

LOCAL COURT
New South Wales
Wollongong

Jurisdiction: Coronial

Matter: Inquest into the death of Michael Parsons

Hearing dates: 22 –24 February 2012

Date of decision: 20 April 2012

Magistrate: Ian Guy
Deputy State Coroner, Wollongong

Representation: Ms P Lawson, Barrister, instructed by the
Crown Solicitor's Office, as Counsel
Assisting the Coroner

Mr M. Cahill, Barrister, for WorkCover

Mr S. Davis, Barrister, for Seawind
Catamarans Pty Ltd and Mr Ward

Mr J. Trevallion, Barrister, for Mr Oste

Reasons for Decision

1. In August 2008, Mr Michael Parsons had been employed with Seawind Catamarans P/L (Seawind) for approximately 7 years. Seawind was engaged in the manufacture of large catamaran sailing craft. Mr Parsons worked as a qualified tradesman holding a certificate of proficiency as a shipwright. He had specialised in the timber fit out stage of the catamaran manufacturing process, in particular, the port side hull.
2. On 25 August 2008, Mr Parsons had been working in the port catamaran hull. He had with him a tin of acetone and a tin of solvent thinners comprised of Bostik 9913, both of which are commonly used for cleaning of the boat under construction. Accidental or deliberate inhalation of the solvent fumes in particular can potentially produce serious health effects ranging from a state similar to intoxication to death. That afternoon, workers found Mr Parsons unconscious in the port hull with his torso, head and both arms inside one of the storage hatches. Inside the hatch was a rag containing the cleaning solvent. A tin of solvents was found nearby in the hull.
3. Fellow workers dragged Mr Parsons from the hull. He was cyanosed and frothing at the mouth. He had several abrasions including one to the forehead. Mr Parsons was not wearing his work respirator or any other personal protection equipment.
4. Resuscitation attempts by workers and subsequently by ambulance personnel were unsuccessful and Mr Parsons was declared deceased at his workplace. A post-mortem concluded the direct cause of death as hypoxemic hypoxia, which is essentially a generalised lack of oxygen. The antecedent cause of death was recorded as respiratory depression secondary to narcosis due to inhalation of an industrial solvent.
5. It is clear Mr Parsons has died from the effects of the solvent. The primary focus of this inquest is how did this happen. The requirements under the Coroners Act 2009 to determine the identity, date and place of death are clearly satisfied. The manner of death and to a lesser extent the medical cause is of primary concern. This inquest is not intended as a broad ranging inquiry as to compliance or otherwise by Seawind of its responsibilities under the Work Safety legislation. Any examination of and comment upon the manner by which Seawind ensured the safety of its workers is in the context of findings as to the manner of Mr Parsons' death and recommendations that might be made to reduce the prospect of a recurrence of a similar event.
6. These findings do not purport to be an exhaustive summary of all the voluminous folders of evidence tendered or of the oral evidence taken, although I have taken into account all the evidence and the written submissions of the parties.

7. Mr Parsons' partner, Jessica Dynes, gave a personal statement to the Court. It is clear the grief she feels for the loss of a partner and father to their young child is immense. Mr Parsons' parents were also present at the inquest.

Issues

8. A number of issues arise for determination. They can be conveniently summarised as ---
 1. What was the medical cause of death?.
 2. Was Mr Parsons carrying out a work related duty preceding his death, deliberately inhaling the solvent for its effect or a combination of both? .
 3. What recommendations can be made to improve worker safety? .

Background facts

9. To better understand how the death occurred, it is appropriate to briefly outline the work processes and company structure.
10. Seawind (formerly Shipcove) is a registered Australian company, in operation since about 1982. It continues to have a substantial market in the production and sale of large catamarans. Among the range of vessels is the "Sea Wind 100", a 10-metre catamaran that Mr Parsons was working on the time of his death.
11. The manufacturing process of the catamaran occurs in two locations, the initial manufacturing of the hulls in Nowra and their subsequent transportation to the Bellambi factory. It is here the boat is physically moved through a series of three discrete building stages, each taking about three weeks, leading to the ultimate launch and delivery of the catamaran to the customer.
12. The work in stage 1 includes the assembly of the components from Nowra, fitting of some bulkheads, fibre glassing and flow coating. Stage 2 includes the fitting of the major bulkheads, carpeting and some plumbing and mechanical installation. Stage 3 was known as the fit out stage and it was here Mr Parsons had worked in the previous five years. Work carried out by a number of people included further plumbing, window fitting, fibre glassing, engine installation and internal timber fit out.
13. Mr Parsons was responsible for the timber fit out in the port hull of the boat. This included the fitting of doorframes and doors, flooring and cabinets.

14. When all of the practical work is completed, workers described as “detailers” are then responsible for the cleaning and detailing of the boat prior to its launch inspection and testing.
15. Mr Parsons was one of about 75 people working at the Bellambi factory. He was one of 2 persons responsible for the timber fit out work on the 10 metre boats. There were a variety of other workers involved in the other manufacturing stages.
16. There were effectively 4 levels of workers within the company. The upper management level comprised Mr Richard Ward, the owner and sole director of the company, Mr Michael Rees production engineer and Mr John Oste operations and manufacturing manager who was primarily responsible for work place safety. There then followed 2 supervisors on the 10-metre production line including Mr Brenton Mahoney who was Mr Parsons’ supervisor. The third level comprised a number of team leaders. The final group comprised workers including Mr Parsons.

Events leading up to the finding of Mr Parsons

17. Although some aspects of the evidence as to events on 25 August 2008 are unclear, the following outline emerges.
18. Mr Jack Smigulski, electrical contractor, saw Mr Parsons when he went to the port hull on arriving at work about 8-8.30am. There were in fact too many people present in the hull for him to do his intended electrical work. He could smell fumes in the hull but didn’t know who was using the chemicals.
19. According to Mr Brenton Mahoney, he saw Mr Parsons about 9 am .He was told he was “cruising”. He spoke to him at the workbench and he was getting into fitting and cutting the frames on the bench. He said Mr Parsons duties that day were fitting of timber frames in the forward hull, that he had fitted the frames but had to remove them for extension and respraying.
20. Post morning tea that is from 9.30 –10am, Mr Verhaaf said Mr Parsons came over to the boat he was working on. Work was quiet and they talked for about 30-45minutes. Mr Parsons told him he was going to clean the bunks and he returned to his boat. Mr Verhaaf said after carpet is attached, there is a lot of glue overspray.
21. About 11.30 am, Mr Mahoney says he saw Mr Parsons again in the port hull and was told he had 2 frames to go. This task according to Mr Verhaaf would take about 2 hours.
22. About 1.20 pm, Mr Paul Allen went to the port hull to install some steering bolts and stayed for a while chatting to Mr Parsons. He saw Mr Parsons using the light on his mobile phone to look for lumps in the carpet. This is supportive in my view of Mr Parsons turning his attention to the finish of the boat.

23. About 1.30pm Mr Mahoney saw Mr Parsons go past him to the toilet and told him he started to fit the veneers.
24. About 2 pm, Eli Jones went below the deck to speak with Mr Parsons, finding him face down on the forward bunker. Unable to get a response he went upstairs to get help. Several workers went below to lift Mr Parsons from the hull and began CPR until ambulance officers arrived.

Issue 1 – the medical cause of death

25. The post mortem report by Dr McBride notes no obvious pathological cause of death. A significant finding that the lungs were nearly twice the normal weight due to congestion and fluid accumulation was considered as favouring a terminal process of respiratory depression resulting in hypoxic lung damage. The respiratory depression and hypoxic lung damage would also result in generalised hypoxia leading to irreversible brain hypoxia and cardiac arrest.
26. Expert toxicologist Professor Whyte agrees Mr Parsons has inhaled the vapours of the solvent Bostik 9133, but based on his own research and knowledge of the toxicity of the solvent, the more likely direct cause of death was from a cardiac arrhythmia, secondary to cardiac sensitisation by an industrial solvent.
27. Seawind says Professor Whyte' s evidence about risk of death is limited to his comments about glue sniffers who seal their heads in a bag or spray glue down their throats and is inconsistent with the level of exposure that could be expected of cleaning duties¹. I do not agree with that assessment of his evidence.
28. Professor Whyte noted Bostik 9133 comprises toluene, petroleum, hydrated light An initial inhalation of high concentration of the vapours, as might be expected in a confined space may produce a euphoric state similar to ethanol but occurring much quicker and more intensely. It may then progress to depression of the central nervous system that in turn affects the ability to breathe, decreasing levels of oxygen to the heart. Toluene acts upon the heart to make it to more sensitive to adrenaline already circulating in the body. Having higher amounts of the toxin in the body will create a higher level of sensitisation of the heart .It would then require a lesser degree of release of adrenalin to produce an arrhythmia (an abnormality) that could be fatal. A movement out of the ordinary is likely to increase adrenalin leading to a cardiac arrhythmia and death².
29. The effects of inhalation of toluene may include lung upper airway irritation with oral frothing, central nervous system depression, nausea, headache and various heart rhythm abnormalities. Exposure to high concentrations can lead to unconsciousness and respiratory depression

¹ Written submissions p 2

² T 22/2/12 p 4

with profound slowing of breathing, hypoxemia (low oxygen in the blood) and death. Brief skin exposure may cause mild irritation. Prolonged contact can lead to severe burns. Skin absorption is limited and systemic effects are unlikely unless exposure is prolonged and extensive. Onset of symptoms is likely to occur rapidly. The inhalation of high concentrations of toluene may induce central nervous system depression within minutes. Peak effects however may not occur for 30 minutes.³

30. Professor Whyte's observations concerning the characteristics of toluene are particularly relevant given the position of Mr Parsons in the locker in the port hull and location of the tin and rag containing Bostik 9913 inside the confined space of the locker.
31. Professor Whyte said toluene is an extremely volatile agent. When exposed to air it rapidly becomes a vapour. The vapour pressure is low and vapour density is three times lighter than of air meaning there is 3 times as much toluene as there is air at any one time. In the case of the containers used by Mr Parsons, the vapours will continue to escape from a metal tin left uncovered until there is nothing left in the tin. The more confined the area in which the toluene is located, the higher the concentration, as it is less able to disburse. The vapours will tend to drop as it comes out of the can into the space from the bottom up into which it is being released⁴. The use of rags with thinners also means the surface area of the toluene was much greater than the holes in the cans because the liquid is shaken out onto the rags and hence a "lot of opportunity for the toluene to evaporate".⁵
32. Fire Brigade officers who attended tested the atmosphere inside the hull identified a potential fire or explosion hazard. The volatile gas level within the hull was vastly in excess of the safe levels.
33. Professor Whyte noted that the presence of toluene and acetone in each tin in the hull with Mr Parsons would have an additive effect on an individual.
34. Depending on their sensitivity, some persons will be more affected by the fumes than others. Professor Whyte referred to the concept of desensitisation with persons working with strong smelling chemicals where the desensitisation of the nasal receptor into the nose is a common occurrence. This observation is relevant, as a number of workers at the hull on 25 August 2008 did not detect any strong smell of chemical. Emergency personnel who had not been previously exposed to the solvent on a regular basis were in some cases overcome by the fumes.

³ Report of Professor Whyte p 7

⁴ ibid p 9

⁵ ibid p6

35. Based upon an outline of Mr Parsons' duties and his handling of the chemicals, Professor Whyte considered he had been chronically exposed to concentrations of toxins. Where a person is chronically exposed and an individual can smell the substance, be it toluene or acetone the concentration of the substance can be very high. The potential danger that flows is in my view self-evident.
36. Professor Whyte noted the material safety data sheet (MSDS) produced by the manufacturers of the solvent Bostik 9133, which outlines the chemical composition and various health warnings associated with its use does not refer to the fact prolonged exposure and intense exposure over a shorter period of time can produce cardiac arrhythmias and death. He also noted health professionals treating a patient suffering from toluene exposure should not administer adrenalin given the heart's already increased sensitivity to adrenalin. Although adrenalin was administered to Mr Parsons, there is no suggestion it lead to the death. It is noted in fact in the ambulance records that on arrival, Mr Parsons' pupils were fixed and dilated. It is clear ambulance officers did all they could to revive him.
37. The warning as to the use of adrenalin and the need for a review of the material safety data sheet are properly matters for recommendations arising from this inquest. It was also very clear from the evidence that employees would not have understood the significance of some of the health warnings appearing in the existing MSDS, for example the term narcosis or central respiratory depression. It follows there is a need in the recommendations for consideration of a review of some of the terminology appearing in the MSDS.

Conclusion on issue 1

38. Based on his expertise in toxicology and research into this substance, I am satisfied that the medical cause of death should be recorded as suggested by Professor Whyte, namely a cardiac arrhythmia from the industrial solvent.

Issue 2 -- Was Mr Parsons carrying out a work related duty preceding his death, deliberately inhaling the solvent for its effect or a combination of both?.

39. Prior to Mr Parsons becoming unconscious in the port hull, was he performing a work related activity namely cleaning; was he carrying out his own activity namely deliberately inhaling the solvent vapours to get a "high" or was there a combination of the two extremes? Seawind submits the evidence either establishes Mr Parsons was deliberately inhaling as a frolic on his own, going through the motions of work but intending to deliberately inhale or at the least an open finding as to manner of death should be returned⁶. Consideration of a number of factors will assist in

⁶ Seawind written submissions p 1

determining on the balance of probabilities what Mr Parsons was doing on 25 August 2008 and the manner of death.

The position of Mr Parsons' body in the storage hatch

40. Mr Parsons was found with his head, torso and both arms inside a small storage hatch, as was the rag containing the solvent. This unusual position on one view may suggest an attempt to place himself in a confined location with solvents to deliberately inhale the fumes.
41. Determination of this issue first requires consideration of the layout of the hatches. The forward port hull has a fibreglass platform with three storage hatches or lockers in the floor. The storage area of each locker opens up under the fibreglass platform.
42. A bunk bed would be placed on top of the platform. The dimensions of the rear and centre lockers are approximately 530 mm x 330 mm; the front locker is approximately 330mm x550mm with a depth of 540 mm and extending under the platform.
43. The evidence is divided as to whether Mr Parsons was found in the centre or front locker, i.e. closest to the front of the hull. An employee, Mr Paul Allen confirmed in evidence his belief it was the centre locker. It is noted however his belief has varied from being pretty sure⁷ in the account to WorkCover to one of greater certainty in the statement he gave to the insurance company (Verifact statement), where he says Mr Parsons head was completely in the middle locker⁸. A former employee, Mr Williams, who failed to attend the inquest, gave a statement supporting the centre locker. Again there was a variation in the strength of belief between the WorkCover and Verifact statement. The other witness who supports the centre locker is the employee Mr Arone. His evidence does not sit comfortably with his Verifact statement that refers to finding Mr Parsons in the third locker⁹, nor the account purportedly taken by Mr Rees, the production engineer that it was the third locker.
44. Support for the third locker comes from employee Mr Eli Jones and from Mr Verhaaf whose account appears consistent in the WorkCover and Verifact statements and the version attributed to him by Mr Rees. Mr Verhaaf finds the rag and liquid on the floor of the front locker which are later identified as containing the solvent. The burns on Mr Parsons' face are consistent with skin contacting the solvent. There is also evidence the Fire Brigade detected high levels of fumes from the rag located in the forward section of the port hull in an underfloor compartment¹⁰. I prefer the consistent evidence of Mr Verhaaf and Mr Eli Jones and am satisfied on balance that Mr Parsons was found in the front locker.

⁷ WorkCover statement q41

⁸ verifact statement para 30

⁹ Verifact statement para 31

¹⁰ Fire Brigade officer Jezzard B/E vol 2 tab 4

45. Determining where Mr Parsons was found is relevant to the report of Dr Short, Biomechanical engineer. Computer simulations of falls within the port hull were conducted to determine the likelihood Mr Parsons accidentally fell into one of the lockers. Dr Short concluded falls from a standing position adjacent to the berth would not result in a headfirst fall into the front locker unless there was a second conscious movement. In the event Mr Parsons was in fact located in the second locker, he concluded a targeted effort was required to achieve the position of the torso, arms and head within the locker.
46. It follows that Mr Parsons' position in the front locker was an intentional act. The question then arises whether there is a reasonable explanation for this position.

Was there a work related reason for such a position in the locker?.

47. Seawind says Mr Parsons' location in the locker is consistent with an intention to place himself in a confined location to maximize the effect of the fumes.
48. It emerged in evidence from several workers that due to the depth and length of the locker under the fibreglass floor, cleaning requires at least the head, an arm and part of the torso leaning into the locker.
 - . Ms Margaret Jones, who works as a "detailer" and is primarily responsible for cleaning of the boats, said she would lie on the bed with her head in the locker. Depending if you were underneath the ledge sometimes you would have both arms, head and torso up to your hips in the locker¹¹. The position sometimes varied with one arm in the locker and the other outside. Relevantly, in the context of Mr Parsons not wearing a mask, Ms Jones said when cleaning the furthest locker you cannot get in there and clean wearing a mask¹².
 - . Mr Eli Jones would lie on the bunks to clean with his head inside the locker with one arm inside and one outside for support¹³.
 - . Mr Mark Verhaaf would also lie on the bunks with the number of arms inside the locker dependent on what for him was the most comfortable position¹⁴. As the front locker is long he would pretty much "get half in there"¹⁵.
 - . Mr Kalon Scales would stand in the second locker and reach with his torso ending up in the furthest locker¹⁶.

¹¹ T 20/2/12 p 94

¹² ibid p 93

¹³ T 21/02/12 p112

¹⁴ T 21/02/12 p 87

¹⁵ T 21/02/12 p 86

¹⁶ T 21/02/12 p 55

49. A view in a written statement by employee Mr Williams that he doubted the need for both arms and head in the locker must be weighed against the concession he has not had experience in cleaning the lockers.
50. There is no evidence this position in the locker had been used by any of the witnesses or Mr Parsons for the purpose of deliberate inhalation of the chemical fumes.
51. The evidence shows other workers who have been in a work-related activity cleaning the forward locker in the port hull have been required to reach inside with their torso, at least one arm and sometimes both in the locker which is similar to the position Mr Parsons was found.

What evidence is there that Mr Parsons could have been cleaning?

52. In a statement prepared by Seawind lawyers, the supervisor Mr Brenton Mahoney says it is at the end of the third week of timber fit out that Mr Parsons was required to help in the detailing and cleaning of the boat, but as the boat was only recently received, cleaning was not part of his duties on 25 August 2008¹⁷. A reasonable inference from this and other comments by Mr Mahoney is Mr Parsons was not carrying out a work-related function and may have been deliberately inhaling the solvent fumes.
53. It is the case the boat had only recently been received in the fit out section of the factory and it is usual for the detailer such as Ms Jones to come onto the boat in the last of the three weeks of this stage. It is she who would have primary responsibility to clean the boat, including the lockers. Ms Jones said when she came on there might be requests made for workers to assist in cleaning the boat. Mr Parsons was according to Ms Jones's statement, engaged as a woodworker and cleaning was not the preferred or normal task. Seawind says these and other observations by witnesses support the view Mr Parsons was not cleaning¹⁸.
54. Among the witnesses Seawind refers to is the evidence of Mr Lofts, who said in his Verifact statement Mr Parsons should not have been cleaning on 25 August as they had just received the boat. He thinks Mr Parsons may also have cleaned the forward bunk on the Thursday or Friday and thought it was unusual as the bunk is cleaned at the end of the cycle.¹⁹ In evidence however, he recalled the blue contact from the bunks had been removed and agreed you could clean it up immediately or leave it. He was unable to remember why he thought it was unusual except that he had been cleaning and agreed it depended what else he had to do²⁰.
55. Seawind refers to the answers given by Mr Scales to WorkCover that he had no idea why Mr Parsons would be working on the inside of the bunk

¹⁷ B/ E vol 2 tab 35

¹⁸ written submissions p 3

¹⁹ Verifact statement para 26-28 B/E vol 2 tab 19

²⁰ T 20/2/12 p 32-33

hatches²¹. He explained in evidence he did not know what stage the boat was at.²²

56. Seawind refers to the statement by Mr Arone there was no glue around on the fibreglass around the hatches and it appeared clean²³. The weight to be given to this statement must be affected by the time available when trying to help Mr Parsons out of the hull and to examine the scene; his assertion that there was no liquid in any of the lockers is inconsistent with the finding of fluid by investigators and there exists a variation in recollection between the WorkCover and Verifact statements. For example, he does not know whether any part of Mr Parsons' body was inside any of the hatches and does not know if he was wearing a mask²⁴, yet in the Verifact statement says he was not wearing a mask and his head and torso was inside the third hatch²⁵.

57. Mr Mahoney's statement that Mr Parsons' duties did not include cleaning on 25 August 2008 does not sit comfortably with several other pieces of evidence --

. According to Senior Constable Holmes, he spoke with Mr Mahoney on 25 August 2008 and was told Mr Parsons had been inside the catamaran using solvents to clean off glue.

. Employee Steine Lofts said Mr Parsons would help out in the detailing/cleaning work if he had nothing else to do²⁶.

. Employee Kalon Scales said it was common practice to "multi task"²⁷; it depended on what timber was available and if Mr Parsons couldn't do anymore with the timber fit out, he would clean in the down time²⁸. According to Mr Scales although there is a general obligation to clean up the mess that a worker may make, there would be resin in the lockers from the previous production stages. He went so far as to say that it never happens that workers completely clean up for themselves and if there was nothing to do they would clean up or they would be instructed to do so.

. Mr Mahoney said in evidence at the inquest although not expecting Mr Parsons necessarily to be engaged in big cleaning jobs on 25 August, it was possible larger cleaning jobs could be undertaken notwithstanding the early stage of the fit out²⁹.

²¹ WorkCover statement B/E vol 2 tab 6 q 45

²² T 21/2/12 p 16

²³ B/E vol 2 tab 12 para 34

²⁴ ibid q28 and 35

²⁵ ibid PARA 21 and 30

²⁶ T 20/2/12 p 30,31

²⁷ T 21/2/2 p 19

²⁸ ibid p16

²⁹ ibid p 109

58. Support for the assertion cleaning is not reserved for the detailers and workers do not always clean up their own mess comes from the observation by Ms Jones that there is a variation in the state of cleanliness of the boats when she goes on board to commence her detailing duties. There is also evidence Mr Rees counselled Mr Parsons about an alleged poor standard of finish to the boat, including an apparent failure to clean off excess carpet glue.
59. Although Mr Mahoney was of the view it was not part of the production stage, he said that if he were cleaning he would have been trying to get ahead of the job³⁰.
60. That cleaning of the port lockers was part of Mr Parsons' duties from time to time comes from the evidence of Mr Scales, who took over the duties in the port hull after Mr Parsons died. He had in that role cleaned the lockers "many times"³¹.
61. There is evidence Mr Parsons was doing some timber fit our work but was also waiting during the morning for the timber frames to be returned to him. He was noted to be talking to several workers during the morning. The evidence points to a conclusion there was time available for Mr Parsons to do some cleaning.
62. Significantly there is also evidence from Mr Verhaaf that after having a chat with Mr Parsons in the morning, Mr Parsons told him he was going to clean the bunks in the port hull³².
63. It is also to be remembered the earlier event in 2008 when Mr Parsons was rendered unconscious occurred when he was cleaning the starboard lockers even though his primary role was carpentry on the port side.
64. The evidence indicates the roles and functions of workers are not tightly confined to a particular stage in the production process. Although it is clear a detailer has primary responsibility for cleaning and at a later stage in the process, staff such as Mr Parsons clean and do so at different stages of the production process. The statement made to Officer Holmes on the morning of the accident that Mr Parsons was cleaning cannot be overlooked nor Mr Parsons' apparent assertion to Mr Verhaaf of an intention to clean. There was certainly no evidence to suggest his cleaning of the bunks or lockers was a task he was not permitted to perform. There is in my view a significant body of evidence Mr Parsons could have been cleaning in the port hull.

The existence of the tin of solvent and acetone in the hull

65. A tin of acetone was found in the hull and a tin of Bostik 9913, which is used for cleaning, was found on top of the forward bunk.

³⁰ Verifact statement para 43

³¹ T 1/2/12 p17

³² WorkCover statement q 22 and Verifact statement par 14

66. Seawind says the evidence is Mr Parsons had solvents with him when it was not necessary for the performance of his duties³³. Mr Mahoney's statement prepared by Seawind lawyers says use of thinners occurs after excess carpet is removed. As this had not happened there was no need for Mr Parsons to have Bostik solvent in his work area on 25 August³⁴. An available inference from this statement is the tin of solvent was not for a work related purpose. The evidence from a number of employees however presents the circumstances in a far less sinister light.
67. Employees including Mr Parsons commonly used tins with holes punched in the lids that were left uncovered with the fumes escaping. Some like Mr Parsons and Eli Jones had their own tins with their names on them while other workers used communal tins. As was noted by Mr Scales, the tins were with you the whole time, not just when detailing.³⁵ Even Mr Mahoney acknowledged at the inquest that Mr Parsons and others routinely kept with them tins of acetone and thinners on board the boat³⁶.
68. Bostik 9133 thinners were commonly used by staff particularly in the fit out stage. There was no system, direction or practice for the location and storage of tins used by employees during the day, at the completion of a particular task or overnight. There is evidence workers may multi task, including cleaning particularly when there is some free time. Staff including Mr Parsons used thinners for a variety of cleaning tasks. It is also clear staff were not given appropriate warnings about the potential serious health risks from exposure to the fumes. These factors strongly suggest the presence of the tins in his primary work place in the port hull was a normal work occurrence and not indicative of an ongoing attempt at deliberate intoxication.

The storage tins

69. Safer plastic squeeze bottles appear to have been available to a few staff, although the numbers appeared limited and there was no enforcement of their use.
70. It is readily apparent the metal containers used by Mr Parsons and other staff was unsafe. There were no lids to stop evaporation and spread of the toxic fumes. There was no system to regulate or restrict the amount of solvent taken from the storage tanks, nor a system to return unused amounts to storage. There was no system for appropriate labelling of containers, despite this issue having been raised in an earlier improvement notices from WorkCover. There was no direction to or training of staff to remove the tins from the hull when they were no longer required.

³³ Seawind submissions p1

³⁴ statement by Mr Mahoney par 15

³⁵ T 21/2/12 p 21

³⁶ 22/2/12 p 111

71. The metal containers were so obviously deficient some staff, to the knowledge of some supervisors, would deliberately hide the containers when they knew a WorkCover inspection was to occur. There is however no evidence to suggest the use of the metal tins was out of the ordinary among workers or was kept to assist in deliberately inhaling the chemical fumes.

The use of solvent as a means to clean

72. Cleaning can involve vacuuming, soapy water and the use of acetone and solvent thinners. Mr Booth said the interior surfaces are generally done with soapy water and if he were cleaning the bunks he would use thinners³⁷. Ms Jones said they would usually reach straight for the acetone and contact thinners and not try the other methods first³⁸. A rag is used with thinners from the tin. Thinners are used to remove glue left from the blue plastic cover when removed from the bunks and also resin from within the lockers. Thinners are according to Eli Jones, used to loosen any hardened pieces of resin.
73. There is nothing on the evidence to suggest thinners as an inappropriate or uncommon method of cleaning.

Earlier accidental or intentional inhalation of fumes

74. Evidence Mr Parsons was previously affected by the fumes might on one view suggest that on 25 August 2008, he was not working but deliberately inhaling the fumes for their intoxicating effect. There are several categories of evidence requiring consideration.

The earlier event when overcome by fumes

75. It is clear Mr Parsons was previously rendered unconscious from inhaling solvent fumes. For reasons shortly explained, the exact date is less clear.
76. On a date prior to his death Mr Parsons was in the starboard hull with fellow worker Kalon Scales. Mr Scales was initially working in the back part of the hull, laying down carpet. Mr Parsons was spraying varnish touch up with an aerosol can in the galley area. He later saw Mr Parsons standing in the first hatch with his head around the open hatch using a rag and wiping the fibreglass bunks. A tin of thinners was next to Mr Parsons, who was not wearing a mask. He does not believe there was at the time a fan blowing air.
77. According to the written account by Mr Scales, Mr Parsons told him he was cleaning and waiting for the varnish to dry. Mr Scales left the area returning about 10 or 15 minutes later to find Mr Parsons fully inside the hatch unconscious with a cut to his nose. He went to get fellow worker Mr Williams. Both were unable to lift him. Mr Williams used an air hose

³⁷ WorkCover statement q65-67

³⁸ Verifact statement para 18

to blow fresh air into the area. They were eventually able to rouse Mr Parsons and get him out of the hull. He appeared drunk, slurring his words, not knowing what was happening.

78. The supervisor Mr Brenton Mahoney was contacted who spoke with Mr Parsons and sent him home for the day. According to Mr Scales, Mr Parsons returned the next day saying he had told his partner Jessica "he'd never touch that stuff again" and would never touch the chemicals again without the proper equipment.
79. Mr Mahoney says this incident happened on 4 June 2008 with a formal warning given to Mr Parsons on 5 June 2008. The family of Mr Parsons suggest it was closer to the fatal accident.
80. The only written record of the earlier event is a handwritten note in Mr Mahoney's diary. He did not advise his supervisors until after Mr Parsons' death. There are some unusual features of the diary entries. Each purport to be initialled by Mr Mahoney and Mr Parsons on the day the entry was created. The wording is however framed as if it was an historical record. For example, "I sent him home for the day"; "after this we went back to work". Mr Mahoney was asked --

Q-. Is it possible Mr Mahoney that when you realised having been told somewhat later how serious it was involving Mr Parsons having been rendered partially unconscious that you went back and put some entries into your diary in relation to the conversation that you had with Mr Parsons after you spoke with Mr Scales and Mr Williams?

A- No not that I am aware of³⁹.

81. Mr Mahoney's statement prepared Seawind lawyers infers his presence in the starboard hull is suspicious, saying, "Parsons had no reason to be on the starboard side as all his work was undertaken on the port side". If this is true then it may add weight to the suggestion the incident on 25 August was a repeat intentional act of inhalation. There was however a noticeable change in Mr Mahoney's evidence at the inquest. He could not explain to the Court why he had said what was recorded. He did not think it was an issue Mr Parsons was on the starboard side, saying if there are no jobs to do, workers sometimes go to different sides of the boat and he may quite possibly have directed Mr Parsons to work on that side⁴⁰.
82. Although the date of the earlier event is in my view uncertain, it is clear he was overcome by solvent fumes and would from this incident have been aware of the possible result of being rendered unconscious. There

³⁹ T 22/2/12 p 118

⁴⁰ T 22/2/12 p 102

is in my view no basis for a conclusion the earlier event on the starboard side was an intentional act of inhaling the fumes.

Whether Mr Parsons and others had been affected on other occasions by fumes.

83. Seawind says Mr Parsons was part of a small group of abusers of chemicals who hid their activities in confined areas and that his death was from this ongoing abuse.

84. It is abundantly clear from the evidence Mr Parsons and other workers had on occasions been affected by solvent fumes or from the contact adhesive used in the application of carpet to the inside of the hulls. It is clear from the witness outline that follows some events were intentional acts. Others occurred when carrying out work duties and viewed as an accepted consequence of working with chemicals.

. Ms Jones was aware within her first year at the factory you could get “high” from inhaling fumes. She refers to events in about 2007 when workers would gather in the hull when carpet glue was being sprayed to obtain the pleasurable high from the vapours. She referred in particular to two events where she was overcome, one being accidental from failing to wear a mask, the other a deliberate act where she was seen to come from the boat trying to strike her head with a chisel. In that case she was taken to a doctor who told her it was “a cheap way to get high”.

. Mr Steine Lofts also became affected by the fumes. Sometimes he would put on a mask and other times he would “push on” with his work without.

. Mr Mark Verhaaf ‘s principal role of spraying contact glue for carpeting produced at times “visitors”, being other workers to the hull who came to see if it was true about the effects of the fumes. He said it seemed to happen a lot when he first started working at the premises. His Verifact statement records that when carpeting, people would want to get high all the years he was there. He had been working there are some 15 years. He said these events happened a couple of times a year. He also acknowledged he would sometimes become affected leading to light-headedness although the fumes would not always affect him. As with several other employees, he said it was easier to carry out his job without wearing a mask.

. Mr Verhaaf said some people would come to see him more than once and would become dizzy and smiley. Those that came regularly not wearing a mask were Mr Scales, Mr Eli Jones and Mr Parsons.

. Mr Kalon Scales rejects the suggestion of being intentionally affected but said when carpeting without a mask he has had the side effects of dizziness, really relaxed but never passed out.⁴¹

. Mr Eli Jones said the effects could sometimes occur from using the solvent yourself or working in close proximity to another worker using the solvent. He had on occasions deliberately not worn a mask to get the “high”. On other times he said it was uncomfortable to wear and he was not in the habit of wearing a mask. It was, he said, common practice for workers not to use a mask when using solvents in the hulls.⁴² He had cleaned the lockers in the port hull some 20 to 30 times. There is no evidence this was done to achieve a “high”.

85. There is also evidence of earlier events involving staff no longer working at the factory that were affected by fumes. Some more recent observations come from apprentice electrical contractor, Mr Stringer who observed Mr Parsons on one occasion in particular “zombie like”. Electrical contractor, Mr Smigulski said there were several occasions in the last 12 months prior to Mr Parsons’ death where he considered Mr Parsons was involved in intentional inhaling of fumes on the aft starboard side. He based his view in part on the strength of the fumes. He had not seen him affected on the port side of the boat. He had seen him with red eyes and staring into space. It appears that Mr Parsons may in any event have been working. He said—

He would just on occasions where the smell would be overpowering the door would be shut to particularly the starboard aft cabin and then Michael would be working in there but the smell would sort of leach out—it would still be annoying being out in the cockpit of the boat
Q—On how many occasions do you think that you observed Michael working on the starboard side?

A-- Probably in the last 12 months before his death probably three or four times⁴³.

86. There is thus evidence other employees accidentally and intentionally exposed themselves to the fumes and Mr Parsons had at times intentionally exposed himself to fumes. Mr Smigulski’s recent observations of Mr Parsons are clearly relevant but comparatively limited in number. There is no evidence this was a daily or indeed weekly event over the many years Mr Parsons worked at the factory.

87. There is substantial evidence that incidental exposure to the fumes was a consequence of the work. Mr Verhaaf sums it up when he said-- “being in a boat working with chemicals is one thing and getting a chemical and sitting in a corner and sniffing is another.”⁴⁴

⁴¹ 21/2/12 p12

⁴² T 21/2/12 p 114

⁴³ T 22/2/12 p 37

⁴⁴ T 21/2/12 p 82

The absence of a mask

88. Mr Parsons was not wearing a mask when found. Is this an indication that he was trying to get a 'high'? Seawind says he was a worker who usually wore his PPE when required and due to health problems with chemicals would have an incentive to wear a mask if he was genuinely cleaning⁴⁵.
89. An examination of the evidence suggests he was not alone in often failing to wear personal protective equipment. Mr Parsons and Mr Scales would not use a mask for spot cleaning⁴⁶. Exactly what the distinction between small and large cleaning jobs is far from clear as is whether staff such as Mr Parsons ever turned their mind to it. Mr Scales was unable to say if cleaning the bunks was a spot cleaning or larger job⁴⁷. The cleaning of the starboard hull lockers when Mr Parsons was rendered unconscious is arguably an example of a larger cleaning job where he was not wearing a mask.
90. Mr Parsons apparently did have health difficulties with some chemicals, although it appeared limited to the resin used in glassing and flow coating. Mr Scales said Mr Parsons would wear a mask when performing that type of work⁴⁸.
91. There is an abundance of evidence indicating Mr Parsons worked in an environment where not using a mask was common among many workers and enforcement was ineffective.

. Reference has previously been made to the failure by Ms Jones to often not wear a mask, even after her incident in 2006 when she was overcome with fumes. She said the failure by staff to wear a mask whilst using chemicals was a regular happening before Mr Parsons' death⁴⁹. The obligation she said was not drilled into you; work areas are sometimes small making it difficult to wear a mask and they were hot causing you to sweat inside and outside the mask.

. Mr Eli Jones failed to wear a mask, saying it was common practice not to wear a respirator in the hull when using solvents⁵⁰.

. The statement of Mr Troy Saunders makes it clear that except for grinding of fibreglass he had never used a mask, as they were uncomfortable.

. Mr Verhaaf's account is most workers did not use masks and he hadn't for most of the boats he had worked on throughout the years he

⁴⁵ Seawind written submissions p5

⁴⁶ T 21/2/12 P 7

⁴⁷ ibid p8

⁴⁸ Verifact statement para 37

⁴⁹ WorkCover statement q 194

⁵⁰ WorkCover statement q 99

worked at the factory, as they were annoying and uncomfortable. The lack of concern about wearing a mask is demonstrated by Mr Verhaaf's account that even with cleaning jobs up to half a day he would only sometimes wear a mask.

. Mr Lofts would wear a mask when it was needed and this somewhat remarkably was determined when he was starting to be overcome by the fumes. Even then there were times when he "pushed through" without a mask even though he was affected⁵¹. For small cleaning jobs he would not wear a mask. For larger jobs, he may forget to wear a mask and would get one if it got too strong. It was he said obvious – "where you started to get dizzy and light-headed, it's that strong it almost makes your eyes water."⁵²

. Mr Lofts' decision to replace the mask was disarmingly simple, yet dangerous. He would replace a mask when he could smell the fumes coming through. Being able to smell the fumes appears in itself troubling with some workers such as Mr Mahoney and Mr Scales confirming that on return from holidays the smell was more noticeable but wore off after a few days. The comments by Professor Whyte concerning desensitisation from chronic exposure to fumes are clearly of relevance.

. Mr Scales' assessment between 2007 and the time of Mr Parsons' death was that people used their PPE when they thought they needed them. It was clearly not considered necessary for small cleaning. He noted he, Mr Parsons and his supervisor would sometimes just grab the chemicals and do the job as the chemicals were always on the boat⁵³.

92. Unlike the action taken by Seawind after Mr Parsons' death, there was no audit as to their use, nor proper instruction as to the appropriate size, fitting or care when not in use. Masks absorb the fumes when left out in the open and there was a failure to provide adequate training as to when the filters were to be changed. Ms Jones initially did not know how to change the filter and she and other staff would blow out their masks with an air hose.
93. The fact Mr Parsons was not wearing a mask at the time he collapsed does not provide support for the suggestion he was deliberately inhaling. A picture emerged of significant non-compliance with wearing masks and other protective equipment and of a lack of effective education of staff and enforcement of the requirement to wear a mask. The evidence paints a markedly different picture to that advanced by the supervisor Mr Mahoney that it was not very often people were not wearing a mask⁵⁴.

⁵¹ T 20/2/12 p 50

⁵² ibid p 34

⁵³ T 21/2/12 p19

⁵⁴ WorkCover statement q 462

The absence of a ventilation fan.

94. Was the absence of a fan in the hull an indication of an attempt to inhale rather than expel the fumes?
95. In 2007, Seawind commissioned a report from hygienists Pickford and Rhyder. It noted that some workers spent extensive periods of time inside the hull of a boat using various resins and glues in small and enclosed areas. It was reported that in some areas the odour of vapour was quite overpowering stating --.
- “It is important to remember that these types of resin and glues must be used in well ventilated areas and that additional ventilation may be required in awkward, small and enclosed areas to reduce the effects of these solvents”⁵⁵
96. Notwithstanding what might be thought as a commonsense and obvious reminder, the ventilation for workers doing cleaning work such as Mr Parsons comprised a couple of small box oscillating fans more commonly seen in residential homes. They were used according to staff for cooling in hot conditions. Workers Allen and Lofts said they had not been given any instruction to use the fans when using solvents. Mr Lofts view that if you had your mask on you didn't have to worry about anything else is testament to the quality of understanding and education about the dangers of working with chemicals. Mr Mahoney said there was a policy requiring fans but it was not routinely enforced⁵⁶.
97. The areas in which some were working at times had open windows and hatches, however as was observed by Professor Whyte, it will achieve little in disbursement of fumes unless there is a difference in air pressure that is needed for airflow.
98. It was only after the death of Mr Parsons that an expert assessment of the effectiveness of the box fans in reducing the fumes and the corresponding risk to employees was obtained. Appropriate extraction fans have now been installed. The view of Mr Ward, director of Seawind that the ventilation system inside the hulls was always considered adequate for the tasks involved is in light of the evidence, difficult to accept⁵⁷.
99. It is clear in my opinion the absence of a fan was not an attempt by Mr Parsons to inhale rather than expel the fumes.

The absence of gloves

100. Was Mr Parsons' failure to wear gloves on 25 August 2008 such a departure from work practice as to suggest he was not intent on working but deliberately inhaling the Bostik fumes?

⁵⁵ B/E vol 6 tab 8

⁵⁶ 22/2/12 p 110

⁵⁷ Brief vol

101. There was from the evidence ineffectual compliance of the need to wear gloves and in some cases inappropriate types of gloves for their use as they would break down when in contact with the thinners. A stark indicator of the lack of education of workers was the accounts by Ms Jones who as a detailer would use thinners regularly and from Mr Lofts that they were never told by management of the dangers of solvent absorption through the skin⁵⁸.

The training, education and supervision of staff.

102. An understanding of the environment in which Mr Parsons worked when it came to glue and solvent use may shed light on how the incident occurred.

103. Education of staff about the dangers of solvents was deficient. Although it is clear some staff were aware inhaling the fumes either intentionally or accidentally might produce a feeling like intoxication, none of the witnesses had been told, as they should have been, of the potentially serious health outcomes, including death.

104. Material Safety Data Sheets should serve an important role in educating workers about the potential dangers of using solvents. The overwhelming evidence is many workers never read them and did not understand the more serious potential health risks. The placement of these sheets on various walls in the factory was at best token compliance with management's obligations and ineffectual in promoting worker safety.

105. The smell of chemicals appears to have been viewed as part of the factory environment. The chemical fumes were at times so strong, electrical contractor Mr Smigulski described it as like "sticking your head in a cupboard and spilling bleach everywhere—it would burn your eyes". His colleague Mr Stringer said the fumes were "overpowering, it hits you like a brick, you use to taste it in your mouth, it would sting your eyes". Mr Eli Jones said the fumes could vary from causing you pleasant effects on occasions to times when they were so strong they made you feel like throwing up⁵⁹. Despite the strength of the fumes and continued use of the chemicals by staff, there was no formal and comprehensive risk assessment and response for the particular tasks undertaken by Mr Parsons and others.

106. Evidence that none of the regular workers at the factory could smell excessive fumes on 25 August 2008 compared to emergency personnel some of whom became nauseas provides some explanation why Mr Parsons did not appreciate the extent of the fumes when working in the hull.

⁵⁸ T 20/2/12 P 47

⁵⁹ T 21/2/12 p 111

107. With no formal training about the proper fitting and care of masks, enforcement of the need to wear a mask when working with chemicals was ad hoc and largely dependant upon a supervisor seeing someone not complying. The consequences of non-compliance gave little encouragement to comply. When Mr Mahoney saw someone using chemicals without a mask, "it was always a tap on the shoulder and come on guys put your masks on"⁶⁰. As Mr Verhaaf said, they were told to wear them if they were caught, "but it wasn't something you were fearful of"⁶¹.
108. The approach taken by supervisors to breaches of safe working practices also provides a context to the incident. Supervisor Mr Chad Booth says he was unaware staff on occasions intentionally inhaled fumes. He was however aware of other workers no longer in the employ who had been affected. He said he had seen Mr Parsons appearing like he was drugged when not using a respirator. He had in earlier years at the company not worn a mask. Mr Smigulski had told him on one occasion Mr Parsons was "off his head". His response when he went to the boat was that it was nothing "extremely bad"⁶². Although Mr Parsons was in his view affected to some degree he did not move him out of the boat, telling him to put on a mask and a fan. He said he reported it to Mr Oste and his co supervisor Mr Mahoney. He asserted belief that the fumes may only cause long term damage is as troubling as his response to the complaint by Mr Smigulski. There was no investigation, risk assessment or disciplinary action.
109. Supervisor Mr Mahoney likewise asserts he was unaware of deliberate inhaling by workers, but is prepared to acknowledge he heard rumours of such a practice⁶³. Even if this is accepted, it is clearly unsatisfactory those apparent suspicions were not relayed to other more senior members of management. His acknowledged failure to tell senior staff of the earlier event involving Mr Parsons was, it is said from his friendship and concern for Mr Parsons' job. Mr Mahoney's assertion that when later told of the serious nature of the event it was too late to do anything is in my view utterly unconvincing. Beyond what is alleged to have been a warning given to Mr Parsons, little encouragement to change behaviour was provided.
110. Senior management was aware of the episode involving Ms Margaret Jones. She was disoriented and holding a chisel. The potential for injury was obvious. This was on any view a serious work place event. Yet there was no formal risk assessment, formal notification of the event to staff and appropriate training or education of staff about the dangers of the fumes and the need to wear appropriate PPE. The earlier event

⁶⁰ T 22/2/12 p 118

⁶¹ T 21/2/12 P 68

⁶² T 22/2/12 p68

⁶³ T 22/2/212 p 116

where Ms Jones said she was affected by contact thinners was she said, met by the then supervisor with a laugh and being told to get some air⁶⁴.

111. There is also reference in the diary of Mr Oste to information provided to him after 25 August 2008 by the production engineer Mr Rees that supervisors and “some of the office staff including the previous OHS manager “ were aware of the existence of the culture of solvent abuse and chemical inhalation”. Seawind’s director, Mr Ward was aware of earlier incidents of intentional exposure to chemical fumes. He noted in his statement that around 2004 they had “some young guys who thought it was clever to sniff the chemicals”. The previous manager, Mr Walkens is said to have addressed the issue by a “hands on approach” and “being there”. The evidence establishes Mr Ward’s asserted belief it has not been an issue since to be in error.
112. There is also more recent evidence of asserted complaints made by the electrical contractor Mr Smigulski to the previous OHS manager, Mr Heggie and then to Mr Oste about inappropriate work practices and the smells of solvents⁶⁵. He said the number of complaints increased in the months preceding Mr Parsons’ death.
113. There is substantial evidence that at least at the supervisor level on the 10 metre line, using solvent without a mask and at times being adversely affected by it was not in either case viewed as a serious breach of safe working practices. It would hardly foster an environment of safety conscious workers when using solvents.
114. It would be unfair to place too much at the feet of the supervisors. It is clear they had very little training in being a supervisor, including the responsibility of enforcing safe work practices and little knowledge themselves about the dangers of the fumes. There were layers of management above them who had an obligation to ensure a safe system of work existed. The supervisors were left in the hapless situation with neither receiving any training to determine if employees under their supervision were being exposed to dangerous quantities of chemicals. Disconcertingly, Mr Mahoney would determine if the atmosphere was unsafe just through smell⁶⁶.
115. It is clear from the statements by Mr Oste and the written submissions where the worker safety programs are outlined that Mr Oste viewed his efforts to improve work place safety were thwarted by the director Mr Ward who in turn disputes the claims. It is unnecessary to resolve the conflict. What is clear is that there was an absence of effective training, education, supervision of staff using solvents and glue and a lack of proper enforcement of relevant safe work practices. It is against this work environment in which Mr Parsons worked that the event on 25 August 2008 falls to be considered.

⁶⁴ T 20/2/12 p 97

⁶⁵ T 22/2/12 p38, 40

⁶⁶ ibid p116

Conclusion on issue 2.

116. Mr Parsons was certainly well aware inhaling of fumes from solvents could produce intoxication to the point of unconsciousness and there is evidence he and several other workers had on occasions sought to deliberately inhale fumes. There is evidence he had at times sought the benefits of carpet glue fumes when he was not carrying out a work function. There is evidence from Mr Smigulski that when he saw Mr Parsons affected by the fumes he was cleaning the boat with a rag that prima facie suggests he was working but also getting a high from the fumes. Although there is some evidence to suggest a deliberate inhalation as a frolic on his own possibly occurred on 25 August 2008, there are a number of factors against this finding. They have been discussed but in summary --

- . The use of a rag with thinners was a normal method of cleaning.
- . The presence of the tins of Bostik 9913 and acetone in the hull was normal work practice.
- . The absence of a mask is consistent with the often-prior practice of Mr Parsons and of numerous staff performing work related tasks.
- . A method of cleaning lockers includes the use of thinners on a rag.
- . A rag with traces of Bostik 9913 was found inside the locker.
- . The presence of the tin of Bostik 9913 used for cleaning found near the front locker is consistent with the stated intention of cleaning.
- . The small box fan used at times by staff was for cooling not ventilation and its use not enforced.
- . The earlier event in 2008 occurred when he had been cleaning the starboard locker.
- . Although it was early to clean in the fit out cycle and the primary person to clean is a detailer, workers may multi task and clean when there is down time.
- . Mr Parsons had some time on his hands.
- . Mr Parsons told another worker he was going to clean the bunks.
- . Cleaning tasks including the bunks was a task he was expected to perform from time to time
- . A worker told Police at the scene Mr Parsons had been cleaning.

. There was no direction that he was not permitted to do the cleaning tasks.

. The position of Mr Parsons within the forward locker is consistent with the practice of cleaning.

. There was a work environment among several co-workers that exposure to solvents was an accepted and incidental part of the work they did.

. Mr Parsons was working in an environment where there was inadequate education, training and supervision of staff in the use of solvents, the potential dangers not appropriately conveyed; among some within management breaches of safe work practices involving solvents was not viewed seriously. A corresponding lack of incentive among a significant number of staff to comply with safe work practices when using solvents and glues existed.

117. It is not simply a case of looking at one factor in isolation. Rather from the combination of the factors and evidence, I am satisfied on the balance of probabilities Mr Parsons was carrying out a work related procedure, namely cleaning of the front locker of the port hull prior to becoming unconscious.

118. It follows from my finding that I do not accept the evidence establishes on balance that Mr Parsons was acting on a frolic of his own or as suggested by Seawind he was going through the motions to deliberately obtain a high. It is at best possible that Mr Parsons anticipated some effect from the chemicals however as discussed above, the environment in which Mr Parsons worked and acceptance of exposure to fumes as incidental to cleaning was such that he would in any event been carrying out his work related duties.

The question of suicide

119. One observation that should be clearly made is there is no evidence at all to suggest Mr Parsons was intending to take his life. There is no evidence of depression or threats of self-harm. He was greatly enjoying having a young child in the family and had plans to work elsewhere in the very near future.

What strategies should have been implemented?

120. To the extent there was a focus by management on safety involving inhalation of fumes, it was primarily reminding staff of the need to wear a mask when staff were detected not wearing appropriate protection.

121. Although not unimportant in any industry where chemicals are regularly used, it is clear the use of a mask is but one of several strategies that should have been implemented. Principles in dealing with chemicals are to be found in a wide variety of sources, for example Material Safety

Data Sheets, Regulations⁶⁷ and views of experts⁶⁸. There are common themes that exist in these sources and are best summed up in the 2006 WorkCover document “control of workplace hazardous substances”⁶⁹. In essence, they are----

- . Obtain and provide information to everyone who needs it
 - . eliminate or control risks by identifying all hazardous substances by doing a work place assessment and determining and applying the controls
 - . The control measures are--
 - . elimination, a reduction of stocks, substitution and isolation from the workplace and from other chemicals
 - . Engineering controls -- use of equipment to reduce the risk of exposure to chemicals; use of exhaust ventilation.
 - . Safe work practices -- change the way people work
 - . Personal protective equipment---always a last resort but in some situations may be the most appropriate
122. In the context of solvents and glues, Seawind failed to implement these strategies in any meaningful way.
123. The Court extends its condolences to the family of Mr Parsons for their loss.

Finding

124. Michael Parsons died on 25 August 2008 at Bellambi, New South Wales from cardiac arrhythmia secondary to cardiac sensitisation caused by acute exposure to chemicals in an industrial solvent whilst cleaning as part of his work related duties the inside forward port hull of a catamaran.

Issue 3.Recommendations

125. Seawind has since installed automatic ventilation fans for use on each boat under construction and has introduced training for employees in the use of PPE and in particular the proper fitting, storage, maintenance and use of masks. There is accordingly no need for specific recommendations on these issues. As raised in issue 1, there is a need for recommendations as to the MSDS and the use of adrenalin.

⁶⁷ See WorkCover submissions p2

⁶⁸ Pickford and Ryder Consulting Report 21 may 2007 B/ E vol 6 tab 8

⁶⁹ B/E vol 8

1. To the Minister responsible for the WorkCover Authority of New South Wales:-
 - a. That the WorkCover Authority of New South Wales issue a Safety Alert advising relevant industry that the effects of inhalation or exposure to high concentrations of the chemicals in Bostik 9913 can include unconsciousness, cardiac arrhythmia and death.
 - b. That the WorkCover Authority of New South Wales issue a Safety Alert to the manufacturer of Bostik Products and the Plastics and Chemicals Industry Association advising that the Material Safety Data Sheets for these products should include, in clear language, that exposure to high concentrations to these chemicals can cause unconsciousness, cardiac arrhythmia and death.

In addition I direct that a copy of these findings, and the reports prepared by Professor Whyte and Phillip Cantrell (*Occupational Hygiene Report for Investigation of a Fatality at Sea Wind Catamarans* by Phillip Cantrell, 23 January 2009), be provided to Bostik Australia Pty Ltd and Plastics and Chemicals Industry Association so that they may consider whether the Safety Data Sheet for Bostik 9913 should be amended to include, in clear language, that inhalation or exposure to high concentrations of Bostik 9913 can cause unconsciousness, cardiac arrhythmia and death.

2. To the Minister for Health, being the department responsible for the NSW Ambulance Service and public hospitals:-
 - a. That the Department of Health consider the issuing of information, advice, education and/or training to ambulance officers and other medical professionals on the dangers of administering adrenalin to patients suffering from acute toluene toxicity.

In addition I direct that a copy of these findings, and the reports prepared by Professor Whyte and Phillip Cantrell (*Occupational Hygiene Report for Investigation of a Fatality at Sea Wind Catamarans* by Phillip Cantrell, 23 January 2009), be provided to the Department of Health to assist in responding to recommendation (2) above.

Ian Guy

Deputy State Coroner

**Wollongong
20 April 2012**