CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of WAYNE EDWARD VICKERY**
Citation:	**[2020] ACTCD 5**
Findings Date:	5 March 2020
Before:	**Coroner Campbell**
Decision:	See [25]-[28].
Catchwords:	**CORONIAL LAW** – cause and manner of death – industrial accident – related indictable offences prosecuted – no matter of public safety – hearing unnecessary
Legislation applicable:	*Coroners Act 1997* (ACT), ss 13(1)(a), 13(1)(f), 34, 34A, 52, 55, 58, 58A
Cases cited:	*R v Canberra Contractors Pty Ltd* [2016] ACTSC 13 *Taing & Buob v Territory Coroner* [2011] NTSC 58
File Number:	CD 305 of 2011

CORONER CAMPBELL:

1. The death of Wayne Edward Vickery was reported to the ACT Coroner on 12 December 2011. Chief Coroner Walker had carriage of the inquest until she became unavailable in 2019. I assumed carriage of this matter last month.

2. Mr Vickery was ordinarily resident in NSW. As he died in the ACT the ACT Coroner has primary jurisdiction to investigate his death.

Facts surrounding death

3. Mr Vickery worked in the construction industry his whole life. Just prior to his death he was promoted by his employer Canberra Constructions Pty Ltd to the position of foreman. He had worked with that company for around 12 years.

4. Mr Vickery was reported as being fit and healthy, with no major illness affecting him. He had a degree of industrial deafness from years of working around heavy machinery but his wife, Fiona Vickery, indicated to police that it did not adversely affect his ability to hear. Mr Vickery was 45 years old when he died.

5. On 12 December 2011 Mr Vickery attended work at the site of a new housing development called Macgregor West 2, Stage 4, located on Macfarlane Burnet Avenue in Macgregor. He arrived around 7am.

6. Mr Vickery was tasked to work in the company of another worker. His role was to measure the required raising or lowering of a blade attached to a road grader. Mr Vickery did this by using a tape measure, inclinometer and previously placed surveyor pegs. On occasion it was necessary for Mr Vickery to be on all fours on the ground in close proximity to the grader while taking measurements. He communicated with the grader driver by way of hand signals.

7. At about 2:15pm, after having moved a load of dirt, the grader driver began to reverse the grader. The driver later told police that prior to reversing, he had looked around the grader from the driver's cabin, but had not seen anyone. After reversing a short distance the driver was alerted by other employees waving at him to stop the grader. He did so. The driver became aware that Mr Vickery was trapped under the grader. Mr Vickery had sustained massive injuries that were incompatible with life.

8. Other employees at the scene later told police that when the grader began to reverse Mr Vickery was kneeling down, looking through a scope to check a level. The grader began to approach Mr Vickery from his left hand side. Mr Vickery

was alerted by shouts from other employees but was unable to move out of the path of the grader.

Investigation

9. Police and Rescue responders attended at the scene shortly after the incident, as did Worksafe ACT investigators. Mr Vickery was formally pronounced life extinct. The grader was checked and found to be in good working order and well maintained. Specifically, the grader's reverse warning signal and revolving orange light that indicated the grader was in operation were both functioning. The driver of the grader was breath tested at the scene and was found to have no alcohol detectable on his breath. Police considered that there were no suspicious circumstances in relation to Mr Vickery's death.

10. Associate Professor Sanjiv Jain conducted a post-mortem examination of Mr Vickery at the direction of Chief Coroner Walker. The Associate Professor's opinion as to Mr Vickery's cause of death was "a crush injury to the head". No drugs or alcohol were detected in Mr Vickery's system.

Hearing and Work Safety prosecution

11. Shortly after Mr Vickery's death Worksafe ACT advised Chief Coroner Walker that it intended to refer the accident and Mr Vickery's employer, Canberra Constructions Pty Ltd, to the Director of Public Prosecutions for consideration of charges being laid under the *Work Safety Act 2008* (as it then was).

12. Chief Coroner Walker listed the inquest for a directions hearing on 26 July 2013. On that occasion the inquest was adjourned to 30 October 2013 to allow Worksafe ACT to obtain an expert report. The DPP was then to consider that report and make a determination as to whether charges would be laid against Mr Vickery's employer. A further directions hearing took place on 15 November 2013 and the inquest was provisionally listed for a full hearing in May 2014. However, on 9 May 2014 the DPP wrote to Chief Coroner Walker to advise that a brief of evidence was being considered and charges would be laid against the employer. The inquest hearing was vacated. Chief Coroner Walker also wrote to the DPP on 19 May 2014 to advise that she had formed the belief that a person had committed an indictable offence in relation to Mr Vickery's death and therefore she referred the matter to the DPP for his further consideration.

13. On 22 August 2014 the DPP advised that two informations had been laid in the ACT Magistrates Court against Canberra Contractors Pty Ltd for failing to

comply with its safety duty and, by reason of its failure, it caused serious harm namely the death of Mr Vickery. The company was charged under s 34(1) of the *Work Safety Act 2008*. Sections 58 and 58A of the C*oroners Act 1997* (the Act) were thus engaged. These precluded the taking of any further substantive action in the inquest until after the finalisation of the prosecution.

14. On 26 January 2016 Canberra Contractors Pty Ltd was convicted and fined $82,500 by Burns J in the ACT Supreme Court in respect of a single count against s 31(1) of the *Work Safety Act 2008* : see *R v Canberra Contractors Pty Ltd* [2016] ACTSC 13. Relevantly, His Honour found:

> The effective cause of the accident was a failure by both the deceased and the driver of the road grader to comply with established safety protocols on the worksite. The deceased was working in an area where he should not have been working at the time that the grader reversed. The grader did not reverse in a straight line, as was clearly anticipated by the deceased, but changed directions, thereby placing him in the line of travel of the grader. The deceased and the driver of the grader did not establish eye contact before the grader began to reverse. (at [5])
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> The director of the defendant, Paul Macor, gave evidence at the sentence hearing and described this as an unnecessary accident which should not have happened. It is very clear that if appropriate supervision had been put in place and the appropriate protocols and rules complied with, this accident would not have occurred. It is accepted by the defendant that it was negligent in failing to provide and maintain a safe workplace and safe system of work. (at [7])
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> It must be acknowledged the defendant company had put in place appropriate protocols and controls designed to ensure a safe workplace and a safe system of work but on this occasion there was a failure to comply with those protocols and controls and a failure to detect that failure. There is no evidence that these failures were commonplace on the worksite. I am satisfied, however, that it was reasonably foreseeable that the deceased would be exposed to a substantial risk of serious harm by works being conducted in the way in which they were on this occasion. (at [8])
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> I accept that the defendant company has a good safety record and has not been prosecuted for any breach of statutory safety duty in its 32 years of existence. The evidence before me also established that the company took its safety duties seriously. The company had in place protocols and controls designed to ensure a safe workplace and a safe system of work. It also regularly trained its employees so that safety requirements were reinforced. (at [13])

> No penalty that this Court may impose can equate to loss of human life. The death of the deceased was tragic and avoidable, but it was not an intended consequence of the activities of the defendant company. The evidence reveals a high degree of negligence but for a short period of time. This is not a case in which there was a systemic failure to recognise the potential danger in the workplace and to put in place systems to guard against that danger. If the protocols and controls which the defendant had put in place had been adhered to this accident would not have occurred. (at [20])
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> The death of the deceased was a consequence of a specific failure by employees on an isolated occasion to adhere to a safe system of work and of other employees to intervene when they observed that the appropriate and safe system of work was not being implemented. (at [21])

15. His Honour's findings are clear and succinct.

16. In accordance with s 58A(1) of the Act, the inquest was able to recommence after the expiry of the appeal period which followed the sentencing of the company.

17. Chief Coroner Walker then determined to seek an expert opinion in relation to systemic issues of heavy plant such as road graders on worksites. However locating a suitably qualified expert who was not conflicted in the matter and was willing to take the commission was difficult. A briefing letter was sent by registered post on 25 May 2018 to Mr David Segrott of Australian Health & Safety Systems requesting him to conduct an expert review and to prepare a report for the assistance of the Chief Coroner. Mr Segrott's report was received at the Court on 5 February 2020. It was made available to Mr Vickery's family.

Scope of Inquest

18. I am required by s 52(1) of the Act to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death. I am also required by s 52(4)(a) of the Act to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, I may comment upon it.

19. My findings are complicated in part by the provisions of s 58A(2) of the Act which relevantly states:

> A coroner may continue an inquest or inquiry after [the completion of criminal proceedings], but must not make a finding inconsistent with the judgment or verdict of the court that finally determined the guilt or innocence of the person for the related indictable offence.

20. Burns J found, when sentencing Canberra Constructions Pty Ltd, that the circumstances of Mr Vickery's death were an isolated incident without any systemic error. I cannot come to any different conclusion nor, on the evidence, would I be minded to do so.

21. In relation to whether a matter of public safety arises it is my view that any question regarding the general adequacy of the regulatory framework in Canberra at the time of Mr Vickery's death is too remote to be within my jurisdiction. It is clear that Canberra Constructions Pty Ltd failed to comply with the standards that applied at the time, so one cannot surmise that more stringent or different standards would have made a material difference in the case. I find that the adequacy of industrial safety standards are not causally related to Mr Vickery's death and accordingly, no matter of public safety arises in this case.

22. I am fortified in this conclusion by Mr Segrott's report, in which he concludes that the circumstances which led to Mr Vickery's death appear to have been the direct result of the lack of completeness in the development and implementation of the safety management approach by his employer at the time. He also observes that the legislative changes that have been made since the time of Mr Vickery's death have resulted in a more harmonised approach to safety management, and a positive effect on improving overall safety performance. I infer that Mr Segrott is referring both to the national harmonisation of work health and safety laws, as well as the ACT Government Review of industrial safety standards in 2012 (the "Getting Home Safely" report). In that context, further investigation of historic work standards and practices by me in this matter is not likely to increase or improve public safety.

23. Although implementation of some of the reforms recommended in the "Getting Home Safely" report and other governmental reviews is still ongoing, such as the devolving of the regulator from Government to ensure its independence, the key reforms that bear on the circumstances of Mr Vickery's death have been implemented.

24. Although two workplace deaths were reported to the ACT Coroner in the early part of 2020 – the first industrial deaths in the ACT in some years – neither of those deaths involve heavy plant and the circumstances of those deaths are very different to Mr Vickery's death. Those deaths will be investigated and reported on in due course. However, given the different circumstances of those matters, the mere fact of those deaths having occurred does not suggest a matter of public safety arises in relation to Mr Vickery's death, or that the holding of a hearing is warranted in this case.

25. In all the circumstances, it is my view there is no utility in or necessity for holding a public hearing in relation to Mr Vickery's death. The decision about whether to hold an inquest hearing is a balancing exercise and *"the discretion needs to be approached assessing the strength of available evidence and determining after consideration, whether there would be any benefit in the holding of an inquest and whether it would be expected to yield further information that thus far has not come to light. … an inquest should not be held where it would clearly be a futile exercise"*: see *Taing & Buob v Territory Coroner* [2011] NTSC 58 at [53]. The manner and cause of death of Mr Vickery are sufficiently disclosed, and I have sufficient material on which to consider if a matter of public safety arises.

26. Mr Vickery's death was a tragic and potentially avoidable accident. As an employee of Canberra Contractors Pty Ltd Mr Vickery was owed a duty of care by the company. The company failed to meet that duty. The company has subsequently been charged and convicted of the offence and in that regard I adopt the decision of Burns J in relation to Canberra Contractors' contribution to the manner and cause of Mr Vickery's death.

27. I find that:

    Wayne Edward Vickery died on 12 December 2011 at a worksite at Macgregor West 2, Stage 4, Macfarlane Burnet Avenue, Macgregor in the Australian Capital Territory;

    The manner and cause of Mr Vickery's death was crush injuries to the head, caused by a road grader that accidentally ran him over; and

    Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

28. I make no recommendations.

29. I direct that these findings be published in due course on the Coroner's Court website.

30. I extend my condolences to Mr Vickery's family and friends, and especially his wife Fiona who has been a strong advocate for her family and for Mr Vickery's memory.

L E CAMPBELL
CORONER