CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the Death of Herman Henrich Holtz**
Citation:	**[2023] ACTCD 6**
Decision Date:	29 March 2023
Before:	**Coroner Archer**
Decision:	See [9], [41]-[46], [48].
Catchwords:	**CORONIAL LAW** – cause and manner of death – industrial accident involving unsafe operation of crane on a work site - breaches of *Work Health and Safety Act 2011* (ACT) – lengthy delay in criminal proceedings – consequential delay in coronial proceedings – administration of justice
Legislation Cited:	*Coroner's Act 1977* (ACT) sections 3BA, 13, 34A, 52, 58 *Coroners Act 2008* (VIC) *Crimes (Sentencing) Act 2005* (ACT) section 48 *Director of Public Prosecutions Act 1990 (ACT)* *Work Health and Safety Act 2011* (ACT) sections 19, 28, 31
Cases Cited:	*R v Watts* [2020] ACTSC 91 *Bradley Cummins v Multiplex Constructions Pty Ltd* [2021] ACTIC 1 *Bradley Cummins v RAR Cranes Pty Ltd* [2022] ACTIC 1 *Commonwealth of Australia v Helicopter Resources Pty Ltd* [2020] HCA 16
Texts Cited:	Gharaie, Lingard and Cooke, 'Causes of Fatal Accidents Involving Cranes in the Australian Construction Industry' (2015) 15(2) *Construction Economics and Building* 1-12 Inquiry into Compliance with Work Health and Safety Requirements in the ACT's Construction Industry, *Getting Home Safely,* (Report, November 2012) Lingard, Harley, Zhang, and Ryan, 'Work Health and Safety Culture in the ACT Construction Industry' (2017) Centre for Construction Work Health and Safety Research WorkSafe ACT, *Annual Report 2021-2022,* (Report, September 2022) Service charter of WorkSafe ACT Family Liaison Officer, *WorkSafe ACT website*.
File Number(s):	**CD 191 of 2016**

CORONER ARCHER

Introduction and Summary

1. Mr Herman Holtz died on 4 August 2016 of catastrophic injuries sustained in an industrial accident. He was crushed by a crane on a building site at the University of Canberra that had overturned because of its unsafe use. Mr Holtz was 62 years old at the time of his death.

2. Mr Holtz's death and the circumstances surrounding it were the subject of criminal proceedings involving a number of individuals and corporate entities. Those proceedings were commenced in the ACT Magistrates Court on 18 April 2018 and were resolved by way of pleas of guilty entered in the Supreme Court (by Mr Michael Watts, the driver of the crane), and in the Magistrates Court by Multiplex Constructions Pty Ltd ("Multiplex"), the company that controlled the construction site, and RAR Cranes Pty Ltd ("RAR Cranes"), the company that owned the crane. Mr Watts' proceedings were finalised on 20 April 2020. The Multiplex proceedings concluded on 21 November 2021. The proceedings involving RAR Cranes were finalised on 25 March 2022. The view had been taken that the resumption of the coronial inquest was not possible until the criminal proceedings had been resolved.

3. The matters of public safety that arise from the inquest into Mr Holtz's death have been canvassed in the criminal proceedings and will not be the subject of recommendations arising from the inquest.

4. There are matters concerning the administration of justice that are connected to the inquest upon which I make comment.

Jurisdiction

5. Mr Holtz's death was formally reported to the coroner, as it fell within the terms of section 13(1)(g) of the *Coroner's Act 1977* (ACT) ("the Act"), being a death that was a result of an accident. The coroner was required to hold an inquest into the manner and cause of Mr Holtz's death and make the findings required by section 52 of the Act. That section of the Act relevantly provides:

> **52 Coroner's findings**
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> (1) A coroner holding an inquest must find, if possible—
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> (a) the identity of the deceased; and
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> (b) when and where the death happened; and
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> (c) the manner and cause of death; and
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> (d) in the case of the suspected death of a person—that the person has died.
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> (4) The coroner, in the coroner's findings—
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> (a) must—
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> (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and

(ii) if a matter of public safety is found to arise—comment on the matter; and

(b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

6. The ability of a coroner to complete an inquest into a death, in respect of which the Court has jurisdiction under section 13 of the Act, is affected by the operation of sections 58 and 58A of the Act. The effect of those provisions is discussed below. In short, the provisions place constraints around the ability of coroners to resolve coronial proceedings whilst indictable criminal proceedings dealing with the causing of the relevant death are being litigated in the courts.

The Hearing and Evidence

7. A hearing was not conducted in this case. I had available to me the following evidence:

   i. the initial police report prepared by AFP coronial investigators;

   ii. the complete brief of evidence prepared by WorkSafe ACT in respect of the criminal proceedings;

   iii. the reasons for sentence of Her Honour Chief Justice Murrell in the matter of *R v Watts* [2020] ACTSC 91 dated 20 April 2020;

   iv. the reasons for sentence of Chief Industrial Magistrate Walker in the matter of *Bradley Cummins v Multiplex Constructions Pty Ltd* [2021] ACTIC 1 dated 12 November 2021;

   v. the reasons for sentence of Chief Industrial Magistrate Walker in the matter of *Bradley Cummins v RAR Cranes Pty Ltd* [2022] ACTIC 1 dated 25 March 2022;

   vi. the autopsy report prepared by Professor Ellis on 29 August 2016; and

   vii. communications from the family outlining their experiences after Mr Holtz's death.

8. Based on this material, for the purposes of section 34A (1) of the Act, I formed the view that the manner and cause of Mr Holtz's death are sufficiently disclosed and that a hearing was unnecessary. On 22 August 2022, I communicated that view to Mr Holtz's family in writing, as is required by section 34A of the Act. In a meeting conducted with the family on 29 November 2022, they indicated their agreement with that approach.

Formal Findings as to the Manner and Cause of Death – Section 52(1) of the Act

9. Professor Ellis, a forensic pathologist, conducted an examination of Mr Holtz's body on 8 August 2016. Consistent with his opinion as to the cause of death, I find:

   > Herman Henrich Holtz died on 4 August 2016 at approximately 1821 hours at the University of Canberra Hospital building site at the corner of Aikman Drive and Ginninderra Drive Belconnen in the Australian Capital Territory as a result of severe crush injuries.

The Events Leading to the Death of Mr Holtz

10. After the relevant indictable proceedings are concluded, the terms of section 58A(2) of the Act place potential limitations around the ability of a coroner to make findings as to facts surrounding the death that are inconsistent with the judgment of the Court that

finally determined the criminal case against the person who may have contributed to the cause of the death being investigated by the coroner. Here, the most serious indictable proceedings were brought against Mr Watts. To avoid any suggestion of an infraction of that provision, I adopted the findings of fact made by Chief Justice Murrell, in relation to the sentencing of Mr Watts. I am otherwise satisfied that they represent a comprehensive survey of the circumstances surrounding Mr Holtz's death:

> *Construction of the University of Canberra Hospital*
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> 12. In 2016, the University of Canberra Hospital was in the early stages of construction. Multiplex Constructions Pty Ltd (Multiplex) was the principal contractor for the construction. For work health and safety purposes, it conducted the business or undertaking at the construction site and had primary responsibility under the *WHS Act*.
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> 13. Multiplex contracted with RAR for the provision of mobile crane services at the construction site. RAR was also an entity conducting a business or undertaking with primary responsibility under the *WHS Act*.
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> *The crane*
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> 14. The crane that was involved in the offence was a 2016 Terex MAC-25 non-slewing "pick and carry" crane. It was the only such crane owned by RAR. It operated differently from other similar types of cranes.
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> 15. The lifting capacity of the crane was determined by the operator, who had to consider the boom length, radius and articulation required for a lift. Usually, the operator's decision would be guided by the load mover indicator (LMI) system on the crane.
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> 16. The LMI system on the crane was important because it calculated the crane's carrying capacity from moment to moment, taking account of the many variables that influenced carrying capacity. The LMI system provided the crane operator with real-time dashboard information, including load/overload, percentage of rated capacity, load radius, boom angle, boom length, and additional lifting capacity. The display showed the crane's "rated capacity", i.e. the maximum load that the crane could safely carry based on its current configurations. The LMI system also showed the terrain and the forward and side tilt of the crane. However, the display only showed the percentage of rated capacity up to 110 per cent. If the load exceeded 110 per cent of rated capacity, the display continued to show 110 per cent.
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> 17. Once the LMI system showed that the crane was overloaded for its configurations, a cut out was immediately activated, as were visual and audible alarms, operating internally and externally. To increase the overloaded state of the crane, the operator had to manually override the safety function.
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> 18. The crane could operate in a "superlift mode" or "301 mode". This mode increased the crane's lifting capacity from 10 tonnes to as much as 25 tonnes, depending on the crane's configurations at the relevant time.
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> 19. For the crane to operate in "superlift mode", the operator had to install a second counterweight at the rear of the crane. The counterweight needed to face a particular direction so that the crane's sensors would register that the counterweight had been fitted, and the LMI system would assess the crane's load capacity by reference to the "superlift mode".
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> 20. Within the crane's cabin, there was an operator manual and lifting chart showing the crane's lifting capacity in various modes, including the "superlift mode". The operator manual clearly stated that the operator should not operate the crane until they had read and understood the manual. The manual explained the safety system, stating that all safety messages should be obeyed "to avoid possible injury or death".

21. At the construction site, there was a generator with a marked gross weight of 10.3 tonnes. It was to be used by Multiplex to provide temporary power. It was fitted with lifting points and pull plates.

Events prior to 4 August 2016

22. Mathew Holt, an RAR employee, operated the crane to perform lifts at the construction site on two occasions. Before operating the crane on the construction site, Mr Holt received the mandatory site induction. On 7 June 2016, he used the crane to move the generator from the front gate of the site. On 18 July 2016, he used the crane to move the generator to a new position.

23. Mr Holt told RAR that he did not believe that it was safe to use the crane to move the generator. This information was not conveyed to the offender. Had the offender been provided with this information, he would have refused to use the crane to undertake the lift. The agreed statement of facts indicates that RAR should have conveyed Mr Holt's opinion to the offender.

24. On 2 and 4 August 2016, Mr Holt was on holiday.

25. On 2 August 2016, the offender was directed to work as the driver/operator of the crane. Mr Paul Kelly was assigned as his dogman. The offender performed one job with the crane but did not use the "superlift" mode.

26. Mr Holt had been given training in how to use the crane, including how to operate the crane in "superlift" mode. However, RAR did not provide the offender with information, training or instruction about how to safely operate the crane, how to use the "superlift" mode, or how to fit the associated counterweight. He was provided with general induction information.

27. Several weeks before 4 August 2016, Multiplex decided that the generator should be moved to a new position about 50 metres away, from where it could provide temporary power to the tower crane.

4 August 2016

28. On 4 August 2016, Multiplex decided that the generator should be moved to its new position as the tower crane was to be used the following day. There was some urgency about repositioning the generator.

29. Between 2:00 and 2:30 PM, Multiplex directed RAR to move the generator that day. Multiplex managers and a RAR representative inspected the site to determine how it would be moved. RAR proposed using a 200-tonne slewing crane or a tilt tray truck. Multiplex rejected the proposal as the cost and logistics of using that equipment were not something that Multiplex was "eager to be part of". The offender did not participate in the discussion and was not told about it.

30. RAR and Multiplex walked the travel route and concluded that the crane would be suitable for the job. Neither Multiplex nor RAR undertook the requisite risk assessment concerning the means and route by which the generator would be moved.

31. That day, commencing at 6:35 AM, the offender and Mr Kelly completed four jobs using the crane, all of which were conducted within the safety limits of the crane. None involved using the "superlift mode".

32. Mr Kelly and the offender were then told by Mr Newton of RAR that there was a further job to be done.

33. At about 4 PM, they returned to the RAR yard and were told by Mr Newton that they were to use the crane to move a generator for Multiplex, and that the job had to be completed that day so that the tower crane could be used the following morning. Mr Newton conveyed the impression that the job was important to RAR.

34. RAR directed the offender and Mr Kelly to take the “superlift” counterweight and “D shackles”.

35. At about 4:52 PM, the offender and Mr Kelly arrived at the construction site. The offender drove the crane; Mr Kelly drove a small truck containing the “superlift” counterweight.

36. When they arrived, they were met by four Multiplex employees: Andrew Drummond (senior site supervisor), Munro Jones (health and safety representative for the site work group), Herman Holtz (tower crane operator), and Timothy Brown (tower crane dogman).

37. Mr Drummond was advised that, as the offender had not previously attended the construction site, he required the mandatory safety induction. The offender himself requested a site induction. However, none was undertaken.

38. All present agreed that the “D shackles” were inappropriate as they were too heavy and did not fit the lifting points.

39. The offender told Mr Drummond that RAR had a 200-tonne slewing crane which would be more appropriate for the job (the same suggestion that had been made earlier in the day by another RAR employee), but was told that it was “not an option” and the crane had to be used for the job and was suitable, having previously been used to move the generator.

40. As stated above, at no stage was the offender told that Mr Holt had expressed a different view regarding the suitability of the crane; had he known of Mr Holt’s view, it would have been decisive in persuading him that he should not proceed with the lift.

41. As the offender was concerned about doing the job and felt that Multiplex was pressuring him to proceed, he called Mr Newton for the purpose of seeking guidance, but Mr Newton did not answer the telephone.

42. The offender felt compelled to proceed because both RAR and Multiplex wanted the job done and he was worried about his job security.

43. However, after discussing the matter with Mr Kelly and Multiplex workers, the offender felt more comfortable with the job. Those present agreed that the lift would be a difficult one, but it could be done.

44. The offender knew that the generator weighed about 10 tonnes (it was 10.3 tonnes) and that the crane had a lifting capacity of 10 tonnes. In addition to the weight of the generator, the weight of the lifting equipment was about 1.2 tonnes, bringing the total weight to 11.5 tonnes. The offender knew that the crane’s lifting capacity would be increased if the “superlift” counterweight was fitted; if so, it would operate in the “301 mode” rather than the basic “201 mode”.

45. The offender was told that he could not move the generator by the shortest route (a straight-line distance of about 50 metres) because of in-ground plumbing. The travel distance would be about 600 metres.

46. The offender considered that the only way in which the generator could be moved was by picking it up with the boom extended and then bringing it close to the crane. All present agreed with this course. Due to the associated configuration of the crane, the load at the commencement of the lift would exceed the safe lifting capacity of the crane as described in the lifting chart for the “301 mode”.

47. Had the offender checked the lifting chart for the “301 mode”, he would have realised that the load exceeded the available lifting capacity, given the necessary configuration of the crane at the commencement of the lift.

48. Prior to commencing the lift, the offender should have undertaken a risk assessment of the lift, but he did not do so because the light was fading, and the generator needed to be moved that day. A risk assessment would have involved driving the unladen crane along the travel path

to assess the terrain and any risks along the path, including the slope of the path which, at one point, involved an unavoidable side slope of 6.59° and other terrain angles of up to 10.27°. The manufacturer warning stated that the crane must not operate on a slope greater than 5°.

49. The offender and Mr Kelly connected the counterweights to the crane. However, the "superlift" counterweight was fitted in the incorrect direction vis-à-vis the crane. This meant that its sensor could not be detected by the crane's computer, and the computer would make calculations as though the counterweight was not fitted; it would not recognise that the crane could operate in "301 mode", and the figures shown on the LMI display for overload and rated capacity of the crane would be inaccurate.

50. Neither the offender nor Mr Kelly knew that these problems would flow if the counterweight was fitted incorrectly, although the process for fitting the counterweight was described in the operator's manual. The offender looked at the manual but did not locate the relevant section.

51. Once the offender realised that the crane's computer was not recognising the "superlift" counterweight and the "301 mode", he tried to call Mr Newton at RAR but again his call went unanswered.

52. The offender then rechecked the load charts in the crane's cabin and decided that the crane could readily perform the lift.

53. The offender believed that the computer was not recognising the "superlift mode" because of a computer malfunction. He informed several people, including Mr Kelly and the deceased, that the crane thought it was in "201 mode" but that it was, in fact, in "301 mode".

54. The offender, Mr Kelly, Mr Holtz and Mr Brown rigged the generator using the dragging lugs of the generator rather than the lifting points. This meant that the load was not rigged in a way that minimised the load height; the height and length of the boom were greater than was required to lift the load. Further, the chains were longer than necessary because they were attached to the dragging lugs rather than the lifting points of the generator, changing the generator's centre of gravity and inducing a tilt of 6.61°. The safer lifting configuration would have reduced the swing of the load and the total slung load height.

Moving the generator

55. At about 5:53 PM, the lifting operation commenced.

56. Initially, the offender had to extend the boom of the crane to pick up the generator. He knew that the crane may be overloaded but that the overloading would cease once the boom was brought in. This was the first occasion that the crane operated in excess of its rated capacity.

57. The crane alarm sounded several times and the computer indicated that the crane was overloaded. However, the offender surmised correctly that the computer system was displaying incorrect information as it had not registered the "superlift" counterweight. Consequently, he overrode the safety mechanism when the alarm sounded.

58. For approximately five minutes after commencing the lift, the offender operated the crane with the safety alarms operating because the LMI system did not register that the "superlift" counterweight was fitted. In fact, the crane was not overloaded.

59. At one stage in the first five minutes, the offender reversed the crane up a slope that, at its steepest, was 9.22°.

60. The offender carried the load as low as he thought that the conditions allowed. However, between 5:59 and 6:01 PM, the load was carried at an excessive height. Contrary to the safety recommendations of the manufacturer and the Crane Industry Council of Australia, the offender operated the crane while the base of the generator was more than two metres above ground.

61. By about 6 PM, it was dark. According to Mr Brown, it was so dark that "he could not see where he was walking". Ordinarily, a series of lighting towers would be used to illuminate such

an area, but no such lighting was provided. To provide additional lighting, Mr Drummond improvised by reversing his vehicle in front of the crane with the spotlights and headlights illuminating the ground in front of the crane.

62. Despite the poor visibility, the offender continued with the lift.

63. The route south sloped downwards from right to left. At the base of the slope, there was a body of standing water. The left wheels of the crane were on the edge of the water, on soft ground of uncertain surface stability. The internal and external visual and audible alarms were activated because of the side slope. Between 6:10 PM and 6:11 PM, the offender drove the crane at a side tilt of more than 5° for one minute and 29 seconds, with a tilt of 10° at 6:10:50 PM.

64. The offender made a right turn and continued forward in a westerly direction to an area where the track narrowed and there were dirt piles on either side. Mr Brown was walking in front of the crane, steadying the load by hand as the load swung. He heard the offender comment that the back wheels were coming off the ground and saw for himself that the back wheels were indeed coming off the ground.

65. The offender continued to drive the crane before stopping and then reversing up an incline on a track that ran north/south.

66. As the offender reversed the crane, Mr Kelly, Mr Jones, Mr Brown and Mr Holtz were positioned at each corner of the generator to assist by manually stabilising it. A “controlled lift” such as this is a recognised practice in the construction industry. At this point, the higher end of the generator was almost 1.8 metres above the ground.

67. At about 6:21 PM, the crane approached a narrow section of the path. The offender stopped and reconfigured the crane so that it would fit. He lowered and telescoped out the boom, then rotated the generator to carry it lengthways, parallel with the crane. The lowering of the boom increased the radius from 2.87 metres to 4.44 metres, overloading the crane so that it was operating at 102.2 per cent of its rated capacity. The alarms were operating but the offender repeatedly overrode the safety system. This was the second occasion on which the crane operated in excess of its rated capacity.

68. The offender drove up the slight incline of the rough and uneven path.

69. At approximately 6:24 PM, the offender repositioned the load so that the generator was across the front of the crane. He continued to reverse up a slight incline and commenced a U-turn. As he was turning, the right wheels of the crane hit a dirt mount on the edge of the travel path, causing the crane to tilt to its left at 10.10° for about one minute. Again, the alarms were activated.

70. From this tilt, the offender drove the crane forward, towards its destination.

71. At about 6:38 PM, the offender manoeuvred the crane by lowering and extending the boom. He used the override function for 13 seconds while the boom was extended to the point where the crane was overloaded to 104.6 per cent of its rated capacity.

72. The offender again extended the boom to rotate the generator. The boom was extended from 8.55 metres to 9.81 metres, and articulation was increased from 11.3° to 30.5°. Because the heavier end of the generator was further from the crane, the crane and load were destabilised. At this stage, the higher end of the generator base was over 2 metres from the ground.

73. At 6:41 PM, the offender operated the crane at 130.5 per cent of its rated capacity. The crane tipped to its right while carrying the generator. As it tipped, the gravitational force of the generator pulled the crane from the tip of the boom, accelerating the boom as it fell to the ground, where four persons were in the immediate vicinity.

74. The tip of the boom impacted Mr Holtz, crushing him between the boom and the ground, and killing him instantly.

11. The agreed facts tendered in the sentencing of Multiplex and RAR Cranes were expressed in similar terms and formed the basis of the Chief Industrial Magistrate's sentences in both proceedings.

The Criminal Proceedings

12. The criminal proceedings began on 18 April 2018, with information laid in respect of Mr Watts, Multiplex, RAR Cranes, and a number of other defendants. Those other defendants included the 'dogman', who was assisting the crane driver at the time of the accident, as well as the site's supervisor and safety officer, both of whom were employed by Multiplex. Multiplex Constructions' chief executive officer and RAR Cranes' managing director were also charged, as was the site manager on the day, who was also employed by Multiplex. The matters first came before the Court on 17 May 2018.

Mr Watts

13. The proceedings involving Mr Watts were eventually committed to the Supreme Court for trial on 28 February 2019. The offences included the offence of manslaughter.

14. On 12 February 2020, Mr Watts pleaded guilty to an offence under section 31 of the *Work Health and Safety Act 2011* (ACT) ("the WHS Act") alleging that he exposed Mr Holtz to the risk of death or serious injury. The offence carried a penalty of $300,000, five years' imprisonment, or both. He had promised to give evidence against Multiplex and the other defendants (who at that stage, were still subject to charge). Sentencing proceedings were conducted on 16 April 2020 before Her Honour Murrell CJ. On 20 April 2020, Her Honour convicted Mr Watts and sentenced him to 12 months' imprisonment, which was wholly suspended upon Mr Watts entering a good behaviour order for 12 months.

15. The offence of manslaughter was not proceeded with and a notice declining to proceed was filed by the ACT Director of Public Prosecutions ("DPP") on 4 May 2021, twelve months after the sentence proceedings were completed.

16. It is noted that Mr Watts has since passed away.

Multiplex

17. On 14 October 2021, Multiplex pleaded guilty to a charge of failing to comply with a health and safety duty, a category 2 offence, pursuant to section 32 of the WHS Act. The maximum penalty for a body corporate was a fine of $1,500,000. Multiplex was convicted and fined $150,000.

RAR Cranes

18. On 14 October 2021, RAR Cranes pleaded guilty to the same offence of failing to comply with a health and safety duty, pursuant to section 32 of the WHS Act. RAR Cranes was convicted and fined $300,000.

19. The proceedings against Multiplex and RAR Cranes had been scheduled to take place on 18 October 2021, in a joint hearing, with a number of the co-offenders to who I have referred. A decision was taken by the DPP to discontinue the proceedings against those co-offenders.

20. I observed that the culpability of the individuals and the corporate entities was differentiated by the differing charges that were brought in each instance. The entering of pleas of guilty to those charges did not, in the case of the corporate entities, involve an admission on their part that the regulatory breaches were causatively related to Mr Holtz's death.

Findings in Respect of Matters of Public Safety

Background – Safety in the Construction Industry in the ACT

21. The use of cranes on construction sites is acknowledged to be a high-risk activity and crane accidents contribute significantly to the rate of construction site deaths around Australia at rates greater than other mobile plants: Gharaie, Lingard and Cooke, 'Causes of Fatal Accidents Involving Cranes in the Australian Construction Industry' (2015) 15(2) *Construction Economics and Building* 1-12.

22. In 2012, the then Attorney General for the ACT commissioned an inquiry into the application of work health and safety laws in the ACT's construction industry. The findings of that inquiry (the *Getting Home Safely Report*) were that the ACT's serious injury rate for the construction industry was 31% higher than the national average. It found that the ACT construction industry's long-term injury performance was 50% worse than most other jurisdictions and double the national average: Inquiry into Compliance with Work Health and Safety Requirements in the ACT's Construction Industry, *Getting Home Safely,* (Report, November 2012).

23. In 2017, the year after Mr Holtz's death, researchers at Royal Institute of Technology were commissioned to examine whether the safety culture on Canberra's building sites had improved since the inquiry of 2012. The study was principally focus-group based. The findings were, relevantly, that the construction industry culture was becoming more supportive of safety culture. However, significant issues remained, particularly in respect of the management of subcontractors by principal contractors: Lingard, Harley, Zhang, and Ryan, 'Work Health and Safety Culture in the ACT Construction Industry' (2017) Centre for Construction Work Health and Safety Research.

24. Safe Work Australia data shows the Australian average frequency rate for serious claims for the construction industry decreased by 4% between 2014–15 and 2018–19. During the same period, the ACT recorded a 9% decrease in its frequency rate. However, the overall safety performance of the sector is, when compared with other jurisdictions, quite poor. As WorkSafe ACT noted in its 2021-2022 Annual Report (page 25), "the construction industry continues to miss the mark in the provision of safe and healthy working environments for its workers".

Safety Issues - Mr Holtz's death

25. These general outcomes in the construction industry reflect the specific safety culture failings that were apparent in respect of Mr Holtz's death.

26. The tragic and unnecessary death of Mr Holtz was caused by the failure of an individual and identified corporate entities to comply with their statutory obligations to ensure that the workplace was safe. Decisions were made to use a crane that was not suited to the task at hand. Mr Watts was not adequately trained in the use of the equipment, the workplace was unfamiliar to him, and the load was too heavy for the crane. The crane itself gave warnings as to that fact but those warnings were overridden. Warnings had been given to RAR Cranes by another employee about the need to find a safer way to move the generator. Multiplex, through its employees, was supposed to sign documentation representing that the use of the crane to perform this task was safe. It

failed to do so. As the Chief Industrial Magistrate found in the RAR Cranes matter, the "likelihood of the crane being operated improperly was apparent in the circumstances. The vulnerability of workers at the scene was obvious. The risk of death or serious injury as a result of a machine being operated improperly was entirely foreseeable" (*Bradley Cummins v RAR Cranes Pty Ltd* [2022] ACTIC 1 at [44]).

27. The brief of evidence prepared in respect of the criminal proceedings did not disclose the safety issues arising from Mr Holtz's death, other than the obvious failings that were detailed by Chief Justice Murrell in her sentencing remarks, and that were particularised in the charges that were brought.

28. I make no recommendations in respect of the public safety issues that arise from the inquest into Mr Holtz's death. The safety regime that was in place at the time, if complied with, would have meant that the accident would, in all likelihood, not have happened.

Matters Concerning the Administration of Justice

29. The Holtz family have raised concerns with the Court about how the prosecution process unfolded.

(i) Lack of Information

The family expressed the view that insufficient information was given to them about the prosecution process.

(ii) The Dropping of Cases and Changing of Charges

The family feel that the number of people originally charged, and the charges that they initially faced, better reflected issues of culpability in respect of Mr Holtz's death. They strongly disagreed with the downgrading of charges and the dropping of cases in respect of some of the people originally charged.

(iii) Inability to read Victim Impact Statements

In the proceedings involving Multiplex, the family complained that they were not allowed to read their victim impact statements.

(iv) Leaving Mr Holtz's body in situ for too Long

The family felt that their loved one's body was left under the crane for too long and should have been removed earlier by investigators.

(v) Delay

The family could not understand why the criminal process took so long.

30. The family feel that, in respect of Mr Holtz's death, justice has not been done.

31. Matters concerning the bringing and maintaining of prosecutions under the WHS Act is, at the moment, entirely a matter for the DPP, who acts independently under the *Director of Public Prosecutions Act 1990* (ACT) in respect of these issues: see sections 6 and 9 of that Act. Witness and family liaison issues that arise in the context of criminal proceedings are managed by the AFP, the DPP, and the Office of the Work Health and Safety Commissioner.

32. The ability of family members to read victim impact statements is affected by the terms of section 48 of the *Crimes (Sentencing) Act 2005* (ACT), which potentiality limits the use

of the victim impact statement process to cases carrying a prison sentence longer than one year (unless otherwise prescribed by regulation).

33. The Coroner's Court, by the publication of these reasons, draws these matters of concern to the attention of the DPP, WorkSafe ACT, the Chief Industrial Magistrate, and the Attorney-General.

34. The Court has received advice from the Work Health and Safety Commissioner that she has met with the Holtz family to discuss their concerns. A family liaison officer position has also been created in the Office of the Work Health and Safe Commissioner, which should facilitate better communication between that Office and families who are caught up in prosecution processes in which the Commissioner is involved: see *Service Charter of WorkSafe ACT Family Liaison Office*r, WorkSafe ACT website.

35. It is also noted that a recent review of the responsibility for conducting the prosecution of ACT Work Health and Safety offences has been undertaken and its recommendations are with Government. Decisions around that issue are a matter for Government and I make no comment in respect of them.

36. I do address two of the issues that the Holtz family have raised as matters that fall within the terms of the Act. By virtue of section 52(4) of the Act, I am given discretion to comment on any matter about the administration of justice connected with the inquest. Further, section 3BA (2) of the Act relevantly provides:

> (2) As far as practicable, the objects of this Act must be carried out in a way that—
>
> (a) for an inquest into a person's death—recognises the following:
>
> (I) the family and friends of the deceased person have an interest in having all reasonable questions about the circumstances of the person's death answered;

37. I am satisfied that two of the matters raised by the family fall within the power of the Court to make comment or to provide an answer to the questions asked.

The positioning of Mr Holtz's body after death

38. Mr Holtz's body remained under the crane until 00:30 on 5 August 2016. I fully understand and acknowledge the distress that reality has caused the family.

39. The fact that Mr Holtz had died instantly of his injuries was quickly assessed. The work site and the overturned crane had to be made safe on the advice of suitably qualified people. A crime scene had to be established and investigators with relevant expertise had to be identified and brought to the site. Once there, they were tasked with capturing detail about the circumstances of Mr Holtz's death, including measurements and photography. A forensic medical officer was not able to exercise safe access to the body for some time (she attended at 23.47). Machinery had to be organised to allow the crane to be moved off Mr Holtz without further desecrating his body.

40. Mr Holtz's body remained draped throughout the investigation.

41. The investigation of death is complex and must be undertaken with care. Here, and as always, a balance must be struck between the dictates of the coronial (and likely criminal) investigation, issues of safety, and the need to ensure that the body of the deceased is treated with respect and dignity. I am satisfied that occurred here.

Delay

42. I observe the reality that the investigation of Mr Holtz's death, the criminal proceedings that flowed from that investigation and the coronial proceedings, have taken six and a half years to complete. The criminal proceedings were not completed until March 2022, approximately five years and seven months from his death and nearly four years after proceedings commenced. The reasons for the Court delay are complex and relate to:

    i. the number of defendants originally charged;

    ii. the charges originally faced by Mr Watts had to be dealt with in the Supreme Court;

    iii. Mr Watts indicated an intention to give evidence against other defendants and the hearing in the Industrial Court was partly delayed pending resolution of his sentence proceedings; and

    iv. the anticipated hearing in the Industrial Court was long and had to be accommodated within available listing periods and subject to the availability of counsel. This provides the context to the fact that on 17 September 2020, the various proceedings in the Industrial Court were listed for a near 3 week hearing on 18 October 2021, over a year later.

43. The management of court lists and the allocation of priorities in respect of the disposition of matters are matters for the head of jurisdiction of the relevant court.

44. Delay in the disposition of cases has consequential effects for a coroner conducting an inquest into the death. When a death gives rise to the possibility of criminal proceedings for indictable offences, the terms of sections 58 and 58A of the Act apply:

58 Procedure where evidence of indictable offence or indictment to be presented

(1) Subsection (3) applies if, during an inquest or inquiry, a coroner has reasonable grounds for believing that, having regard to the evidence given at the inquest or inquiry, a person mentioned at the inquest or inquiry has committed an indictable offence.

(2) For subsection (1), the coroner must have regard to—

  (a) the admissibility at trial of the evidence given at the inquest or inquiry; and

  (b) whether the director of public prosecutions, or a person who may be affected by the referral to the director of public prosecutions of evidence relevant to the alleged offence, is, or has been, given the opportunity to present or give evidence in connection with the alleged offence.

(3) The coroner—

  (a) must, by written notice, tell the director of public prosecutions about the coroner's belief; and

  (b) for a related indictable offence—must not proceed further with the inquest or inquiry until the day worked out under section 58A, other than to establish the following facts:

    (i) for an inquest—the death of a person, the person's identity and the date and place of the person's death;

    (ii) for an inquiry—the date and place of a fire or disaster.

(4) Subsection (5) applies if, during an inquest or inquiry—

(a) the director of public prosecutions, by written notice, tells the coroner holding the inquest or inquiry that an indictment will be presented against a person for a related indictable offence in relation to—

(i) the death of a person who is the subject of the inquest; or

(ii) the matter the subject of the inquiry; or

(b) the Attorney-General presents an indictment against the person for a related indictable offence.

Note ***Indictment*** includes information, and ***present*** an indictment includes lay an information (see Legislation Act, dict, pt 1).

(5) The coroner must not proceed further with the inquest or inquiry until the day worked out under section 58A unless the coroner limits the inquest or inquiry to establishing only the facts mentioned in subsection (3) (b) (i) or (ii).

(6) A coroner must not continue holding an inquest or inquiry if satisfied that the inquest or inquiry should not be continued.

(7) In this section:

related indictable offence, in relation to an inquest or inquiry, means an indictable offence that raises the issue of whether a person caused a death, suspected death, fire or disaster the subject of the inquest or inquiry.

58A When inquest or inquiry may proceed—s 58

(1) For section 58 (3) or (5), the coroner may proceed with the inquest or inquiry—

(a) if a prosecution is not started on or before the day after the day that is 3 months after the day the coroner—

(i) gave notice to the director of public prosecutions under section 58 (3) (a); or

(ii) received notice from the director of public prosecutions under section 58 (4) (a); or

(b) on a day after—

(i) the day the director of public prosecutions gives notice to the coroner that—

(A) no indictment is to be presented in relation to the related indictable offence; or

(B) if an indictment was presented in relation to the offence—the director of public prosecutions has discontinued or intends to discontinue the proceeding started by the indictment; or

(ii) if the person is not committed to stand trial for the offence (the person is ***discharged***), and is not indicted for the offence by the director of public prosecutions or the Attorney-General within 28 days after the day the person is discharged—30 days after the day the person is discharged; or

(iii) if the person is committed for trial or indicted for the offence—the day after the day the director of public prosecutions gives notice to the coroner that the proceeding for the offence has been finally decided; or

(iv) if the person is found guilty of the offence, and the director of public prosecutions has not given notice under subparagraph (iii) that the proceeding for the offence is finally decided—30 days after the proceeding is finally decided.

(2) A coroner may continue an inquest or inquiry after the day mentioned in subsection (1) 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.

45. As a matter of principle, the legislative scheme set out in these sections is founded on a concern about coronial investigations interfering with criminal trials; in particular, by potentially exposing accused persons to compulsory coronial processes, in advance of issues of guilt or innocence being determined. As those provisions have been interpreted and applied, the coronial inquest that is enlivened by a death falling within the jurisdiction of the coroner is held in abeyance if the requirements of sections 58(1) and 58(4) are satisfied. As a result of the application of the terms of section 58A, the finalisation of the inquest can be deferred for lengthy periods of time, often amounting to (more than a few) years. The trauma caused to the family has been noted. It also means that recommendations as to issues of public safety and public administration that form a central part of the coroner's role fall to be considered (as here) many years after the relevant events. In this case, safety concerns were effectively addressed in the safety breaches that were prosecuted. In other cases (child or family violence deaths, for example), consideration by a coroner of recommendations for systemic change to enhance protections for those who are vulnerable may be unreasonably delayed.

46. The terms of sections 58 and 58A of the Act are ambiguous and do not place obligations on the named entities to comply with the legislative scheme they create. The notices contemplated by the provisions are not mandated, and, in practice, often not issued. The time frames set out in section 58A of the Act do not, in practice, serve any meaningful purpose.

47. The terms of those sections are inapposite given the different meaning that otherwise applies to the meaning of an "inquest" under the Act. All deaths that fall within the jurisdiction of the coroner under section 13 of the Act are "inquests". The ACT differs from other jurisdictions in that regard. In other jurisdictions, "inquests" refer to the "hearings" conducted by a coroner in respect of a death. The prohibitions contained in section 58, as they have historically been applied in the ACT, place what may be unnecessarily inflexible constraints around a coroner investigating a death in circumstances where that may have little or no bearing on the ongoing criminal process. The exercise of the investigative powers of the coroner (not necessarily associated with the holding of a hearing and not necessarily involving an accused person) during the currency of a related criminal prosecution does not necessarily compromise traditional fair trial protections vested in accused persons or constitute a contempt of those criminal proceedings: see generally *Commonwealth of Australia v Helicopter Resources Pty Ltd* [2020] HCA 16.

48. The legislative scheme created by section 58 and section 58A of the Act, with some (often significant) variation, has its equivalent in all other jurisdictions in Australia. The same consequential delay issues are also experienced elsewhere.

Recommendation

49. I recommend that the Government consult with the Court and other stakeholders with a view to reviewing the operation of sections 58 and 58A of the Act. The Victorian *Coroners Act 2008*, for example, has a much simpler model that vests a greater deal of discretion in a coroner to not hold hearings (inquests) in cases that may involve related criminal proceedings.

PROVISIONAL FINDINGS & SECTION 55 OF THE ACT

50. On 8 March 2023, I sent provisional findings to parties that may have had an interest in the inquest; the family, the corporate entities that were prosecuted, and the Work Health and Safety Commissioner. The provisional findings duplicated these findings except for [50] to [53]. The provisional findings were sent to the corporate entities in terms that attracted the operation of section 55 of the Act. They were given the opportunity to respond to the adverse comments that had been made in the provisional findings. I received no response from those entities.

51. The family chose to respond to the provisional findings. The family re-iterated their dissatisfaction with the criminal processes both as to outcomes and delays. The family indicated that there were aspects of the fact finding made by Chief Justice Murrell that they disagreed with, particularly in those passages where Her Honour indicated that Mr Holtz had agreed with suggestions as to how the generator was to be moved. They also expressed their disappointment that the coroner's retention of Mr Holtz's body for a time after death, and the extent of Mr Holtz's injuries, prevented the traditional Māori mourning ceremony (*tangihanga*) from taking place.

52. The Work Health and Safety Commissioner provided a response, pointing out that the prosecution of work health and safety matters in the ACT had been reviewed and that a series of recommendations had been made to Government. The review had been made public on 16 March 2023. The Commissioner indicated that she had responded to the review and that the Government were considering the model that had been recommended. The Commissioner expressed reservations about inquests preceding in advance of the prosecution of Work Health and Safety prosecutions.

53. As indicated above, any changes to sections 58 and 58A of the Act would have to take into account the impact of the continuation of coronial *investigations* on the integrity of an unresolved prosecution process.

CONDOLENCES

54. Mr Holtz and his wife, Rangimarie Nellie Holtz, met when she was 15 years old, and he was 17 years old. Their 42-year marriage was filled with happy times spent with family and friends enjoying birthdays, holidays, weddings, family gatherings and trips together. Mr Holtz was a hard-working man who was deeply committed to caring for his family. Mrs Holtz described him as a beautiful husband, a wonderful father to their children, and the greatest grandfather to their grandchildren. To his family, Mr Holtz was a loving, strong, and reliable figure in their lives, and his death is still profoundly felt by those who knew and loved him. He did not deserve to die in the way he did. The victim impact statements that were received by the Court in the Watts proceedings attest to the family's grief and the tragic emotional dislocation that has been caused by his senseless death.

55. I express my condolences to the Holtz family.

56. As I have done in other inquests, I observe that section 3BA of the Act requires inquests to be carried out in way that recognises that the death of a person, and an inquest into the person's death, has a significant impact on the person's family and friends. Again, as in other matters, I am forced to acknowledge that that statutory obligation has not been discharged. In this case, the coronial proceedings have been delayed by the criminal processes that were involved. However, this Court is not free of culpability in that regard. The inquest could have been resumed from the time that the indictable proceedings against the co-offenders were discontinued in October 2021.

57. Delay in the disposition of a coronial inquest can add significantly to the trauma experienced by surviving family, and on behalf of the Coroner's Court, an apology is made to Mr Holtz's family for the delay they have experienced and the trauma that delay has caused.

I certify that the preceding fifty-seven [57] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Magistrate Archer

Associate: Jessica Friendship

Date: 29 March 2023