CITATION: *Inquest into the death of Damien Victor Kyle-Little* [2017] NTLC 025

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0022/2016
DELIVERED ON:	24 November 2017
DELIVERED AT:	Darwin
HEARING DATE(s):	12 & 13 October 2017
FINDING OF:	Deputy Coroner Kelvin Currie
CATCHWORDS:	**Fall from a tower, no high risk work licence, no harness, non-compliance with Safe Work Method Statement**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
NT WorkSafe:	Helena Blundell
Telstra:	Tom Anderson

Judgment category classification:	B
Judgement ID number:	[2017] NTLC 025
Number of paragraphs:	83
Number of pages:	17

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

No. D0022/2016

In the matter of an Inquest into the death of

DAMIEN VICTOR KYLE-LITTLE
ON 3 FEBRUARY 2016
AT FOUNTAIN HEAD MOBILE SITE,
HAYES CREEK

FINDINGS

Deputy Coroner Kelvin Currie

Introduction

1. Damien Victor Kyle-Little ("Damien") was born in Brisbane in the State of Queensland on 1 February 1973. His father was Sydney Kyle-Little and his mother is Marianne Kyle-Little. He is survived by his mother and three (3) older brothers, one of whom attended each day of the inquest to represent the family.

2. Damien died on 3 February 2016 after falling 66 metres from a Telstra tower, upon which he was working, located at the Fountain Head mobile site in a relatively remote area off the Stuart Highway via Hayes Creek.

3. At the time he fell, he had climbed the tower alone to retrieve some power tools prior to the arrival of an approaching storm. The tools were to be placed in a bag and lowered on a rope by those on the ground. He did not wear a harness.

4. There seemed to be an issue with the rigging. Damien stood on the railing of the 66 metre platform on one foot. He used his other foot in what appeared to be an attempt to free a rope from the rigging. He slipped and fell. The time was 2.25pm.

5. Damien died of multiple injuries sustained as a result of the fall. Forensic Pathologist, Dr John Rutherford summarised his injuries:

5.1 Widespread multiple bruises, lacerations and abrasions of the skin.

5.2 Fractures of the facial bones, right side of the mandible, several ribs, the sternum, the left humerus, the lumbar vertebral transverse process, the sacral bone and the right ankle. Bruising was associated with all the fractures.

5.3 Right frontal cerebral contusion.

5.4 Pulmonary contusion; most marked in the left upper lobe.

5.5 Subluxation between the 2nd and 3rd thoracic vertebral bodies.

6. After falling Damien was conscious for a period of approximately 30 minutes before his condition deteriorated and he lost consciousness. Cardio Pulmonary Resuscitation (CPR) was commenced. However, it is likely that he died soon after he lost consciousness.

7. When a medic from a nearby mining camp attended an hour later, Damien had no shockable rhythm and was cold to the touch. The medic was told by those administering CPR that they had not seen his chest rise and fall during CPR.

8. A registered nurse arrived at 4.09pm from Adelaide River Health Clinic. He found Damien unresponsive with fixed and dilated pupils. Damien was pronounced deceased at 4.12pm. He was 43 years of age.

9. His death was a tragedy for his family, his friends and workmates and the community.

What happened?

10. Work had begun at the site on 27 January 2016 by Ozziebuild Pty Ltd ("Ozziebuild"). On site, Damien and one other worker, Mr Rod Teece

("Rod"), performed the work at heights on the tower. Two other workers, Mr Bairamis and Mr Maillis worked on the ground.

11. On 3 February 2016 at about 1.15pm the group stopped for lunch. Rod and Damien both came down the tower wearing their harnesses. After lunch, it was noticed that a storm was approaching and the decision was made to cease work for the day. Damien said there were some power tools left on the 66 metre platform where he had been working and that he would get them.

12. The other workers said that they did not see Damien commence his climb of the tower. They were focussed on their own "cleaning up" tasks. They said they would never have anticipated that Damien would have gone up the tower without his harness.

13. It was difficult for those on the ground to see what Damien was doing or whether he was wearing his harness once climbing the tower. Those on the ground hauled the bag up to him on the rigging so the tools could be placed in it. Rod heard Damien yell "Stop". Rod said that it looked as if Damien was loading the tools into the haul bag. It then appeared that something got tangled with the haul bag.

14. Rod saw Damien standing on top of the safety railing, surrounding the platform, with his foot out and around the cables that ran up the tower. Those cables were on the outside of the railing. Rod said:

> "From what I could tell when I was looking at it, he was trying to unhook the haul rope from being tangled up by a bit of rod, or whatever it was that it was caught on and he was trying to sort of lift his foot around it and then lift it out and around.
>
> At this time it was not raining from what I could see. However, the conditions up above could have been different from below. I looked up and saw Damien falling. I was in shock watching it all happen because it was in slow motion."

15. Damien struck the tower several times on the way down before landing face down on the ground.

Safety Procedures

16. At the time of his death, Damien was working as a sub-contractor to Ozziebuild, a local Darwin building company. The Directors of the company were Michael Bairamis and Steven Teece.

17. In 2013 Ozziebuild had become one of the preferred contractors with Telstra Network Construction. Ozziebuild had undertaken projects for Telstra from running 'pit and pipe' to constructing a 50 metre tower. On this occasion the project was to "upgrade to LTE 700, install steel work, new feeders, antennas".

18. The Safe Work Method Statement ("SWMS") recorded those undertaking the work as:

    18.1 Michael Bairamis – Advanced Rigger;

    18.2 Damien Kyle-Little –Climber.

    18.3 Nomikos Maillis – Trades Assistant;

    18.4 Rod Teece – Basic Rigger;

19. The work commencing on 27 January 2016 was due to be completed 16 days later. The safety procedures and culture at the site were of significant importance in understanding why Damien had climbed the tower without a harness.

20. Michael Bairamis and Steven Teece described the safety requirements and the documentation utilised (and required by Telstra):

    - The SWMS was required to be understood and signed before commencement of the work;
    - The company had a *Safe Work at Heights Procedure*. The procedure required a full body harness that had front and rear fall arrest attachment points and a safety secondary restraint line used

in conjunction with the secure line. Free fall was to be limited to 600mm.[1]

- Tool-box meetings were held each morning stressing safety, and required sign-off by each worker every day. They lasted 10 minutes on each occasion and on most of the days preceding the fall were said to have included the topics of "working at heights", "wet steel" and "storms".

21. Mr Bairamis stated that in all the years he had worked with Damien, he had never seen him do something onsite that he considered unsafe. He stated that it was his experience that Damien was "always connected".[2]

22. Mr Maillis said (through a Greek interpreter) that the Tool-box talks occurred each day:

> "Every day before commencement of work there was a discussion about general issues on how the day would be planned and also a discussion in relation to safety issues, like for example that they should wear gloves, they should wear eyewear, helmets".[3]

23. Mr Bairamis said Damien was safety conscious:

> "Damien would be the bloke that would set-up and make the - you know, I mean especially after he came back from the refresher courses he was like, you know, over and above he would - I mean, he'd place the static lines up when they weren't required - you know what I mean - on site but he would be the - go the extra mile to make sure that, you know, things were done properly".[4]

24. From that evidence it appeared that safety was understood and controlled. Damien had known the two Directors of Ozziebuild since high school. Mr Bairamis was his best friend. Nevertheless, Mr Bairamis said that if he had known Damien had removed his safety harness, it would be "automatic dismissal".[5]

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[1] Part 3.3
[2] Transcript p76
[3] Transcript p63
[4] Transcript p59
[5] Transcript p75

25. But not all of the evidence supported a picture of a controlled and safety conscious work environment. Indeed, the very act of Damien climbing the tower without his harness (or other Personal Protective Equipment (PPE)) seems most unlikely in such an environment.

26. Apparently, Damien was a loveable larrikin with a big personality. His brother, Scott, described him as "cavalier" and always telling a joke. In the view of his brother he was not meticulous about processes or procedures, but was very good at getting the job done.

27. His brother provided evidence that Damien took pride in his fitness. One of his aims that Damien communicated to his brother was to climb the tower without stopping. In relation to the last climb that ended in Damien's death, Scott said:

> "… I can see my brother going up, 'don't worry, I'll get them, I'll get the tools'. That's the sort of person he was and he would have done it half for the fitness".[6]

28. His workmates at the Telstra tower described him as an "extremely confident" and "competent" climber. He was described as moving "quickly" and "with ease" around the Telstra tower.

29. It is obvious that a great deal of faith, trust and confidence was placed in Damien and his abilities while on the worksite. He was a climber with over 20 years' experience. Rod said that Damien was much faster than he was when climbing around the tower.

30. The confidence, experience and ability demonstrated by Damien seems to have led to some confusion in roles. Although being certified for "Working with Heights" and for "Tower Rescue", Damien was not a qualified rigger. Rod was qualified as a basic rigger and yet regarded Damien as having more

[6] Transcript p115

expertise in both rigging and climbing.[7] He tended to follow the directions of Damien rather than the other way around.

31. Rod said that neither he nor Damien connected to the tower when climbing to the working height. He said that on the way up Damien would wear the required hard hat but would change that to a cap when they got to working height.

32. As to the Tool-box meetings each morning that were suggested to contain a discussion of safety issues, Rod said:

> "I don't know what you mean by safety. Like, we just talked about how we'd do things. And we knew what the safety was. We knew we had to climb up with a harness but it wasn't – it wasn't something that we'd constantly reiterate every day because we knew what we were doing."
>
> Q. You didn't need to be told to put a harness on?
>
> A. Not every day, no.
>
> Q. Were there discussions about what to do in an emergency?
>
> A. No, not that I can recall.
>
> Q. Are you strapped to anything when you're climbing the ladder?
>
> A. No because it's hard work to climb up a ladder so you want to climb up fast.

33. If neither Rod nor Damien were in the habit of connecting their harness to the tower for the climb it would be somewhat surprising if that was not known to others at the site.

34. Similarly, changing out of the PPE hard hat when at working level, is not consistent with the controlled and safety conscious picture.

[7] Transcript p36

35. Damien's smart phone contained "selfies" taken by Damien at 8.59am on the very morning of the day he fell. The selfies show him high in the tower with bare shoulders and chest, sunglasses and cap against the background of the surrounding countryside.

36. The images don't show the lower part of his chest and so it is not possible to determine whether he had just removed the upper portion of his harness and shirt for the photograph or whether the harness was completely removed.

37. When asked about those photographs Mr Bairamis stated that if he was aware of Damien taking selfies he would have made him come down from the tower for a discussion that would have led to disciplinary action.

38. The picture painted of a worker that didn't connect to the tower on the way up, didn't wear his hard hat when working at heights, and being enough of a character to take selfies while up the tower (suggesting he was without shirt and harness) is consistent with the evaluation of Damien's brother.

39. That picture is also more consistent with Damien climbing the tower without a harness to quickly put the electric tools in the haul bag so they could be retrieved ahead of the incoming storm.

40. Why he would climb the structure and stand on the rail without a harness becomes more easily understood. He may well have thought he was just climbing up, putting the tools in the haul bag and climbing down. If it wasn't his practice to attach for the climb he may have thought wearing a harness was simply adding weight as he would not connect it to the structure in any event.

41. However, while he was on the 66 metre platform, the lines unexpectedly became tangled and without a harness available he took the further risk of trying to untangle the equipment. Standing with just one foot on a thin steel railing that may have been damp at the time he slipped.

No high risk licence

42. Pursuant to the *Work Health and Safety (National Uniform Legislation) Act and Regulations* the work being carried out on the Telstra tower was high risk construction work.

43. Regulation 289 provides a definition of "construction work":

> ***construction work*** means any work carried out in connection with the construction, alteration, conversion, fitting-out, commissioning, renovation, repair, maintenance, refurbishment, demolition, decommissioning or dismantling of a structure.

44. Structure is defined in section 4 of the Act and regulation 290:

> ***structure*** means anything that is constructed, whether fixed or moveable, temporary or permanent, and includes:
>
> (a) buildings, masts, towers, framework, pipelines, transport infrastructure and underground works (shafts or tunnels); and
>
> (b) any component of a structure; and
>
> (c) part of a structure.

45. High risk construction work is defined in regulation 291 to include:

> ***high risk construction work*** means construction work that:
>
> (a) involves a risk of a person falling more than 2 m; or
>
> (b) is carried out on a telecommunication tower;
>
> …

46. Persons carrying out high risk work are required to hold high risk work licences:

> **81 Licence required to carry out high risk work**
>
> A person must not carry out a class of high risk work unless the person holds a high risk work licence for that class of high risk work, except as provided in regulation 82.

Notes for regulation 81

1. See section 43 of the Act.

2. Schedule 3 sets out the high risk work licences and classes of high risk work that are within the scope of each licence. Schedule 4 sets out the qualifications required for a high risk work licence.

47. The classes of high risk work in Schedule 3 include the following:

> (2) Rigging work involving any of the following:
> (a) structural steel erection;
> (b) hoists;
> (c) precast concrete members of a structure;
> (d) safety nets and static lines;
> (e) mast climbing work platforms;
> (f) perimeter safety screens and shutters;
> (g) cantilevered crane loading platforms;
> but excluding rigging work involving equipment, loads or tasks listed in items 6(b) to (f) and 7(b) to (e)

48. In their report of 19 December 2016, NT WorkSafe believed the work to fit within Schedule 3:

> "There is little doubt that the work being conducted by these contractors on this site fits within the definition of rigging."[8]

49. Despite the requirement to do so, Damien did not hold a basic riggers ticket or any other high risk work licence.

Management of Risk

50. Ozziebuild was required to manage the risks pursuant to regulation 297:

> **297 Management of risks to health and safety**
>
> A person conducting a business or undertaking must manage risks associated with the carrying out of construction work in accordance with Part 3.1.
>
> *Note for regulation 297*

[8] Page 4

WHS (NUL) Act – section 19 (see regulation 9).

51. Regulation 299 required there to be a Safe Work Method Statement (SWMS).

52. The SWMS prepared by Ozziebuild identified the risks and provided the mitigation treatments for those risks. Two of the risks identified were, "slips, trips and falls" and "falling off structure". The mitigation for each included "all climbers must have basic riggers ticket" and "must have 100% attachments at all times".

53. Regulation 300 required that the work be carried out in accordance with the SWMS:

> **300 Compliance with safe work method statement**
>
> (1) A person conducting a business or undertaking that includes the carrying out of high risk construction work must put in place arrangements for ensuring that high risk construction work is carried out in accordance with the safe work method statement for the work.
>
> Maximum penalty:
>
> (a) in the case of an individual – $6 000.
>
> (b) in the case of a body corporate – $30 000.
>
> *Note for subregulation (1)*
>
> *Strict liability applies to each physical element of this offence. See section 12B of the Act.*

54. The director of Ozziebuild, Steven Teece said he had put the requirement for all climbers to have a basic riggers ticket in the SWMS but later believed it wasn't necessary.[9] He said the SWMS was not altered because he would have needed to get it reapproved by Telstra.[10]

[9] Transcript pp52-53
[10] Transcript p53

55. However, plainly the work was not carried out in accordance with the SWMS:

a. At no time did Damien have a basic riggers licence; and

b. The persons climbing the tower did not have attachment 100% of the time.

56. The identified risks of "slips, trips and falls" and "falling off structure" were not mitigated in accordance with the SWMS and it was plain that, at least in relation to the absence of the basic riggers licence, that was a fact known to Ozziebuild.

NT WorkSafe

57. NT WorkSafe undertook an investigation. In a report dated 19 December 2016 they determined not to proceed with punitive action. The NT WorkSafe, Director of Operations, Mr Neil Burgess stated:

> "In this case, it was concluded that Ozziebuild as the primary duty holder had taken all reasonably practicable steps to mitigate risks as set out in paragraph 9. It should be noted, that workers also have WHS duties, as detailed in section 28 of the WHS Act, which requires them to take reasonable care of themselves and others in a work place, as well as to follow directions such as the use of PPE." [11]

58. In the opinion of NT WorkSafe, Damien was not required to be licenced to undertake high risk work. They were of the opinion that Regulation 82 provided an exception where a person was under the supervision of a person licensed to carry out the high risk work.

59. There is however no such exception in regulation 82:

> **82 Exceptions**
>
> (1) A person who carries out high risk work is not required to be licensed to carry out the work if the work is carried out:

[11] Affidavit Neil Burgess paragraph 17

(a) in the course of training towards a certification in order to be licensed to carry out the high risk work; and

(b) under the supervision of a person who is licensed to carry out the high risk work.

60. The exception relates to persons in the course of training toward certification and under supervision. Damien was not in the course of training toward certification.

61. The opinion of NT WorkSafe appears to have been derived from a conversation with a Telstra project manager:

> "A Project Manager at Telstra advises that there is no requirement for all climbers to be qualified riggers; however an advanced rigger must be on site when the rigging work is being conducted" [12]

62. During the inquest, Mr Burgess provided the opinion that Damien was "climbing" rather than "rigging" at the time he fell. Certainly that is arguable given that at the time he fell Damien was attempting to free the hoist from another line or lines.

63. However, regulation 81 appears not permit such distinctions. Damien was undertaking high risk work and did not possess a high risk work license.

Emergency Response Procedure

64. Mr Steven Teece said he employed a company to properly prepare the tender documents for obtaining the work from Telstra. Included within the documents prepared was an "Emergency Response Procedure".

65. Following Damien's death, there was an investigation carried out by Comcare due to the involvement of Telstra. Comcare determined that the Emergency Response Procedure provided by Ozziebuild (and approved by Telstra when granting the tender to Ozziebuild) was not compliant with

[12] NT Work Safe Investigation Report p4

regulations 43 and 80 of the *Commonwealth Work Health and Safety Regulations*.

66. Comcare directed Telstra to ensure compliance with those regulations. Telstra complied.

67. The Northern Territory *Work Health and Safety (National Uniform Legislation) Regulations* are substantially in the same terms as the Commonwealth Regulations.

68. The Directors of Ozziebuild were not informed of the determination and direction by Comcare. Nor was that issue raised or discussed with them by NT WorkSafe. Mr Burgess, the Director of Operations for NT WorkSafe conceded that those issues should have been discussed with Ozziebuild.

Emergency Retrieval

69. Immediately after Damien fell, a call was made to 000 for emergency assistance. The communication records for NT Emergency Services record the call as occurring at 2.26pm. The operator of that call remained on the line and provided advice and assistance to Rod and Mr Bairamis as they performed first aid and CPR.

70. Contact was made by the 000 operator with the Adelaide River clinic for an ambulance to be sent.

71. A call was made by a Telstra technician to a nearby mining camp. The medic from the camp received a call at 2.52pm and departed from the mine with another worker headed for the tower at about 3.00pm. They arrived at about 3.25pm. At that time there was no evidence of signs of life and Damien's body was cold.

72. On that day the Care Flight helicopter was undergoing scheduled maintenance. Evidence from the Department of Health indicated the helicopter had commenced its 500 hourly scheduled maintenance on 29

January 2016 and was scheduled to complete the maintenance on 7 February 2016.

73. The evidence was that over a twelve month period the helicopter would have an average of 39 days in scheduled maintenance. The days were spread over time periods of 2 days to 2 weeks.

74. At 2.55pm the records indicate that discussion took place concerning the closest air strip, the Batchelor Air Strip, so as to retrieve Damien with a fixed wing aircraft.

75. It was arranged that Adelaide River Clinic would call Care Flight on their departure with the patient. At that time the Care Flight fixed wing aircraft would be deployed. It was estimated that the aircraft would arrive in advance of the arrival of the ambulance at the air strip.

76. At approximately 3.14pm there were further discussions about the possibility of using a military helicopter out of Tindal Airport. It was noted that the helicopter did not typically have medical crew on board and would need to be released from the military. Inquiries were made for its release. It was not available.

77. Even if the Care Flight helicopter had been available it would not have been able to reach the site prior to Damien dying. Flight time alone was likely to be 40 minutes. However, it is curious that there were no arrangements to use another helicopter should the need arise while the Care Flight Helicopter was being serviced.

78. I encourage Care Flight to consider arrangements for such emergencies in advance of scheduled maintenance.

Formal Findings

79. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Damien Victor Kyle-Little born 1 February 1973, in Brisbane, Queensland.

(ii) The time of death was 3.25pm, 3 February 2016. The place of death was Fountain Head Telstra Tower, Northern Territory.

(iii) The cause of death was multiple injuries.

(iv) The particulars required to register the death:

1. The deceased was Damien Victor Kyle-Little.

2. The deceased was of Caucasian descent.

3. The deceased was a sub-contractor at the time of his death.

4. The death was reported to the Coroner by Northern Territory Police.

5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother was Marianne Kyle-Little and his father was Sydney Kyle-Little.

Report and Referral

80. Section 35(3) is in the following terms:

> A coroner may 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 an offence may have been committed in connection with a death or disaster investigated by the coroner.

81. Where, as in this case, any offences would likely be due to contravention of the *Work Health and Safety (National Uniform Legislation) Act* and *Regulations* it would be unusual for the Police to be involved. The usual agencies would be NT WorkSafe and the Director of Public Prosecutions (DPP). Nevertheless, the report is made in accordance with the Act.

82. I believe that offences may have been committed in connection with the death of Damien Kyle-Little and in accordance with section 35(3) I report my belief to the Commissioner of Police and the Director of Public Prosecutions.

83. I refer the matter to NT WorkSafe for their further consideration.

Dated this 24th day of November 2017.

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KELVIN CURRIE
DEPUTY CORONER