CITATION: *Inquest into the death of Nathan Wade Brooks* [2001] NTMC 75

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	45/2000
DELIVERED ON:	2 November 2001
DELIVERED AT:	Darwin
HEARING DATE(s):	27, 28,29 March and 2 April 2001
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

CORONIAL – INQUEST, death by electrocution, work place safety

REPRESENTATION:

Counsel:

Assisting:	Ms Jenny Blokland
Roofclad	Mr Jon Tippett
Work Heath Authority	Mr Duncan McConnell
Mr Michael Taylor	Mr Fred Davis

Solicitors:

Roofclad	Markus Spazzapan
Work Health Authority	Morgan Buckley
Mr Michael Taylor	Davis Norman

Judgment category classification:	B
Judgment ID number:	[2001] NTMC 75
Number of paragraphs:	43
Number of pages:	20

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 45/2000

In the matter of an Inquest into the death of

NATHAN WADE BROOKS
ON 20 MARCH 2000
AT ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered 2 November 2001)

Mr CAVANAGH:

THE NATURE AND SCOPE OF THE INQUEST

1. Nathan Wade Brooks ("the deceased") died at around 2.24pm on 20 March 2000 as the result of an electrocution.

2. Section 12(1) of the *Coroners Act* ("the Act") defines a "reportable death" to mean a death that:

> "appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury".

3. For reasons that appear in the body of these Findings, the death fell within the ambit of that definition and this Inquest is held as a matter of discretion pursuant to s15(2) of the Act.

4. Section 34(1) of the Act details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> (1) A coroner investigating -
>
> (a) a death shall, if possible, find -
>
> (i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(v) any relevant circumstances concerning the death.

5. Section 34(2) of the Act operates to extend my function as follows:

> A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.

6. The duties and discretions set out in ss 34(1) and (2) are enlarged by s35 of the Act, which provides as follows:

1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

3) A coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the *Director of Public Prosecutions Act* if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner.

7. The public Inquest in this matter was heard at the Darwin Magistrates Court on the 27th, 28th, and 29th of March, and the 2nd of April 2001. Counsel assisting me was Ms Jenny Blokland of James Muirhead Chambers. Mr Jon Tippett sought leave to appear on behalf of Roofclad Pty Ltd, Mr Duncan McConnell sought leave to appear on behalf of the Work Health Authority and Mr Fred Davis sought leave to appear on behalf of Mr Michael Taylor. I granted leave pursuant to s40(3) of the Act.

8. This evidence enables me to make the following formal findings as required by the Coroner's Act:

FORMAL FINDINGS

(a) The identity of the deceased was Nathan Wade Brooks, a Caucasian male born on the 12th December 1979 at Stirling, South Australia.

(b) The time and place of death was on the 20th of March 2000 at 14:24hrs at the Accident and Emergency Department, Royal Darwin Hospital.

(c) The cause of death was electrocution.

(d) The particulars required to register the death are:

1. The deceased was a male.
2. The deceased was of Caucasian Australian origin.
3. The death was reported to the Coroner.
4. The cause of death was confirmed by post-mortem examination.
5. The death was caused in the matter described in paragraph (c) above.
6. The pathologist viewed the body after death.
7. The pathologist was Dr Michael Zillman of the Royal Darwin Hospital.
8. The father of the deceased is Terry Dean Brooks and the mother of the deceased is Lynette Helen Brooks.
9. The usual address of the deceased was 45 Evelina Court, Howard Springs, in the Northern Territory of Australia.
10. The deceased's occupation was as a roofer.

9. This inquest was held to inquire into the circumstances surrounding the death of Nathan Wade Brooks. The focus of the inquest was to consider whether the death of Nathan Wade Brooks was preventable and if so, how the circumstances giving rise to his death could be prevented in the future. The inquiry has had the benefit of the cooperation of both lay witnesses attesting to the direct circumstances surrounding the death as well as a number of officers employed by the Work Health Authority and the Power and Water Authority who have investigated the circumstances and provided the inquiry with the benefit of their expertise in occupational health and safety and related issues. A number of suggestions have been made by various witnesses on how work place safety could be improved by changes to practice in the building and construction industry as well as strengthening or reforming the regulatory aspects of workplace safety including a number of witnesses who have testified in favour of the introduction of a system of registration of builders.

The deceased

10. The deceased was born on 12 December 1979 at Stirling, South Australia. He died on the 20th March 2000 at Yarrawonga and was pronounced dead at 1424 hours at the Royal Darwin Hospital. The cause of death was electrocution resulting in cardiac arrhythmia, which progresses to cardiac arrest. He was twenty years of age. The next of kin of the deceased were not formally represented at the inquest although his wife and members of her family were present throughout most of the proceedings.

11. At the request of counsel for Roofclad Pty Ltd, and is clear in any event from the evidence, the inquiry observes that the deceased was a hard working man respected by his work mates and will be sorely missed. I confirm my comments also made to Jamie Murnane after he gave evidence, that the inquiry notes his courage and bravery for remaining with his injured colleague and attempting to render assistance when he himself had received

a shock and was in some danger. The inquiry also expresses its sympathy to the deceased's wife and family.

RELEVANT CIRCUMSTANCES

Background Facts

12. The relevant circumstances concern facts of a direct and indirect nature. This accident has occurred through a number of seemingly small minimally related events and factors. Regrettably, the accumulation of those events and factors led to the death of the deceased. Mr Michael Bruce Taylor's company, (*Winnellie Transmission Services Pty Ltd)* for which he and his wife are the sole directors, own a block of land at Lot 4618 McKenzie Place Yarrawonga. Mr Taylor described himself as the *owner of the property* to work health investigators, although his counsel brought the fact that the property is owned by his company to the attention of this inquiry. Mr Taylor applied for a building permit to construct a steel pre-fabricated shed, although he applied as *Michael Taylor*, and not *Winnellie Transmission Services Pty Ltd.* He obtained building approval on 19 November 2000. The building permit file summonsed and is before this inquiry. It has been revealed that Mr Taylor indicated the builder would be *Telford's Building* on his permit application. He has explained in evidence he thought that as *Telford's Building* at the time were in Darwin, that they would build the shed. That is not the way events unfolded and in any event not a great deal turns on it, save for noting that it doesn't seem to matter whether a builder is a professional builder or *owner-builder* for the purposes of obtaining a permit to build. In any event, Mr Taylor did not have a head contractor or other person nominated who would be responsible for a safe working environment. He acknowledged in response to questioning by me that he had responsibility for a safe working environment. This was not clearly acknowledged when Work Health Authority investigators interviewed him.

Events of 20 March 2000

13. Mr Taylor contracted with Mr Lee Ward, the steel fabricator, to put in all of the rafters, bracing, structural steel and purlins prior to the roofers being employed. He also contracted with Roofclad Pty Ltd to fit the roof and to clad the building. Mr Ward had finished most of his part of the contract prior to the 20 March 2000. However, he was called back to the site a few days before the 20 March 2000 to trim some purlins so that the cladders could complete their work. He wasn't certain in his evidence about precisely which events took place on the Saturday before the death or on the day itself, but it appears that with the evidence of Mr Barwick, another Roofclad subcontractor, that it was on the day of the death of the deceased, Mr Ward was using the mobile scaffold belonging to Roofclad to complete his work. He was initially going to complete his work using ropes and ladders, however Roofclad's subcontractors asked him if he wanted to use the Roofclad mobile scaffold.

14. That scaffold had previously been erected to around 3.7 metres by Roofclad employees – the 3.7 metres as it turns out is the measurement to the platform (and not the actual height of the scaffold, which is higher). Mr Chris Best, the Roofclad supervisor takes the measure of scaffold to its platform, whereas Mr Barwick, the other cladder put the height at around 5.5 metres as Mr Barwick takes his measure of the height to the top of the scaffold rather than the platform. Mr Ward took the scaffold up to a height of 8 metres. That was the measurement taken by Work Health Officers and appears in their report. Mr Best has said in evidence that he thought the scaffold was *about* seven metres, however, the scaffold had been measured by Work Health Officers and I accept eight metres is correct (para 1.15 Work Health report). Mr Ward gives evidence that it was probably the deceased and another person, who turned out to be Mr Stephen Barwick who told Mr Ward he could use Roofclad's scaffold. Mr Ward says he used the scaffold at this greater height as it was suitable for his work.

15. Mr Ward says he dismantled the upper two sections of the scaffold and with the help of the two cladders, moved it to the southern end of the shed. He says he then replaced the upper two sections of the scaffold. Stephen Barwick had arrived on site at Yarrawonga before 7.00am on Monday 20 March 2000. He told the inquiry that he was asked to move the mobile scaffold from the northern end of the building to the southern end so that Mr Ward could cut the purlins. The site at which Mr Ward left the scaffold and the height that it was left at (after Mr Ward had finished) corresponds with the evidence of Jamie Murnane who says that he and the deceased commenced work at the greater height and then didn't need it for that height for the work they were about to commence. There was a significant deal of contention about whether Mr Ward put the top sections of the scaffold on, removed them and added them again – in the final analysis it doesn't matter, however, I note he obtains no advantage for himself in giving this evidence, there's no reason he should not be believed. He also says that the reason he took the top sections off before moving it was that he was worried about the power lines.

16. Mr Ward says he called out to the roofers, that is, the deceased and Stephen Barwick to bring the power lines to their attention. That fact was initially disputed by representatives for other parties at the inquest, however, Mr Barwick himself says the three did discuss the power lines at the time when they were moving them. Mr Barwick gave evidence that as the deceased, Mr Ward and he moved the scaffold down the western side of the building they found they had to negotiate the distance between Mr Barwick's Toyota and the power lines. Mr Barwick recalls that was done by him standing at or under the lines to guide the scaffold through. I accept that those three persons, Mr Ward, Mr Barwick and the deceased knew of the presence and proximity of the power lines.

17. The combined evidence of Mr Best, Mr Murnane, Mr Barwick and Mr Ward indicate that the deceased was leading hand for this gang for this cladding

job. He was keen to get the job done. He had about two years working for Roofclad and he possessed a scaffolding ticket – although that was not a fact which was clear until this inquest. The deceased was obviously a sound worker enthusiastic about his job and was keen to please.

18. The deceased and Mr Barwick had been at the site on 20 March 2000 from about 7.00 am that morning. Some time after they assisted Mr Ward, Mr Best, (the Roofclad supervisor), phoned the deceased and told him it was too wet and to leave the site. Both of them did leave the site. Jamie Murnane received a call from the deceased later on that morning asking him to come and work because it had stopped raining. Stephen Barwick did not come back to work because of car trouble and so Jamie Murnane and the deceased commenced working on some smaller jobs that needed completion. The deceased did not follow the usual Roofclad practice of notifying Mr Best that they were returning to a site after being sent home. The deceased and Mr Murnane initially began working on the scaffold at its increased height on the southern side of the building and then started to move the scaffold. It was difficult to move the scaffold through the muddy soil but the deceased got inside the frame at the front and Mr Murnane pushed from behind. Sadly, according to Mr Murnane, they did not need the scaffold at the increased height to do the next part of their work. They pushed the mobile scaffold around the corner of the building when they started to get some momentum. At the corner of the building there was some harder ground making the pushing a bit easier. They started to go around what appears to be a muddy patch or puddle and at that time did not notice or think about the power lines above them. Mr Murnane had not seen the power lines. Probably the deceased had seen them earlier but on balance it seems they would have been putting so much effort into pushing the scaffold and looking down at the ground, that the danger above was not realised. Accordingly, the power lines running next to Lot 4618 McKenzie Place, which are actually on the neighbouring property, came into contact with the top of the moving

scaffold. As a result of contact between the power lines, the scaffold and the deceased, the deceased was electrocuted and did not regain consciousness despite efforts made by Mr Murnane, Mr Hill (from the next door business, *Darwin Bob-Cat Hire*) and ambulance officers. Mr Murnane also suffered a serious shock and felt as if he was glued to the aluminium scaffold. He lost consciousness for a period. When Jamie Murnane regained consciousness he immediately went to Nathan's aid. He used his boot that was rubber soled to kick Nathan away from the metal. He then crawled in under the scaffold to grab Nathan and pull him free. As he was engaged in that process the power came on again. It was at that point Mr Murnane ran to Darwin Bobcat Hire business and raised the alarm. Patricia Burn, an employee of the business called the ambulance. Jamie Murnane and Mr Hill then returned to the deceased to attempt resuscitation.

19. Most of the witnesses have regarded the death as preventable. Mr Best gave evidence saying any one of a hundred things could have changed the course of events of the day. Some of the facts that witnesses have mentioned as significant to them are:

- if the deceased had not gone back to work after being sent home.
- if the ground had not become muddy or boggy due to a downpour of rain then there would have been no need to detour into the power lines.
- if Jamie Murnane had been aware of the lines (he hadn't been working on the roof or at height like most of the other people on site, such as Mr Barwick who says they all knew of the power lines).
- if the scaffold height had not been raised.
- if the deceased and Jamie Murnane had dismantled the top two sections of the scaffold before attempting to move it given they no longer needed to work at the raised height.

- if Stephen Barwick had come back so there would have been three working instead of two, making the moving of the scaffold easier.
- if the power lines had been clearly marked, signed or fenced off.
- if boards or 'C' purlins had been used under the scaffold so it wouldn't have had to be pushed around so wide of the building (remembering the lines are 6.9 metres from the shed).
- if the fill hadn't gone beyond the boundary and under the power lines, so that perhaps a change in terrain would have been noticed.

20. No doubt there are others, they are just some of the "*if onlys"* mentioned by some of the witnesses which indicate the death was preventable. Broadly there are a number of factors isolated by Work Health Officers and other witnesses which have required examination to fully appreciate the circumstances of the accident and hence the death.

Safety Management of the Construction Site

21. The point made very strongly in the Work Health report and repeated by those Work Health Authority officers in evidence is that there was no coordination of safety matters between the various subcontractors who had different tasks to do at the site. The overall lack of coordination permitted a situation to arise where each individual may be looking out for their own safety, but there was no satisfactory responsibility taken for the site as a whole. It has also been noted during the course of evidence and argument that the governing legislation, the *Work Health Act* has some ambiguity. The relevant provisions of the *Work Health Act* operate to impose duties on employers, owners, occupiers and others for keeping and maintaining a safe working environment, or, safe access and egress in the case of occupiers.

22. For the purposes of the occupational health and safety parts of the *Work Health Act*, *worker* is defined as a natural person who, under a contract or

agreement of any kind (whether expressed or implied, oral or in writing or under a law of the Territory or not), performs work or a service of any kind for another person . That definition is to be distinguished from the compensation and rehabilitation parts of the Act which defines worker in a narrower way.

23. Pursuant to s 29 *Work Health Act*, employers shall provide and maintain a working environment at a work place that is safe and without risk to the health or safety of the workers working at the work place. Roofclad Pty Ltd clearly have responsibilities in relation to their own workers. That is acknowledged in the Roofclad director's statement to Work Health investigating officers. It would be expected that risk assessment might include generally identifying hazards at the site and ensuring equipment and conditions are safe; consideration would be given to the safety of the scaffolding and the rain. Similarly, it might be appropriate for Roofclad to consider the safety of the power lines, identifying the risk and making sure all workers know of their existence. It is not for this inquiry however to assess whether or not the duties under the *Work Health Act* have been breached because such a breach would involve potentially criminal responsibility (not for a *crime* but for a *simple offence* or in some instances *regulatory* offences) which is outside of the jurisdiction of this inquest. It is clear that Roofclad accept they have responsibilities for workers and clearly they have obligations under the *Work Health Act.* In this case however, Roofclad are the contractors coming onto a pre-existing site. That is where something of a hiatus in responsibility may occur. Roofclad had identified previously, the risks of work at height, however its identification was limited to the roofing task – it did not extend to the whole site. The power lines would have been clearly evident to the roofing task, although they were not close to the building. They were not clearly evident to Jamie Murnane who was working as a cladder. The *Guidelines for design and maintenance of overhead distribution and transmission lines,* recommends

the horizontal distance of power lines to buildings should be 2.1 metre for structures *normally accessibile to persons* or 1.5 metres from structures *not normally accessable to persons:* (report, see Chris Pemberton). The position of the lines *viv a vis* the shed were well within acceptable standards.

24. A person in the position of Mr Taylor, either has obligations over some of the workers as an *employer* under s 29 Work Health Act or as an *occupier* under s 30 that the work place and the means of access and egress from it are safe and without risk to health. Initially it had been suggested in the inquiry there may be a duty on him as an owner under s 30C but that is less clear in the construction stage and that section is inapplicable. In his interview with work health officers, Mr Taylor says that site safety is the responsibility of Roofclad. Clearly both have responsibilities but a person in Mr Taylor's position may not be aware that he cannot contract out his own site safety responsibility to a sub-contractor.

25. The work health officers are correct when they identify this lack of overall site safety coordination. Mr Taylor, in evidence before the inquiry seemed to indicate that now he does accept that he had certain responsibilities for the site.

26. Mr Gillis, from the Work health Authority by chance, visited the site on or about 2 February 2000 and spoke to a Roofclad worker known as "Squid" about the scaffold requirements for roofing and requested some improvements. Mr Gillis said he was confident that was being attended to and he checked the next day. He doesn't recall seeing the power lines, probably because he was focussed on other matters to do with correct scaffold for roofing. The lines were not noted by him as being a hazard.

27. Under the Work Health Act, both self employed persons and workers have responsibilities for their own safety and that of other persons on a site. There is a multi-layered approach to occupational health and safety in terms of the legislation, however, because it potentially involves a number of

different people and organizations, it must be coordinated. That was missing at this construction site.

Owner/builder responsibilities

28. The work health officers suggest that owner/ builders represent something of grey area in terms of occupational health and safety responsibilities. It may be that the position of so-called owner-builders needs to be clarified by way of statute and the general public need to made aware that owner-builders do have responsibilities for occupational health and safety, particularly if they are occupiers and employers, which will often be the case. The owner builder attempts to keep their costs down by contracting out each task, but because of that process, there is no principal contractor, and hence there needs to be some attention given to the occupational health and safety issues. "Tag teaming" of occupational health and safety issues is fraught with risk. Under reg 38 of the Work Health (Occupational Health and Safety) Regulations an employer is obligated to ensure that appropriate measures are undertaken to identify all hazards from work which may affect the health and safety of a worker and any other person who could be affected by the work.

Failure to maintain certain industry standards

29. A number of industry standards have been mentioned by Work Health Officers in their report and in evidence. The mobile scaffold, when at its extended height, exceeded the industry accepted height to base ratio of 3:1. It should not have been used at that height. It may have had implications for stability. In evidence Mr Caldwell of the Work Health Authority also explained the scaffold should have had more cross braces for the height it was at. Mr Best agreed in evidence that more cross bracing was needed at the extended height. There is a clear industry standard, set out in the Work Health Report and associated material that scaffold should only be used on

firm level surfaces and c-purlins or planks should be used to provide a firm surface. The surface was muddy. It is clear the mobile scaffold should have been used on a firm surface, or c-purlins or planks should have been used. If they had been used for moving the scaffold there would not have been the necessity to go around the muddy areas. Mr Best agreed he had corresponded with the Work Health Authority about the need for the use of 'c' purlins on a previous occasion. He doesn't appear to think they are necessary in this situation, however the Work Health Authority officers clearly do think so. This is clear from Mr Hollowood's evidence and the report. Industry Standards indicate that mobile scaffolding should not be used on soft uneven ground. The Industry Standards, AS/NZS 4576/1995 has not been incorporated into the *Work Health Regulations*, however, industry Standard AS 1576 has been, the relevant part stating that the *supporting structure of a mobile scaffold shall be a hard flat surface.* That is a matter of relevance to all the persons using or supervising the use of the mobile scaffold being the deceased himself, Mr Murnane, Mr Ward and Mr Barwick earlier in the day, Mr Best and from the point of view of safety of the site, Mr Taylor. Boards or "c" purlins should have been used in these circumstances.

30. Some points have been made concerning reg 137 of the *Work Health (Occupational Health and Safety) Regs* and whether or not fencing of a site such as this one should have occurred. On one reading of those regulations it indicates that a fence was not strictly required. Mr Gillis from the Work Health Authority indicated that there was no need for fencing due to the fact that it was not in suburbia, there was little risk of a member of the public coming onto the block and the regulation is directed to protecting members of the public who are not workers. In retrospect, it can be seen that if the boundary had been fenced the accident would not have occurred. Roofclad have argued that the property was required to be fenced; that the regulation does not confine itself to suburban areas; it simply requires that there be

fencing if any other person other than a worker has access to the construction site. The evidence showed that the area was a light industrial area in which other businesses operated including the Bobcat Hire business. Roofclad have argued that it was still a safety regulation which should have been adhered to; that if the fatality had been as a result of a child of an owner of a business in the immediate vicinity, clearly there would have been a finding that the owner/builder was at fault. In my view, the building site should have been fenced despite the opinion of the Work Health Inspector.

31. Both Mr Taylor and Roofclad were under an obligation as employers to identify risks and hazards. No consideration was given to flagging the power lines so as to better identify the hazard to workers. In hindsight, some sort of flagging or use of the *tiger tails* as a visual marker would have assisted.

Mr Brooke's Position

32. The deceased was supervisor of the particular gang at the site. He held a scaffold ticket. He wanted to get the work done and was more eager than the rest of his colleagues to finish the job. As supervisor and a holder of a mobile scaffold ticket, he should have noted the non complying nature of the scaffold but apparently he did not. It also appears he was aware of the power lines. During the investigation it was queried whether he had returned to work because he was a sub- contractor and needed to work for financial reasons as soon as the rains let up. There is not enough evidence to support a conclusion along those lines. Mr Best says he has checked the records in that regard and the deceased did have regular work over the wet season. It should also be noted that employees have stand down clauses of a similar type in the Roofclad workplace contracts. The financial considerations alone do not appear to be the motivating factor here. The deceased was obviously very keen to impress, keen to do the job. He came back to work after being sent home. Whatever the case, he did not appreciate the consequences of the risks he was taking in going back to work and moving around a scaffold in

the mud, scaffold which was not properly configured, with only the two workers. There should have been three at least to move the scaffold.

Power and Water Authority

33. There was some concern expressed by rescuers, namely Greg Hill, Patricia Byrne and Jamie Murnane about the power coming back on during the attempt to rescue the deceased. The area around the scaffold had become dangerous and Mr Hill received a shock. Because of the danger, ambulance officers did not access the area. Having heard evidence from Mr Pemberton, Mr Hallam and Mr Harpley, I am satisfied of the procedures the Power and Water Authority have in relation to re-energising power lines. The usual procedure for the circuit breaker to open and automatically close after three seconds happened to be disabled on this day, however, the evidence is clearly that the procedure to re-energise the power line manually in these circumstances is well within acceptable industry standards. The statement of the ambulance officer Virginia Dowsan does indicate that with knowledge of the PAWA procedures, a precautionary approach may be required. It may be opportune to emphasize the danger of being in proximity with power lines and always assume that the wires might be live, even as here, people in the vicinity assumed the power would be off after it initially did go off with the interference that was created by the scaffold on the line. Mr Chris Hallam, the electrical safety officer who looked at the technical aspects of this procedure for the Work Health investigators did not disagree with the conclusions given by Mr Pemberton.

Recommendations and comments

34. I recommend that industry standards be respected and enforced in relation to the use of mobile scaffolding, in particular, compliance with the base: height ratio of 3:1; using scaffold only on firm level surfaces and using c-purlins or

boards to provide a level surface when the scaffold is not on a firm level surface, and if needs be, such respect be mandated by regulation. In this regard I commend the evidence of the following witness (Transcript P179):

> "MR McCONNELL: Please give the Coroner your full name, address and occupation?---Peter Joseph Hollowood, 23 Pitman Court, Malak. I'm a work health officer employed by the Department of Industries and Business.
>
> How long have you been a work health officer with the Department of Industry and Business?---A bit over three years.
>
> Prior to that what did you do?---20 years in the construction industry, 10 years running Darwin Scaffolding and Rigging here in the Territory, two years prior to that elsewhere in the country, north west shelf and various places.
>
> You were an author of a work health accident report in relation to an electrocution death at lot 4618 McKenzie Road, Yarrawonga, on 20 March last year, is that the case?---Yes I was.
>
> Are you able to say why you were involved in the authoring of that report?---I would imagine through my industry expertise in the scaffolding and construction industry."

And (Transcript P188):

> "THE CORONER: Am I to take it, as you have been in agreement with the trend of the questions asked by Mr Tippett, that you would agree that eventually this industry code of conduct, in terms of workplace safety for workers, ought to be a compulsory one rather than a voluntary one?---That's the intention.
>
> Is that the intention, is that the way things are going?---The intention is that a code of practice, as Mr Gilles explained earlier, would become the minimum standard. You would either reach that minimum standard or a higher one. There are parts in that code of practice, in particular relating to the roofers where we have mandated the use of safety mesh on commercial projects. It's the only way to ensure that we get a whole complete safety picture happening on the roofs. There's no use putting handrails around the edge if you can fall right through the middle.
>
> So in that regard they ought not be voluntary, they ought to be compulsory?---That's correct.

If they are going to be compulsory and work there ought to be adequate compliance mechanisms put in place?---That's right."

35. That consideration be given to the use of tiger tails or insulation when power lines are in the vicinity of construction sites and are not otherwise fenced off or signed in some way to bring the lines to the attention of all workers.

36. That all workers and employers, however described be reminded of their responsibilities to carry out hazard identification and site safety planning for all construction sites by worker/employer education, counselling and advertisement.

Procedure for notifying the Work Health Authority of construction

37. This is a matter which goes back to the issue of lack of safety coordination at a site involving a lot of different sub-contractors for different purposes. Each employer is required to under reg 38 Work Health Occupational Health and Safety regulations to identify hazards. However, it may be appropriate that a mechanism be developed for notifying the Work Health Authority every time a construction site commences as at least the Authority would then be aware of each construction site and be able to make a decision on whether the construction site should be visited. If appropriate, the authority could examine safety plans, hazards and the like and check that safety is being properly monitored. Ironically here, the site was visited but it was only with the immediate task of roofing in mind and the use of the mobile scaffold and hand rails used for that task. Had Mr Taylor been required to notify Work Health of the commencement of construction, there may have been reasons for the Work Health Authority to get involved earlier. The difficulty is finding the appropriate trigger for that notification. Work Health Officers in evidence suggested the time lag between planning authorisation and actual commencement of the work meant that notification was not necessarily practical upon planning application. One mechanism

may be to include all construction involving *work at height* in *Schedule 2* notifications of the regulations (reg 10of the *Building Act.* Under the regulations to the *Building Act,* the Work Health Authority must be notified by the *building certifier* of certain types of building prior to issuing a permit to start work. For example, the Work Health Authority must be notified of buildings to be used for education, abrasive blasting chamber, spray painting booth, buildings used for the storage of dangerous goods, buildings that are to contain lifts or elevators and buildings constructed of scaffold. The Work Health Authority are then required to make a report to the building certifier. By adding *any construction site* or *any construction site involving fall safety* or *work at height,* alternatively, any *construction site over a certain monetary limit,* the Work Health Authority could be automatically notified and could make reports on matters concerning safety to the building certifier prior to a permit being granted. Notification of the Work Health Authority of commencement of construction work would enhance occupational health and safety on construction sites.

Builder Registration

38. Much has been said of the suggestion of builder registration from both work health investigators and some of the witnesses involved in industry, the Northern Territory being one of the few jurisdictions without a system of builder registration. Would it have prevented the death in this case? That's not entirely clear, but it may have, for instance, if the owner builder had qualifications or training of some sort with respect to work place safety. New South Wales has the *Home Building Act* which prohibits unlicensed and unqualified persons from carrying out building work, but it does also regulate permits for owner-builders carrying out residential work. The licenses or permits must be applied for. I recommend that this type of regulatory system be discussed fully within government, industry and the broader community. Given the inquiry has been told that industry must take

responsibility itself for occupational health and safety, it is apparent that there needs to be some regulation so that only properly qualified persons are carrying out work as builders. The evidence of Mr Stephen Caldwell of the Work Health Authority is relevant and I quote (Transcript P207):

> "Would you regard a registration system for builders as a valuable thing for the Northern Territory if it was introduced?---A valuable thing? I don't know if it's my role to say whether that is the way to overcome the problem of owner/builders which is definitely a problem that we have.
>
> THE CORONER: We can get on to that in a moment. What about in the context of workplace safety on building sites. Do you think registration of builders in the first place, in terms of making sure they are of a certain standard, would help in terms of workplace safety on building sites?---Possible, I think we need to clearly identify who has responsibility on a building site for all the sub contractors. I think that's the key issue. Maybe builders registration is something that could be investigated but I wouldn't like to say that was the - - -"

The role of the Work Health Authority

39. The current compliance policy of the Work Health Authority means that the roles of education, dissemination of information are merged with the investigation and policing roles. There have been very few prosecutions for breaches of occupational health and safety in the life of the Authority. In terms of developing safe systems of work, the Authority does rely heavily on industry and that must be of some advantage, however, as has been discussed throughout the inquiry, that may make the investigation and prosecution role problematic. A number of industry guidelines are not compulsory, in the sense that non-compliance has no sanction. Consideration may need to be given to a more specialized inspection and enforcement section of the Authority, from the point of view of general public safety.

40. A number of facts did not become evident during the course of the Work Health investigation. Those facts have been revealed either during the lead up to this inquiry or at the inquiry itself. On the whole however, I am satisfied with the investigation. The Authority itself has recognised the need for training of its investigators and that needs to be encouraged. The use of pre-prepared questions and cautions when there is not a particular offence in mind are matters which have come out in the inquiry which might be addressed by training.

41. The inquiry has had the benefit of evidence from Mr Scott Caton, the manager of Occupational Health and Safety for the Work Health Authority. A number of matters raised concerning training are being redressed. The issue of whether the Work Health Authority is properly resourced to carry out its occupational health and safety functions has been raised. There is not sufficient evidence to conclude that the Authority is not properly resourced.

42. In my view, the fact, that in the one Government department, (Department of Industries and Development) there is to be found the unit responsible for industry regulation (Work Health authority) and other units responsible for Industry promotion results in obvious potential for conflict of interest (with Public Servants eventually reporting to the same superiors).

Conclusions

43. This incident was truly an accident, however, it would been prevented if any number of site safety issues which have been noted above had been observed.

Dated this 2nd day of November 2001.

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GREG CAVANAGH

TERRITORY CORONER