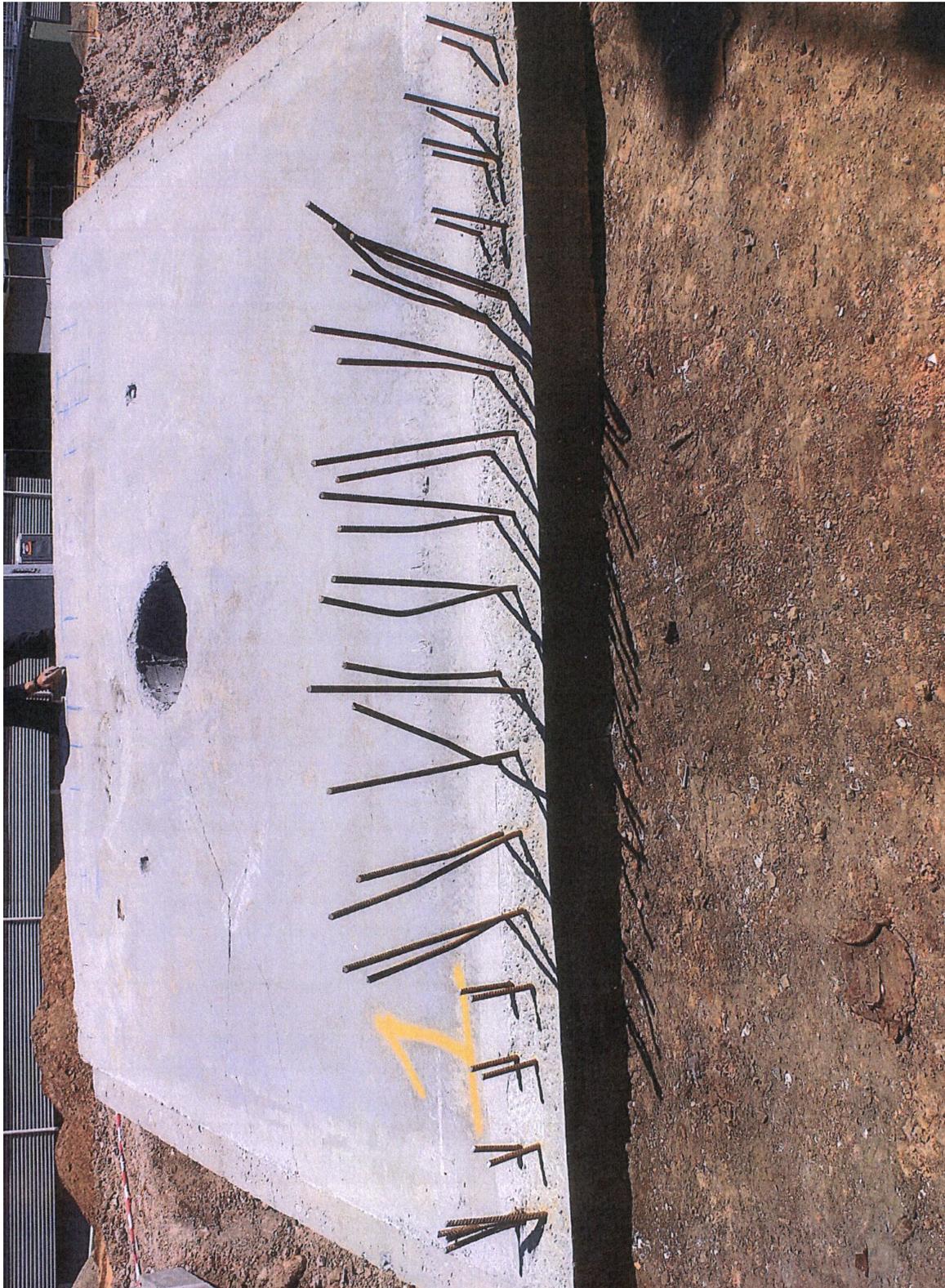


Image 4: Panel 1 having been removed from the pit taken on 12 October 2016.



Image 5: Panel 4 having been removed from the pit taken on 12 October 2016.



Image 6: Photograph of investigators searching for evidence on 12 October 2016 indicating the depth of the pit in comparison to the height of the deceased.



Image 7: A photograph taken on 12 October 2016 after reconstructing the crane lowering a panel to the ground as Mr D'Alessandro's team did on 6 October 2016.



Image 8: A photograph taken on 12 October 2016 noting the absence of a concrete furrow into which the panels could have been lowered thus preventing a falling over.

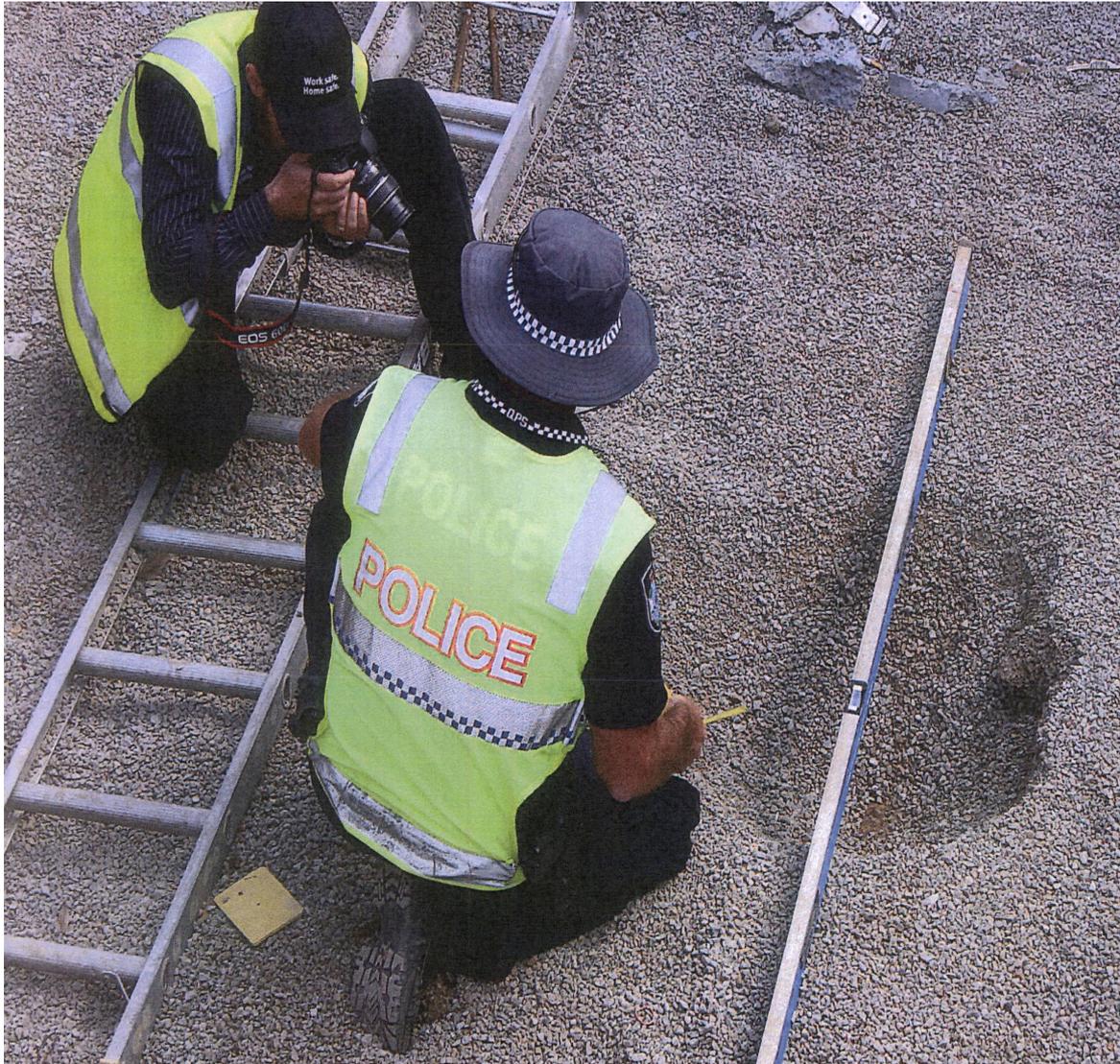


Image 9: QPS Photographing the unlevel gravel floor of the subject pit. The unstable gravel contributed to the panels' insecurity.

69. At about 09.45 hours on Tuesday 15 November 2016 Police were notified by the Australian Federal Police at the Brisbane International Airport that Mr D'Alessandro was attempting to board a flight to Manilla, Philippines and he had been detained by Australian Border Force. He was arrested for questioning and conveyed to Boondall Police Station. He exercised his right to telephone a lawyer of his choice, Mr Michael Purcell of Potts Lawyers and declined to be formally interviewed in relation to this matter. (Indeed, Mr D'Alessandro only provided one signed statement to WHSQ investigators which only dealt with matters ancillary to these deaths. It appears as Annexure 3 to these Findings.) He did admit to purchasing the overseas flight during the evening of Monday 14 November 2016 with the intention of returning within four days. The deft. was subsequently conveyed to the Brisbane City Watchhouse and formally charged.

70. A decision was made by QPS prosecutors to prosecute Mr D'Alessandro on 14 November 2016 on two counts of manslaughter. The matter progressed very slowly over the next three years frustrating both prosecutors and the families of the deceased.
71. Mr D'Alessandro was committed for trial from the Magistrates Court at Brisbane to the Supreme Court at Brisbane on two counts of manslaughter. An indictment was presented on 20 August 2019 and multiple adjournments followed.
72. On or about 19 December 2019, Mr D'Alessandro suffered a stroke. The matter was ultimately referred to the Mental Health Court. On 15 December 2022, Mr D'Alessandro was found to be permanently unfit for trial and the criminal proceedings were discontinued in the Supreme Court at Brisbane in early 2023 also, by operation of section 122(a) of the *Mental Health Act 2016*, the prosecution against him under the WHS Act was also discontinued.
73. Charges under the WHS Act against the director of Criscon, Clemente Crisci, and Collin Young (the crane operator) were discontinued on 20 July 2018. Charges under the WHS Act against the site manager, Michael Crisci, were also discontinued on 18 December 2020.
74. I have not been provided with the particulars of alleged criminal negligence of Mr D'Alessandro settled by the Director of Public prosecutions. I suspect that the matter had not proceeded sufficiently in the Supreme Court for that to be necessary. Nevertheless, the factual scenario placed before the Magistrates Court in the relevant QP9 Police Precip gives some insight:

“Charge 1 of 2 // [CC] 310 Manslaughter

- 1. That on the 6th day of October 2016 at Ascot in the State of Queensland one Claudio D'Alessandro unlawfully killed Ashley Pengana MORRIS*

and further

Charge 2 of 2 // [CC] 310 Manslaughter

- 2. That on the 6th day of October 2016 at Ascot in the State of Queensland one Claudio D'Alessandro unlawfully killed Humberto Ferreira LEITE*

Facts of the charges 1 and 2:

The defendant in this matter, Claudio D'ALESSANDRO is a 58-year-old male Australian citizen. The deft. is an experienced caster and

erector of prefabricated concrete building panels with over 40 years' experience in the building industry within Australia and Europe.

In May/June 2016 the deft. entered into a verbal agreement with representatives of builders Criscon Pty Ltd to cast and erect numerous concrete panels within the Eagle Farm Racecourse redevelopment precinct, located on Lancaster Road, Ascot. The vast majority of the works completed involved casting concrete panels on site to form horse stables within the racecourse itself. In excess of 100 panels were cast and erected on site.

These panels were cast with ferrules (threaded metal sleeves) that were cast into the panels to allow temporary bracing to be screwed into and hold in place securely while permanent bracing methods were installed.

The deft. employed workers on a sub-contract/hourly basis to assist with the fabrication and installation of these pre cast concrete panels. The deft. was the sole person issuing instructions on site to these workers in relation to panel dimensions, specifications and erecting protocols. Two of these workers were Humberto Ferreira LEITE (26/9/61) and Ashley Pengana MORRIS (11/6/82). Both LEITE and MORRIS were experienced workers in the building industry.

On Thursday 6 October 2016 the deft. was supervising the installation of the 2nd foul water settling tank that were designed to house waste products from the nearby stables. This settling tank was designed by Edge Consulting Engineers as a pre cast solution and involved four pre cast concrete panel walls individually lowered into an excavated pit with the concrete lid approximately level with the ground.

These panel walls had rebated edges and weighted about 10 tonne each. Lifting clutch hooks were recessed into the inner surfaces of each panel however no ferrules were installed to accommodate temporary bracing as had been installed on the other panels cast and erected within the site.

At the base of the pit were four circular concrete levelling pads in each corner to temporarily support these panels until a concrete slab was poured in the base of the pit. Early in the installation phase (panel 1) it was identified by deceased Ashley MORRIS that the panels did not fit on the concrete pads. This was conveyed by MORRIS to the deft. via text message.

A series of timber and plastic packers were utilised on top of the gravel base in an attempt overcome the inaccuracies with the concrete levelling pads. As each panel was lowered into position the deft. adopted and fastened a horizontal bracing technique whereby each panel was connected to each other panel diagonally with a

temporary brace on the top edge of each panel. This system has no bracing integrity and was not designed/adopted by an engineer.

The deft. would often stand on the western side outside of the pit, giving instructions to both LEITE and MORRIS who were within the pit whilst also giving hand signals to the mobile crane operator lifting the panels. The only method of escape from the pit for LEITE and MORRIS was one steel extension ladder from the bottom of the pit to the top of one of the panels.

As the fourth and last panel was being lowered in position and was about one metre from the base of the pit, it is believed the base of panels 1 and 3 were too close to each other and as panel four was being lowered into position, it has caused panel 3 to move outwards causing panels 2 and 1 to fall into the pit, crushing LEITE and MORRIS.

The deft. voluntarily participated in a field interview at the scene which was recorded via video. Proper warnings were administered. During the interview the deft. was unsure how the incident occurred and stated that he braced the initial panel back to the concrete levelling pads by bolting to the side of the panel. There was no evidence any rebated edges of the panels were fixed by temporary bracing, there were no penetrations in any of the levelling pads to take temporary bracing the temporary bracing present were of an inadequate length to use as bracing. The deft. further stated he felt responsible for the deaths of both LEITE and MORRIS.

On the day of the Incident the pit was inspected by engineers with the Division of Workplace Health and Safety Queensland. They stated that the work procedures and safety systems in place were grossly deficient. This is the basis of the charges using s. 289 (Duty of persons in charge of dangerous things) and s. 290 (Duty to do certain acts) of the Criminal Code.

On Friday 7 October 2016, the initial foul water settling tank was located east of the incident pit that was constructed by the deft. about a week earlier. Evidence on the top of the panels suggests a similar diagonal/horizontal bracing technique was utilised with the initial panel braced to a concrete drain offset to the tank using a temporary brace. Photographs of this bracing system were later supplied by a contractor.”

Mental Health Court Proceedings

75. On or about 19 December 2019, Mr D’Alessandro apparently suffered a debilitating stroke. The matter was ultimately referred to the Mental Health Court on the basis that pursuant to Section 613 of the Queensland

Criminal Code he was not fit for trial and that unfitness is of a permanent nature. The Mental Health Act 2000 provides by s 257 that the matter of the mental condition of a person alleged to have committed an indictable offence may be referred to the Mental Health Court. Where the Mental Health Court decides a person is unfit for trial and the unfitness is of a permanent nature, the proceedings against the person are discontinued (s 283). Where the Mental Health Court decides that the unfitness for trial is not of a permanent nature, proceedings for the offence are stayed until a Mental Health Review Tribunal decides that the person is fit for trial (s 280).

76. On 15 December 2022, Mr D'Alessandro was found to be permanently unfit for trial and the criminal proceedings were discontinued in the Supreme Court at Brisbane in early 2023. Also, by operation of section 122(a) of the *Mental Health Act 2016*, the prosecution against him under the WHS Act was also discontinued.
77. The Registrar of the Mental Health Court refused to provide to me the written judgement and findings of the Mental Health Court citing the confidentiality provisions of the Mental Health Act (Qld). I was only provided with the formal order of the Mental Health Court:

MENTAL HEALTH COURT OF QUEENSLAND

REGISTRY: Brisbane
NUMBER: 21/0042

In the reference of Claudio D' ALESSANDRO

Date of birth: 06/09/1958

FINDINGS AND ORDERS

Before: Justice Wilson
Date: 05/12/2022

Initiating document: references filed on 10/03/2021 & 10/05/2021

THE COURT FINDS THAT:

1. There is a substantial dispute about whether Claudio D' Alessandro committed the following offences:

1	Manslaughter	06/10/2016	Brisbane Supreme Court	1351/19
2	Manslaughter	06/20/2016	Brisbane Supreme Court	1351/19
3	Section 31, WHS Act 2011 Reckless conduct – Category 1	30.09.2016	Brisbane Magistrates Court	N/A

2. Claudio D' Alessandro is not fit for trial and that unfitness is of a permanent nature.

THE COURT ORDERS THAT:

Proceedings

3. Proceedings against Claudio D' Alessandro in relation to the above offences are to be discontinued.

Signed: A/Register”

78. Curiously, the Mental Health Court has previously, and since my request, provided medical reports, judgements and transcripts in homicide matters before it.¹³ The families of the deceased and this Court have only been told that the deceased had a debilitating stroke and all charges in relation to the deaths of Mr Morris and Mr Leite, after eight years, have been withdrawn. There has been no explanation why Mr D'Alessandro was found permanently unfit for trial. Commonly, applicants claiming to have a permanent disability are granted temporary stay of their criminal proceedings and are monitored by the Mental Health Court before a permanent unfitness for trial is granted.

Work Health and Safety Initiatives since 2016

79. The Office of Industrial Relations and its investigation unit WHSQ, have been very proactive in agitating for reform in the work, health and safety education and prosecution of “cowboy” operators. On 12 October 2016, the Office of Industrial Relations issued a safety alert in relation to the fatalities such as the subject deaths.¹⁴
80. On 5 April 2017, in response to the incident, and the tragic loss of lives at Dreamworld in October 2016, the then Minister for Industrial Relations, Minister for Racing and Minister for Multicultural Affairs announced an independent best practice review (BPR) of WHSQ to consider the department’s effectiveness including what further

¹³ See Inquest into the death of Manmeet SHARMA

¹⁴ https://www.worksafe.qld.gov.au/news-and-events/alerts/workplace-health-and-safety-alerts/2016/concrete-wall-panels/_nocache

measures could be taken to discourage unsafe work practices.¹⁵

81. In October 2017, following consideration of the BPR recommendations, the Queensland Government introduced a new offence of industrial manslaughter which includes offences for both a “senior officer” and an “employer” where conduct negligently causes the death of a worker (Part 2A of the *Work Health and Safety Act 2011*). Maximum penalties include 20 years imprisonment for an individual and a maximum fine of \$10 million for a corporate offender.
82. Other legal reforms following the BPR included,
 - Establishing an independent statutory office for workplace health and safety prosecutions;
 - Restoring the status of codes of practice to require the safety measures in a code of practice to be followed unless equal to or better than measures can be demonstrated; and
 - Reintroducing the role of workplace health and safety officers and establishing a framework for health and safety representatives with powers including the power to inspect their workplaces.
83. In response to the BPR, WHSQ and the Electrical Safety Office (ESO) also developed a compliance monitoring and enforcement policy to guide inspectors and their managers in the use of enforcement measures.
84. Finally, the *Tilt-up and Pre-cast Construction Code of Practice 2003* (Code), which applied to the work undertaken by Mr Morris and Mr Leite, was subject to a review which included careful consideration of the circumstances of the subject incident to prevent a recurrence. The review involved close collaboration with industry and employee representatives.

Conclusion

85. The *Coroners Act 2003* (Act) makes it clear that the role of a Coroner is not to determine questions of civil or criminal liability, or to apportion blame. WHSQ conducted their own investigations into the deaths which resulted in a (successful) prosecution for offences under work safety legislation. In addition, the QPS investigation led to criminal charges being pursued against Mr D’Alessandro in relation to the deaths.
86. I have already explained that it is unlikely that the holding of an inquest will illicit any further evidence that is otherwise available. I am of the view that the use of the judicial forensic processes such as cross-examination,

¹⁵ <https://www.worksafe.qld.gov.au/about/who-we-are/workplace-health-and-safety-queensland/best-practice-review-of-workplace-health-and-safety-queensland>

compulsory evidence-giving or public exposure and scrutiny are unlikely, to provide any further explanations for the tragic deaths. The effect of the effluxion of time on memories and the incapability of Mr D'Alessandro to give evidence are key factors.

87. However, I do consider publishing these findings will act a beacon exposing the egregious disregard for the safety of Mr Morris and Mr Leite which caused their deaths. This conclusion has been formed having regard to public interest factors including the incapacity of Mr D'Alessandro (a key witness), reforms that have occurred in the workplace health and safety context, the time that has passed since the incident, and the likelihood that an inquest will not produce any further evidence.
88. There does not appear to be any prospect of making recommendations that would reduce the likelihood of similar deaths occurring in the future or otherwise contributing to public health and safety or the administration of justice. In relation to these two tragic deaths, whether Ms D'Alessandro committed criminal offences or is civilly liable is matter for other courts and I have made no such findings.
89. I have great sympathy for the families of the deceased, there have been lengthy delays in the criminal justice, mental health and coronial systems and I can readily understand their frustrations. I hope these findings will assist in their understanding of how their loved ones were killed.
90. Formally I make formal findings pursuant to Section 45 of the Coroners Act (Qld):

Identities of the deceased: Ashley Pengana MORRIS and Humberto Ferreira LEITE

How they died: They died from injuries sustained when a concrete wall panel collapsed on them due to a failure of proper work, health, and safety procedures.

Date of death: On 6 October 2016.

Place of death: At the incident location – Eagle Farm Racecourse, 230 Lancaster Road, Ascot, Queensland.

What caused the persons to die:

Mr Morris' cause of death was determined to be:

1(a) Multiple injuries,
due to or as a consequence of

1(b) Concrete wall collapse

Mr Leite's cause of death was determined to be:

1(a) Multiple injuries,
due to or as a consequence of
1(b) Concrete wall collapse

91. These are the Non-Inquest Findings. I am indebted to counsel Mr Pat McCafferty (now Justice McCafferty of the Supreme Court) and Ms Karen Dodds for their assistance.

Donald MacKenzie
Coroner
BRISBANE

1 December 2025

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TRANSCRIPT OF PROCEEDINGS

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MAGISTRATES COURT

CULL, Magistrate

MAG-135282/18

WORK HEALTH AND SAFETY QUEENSLAND Complainant

and

CRISCON PTY LTD Defendant

BRISBANE

11.03 AM, TUESDAY, 4 SEPTEMBER 2018

DECISION

Any Rulings that may be included in this transcript, may be extracted and subject to revision by the Presiding Judge.

WARNING: The publication of information or details likely to lead to the identification of persons in some proceedings is a criminal offence. This is so particularly in relation to the identification of children who are involved in criminal proceedings or proceedings for their protection under the *Child Protection Act 1999*, and complainants in criminal sexual offences, but is not limited to those categories. You may wish to seek legal advice before giving others access to the details of any person named in these proceedings.

Annexure 1 - Transcript of Proceedings

BENCH: Obligations under the Work Health and Safety Legislation at the centre of this prosecution: safe work method statements must be prepared, need comply with a code of practice. I am assisted by the agreed statement of facts. The safe work method statement provided by D'Alessandro was not appropriate to the task but, in any event, was not followed. Criscon's work health and safety plan 14 March 2016 nominated two workers as health and safety coordinators. They were unaware of their designation as such and had not even seen the plan. Accordingly, I think it is fair to say that Criscon paid lip service to its obligation by creating a paper plan which it did not implement. It says that it relied on D'Alessandro and its related entity, CBT, Construction Building Technologies.

It relies on the case of Baiada Poultry, which is a very different matter. Reliance on expertise of a skilled subcontractor in that case was of much greater weight than can be attributed in this case. In Kanimbla, which is referred to by Mr Holt, the subjective offence was at the lower end of culpability, and unlike Kanimbla, where specific personal deterrence was not a significant factor, here I consider the poor approach to responsibility for supervising a workplace health and safety legislation plan should be acknowledged. I note Criscon has taken remedial steps at considerable cost since the incident.

This was clearly dangerous work. The makeshift use of an in situ sewage pipe as a dead man bracing on pit 1 was optimistic and opportunistic, rather than based on engineering principles. The lack of escape route was worse than careless. There was no planning for below ground level work. General deterrence is clearly a factor of great weight in matters such as these.

So far as the character of the Defendant, I accept that Criscon has no previous history and can be described as a good corporate citizen. These are category 2 offences. The project was one where much of the construction was by use of precast concrete, giving rise to significant risk factors that must be managed. Criscon is a long-established family company. Its reputation has been very greatly damaged by this incident. I do accept that the remorse of members of the Crisci family is very real, and I accept the company has now embarked on proper work health and safety planning. The company has sustained very, very high financial losses because of the incident. Clearly, an early plea has been entered.

In terms of actual culpability, the failure to implement any plan to check compliance of its subcontractor with the relevant code, and in particular, to prepare appropriate safe work plans and to audit compliance with those plans makes this a more serious matter. This was not a technical oversight. There was an obvious lack of bracing and no dedicated Criscon worker to identify that. The victim impact statements are poignant and telling. The sudden loss of loved young family men was devastating and the circumstances particularly distressing.

In Cudal Lime Products in New South Wales, a case referred to by Mr Holt, where a maximum penalty of \$3 million was available, a fine of \$900,000 was imposed, in circumstances of gross negligence by the Defendant in that case, with one death.

Annexure 1 - Transcript of Proceedings

5 Whilst I do not and would not put a money value on a life, in the present case, two men have died. Negligence on the part of D'Alessandro, the subcontractor, is alleged, and Criscon did nothing to identify this, notwithstanding that there was a course of conduct on the site, over at least seven days, where construction methods were ad hoc, when compared with the above ground structures that were also being installed at the time.

10 Although I intend to impose a single global penalty, in fact, the maximum penalty here is \$3 million, being \$1.5 million for each offence. In this case, having regard to the matters that I have outlined, I would impose a fine of \$540,000, which I would reduce by 25 per cent to reflect the early plea and the genuine remorse of the Defendant. Accordingly, the monetary penalty to be imposed is \$405,000. I note also that limited costs are sought - - -

15 MR HOLT: There is no objection to those, your Honour.

20 BENCH: - - - by Prosecution. The costs that are sought are only \$3000 in total, plus a hundred and - \$3179.20. With respect to the recording of a conviction, the matters to which the Court has regard, under section 12 of the Penalties and Sentences Act, of course, give weight to matters of history, also of remorse, but impact on the Defendant, in this case. I think it is proper to note the attempt to continue to trade, the significant impact on that of this incident and that the recording of a conviction would further exacerbate the difficulty of trading, and I say that because of the employment offered to other workers, and that is something the Court can have regard to.

25 As far as the payment of the money, I would expect there to be some arrangement where that could be properly paid. What time do you say? I appreciate there are financial difficulties and it is a significant sum.

30 MR HOLT: Your Honour, might I just - - -

35 MR HURREY: I understand, your Honour, that it can just be referred to SPER, and they could - - -

BENCH: I do not like to do that. I prefer not to. The company - - -

40 MR HOLT: No, I - it might be better in this case to have a certainty. If I might just have a moment, your Honour.

BENCH: Twenty-four months?

MR HOLT: I am instructed, your Honour, 12 months. Thank you.

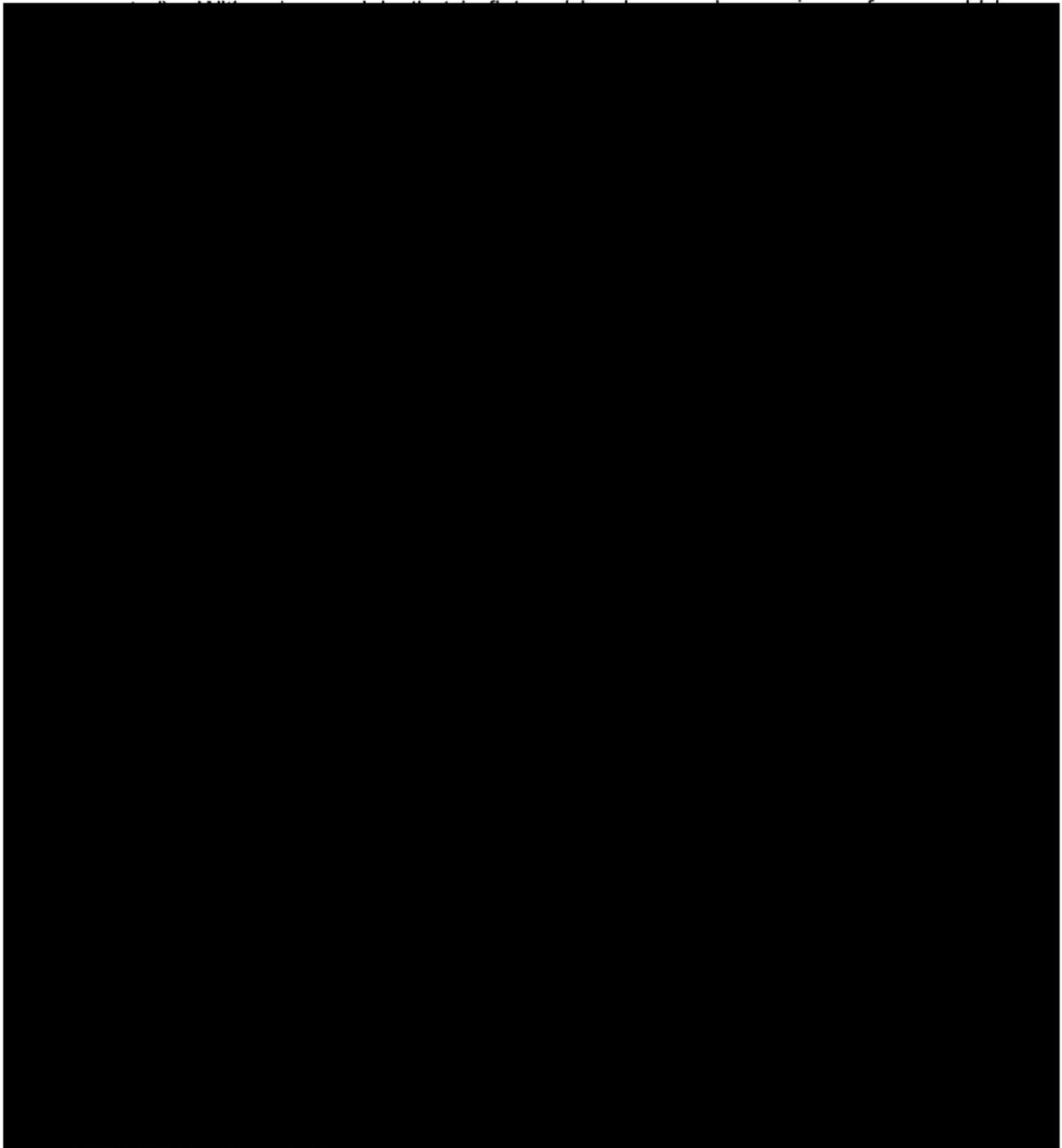
45 BENCH: Twelve months to pay, then. There will be interest fees. All right. Very well. Is there anything else, Mr Holt, Mr - - -

Annexure 1 - Transcript of Proceedings

MR HOLT: No, thank you, your Honour.

BENCH: No, thank you. You may be excused now, thank you.

5



Alternative systems of work

55. This incident has highlighted the result of inadequate bracing of concrete wall panels and illustrates the potentially severe consequences. It is appropriate to discuss alternative systems of work that could have been used to avoid the incident and the practicability of these systems. This report highlights the lack of adequate bracing to the tops of the panels and the lack of an effective lateral restraint to the bottom edges of the panels. However, the lack of an

effective system to finely adjust the relative panel positions without the need to rely on excessive force from the crane is also a key issue. Even if adequate restraint was provided and the panel position could be finely adjusted one clear fact remains, if workers are required in the pit during panel erection and panels become unstable there is *no escape route and the risk of fatality is high*.

56. One of the more cost effective systems would be to provide angled braces on the inside of the pit that are provided at an angle between the base of the pit to the walls, typically having the braces bolt onto the walls about two thirds of the way up. Braces could be anchored at the pit floor either to a single mass concrete footing (i.e. a "deadman") or preferably to a concrete slab that makes up the floor of the pit. A total of eight braces could be provided, two per each of the four wall panels. While this work system would have provided greater level of safety to workers, it still requires workers to be located in a high risk zone to install the braces and possibly to place packers under the concrete panels. If a panel becomes unstable, possibly due to being knocked by a panel being lifted into place, workers will still be exposed to the risk of being crushed by a falling panel, without an escape route being available. It is the Author's opinion that this work system is not the best alternative and it would be safest to provide braces and their associated footings on the *outside* of the pit.
57. To provide external braces and to remove the need for worker(s) to be located in the pit the need to adjust the panel heights by inserting packers or shims under the panels also has to be removed. One work system that removes the need for workers from the pit includes the following steps:
- Initially make an excavation with adequate benching and or battering to control the risk of collapse of the walls.
 - Pour a concrete slab, of adequate strength and depth, at the base of the pit that is larger than the base dimensions of the final structure and includes rectangular recesses that the wall panels can be slotted into (refer Diagrams 5 and 6). The slab and recesses are to be constructed level so that levelling shims under the panels are not required. These recesses are designed to provide lateral restraint for the bottom of the panels during erection. The slab is left for adequate time to cure (i.e. typically at least one week).

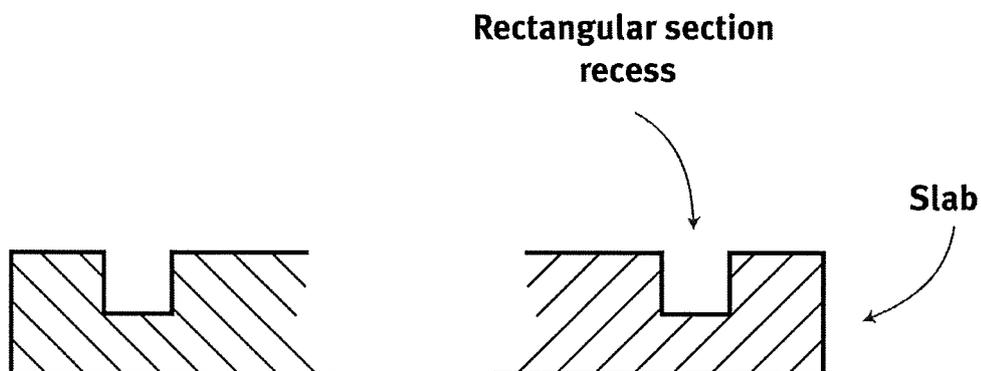


Diagram 5 – Sectional sketch of rectangular recess for panel - not to scale and for illustrative purposes

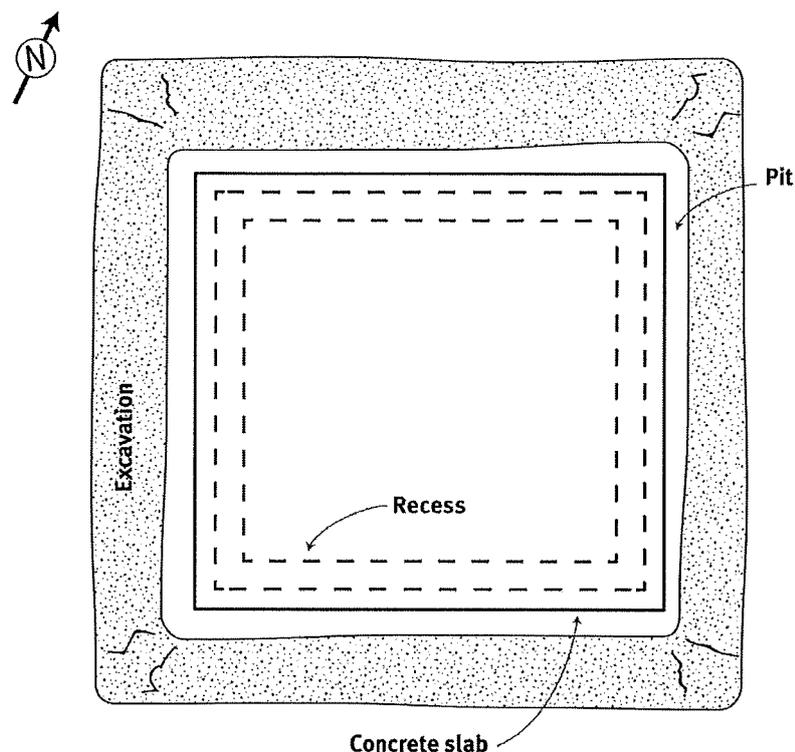


Diagram 6 – Plan sketch showing rectangular recess - not to scale and for illustrative purposes

- c) At the same time as the concrete slab is poured, two cylindrical concrete footings (i.e. deadmen) per each of the four sides of the excavation are poured. This makes a total of 8 deadmen for the structure. The holes for deadmen are typically dug with an auger and are far enough from the excavation wall to prevent collapse. The deadmen are located so that the brace will be at 90 degrees to the panel, when viewed from above.
- d) Each panel is provided with edge lifters so that the panels will hang vertically from the crane hook. This will assist when the bottom edge of the panels are slotted into the rectangular recesses on the floor slab. Prior to lifting each panel, two extendable (i.e. telescopic) braces are attached to the panel face close to the top edge.
- e) Panels are lifted one by one and then progressively installed in the excavation. As each panel approaches the excavation, Intermediate Riggers pull the bottom of the brace away from the panel face by means of a rope that has been pre-attached to the each brace. This action will allow the bottom of the braces to be moved away from the excavation as the panel is lowered. Each brace may also need to be extended so that its end can rest on the edge of the excavation until the panel is slotted into the slab recess.
- f) Once a panel is sitting in a recess, with the crane still supporting the top of the panel, the end of the brace is bolted to the top of it's deadman by the Rigger(s). Once attached the position of the top of the panel can then be moved inwards or outwards using the screw adjustment on the brace (Diagram 7 shows a view from above once all braces have been attached).

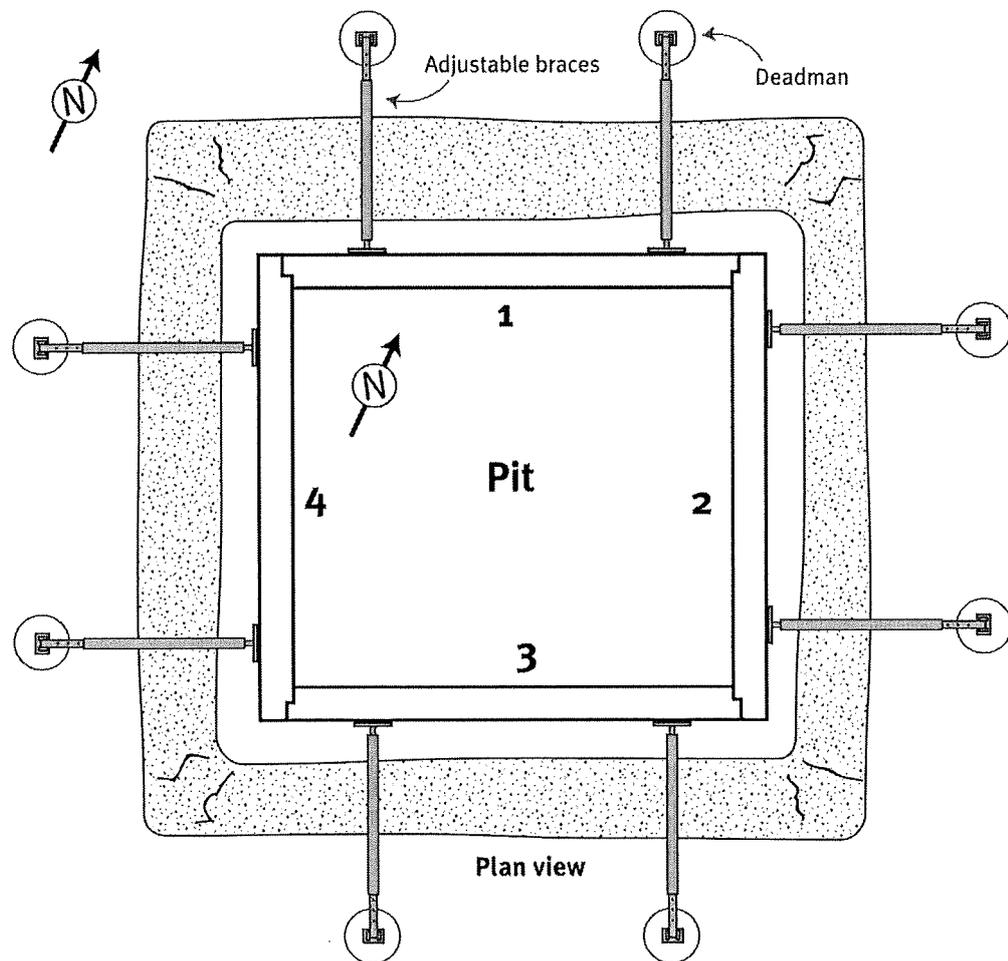


Diagram 7 – Plan view of excavation showing relative positions of panels, braces and deadmen

- g) Once all of the wall panels are installed and final adjustments have been made, the abutting steel plates on the panel edges can be welded together. Any gaps between panels can be filled with grout to seal the structure. The braces can then be removed and the outside of the pit back filled with earth.
58. In developing the safe system of work, a professional engineer would be required to certify both the lifting system and the temporary bracing system. The documentation should comply with the instructions provided in the Tilt-up and Pre-cast Construction Code of Practice 2003. In addition to information provided in the Code, a geo-technical engineer should certify that the risk of collapse of the excavation walls has been suitably controlled before workers are permitted to enter the excavation.

2

STATEMENT OF CLAUDIO D'ALESSANDRO

I, CLAUDIO D'ALESSANDRO of [REDACTED] in the State of Queensland, states as follows:-

Criscon Pty Ltd

1. I have known and completed projects with Criscon Pty Ltd (Criscon) for approximately 15 years. Further, I have known the director of Criscon, Mr Clem Crisci, for approximately 15 years.
2. Previously, I owned and operated a company called Satch Constructions. Satch Constructions completed numerous construction projects with Criscon. The projects with Criscon amounted to approximately 10-20 percent of the projects completed by Satch Constructions. Over seven years ago, Satch Constructions went into liquidation and ceased to operate. I have since completed concrete construction and pre-cast work through the entity Construction Building Technologies (CBT).
3. For the two year prior to the commencement of the Eagle Farm Raceway Project (the project), I had not completed any projects for Criscon or under the instructions of Clem Crisci.

Eagle Farm Raceway Project

4. In around June 2015, around a year before the project commenced, I was contacted by Clem Crisci on behalf of Criscon. Clem Crisci asked whether I was interested in completing a pre-cast project for the Eagle Farm Raceway upgrade. Mr Crisci provided me with plans and we discussed the manner in which the project was to be completed.
5. The original proposal involved a contract to construct/fabricate pre-cast concrete panels offsite and then transport and install them at the Eagle Farm Raceway. I recall that at the time, I provided a cost estimate to Criscon to complete the project. My initial quote was to complete the project on a contract based on a metered rate. However, the project did not commence and no further action was taken by either Criscon or CBT at that time.
6. In around June 2016, around a year after I provided the initial cost estimate to Criscon, I was contacted again by Clem Crisci on behalf of Criscon. Clem Crisci wanted to accept my initial cost estimate to complete the contract for the construction/fabrication and installation of the concrete panels. In response, I told Mr Crisci that I would need to review the plans and shop drawings in order to provide an updated quote for the project contract. I was concerned that due to holding limited funds I was unable to complete the project based on a metered rate.

13. It was also agreed that I would not be responsible for supplying material. Criscon therefore supplied material and equipment including plywood, timber, concrete steel and all the fixings and plans. Generally, I requested that Criscon order the materials and concrete to complete each stage of the project.
14. I recall that the project was slow to commence and that there were concerns from Criscon that it was running behind schedule. As a result Michael Crisci (the son of Clem Crisci and the project's site manager) organized two meetings with some of the contractors working on the project, including myself, in order to provide directions and instructions for the project. The meeting requests are attached and **attachment CD1 and attachment CD2**. An email was also by Michael Crisci attaching instructions (**attachment CD3**) relating to the works being carried out on the project. As a result of these meetings I felt I understood what Criscon expected.
15. As the project manager, Michael Crisci continued to provide directions and instructions in relation to the project. For instance, Michael would provide plans, instructions and set timelines. I have attached an email from Micheal dated 13 September 2016 where he forwarded plans for a section of the project that needed completing (**attachment CD4**).

Invoicing system

16. Whilst working on the project, all individuals were required to sign in and out via an onsite time recording book controlled by Criscon. Michael Crisci would then provide me with copy of the hours completed by the individual contractors. I have retained copies of the records of hours worked by contractors which are attached in a bundle marked **attachment CD5**.
17. It had been arranged that Criscon pay the contractors directly (see paragraph 12 above). Criscon suggested that it would be easier if the contractors were to invoice Construction Building Technologies. Construction Building Technologies would then provide one invoice to Criscon incorporating all of the individual contractor's invoices. I agreed to this arrangement. The additional men that Clem had brought onto the project including Stan Corbet were included in this arrangement.
18. The contractors would provide me with an invoice for the days/hours completed per week. I would receive an invoice from each contractor and the invoices would include GST. I have attached copies of the invoices the contractors provided to me (**attachment CD6**). My usual process was to check the hours that the each contractor had completed against the onsite time recording book and my own diary. In the event the hours were recorded correctly and the work was completed by the contractor, I would then incorporate all of the individual invoices into one invoice under Construction Building Technologies Construction Building Technologies would then issue one invoice to Criscon (**attachment CD7**).

25. In around July 2016, I brought Mr Morris onto the Eagle Farm Raceway Project. I can recall Mr Morris said he was interested in the project as it was close to his residence. Mr Morris was brought on to the project as a contractor to fabricate and install concrete panels.
26. CBT did not enter into an employment contract with Mr Morris. As Mr Morris was a contractor, I told him to seek his own insurance. However, no proof of insurance was provided to me or Construction Building Technologies. Construction Building Technologies made several requests for proof of insurance over the time that Mr Morris worked as a contractor.
27. Initially Mr Morris was paid a daily rate of \$400.00 when he commenced work on the project. According to the invoices of Mr Morris he was paid this daily rate from July to part way through September 2016. During the course of the project I requested that Mr Morris change to an hourly rate. I recall that I explained that it was in general more economical to pay by the hour.
28. Mr Morris was agreeable to this change in method of payment. It was agreed that Mr Morris would issue a weekly invoice for the hours of work completed plus GST. I would receive a weekly invoice from Mr Morris for the hours of work completed, usually over 5-6 days. Copies of some of these invoices are attached and marked as **attachment CD8**). The invoices contain details of work for various dates from 12 July 2016 through to 28 October 2016.
29. I recall that shortly after this arrangement was made, in around September or October 2016, Mr Morris told me was leaving the project. I didn't question Mr Morris about where he was going. My understanding was that he was offered alternate work in the Brisbane area at a higher rate. I recall that after a very short time, Mr Morris returned and asked whether he could return to work on the project. I recall that Mr Morris was gone for about a week.
30. When Mr Morris returned, I recall that he wanted to be paid more than \$40 per hour. Mr Morris pointed out that he was supplying his own equipment. Mr Morris also told me that he wanted to employ his step son to assist with labour. We agreed that Mr Morris would still be paid on an hourly rate but that this would be increased from \$40.00 to \$45.00. This was in recognition of the additional labour of Mr Morris's step son. Mr Morris later said he would provide further equipment including a laser. The change in Mr Morris's pay is reflected in the invoices he issued from mid September (**attachment CD8**)
31. I can recall that Mr Morris's step son only completed work as a labourer for approximately 2 to 3 weeks. Construction Building Technologies never paid the step son, as he was engaged by Mr Morris who was a contractor.

39. I told WorkCover that I had relevant documentation (now attached to this statement) including tax invoices and the like, but WorkCover did not appear interested. I got the impression that WorkCover wanted to treat the deceased contractors as employees despite the evidence that they were clearly contractors – perhaps so that they could make payments to the families of the deceased.
40. I have since been advised by WorkCover that they will attempt to recover any money they pay with respect to this matter from me personally. I do not have many assets and those assets that I do have are highly encumbered. It has been extremely difficult for me to find work since the incident occurred and I have been forced to sell work vehicles to pay for living expenses.



CLAUDIO D'ALESSANDRO

7-4-17

DATE