QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the cause and circumstances surrounding the death of BILLY-JOH WATTS**
TITLE OF COURT:	Coroners Court of Queensland
JURISDICTION:	BRISBANE
FILE NO(s):	2017/1888
DELIVERED ON:	2 May 2023
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 May 2022, 4, 5 and 6 October 2022 and 14 November 2022
FINDINGS OF:	Donald MacKenzie, Coroner
CATCHWORDS:	Coroners: Inquest, Work, Health & Safety incident, Deceased fatally crushed by falling pipe from forklift unloading truck, Non-suspicious death

REPRESENTATION:

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Watts Family:	Ms P. Willoughby (Counsel)

	Instructed by Caxton Legal Centre Inc
Neil Mansell Group:	Mr A. McLean-Williams (Counsel) Instructed by MacPherson Kelly Lawyers
Office of Industrial Relations:	Ms J. Franco (Senior Principal Lawyer) Crown Law on behalf of OIR

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EXECUTIVE SUMMARY

Mr Billy-Joh "BJ" Watts ("the deceased") was a 36-year-old truck driver employed by Neil Mansell Transport Pty Ltd (NMT), which was owned by the parent company group Neil Mansell Group (NMG)[1], since 8 October 2016 as a heavy vehicle operator. He was generally in good health, held appropriate licences for this work and had completed all relevant training.

NMT records indicate that Mr Watts worked 26 days straight without a break from 3 to 28 April 2017, then had two "days off" on 29 and 30 April 2017 and returned to work on 1 May 2017. On 4 May 2017, a friend and work colleague was killed in a road traffic crash near Yuleba. On 4 and 5 May 2017, the deceased was on two days stand down and doing light duties around the depot because NMT issued a compulsory three day stand down, commencing 4 May 2017.

A "counsellor" from Benestar, Shane Addicott, was arranged to attend the NMT site to assess staff for their reactions to trauma, grief and loss. Mr Addicott described his duties as providing "psychological first aid", self-care and coping strategies to assist NMT staff.

On Saturday, 6 May 2017, at approximately 05:45 hours, Mr Watts commenced work at the Chinchilla Depot and carried out the normal NMT procedures for the commencement of work which included mandatory alcohol testing via wall mounted breathalyser. Mr Watts registered "0.00" breath alcohol content at 05:50 hours. An experienced hand, Mr Rodney Redgen was a supervisor on site that day and he was permitted by NMG Managers to perform work involving the unloading of steel pipes at the DFI Energy Services Pty Ltd ("DFI") laydown yard at Malduf Street, Chinchilla. At approximately 08:00 hours, Mr Watts and a co-worker Mr Brian Mace approached Mr Addicott. They asked if they could move the truck and trailer parked at the Warrego Highway and drive it to the DFI lay down yard to unload it. Mr Mace understood that Mr Addicott had "cleared" them to perform that work.

The truck and flatbed trailer were placed in the DFI laydown yard 1.5 metres from, and parallel to, a line of unloaded pipes. A rudimentary exclusion zone was set up around the vehicle and trailer 4 metres from the driver's side from where the unloading would take place using a Front-end Loader ("FEL")[2] equipped with forklift tynes. The 1.5 metre gap on the passenger's side represented the exclusion zone there. When unloading commenced, Mr Watts acted as "spotter" and stood at the rear of the flatbed trailer.

The pipes were 10 metres in length, 30 centimetres in circumference and weighed between 600 and 700 kilograms. There were 25 pipes loaded on the trailer with seven pipes across the bottom three rows and four across the

[1] "NMT" and "NMG" will be used interchangeably in these Findings
[2] Forklift with two flat tynes

top. They were held in place by stanchions which were not taller than the highest placed pipe.

Once all other persons were clear from the area, Mr Redgen commenced unloading the top row of pipes. Mr Watts remained near the rear witches' hat and assisted Mr Redgen by giving him guidance through hand signals. The FEL could only approach the trailer on the driver's side of the truck because the passenger's side was approximately 1.5 metres from a line of stacked pipes. Mr Redgen removed three pipes from the top row and laid them down in an area behind him (opposite the driver's side of the truck). The fourth pipe was not taken with the first three and remained on the passenger side of the truck, resting against the stanchions, still in place on top.

Mr Redgen reversed and stacked the three pipes and then approached the trailer again to collect the fourth pipe. He had to stretch the tynes right across the trailer to reach it because the tynes were shorter than the width of the flatbed trailer. Mr Watts stood at the rear of the trailer. Mr Redgen had the tynes set at even level and when they were all the way under the pipe, Mr Watts gave him the thumbs up to commence lifting the remaining fourth pipe.

Mr Redgen then raised the tynes and, as he lifted the pipe, it started to roll forward to the front of the tynes and towards the passenger side of the flatbed trailer. Mr Redgen had lost sight of Mr Watts when he realised the pipe was rolling forward. He dropped the tynes down to try and get the pipe back on the trailer. However, the pipe had rolled too far and it rolled over the side of the trailer. It rolled off at an even level and not by one end first. Mr Redgen estimated the period between receiving the thumbs up signal from Mr Watts to the pipe falling was about 30 seconds.

Unbeknown to Mr Redgen, the deceased had moved towards the flatbed trailer apparently to load chains into a trailer box. The falling pipe struck and killed Mr Watts instantly.

There are multi-facetted explanations for the deceased moving into the exclusion zone exposing himself to the falling pipe. It is a golden rule that no-one should enter an exclusion zone when a load is being removed by a FEL. There are four possible explanations for the deceased's action and two valid criticisms of the unloading operation:

1. Inadvertent carelessness through complacency. (To investigators, Mr Mace made the most telling admission about what occurred on 6 May 2017: "*It was a job they had done a hundred times before*").

2. Deafness. The deceased was totally deaf in his left ear. This might have impeded his ability to determine exactly where the FEL was working.

3. Inattention through distraction. The deceased had just lost a close friend in a road traffic crash and his mind might well have been

"elsewhere". The counsellor, unhelpfully and unqualified to do so, seems to have led NMT to believing that the deceased was "fit to work". Accordingly, that the deceased's situational awareness might have been impaired, was not properly assessed because of ineffective psychological support.

4. Fatigue. The deceased had apparently just worked 26 days straight (in breach of the *Heavy Vehicle National Law (Queensland* - fatigue management laws), had two "days off" and then was confronted with the death of a close friend and work colleague.

5. Inadequate Exclusion Zone. The 1.5 metre gap in which the deceased had to move produced two problems. First, Mr Redgen's view of the deceased was obstructed and, second, the deceased would have had a limited range of movement to avoid the falling pipe. A spotter and machine operator should at all times be able to see each other and, if not, the work should cease immediately.

6. Inherently unsafe loading manoeuvre. The FEL was only able to unload from the driver's side. Because of the "tight" turning area, the flatbed trailer was parked 1.5 metres from pipes stacked on the passenger's side. Consequently, the FEL had to "reach across" to collect the pipe of which Mr Redgen lost control. The tynes were 22.5 centimetres short from the driver's side meaning loss of control of the pipe was likely. The tynes used could have been extended in length by the use of "slippers" but none were available. Other methods of pipe removal such as using a grapple (hydraulic tongs) or a crane with a sling attachment would have been preferable but not mandatory.

This death was not an accident. The law does not recognise an event as an accident when there was a duty to keep the injured person safe. The difficulty is recognising the extent of the breach of that duty. It is not possible to prefer any one of these six explanations over the other. It is probable that they each worked in combination. Whilst the effluxion of time has denuded memories, which makes definitive conclusions difficult, it is without doubt that the transport industry can learn much from this tragedy. Accordingly, it is hoped that the death of Billy-Joh Watts provides a template for safety in the trucking industry for many years to come.

THE CORONIAL JURISDICTION

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction. The basis of this jurisdiction arises because the police officer who attended this crash scene considered the death to be "a violent or unnatural death" within the terms of s7(1)(a)(i) of the Act, which he was obliged by s7(4) to report it to a Coroner. Section 11(2) confers jurisdiction on a Coroner to investigate such a death and s28(1) authorises the holding of an inquest into it.

Section 45(2) of the Coroners Act (Qld) provides:

(2) 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.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved. An inquest is not a trial between opposing parties but an inquiry into the death. Lord Lane CJ in *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625 described a coronial inquest in this way:

> *"… an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends," … (and) … "the function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires."*

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 authorises a Coroner to make preventive recommendations (s46) but 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)).

Proceedings in a Coroner's Court are not bound by the rules of evidence because s37 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 an inquest 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.[3]

[3] 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 327at [14] (Coroners Court matter) and *Epeabaka v MIMA* (1997) 150 ALR 397 at 400.

A Coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the Briginshaw sliding scale is applicable.[4] This means that the more significant the issue to be determined, the more serious an 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.[5] It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[6] This means that 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* (1990) 65 ALJR 167 at 168 this includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

Further, by s46(1) of the Act a Coroner may whenever appropriate comment on anything connected with a death investigated at an inquest that relates to:

(i) public health or safety; or
(ii) the administration of justice; or
(iii) ways to prevent deaths from happening in similar circumstances in the future.

For the purposes of s46(1) of the Act, issues to be dealt with at this Inquest were:

1. The findings required by s45(2) of the Coroners Act 2003 (Qld); namely the identity of the deceased, when, where and how he died and what caused his death;

2. (a) Whether there was appropriate fatigue and mental health management by the Neil Mansell Group;

3. Whether appropriate measures were in place for the unloading of the steel pipes; and

4. Whether there are any further recommendations which could be made which could prevent deaths from happening in similar circumstances in the future.

[4] *Anderson v Blashki* [1993] 2 VR 89 at 96 (per Gobbo J)
[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[6] *Harmsworth v State Coroner* [1989] VR 989 at 994; Freckelton I., "Inquest Law" in The Inquest Handbook, Selby H., Federation Press, 1998 at p13

THE CIRCUMSTANCES OF THIS DEATH

1. Mr Billy-Joh "BJ" Watts ("the deceased') was a 36-year-old truck driver employed by Neil Mansell Transport Pty Ltd (NMT), which was owned by the parent company group Neil Mansell Group (NMG)[7], since 8 October 2016 as a heavy vehicle operator. He was generally in good health, held appropriate licences for this work and had completed all relevant training. Of note was that Mr Watts was profoundly deaf in his left ear. As a child, he suffered a viral infection which caused this deafness.

2. Mr Watts worked from the NMT Chinchilla Depot, located at Zeller Street. NMT had been contracted to perform work for DFI, a company involved in the construction of pylons and steel foundations primarily for the gas and energy sectors. The contract was primarily to transport and deliver steel pipes from Brisbane to DFI's laydown yard at Malduf Street, Chinchilla.

3. Incomplete NMG records show that Mr Watts worked 26 days straight without a break from 3 to 28 April 2017. (It was submitted by the deceased's family that this was arguably in breach of the Heavy Vehicle National Law (Queensland). Mr Watts had two "days off" on 29 and 30 April 2017, and returned to work on 1 May 2017. On 4 and 5 May 2017, he was on two days stand down, doing light duties around the depot but not driving trucks. This was because NMT issued a compulsory three day "shut down"[8] for their staff in Southeast Queensland, commencing on 4 May 2017. On 4 May 2017, a co-worker and fellow NMT truck driver had died after the truck he was driving collided with a tree in a single vehicle road traffic crash.

4. The conditions of the stand down included the cessation of all employees from driving their trucks and servicing clients. The Chinchilla depot remained open for any employees that wanted to attend the depot, particularly for the drivers that lived locally. While on site, employees completed odd jobs around the yard, including cleaning.[9] The procedures for those employees on site remained the same as a usual workday, including the conduct of breath analysis and the presentation of a Toolbox Talk.

5. A "counsellor" from Benestar, Shane Addicott, was arranged to attend the NMT site to meet staff regarding their reactions to trauma, grief and loss. Mr Addicott described his duties as providing "psychological first aid", self-care and coping strategies to assist NMT staff.[10] On 5 May 2017, Mr Watts attended a mandated counselling session with Mr Addicott. He had been directed to perform light duties around the

[7] "NMT" and "NMG" will be used interchangeably in the Findings
[8] Witness used the terms "stand down" and "shut down" interchangeably
[9] Inquest Transcript Day 2, 5 October 2022, P1-97
[10] Ex B13 – Statement of Shane Addicott

Chinchilla Depot for a further two days pending clearance to operate heavy vehicles.[11] Co-workers described Mr Watts as appearing 'down' during this stand down period.

6. On Saturday, 6 May 2017 at around 05:45 hours, Mr Watts commenced work at the Chinchilla Depot, and carried out the normal NMT procedures for commencement of work. This included mandatory alcohol testing via wall mounted breathalyser.[12] Mr Watts registered "0.00" breath alcohol content at 05:50 hours. At approximately 06:15 hours, NMT staff attended the morning 'Toolbox talk' conducted by Shane Eyers as the NMG Health Safety and Environment Manager.[13]

7. The topics covered during the talk included, life-saving rules, fitness for work, declaration of medication to management, seat belts, mobile phone usage, fatigue management, pre-starts, logbooks, and incident reporting.[14] The talk directed staff, inter alia, that they were not to be driving their trucks as the company was still in stand down.[15]

8. Mr Rodney Redgen was a supervisor on site that day. He was permitted by NMG Managers to perform work for a client involving the unloading of steel pipes at the DFI Energy Services laydown yard at Malduf Street, Chinchilla. At approximately 08:00 hours, Mr Watts and a co-worker Mr Brian Mace approached Mr Addicott and asked if they could assist Mr Redgen to move the truck and trailer parked at the Warrego Highway and drive it to the DFI lay down yard and unload it. Mr Mace understood that Mr Addicott had cleared them to perform that work.[16]

9. At approximately 08:45 hours, Mr Watts and Mr Mace collected the truck and trailer containing steel piping from the Warrego Highway which was approximately 300 metres from the DFI lay down yard. Mr Watts drove the truck to the DFI yard. The trailer had 25 pipes loaded onto it, with seven pipes across the bottom three rows and four pipes across the top. The flatbed trailer had four stanchions (or "ballasts") with two on each side to prevent sideways movement of the pipes. The pipes were secured down by chains and ratchet straps. Each row, including the bottom had a length of timber between it and the next row. The image below demonstrates how the pipes were stacked on the trailer. The stanchions rose to 16.1 centimetres above the pipes as depicted in Image 1.:[17]

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[11] Ex C2 – OIR Investigation Report, p16 (p18 of Ex C2), Incident Investigation Report #9.14 (DFI yard Chinchilla 6 May 2017), p3

[12] Ex C2 – OIR Investigation Report, p 15(P17 of Ex C2)

[13] Ex C2 -OIR Investigation Report, (p18 of Ex C2), Ex C8,p33

[14] Ex C14.4, p47 – Toolbox talk meeting record #14300. Mr Watts, Mr Redgen and Mr Mace all attended this talk and signed their attendance

[15] ExB6.1 – Transcript of interview with Brian Mace, p52

[16] Ex B6.1 – Transcript of interview with Brian Mace, p53

[17] Ex E1- QPS SOCO Photographs, p32

Image 1: Pipes, separating wood blocks and stanchions – note the top (fourth) row had been removed in this photograph

10. At around 09:00 hours, Mr Watts parked the truck in the middle of the yard as directed by Mr Redgen.[18]

11. The passenger side of the truck (the offside) was parked about 1.5 metres from a stockpile of pipes against the far-left side of the laydown yard.[19] Once the truck was parked, Mr Redgen told investigators that he had set up an exclusion zone by placing two witches' hats on the driver's side of the truck (onside), one at the front of the truck and one at the rear at distance of two metres from the side of the flatbed trailer.

12. Mr Redgen told police that he would usually set up four witches' hats, but due to the position of the fence and the already laid down pipes as a physical barrier no one could access the offside anyway. The image 2 below depicts the pile of pipes against the fence of the DFI laydown yard as they were stacked on the offside of the trailer. Mr Redgen claimed that he, Mr Watts and Mr Mace were aware of the exclusion zone, and they had all worked together multiples times[20] and were aware of the ruling around entering exclusion zones. Mr Watts and Mr Mace unstrapped the chains and straps from the pipes and laid them on the ground on the passenger side of the trailer (Mr Redgen told investigators he also assisted in the removal of the straps).

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[18] Ex A6 – Forensic Crash Unit report; Inquest Transcript, Day 2, 5 October 2022, P1-85, L1

[19] Inquest Transcript, Day 2, 5 October 2022.P1-85. L1 13 E2 – OIR Photographs, p4

[20] This was the first time Mr Watts and Mr Redgen worked together in unloading pipes

Image 2 depicts the Front-End Loader with the pipe on the tynes that was lifted from the deceased's body. (The truck had been moved.) On the left is the pile of pipes that were 1.5 metres from the flatbed trailer.

13. Mr Mace then went to the front of the DFI yard to speak with another truck driver who had another load to deliver. Mr Redgen was to operate the FEL to remove the pipes from the trailer and stack them. The pipes were 10 metres in length, 30 centimetres in circumference and weighed between 600 and 700 kilograms. There were 25 pipes loaded on the trailer with seven pipes across the bottom three rows and four across the top. They were held in place by stanchions which were not taller than the highest placed pipe, indeed 16.1 centimetres short.

14. Once all other persons were clear from the area, Mr Redgen commenced unloading the top row of pipes. Mr Watts remained near the rear witches' hat and assisted Mr Redgen by giving him guidance through hand signals. The FEL could only approach the trailer on the driver's side of the truck because the passenger's side was approximately 1.5 metres from the line of stacked pipes. Mr Redgen then removed three pipes from the top row and laid them down in an area behind him (opposite the driver's side of the truck). The fourth pipe rolled to the passenger side of the truck and rested against the stanchions.

15. Mr Redgen reversed and stacked the three pipes then approached the trailer again to collect the fourth pipe. He had to stretch the tynes across the trailer to reach it because the tynes were shorter that the width of the flatbed trailer. Mr Watts stood at the rear of the trailer. Mr Redgen had the tynes set at even level and when they were all the way under the pipe, Mr Watts gave him the thumbs up to commence lifting the fourth pipe.

16. Mr Redgen then raised the tynes and as he lifted the pipe, he observed it start to roll forward to the front of the tynes. Mr Redgen lost sight of Mr Watts as he began to tilt the tynes backwards but when he realised the pipe was rolling forward, he dropped the tynes down to try and get the pipe back on the trailer. However, the pipe had rolled too far and it rolled over the side of the trailer. The piped rolled off at an even level and not by one side first. Mr Redgen estimated the period between receiving the thumbs up signal from Mr Watts to the pipe falling was about 30 seconds.

17. Mr Redgen told police that he initially did not think anything of the pipe rolling off, other than he would pick it up later once the trailer was driven away. He looked over to tell Mr Watts to remove the timbers and start unloading the next row when he noticed Mr Watts was no longer at the rear of the trailer. He thought that maybe Mr Watts had gone around the side of the trailer to look at where the pipe landed.

18. Mr Redgen exited the cab of the FEL and walked around the truck where he located Mr Watts slumped with his head between his knees. The pipe was across the rear of the neck and shoulder area. Mr Redgen was unable to lift the pipe by hand. He ran to the front of the yard to Mr Mace saying: "*I've killed him, I've killed him*". Mr Mace returned with Mr Redgen. Mr Redgen then moved the truck and trailer and then used the FEL to lift the pipe off Mr Watts' body. Mr Mace rang triple zero and ran across to another nearby yard for help.

19. The below image (Image 2) depicts the position of the trailer and forklift at the time of the incident. Position 5 shows where the truck and trailer were positioned upon police arrival, after it was moved to access Mr Watts with the FEL.[21] Position 7 (circled) depicts where the truck and trailer were at the time of the incident:[22]

20. A box where the chains are stored on the passenger's side of the flatbed trailer was open with a chain half inside. This is consistent with the deceased entering the passenger's side exclusion zone to place chains in the trailer box perhaps while he thought that the FEL was away from the flatbed trailer.

[21] Ex B9 – Transcript of interview with Rodney Redgen, p40
[22] This movement of the truck is confirmed by the vehicle's built in monitoring system.

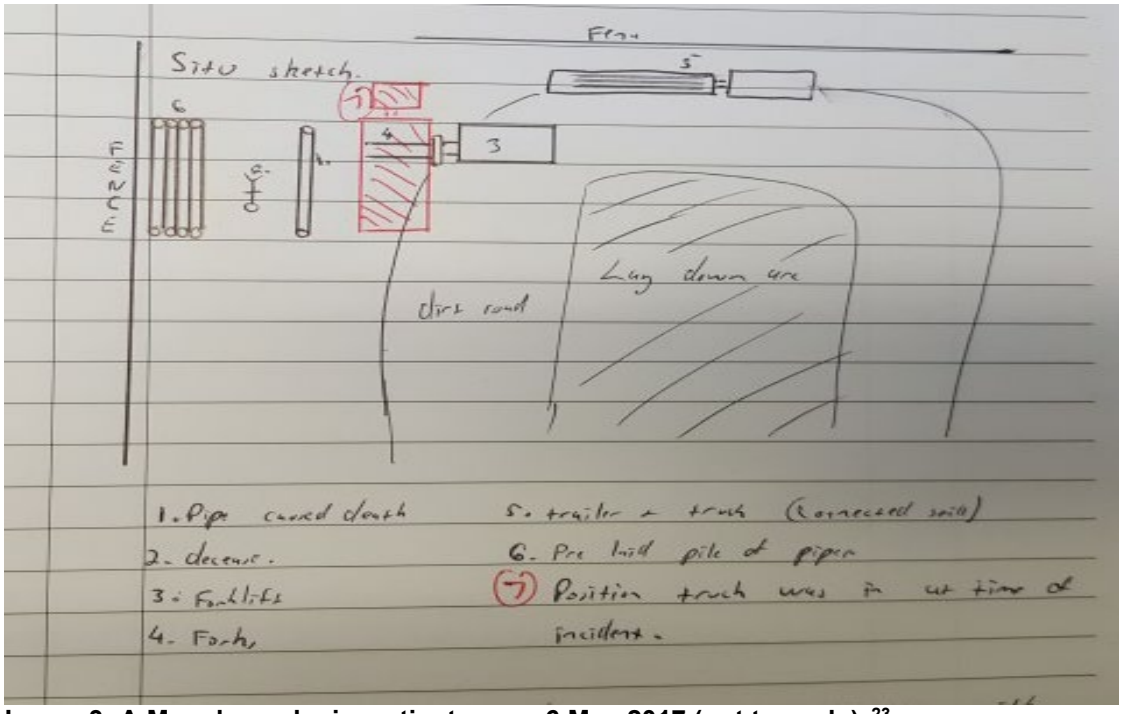

Image 3: A Map drawn by investigators on 6 May 2017 (not to scale).[23]

21. Ms Debbie Thorley was at the gate of the Landmark yard when she saw Mr Mace obviously distressed walking along Malduf Street on the telephone to the Queensland Ambulance service ("QAS"). She asked if he was alright, and Mr Mace told her there was an "accident". He was on the phone with the ambulance. Ms Thorley took the phone from Mr Mace and was advised by the operator what had occurred. She advised Mr Mace that she was first aid qualified and followed him to the DFI yard. Ms Thorley felt Mr Watts for a pulse but could not find one. Mr Mace gave her the phone and she was instructed by the operator to commence CPR.

22. Ms Thorley asked for someone to go to the Landmark office and advise her co-worker Ms Carina Kirkwood to come over and assist her. Ms Thorley and Ms Kirkwood continued CPR until the QAS arrived on the scene at 09:26 hours and immediately took over CPR. Paramedics attached the defibrillator pads to Mr Watts but it advised that he was in asystolic arrest and he was declared life extinct. Both Mr Mace and Mr Redgen were treated by paramedics for shock.

AUTOPSY

23. On 10 May 2017, Dr Nadine Forde conducted an autopsy consisting of an external examination, post-mortem CT scans, a review of the deceased's medical records (including Queensland Ambulance Service

[23] Ex A6, Forensic Crash Unit Report

records) and various tests such as toxicological examination of post-mortem blood and urine samples.

24. The external examination noted evidence of a traumatic crush injury to the torso and a compound fracture to the left lower leg. CT scans showed several severe injuries including a small subarachnoid haemorrhage, crush injury of the thorax, mid thoracic spine fracture with distraction and disruption of the spinal cord, thecal sac and thoracic aorta and suspected disruption of the distal oesophagus. There were also severe intra-abdominal injuries with transection of the pancreas, right kidney and suspected shattered spleen. Multiple other lumbar spinal fractures and pelvic fractures were also noted.

25. Toxicological analysis of the deceased's post-mortem blood sample detected neither drugs nor alcohol.

26. Dr Forde concluded, uncontroversially, that the cause of death was:

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

    1(b) Struck by falling pipe

THE INVESTIGATION

27. The Queensland Police Service (initially) and the Office of Industrial Relations commenced their investigations on the day of Mr Watts' death. Mr Mace was compelled to participate in an interview with investigators on 2 June 2017. Mr Mace then contacted investigators and voluntarily participated in another interview which was conducted on 1 November 2017. There were some discrepancies in his versions which will be examined later.

28. Inspector Nicholas Finn, from the Office of Industrial relations ("OIR") took over the investigation on 7 August 2017 and produced an investigation report following the fatality. It is accepted that the investigation was thorough, adequate and of a high standard. As a result of the evidence gained during the investigation, Mr Finn concluded NMT[24]:

    a. Failed to conduct any assessment as to the suitability and ability of the FEL fitted with forklift tynes to safely achieve the tasks which it was being put to in unloading tubular loads.

    b. Failed to supply plant and attachments of a suitable nature to safely perform the task at hand during the incident evidenced by

[24] Exhibit C2 – Office of Industrial Relations – Investigation Report, P48

the lack of assessment to establish the suitability of the plant and attachments.

c. Failed to supply equipment that would effectively delineate, and establish the existence of an exclusion zone at the time of the incident.
d. Failed to ensure effective exclusion zones were being established while unloading tasks were being conducted, evidenced by the lack of equipment provided.

29. Essentially the controversies reviewed were two-fold: the appropriateness of the plant used and the effectiveness of the exclusion zone.

30. Ultimately, the Senior Director of OIR's Prosecution Services Unit, on 10 January 2019, did not support the incident being escalated to a criminal prosecution. It concluded that a miscalculation and error on the loader operator's part and the actions of Mr Watts were contributory factors. Further, that there was evidence of previous safe use of the FEL using only tynes and an exclusion zone of some nature was in place.

31. Accordingly, there was insufficient evidence to conclude that the loader and forklift attachment was inadequate, faulty or incorrect for the task. Further, the suggestion of exclusion zone delineation with greater clarity was insufficient to prove a case to a criminal standard against NMT given the background of the workers' training, experience and awareness. I make no criticism of the OIR investigation.

32. The original coronial investigation was finalised by way of Chamber findings on 6 November 2020. It relied heavily upon the comprehensive OIR report. On 16 November 2020, Mr Watts' family sought review of the findings and submitted to the State Coroner that an inquest should be held into Mr Watts' death. On 8 July 2021, the (then) Acting State Coroner, upon review of the application determined it would be in the public interest to hold an Inquest. This was, in part, because there were gaps in the available evidence because Neil Mansell Group and others had exercised their lawful right to refuse to answer some police and Work Health and Safety questions. At Inquest that right is not readily available.

THE INQUEST

33. A pre-inquest conference was heard on 16 May 2022. The inquest proper was conducted over four days in Brisbane from 4 to 6 October 2022 and on 14 November 2022.

34. It was hoped to be scheduled earlier but COVID-19 considerations intervened. There were originally many witnesses to be called but

interstate closures and the unavailability of experts caused frustrating delays.

35. The Inquest formally considered four primary issues:

    i. The findings required by s 45(2) of the *Coroners Act 2003* (Qld); namely the identity of the deceased, when, where and how he died and what caused his death;

    ii. Whether there was appropriate fatigue and mental health management by the Neil Mansell Group;

    iii. Whether appropriate measures were in place of the unloading of the steel pipes;

    iv. Whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.

36. Eleven witnesses were called to give evidence:

    - Mr Keith Alexander Watts (father of the deceased)
    - Mr Joe James Watts (brother of the deceased)
    - Mr Nicholas Finn (Investigator Work, Health and Safety Qld)
    - Mr Shane Addicott (Counsellor with Benestar)
    - Ms Catherine Tam (Civil Engineer, Work, Health and Safety Qld)
    - Mr Brian Mace (Driver, Neil Mansell Transport)
    - Mr Rodney Redgen (Supervisor, Neil Mansell Transport)
    - Mr Jason Von Borstel (Manager, Neil Mansell Transport)
    - Mr David Whitefield (Manager, People and Risk)
    - Ms Roxanne Mysko (Managing Director, CTRS Solutions)
    - Mr Shane Eyers (Regional Manager, Neil Mansell Transport)

37. Mr Keith Watts was the father of the deceased and gave evidence in accordance with his experience as a truck driver of some 26 years. He gave evidence of the deceased's hearing impediment in the left ear, his excessive workloads and long working hours, his safety-consciousness, keeping a personal diary (which has never been located) and his depressed mood following the death of a close friend on 4 May 2017. Under cross-examination he disclosed that Mr Mace had admitted to him that there was no exclusion zone in place at the time of this death.

38. Mr Joe Watts was the brother of the deceased and also a truck driver. He confirmed the roles of a spotter and FEL operator whilst unloading, and the importance of exclusion zones. He said that the deceased was

often tired from long working hours and, in particular, “down” in mood following the death of a work colleague on 4 May 2017. He said that the deceased like all drivers often worked beyond the regulated safe working hours “to just get the job done.” He explained that the various driver hour monitoring systems were not always accurate. Mr Joe Watts also noted that NMT did not use “slippers” which extended the length of tynes and are readily available.

39. Inspector Nicholas Finn gave evidence that he took over the investigation into this death on 7 August 2017. He produced an investigation report following the fatality. Mr Finn made it clear that where there were discrepancies apparent between versions provided by Mr Mace and primary hazards that required management in this matter, being: a) uncontrolled fall of materials from height and b) working around exclusion zones. He concluded that the measures in place to combat the hazards by NMT were deficient. In particular: “the uncontrolled fallen materials from height, the plant selected led to a heightened risk of that occurring and … the effective exclusion zone had not been established by the mere use of two witches hats..”

40. Mr Addicott told the Court that he was a counsellor from Benestar, arranged to attend the NMT site to assess staff for their reactions to trauma, grief and loss of a work colleague on 4 May 2017. He provided psychological first aid, self-care and coping strategies to assist staff. He gave evidence that the scope of his role was to provide post-critical incident support and provide coping techniques for employees. The support involved active listening, allowing a safe space for employees to discuss their thoughts and feelings regarding the incident, provide psychoeducation on common reactions to critical incidents and then coping techniques for any identified symptoms they were experiences. This support was provided by way of one-on-one counselling sessions.

41. He stated that he had been employed with Benestar since 2013 as a counsellor. He holds the qualifications of a Bachelor of Science (with major in Psychology) and a Master of Social Work Studies. As part of the Benestar policies and protocols, Mr Addicott underwent annual ‘Incident Management Accreditation’ and annual ‘Trauma Assist’ training. On 5 May 2017, Mr Watts attended a mandated counselling session with Mr Addicott. He had been directed to perform light duties around the Chinchilla Depot for a further two days pending clearance to operate heavy vehicles.

42. The evidence of Mr Addicott is that Shane Eyers wanted him to provide employees clearance to work. He maintained that he specifically advised Mr Eyers that his role was not to provide clearance for work as it was not in accordance with Benestar’s universal policy. (Mr Addicott’s evidence is dealt with in greater detail later.)

43. Ms Catherine Tam, an expert engineer from the Office of Industrial Relations, gave evidence in relation to a technical report she provided

to Work, Health and Safety investigators. She explored the plant involved in the subject incident and whether it was appropriate for the task. Ms Tam opined there were three key factors resulting in the incident. Ms Tam's oral evidence was that the arrangement of the pipes on the trailer was a key factor in the incident. The pipe rollover could have been prevented by the height of the stanchion being "higher than the pipe itself".

44. Ms Tam opined that it is unlikely that the pallet forks ('tynes') fitted to the FEL while it was being used as a forklift were of a suitable length to safely reach and lift the fourth pipe on the far side of the trailer from where unloading was being conducted.

45. She explained that prior to the fatal incident, the centre of gravity of the pipes on the top row was most likely above the stanchions and Mr Redgen, the FEL operator, would not have to lift the pipe very high up for it to roll over the stanchion. Alternative and safer methods which would have reduced the likelihood of this incident occurring were outlined. Tam suggested an attachment with 'grab' function, such as a pipe grapple to unload the steel pipes. Further, if tynes were to be used to unload the pipes, palletise, or strap the pipes together to prevent them from rolling freely.

46. Ms Tam also criticised the lack of communication between the deceased and Mr Redgen. She proffered that two-way radios were far preferable to hand signals.

47. Mr Brian Mace was employed within the NMG as a truck driver, based at its Chinchilla Depot. He was Mr Watts' work colleague, and each of them reported to Mr Von Borstel. At the time of the incident Mr Mace had been working for NMG for 7 years. Mr Mace was interviewed by the police on 6 May 2017 and twice further interviewed by Inspectors from Workplace Health and Safety Queensland: on 2 June 2017 and 1 November 2017. Mr Mace's evidence in his two WHSQ interviews appeared to conflict: firstly, indicating that there was an exclusion zone and later contradicting that assertion. Under cross-examination, he conceded that he was already outside the DFI yard and/or not present in the moments immediately prior to Mr Watts' death.

48. Mr Mace said that Mr Redgen had asked him to assist with the unloading task at the DFI yard subject to Mr Addicott having first cleared him to perform the work. Mr Mace's recollection was that he saw Mr Addicott on three or four occasions,[25] and that on the morning of 6 May 2017, he spoke to Mr Addicott to: *"…see if he – if he thought we were in the right mood to* [work]*. And he gave the okay. Gave the all clear."* Mr Mace said that when he saw Mr Addicott, he was not only cleared to do the work, but also positively encouraged to do so:

[25] Inquest Transcript, Day 2, 5 October 2022, P1-19 at L25; P1-43 at L3

"*Did you say to Mr Addicott, 'We've got to load of pipes we have to unload this morning'? That's right, yes. And did you ask him words to the effect, 'Can we do it? Are we okay to do it?'? Exactly. And he told you that you were? Yes, that's right."*[26]

49. Mr Rodney Redgen gave critical evidence to this Inquest. He was the only witness to the events immediately leading up to Mr Watts' death. He was a supervisor employed within NMG, based at the Chinchilla Depot. On 6 May 2017, Mr Redgen was Mr Watts' supervisor and Mr Redgen reported to Mr Jason Von Borstel. At the time of the incident, Mr Redgen had been working for NMG for 5 ½ years. He was, and continues to be, a truck driver by trade.

50. Aside from some minor variances, Mr Redgen's evidence was essentially consistent within itself and previous documentary proofs and other witnesses. I considered him to be an honest witness and I accept his account in relation to the establishment of an exclusion zone which is outlined in the factual basis preceding.

51. Mr Redgen saw Shane Addicott on 5 May 2017, and possibly on more than one occasion. Mr Redgen understood Mr Addicott to be a psychologist. Mr Addicott advised Mr Redgen, *"You're right to go back to work. You don't need to talk to me anymore,"* after which Mr Redgen advised Mr Von Borstel that he had been cleared to work. In relation to Mr Redgen, Mr Addicott's "clinical notes" record: "OK to work".

52. In relation to the exclusion zone, Mr Redgen gave evidence that, because of confined space, he and Mr Watts decided they would just use two cones on the driver's side and then use an existing pile of pipes, already lying on the ground on the passenger's or "off" side of the trailer - to delineate the passenger-side exclusion zone: "*…on the left-hand side, the passenger side of the truck, did you put witches hats out on that? No. We didn't put witches hats out there because we utilised the pipe that was already there. And because it was only me and Billy-Joh there."*[27]

53. Mr Redgen was unquestionably a competent front-end loader operator and both he and Mr Watts had received specific training from NMG in relation to exclusion zones. He confirmed that there was a routine toolbox meeting on the morning of 6 May 2017. When asked if Mr Redgen and Mr Watts had risk-assessed the possibility of an uncontrolled movement of pipes, Mr Redgen said: "*And so, what was your proposal to mitigate that risk? Well, that's why BJ was standing at the back of the trailer in case there was something that went astray."* [28]

54. Whilst Mr Redgen was transporting the first load of three pipes away from the trailer, he believes that Mr Watts had started putting chains

[26] Inquest Transcript, Day 2, 5 October 2022, P1-43 at L25
[27] Inquest Transcript, Day 2, 5 October 2022, P1-63 at L40
[28] Inquest Transcript, Day 2, 5 October 2022, P1-76 at L38

away. This meant that Mr Watts had entered the exclusion zone, but Mr Redgen was also very clear in stating that Mr Watts subsequently exited the exclusion zone upon the front-end loader having returned to the trailer:

> *"And so, when you re-approached the trailer to remove the fourth pipe, where was Billy-Joh? Just coming round the back of the trailer.*
>
> *So is it the case you wouldn't move forward to unload that fourth pipe until you saw Billy-Joh was safe? Yeah. Yeah.*
>
> *And so, when you've gone in to collect the last pipe from the top row whereabouts did you see Billy-Joh? He was standing at the corner of the trailer, the same as the first thing, and then once – because your spotter directs you - - -*
>
> *Yes? and then once you've come into the top, and then the spotter gives you the all-clear, that you're good, you don't look at the spotter anymore. You just concentrate on what you're doing.*
>
> *And when you say he was at the corner of the trailer, was that on the passenger side corner or the driver's side corner? No. The driver's side.*
>
> *And you could clearly see him when you've gone in and set the tynes down? Yep.*
>
> *And at what point did you stop looking at Billy-Joh? At that point. Okay? When we both gave each other the thumbs up.*
>
> *… I had the forks on level, and got my forks all the way under as BJ gave me the thumbs up to tell me I was under enough to lift."*[29]

55. Mr Von Borstel was a Branch Manager employed by NMG and based at the Chinchilla Depot. He oversaw about 80 staff. Mr Von Borstel was Mr Watts' supervisor, and friend. Consistent with other witnesses, Mr Von Borstel was unaware that Mr Watts had a hearing deficit. In all events, it did not appear to affect his ability to work.

56. Mr Von Borstel confirmed that Mr Watts had been certified as competent to operate heavy vehicles and a loader forklift and both competencies involved checking Mr Watts' knowledge of exclusion zones. He also confirmed that Mr Watts was inducted in the *NMG Guidelines*, including chain-of-responsibility training; fatigue management; and the loading and unloading of general freight.

[29] Exhibit B9.1 at paragraphs 14 and 15

57. Mr Von Borstel confirmed that there was a morning toolbox talk on 6 May 2017 and personally saw both Mr Watts, and Mr Mace at that toolbox meeting. He also thought Mr Addicott to be a psychologist. He gave significant detail of his discussions with Mr Addicott, and he sheets home responsibility for permitting Mr Watts to work that day to Mr Addicott. However, Mr Von Borstel also accepted failings by the NMG:

> *"And so, BJ had worked for 26 days in a row without any day off in that period, hadn't he, Mr von Borstel? Yes. He had. And is that in compliance with the fatigue management policy for an employee on standard hours? No. It's not.*
>
> *And is it in compliance with the National Heavy Vehicle Regulator's requirements? No. It's not."* [30]

58. He also stated it was common practice to use a FEL with forklift tynes to remove pipes from a flatbed trailer. No other means was available at the Chinchilla depot.

59. Mr David Whitefield, a safety expert, of 'People and Risk' was engaged by NMG to provide advice in relation to the establishment of the exclusion zones around the trailers during loading and unloading, and where the practices of NMG fell within industry standards and expectations. Mr Whitefield opined that the methods chosen by NMT in relation to the provision and implementation of exclusion zones provided an effective balance between available controls and identifiable risks.

60. Ms Roxanne Mysko gave evidence as an expert in safety investigations. She provided a 'Chain of Responsibility' audit in relation to Mr Watts' death, dated 18 May 2017. She acknowledged that there were limitations to her report as she did not have access to all records and all witnesses. Critically, she stated that human error on the part of the deceased could not be excluded as a direct cause of this death. She was cross-examined extensively about the inadequacy of the exclusion zone. I have trouble understanding the point. There were only two people who entered the exclusion zone: Mr Redgen and the deceased. Ms Mysko unreservedly said that the deceased effectively breached the golden rule that no-one should enter an exclusion zone when a load is being removed by a FEL.

61. Mr Shane Eyers who held the role of Health, Safety, Environment and Quality Manager at Neil Mansell Transport in May 2017 also gave evidence. He was based at Toowoomba. Mr Eyers stated that Mr Redgen had a very good compliance history regarding safety matters. When giving evidence at the resumed Inquest on 14 November 2022, his view was that the exclusion zone implemented by Mr Redgen was an acceptable site-specific modification. Using only two witches' hats and a 1.5 metre wide "off side" in a confined location was appropriate on

[30] Inquest Transcript, Day 2, 5 October 2022, P1-123 at L18

the proviso the staff engaged in the task also had an agreed understanding.

62. Mr Eyers believed Shane Addicott to be a clinical psychologist, sent to Chinchilla to assess workers in terms of their suitability to return to work: *"He was dictating to us what he would be doing. --- And it was centred around – in his – in his opinion, he would – he would be speaking to them and letting us know when they would be right to go back to work"*.[31]

63. He stated that he did not have a conversation with Mr Addicott in which Mr Addicott had made clear that his role did *not* include certifying people as being fit for work.

64. From the evidence given by Mr Eyers, the NMG relied on the IVMS records and logbooks to track fatigue management. The driver timesheets were for the sole purpose of determining how much drivers were paid; they were not forwarded to the NMG compliance officer for checking compliance with fatigue laws. In his statement, Mr Eyers concedes that Mr Watts may have worked in excess of standard hours, but that by 6 May 2017 he had ample rest. As of 4 May 2017, NMG did not have any procedures for managing workplace fatalities. Mr Eyers admitted that the possibility of a traumatic event had not been contemplated.

ANALYSIS OF THE ISSUES

65. Distilling out a small number of irrelevant matters that were traversed, mostly in cross-examination, the following issues became clear:

    i. Whether the task undertaken, and equipment used to unload the pipes was inherently unsafe

    ii. Whether there had been an adequate Exclusion Zone established

    iii. Whether the deceased's personal health and training was suitable for the unloading task at hand

    iv. Whether the deceased was too fatigued to safely perform his role in the unloading task at hand

    v. Whether the mental health of the deceased was inadequately triaged such that it affected his ability to safely perform his role in the unloading task at hand

i. Whether the task undertaken, and equipment used to unload the pipes was inherently unsafe

[31] Inquest Transcript, Day 1, 14 November 2022, P 1-11 at L9-13

66. The first issue is the loading of the pipes on the flatbed trailer. Mr Watts' allocated truck was a 2010 Western Star 4864 FXB Prime Mover. The flatbed-trailer attached to it was a 2011 model Haulmark trailer. It was fitted with restraining stanchions 1500mm height from the trailer deck, with the trailer width of 2400mm. The FEL was a 2007 Caterpillar 928Gz model fitted with standard forklift tynes.

67. The flatbed trailer was loaded in Brisbane and there is no evidence of load movement on the journey to Chinchilla. However, the top row of four rows of pipes was extended some 19.5 centimetres beyond the height of the stanchions (The Load Restraint Guide 2004 was silent on the subject of load exceeding the height of stanchions). This meant that the forklift could not use the stanchion as a "backwall" to hold the pipe while the tynes slipped underneath and it was little wonder that the top pipe fell on to the trailer and had to be removed separately. With the chains and straps removed the pipes were unrestrained. Whilst it is possible to speculate that if the stanchions had been higher, the fourth pipe would not have fallen off the trailer. However, the stanchion's height has to be limited so pipes can be lifted high enough to be lifted over them when unloading.

68. Exacerbating the unloading problem was the fact that the FEL was only able to unload from the driver's side. Because of the "tight" turning area, the flatbed trailer was parked 1.5 metres from pipes stacked on the passenger's side. Consequently, FEL had to "reach across" and were 22.5 centimetres short from the driver's side potentially losing considerable control of the load. The tynes used could have been extended in length by the use of "slippers" but none were available.

69. A grapple attachment which acts like a set of hydraulic jaws, is the preferred device for lifting pipes by a FEL, as well as a crane with a sling attachment. Neither were used by NMT as they mainly moved a lot of general freight, and the organisations that did invest in grapple attachments were those where pipes were their core business It was also explained that the pipes cannot be palletised given their weight and length, and creates a greater danger to workers trying to unload trailers.[32]

70. Ms Tam's opinion was pallet fork attachments are not suitable for unloading unrestrained circular steel pipes. There is no specific law or guideline mandating the equipment to be used beyond or different from that used by NMH on 6 May 2017. Roxanne Mysko was engaged by NMG to provide a 'Chain of Responsibility' audit after Mr Watt's death. She gave evidence that the industry should not be extremely prescriptive about the equipment used, as the industry is diverse and dangerous, and there are so many ways a depot can operate.[33]

[32] Inquest Transcript, Day 2, 5 October 2022, P1-1-2 at L5
[33] Inquest Transcript, Day 3, 6 October 2022, P3-53 at L35-40

71. Furthermore the positioning of the deceased (acting as "spotter") at the rear of the flatbed trailer, compromised his ability to observe and signal danger to Mr Redgen, the driver of the FEL and vice versa. Hand signal was the only form of communication available and the load, the flatbed trailer stanchions and the moving FEL were clear obstacles to that form of communication. Ms Tam stated that instead of eye contact and hand signals, they could have used two-way radios to communicate. Notably, the Loading, Unloading, Exclusion Zones & Spotting Guideline. ("LUEZ" Guideline 4.3 applicable at the time) states that if the driver/spotter ceases to be in the direct line of sight of the operator at any stage during the loading/ unloading activity, the loading/unloading activity should immediately stop and not resume again until a direct line of sight is re-established between the operator and the driver.

72. I do not accept that the Watts Family submission that Mr Redgen was in breach of the NGM Load/Unload General Freight SWP dated 10 May 2017 applied on 6 May 2017. It required observance of the UHF 4 Step Positive Communications Protocol.[34]

ii. Whether there had been an adequate Exclusion Zone established

73. The purpose of exclusion zones is to keep people out of danger by excluding them from entering a space when freight is being unloaded. It is not contentious that all the employees involved in the fatal incident were aware of what an exclusion zone was and its purpose.

74. The exclusion zone procedures in place at the time of the fatal incident were contained in:

    a. NMG Life Saving Rules
    b. NMG training PowerPoints on the *Life Saving Rules*
    c. NMG Induction training
    d. NMG Load/ Unload General Freight SWP
    e. NMG Toolbox Talks
    f. NMG Safe Work Procedures

75. Staff were trained in the use of exclusion zones annually and that training is refreshed in regular Toolbox Talks, and Verification of Competency (VOC) processes. The topic of exclusion zones was covered in the Toolbox Talk presented on the morning of 6 May 2017, and attended by Messrs Watts, Mace and Redgen. Also, NMT followed the industry standard for exclusion zones, which are contained in the *LUEZ Guidelines 2010* and approved as an industry standard.
76. The LUEZ Guidelines, in place at the time of the incident, clearly articulated that:

[34] 21Exhibit C.17.2 Page 30 (This was introduced in response to the subject death.)

a. personnel must remain in the safety zone or be removed to another area from the LUEZ area;

b. personnel must not enter the LUEZ area without the authorisation of the operator;

c. prior to entry/ exit of the LUEZ zone, machinery must be stationary; and

d. no movement of machinery and people at the same time within the LUEZ zone.

77. There was initially some discrepancy between the versions of Mr Mace relating to the setup of the exclusion zone. Mr Mace stated in his first interview he believed the exclusion zone had already been set up when the truck was driven into the yard. In a second interview he stated he could not recall any exclusion zone being established at all while he was at the DFI yard and certainly that had not been set up on entering the yard as he first indicated. At the inquest Mr Mace reasonably conceded that he could not remember an exclusion zone set up, and accepted one could have been set up once he left the yard.

78. Mr Mace was also not able to recall if either Mr Watts or Mr Redgen had brought cones for setting up an exclusion zone from the NMT yard and suggested that any cones used may have been ones used to mark the end of stockpiles in the DFI yard. Mr Mace stated he was aware it was not standard practice for cones to be on either of the trucks or FEL at the time nor was there a stockpile of equipment at the yard for the purpose of establishing exclusion zones. Mr Von Borstel in his discussion with investigators advised that the clients are to have this equipment available on site for their drivers to use.

79. Mr Redgen's evidence is that he and Mr Watts had a discussion about how they were going to unload and where the exclusion zones was to be set. Given the limited amount of space, they decided to utilise the stockpile of pipes on the offside of the trailer as the marker for the exclusion zone on the offside of the trailer. They used two witches' hats to mark the onside section where Mr Redgen would be working. Mr Redgen placed the witches' hats at a distance of about two metres from the onside of the trailer. Mr Redgen stated that he and Mr Watts knew once the exclusion zone was established that they were not to go in it. They then established a safe position for Mr Watts to stand as the spotter, at about a metre from the rear of the trailer. Mr Redgen was confident that if Mr Watts remained in that position, then he would be safe from any pipe rolling.

80. Ms Willoughby submitted to this Court that there was no acceptable evidence that an exclusion zone had been in existence. I do not accept that submission. Mr Redgen gave uncontradicted evidence that an exclusion zone had been set up. Witches hats are clearly visible in the

scene photographs after the arrival of police. That Mr Mace did not see an exclusion zone in circumstances where he was absent for a short period does not form a contradiction. The setting up of an exclusion zone is unsophisticated and non-time-consuming exercise. Uncontradicted evidence should be accepted prima facie.

81. It is another matter though, whether or not the rudimentary exclusion zone was suitable. Mr Redgen gave the following evidence:

> *"…the DFI yard is so small you're limited to space. So, we decided we – the truck was where it was to utilise the pipes behind it as an exclusion zone as well, and we'd use the cones out the front on the section where we'd all be working.*
>
> *…on the left-hand side, the passenger side of the truck, did you put witches hats out on that? No. We didn't put witches hats out there because we utilised the pipe that was already there. And because it was only me and Billy-Joh there.*
>
> *Yes? We decided that we'd just utilise the pipes on the left-hand side and use the cones on the right-hand side where we'd be.*
>
> *Okay. So then, whereabouts did you place the witches' hats? Out on the right-hand side of the truck where we were unloading.*
>
> *And how far away from the trailer did you place those witches' hats? About two metres off the trailer.*
>
> *And when you say off the trailer, do you mean off to the driver's side? Yeah.*
>
> *Or off to the rear end of it? Off, from the trailer two metres out."* [35]

82. Clearly, the exclusion zone was in breach of NMT Load Restraint SWP policy, in that the witches hats were not four metres either side of the flatbed trailer. When giving evidence at the resumed Inquest on 14 November 2022, Mr Eyers (the NMG Health Safety Environment and Quality Manager) expressed the view that it was an acceptable site-specific modification to only use two witches' hats in a confined location - on the proviso the staff engaged in the task also had an agreed understanding.[36] However, one important consideration is that the reduced size of the passenger's side exclusion zone (1.5 metres) impeded the deceased's manoeuvrability to avoid the falling pipe.
83. A preferred exclusion zone set up might have been established by using a barricade or fencing, tapes, or chains. The use of a notional barrier of tape or similar that required some physical action such as having to duck under the barrier, might have raised Mr Watts situational and risk

[35] Inquest Transcript Day 2, 5 October 2022, P1-63 at L40
[36] Inquest Transcript Day 1, 14 November 2022, P32 at L26; P34 at L7

awareness of entering into an exclusion zone. However, what cannot be ignored is that Mr Watts, who was trained in the procedures as part of his employment, would have been aware the offside of the trailer would be an exclusion zone and the pipes already acted in some fashion as a notional barrier. It is well-known and common sense that, regardless of an exclusion zone, no-one should approach either side of a platform like a flatbed trailer whilst being unloaded by a FEL or forklift.

84. Mr Watts was a diligent worker on all accounts, and I adopt the submission of Ms Franco: "…*it is a reasonably supportable conclusion that Watts was most likely in the area at the time of the incident to load the restraining devices and chains removed from that load into the storage box on the offside of the trailer. However, it is not possible to conclude whether Watts' breach of the exclusion zone was a deliberate action to advance his work in contradiction to safety practices, or has occurred through inattention, distraction, and / or lack of situational awareness (i.e., missed auditory cues).*"

iii. Whether the deceased's personal health and training was suitable for the unloading task at hand

85. Mr Watts had been working as a truck driver for less than two years. He began driving for a company called Kurtz Transport in Chinchilla doing local transport, which did not involve overnight transports. Kurtz Transport had folded about a year later and NMT took on many of their contracts. As a result of the collapse of Kurtz Transport Mr Watts was employed by NMT since 8 October 2016 as a heavy vehicle operator. His routine tasks were that of a heavy vehicle operator engaged in workover rig moving and general transport haulage. Mr Watts was deemed competent in the operation of a FEL and would operate varying items of machinery as required. On 19 October 2016, Mr Watts completed the requisite Safe Work Procedure training and competencies, including loading and unloading general freight. On 26 January 2017, Mr Watts had a verification of competency assessment conducted by the NMT driver trainer for front end loaders with fork attachments. Also included in this training was a component for exclusion zone requirements.

86. Particularly given the supervision of Mr Redgen, I can find no deficiencies and the training and commitment to safe work practices of the deceased. However, it is concerning that he was profoundly deaf in his left ear. A number of years preceding his death, Mr Watts suffered a viral infection that caused his deafness. Mr Watts' father, Keith Watts, gave evidence at the inquest that Mr Watts was still going to school at the time he became deaf. Mr Keith Watts explained that Mr Watts' deafness was so profound that if someone stood on his left side and spoke to him, he could not hear them talk properly. Mr Watts had not been required to undergo medical assessment when he commenced working with NMT, given he was working under the standard hours

fatigue management and NMT did not have a policy requiring medical assessment of all drivers on commencement of work.

87. The OIR investigators stated it was not possible to attribute the hearing impairment as a causal factor in its own right, but it likely contributed in some degree to the incident, in conjunction with other factors.[37] I find it hard to categorise the deceased's deafness as a causal factor in its own right. Given the interrupted vision of the FEL that he would have experienced at the rear of the flatbed trailer, reliance on the sound of the FEL to determine its position would be unremarkable. (Experience truck drivers can determine the make, model and age of vehicles and machinery through hearing even when unsighted).

88. If the deceased was facing the passenger's side of the flatbed trailer his left ear would have been closest to the FEL. I readily accept that the deceased's impaired hearing delayed his awareness that the FEL was approaching to load from the driver's side.

iv. Whether the deceased was too fatigued to safely perform his role in the unloading task at hand

89. This is the most concerning evidence regarding NMT's safety practices. I do not accept the NGM submission that fatigue is not able to be categorised as a matter that is "connected with" the death of Billy-Joh Watts, in the manner required by s.46(1). The deceased's irrational decision to enter the exclusion zone whilst unloading was taking place could well be explained, inter alia, by overtiredness from excessively long hours.

90. The NMG procedures and practices for fatigue management in 2017 were contained in:

    i. *Transport Operations (Road Use Management) Act 1995* and the *Heavy Vehicle National Law (Queensland)* (fatigue management laws), including a logbook system designed to prevent workers operating when fatigued
    ii. NMG Life Saving Rules
    iii. NMG Fatigue Management Policy
    iv. NMG Fit for Work Policy

91. Mr Watts was under a "standard hours" fatigue management plan, which meant he was supposed to work as a driver for no more than 12 hours each day and for no more than 6 days at a time.
92. Each NMT truck was fitted with an In Vehicle Monitory System or IVMS. This system captured a vehicles location, speed and operating times and is used in part for fatigue monitoring. Each driver had a unique tag for the system issued by the employer and logs onto a database when

[37] Ex C2 – OIR Investigation Report, p27

they operate the vehicle. The IVMS record demonstrated that Mr Watts' truck (PM321) was operational daily between 3 April and 28 April 2017. However there were two versions of the IVMS records provided to this Court by NMT. The complete IVMS record does not show the IVMS key as showing Mr Watts as the driver. A different set of records from 23 April 2017 to 6 May 2017, containing the same data, identified Mr Watts as the driver of a truck at any time. Evidence was given at the inquest that there should not be any reason why a driver was using an IVMS key other than their own.

93. Further, Mr Watts' driver fortnightly timesheets established that he had worked 26 days straight between 3 April 2017 and 28 April 2017. Between 28 April 2017 and 6 May 2017 Mr Watts had two "days off" work and the two stand-down days (5 and 6 May 2017) where he was not driving but still working. From the evidence given by Mr Eyers, NMT relied on the IVMS records and logbooks to track fatigue management. The driver timesheets were for the sole purpose of determining how much drivers were paid and they were not forwarded to the NMT compliance officer to check for compliance with fatigue laws. In his statement, Mr Eyers conceded that Mr Watts may have worked in excess of standard hours but opined that by 6 May 2017 he had ample rest.

94. Ms Mysko also considered that the two days break on 29 and 30 April 2017 and the stand down on 4 and 5 May 2017 was sufficient and did not think that fatigue was a contributing factor in Mr Watts' death. However, Ms Mysko's investigation did not identify the period of 26 days Mr Watts worked straight through. She accepted in evidence at the Inquest, that it was a concern.

95. The OIR investigation determined that was unable to make any finding as to whether the two "days off" on 29 and 30 April 2017 and the two days of stand down light duties demonstrated sufficient rest for Mr Watts to diminish his fatigue. However, investigators did not attempt an analysis in relation to other potential breaches of fatigue standards such as the length of time in excess that Mr Watts was alleged to have been on the road for on any particular day.

96. Inspector Finn reported:

> *"An analysis and cross referencing of the documentation that was able to be located after the exercising of a number of coercive notices under sections 155 and 171 of the Act identified areas of concern in relation to fatigue management. The analysis established a pattern of work consistent with that attributed to Watts by friends and family, particular that of Keith Watts who described a conversation with Watts who provided he had worked 26 straight days. A period matching this was established from timesheets to have occurred between 3 April 2017 and 28 April 2017.*

In the intervening eight days between 28 April 2018 and 6 May 2018 Watts has had two days off work and two stand down days where he was not driving however was working. The question as to if this provided sufficient rest for Watts to diminish his fatigue and what level of fatigue Watts was experiencing at the time of the incident is not one that is able to be quantified to the point that it can be considered a causal factor in its own right. It is reasonable however to acknowledge that a real potential existed for Watts to be affected by fatigue and that any level of fatigue would decrease Watt's situational or risk awareness at the time of the incident to some degree."

97. Relevantly, Mr Watts self-reported on the day of the incident that he had only five hours of sleep. However, he did not report that his fatigue was such that it was affecting his work performance.

98. There is a real inference to be drawn that the deceased's fatigue especially in combination with his grief reaction to the proximate death of a work colleague played a significant role in his concentration on situational awareness in the dangerous task of unloading the pipes. I conclude that the deceased's fatigue, at least contributed to by breaches of the NHVR and NMG policy, was a factor connected to his death. It is of note that NMT introduced a NMG Fatigue Management SWP on 17 May 2017, shortly after Mr Watts' death.

v. Whether the mental health of the deceased was inadequately triaged such that it affected his ability to safely perform his role in the unloading task at hand

99. On 4 May 2017, the deceased attended work and performed driving duties. On that date, Mr Adrian Stehbens, an employee of NMT, and friend of Mr WATTS, was killed in an unrelated single vehicle incident. Mr Stehbens was nicknamed "Kermit". On 4 May 2017, Mr Watts was recalled to the NMT depot located at Zeller Street, Chinchilla (Depot). He did not perform further truck driving duties on that date, and NMT mandated a three-day shutdown.
100. Mr Shane Eyers admitted that the possibility of a traumatic event had not been contemplated. Origin Energy was a client of NMG and they offered to engage their own Employee Assistance Provider [EAP], Benestar, to offer support to NMG staff. As a result of NMG's inexperience with counselling services they accepted the offer.

101. During the stand-down on 4 May 2017, the NMT put in place the procedures to support the staff's mental health. Initially, two local counsellors were organised, who were then replaced by Benestar's Shane Addicott to counsel employees. A mandatory shutdown on full pay for all southeast Queensland, including Chinchilla, Roma, Wondoan

and Toowoomba employees. The length of the shutdown varied depending on location and extended for 2 weeks in Chinchilla.

102. Shane Addicott had been employed with Benestar since 2013 as a counsellor. He holds the qualifications of a Bachelor of Science (with major in Psychology) and a Master of Social Work Studies. As part of the Benestar policies and protocols, Mr Addicott underwent annual 'Incident Management Accreditation' and annual 'Trauma Assist' training.

103. Mr Addicott arrived at the Chinchilla depot on 4 May 2017. He gave evidence that the scope of his role was to provide post-critical incident support and provide coping techniques for employees. The support involved active listening, allowing a safe space for employees to discuss their thoughts and feelings regarding the incident, provide psychoeducation on common reactions to critical incidents and then coping techniques for any identified symptoms they were experiences. This support was provided by way of one-on-one counselling sessions. The counselling sessions were offered and strongly encouraged to all employees at the Chinchilla depot.27

104. The evidence given at inquest by Shane Eyers, Jason Von Borstel, Brian Mace, and Rodney Redgen is that they all believed Mr Addicott was a clinical psychologist. The consistent understanding was that he would provide clearance for employees to return to usual work. Mr Mace's evidence was that he and Mr Watts separately approached Mr Addicott on the morning of 6 May 2017 to "see if he thought we were in the right mood to go and do it" (work with Mr Redgen), and Mr Addicott "gave all clear." Mr Mace also told the inquest that Mr Addicott thought that the best thing for him and Mr Watts to do was to go back out and do that job, instead of sitting around brooding. Mr Redgen gave evidence that on 5 May 2017 he spoke to Mr Addicott and was told "you're right to get back to work. You don't need to talk to me anymore." Mr Redgen advised Mr Von Borstel that the counsellor said he was cleared to work, and as a result he was given the job at the DFI yard.

105. From the evidence provided by Benestar, it is clear that Mr Addicott did not have any authority to provide clearance for employees to return to work. However, the evidence from four independent witnesses who were at the Chinchilla depot on 5 and 6 March, 2017 was that Mr Addicott did hold that role and responsibility. Messrs Mace, Redgen, Eyers and Von Borstel each gave evidence that Mr Addicott purported to be a psychologist through his demeanour and conduct. He behaved as if his role was to assess their fitness for work, and they relied on his "professional" opinion.

106. On the contrary, Mr Addicott gave evidence that Mr Shane Eyers wanted him to provide employees clearance to work but he specifically advised Mr Eyers that this was not his role. Clearance for work was not in accordance with Benestar's universal policy. Mr Addicott gave

evidence at the Inquest that he sent an email to NMT stating that he has no authority to clear any employees for work, however no such email has been produced to the court.

107. It was put to Mr Addicott that, if he had concerns about Mr Watts' mental health and ability to continue working, regardless of the scope of his role, would he advise NMT of these concerns. He said he would. Mr Addicott stated that he "would not have probably thought (it was) an issue for him to return to work." Mr Addicott told the inquest there was no evidence to suggest that Mr Watts was not ready for work.

108. Mr Addicott's working notes showed that he saw Mr Watts for two counselling sessions on 5 and 6 May 2017. The entry on 5 May 2017 states:

> *"BJ (Billy-Joh Watts) went to bed not feeling too bad. Ruminating a bit in bed this morning. Local in town, single with a dog. No family in town. Sister in Toowoomba, parents in Nth Qld. Wants to get back to doing something. Thinking about where the accident happened. Ok to work."*

109. Mr Addicott clarified that his note "ok to work" was something that Mr Watts said to him, that Mr Watts had reported his willingness to return to some work activities. The note was not an assessment he made about Mr Watts. There was a second, undated entry that read: *BJ (Billy-Joh Watts) – Not too bad, 5 hours good sleep.* Mr Mace gave evidence that on 6 May 2017, he did not think that himself nor Mr Watts were in the right frame of mind to be working.

110. Mr Von Borstel gave evidence at the inquest that he did not think that Mr Watts should have been working at all. Had he not left the depot to attend a meeting then he would have prevented Mr Watts from leaving the depot to perform other work.

111. Mr Addicott was *not* a registered health practitioner. Mr Addicott is obliged to be registered as a health practitioner if he practices in psychology. In his evidence before the Inquest, Mr Shane Eyers advised that Mr Addicott presented as being a clinical psychologist: *'…He presented as one'*.[38] Mr Jason Von Borstel was acting under the same understanding. The deceased was described as "withdrawn" or "sad" during the shutdown.

112. On the evening of 6 May 2017, Mr Addicott sent an email to Shane Eyers:

> *"Hi Shane.*
>
> *I was deeply shocked and saddened to hear that BJ passed away today, as I had only had my last session with him this morning.*

[38] Inquest Transcript Day 1, 14 November 2022, P1-10 at L47; P46 at L14

My thoughts and condolences are with you all through this tragic time and I will continue to provide what support I can over the coming weeks.
My initial report is now moot as staff will have to be reassessed, so I have passed key information to Mike Stubbly, the clinician who will be on site by now, for him to include in his report.

Your sincerely,
Shane."[39]

113. There is no evidence of any subsequent interaction between a Mike Stubbly and NMG following this email. In his evidence about his email of 6 May 2017, Mr Addicott used language that clearly suggested he had prepared an initial report. However, his use of language was at least casual:

> *"... Mr Addicott, in the email that I read out to you, you make reference to 'my initial report' and it's now being moot? Mmm.*
>
> *Had you started to prepare an initial report in this matter? Not really because I'd only just gotten home and they had stated that they didn't want a report so I didn't start a report. But I did – I transcribed basically my clinical notes in the – in a – quite a lengthy email to the other clinician that had been sent there. So – so basically that – that is a summary of – of those clinical notes for each of the clients.*
>
> *Could you provide a copy of that as well? Well, that – I would say they would be on the same hard drive but the – the other person that I sent it to should have a copy of it."*

114. Mr Addicott was asked to produce that *"report" and has not done so*. I found Mr Addicott to be a less than credible witness. This was particularly in relation to his denial that he was holding himself out to be providing psychological services. In relation to the incident involving Mr Watts, Mr Addicott said that he provided *"psychological first aid". He added*: *"Basically, it means I'm a counsellor or a – you know, providing psychological first aid, in the context of that particular case."*[40]

[39] Exhibit C17.2, P110
[40] Inquest Transcript Day 1, 4 October 2022, P1-80 at L26

COMMENTS

115. The effluxion of time since this tragic death of Mr WATTS on 6 May 2017 belies a difficulty in making clear factual findings. With the possible exception of Mr ADDICOTT, I do not consider any of the witness were doing less that try to recall accurately the events of that day. From the evidence, Mr Watts, Mr Redgen and Mr Mace were all experienced and diligent workers in the industry, and understood their roles and safe practices when unloading. Mr Mace made perhaps the most telling admission about what occurred on 6 May 2017 when he said: It was *"a job they had done a hundred times before and that complacency may have been a factor.*"[41]

116. There are multi-facetted explanations for the deceased moving into the exclusion zone exposing himself to the falling pipe. It is a golden rule that no-one should enter an exclusion zone when a load is being removed by a FEL. There are four possible explanations for the deceased's action and two valid criticisms of the unloading operation:

    i. Inadvertent carelessness through complacency (Mr Mace made the most telling admission about what occurred on 6 May 2017: "It was a job they had done a hundred times before");

    ii. Deafness. The deceased was totally deaf in his left ear. This might have impeded his ability to determine exactly where the FEL was working;

    iii. Inattention through distraction. The deceased had just lost a close friend in a road traffic crash and his mind might well have been "elsewhere". The counsellor, unhelpfully and unqualified to do so, seems to have led NMT to believing that the deceased was "fit to work" and benefit his mental health by working. Accordingly, the deceased's situational awareness might have been impaired through ineffective psychological support.

    iv. Fatigue. The deceased had just potentially worked 26 days straight (in breach of the *Heavy Vehicle National Law (Queensland)* (fatigue management laws), had two "days off" and then was confronted with the death of a close friend and work colleague.

    v. Inadequate Exclusion Zone. The 1.5 metre gap in which the deceased had to move produced two problems. First, Mr Redgen's view of the deceased was obstructed and, second, the deceased would have had a limited range of movement to avoid the falling pipe. A spotter and load should at all times be able to see each other and, if not, the work should cease immediately.

[41] Inquest Transcript Day 2, P1-27 at L30

vi. Inherently unsafe loading manoeuvre. The FEL was only able to unload from the driver's side. Because of the "tight" turning area, the flatbed trailer was parked 1.5 metres from pipes stacked on the passenger's side. Consequently, the FEL had to "reach across" to collect the pipe of which Mr Redgen lost control. The tynes were 22.5 centimetres short from the driver's side meaning loss of control of the pipe was likely. The tynes used could have been extended in length by the use of "slippers" but none were available. Other methods of pipe removal such as using a grapple (hydraulic tongs) or a crane with a sling attachment would have been preferable but not mandatory.

117. It is not possible to prefer any one of these explanations over the other. It is probable that they each worked in combination. Whilst the effluxion of time has denuded memories, which makes definitive conclusions difficult, it is without doubt that the transport industry can learn much from this tragedy. Accordingly, it is hoped that the death of Billy-Joh Watts provides a template for safety in the trucking industry and, in particular, the Neil Mansell Group for many years to come.

FINDINGS REQUIRED BY S. 45 CORONERS ACT (QLD):

(a) **Identity of the deceased** – Billy-Joh Watts

(b) **How he died** – Struck by falling pipe unloading a truck

(c) **Place of death** – DFI Energy Yard, Malduf Street, Chinchilla

(d) **Date of Death** – 6 May 2017

(e) **Cause of Death –** 1(a). Multiple Injuries; *due to or as a consequence of* 1(b) Struck by falling pipe.

RECOMMENDATIONS

118. The window of hindsight is the clearest window of all. With the benefit of hindsight there are some simple practical alternatives methods to unloading that day that could have potentially been outcome changing, for example: physical or well identified exclusion zone barriers with tape (where it does not interfere with the unloading), the mandatory use of two-way radios to communicate between the FEL operator (Mr Redgen) and the spotter (Mr Watts) rather than relying on hand signals (which I understand NMG has introduced) and use of different mechanical devices: extensions to the tynes, a hydraulic grapple attachment, or a crane with a sling attachment.

119. It is evident that NMT had appropriate safe work methods statements and safety processes in place. However, it is clear that there were gaps

in their safety processes: the flaws in the loading of the pipes, placement of the trailer, exclusion zone limitations, fatigue management, psychologic assistance and assessment of employees following trauma and identification of physical deficits potentially endangering employees (viz the deceased's loss of hearing in one ear).

120. There was only one witness present at the time of Mr Watts' death: Mr Redgen. He presented as an honest and credible witness at the inquest. His evidence was that once he got the thumbs up to unload that his sole focus went onto that task. The evidence by Mr Keith Watts was that once the FEL operator lost sight of the spotter they should drop the tynes immediately in accordance with LUEZ Guideline 4. Strict compliance would have been largely impractical. It would be impossible for Mr Redgen to concentrate solely on loading the pipes and looking at Mr Watts, coincidentally. The window of hindsight is the clearest window of all. I accept that the view of the deceased could have been achieved with a better exclusion zone. However, Mr Redgen was right to expect that an experienced worker like Mr Watts would not enter the exclusion zone once the FEL had begun the unloading process. This was , particularly so on the off side of the trailer where he could not be seen by Mr Redgen.

121. Critically, it is impossible to clearly understand why the deceased entered the exclusion zone. He was described as a meticulous worker that was compliant with all safety measures and policies. It might have been impaired situational awareness from the potential impacts of fatigue and the personal trauma of losing a colleague just two days prior. However, those are two of a number of potential reasons including carelessness from complacency.

122. Any inconsistencies in the evidence of witnesses given at the Inquest some five years after the events of May 2016 could not sensibly been seen to be critical blows to their credibility. Accordingly, I do not propose to act on the inconsistencies in Mr Mace's evidence, for instance, and I find him to be a credible witness who was doing his best to recollect the events of Mr Watts' death, and assist the Court. Similarly, the evidence that NMG was in breach of the *Heavy Vehicle National Law (Queensland)* (fatigue management laws) by allowing the deceased operate a truck for 26 days consecutively is lacking in clarity. It is based on hearsay statements from the deceased, unclear documentary evidence and other circumstantial inferences that would not reach a criminal prosecution standard. Further, any prosecution is likely to be statute barred or subject to a stay application given the delay. Having said that, I have acted on this evidence and accept that the deceased was fatigued from long days and scheduled driving, which was a causative factor contributing to this death, although of unknown significance.

123. I do find Mr Addicott to be an unimpressive witness. However, he did not resile from the position that he explicitly told NMT managers that he

was not authorised to assess employees for their fitness to return to work. Mr Addicott referred to discussions and email chains explicitly identifying his role, which do not seem to exist, and are in stark contradiction to the recollection and beliefs of all the NMG employees that gave evidence. Whilst he did not present as a particularly candid or forthcoming witness at the inquest, the evidence does not amount to an exercisable disciplinary complaint to the appropriate regulatory body.

124. It is important to note that NMG has formalised the use of "exclusion zones" to meet industry standards within the *LUEZ Guidelines 2010* and the *Load Restraint Guide 2018*. Since the fatal incident, DFI Energy Services Pty Ltd also reviewed and amended the Safe Work Method Statement (SWMS): Unloading Piles on Job Sites. The amendments to the SWMS made it explicit that no one was to enter exclusion zones.

125. Counsel Assisting, Counsel for the Office of Industrial Relations and Counsel for Neil Mansell Transport each have submitted that there is no requirement for Recommendations to be made following this Inquest. In Watts Family's submitted that the following recommendations would be appropriate to minimise the risk of such incidents as the subject dearth occurring in the future:

> "(*a) that the MOU in place between OIR, QPS, DTMR be strengthened to require the referral of information to the relevant agency that WHSQ (or any party to the MOU) may identify in the course of exercising its powers, which may be relevant to the enforcement of a law or regulation by the other agency.*
>
> *(b) that the Load Restraint Guide 2018 be adopted by WHSQ as a Code of Practice;*
>
> *(c) that future guidelines or Codes of Practice recommend that the upper 10% of each stanchion be painted red, or a high impact colour, to act as a visual cue to those carrying out loading and unloading activities;*
>
> *(d) that the Loading, Unloading, Exclusion Zone Guidelines be adopted by WHSQ as a Code of Practice."*

126. In relation to (a) above, I have been assisted by Ms Franco for the Office of Industrial Relations. She referred this Court to the Findings into the death of Stephen Ross Brown (27 March 2018) where Coroner Lock recommended that the process of revising the current MOU between QPS and WHSQ include a process for the notification of heavy vehicle incidents to the NHVR. The government response to this recommendation provided an update as follows:

> *"A new MOU between the Office of Industrial Relations, the Queensland Police Service and the department of Transport and Main Roads is complete.*

The MOU builds and maintains professional relationships between the agencies; clarifies specific working arrangements between the agencies in relation to the attendance, investigation and reporting of traffic incidents; ensures a thorough investigation of the incident is conducted; and ensures coroners are informed of the extent of each agency's investigation into a reportable death.

Part 3 of the MOU includes a process for notification of serious incidents involving a heavy vehicle under the Heavy Vehicle National Law to the National Heavy Vehicle Regulator by the Queensland Police Service."

127. This reassures me that there is now a framework supporting professional relationships between Regulators including the sharing of information and an established process for notifications of serious incidents involving a heavy vehicle under the Heavy Vehicle National Law to the National Heavy Vehicle Regulator. Had OIR investigators been investigating this potentially egregious breach of HVNL involving the deceased driving some 26 days without a break, today, the evidence would have been passed on to the National Heavy Vehicle Regulator.

128. Ms Franco also submitted that I could recommend that the Office of Industrial Relations review their "Event Management" procedure to assist in this information sharing process. The Event Management procedure provides guidance for officers when responding to work, health and safety incidents. Accordingly, I could recommend the sharing of information with other regulators where an inspector obtains information that may be relevant to the enforcement of another Act whether Queensland, interstate or Commonwealth if necessary to lessen or prevent a serious risk to public health or safety pursuant to section 271 of the *Work Health and Safety Act 2011*.

129. **I recommend that the Office of Industrial Relations review their "Event Management" procedure to facilitate the sharing of information with other regulators where an inspector obtains information that may be relevant to the enforcement of another Act whether Queensland, interstate or Commonwealth if necessary to lessen or prevent a serious risk to public health or safety pursuant to section 271 of the Work Health and Safety Act 2011.**

130. In relation to (b), (c) and (d) there is no evidence before me to consider the issues involved in recommending that an industry guideline be upgraded to a Code of Practice and specifically in relation the industry guidelines mentioned. The regulatory framework was not a specific issue examined at this Inquest. No evidence was adduced, nor witnesses called to identify any gap in the regulatory framework that would warrant the creation of Code of Practices. Further, no evidence was adduced, nor witnesses called to canvass the implementation of such Codes of Practice.

131. There is already a structured legislative framework in place with safety duties owed under the *Workplace Health and Safety Act 2011* and the *Workplace Health and Safety Regulation*s 2011 (the WHS Regulations) to eliminate/ minimise risks to health and safety so far as it reasonably practicable. There are also other relevant Codes of Practice, Standards and guidance material in place that are relevant and applicable. The *Managing the risks of plant in the workplace Code of Practice 2021* is a code based on a national model code of practice written by Safe Work Australia and adopted in Queensland. This code sets out the risk management process and incudes a hazard checklist at appendix C. Appendix D of this COP References the AS 2359 (series) Industrial (forklift) trucks as an example of a published technical standard providing guidance on the design, manufacture, and use of certain types of plant.[42]

132. The *How to manage Workplace Health and Safety Risks 2021* is also a code based on a national model code of practice written by Safe Work Australia and adopted in Queensland. The code outlines how to identify hazards, how to assess risk, how to control risks, how to review controls and how to keep records. There is also the SAI Global, Australian Standard AS2359.2 2013 Powered Industrial trucks, Part 2 Operation[43] outlines the hazard of loads falling when being handled by a Powered industrial truck, being a forklift or similar.

133. I my view there is sufficient guidance in place without the need for a Code of Conduct based on the information before me.

I close the inquest.

Donald MacKenzie
Coroner
BRISBANE

2 May 2023.

[42] *Managing the risks of plant in the workplace Code of Practice 2021*, P59
[43] Exhibit C28e