



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25<sup>th</sup> day of January 2018, the 28<sup>th</sup> day of February 2018, the 19<sup>th</sup>, 20<sup>th</sup>, 21<sup>st</sup>, 22<sup>nd</sup>, 23<sup>rd</sup>, 26<sup>th</sup>, 27<sup>th</sup>, 28<sup>th</sup> and 29<sup>th</sup> days of March 2018, the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> days of April 2018, the 20<sup>th</sup>, 21<sup>st</sup>, 22<sup>nd</sup>, 23<sup>rd</sup>, 24<sup>th</sup>, 27<sup>th</sup> and 28<sup>th</sup> days of August 2018 and the 1<sup>st</sup> day of November 2018, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Jorge Alberto Castillo-Riffo.*

*The said Court finds that Jorge Alberto Castillo-Riffo aged 54 years, late of 11 Dingo Road, Aldinga Beach, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 28<sup>th</sup> day of November 2014 as a result of hypoxic-ischaemic encephalopathy. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction and cause of death**

1.1. Jorge Alberto Castillo-Riffo died on 28 November 2014. He was 54 years of age. An autopsy was carried out by Dr Neil Langlois of Forensic Science South Australia on 3 December 2014. In a post-mortem reported dated 19 June 2015<sup>1</sup> Dr Langlois gave the cause of death as hypoxic-ischaemic encephalopathy, and I so find.

### **2. New Royal Adelaide Hospital construction site - 27 November 2014**

2.1. On 27 November 2014 Mr Castillo-Riffo went to work at the new Royal Adelaide Hospital construction site where he had been employed in the construction work for the building of the new hospital. Mr Castillo-Riffo was found at approximately 0700 hours

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<sup>1</sup> Exhibit C75

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by Christopher Hales<sup>2</sup> who was another worker at the site. Mr Hales had entered the area where Mr Castillo-Riffo had been working in order to obtain some materials required by Mr Hales for the job he was performing. He was aware already that Mr Castillo-Riffo had been using a scissor lift for the task of patching holes on the edge of the concrete slab of the third floor of the building. I will provide a more detailed explanation of the exact nature of the task Mr Castillo-Riffo had been performing later in this finding. It is sufficient for present purposes to say that Mr Castillo-Riffo was working on the second floor of the building and that the second floor of the building at that stage was mostly bare concrete with incomplete internal framing and walling, and that the underside of the concrete slab of the third floor was the ceiling of the space on the second floor in which Mr Castillo-Riffo had been working. The building had no exterior walls or windows and work had been commenced upon the installation of the interior second fixings to the extent that a number of internal metal wall frames had been erected and some plasterboard had been installed. Again, I will provide further detail of these matters later in this finding.

- 2.2. Having set the basic scene, I return to the circumstances in which Mr Hales came upon Mr Castillo-Riffo at 0700 hours that morning. Mr Hales, having entered the area in which he knew Mr Castillo-Riffo had been working, noticed a scissor lift that he knew Mr Castillo-Riffo had been using, was in an elevated position towards the underside of the third floor slab. Mr Hales looked up and observed Mr Castillo-Riffo slumped over the top bar of the platform fence of the scissor lift. Mr Hales thought something was not right so he moved into a position to get a better look. He observed Mr Castillo-Riffo's head to be pinned between the top bar of the scissor lift platform fence and the underside of the concrete slab of the third floor of the building. Mr Hales noted that there was no colour in Mr Castillo-Riffo's face, he was motionless and appeared to be dead. Mr Hales said that he looked for the 'emergency handle' on the scissor lift, but he could not find it. He then went and alerted his colleague, Mr Gordon Haig<sup>3</sup>, to come and assist. Mr Haig came across to the scissor lift from the area where he had been working with Mr Hales. Mr Haig started to look for the emergency release. While he was doing that Mr Hales ran to press the emergency nurse call button which was situated approximately 25 metres away. When he returned to the scissor lift he observed that the platform had been lowered approximately a metre. He noted that

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<sup>2</sup> Exhibit C3a

<sup>3</sup> Exhibit C4a

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Mr Castillo-Riffo had been released from the position he had first seen him in and was now lying on the floor of the scissor lift, which was still in an elevated position<sup>4</sup>. Mr Hales said that by the time he returned other people had arrived at the scene and he observed a person climb onto the scissor lift platform, preparing to commence cardio-pulmonary resuscitation (CPR). Mr Hales said that after this medics arrived and took over and provided CPR until an ambulance arrived approximately 10 to 15 minutes later. The above observations come from Mr Hales' first statement which was made on 14 May 2015<sup>5</sup>. In a further statement dated 12 August 2015<sup>6</sup> Mr Hales provided some further detail. In that statement he said that at about 7am he entered the area Mr Castillo-Riffo was working in and saw the scissor lift was raised up high and that Mr Castillo-Riffo's head was pinned between the concrete slab above and the top rail of the scissor lift. He said that Mr Castillo-Riffo was closer to the end of the scissor lift that was nearest the edge of the building. His head was 'slumped over to the left and over the top bar of the scissor lift'<sup>7</sup>. He did not appear to be breathing and he was 'grey as'. He had blood coming from his nose and appeared to be dead.

2.3. In a third statement given by Mr Hales on 8 February 2017<sup>8</sup> he stated as follows:

'When I entered the work area where Jorge had been working on the 27<sup>th</sup> November 2014 and approached the scissor lift I saw Jorge's head was facing down towards the ground on the left top rail of the scissor lift his body was hunched, with his feet facing towards the front of the scissor lift where the platform extends. His body was twisted so it was more in line with his head and horizontal with the left handrail.'<sup>9</sup>

In that passage Mr Hales refers to the front of the scissor lift and the left hand rail of the scissor lift. From other evidence it is clear to me, and I find, that Mr Hales' reference to the front of the scissor lift is a reference to the southern end of the scissor lift which was the end nearest the edge of the building. The reference to the left hand rail is a reference to the hand rail on the left if one were to look at the scissor lift from a position north of the scissor lift, looking south towards the scissor lift. I will explain in greater detail the layout of the building and its orientation to the points of the compass later in this finding.

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<sup>4</sup> Exhibit C3a, page 3

<sup>5</sup> Exhibit C3a

<sup>6</sup> Exhibit C3b

<sup>7</sup> Exhibit C3b

<sup>8</sup> Exhibit C3c

<sup>9</sup> Exhibit C3c, page 8

MPS

- 2.4. Mr Gordon Haig also provided statements and his account is considerably more detailed than that of Mr Hales with respect to the exact position in which Mr Castillo-Riffo was found. Mr Haig's first statement was provided on the day of the incident within hours of Mr Castillo-Riffo's discovery<sup>10</sup>. Mr Haig said that he entered the area from the northern side and saw an elevated work platform<sup>11</sup>. I will refer to the elevated work platform as the scissor lift. Mr Haig noted that the scissor lift was on the southern side of the area and was in a raised position. He saw a male worker on top. He noted that the male was wearing a white hard hat and had a small amount of blood around his mouth. Mr Haig said that his head and body were facing south. His head was wedged between the top bar of the railings of the scissor lift and the concrete slab just above. The man's head was tilting to the left. That aspect of the statement is liable to more than one interpretation. It could mean that Mr Castillo-Riffo's head was tilting to his left, or it could mean that his head was tilting to the left as perceived from Mr Haig's position. From the whole of the evidence, it is clear to me that Mr Haig was referring to the left hand side as perceived by him. This is consistent with other evidence which established that Mr Castillo-Riffo's head was pinned between the left hand railing of the scissor lift as observed from a position north of the scissor lift, looking south. In other words from the position that Mr Haig was in when he first entered the area.
- 2.5. Mr Haig said that Mr Hales told him that he could not find the safety release lever to lower the scissor lift. Mr Haig went to the northern end of the scissor lift to look for the safety release lever and could not find it. He then went to the southern end and was able to see the safety release lever, but because the scissor lift was flush against the safety barrier on the edge of the building, Mr Haig could only lower the 'safety release lever' (sic) to a certain height to avoid crushing his hand<sup>12</sup>. Mr Haig said that as soon as he released the lever the male worker fell backwards onto the scissor lift. His hard hat fell off when he fell.
- 2.6. Mr Haig gave a further statement on 8 December 2014<sup>13</sup>. In this statement he said that the police had shown him an image of a scissor lift and a silhouette of a person that could be manipulated into a position. He said that he assisted Senior Constable Nikolic

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<sup>10</sup> Exhibit C4a

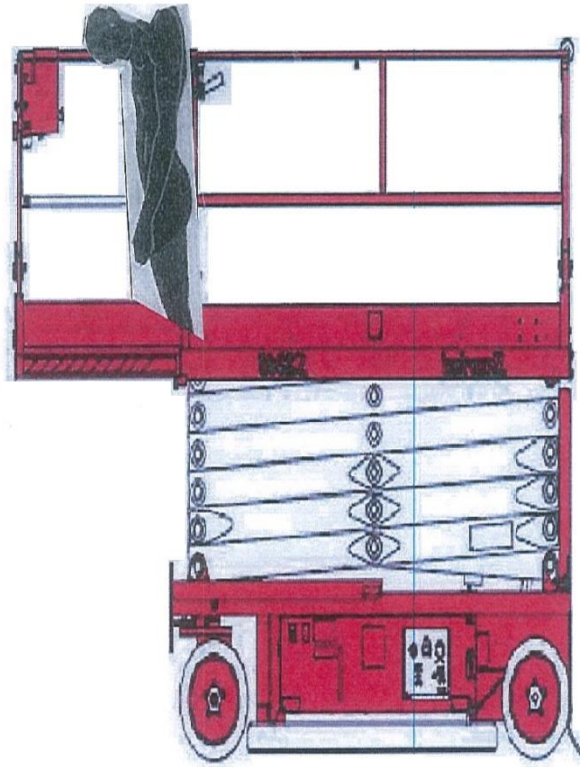
<sup>11</sup> An elevated work platform is a more general term that includes scissor lifts and certain other devices with the capacity to provide a platform to work at elevation

<sup>12</sup> Exhibit C4a, page 3

<sup>13</sup> Exhibit C4b

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in constructing a depiction which represented the position he saw the male person in. He labelled the image as GH1 and I reproduce it below.



- 2.7. Mr Haig stated that ‘the male’s head (face) was oriented to the east’. He said that the top bar of the scissor lift was across the male’s lower nose or mouth as well as his right cheek and that he was wearing his helmet<sup>14</sup>. The image showing the silhouette of a person set out above is the best and most reliable evidence of the position in which Mr Castillo-Riffo was found. I accept the depiction as an accurate representation of the position in which Mr Castillo-Riffo was found, allowing for the limitations of the process of manipulation of such a silhouette. For example, the silhouette is clearly not to scale in relation to the height of the railing of the scissor lift. The accounts of Mr Hales and Mr Haig taken together make it clear that Mr Castillo-Riffo was bending from the hips forwards – as Mr Hales said in his third statement<sup>15</sup>, Mr Castillo-Riffo’s body was ‘hunched’, his feet were facing towards the front of the scissor lift (facing south) and his body was horizontal with the left hand rail<sup>16</sup>. The reference to his body being horizontal with the left hand rail can only be a reference to Mr Castillo-Riffo’s upper body. The height of the rail of the scissor lift was 111.8cm. Thus it is clear that Mr Castillo-Riffo could not have been standing upright and must have been bending at

<sup>14</sup> Exhibit C4b, page 2

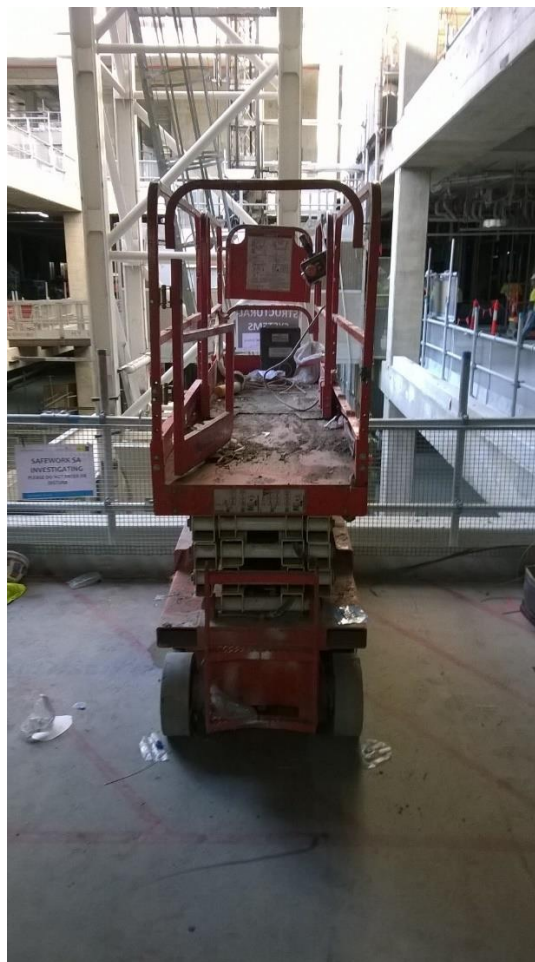
<sup>15</sup> Exhibit C3c

<sup>16</sup> Exhibit C3c, page 8

MPS

the hips so that his torso was horizontal with the hand rail as described by Mr Hales. Thus the silhouette depiction set out above and adopted by Mr Haig is not to be taken literally. I adopt it however as evidence that Mr Castillo-Riffo's head was oriented in such a way that the right hand side of his head was generally against the rail of the scissor lift, and the left hand side of his head was generally against the underside of the third floor concrete slab.

- 2.8. Mr Hales also gave oral evidence at the Inquest. Mr Hales said that when he entered the room he approached the scissor lift from its left hand side by reference to photograph number 2 of Exhibit C60 which is reproduced below.



That photograph is taken from a position to the north of the scissor lift and is facing in a southerly direction. Mr Hales said that Mr Castillo-Riffo's face was facing towards him as he approached the scissor lift from the left hand side. Again this is consistent with the other evidence that Mr Castillo-Riffo was pinned between the rail on the eastern-most side of the scissor lift and the concrete slab above<sup>17</sup>. Mr Hales said that

<sup>17</sup> Transcript, page 697

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Mr Castillo-Riffo's legs were facing 'front ways' but his torso was twisted to the left<sup>18</sup>. I take the reference to 'front ways' to be a reference to the front of the scissor lift, in other words the southern end of the scissor lift.

- 2.9. The oral evidence of Mr Hales was consistent with the accounts provided by him in his various statements and with the accounts provided in the statements of Mr Haig.

### 3. **The resuscitation**

- 3.1. I have noticed that the case notes of Mr Castillo-Riffo were not formally tendered during the Inquest. They were, however, distributed to all parties as part of the brief of evidence that was available before the Inquest. The questioning of Dr Langlois revealed a knowledge of Mr Castillo-Riffo's medical history<sup>19</sup>. I intend to receive the medical records and assign them exhibit numbers. There ought be no disadvantage to any party represented at the Inquest in this course. All had access to the notes as part of the brief. I caused a letter to be written to the represented parties advising of my proposed course of action regarding the casenotes and affording an opportunity to make additional submissions if so advised. Only one party, HYLC, availed itself of that opportunity. The casenotes are relevant, and should be part of the evidence formally before the Court. The exhibit numbers are as set out by footnote.
- 3.2. The South Australian Ambulance Service (SAAS) patient report form<sup>20</sup> indicates that the ambulance service received the call in relation to Mr Castillo-Riffo at 0714 hours. They arrived at Mr Castillo-Riffo's location at 0726 hours. The lead clinician of the four paramedics who attended was Ms Collinhole<sup>21</sup>. When she arrived at the scene Mr Castillo-Riffo was lying on his back on the scissor lift. There was a site nurse on the scene who had placed an oropharyngeal into Mr Castillo-Riffo's airway and two other paramedics were attempting resuscitation. Ms Collinhole applied a neck brace and then placed her hand on Mr Castillo-Riffo's jaw in an attempt to lift his jaw and encourage an open airway. She said she felt her fingers sink into Mr Castillo-Riffo's jaw cavity and knew that his jaw was shattered. She said that, together with the onsite nurse and the other paramedics, CPR was performed on Mr Castillo-Riffo. A number of shocks were administered using a defibrillator. She said that they slid a spinal board and blue slide sheet under Mr Castillo-Riffo before placing him on a stretcher. Once

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<sup>18</sup> Transcript, page 700

<sup>19</sup> Transcript, page 1316

<sup>20</sup> Exhibit C113, page 157

<sup>21</sup> Exhibit C17

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he was on the stretcher he was placed in a SAAS vehicle and conveyed to the Royal Adelaide Hospital. While conveying Mr Castillo-Riffo to the Royal Adelaide Hospital, one of the paramedics continued to perform compressions and Ms Collinhole and another paramedic monitored his airway. She said there was no change in Mr Castillo-Riffo's condition during the trip to the hospital. On arrival at the hospital the paramedics handed Mr Castillo-Riffo over to Dr Mazur who was a member of the Royal Adelaide Hospital resuscitation team that morning. He took over the management of Mr Castillo-Riffo<sup>22</sup>.

- 3.3. A review of the SAAS patient report form shows that five separate 1mg doses of adrenaline were administered to Mr Castillo-Riffo along with 300mg of Amiodarone. He was also cannulated in one of his arms with a saline drip. The SAAS patient report form shows that Mr Castillo-Riffo was in asystole at 0727 hours. There were two episodes of coarse ventricular fibrillation during which shocks were applied. He returned to asystole and in the latter part of the journey to the Royal Adelaide Hospital there was pulseless electrical activity occurring.
- 3.4. Dr Mazur was an emergency physician at the Royal Adelaide Hospital and was on duty as the resuscitation consultant at the Emergency Department on the morning of 27 November 2014. He arrived at the Emergency Department for work as Mr Castillo-Riffo was arriving with the SAAS officers performing CPR. Dr Mazur followed the officers and Mr Castillo-Riffo into a resuscitation room. Dr Mazur received a handover from the SAAS officers. He said that based on the information provided to him, Dr Mazur's initial thoughts were that Mr Castillo-Riffo had collapsed as a result of suffering a cardiac arrest and that the injuries to his head and jaw were the result of his collapse<sup>23</sup>. Dr Mazur said that Mr Castillo-Riffo presented in asystole. At about 0804 hours he was intubated with a tube being inserted into his larynx. He was given intravenous adrenaline over the next 9 to 12 minutes and his chest was decompressed to deal with the possibility of a tension pneumothorax. Treatment was ultimately successful in that Mr Castillo-Riffo regained a cardiac output at about 0812 hours. Mr Castillo-Riffo lost cardiac output again for a period at approximately 0824 hours and chest compressions were recommenced. Cardiac output was regained at 0835 hours. Mr Castillo-Riffo was sent for a CT scan at 0845 hours. It was while that was occurring that Dr Mazur spoke with some of Mr Castillo-Riffo's work colleagues who

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<sup>22</sup> Exhibit C19, page 4

<sup>23</sup> Exhibit C19, page 3

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must have been present at the hospital<sup>24</sup>. This was the first time Dr Mazur became aware that Mr Castillo-Riffo had been working on a scissor lift immediately prior to his collapse and that his head may have become jammed between the roof and the scissor lift. Dr Mazur said that having received this new information he updated Mr Castillo-Riffo's notes to record the fact that the cardiac arrest may have been the result of a traumatic cause rather than a medical cause.

- 3.5. Dr Mazur said that Mr Castillo-Riffo was returned to the resuscitation room at about 0908 hours and transferred to the Intensive Care Unit.
- 3.6. The CT scan revealed hypoxic brain injury with cerebral oedema and the fractured mandible.
- 3.7. A statement was obtained from Dr Strickland who is a Fellow of the College of Intensive Care Medicine and a Fellow of the Australian College of Emergency Medicine<sup>25</sup>. He said that Mr Castillo-Riffo arrived at the Intensive Care Unit at about 1020 hours. He was unresponsive and on a ventilator. He was on a significant dose of adrenaline. Dr Strickland said that the severity of cerebral oedema identified in the initial CT scans was indicative of a prolonged cardiac arrest and very concerning. He said that Mr Castillo-Riffo developed progressive signs of cerebral dysfunction and anoxic brain injury. A subsequent cerebral perfusion scan was consistent with medical brain death and a diagnosis of brain death was ultimately made.
- 3.8. Dr Strickland completed a Medical Report of Death to the Coroner on 28 November 2014. He gave as his opinion as to cause of death:

'Hypoxic encephalopathy post cardio-respiratory arrest from airway obstruction.'<sup>26</sup>

#### **4. The autopsy and the evidence of Dr Langlois**

- 4.1. As I have previously mentioned, Dr Langlois was the forensic pathologist who performed the autopsy upon Mr Castillo-Riffo.

#### **4.2. The involvement of Dr Griggs**

Dr Langlois said that he received a telephone call from Dr Griggs, trauma consultant at the Royal Adelaide Hospital, at around 1030 hours on 2 December 2014, which was

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<sup>24</sup> Exhibit C19, page 5

<sup>25</sup> Exhibit C18

<sup>26</sup> Exhibit C113, page 9

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the day prior to the autopsy. Dr Langlois made reference to this telephone call in his autopsy report dated 19 June 2015 in the following terms:

'At around 1030 hours on 02/12/2014, I received a phone call from Dr Bill GRIGGS (Trauma Consultant, Royal Adelaide Hospital) - he reported that their assessment indicated the deceased had a fractured jaw, but no trauma was identified to have caused his death. The ECG change suggested posterior myocardial ischaemia and the possibility of a cardiac event causing a collapse.'<sup>27</sup>

Dr Langlois was asked about the conversation with Dr Griggs in his oral evidence. He was asked if he saw the ECG change referred to by Dr Griggs, or the ECG itself. He said that he did see various ECGs in the medical notes, but that his ability to interpret them is limited to reading what the computer generates at the top of the report. He said that he was unable to interpret the ECGs and merely accepted the interpretation he had been provided<sup>28</sup>. It was put to Dr Langlois that Dr Griggs appeared to be suggesting that on a reading of the ECG changes the posterior myocardial ischaemia might 'suggest that there was a cardiac event causing the collapse' and Dr Langlois agreed<sup>29</sup>. Dr Langlois was asked if he explored that subject with Dr Griggs and he replied:

'Then he was calling to alert us of this possibility because as we explained in terms of the injuries present these would not account for death and he basically was concerned so that we would not miss the possibility of a heart attack having been involved in the death.'<sup>30</sup>

- 4.3. The evidence also shows that Dr Griggs made contact with a senior Workplace Health and Safety Inspector employed by SafeWork SA, Mr Shane Moss<sup>31</sup>. There is a record of a telephone call received by Mr Moss<sup>32</sup>. The record states that a telephone call was received by Mr Moss on 1 December 2014 at 0900 hours from Dr Bill Griggs (RAH) 'who wanted to inform me that the IP<sup>33</sup> suffered a heart attack. He was unsure if we were aware'. Mr Moss also gave oral evidence at the Inquest. He was asked questions about the contact he received from Dr Griggs. He was not aware whether Dr Griggs was Mr Castillo-Riffo's treating practitioner<sup>34</sup>. He was asked if he conveyed the information he received from Dr Griggs to any other person and responded that he would have conveyed the information to his team leader, Mr Kevin Perry. He was asked what Mr Perry did with the information and he responded that Mr Perry did

<sup>27</sup> Exhibit C75

<sup>28</sup> Transcript, page 1313

<sup>29</sup> Transcript, page 1313

<sup>30</sup> Transcript, page 1313

<sup>31</sup> Exhibit C48

<sup>32</sup> Exhibit C48ao, page 22

<sup>33</sup> This is an acronym for 'injured person' and is a reference to Mr Castillo-Riffo

<sup>34</sup> Transcript, page 2552

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nothing with it at that time<sup>35</sup>. Mr Moss was asked whether he or anyone else from SafeWork SA followed up on the telephone call from Dr Griggs and he replied:

'When you say follow-up on the call, the call was from Mr Griggs (sic) point of view I'm sure a courtesy call to alert us to the fact that the incident may have been the direct result of a heart attack.'<sup>36</sup>

- 4.4. Later Mr Moss was asked whether he determined whether Dr Griggs meant that Mr Castillo-Riffo had had a heart attack and therefore had this accident, or whether Dr Griggs was saying that the accident had caused the heart attack, Mr Moss replied:

'I think Mr Griggs (sic) called me as a courtesy call just to forewarn us that the death of Mr Castillo-Riffo may have been caused because of a heart attack, prior to other injuries.'<sup>37</sup>

- 4.5. Under further questioning about the conversation with Dr Griggs, Mr Moss stated in respect of the conversation:

'It just made me aware that there may have been a heart attack at (sic) the cause of the incident. That that was a possibility.'<sup>38</sup>

- 4.6. That is the sum total of the evidence at the Inquest about Dr Griggs' involvement in this matter. A search of the Royal Adelaide Hospital notes for Mr Castillo-Riffo, to which I have already referred<sup>39</sup>, does not reveal any notation by Dr Griggs to indicate his involvement as a member of the treating team for Mr Castillo-Riffo, nor is his name to be found anywhere in the casenotes for 27 and 28 November 2014 for Mr Castillo-Riffo.

- 4.7. I have previously mentioned the involvement of Dr Mazur. At page 184 of the notes<sup>40</sup> he made the following entry on 27 November 2014 at 1020 hours:

'NB Impt Addit<sup>41</sup>

History from workmates. Was raising himself on scissor lift and caught his head between concrete and top of scissor lift which was jamming him – head sideways. Machine lowered down by workmates and resus started then.

Hence mech: - 2° to trauma – crush, head/neck

- ? carotid occlusion? airway occlusion?

- ? other'

<sup>35</sup> Transcript, page 2552

<sup>36</sup> Transcript, page 2552

<sup>37</sup> Transcript, page 2622

<sup>38</sup> Transcript, page 2668

<sup>39</sup> Exhibit C113

<sup>40</sup> Exhibit C113

<sup>41</sup> Important addition

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- 4.8. A note immediately underneath which appears to have been made by Dr Bautz states:

'Not obvious traumatic cause - ? crushed head but no # seen or mechanical occlusion of neck structures → arrest'

These notes are indicative of the trauma doctors who did treat Mr Castillo-Riffo attempting to work out what was the mechanism of the incident leading to his collapse. It demonstrates that they were unable to find an obvious traumatic cause of Mr Castillo-Riffo's collapse, but were considering that it may have been secondary to trauma or carotid occlusion, or airway occlusion, or to use the words of Dr Bautz, no mechanical occlusion of the neck structures was seen by the treating doctors to lead to the arrest.

- 4.9. Nevertheless, as I have previously noted, Dr Strickland, when completing the Medical Report of Death to the Coroner, gave the cause of death as hypoxic encephalopathy post cardio-respiratory arrest from airway obstruction (the underlining is mine). Thus at least by the time of the completion of that document on 28 November 2014 we may be confident that Dr Strickland thought there was some involvement of airway obstruction that may have precipitated the cardio-respiratory arrest<sup>42</sup>.

- 4.10. Dr Peter Bautz forwarded a final separation summary to Mr Castillo-Riffo's general practice, the Fountain Corner Family Practice<sup>43</sup>, on 1 December 2014 at 1525 hours summarising the admission of 27 and 28 November 2014. The final separation summary<sup>44</sup> gives as the principal diagnosis 'traumatic cardiac arrest' with a complication of 'fractured mandible'. Under clinical synopsis the following appears:

'Mr Castillo (sic) was transferred to the RAH from the nRAH construction site where he was involved Mr Castillo was transferred to the RAH from the nRAH construction site where he was involved in a scissor lift accident resulting in a cardiac arrest at approximately 0715 hours.

He was lowered to the ground by colleagues who then began CPR prior to SAAS arrival, upon which he was found to be in VF arrest and given 2 x shocks. He then reverted to PEA and was transported to the RAH with CPR continuing.

On arrival to the RAH he was in asystole. Mr Castillo (sic) required multiple rounds of CPR and multiple large doses of adrenaline before return of spontaneous circulation was achieved at approximately 0840.

At this time he was deemed stable for a non-contrast PAN CT which demonstrated likely hypoxic brain injury with an associated mandibular fracture. He was transferred to ICU where he had absent brain stem reflexes but preserved respiratory drive. This unfortunately subsided during the following night.

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<sup>42</sup> Exhibit C113, page 9

<sup>43</sup> Exhibit C117

<sup>44</sup> Exhibit C117, page 209

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A CT Brain perfusion scan was performed which showed no cerebral blood flow and he was pronounced brain dead. His ventilator was switched off at 1430 on 28/11/14 and he passed away with his family present at 1440.'

#### 4.11. Conclusions as to the involvement of Dr Griggs

In the submissions in this case by the Hansen Yuncken Leighton Contractor Joint Venture (HYLC) considerable emphasis was placed upon Dr Griggs' involvement. From the above summary that I have provided it is clear that at no time did Dr Griggs proffer an opinion that Mr Castillo-Riffo suffered a cardiac arrest prior to his entrapment between the scissor lift and the concrete slab. He merely alerted, first Mr Moss, and then Dr Langlois, to the possibility that that had been the sequence of events. The submissions of HYLC assert that Dr Griggs was of the opinion that there was a cardiac event prior to the crushing incident<sup>45</sup>. There was no such opinion expressed by Dr Griggs. It was also suggested in the submissions that Dr Griggs 'treated the cardiac problem that led to Mr Castillo-Riffo's death'<sup>46</sup>. There is nothing to suggest that Dr Griggs treated Mr Castillo-Riffo at all. There is simply no evidence to support that contention. HYLC also submitted that Dr Griggs 'considered it (the cardiac arrest) occurred prior to the crush injury'<sup>47</sup>. There is no evidence that Dr Griggs was of that opinion. As I say, the highest the evidence in respect of Dr Griggs gets is that he alerted first the SafeWork SA investigator and secondly, and more appropriately, the forensic pathologist to the possibility of a cardiac involvement.

#### 4.12. Mr Castillo-Riffo's cardiac history

Mr Castillo-Riffo's medical records reveal two episodes, one in 2009 and one in 2012, that might be regarded as having some cardiac involvement. On careful analysis neither of them should be so construed. Unfortunately, Dr Langlois appeared not to be aware when giving evidence of the second of those instances – in 2012. Nevertheless, he demonstrated a clear understanding of the investigations that had been performed in the past and stated that those investigations 'indicated no evidence that he'd had a heart attack in the past'<sup>48</sup>.

4.13. It is interesting to note that both the 2009 and 2012 episodes occurred within a short period after Mr Castillo-Riffo had long flights in aircraft. On 26 March 2009 he presented to his general practitioner at the Fountain Corner Family Practice<sup>49</sup>. The

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<sup>45</sup> HYLC Submissions, page 47

<sup>46</sup> HYLC Submissions, page 48

<sup>47</sup> HYLC Submissions, page 48

<sup>48</sup> Transcript, page 1303

<sup>49</sup> Exhibit C113, page 33

MFS

general practitioner referred him by ambulance to the Royal Adelaide Hospital with a letter noting that he was suffering ‘acute chest pain radiating into back’. The letter recorded that the pain had commenced at 8:30am that morning and increased throughout the morning. It was severe on deep inspiration. There was no cough and no vomiting and he presented at the surgery at 1:20pm sweaty and pale and with tachycardia. The letter noted that he had flown from Perth in a plane three days previously. The letter noted that IVT had been commenced, GTN spray had been given with nil effect and his blood pressure was <sup>151</sup>/<sub>127</sub>. The letter then stated ‘???PE’<sup>50</sup>. Mr Castillo-Riffo duly presented to the Emergency Department that same day at 1359 hours. A discharge letter is to be found at page 34 of Exhibit C113. It states that the presenting problem was ‘CVS – chest pain, left sided radiating to back’. The discharge note stated that on examination Mr Castillo-Riffo had normal observations, that Troponin and D-dimer were negative. A chest X-ray showed no abnormalities. He went on to have a VQ scan which did not show any evidence of pulmonary embolus. His ECG was normal sinus rhythm with no acute changes. He was managed with analgesia and discharged home.

- 4.14. That is all of the information available in respect of the incident in 2009. On admission, Mr Castillo-Riffo’s symptoms might have been postulated to be cardiac or pulmonary embolus. Both possibilities were excluded by the doctors at the Royal Adelaide Hospital, and he was duly discharged with no follow-up plan. Properly analysed, this cannot be described as a cardiac incident for the purposes of Mr Castillo-Riffo’s medical history.
- 4.15. The 2012 incident is to be found in the Noarlunga Hospital casenotes<sup>51</sup>. In that case it is recorded that Mr Castillo-Riffo presented at the Noarlunga Hospital on 28 April 2012 complaining of chest pain and shortness of breath. Three days previously he had flown to Australia from Chile on a 28 hour flight and noticed calf pain when getting off the flight. He had developed chest pain and shortness of breath and the pain went across the centre of the back and the base of the neck. ECGs were normal. Duplex ultrasound of both leg veins detected no deep venous thrombus. Mr Castillo-Riffo was examined by a doctor and no abnormalities were detected and he was sent home. On no view could this episode be described as having resulted in a diagnosis of a cardiac problem.

<sup>50</sup> PE is an acronym for pulmonary embolism

<sup>51</sup> Exhibit C115, page 34

MPS

4.16. Mr Castillo-Riffo's complete blood exam on 28 April 2012 showed total cholesterol of 7.2. His Fountain Corner Family Practice notes reveal the following cholesterol levels: 19 June 2008 - 7.8, 9 September 2009 - 7.9, 23 July 2010 - 6.7 and 13 September 2013 - 7.5. These results do not alter Dr Langlois' conclusions that the histological examinations of the heart were normal<sup>52</sup>, that 'the post mortem examination revealed no evidence of a classical heart attack'<sup>53</sup>, that 'there was no definite abnormality to indicate a cardiac event had occurred prior to becoming trapped'<sup>54</sup> and the findings as to the cardiovascular system<sup>55</sup>. I reject the submission of HYLIC which described these incidents as 'two cardiac incidents'<sup>56</sup>.

4.17. Dr Langlois' autopsy report and other reports

In his autopsy report<sup>57</sup> Dr Langlois recorded the significant findings as:

1. Left jaw fracture
2. Haemorrhages strap muscles neck (right more than left)
3. Haemorrhages deep to thyroid gland
4. Haemorrhage into right carotid sheath
5. Patchy bruising under scalp
6. Coronary arteries patent
7. Haemorrhage papillary muscle heart - attributed to resuscitation
8. Haemorrhage anterior pericardium and rib fractures - attributed to resuscitation'

As I have said, Dr Langlois gave the cause of death as hypoxic-ischaemic encephalopathy which in itself is not particularly informative. Dr Langlois went on under the heading 'comments' to say that the underlying cause of the hypoxic-ischaemic encephalopathy was not clear. He said that it could have resulted from cardiac arrest. Dr Langlois noted that there was left anterior coronary artery tunnelling into the myocardium which was not an unusual finding. He said that the tunnelling was not sufficient in length and depth to be regarded as significant and there was no scarring of the left ventricle to suggest impairment of blood supply to the heart in the past. He noted the haemorrhage to the anterior papillary muscle without evidence of myocardial necrosis or inflammatory reaction. He said the cause was unclear but likely represented the consequence of cardiac arrest and subsequent resuscitation.

4.18. Dr Langlois said there was no definite abnormality to indicate that a cardiac event had occurred prior to Mr Castillo-Riffo becoming trapped by the scissor lift. However, he

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<sup>52</sup> Exhibit C75a

<sup>53</sup> Exhibit C75b, page 3

<sup>54</sup> Exhibit C75, page 3

<sup>55</sup> Exhibit C75, page 5

<sup>56</sup> HYLIC Submissions – page 49

<sup>57</sup> Exhibit C75

MPS

acknowledged that a formal cardiac examination was not performed. In his oral evidence Dr Langlois said that at the time of the autopsy he was of the opinion that the autopsy he would perform, which involved taking multiple sections of the heart, would be a sufficient examination<sup>58</sup>. HYLIC levelled some criticism at Dr Langlois for not having directed a special heart examination in this case. In my opinion that criticism is misguided. A special cardiac examination is only ever directed by the examining pathologist and in this case Dr Langlois was clearly of the opinion that it was not necessary.

- 4.19. I return to Dr Langlois' comments in the post-mortem report. Dr Langlois said that even in the absence of a detectable abnormality of the heart, there was a possibility of an abnormality of the electrical function of the heart which needed to be acknowledged. He discussed the nature of such electrical syndromes or channelopathies and noted that they can cause sudden death through uncoordinated contraction of the heart muscles such that the heart can no longer pump. Dr Langlois noted, quite properly, that a spontaneous cardiac arrhythmia could not be excluded in Mr Castillo-Riffo's case. Thus Dr Langlois left open the possibility of a cardiac event preceding Mr Castillo-Riffo's entrapment.
- 4.20. On the other hand Dr Langlois noted that the description he had been provided of Mr Castillo-Riffo's position, together with the observation of external injuries on the external surface of the right side of the neck, deep bruising of the neck (involving the muscles) and the fracture of the jaw were suggestive of Mr Castillo-Riffo's neck having been compressed. Dr Langlois noted that sustained compression of the neck will cause rapid unconsciousness (in around 10 to 30 seconds) if the carotid arteries are occluded. Cardiac arrest will then follow if the compression is not relieved. Sustained compression with subsequent cardiac arrest would cause hypoxic-ischaemic encephalopathy.
- 4.21. Dr Langlois noted that neuropathological examination of Mr Castillo-Riffo's brain did not identify any pathology that may have been a cause for him becoming incapacitated.
- 4.22. Under the heading of 'noteworthy recent trauma' Dr Langlois remarked upon an abrasion on the right side of the neck in the region of the carotid artery on that side. He

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<sup>58</sup> Transcript, page 1312

MFS

also noted on the left side of the neck an ill-defined area of erythema, also in the region of the carotid artery. As to the neck, he summarised the position as follows:

'Patchy haemorrhage along height of right sternomastoid muscle extending into lateral aspect of right carotid sheath (but not into carotid sheath). Haemorrhage 9 x 4 cm over left body of mandible. Haemorrhage deep to left and right lobes of thyroid gland (more marked on the left).'<sup>59</sup>

- 4.23. In summary, in his post-mortem report Dr Langlois adopted a neutral position offering two possible explanations of the event that precipitated the hypoxic-ischaemic encephalopathy – either a cardiac event of which there was no evidence at autopsy, or neck compression.
- 4.24. Some 18 months later on 2 December 2016 Dr Langlois made a statement to SafeWork SA Inspector Vinall<sup>60</sup>. In that statement he made reference to his post-mortem report, a copy of which was attached to the statement. He also made reference to the medical records from the Royal Adelaide Hospital pertaining to the investigation for pulmonary embolus following chest pain in 2009, a copy of which was also attached to his record of interview.
- 4.25. In the record of interview Dr Langlois referred to his post-mortem report and his reference to the possibility of cardiac arrest due to an arrhythmia. He then stated as follows:

'However, in the absence of a preceding history of syncope or other symptoms (other than one episode of chest pain) at the age of 54 I would consider it unlikely that there had been a cardiac event/arrest through an electrical or other medical issue, just prior to the deceased's head becoming trapped between a concrete roof and the top rail of the scissor lift with his head sideways.'<sup>61</sup>

Dr Langlois then noted that there was no definite evidence of a cardiac event having preceded Mr Castillo-Riffo's entrapment. He noted the position of Mr Castillo-Riffo's body as described in the statement by Mr Haig and said that statement, together with Dr Langlois' observations of the deep bruising of the neck and the fractured jaw, suggested a likelihood that the carotid arteries had been occluded, thus causing the cardiac arrest and the hypoxic-ischaemic encephalopathy. He noted that no pathology or testing could establish that the carotid arteries had been occluded.

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<sup>59</sup> Exhibit C75, page 8

<sup>60</sup> Exhibit C75d

<sup>61</sup> Exhibit C75d, page 2

MPS

- 4.26. Comparing Dr Langlois' statement to Ms Vinall with the initial post-mortem report of 19 June 2015 one can observe that in the interview with Ms Vinall he appears to have moved more firmly in favour of a conclusion that Mr Castillo-Riffo's hypoxic-ischaemic encephalopathy was caused by neck compression rather than by a cardiac arrest.
- 4.27. Dr Langlois' next expression of opinion in this matter took the form of a supplementary report dated 19 January 2017<sup>62</sup>. That report stated that Dr Langlois had re-examined the histological sections that he had taken from Mr Castillo-Riffo's heart. The report continued:
- 'The 12 sections of left ventricle wall (four quadrants sampled at three levels) are normal. The samples that include the haemorrhagic appearing papillary muscle (blocks N, AF and AG) show interstitial haemorrhage and early degenerative change of myocytes (cytoplasmic alteration with loss of nuclear staining) with only a focal, very minor acute inflammatory reaction. The samples from the right ventricle (4 blocks) are normal with no features of cardiomyopathy. The samples including the mitral valve, tricuspid valve, left atrial wall and right atrial wall are normal.'<sup>63</sup>
- 4.28. Dr Langlois was asked about the circumstances in which he re-examined the histological sections. He said that he did so following contact he had received from a number of different lawyers involved in prosecutions flowing from the death of Mr Castillo-Riffo.
- 4.29. Dr Langlois prepared a further supplementary report on 2 February 2017<sup>64</sup>, this time in response to a request for clarification of some matters made by Kelledy Jones Lawyers who were acting for SafeWork SA in the prosecution proceedings. Dr Langlois repeated his observations about the bruising to the neck and the underlying structures of the neck and the jaw fractures, but omitted to mention the witness statements he had previously listed. He stated that the autopsy observations were 'in keeping with compression of the neck having occurred'. He then said that the overall pattern of bruises under the scalp on the left and bruising of the right carotid sheath suggested the left side of the head was under the concrete slab and the right side was against the railing of the scissor lift. It is important to note that in the original autopsy report dated 19 June 2015 Dr Langlois had stated that he had been informed that the left side of Mr Castillo-Riffo's head/neck was against the scissor lift. Thus his assertion in this

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<sup>62</sup> Exhibit C75a

<sup>63</sup> Exhibit C75a

<sup>64</sup> Exhibit C75b

MPS

supplementary report is saying the opposite, namely that the right side of the head/neck was against the railing of the scissor lift. In the supplementary report Dr Langlois provides no explanation of his change of view on this subject. This was a matter for which he was later criticised and I will deal with it presently.

- 4.30. In the supplementary report dated 2 February 2017 Dr Langlois went on to say that from the witness statements and post-mortem findings it is possible to suggest the hypoxic-ischaemic encephalopathy resulted from compression of the neck by entrapment. He said that compression of the neck alone could have been responsible, or compression of the neck resulting in cardiac arrest which itself completed the hypoxic-ischaemic encephalopathy due to failure of circulation. He said in either case the initial and causing event would be the compression of the neck.
- 4.31. Dr Langlois went on to note that if Mr Castillo-Riffo had suffered a cardiac event resulting in failure of circulation prior to being trapped, minimal to no bleeding would be expected into the neck and thus the bruising that he noticed at post-mortem would not have been evident. However, the situation was complicated by the restoration of circulation while in hospital and this prevented a determination at post-mortem of whether cardiac arrest preceded or followed neck compression.
- 4.32. Dr Langlois next stated that the post-mortem examination itself could not determine which of the possibilities, namely neck compression alone or neck compression followed by cardiac arrest, or cardiac arrest followed by neck compression, occurred. Dr Langlois then rehearsed his previous observations that there had been no evidence of a classical heart attack, but that this did not rule out the possibility of abnormal electrical conduction leading to sudden arrhythmia and resultant cardiac arrest. He noted that a cardiac event could cause a drop of blood pressure which could cause faintness, light-headedness, impairment of vision, impairment of hearing and confusion which could progress into unconsciousness with loss of awareness and collapse due to loss of muscle tone.
- 4.33. He ended with the observation that ‘in my opinion, it is not possible from the statements and post-mortem findings to determine how Mr Castillo-Riffo came to be trapped’<sup>65</sup>. That last observation represents a change of position from Dr Langlois’ opinion as

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<sup>65</sup> Exhibit C75b

MPS

expressed in his interview with Ms Vinall<sup>66</sup>. Thus by 2 February 2017 Dr Langlois has moved from the opinion expressed in the interview with Ms Vinall in which he was favouring neck compression leading to cardiac arrest, to now be saying that it was not possible to say one way or the other what came first, the cardiac arrest or the neck compression.

4.34. Finally, Dr Langlois provided a further supplementary report in response to a request from counsel assisting me. This report is dated 7 March 2018<sup>67</sup>. Counsel assisting asked two questions of Dr Langlois – how long might Mr Castillo-Riffo have been trapped? and are you able to determine what time he went into cardiac arrest?

4.35. In his response, Dr Langlois said that from his findings at post-mortem he could not perceive a method to estimate how long Mr Castillo-Riffo had been trapped, but that in the absence of such a method it may be possible to estimate the time interval from evidence in the literature. He then went on to state that the duration of entrapment ‘must have been long enough to cause his heart to stop, but not so long that it was not possible to restart it by resuscitation’<sup>68</sup>. The significance of that remark is that it contains an assumption on the part of Dr Langlois that the entrapment caused the heart to stop. This is at odds with the position he expressed in his immediately preceding supplementary report dated 2 February 2017 in which he appeared to be of the opinion that he could not express a view one way or another about whether entrapment preceded cardiac arrest or whether cardiac arrest preceded entrapment. Thus, one might say that Dr Langlois had once again shifted his opinion.

4.36. More helpfully, Dr Langlois expressed an opinion on the matter of timing about how long after cardiac arrest there would be an opportunity to restore circulation. He expressed the opinion that once Mr Castillo-Riffo had passed into cardiac arrest the opportunity to restore his circulation would have been short, which suggested that cardiac arrest would have occurred close to the time he was found.

4.37. Dr Langlois’ oral evidence

Against the background of the rather confusing shift of opinion in the succession of reports recording Dr Langlois’ opinions, he came to give his oral evidence. In evidence-in-chief Dr Langlois was asked whether it was possible that Mr Castillo-Riffo

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<sup>66</sup> Exhibit C75d

<sup>67</sup> Exhibit C75c

<sup>68</sup> Exhibit C75c

MPS

had the cardiac event before the entrapment<sup>69</sup>. Dr Langlois responded that this was a problem with a post-mortem and said that it was possible for cardiac arrest to precede the entrapment. He then went on to pose the question 'was there any reason why [Mr Castillo-Riffo] should have had a heart attack' and he said 'the honest answer is no'<sup>70</sup>. He then explained his reason for that. He noted the tunnelling of one of the coronary arteries but explained that it was not significant. He noted that Mr Castillo-Riffo did not have significant coronary artery disease and said that in his opinion there was no structural reason for Mr Castillo-Riffo to have had a heart attack<sup>71</sup>. He then acknowledged that certain mechanisms of heart attack may not leave physical evidence for discovery at post-mortem examination, but went on to say:

'.. but to put it bluntly I could get a lottery ticket and I could win the lottery but you really don't expect it and that's really where we are. Yes, he could have had a cardiac event leading to confusion, leading him to fall into exactly the position where then by (sic) he subsequently manages to rank up the machine and trap his neck. So you're saying that it's an unlikely event that he's had a heart attack and then that's resulted in the unlikely event that he's managed to trap his neck, which has then caused him to then collapse and have a cardiac arrest, a complete cardiac arrest not that long before he's found.'<sup>72</sup>

- 4.38. Under cross-examination by counsel for HYLIC, Dr Langlois was asked why he did not arrange for a formal cardiac examination to be performed and, as I have already stated, he responded that he was of the opinion that it was not necessary<sup>73</sup>. He was asked about his interaction with Dr Griggs which I have already detailed above. He was also asked whether he was aware of two episodes in the past of chest pain because his interview with Ms Vinall<sup>74</sup> mentioned only one episode. Dr Langlois said that he thought that the episode he was referring to was the one which occurred in 2009<sup>75</sup>. He was asked if it was possible that he was not aware of an incident in 2012 and he acknowledged that he may not have been<sup>76</sup>.
- 4.39. The next stage of the cross-examination dealt with the discrepancy between his autopsy report dated 19 June 2015<sup>77</sup> and his supplementary report dated 2 February 2017<sup>78</sup> as to which side of Mr Castillo-Riffo's neck was against the rail of the scissor lift<sup>79</sup>. It was

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<sup>69</sup> Transcript, pages 1300-1301

<sup>70</sup> Transcript, page 1300

<sup>71</sup> Transcript, page 1301

<sup>72</sup> Transcript, page 1301

<sup>73</sup> Transcript, page 1312

<sup>74</sup> Exhibit C75d

<sup>75</sup> Transcript, page 1315

<sup>76</sup> Transcript, page 1316

<sup>77</sup> Exhibit C75

<sup>78</sup> Exhibit C75b

<sup>79</sup> Transcript, pages 1317-1333

MFS

suggested to Dr Langlois that at the conference with the prosecuting lawyers, Kelledy Jones, he was told something different as to which side of the head was against the scissor lift. He responded by saying he did not remember being told that the head was oriented the other way, but that:

'I just remember that it was an issue and as I said it was the first time I've actually been asked 'What side do you think he was on!.''<sup>80</sup>

Dr Langlois was asked whether he then changed his mind about the pattern of injuries and he said that he did not change his mind about the pattern of injuries, but that in the first post-mortem report he had simply accepted what he was told as to the orientation of the head. Dr Langlois attempted to explain the situation by saying that in the first post-mortem report he did not interpret the injury patterns with a view to determining the orientation of Mr Castillo-Riffo's head, but that he merely documented what he had been told and then documented his findings<sup>81</sup>.

4.40. I note that if that is what happened, it would mean that Dr Langlois had overlooked at the time of writing the autopsy report that his observations about the pattern of injury were different from the orientation of the head as described in the witness statement. That would be a matter of concern.

4.41. Dr Langlois said that having been asked at the meeting with Kelledy Jones Lawyers which way he thought the head was oriented, he went away and thought about it and decided that the pattern of injuries that he had observed at the autopsy were suggestive of the orientation which he described in the report on 2 February 2017<sup>82</sup>. Unfortunately Dr Langlois became rather agitated at this point in his evidence. He said that he had been doing 'this job' a long time and had seen a lot of things that he would think were impossible and did not make sense, and that he would not necessarily remark in a post-mortem report a conflict between the view of an eyewitness and his own conclusions. He stated:

'So I'm not determining it; I'm taking a punt, I'm flipping a coin and I'm saying if I flick that coin it's going to come down more often on the right side than the left but it's a punt. It's my best guess. It is not necessarily correct and therefore I think as the Coroner has correctly stated we are making a lot of suppositions and we don't know.'<sup>83</sup>

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<sup>80</sup> Transcript, page 1320

<sup>81</sup> Transcript, page 1322

<sup>82</sup> Exhibit C75b

<sup>83</sup> Transcript, page 1324

MPS

- 4.42. In his original post-mortem report<sup>84</sup> Dr Langlois had observed that from the position of Mr Castillo-Riffo as it had been described to him with the left side of his head against the scissor lift:

'From his position, he would have been able to reach the controls that were on the opposite side of the scissor lift.'<sup>85</sup>

- 4.43. Under cross-examination he was asked whether in 2017 his change of position about the orientation of Mr Castillo-Riffo's head was affected by what he was told at the meeting with Kelledy Jones Lawyers about whether Mr Castillo-Riffo could reach the controls. Initially Dr Langlois was somewhat combative<sup>86</sup> but ultimately denied that he would change his opinion because he was asked to do so or because there was any pressure on him<sup>87</sup>. He then elaborated as follows:

'As you possibly noticed, I hope, at the beginning of this procedure, I affirmed, and that is because the evidence I give and what I present is, to my belief, true, and the truth that I give you is that I was asked the question and I gave an opinion which, to be perfectly honest, is only slightly better than a guess, really, in this circumstance, as to which side his head was on, based on the post-mortem report.'<sup>88</sup>

- 4.44. Dr Langlois did say that he accepted the possibility that during the course of the discussion with Kelledy Jones Lawyers there may have been 'a suggestive idea that he was the alternative side down'<sup>89</sup>, but that Dr Langlois still believed that on his findings at autopsy the right side of Mr Castillo-Riffo's head had been against the bar which was the position he described in the supplementary report of 2 February 2017<sup>90</sup>,

- 4.45. It was put to Dr Langlois that there is a difference between his two reported positions and that he did not describe in the second report how and why he made the change of opinion. The fact of the matter is that the supplementary report does not disclose that the opinion he reached was different from the observation described in the autopsy report and Dr Langlois was unable to provide a satisfactory explanation of that in his evidence<sup>91</sup>.

- 4.46. Dr Langlois reaffirmed that the time between Mr Castillo-Riffo's cardiac arrest and his rescue must have been short and only in the order of a few minutes<sup>92</sup> and that by rescue

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<sup>84</sup> Exhibit C75

<sup>85</sup> Exhibit C75, page 2

<sup>86</sup> Transcript, page 1330

<sup>87</sup> Transcript, page 1331

<sup>88</sup> Transcript, page 1331

<sup>89</sup> Transcript, page 1333

<sup>90</sup> Exhibit C75b

<sup>91</sup> Transcript, page 1333

<sup>92</sup> Transcript, page 1343

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he meant the commencement of chest compressions<sup>93</sup>. Dr Langlois concluded his oral evidence by agreeing that the placement of Mr Castillo-Riffo's head did not make any difference to his ultimate opinion about the mechanism of death on the basis that it did not make any difference to the mechanism of entrapment which side of the head was on one side of the two opposing forces and which side was on the other<sup>94</sup> because the real point is that the compression itself is what causes the occlusion<sup>95</sup>.

4.47. My conclusions as to Mr Castillo-Riffo's mechanism of death

As I have previously mentioned, counsel for HYLIC in closing submissions mounted a strong attack on Dr Langlois' evidence. I have already referred to aspects of HYLIC's attack on Dr Langlois above, and have discounted those criticisms. However, there is no doubt that the succession of reports produced by Dr Langlois invited a certain amount of criticism. The failure by Dr Langlois to properly explain in his supplementary report dated 2 February 2017<sup>96</sup> the fact that he had then reached an opinion about the position of Mr Castillo-Riffo's head that was different to the observations stated in the first post-mortem report dated 19 June 2015<sup>97</sup> certainly warranted criticism. Dr Langlois never satisfactorily explained why he did not in the second report explain the inconsistency between the two reports. Although he did not suggest it, one might note that the first report ascribed the head position to the statement of an eyewitness and the second report ascribed it to Dr Langlois' observations at autopsy, and thus there was no change of opinion. But that would be a superficial and glib explanation at best. Another possibility is that by the time he came to write the second report Dr Langlois had forgotten what he had written in the post-mortem report and did not go back and thoroughly check it. If that were the case, he ought to have acknowledged it squarely and admitted the error. He did not do so.

4.48. As Dr Langlois said in answer to a question in re-examination, the position of Mr Castillo-Riffo's head between the two opposing forces, namely the slab and the scissor lift rail, made no difference to the compressive forces that he was subjected to and therefore one might say that it did not matter. Strictly from the point of view of the compressive effects of the two combined forces that is true. Nevertheless, one expects a post-mortem report to be accurate in all respects, and if a pathologist thinks that there is medical evidence to suggest that information he was provided at the time of autopsy

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<sup>93</sup> Transcript, page 1343

<sup>94</sup> Transcript, page 1345

<sup>95</sup> Transcript, page 1345

<sup>96</sup> Exhibit C75b

<sup>97</sup> Exhibit C75

MPS

about the orientation of the deceased's head in a case such as this was wrong or possibly wrong, it is a matter that the forensic pathologist is duty bound to alert the Coroner to.

- 4.49. Dr Langlois was not challenged in respect of the medical observations that he made and his documentation of Mr Castillo-Riffo's injuries and the condition of his heart, mandible and other scientific observations made in the autopsy process. As counsel for HYLC submitted, the question of whether the cardiac event preceded the entrapment or whether the entrapment preceded the cardiac event is one for the ultimate decision maker, namely the Court in a case such as this. Dr Langlois acknowledged that there was no medical principle or finding upon which he could categorically base an opinion on that subject and in hindsight it may be better that he had never attempted to do so.
- 4.50. Thus I do not rely on Dr Langlois' evidence for the purposes of determining whether the cardiac arrest preceded the entrapment or vice versa. If a conclusion can be reached about that matter at all, it is a conclusion to be reached by the Court. However, in saying this, I cast no doubt on Dr Langlois' findings that there was no abnormality of the heart to indicate classical heart attack. HYLC attacked Dr Langlois' cardiac expertise. I reject that criticism. A heart examination is a fundamental aspect of an autopsy. Dr Langlois was certainly qualified to express the opinions he did about Mr Castillo-Riffo's heart. This was not a case that required a special heart examination, nor a cardiologist's opinion.
- 4.51. In its submissions, HYLC argued that preferring one hypothesis over the other is a matter for sound evidence and not guesswork, and that there is no firm evidence one way or the other to prefer one hypothesis over the other. HYLC submitted that no finding should be made on this subject. On the other hand, in its closing submissions SafeWork SA urged that the evidence overwhelmingly supports that the death by hypoxic-ischaemic encephalopathy was caused by Mr Castillo-Riffo becoming trapped, that the trapping constricted the carotid arteries compromising the oxygenation of the brain and resulting in loss of consciousness, cardiac arrest and brain injury. SafeWork SA submitted that it is completely implausible to suppose that:
1. During the very short period of a few seconds when Mr Castillo-Riffo was exposed to the risk that his neck would be trapped and the blood flow and/or air supply to his brain cut off.
  2. That at that very moment Mr Castillo-Riffo suffered a cardiac arrest.

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3. But that the cardiac arrest was of a nature which did not prevent him continuing to operate the scissor lift, thereby causing him to trap his neck between the guard rail and the concrete slab.
- 4.52. SafeWork SA pointed out that if Mr Castillo-Riffo had suffered a cardiac arrest before becoming trapped it is unlikely that he would have continued to move the platform up. The movement of the platform in an upward direction required Mr Castillo-Riffo to pull the joy stick on the control panel at the same time as pressing the 'dead man' switch on the front of the joystick. It is highly unlikely that upon Mr Castillo-Riffo suffering a cardiac arrest he would be able to continue to engage the joystick while pressing the 'dead man' switch. Furthermore, blood was observed emanating from Mr Castillo-Riffo's mouth by the first responders<sup>98</sup> and this observation is inconsistent with an antecedent cardiac event because if Mr Castillo-Riffo had suffered an antecedent cardiac arrest it would have resulted in a loss of blood circulation and hence minimal to no bleeding would be expected into the neck or via the mouth. That contention is certainly supported by the remarks of Dr Langlois in the supplementary reported dated 2 February 2017<sup>99</sup> about how he would have expected minimal or no bleeding in the neck if a cardiac event had been the precipitating occurrence (but in that passage Dr Langlois went on to note the restoration of circulation in the hospital, thus preventing any conclusion being drawn one way or the other in that context which was bruising and haemorrhaging into tissues around the neck, and Dr Langlois' observations at post-mortem which were of course after hospitalisation). The observations of the first responders were of course made prior to the restoration of circulation and thus the presence of blood around the mouth is not affected by the restoration of circulation that was established during hospitalisation. There is force in the submission that the presence of blood around the mouth is inconsistent with a cardiac event preceding entrapment.
- 4.53. Before a conclusion can be reached, it is necessary to consider the mechanical operation of the scissor lift and the configuration of its controls.

## 5. **The mechanical operation of the scissor lift**

- 5.1. The mechanical operation of the scissor lift is best described by reference to the operator manual<sup>100</sup> for the scissor lift that was being used by Mr Castillo-Riffo. The manual was

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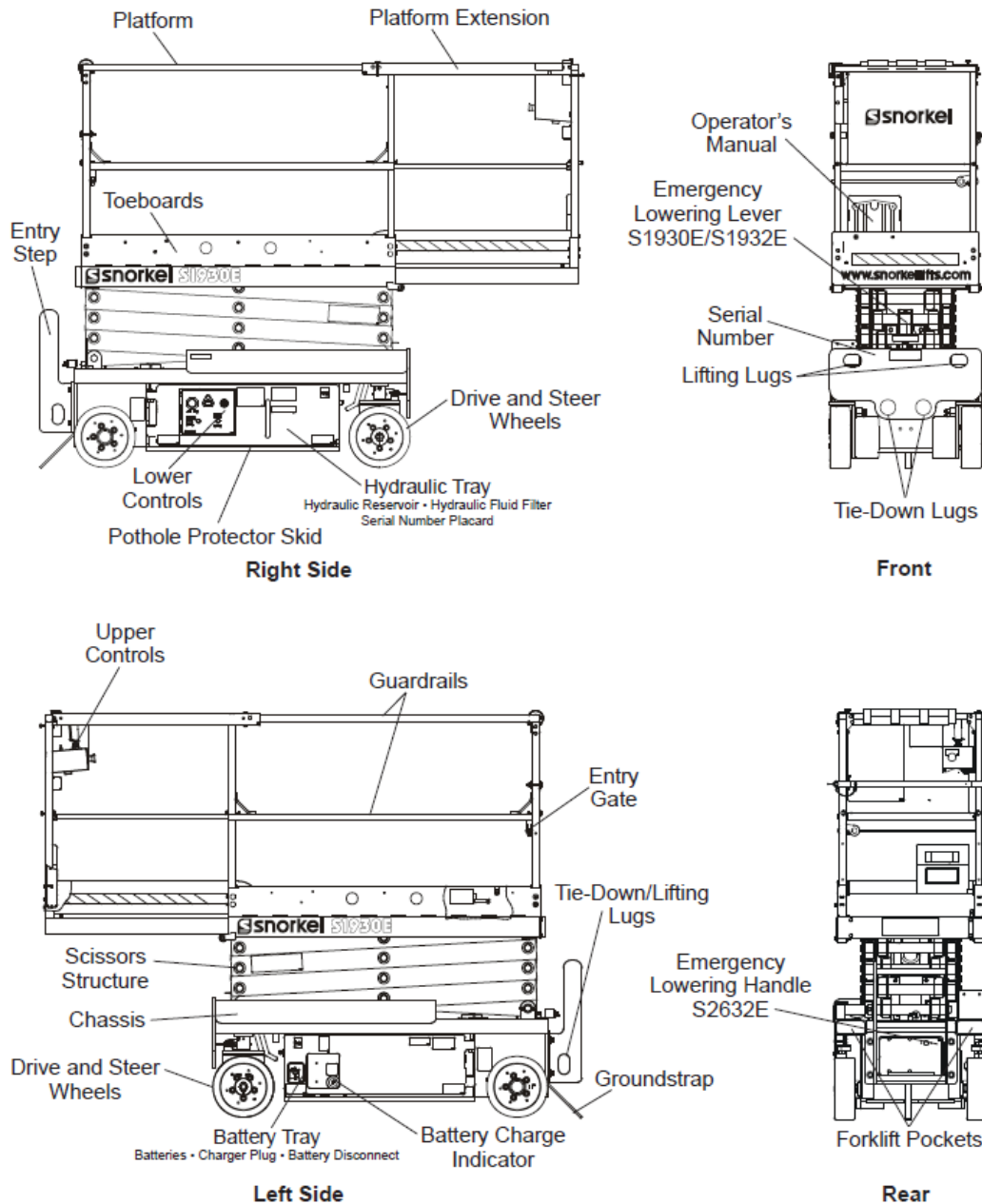
<sup>98</sup> See for example Exhibit C70, page 3

<sup>99</sup> Exhibit C75b

<sup>100</sup> Exhibit C34d

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seized by Mr Pfeffer of SafeWork SA on 27 November 2014<sup>101</sup>. The brand name of the scissor lift was Snorkel, the model number was S1930E, the serial number was 00775 and the date of manufacture was June 2012<sup>102</sup>. I reproduce here diagrams of the scissor lift which are to be found in the safety manual and which show diagrams of the lift seen from the right side, the left side, the front and the rear.



5.2. In order to orient the diagram to the position of the scissor lift when Mr Castillo-Riffo was discovered in a state of collapse, it is sufficient to note that the front of the scissor lift as depicted in the diagram is at the end with the platform extension. When

<sup>101</sup> Exhibit C34a, page 11

<sup>102</sup> Exhibit C65, page 4; Exhibit C34e, page 2

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Mr Castillo-Riffo was found the platform extension, or the front of scissor lift, was facing south. The rear of the scissor lift was facing north, the left side of the scissor lift was facing east and the right side of the scissor lift was facing west.

- 5.3. It can be seen from the diagram that the scissor lift has scissors between the chassis and the platform which are capable of extending thus raising the platform. The platform in a raised position is depicted on the front of the manual<sup>103</sup> which is reproduced below.



- 5.4. If one examines the diagram of the scissor lift the notable features are the platform extension, the lower controls which are on the chassis on the right hand side, the upper controls which are depicted in the diagram as a box hanging from the upper guard rail on the platform extension at the front of the scissor lift. The scissor lift is entered via the entry gate and the entry step at the rear of the scissor lift. The working height of the scissor lift is 7.6 metres<sup>104</sup>.
- 5.5. The lower controls of the scissor lift which are located on the right side of the chassis may be used to raise or lower the platform, but cannot be used to drive the scissor lift forwards or backwards. The lower controls include a key which activates a selector

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<sup>103</sup> Exhibit C34d

<sup>104</sup> Exhibit C34d, page 20

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switch which can be used to activate the lower controls only, or the upper controls. The lower controls permit the raising or lowering of the platform. In order to raise or lower the platform from the lower controls it is necessary that the operator continuously hold another switch called the ‘ground operation switch’ while simultaneously selecting either the raise or lower function of another switch which is called the ‘platform raise/lower switch’. Thus it is necessary to activate two switches to either raise or lower the platform. The switches must be activated simultaneously. This is significant as the first responders were unable to use the lower control panel to lower the platform when Mr Castillo-Riffo was first discovered. Instead they were required to use the emergency lowering system which is described in the operators manual. It is depicted in the diagram above as the ‘emergency lowering lever S1930E/S1932E’ at the front of the machine. The lever is operated by pushing downwards in order to lower the platform. When that is done the hydraulic system is manually activated to cause the platform to lower. As will be seen later in this finding, the position of the emergency lowering lever on Mr Castillo-Riffo’s machine assumes some importance. Because it was located at the front of the machine, which was up against a guard rail, first responders had some difficulty in locating it and then in activating it.

- 5.6. It is particularly important to describe the operation of the upper controls. These are depicted in a photograph taken by Mr Pfeffer on 27 November 2014 which is photograph 12 in Exhibit C34b and it is reproduced below.



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- 5.7. It will be apparent from the photograph that the upper control consists of a metal box with switches and a joystick on the top. What is not apparent from the photograph is that the box is portable and is connected to the machine by a cord. The box can be moved around the machine and hangs from the upper railing of the machine in a place of the operator's choosing.
- 5.8. The evidence at the Inquest shows that the control box for Mr Castillo-Riffo's scissor lift was located hanging from the right hand side guard rail (the western side) facing into the machine. It was towards the front of the machine and was roughly in line with the position at which Mr Castillo-Riffo's head was trapped by the railing on the opposite, left (eastern) side of the machine.
- 5.9. The platform dimensions are as follows. The main part of the platform is 74cm wide by 156cm long, and the extension part of the platform is 61cm wide by 91cm long and the total length of the platform with the extension out is 247.5cm. The height of the guard rail is 111.8cm.
- 5.10. Returning to the upper control box, by reference to the photograph above, two toggle switches can be seen and a joystick can also be seen. The joystick has an interlock switch on the side of the handle. It is necessary that the interlock switch be engaged by pulling or otherwise moving it in towards the handle. If it is not engaged, a movement of the handle forwards or backwards will not cause the machine to respond. The movement of the joystick forwards or backwards may cause the machine to drive in a forwards or backwards direction, or cause the platform to raise or lower. It cannot perform both of those functions simultaneously however. One of the two toggle switches which can be seen to the left of the joystick in the photograph, being the nearer toggle switch to the joystick, permits the mode of operation to be switched between the raise and lower function and the drive function. When the switch is in the raise and lower function the joystick can be used to raise or lower the machine, but it cannot be used to cause the machine to go forwards or backwards. When the toggle switch is in the drive mode, the joystick can be used to move the machine backwards or forwards, but cannot be used to raise or lower the platform.
- 5.11. Clearly it is important for the operator to be aware before activating the joystick by holding the interlock switch and moving the joystick backwards or forwards, of which mode the raise/lower/drive switch is in. It is clear that there is a risk to an operator of

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inadvertently raising or lowering the machine if the operator thinks that the toggle switch is in the drive mode and intends to move the machine forward or backward and not up or down. A similar risk of inadvertently moving the machine forwards or backwards when under the mistaken belief that the machine is in the raising or lowering mode also exists.

- 5.12. It will be observed from the photograph of the control box that the joystick has another toggle switch on its uppermost surface. The purpose of that toggle switch is to turn the steering wheels which are at the front of the machine, to the left or to the right. The manual cautions that the operator ought to orient the control box by hanging it from the rail at the front of the machine in order to avoid confusion about the direction of the steering toggle for obvious reasons. It was clear from the evidence that operators do not confine themselves to the placement of the toggle box on the front of the machine, but move it around to suit the convenience of the task they are performing. Indeed, it is clear that Mr Castillo-Riffo had the control box on the right hand side of the machine, and not on the front. In saying that I imply no criticism of him, it was obviously a common practice from all of the evidence I heard.
- 5.13. Lastly, it should be noted that the steering toggle switch does not automatically return the wheels to a straight position after the machine has been turned. It is necessary to return the steering wheels to the straight position by reversing the toggle switch. Thus, steering is far from an intuitive action as experienced when one drives a motor vehicle.

## **6. Conclusion as to whether entrapment caused cardiac arrest or cardiac arrest caused entrapment**

- 6.1. Having set out the evidence of the witnesses, Mr Haig and Mr Hales, it is clear that when he was found Mr Castillo-Riffo's head was jammed between the concrete slab above and the rail on the left hand side, or eastern side, of the scissor lift. The medical evidence supports the conclusion that his neck was compressed in the region of the carotid arteries<sup>105</sup>. It is not to the point whether his head was oriented such that the right side of the neck was against the railing or the left side, it is clear that however that may be, Dr Langlois' findings as to neck compression remain valid. Those findings and his expert opinion are that neck compression can cause loss of oxygenated blood to the brain, unconsciousness, cardiac arrest and finally hypoxic-ischaemic encephalopathy.

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<sup>105</sup> I refer to the deep bruising noted by Dr Langlois, and of course, the fractured jaw

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However, as I have observed above, it is acknowledged that Dr Langlois cannot rule out cardiac arrest and whether cardiac arrest preceded entrapment or entrapment preceded cardiac arrest is a matter for me.

- 6.2. It is also significant that Mr Castillo-Riffo's head was jammed so that he was looking outside the scissor lift and could not view or see the control box which was on the right hand side rail opposite where Mr Castillo-Riffo's head was jammed. It is a reasonable inference that Mr Castillo-Riffo's head must have been in that position, or a similar position, immediately before his head was trapped. Indeed, that conclusion is inescapable given the fact of entrapment. It follows that immediately before entrapment the head was in a position which enabled the entrapment to occur. It is also clear that no mechanical fault was found with the machine such that the machine might have activated itself. It is clear from Mr Glover's evidence that the machine did not suffer from a mechanical defect that would have produced a movement upwards with no action on the part of Mr Castillo-Riffo or someone else to activate the controls of the machine in such a way that the machine would rise, thus jamming Mr Castillo-Riffo's head.
- 6.3. There was no evidence of the involvement of any other person and no reason to suppose that any other person somehow activated the controls of the machine in order to cause Mr Castillo-Riffo to become trapped.
- 6.4. Because Mr Castillo-Riffo was looking outside of the machine at the time the controls were being activated, it follows that he must somehow have placed his hand on the joystick in a manner sufficient to activate the interconnector on the joystick and at the same time to push the joystick in a lateral path to cause the machine to rise. That action required some coordination, first of all to locate the position of the controller and the joystick and secondly to manipulate it in a way that the interlock device was operated and the joystick moved laterally simultaneously.
- 6.5. HYLIC in its submissions strongly asserted that the Court should not prefer one hypothesis over the other and that there is no firm evidence one way or the other out of the two possibilities, namely that Mr Castillo-Riffo deliberately but mistakenly activated the joystick causing it to go upwards, or that a cardiac arrest caused him to become disoriented and confused and to place his head in a position that enabled it to be jammed in the manner ultimately found. That second possibility however carries

with it the need to accept that after the cardiac arrest other events followed: Mr Castillo-Riffo somehow waved one of his arms in such a manner that he was able to touch the joystick, a distance close to the width of the platform of the machine, and in doing so was able to deactivate the interlock device and move the joystick in the correct direction for the tragic outcome to occur.

- 6.6. I am urged by HYLC to exercise caution and to apply the well-known standard of proof expounded in **Briginshaw v Briginshaw** (1938) (60CLR336). I accept that standard of proof as appropriate in making a conclusion about the mechanism of death and I have applied it.
- 6.7. It is clear that merely because an event is unseen, it does not follow that its cause cannot be reasonably inferred. Inferences from actual facts that are proved are permissible and circumstances raising a more probable inference in favour of a particular outcome may be relied upon if they do more than give rise to conflicting inferences of an equal degree of probability, so that the choice between them is mere conjecture. However, if an inference is more probable from the circumstances it may be relied upon, and having regard to what is said in **Briginshaw v Briginshaw** I am satisfied that the inference may safely be drawn that Mr Castillo-Riffo was trapped in a position which led to the compression of his neck thus leading to the cardiac arrest rather than the other way around.
- 6.8. I regard it as very improbable that Mr Castillo-Riffo should have a heart attack immediately before moving such that his head was in the position, or close to the position, in which it was ultimately jammed, whilst simultaneously moving his arm about out of his field of vision in a manner that resulted in his hand or arm deactivating the interlock device and moving the joystick to cause the raising of the platform.
- 6.9. For these reasons I conclude that it was entrapment that led to cardiac arrest and hypoxic-ischaemic encephalopathy and that Mr Castillo-Riffo did not suffer an antecedent cardiac event.
- 6.10. The question then arises: why did Mr Castillo-Riffo have his head over the side of the machine while having his hand on the joystick? I believe that I can safely rule out the possibility that Mr Castillo-Riffo was intending to cause the platform to raise because he was well aware of the proximity of the concrete slab above him and the danger it posed of entrapment. That leaves the possibility that he was intending to lower the

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machine, or perhaps that he was intending to move it backwards or forwards. There is no way of knowing which of these possibilities was motivating him to do what he did and I make no finding about that matter.

## 7. **The nRAH project**

- 7.1. As stated in the submissions of HYLC the construction of nRAH was a large project of national significance. The project cost was in the sum of approximately \$2.3 billion and was constructed on the 13 hectare site and North Terrace, Adelaide. During construction workforce levels varied, but at its height over 2,000 workers were working on the site. By early 2014 the main structure had all but been completed. This meant that the site works then changed over a period from the erection of the structure to the fitout of the hospital building itself.
- 7.2. It may be assumed by some that the building of South Australia's pre-eminent public hospital would be a project commissioned by the State of South Australia and that the State of South Australia may have had some role to play in the construction of the hospital. For reasons explained by Mr Deegan, who was then Chief Executive of the Department of Planning, Transport and Infrastructure<sup>106</sup>, that was not so. Instead, the Minister for Health had entered into a project agreement with SA Health Partnership Nominees Pty Ltd (Celsus) whereby Celsus would finance, design, construct and operate the new Royal Adelaide Hospital for a fixed period including the construction phase. Mr Deegan said that Celsus was a private entity created for the sole purpose of administering the project. The project agreement entered into by the Minister and Celsus is a Public Private Partnership under which Celsus was required to finance or procure financing for the design and construction of the nRAH. The terms of the project agreement were that Celsus was entirely responsible for the design and construction of the nRAH and related issues. Celsus managed the entirety of all the different design and construction activities involved in the project from beginning to end of the construction phase and had control of and responsibility for the site during that period. In turn Celsus entered into a separate subcontract with Hansen Yuncken Leighton Contractors (HYLC) under which HYLC would construct the nRAH including by managing the site on a day to day basis during the construction phase, subcontracting of trades and payment of those subcontractors. Mr Deegan said that the State of South

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<sup>106</sup> Exhibit C58a

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Australia is not a party to the construction agreement entered into between Celsus and HYLC and that the State of South Australia did not have any role in the employment or supervision of the workforce.

- 7.3. At the Directions Hearings on 25 January 2018 and 28 February 2018 the Court made efforts to ascertain the role and responsibility of the State of South Australia in the project. That was so that I might have some understanding of the contract administration and the effect that may have had on the way events unfolded<sup>107</sup>.
- 7.4. At the second Directions Hearing on 28 February 2018 the affidavit of Mr Deegan was produced<sup>108</sup>. I note that the affidavit states that the contractual arrangements provide that Celsus is responsible for all health and safety at the site, for ensuring it had a safety management plan in place adequately addressing its obligations and what is described in the affidavit as ‘OHS legislation’, which I assume is a reference to the Work, Health and Safety Act 2012. The effect of the Crown’s submissions through counsel for Department of Industry, Planning, Transport and Infrastructure was that the State Government had no role in the matter that could in any way be connected to Mr Castillo-Riffo’s incident and that nothing the State Government did could have influenced the outcome one way or the other. Effectively the State of South Australia declined to be represented in its capacity as the owner of the land upon which the activity occurred, and upon which the State’s major tertiary public hospital is to conduct its activities for many decades to come. Given the number of interviews given by Ministers of Health during the period under which the nRAH was under construction, answering questions about the scheduling for the opening of the nRAH, that came as something of a surprise to the Court. It is notable that counsel for SafeWork SA, the entity responsible for regulating safety in the construction industry particularly, and in the workplace generally, submitted in its closing submissions that ‘on a proper review of the WHS Act ... there would have been no reasonable basis for any allegation of breach of any of the health and safety duties in the WHS Act on the part of Project Co. Indeed no other party in the Inquest identified any that Project Co conceivably breached’<sup>109</sup>.

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<sup>107</sup> Transcript, page 4

<sup>108</sup> Exhibit C58a

<sup>109</sup> The reference to Project Co is a reference to SA Health Partnership Nominees Pty Ltd or Celsus as is apparent from the project agreement MD1 exhibit to Mr Deegan’s affidavit – Exhibit C58b – in which the contracting partner, namely SA Health Partnership Nominees Pty Ltd in its personal capacity and in its capacity as trustee of the Trust is thereafter referred to as ‘Project Co’

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7.5. Thus, while it may seem curious to the uninformed that the State of South Australia played no part in this Inquest (other than in a separate capacity through its entity SafeWork SA) that was the ultimate outcome.

## **8. SRG Pty Ltd - a subcontractor**

8.1. As previously mentioned, HYLC were expected to use not only its own employees, but also contractors and the employees of those contractors. Thus it was that HYLC contracted SRG Pty Ltd to perform post-tensioning work as part of the nRAH project. Post-tensioning involves the installation of post-tensioning tendons into the formwork, the initial stressing of the tendons after the concrete is poured into the formwork, final stressing and ultimately the cutting, sealing and grouting of the tendons<sup>110</sup>.

8.2. Mr Castillo-Riffo was employed by SRG as a labourer to perform work at the site. He commenced employment with SRG in October 2014<sup>111</sup>. He had previously been engaged by SRG via a labour hire company.

8.3. During the course of the Inquest the Court examined the actions of both HYLC and SRG as executed through their respective employees and agents. Both employees and agents of HYLC and SRG played some part in the circumstances leading up to the death of Mr Castillo-Riffo.

## **9. Post-tensioning and patching**

9.1. There was a considerable amount of evidence during the Inquest about post-tensioning. It is not necessary to provide a detailed explanation of what is involved in post-tensioning. It is sufficient to say that steel cables are placed inside ducting which is ultimately to be enclosed by concrete when concrete is poured. The wet concrete is obviously held in place by means of formwork which is supported by scaffolding, jacks and heavy timbers. The steel cables I have referred to travel from one edge of a concrete slab all the way across to the opposite edge of the concrete slab. A space is formed where the steel cable meets the plywood formwork on the edge. The space is formed by means of a plastic mould, the purpose of which is to leave a pocket which can be accessed after removal of the plywood formwork once the concrete has partially set. At that point the plastic mould will be removed and the ends of the steel cable will be

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<sup>110</sup> Transcript, page 1855

<sup>111</sup> Exhibit C48aa

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exposed. Tension will be applied to the steel cables which are exposed within the pockets on the edge of the concrete slab. These pockets could be described as ‘stressing pockets’ and they leave the steel cables exposed for stressing. It occurs after the concrete pour and once the concrete starts to set, thus the expression ‘post-tensioning’. Shortly after the concrete has been poured and partially set, workers will apply large jacks which grab hold of each end of the cables in the stressing ducts that run through the concrete slab. They will apply pressure to a certain level in the initial stress, and later when the concrete has come up to full strength, the jacks will be reapplied and the cables will be brought to their final tension. At that point the cables will be fixed with some permanent fixing device and the excess cable will be cut off. After that workmen will come along and patch over the hollow that is left from the stressing pocket with a mixture of sand and cement and possibly other agents. This will happen while most of the original formwork that supported the concrete slabs initially is still in place, in particular the walkway around the external edge of the concrete slab which was at least 700mm wide. The walkway has guard rails erected on it and those guard rails in turn have screening to prevent workers or objects from falling.

- 9.2. It is important to note that the patching work is intended to be done at the point where the scaffolding is still in place so that the workers have easy access to the pockets. Once the patching work has been done, the remaining formwork is quickly removed so that it can be used elsewhere on the site<sup>112</sup>. It was common ground from numerous witnesses that ordinarily patching is done off the formwork or original scaffolding<sup>113</sup>.
- 9.3. It is clear that the process of patching post-tensioning pockets is not inherently unsafe when being carried out in the manner that the system generally envisages, namely from the formwork on scaffolding with safety railing and screening. In such an instance there is no crushing risk, there is no awkwardness and there is no difficulty in gaining access.
- 9.4. At the time of the incident Mr Castillo-Riffo was performing rectification work on post-tension pockets which had previously been filled. The nature of the work on the bulk of the evidence appears to have been intended to chip away part of the material which had been used to fill the pocket and then apply new material over the pocket so that its surface would match the appearance of the adjoining concrete surrounding the original

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<sup>112</sup> Transcript, pages 595-597

<sup>113</sup> Transcript, pages 767, 1240, 1389, 1562, 1563, 1812 and 1854

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pocket. The need for this work had been the subject of some dispute between SRG and HYLK, the details of which need not be discussed in this finding. It is sufficient to note that had the original patching been done satisfactorily from the framework, it would not have been necessary for Mr Castillo-Riffo to have been undertaking the rectification work that was occurring on 27 November 2014.

- 9.5. The original formwork was down and had been down for some time when the incident occurred<sup>114</sup>. Mr Parkinson said it was probably removed around August 2014<sup>115</sup>. Mr Traeger gave evidence that the formwork was taken down quickly so that it could be moved to different areas to progress the building work<sup>116</sup>.
- 9.6. In any event, when it was necessary to undertake the remediation there was no formwork in situ from which SRG workers could access the pockets that required work. Thus it was necessary for SRG to identify an alternative means by which the workers could access the pockets. The employee of SRG who was responsible for that task was Mr John Traeger who gave evidence at the Inquest. Mr Traeger was a senior leading hand employed by SRG at the nRAH site. It was his role to delegate work for his team and make sure that his workers knew what to do and had the necessary equipment to do it.

## 10. Patching from the scissor lift

- 10.1. It is necessary to explain in some detail the task being performed by Mr Castillo-Riffo using the scissor lift, and the work area in which he was performing the task. The work area has been discussed briefly above. It was on the northern side of a penetration in the building which goes from the top of the building right to the ground floor and was included so that there could be a garden area within a courtyard inside the main building. There were a number of such penetrations in different parts of the entire building. The work Mr Castillo-Riffo was performing was on the edge of the concrete slab of the third floor of the building and he was working from a scissor lift which was standing on the second floor of the building. The pockets being patched on the outside of the level three slab were roughly 0.5 metres above the underside of that slab.

<sup>114</sup> Transcript, page 355, 1203 and 1859

<sup>115</sup> Transcript, page 1859

<sup>116</sup> Transcript, page 770

MPS

- 10.2. In order for Mr Castillo-Riffo to access the outside of the level three concrete slab it was necessary for him to extend the extension platform of the scissor lift as far as possible so that he could stand out in the void and reach the patching pockets on the overhead slab. Thus he was extended out into the void which was outside the footprint of the slab to access the pockets on the outside of the overhead slab by means of the extension platform of the scissor lift which protruded into the void, or penetration.
- 10.3. The extension platform of the scissor lift was able to extend 0.9 metres from what would otherwise be the edge of the scissor lift<sup>117</sup>. However, Mr Castillo-Riffo could not extend out the whole of that distance from the edge of the concrete slab because there was a barrier fence along the edge to stop people or objects falling into the penetration. The barrier fence had the result that Mr Castillo-Riffo could not bring the scissor lift to the very edge of the concrete slab. The barrier fence was set back 590mm from the edge of the concrete slab<sup>118</sup>.
- 10.4. Due to the effect of the barrier fence the extension platform would only extend approximately 360mm beyond the edge of the concrete slab. Thus, that was the depth of the workspace between the edge of the overhead beam on which Mr Castillo-Riffo was patching and the end of the scissor lift extension platform. Mr Castillo-Riffo positioned the scissor lift flush with the barrier fence thus giving himself the maximum area in which to work. If the scissor lift had not been hard up against the barrier fence, the working area would have been less.
- 10.5. The internal width of the scissor lift was 622mm. It follows that Mr Castillo-Riffo's working space was 360mm x 620mm which was, on any view, extremely small.
- 10.6. In order to reach high enough to work on the pockets, Mr Castillo-Riffo had to raise the scissor lift so that its railing was very close to the bottom side of the overhead concrete slab. The guard rail of the scissor lift platform was 1112mm above the floor of the scissor lift<sup>119</sup>. According to the witness Glen Steele who saw Mr Castillo-Riffo working on the patching at about 6:40am that morning, the rail of the scissor lift was approximately 200mm to 300mm below the underside of the third floor concrete slab<sup>120</sup>. Therefore the floor of the scissor lift was 1312mm to 1412mm below the overhead

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<sup>117</sup> Exhibit C34d, page 21

<sup>118</sup> Exhibit C36j being the diagram drawn by Inspector Croci

<sup>119</sup> Exhibit C34d (actually 1111.8mm, but I have rounded it for simplicity)

<sup>120</sup> Exhibit C63, page 7

MPS

slab<sup>121</sup>. Mr Castillo-Riffo was 1.77m tall<sup>122</sup>. Therefore approximately 360mm to 460mm of Mr Castillo-Riffo's body would have been above the underside of the third floor concrete slab.

- 10.7. Mr Castillo-Riffo's task involved the plastering of filler material into the pocket to make the pocket appear similar to the surrounding concrete. The material he was using was contained in a bucket which he had presumably mixed while in a lowered position. Thus Mr Castillo-Riffo was required to manage the patching bucket and his tools, including the tool used to plaster the patching material into the exposed pocket.

## 11. Movement between patching pockets

- 11.1. It was not clear how many pockets Mr Castillo-Riffo worked on that morning. It did appear that he may have completed two pockets. In any event it is as well to describe the manoeuvring of the scissor lift that would have been required to move from one pocket to the next. Mr Castillo-Riffo would have been required to cause the scissor lift to lower by means of the joystick with the appropriate toggle switch in the correct position. He would then have to put the toggle switch in the forward/reverse position and then move the scissor lift away from the edge of the building. He would also need to manipulate the direction control on top of the joystick to cause the machine to line up appropriately with the next pocket requiring attention. Because the front of the machine was positioned up against the guard rail, the steering wheels of the machine were closer to the guard rail and the edge of the building. Mr Castillo-Riffo would need to bear in mind that he was effectively reversing the machine and look out for obstacles in his path in order to carry out the manoeuvre. Once he had reversed sufficiently far away from the guard rail, he would then need to move in a forward direction, all the time adjusting the steering by means of the direction control on top of the joystick. Once he had positioned the machine under the next pocket he would then need to switch the relevant toggle switch to the lower/raise mode, position himself at the end of the extension bridge so as to avoid being crushed by the overhead concrete slab while raising the scissor lift, and then move the joystick in a manner that would enable the scissor lift to move upwards so he could work on the next concrete slab.

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<sup>121</sup> Being the sum of the guard rail height of 1112mm and the 200mm to 300mm described by Mr Steele

<sup>122</sup> Exhibit C75, page 4

MPS

11.2. It should be noted that Mr Castillo-Riffo's entrapment did not occur while he was patching on the edge of the third floor concrete slab. That much is obvious because if he had been carrying out that task he would not have been underneath the concrete slab in a position that exposed him to the risk of crushing between the rail of the scissor lift and the underside of the third floor concrete slab. I have noted elsewhere that it is not possible to ascertain precisely what Mr Castillo-Riffo was doing immediately before he became trapped. It is clear enough that what he was not doing was actual patching work. It is probable that he was in the process of moving the scissor lift from one position to another. It may be that he was in the process of moving the scissor lift from a completed pocket to the next pocket to be worked on. There was no evidence before the Court as to the state of the pockets Mr Castillo-Riffo had completed that morning. As best I can tell from the photographic evidence, it appears that there was no incomplete pocket. In other words, there was no pocket that Mr Castillo-Riffo had roughened up and chipped the surface out of ready for patching to the necessary standard as required by the work process, but which had not yet been fully refilled and surfaced. It is reasonable to suppose therefore that Mr Castillo-Riffo had just completed a pocket and was in the process of moving or preparing to move the machine from one position to another.

## **12. Evidence that Mr Castillo-Riffo had expressed concern about scissor lifts**

12.1. Mr Castillo-Riffo's partner, Ms Gurner-Hall, gave evidence at the Inquest. She gave evidence that Mr Castillo-Riffo had expressed to her that he was nervous about using the scissor lift for the task he was working on at the site<sup>123</sup>. He also complained that it was necessary for him to move the scissor lift close to the edge and the space in which he had to operate was very, very small<sup>124</sup>.

12.2. Evidence was also given by Mr Aaron Cartledge who was the State Secretary of the Construction, Forestry, Mining and Energy Union (CFMEU) as it was then known<sup>125</sup>. Mr Cartledge gave evidence of a conversation that he had with Mr Castillo-Riffo on the morning of 27 November 2014. Mr Cartledge said that the CFMEU had arranged with the ceiling contractors to have an enterprise bargaining agreement meeting on the morning of 27 November 2014. It was for this reason that he arrived at the nRAH site

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<sup>123</sup> Transcript, pages 120-122

<sup>124</sup> Transcript, page 124

<sup>125</sup> The Union became known as the Construction, Forestry, Maritime, Mining and Energy Union following a merger with the Maritime Union of Australia which took effect in March 2018

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at about 5:40am that morning and walked up North Terrace. As he was walking along North Terrace he encountered Mr Castillo-Riffo by the main gates.

12.3. He and Mr Castillo-Riffo walked east up North Terrace towards the SAHMRI building and had a conversation in which Mr Castillo-Riffo said to Mr Cartledge that he hated using the scissor lifts. He made comments to the effect of 'you gotta see how I'm having to do this work'. He said that it was nice to be working for a good company such as SRG, but he said that the way they had him doing the patching work is 'much harder'. There was then a brief conversation about why patching was taking place from a scissor lift and reference to the fact that the formwork was no longer in situ. Mr Castillo-Riffo said that he did not like the scissor lift, that he had to drive it to the edge and then take it up and it made him nervous. By that stage of the conversation they had reached the turnstile and Mr Cartledge suggested that Mr Castillo-Riffo talk to someone about it. Mr Castillo-Riffo said words to the effect 'it's a good company and I don't want to cause trouble' and they parted ways.

12.4. There is no evidence of Mr Castillo-Riffo raising his concerns with any other person, including with any of his workmates or management of SRG.

### **13. Was Mr Castillo-Riffo under pressure to complete his tasks quickly**

13.1. There is no evidence to support the contention that Mr Castillo-Riffo was under undue time constraints to complete his work. In fact the evidence appears to be to the contrary, most starkly in the evidence of Mr Steele who was asked whether during the period he had been undertaking rectification works, he felt rushed or hurried:

'No, we were - I think we were all in slowmo then. Like, we'd all been laid off, you know, two weeks before, like, get back at the company but 'Hey, we'll milk it out' we're on no time restraints there. We wanted the job to last as long as we want. Building a structure - yeah, you got time restraints, we got to get it done. This patching stuff - look, we still had to get it done in a timely manner but there was nothing to say 'Hey, you got five minutes to get it done or get out'. Nah, we were - I'm going to say easy street. Sorry for the terms, but hey, like we're milking a little bit there, you know, like -'<sup>126</sup>

13.2. Mr King, another worker, gave evidence that he did not feel that he was being rushed to get the task done<sup>127</sup>.

<sup>126</sup> Transcript, page 405

<sup>127</sup> Transcript, page 187

MPS

- 13.3. Mr Traeger said that he did not put any time pressure on his crew to undertake the patching work because he knew it was going to be a lengthy process. Nor did he experience any time pressure being put upon him by HYLC staff<sup>128</sup>.
- 13.4. In summary, there was no evidence that SRG's workers felt pressure to perform the rectification work quickly. If anything, the evidence is to the contrary.

**14. Were other SRG employees using scissor lifts over penetrations?**

- 14.1. The evidence showed that Mr King had performed patching work from scissor lifts over penetrations<sup>129</sup> and he had seen Mr Castillo-Riffo doing such work more than ten times<sup>130</sup>. Mr Yuckich, another SRG leading hand, gave evidence that he had used a scissor lift to perform patching work over penetrations<sup>131</sup>. Mr Traeger gave evidence that he himself had used a scissor lift to perform patching work over a penetration<sup>132</sup>. The only other SRG employee who was questioned about this subject, Mr Steele, said that he had not used a scissor lift to perform patching work over a penetration<sup>133</sup>.
- 14.2. I conclude that the performance of the patching work by the use of scissor lifts over penetrations was a well-established work practice within the SRG workforce performing the rectification works in November 2014. There was also evidence of the use of boom lifts for the same task. Mr King gave evidence that he had used boom lifts to perform the task<sup>134</sup>. Mr Traeger said that knuckle booms were used for the performance of patching work<sup>135</sup> and Mr Yuckich also said that he had performed the patching work from a boom lift<sup>136</sup>.

**15. Mr Traeger's efforts to gain access for boom lift**

- 15.1. Mr Traeger was responsible for supervising and allocating the duties of the SRG employees, including Mr Castillo-Riffo. In the weeks leading up to 27 November 2014 Mr Castillo-Riffo and Mr Yuckich had been completing patching work on various levels within the penetration. Mr Traeger gave evidence that in doing this work a variety of plant and equipment was used including a scissor lift and a knuckle boom.

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<sup>128</sup> Transcript, page 733

<sup>129</sup> Transcript, page 187

<sup>130</sup> Transcript, page 188

<sup>131</sup> Transcript, page 1546

<sup>132</sup> Transcript, page 736

<sup>133</sup> Transcript, page 331

<sup>134</sup> Transcript, page 184

<sup>135</sup> Transcript, page 736

<sup>136</sup> Transcript, page 1546

MPS

He said when using the scissor lift to perform patching work within the penetration during that period, the scissor lifts were used in the same way as that adopted by Mr Castillo-Riffo in that they were positioned up against the hand rail with the platform extended out and into the penetration<sup>137</sup>. Mr Traeger said that SRG had access to three scissor lifts, all being the same size, and it was these scissor lifts which were being used in the weeks prior to 27 November 2014<sup>138</sup>.

15.2. Mr Traeger said that the knuckle boom was SRG's:

'...first preference to do the patching because it is a machine that extends by an arm, which moves the basket in which the operator stands out past the edge of the slab. It is the easiest and fastest way of accessing the area.'<sup>139</sup>

15.3. On or about 20 November 2014 Mr Traeger seems to have turned his mind to the question of the work that would come to be performed by Mr Castillo-Riffo from the second floor upon the fascia of the third floor concrete slab. Mr Traeger became aware that he would not be able to get a boom into the area because internal wall frames had been installed by the internal fixing workers. He said that on or about that day he spoke to Ray Plant who he understood to be the HYLC site construction supervisor. He mentioned the issue of concern and Mr Plant told him that he was no longer supervising the area and that he needed to speak to Ms McGill, HYLC site superintendent for steel structure in the area. Mr Plant offered to get Ms McGill to contact Mr Traeger, however as it happened Mr Traeger encountered Ms McGill in the vicinity of the work area soon after and told her that he would like to get a boom lift into the area and needed to move the internal frames<sup>140</sup>. Ms McGill told him that he could not separate the walls himself and would need to obtain the consent of the fitout supervisors for the internal fitout. She showed him a noticeboard with the relevant contact numbers and names. It was from this source that Mr Traeger identified Mr Todd Kinsman as the fitout supervisor to whom he should direct his enquiry. After some toing and froing Mr Traeger rang Mr Kinsman and told him that he needed to meet with him to discuss moving some internal frames in the area to get a boom in<sup>141</sup>. Mr Traeger then met with Mr Kinsman at the area on either 24 or 25 November 2014. Mr Kinsman, according to Mr Traeger, told him that he could not remove the studs. Mr Traeger said in his statement that

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<sup>137</sup> Exhibit C67, page 4

<sup>138</sup> Exhibit C67, page 4

<sup>139</sup> Exhibit C67, page 4

<sup>140</sup> Exhibit C67, page 5

<sup>141</sup> Exhibit C67, page 6

MFS

Mr Kinsman suggested that he should be able to get a scissor lift in. Mr Traeger said that he himself responded by expressing doubt as to whether the scissor lift would extend out enough, by which he meant extending the platform that the scissor lift operator would stand on<sup>142</sup>.

- 15.4. Mr Traeger said that Mr Kinsman had a measuring tape and between them they took some measurements after which Mr Traeger formed the view that the task could be done safely with a scissor lift<sup>143</sup>. In making that assessment Mr Traeger took into consideration whether the scissor lift could be delivered into the area, the need to clear the area and the question of how far the platform would extend into the penetration. He said that he and Mr Kinsman worked out that the platform would extend about one metre past the hand rail. Mr Traeger said that Mr Kinsman then offered to borrow a scissor lift from one of the other contractors<sup>144</sup>.
- 15.5. According to Mr Traeger, Mr Kinsman made some enquiries about another scissor lift although these eventually came to nothing.
- 15.6. Mr Plant gave evidence at the Inquest. He said that he received a phone call from Mr Traeger to obtain assistance with moving some material so that Mr Traeger could perform some work. Mr Plant said that he did assess the area and noted that there was a doorway. He said that:

'... for size purposes I gave him an indication of what equipment would fit through for what I assessed the access to be ...' <sup>145</sup>

He said:

'I didn't know what John was bringing in. That was just an indication of how big the doorway was and what would actually fit through it.' <sup>146</sup>

It seems that Mr Plant did not hear further from Mr Traeger and contacted him again. Mr Traeger in that conversation told him that there was no need to worry about the issue because Mr Traeger now had access<sup>147</sup>. Mr Plant's involvement was somewhat peripheral. The main interaction was between Mr Traeger and Mr Kinsman.

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<sup>142</sup> Exhibit C67, page 7

<sup>143</sup> Exhibit C67, page 7

<sup>144</sup> Exhibit C67, pages 7-8

<sup>145</sup> Transcript, page 1145

<sup>146</sup> Transcript, page 1146

<sup>147</sup> Transcript, pages 1144-1146

MPS

- 15.7. Mr Kinsman gave evidence at the Inquest. He was the fitout supervisor on the project in the employment of HYLK. Mr Kinsman's recollection was that Mr Traeger contacted him about access issues into Mr Kinsman's area and they met after Mr Kinsman's pre-start meeting at approximate 6:30am on 26 November 2014, the day before the incident<sup>148</sup>. They duly met at the site of the work that Mr Castillo-Riffo was to perform and when Mr Kinsman arrived Mr Traeger was already there. Mr Traeger told him that he was having trouble reaching post-tension pockets on the slab of level three and he wanted to use a boom lift. Mr Kinsman said that there was a boom lift nearby which he assumed to be the machine Mr Traeger was wishing to use<sup>149</sup>. Mr Kinsman understood that Mr Traeger wanted to move the boom lift around through Mr Kinsman's construction area and into the room on the northern side of level two. He said that he walked the path with Mr Traeger<sup>150</sup>. He said that Mr Traeger's thought was that the boom lift could be driven through and they could remove some internal framing to get into the room. Mr Kinsman said that he did not have any difficulty with the suggestion of moving the framework<sup>151</sup>. He said it was a relatively simple task. However, he told Mr Traeger that he would not permit Mr Traeger to bring the boom lift in.
- 15.8. Although he did not explain them to Mr Traeger, he said he had numerous reasons for this. He said it was not typical to drive a boom lift through an area of such heavy congestion with other construction workers, partitioned walls and door frames already installed, and furthermore there was an electrical distribution board in the corridor of the path of travel<sup>152</sup>. Mr Kinsman did not specifically refer to the electrical distribution board in his conversation with Mr Traeger<sup>153</sup>. Mr Kinsman said that there were other subcontractors working and operating plant in the area, namely ceiling contractors who were using scissor lifts to install ceilings as part of the first fix services<sup>154</sup>. The electrical distribution board which was a temporary power supply for trades in the area was located on the northern side of a corridor to the north of the area in which Mr Castillo-Riffo was to perform the work. Mr Kinsman said that it would be necessary for a boom lift to be taken past the temporary electrical distribution board and that this would be

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<sup>148</sup> Transcript, page 1045

<sup>149</sup> Transcript, page 1046

<sup>150</sup> Transcript, page 1046

<sup>151</sup> Transcript, page 1048

<sup>152</sup> Transcript, page 1048

<sup>153</sup> Transcript, page 1048

<sup>154</sup> Transcript, page 1051

MPS

dangerous. He said that his concern was the ‘potential damage to the area, potentially have a catastrophic incident by hitting the distribution board’<sup>155</sup>.

- 15.9. Mr Kinsman said that he sought to assist Mr Traeger to find a possible solution. He said they talked about potentially using a scissor lift<sup>156</sup>. Mr Kinsman was thinking of a scissor lift that was being used by one of the subcontractors for whom he was responsible<sup>157</sup>.
- 15.10. Mr Kinsman said that he went and measured the contractor’s scissor lift. He did not know at the time what sort of scissor lift Mr Traeger and SRG had access to and the particular scissor lift that Mr Castillo-Riffo would ultimately come to use. However, Mr Kinsman had been shown a photograph of the scissor lift used by Mr Castillo-Riffo. He said that the one that he was contemplating was of a larger size. He said that it had an extendable platform that would have allowed the basket to cantilever past an obstruction in the same way that the scissor lift used by Mr Castillo-Riffo did<sup>158</sup>.
- 15.11. Mr Kinsman could not remember the dimensions at the time of giving his evidence<sup>159</sup>. He said that he and Mr Traeger then used his tape measure to measure from the hand rail out into the void, the dimension that Mr Kinsman had taken from the contractor’s scissor lift<sup>160</sup>. He said the measurement they were using was the distance of the cantilever of the contractor’s scissor lift<sup>161</sup>. Mr Kinsman said that he and Mr Traeger were simply looking at options. Mr Kinsman said that he offered to speak to the subcontractor, but although he had the best of intentions at the time, other matters intervened and he did not do so<sup>162</sup>.
- 15.12. Mr Kinsman was cross-examined extensively about his participation in the decision making process by which Mr Traeger came to arrange for Mr Castillo-Riffo to use a scissor lift. Mr Kinsman insisted that he was merely discussing an option with Mr Traeger and denied that he involved himself in a discussion about the appropriate elevating work platform to be used<sup>163</sup>.

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<sup>155</sup> Transcript, page 1053

<sup>156</sup> Transcript, page 1053

<sup>157</sup> Transcript, page 1054

<sup>158</sup> Transcript, pages 1054-1055

<sup>159</sup> Transcript, page 1056

<sup>160</sup> Transcript, pages 1056-1057

<sup>161</sup> Transcript, page 1058

<sup>162</sup> Transcript, page 1058

<sup>163</sup> Transcript, pages 1063-1064 and 1100

MFS

- 15.13. Mr Kinsman acknowledged that the boom lift he had seen on the day of his discussion with Mr Traeger, which he understood Mr Traeger wanted to get into the room, was a Haulotte Star 10 boom lift<sup>164</sup>.
- 15.14. The dimensions of the Haulotte Star 10 are in evidence<sup>165</sup>. The length is 2.6 metres, the width 0.99 metres, the stowed height 1.99 metres and the outside turning radius 1.7 metres.
- 15.15. The dimensions of the scissor lift used by Mr Castillo-Riffo are also in evidence<sup>166</sup>. The stowed length is 1.9 metres, the stowed width is 81.3 centimetres and the stowed height is 2.17 metres. The outside turning radius is 1.64 metres.
- 15.16. In citing these dimensions, I do not mean to be taken as concluding that it would have been possible to manoeuvre the Haulotte Star 10 into the position used by Mr Castillo-Riffo's Snorkel scissor lift on 27 November 2014. There is insufficient evidence as to the precise dimensions of the corridor. Furthermore, the matter was not raised at the Inquest, nor in submissions.
- 15.17. I merely note the similarity of the dimensions, accepting that the Haulotte Star 10 is slightly larger than the Snorkel, particularly as regards its width.
- 15.18. It may be that if Mr Traeger and Mr Kinsman had measured not only the contractor's nearby scissor lift, but the Haulotte Star 10 as well, they may have reached the conclusion that it was feasible to get the Haulotte Star 10 into the area in question.
- 15.19. In any event, I find that Mr Kinsman did not assume responsibility for deciding which piece of equipment ought to be used for the task. That responsibility fell to Mr Traeger on the evidence, and he accepted that responsibility when he said in his statement:

'It measured to be sufficient enough to use a scissor lift. I looked at the area carefully based on what Todd was directing. I assessed that the task could be done safely with a scissor lift.'<sup>167</sup>

## **16. Mr Traeger discusses use of scissor lift with Mr Castillo-Riffo**

- 16.1. Mr Traeger said in his statement<sup>168</sup> that on 26 November 2014 after his discussion with Mr Kinsman he spoke with Mr Castillo-Riffo as to whether he was happy to use a

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<sup>164</sup> Transcript, page 1085

<sup>165</sup> Exhibit C65a, page 14

<sup>166</sup> Exhibit C34d, page 21

<sup>167</sup> Exhibit C67, page 7

<sup>168</sup> Exhibit C67, page 8

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scissor lift to do the patching. Mr Traeger also asked if Mr Castillo-Riffo would be willing to stay back after 2:30pm that day to undertake the work because he had understood from his earlier conversation with Mr Kinsman that the other contractor's scissor lift may be available after that time. Mr Castillo-Riffo said yes and to let him know about whether he had to stay later. Mr Traeger said that Mr Castillo-Riffo did not express any concerns about using the scissor lift. He said he told Mr Castillo-Riffo that they would not be able to get a boom lift into the area and it would be necessary to use a scissor lift<sup>169</sup>. During the course of the day Mr Traeger realised that Mr Kinsman had not been able to supply the offer of the use of the contractor's scissor lift. He therefore told Mr Castillo-Riffo that he would not be required to stay back that day and requested that Mr Castillo-Riffo start at 6am the following morning, which was earlier than the usual start time, 'to avoid traffic that would be in the area'<sup>170</sup>.

- 16.2. Mr Traeger said that he told Mr Castillo-Riffo that there were two scissor lifts that were on charge and that had been used by SRG staff the day before. Mr Castillo-Riffo said that he was aware of the scissor lifts. They spoke about the tasks for the following day and the equipment that would be needed. He told Mr Castillo-Riffo that he was to use one of the scissor lifts to do the pockets. They made an arrangement to meet in the morning.

**17. The events of 27 November 2014 prior to the incident**

- 17.1. Mr Traeger said in his statement<sup>171</sup> that he met Mr Castillo-Riffo at about 5:39am. The idea was that he could get Mr Castillo-Riffo underway at 6am to get set up before what he described as more traffic coming in with other trades to avoid delays in getting the scissor lift through into the work area which would be caused by the presence of more people<sup>172</sup>. Mr Traeger said that he met Mr Castillo-Riffo at the gate where he got out some material to be used during the day and they discussed what Mr Castillo-Riffo would be doing. Mr Traeger said that he told Mr Castillo-Riffo that there were two scissor lifts being charged and that he should grab one of them. He said he should make sure the machine was fully charged, then get his materials, check the machine off, do his exclusion zones and make sure that he can get down through to the area and get set up. Mr Traeger said that he himself would be at the area in 15 minutes and in the

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<sup>169</sup> Exhibit C67, page 8

<sup>170</sup> Exhibit C67, page 9

<sup>171</sup> Exhibit C67, page 10

<sup>172</sup> Transcript, page 752

MPS

meantime he would park his car, open the office and speak to the other SRG 'boys', pre-start them with their pre-start routines and then come over and check on Mr Castillo-Riffo<sup>173</sup>. Mr Traeger described this process as a pre-start with Mr Castillo-Riffo<sup>174</sup>. Mr Traeger said that after that he left Mr Castillo-Riffo, went and parked his vehicle and opened up the office. At the office he met with Mr King, Mr Yuckich and Mr Steele. He assigned the various tasks that they were to work on that day, talked about what equipment they needed and then asked Mr Steele to go over to where the scissor lifts were charging and get one for the tasks that he had to do that day. He then spoke to Mr Yuckich and Mr King about tasks they had to do in the basement. While he was doing that Mr Steele came back past him to say that Mr Castillo-Riffo had taken the scissor lift that Mr Steele had been using the previous day. Mr Steele had left his tools in that scissor lift and so Mr Traeger told Mr Steele where to find Mr Castillo-Riffo so that Mr Steele could get his tools from the scissor lift. Mr Traeger continued his briefing with Mr King and Mr Yuckich and sent them down to the basement. He told them he would be down there shortly. At that point Mr Steele came back and said that he had retrieved his tools from Mr Castillo-Riffo's scissor lift and had spoken to Mr Castillo-Riffo who was where he was supposed to be and appeared to be okay<sup>175</sup>. Mr Traeger described the tools that Mr Castillo-Riffo needed to do his job which included a little chisel hammer, a little jack hammer, buckets, trowels, the filling product, safety gear, gloves, glasses and helmets<sup>176</sup>.

- 17.2. Mr Traeger then went to see how Mr Castillo-Riffo was going. When he arrived at the area Mr Castillo-Riffo was in the scissor lift working on the first pocket<sup>177</sup>. When he saw Mr Castillo-Riffo he was actually doing the patching work on the first pocket. He was in the scissor lift which was raised and Mr Castillo-Riffo was facing the edge of the third floor concrete slab. Mr Traeger had a conversation with Mr Castillo-Riffo<sup>178</sup>. Mr Traeger asked if he was okay and Mr Castillo-Riffo replied 'all good'. Mr Castillo-Riffo asked Mr Traeger to remove some rubbish out of his way and a pallet with some product on it that was also in the way. Mr Traeger described how he went and found a pallet jack and moved the pallet and cleared away some of the debris that had appeared

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<sup>173</sup> Transcript, page 752

<sup>174</sup> Transcript, page 754

<sup>175</sup> Transcript, page 754

<sup>176</sup> Transcript, page 754

<sup>177</sup> Transcript, page 755

<sup>178</sup> Transcript, page 756

MFS

overnight<sup>179</sup>. Mr Traeger then asked Mr Castillo-Riffo what he planned on doing after he finished the patching in that area. They talked about the possibility of Mr Castillo-Riffo working in another area after he had finished the pockets. Mr Traeger described the other area as 'some balconies'. Mr Traeger then had to speak to the exclusion zone person for those balconies to see if it would be possible for Mr Castillo-Riffo to move into that sector, which was Mr Traeger's next task.

- 17.3. Mr Traeger said that when he was talking to Mr Castillo-Riffo at that time, Mr Castillo-Riffo 'looked comfortable'. He said:

'He was comfortable working like he is. He enjoyed what he did. He was a very meticulous man and he really had this work - he had control. He was doing it quite swiftly and - I might add - good.'<sup>180</sup>

- 17.4. Mr Traeger described the position of Mr Castillo-Riffo's scissor lift as being up to the safety rail with the extension platform pushed out beyond the safety rail and into the void so that Mr Castillo-Riffo could access the pockets<sup>181</sup>.

- 17.5. Mr Traeger said that his conversation on that occasion with Mr Castillo-Riffo occupied 5 to 10 minutes<sup>182</sup>. Mr Traeger said that he then went to the area of the balconies where he hoped that Mr Castillo-Riffo might be able to move to after completing the pockets. He spoke to the relevant exclusion zone permit holder. He said they indicated that they were fitting glass and that SRG would not be able to access the area until the following morning<sup>183</sup>. Mr Traeger said that according to his mobile phone records he spoke to the exclusion zone holder for the balcony, Mr James Ko, at 6:53am. The evidence suggests that Mr Traeger was in the balcony area while making that telephone call. Presumably Mr Ko was somewhere else. In any event, it was after 6:53am that Mr Traeger went past where Mr Castillo-Riffo was working to tell him that he would not be able to work in the balcony area until the following day. Mr Traeger said that he thought that by that time Mr Castillo-Riffo might have moved from the first pocket and was working on the second pocket<sup>184</sup>. Mr Traeger said that he told Mr Castillo-Riffo that he would not be able to work in the balcony area until the following day.

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<sup>179</sup> Transcript, page 757

<sup>180</sup> Transcript, page 757

<sup>181</sup> Transcript, page 759

<sup>182</sup> Transcript, page 760

<sup>183</sup> Transcript, page 760

<sup>184</sup> Exhibit C67, page 12

MFS

- 17.6. That conversation was the last occasion on which any person saw Mr Castillo-Riffo before the incident. Mr Traeger said that the conversation took place at a distance and he had to yell out to Mr Castillo-Riffo. Mr Traeger could see Mr Castillo-Riffo across the penetration because Mr Traeger was on the edge of the penetration where the Pega hoists were, which was the western side of the penetration. Looking across Mr Traeger could see Mr Castillo-Riffo in the scissor lift, again facing the edge of the concrete slab. Mr Traeger said that he could see Mr Castillo-Riffo quite clearly<sup>185</sup>. He said that Mr Castillo-Riffo did not look around to reply, but he did answer. Mr Traeger noted that Mr Castillo-Riffo appeared to be working at the time<sup>186</sup>.
- 17.7. As I have noted, while Mr Traeger had been 'pre-starting' Mr Yuckich and Mr King, Mr Steele had needed to go and retrieve his tools from Mr Castillo-Riffo's scissor lift. Mr Steele gave evidence about what transpired in his interaction with Mr Castillo-Riffo that morning.
- 17.8. Mr Steele said that when he arrived at Mr Castillo-Riffo's location, Mr Castillo-Riffo was in the scissor lift which was elevated and Mr Castillo-Riffo was working on the edge of the third floor concrete slab<sup>187</sup>. Mr Steele said that Mr Castillo-Riffo was standing on the outside looking back to the fascia, or the edge of the slab. Mr Steele called to Mr Castillo-Riffo and Mr Castillo-Riffo then lowered the scissor lift<sup>188</sup>. Mr Steele said that Mr Castillo-Riffo lowered the scissor lift all the way down and did so in a standing position with his upper body still on the outside of the fascia. Mr Castillo-Riffo then handed Mr Steele his tools. Mr Steele could not recall where the control box was located when Mr Castillo-Riffo was lowering the scissor lift, but said that it was close enough for him to reach without bending down and reaching under the slab<sup>189</sup>. Mr Steele said that he observed Mr Castillo-Riffo coming down in the scissor lift and said that Mr Castillo-Riffo appeared to be quite comfortable in controlling it. He said that if you see someone who is not confident on a scissor lift, the lift might jerk, it might go the wrong way, but that was not the case with Mr Castillo-Riffo and Mr Steele had no concerns<sup>190</sup>.

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<sup>185</sup> Transcript, page 762

<sup>186</sup> Transcript, page 762

<sup>187</sup> Transcript, pages 334-335

<sup>188</sup> Transcript, page 336

<sup>189</sup> Exhibit C63, page 7

<sup>190</sup> Transcript, page 337

MPS

- 17.9. Mr Steele did not remember having any particular conversation with Mr Castillo-Riffo other than to say good morning and what he described as ‘general tradie talk’. He said that Mr Castillo-Riffo asked where Mr Steele was working and that was the extent of the conversation. Mr Steele said that he observed ‘multiple trades’ working in the general vicinity including gyprockers, plumbers and electricians<sup>191</sup>. He also noted that there were concreters preparing for a pour some 20 to 30 metres away and there were about ten of them<sup>192</sup>. Mr Steele said that he assumed that those people would have been within ‘eyeshot and/or earshot’ of Mr Castillo-Riffo<sup>193</sup>.
- 17.10. Mr Steele said that when Mr Castillo-Riffo was in the elevated position, the top rail of the scissor lift was approximately 20cm to 30cm below the underside of the concrete slab<sup>194</sup>. Mr Steele estimated that he was with Mr Castillo-Riffo for no more than a couple of minutes<sup>195</sup>.
- 17.11. Ms Fallon who was the nurse employed by HYLC on site on 27 November 2014 said that she received the page that had been activated after Mr Castillo-Riffo’s discovery by Mr Hales and Mr Haig at 0711 hours<sup>196</sup>. Thus, bearing in mind that Mr Traeger fixed the time of his last conversation with Mr Castillo-Riffo as having taken place sometime after 0653 hours that morning, it is possible to conclude that Mr Castillo-Riffo’s incident occurred sometime between 0653 hours (probably some minutes after this given that Mr Traeger did not speak to Mr Castillo-Riffo immediately after making the telephone call) and 0711 hours. One could probably narrow the interval further and say that the earliest the entrapment might have occurred would have been approximately 0655 hours and the latest approximately 0710 hours. A window of 15 minutes.

## 18. The legislative framework

- 18.1. In 2008 the Council of Australian Governments (COAG) decided to harmonise work, health and safety laws throughout the Commonwealth, noting that such laws were the province of the States and Territories. Of course, the Commonwealth Government has such laws in respect of Commonwealth employees and workplaces. By 2012 new WHS laws commenced in a number of jurisdictions including the Commonwealth. South

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<sup>191</sup> Transcript, page 337

<sup>192</sup> Transcript, page 337

<sup>193</sup> Transcript, page 338

<sup>194</sup> Transcript, page 362

<sup>195</sup> Exhibit C63, page 8

<sup>196</sup> Exhibit C70, page 2

MFS

Australia implemented the harmonised laws in 2013. The relevant legislation in South Australia as at November 2014 was the Work, Health and Safety Act 2012. The relevant regulations were the Work, Health and Safety Regulations 2012. I refer to them respectively as the WHS Act and the WHS Regulations.

- 18.2. The following analysis is taken from the submissions of SafeWork SA. The analysis of itself is not controversial.
- 18.3. Health and safety duties are imposed by Part 2 of the WHS Act 2012. The WHS Act prescribes a primary duty of care (in s19), supplemented by a series of further specific obligations. The primary duty of care is owed by ‘a person conducting a business or undertaking’ (PCBU). The duty is owed to ‘workers’ (defined broadly in s7) and ‘others’. The relationship does not have to be a direct contractual relationship. It is sufficient if the worker has been ‘caused to be engaged’ by the PCBU or the worker’s activities in carrying out work have been ‘influenced or directed’ by the PCBU.
- 18.4. The primary duty requires the PCBU to eliminate or minimise risks ‘so far as is reasonably practicable’, taking into account and weighing up relevant, specified matters, including the likelihood of a hazard or risk occurring, the degree of harm that might result and the ways of eliminating or minimising the risk.
- 18.5. Duty-holders are expected to take reasonable steps to identify hazards or risks in the workplace by, for example, consulting other duty-holders and workers, undertaking risk assessments, analysing previous incidents and considering relevant regulations and Codes of Practice. Courts may have regard to control measures contained in Codes of Practice as evidence of what is known about a hazard or risk and rely on this to determine what is reasonably practicable in the circumstances.
- 18.6. Duties are not transferrable; they cannot be delegated to someone else. A person can also have more than one duty. More than one person can concurrently have the same duty. So for example HYLK and SRG each had concurrent duties in the case of Mr Castillo-Riffo’s work.
- 18.7. The WHS Act places significant emphasis on consultation. Duty holders must consult with each other. Duty holders must consult with workers.

- 18.8. The legislation provides that workers must take reasonable care for their own health and safety and that of other workers.
- 18.9. The WHS Act and the WHS Regulations have particular provisions and standards relating to ‘construction work’ and ‘high risk construction work’. These provisions and standards give rise to additional duties and obligations on PCBUs beyond the general duties in the WHS Act and the WHS Regulations. Relevantly, the ‘principal contractor’ has several specific duties (additional to the primary duty of care, if applicable) if certain work is ‘high risk construction work’ (within the 18 types of work that involves). Relevantly, the PCBU must ensure that a safe work method statement (SWMS) is prepared before the work commences (as well as associated duties) and the principal contractor must take ‘all reasonable steps to obtain a copy of the’ SWMS before the work starts.
- 18.10. The WHS Regulations define ‘construction work’, ‘high risk work’ and ‘high risk construction work’ (regs 5, 289 and 291). ‘Construction work’ is very broadly defined in regulation 289.
- 18.11. ‘High risk construction work’ is construction work that:
- a) ‘is carried out in an area at a workplace in which there is any movement of powered mobile plant’
  - b) ‘involves a risk of a person falling more than 3 metres’.

The regulations do not prescribe the use of a scissor lift as ‘high risk work’. However, each of the SRG workers held licences entitling them to operate a scissor lift. As it happened Mr Castillo-Riffo also held a licence that permitted him to use a boom lift. A PCBU with a s19 duty must manage risks associated with that duty in accordance with Part 3 of Chapter 6 of the WHS Regulations (reg 297) and this requires the PCBU to ensure a ‘safe work method statement’ (SWMS) is in place before high risk construction work commences (reg 299(1)).

- 18.12. The SWMS must identify the work is ‘high risk construction work’, specify the hazards and risks associated with it, describe the measures to be implemented to control the risks and describe how the control measures are to be implemented, monitored and reviewed.

- 18.13. A PCBU must put in place arrangements to ensure the ‘high risk construction work’ is carried out in accordance with the SWMS for that work (reg 300(1)).
- 18.14. Where the value of construction work exceeds \$250,000 the principal contractor must prepare a written WHS management plan for the workplace. The WHS management plan must include the names, positions and health and safety responsibilities of all persons at the workplace whose positions or roles involve specific health and safety responsibilities in connection with the project. It must include a plethora of other matters relating to health and safety arrangements.

**19. The prosecution**

- 19.1. I have previously mentioned that SafeWork SA was a business unit within the Department of Government, or administrative unit, responsible for the administration of the WHS Act. The Executive Director of SafeWork SA is, for the purposes of the WHS Act, the regulator. Pursuant to s230 of the WHS Act, the regulator or an inspector may bring proceedings for an offence against the WHS Act.
- 19.2. On 27 October 2015 the then regulator (Ms Boland) laid charges against Hansen Yuncken Pty Ltd, Leighton Contractors Pty Ltd and SRG Building (Southern) Pty Ltd (SRG) alleging breaches of the WHS Act against all three defendants arising out of Mr Castillo-Riffo’s death. No other charges against any other parties were laid in respect of the fatality. The defendants pleaded not guilty.
- 19.3. All of the matters were listed for a contested hearing before the Industrial Court of South Australia which was to commence on Monday 13 February 2017.
- 19.4. SRG and the regulator entered into an enforceable undertaking which obliged SRG to expend \$76,500 to design, manufacture and supply early warning devices to be affixed to scissor lifts within the South Australian community. SRG undertook certain other obligations.
- 19.5. With respect to Hansen Yuncken and Leighton Contractors, the proceedings were listed before Industrial Magistrate Ardlie on Friday 10 February 2017 at which time the regulator led no evidence against both defendants. Both complaints were struck out.
- 19.6. At the hearing of the Inquest the Court admitted evidence relating to the conduct of the investigation into Mr Castillo-Riffo’s death by SafeWork SA. The Court did not admit

MPS

evidence relating to the legal advice and decisions concerning the prosecution and particularly the decision to lead no evidence. However, the Court received and admitted into evidence<sup>197</sup> a document published by the Government of South Australia entitled 'Legal advice on the investigation and prosecution arrangements at SafeWork SA'. That document states that:

'In March 2017, following consideration of the outcome in the prosecution against Hansen Yuncken and Leighton Contractors regarding the death of Mr Jorge Castillo-Riffo, the Chief Executive of the Attorney-General's Department directed the preparation of a legal advice into the investigation and prosecution arrangements for offences under the Work Health and Safety Act 2012 (WHS Act). This review was conducted by a senior prosecutor from the Office of the Director of Public Prosecutions.'

The document also announced that the Premier had revealed publicly that the review was being conducted on 11 April 2017. The review was finalised on 16 June 2017. The document said that the review was not a review of 'any individual matter'. However, the reviewer found that there was significant room for improvement in the current arrangements for the investigation and prosecution of offences within SafeWork SA, including the need for both immediate and ongoing training for SafeWork SA investigators about issues such as the engagement of experts, conducting interviews and the application of certain compulsive powers. It recommended a review of the structure and management of the SafeWork SA investigation team and the way in which investigation files are case managed and peer reviewed. It recommended the need to review existing practices and procedures on topics such as the engagement of experts, the consideration of enforceable undertakings, SafeWork SA's first response protocol and the way in which victim assistance services are provided. The document announced that the Government had accepted all 18 recommendations of the review.

## **20. The conduct of the Inquest**

- 20.1. The task of the Court in this Inquest, as in any Inquest, is to give findings in writing, setting out as far as has been ascertained, the cause and circumstances of the event that was the subject of the Inquest<sup>198</sup>. The Court must not make any finding, or suggestion, of criminal or civil liability<sup>199</sup>. Clearly enough, in this particular case it was not the Court's function to reach any conclusion as to whether HYLC, SRG or any other person had committed breaches of the WHS Act or WHS Regulations. To do so would be to

<sup>197</sup> Exhibit C36q

<sup>198</sup> Coroners Act 2003, Section 25(1)

<sup>199</sup> Coroners Act 2003, Section 25(3)

MPS

make a finding or suggestion of criminal liability. Nevertheless, it was inevitable that the provisions of the WHS Act and the WHS Regulations would loom large. That is because it is relevant for the Court to be aware of the existence of such things as safe work method statements and whether they existed or not in relation to the work Mr Castillo-Riffo was performing. Other aspects of the WHS Act and WHS Regulations are, in my opinion, less relevant and some are much less relevant. For example, the WHS Act and WHS Regulations contain provisions relating to whether a person is ‘working alone’ or not. I do not see it as any part of my function to express an opinion as to whether Mr Castillo-Riffo was working alone or not, to the extent that that expression is defined and the consequences of working alone are prescribed in that legislation. The extent however to which Mr Castillo-Riffo could be said to have been working alone in the ordinary meaning of working alone, outside the context of the WHS legislation, was however obviously relevant in the context of the cause and circumstances of his death.

## **21. The HYLC nRAH safety system**

- 21.1. There was in place at the nRAH project an overarching WHS management plan as well as a system of SWMS<sup>200</sup>. This was known to SafeWork SA<sup>201</sup>. SafeWork SA had a significant presence on the site over the course of construction. SafeWork SA officers regularly attended and inspected.
- 21.2. The workers who gave evidence at the Inquest, Mr King, Mr Steele and Mr Yuckich described their training in scissor lift use and elevated work platforms generally. They explained the operation of the safety system. Mr King described the system of pre-start talks occurring every day<sup>202</sup> and how a pre-start safety check of a scissor lift is mandatory<sup>203</sup>. Mr Steele described how risks would be discussed in the pre-start meetings and the toolbox talks<sup>204</sup>. Mr Yuckich described the system of the start-up check for the scissor lift and how if something wrong was found the scissor lift would be tagged out<sup>205</sup>.

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<sup>200</sup> Safe Work Method Statement

<sup>201</sup> See for example Transcript, page 1639

<sup>202</sup> Transcript, page 184

<sup>203</sup> Transcript, page 185

<sup>204</sup> Transcript, page 333

<sup>205</sup> Transcript, page 1550

MPS

- 21.3. There was consistent evidence about warnings as to crush risks being given at inductions and toolbox meetings<sup>206</sup>.
- 21.4. The Court heard evidence from a number of health, safety and environment officers, including Mr Hayes, Mr Grover and Mr Lynch. Mr Hayes said that in performing his role as an HSE officer he relied on HYLIC's safety management plan<sup>207</sup>. He dealt with exclusion zones and SWMS<sup>208</sup>. He would spend 70% to 80% of his time on the site doing site inspections, toolbox talks and approaching subcontractors to discuss their works and any safety issues they may have been experiencing<sup>209</sup>. Mr Hayes said that he never saw the performance of work such as patching from a scissor lift extended into a penetration<sup>210</sup>. Mr Hayes said that had he seen such work being performed he would have approached the worker, asked him to lower the scissor lift and had a discussion about the task that he was doing<sup>211</sup>. He acknowledged that he would have been interested in examining a SWMS for the kind of work and would have been concerned if he realised that the emergency lever was hard to see because it was between the front of the scissor lift and the safety fence<sup>212</sup>. Mr Hayes was involved in the resuscitation efforts following Mr Castillo-Riffo's accident.
- 21.5. Mr Grover gave evidence about his work as an HSE officer on the nRAH site also. He also referred to subcontractors' pre-start meetings, risk assessments and general safety meetings<sup>213</sup>. Mr Grover also was involved in the efforts to rescue Mr Castillo-Riffo<sup>214</sup>.
- 21.6. Mr Grover gave evidence that if he had seen Mr Castillo-Riffo's system of work in place as at 27 November 2014 he would have asked him to 'cease work and obtain the appropriate machine for the task'<sup>215</sup>. Mr Grover said other options would have included boom lifts, but he regarded the scissor lift as not providing adequate room for the task assigned.
- 21.7. Mr Lynch also gave evidence. Mr Lynch is also a project HSE manager for HYLIC and was working on the nRAH site in 2014<sup>216</sup>. He said that he attended pre-start and toolbox

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<sup>206</sup> Mr King at Transcript, page 298, Mr Hales at Transcript, page 692, Mr Traeger at Transcript, pages 753-754 and 766

<sup>207</sup> Transcript, page 903

<sup>208</sup> Transcript, page 903

<sup>209</sup> Transcript, page 906

<sup>210</sup> Transcript, pages 932-933

<sup>211</sup> Transcript, page 936

<sup>212</sup> See generally Transcript, pages 933-942

<sup>213</sup> Transcript, page 988

<sup>214</sup> Transcript, pages 991-992

<sup>215</sup> Transcript, page 1009

<sup>216</sup> Transcript, page 1751

MFS

talks with various subcontractors and performed similar duties to the other HSE officers<sup>217</sup>. Mr Lynch said that he had a role to play in SWMS review and approval. He stated that the subcontractors needed to send their SWMS via the document register system which was operating within the project<sup>218</sup> and the relevant project manager, site manager and safety supervisor or HSE coordinator within that particular area at that particular time would review the works or the SWMS prior to the activity being undertaken<sup>219</sup>. He said that the arrangement was that the subcontractor would submit his SWMS after consulting with his workers for a particular activity<sup>220</sup>.

- 21.8. Mr Lynch gave evidence that his assessment of the work being done by Mr Castillo-Riffo was that the scissor lift was positioned up against the hand rail and there was not plenty of room to move for Mr Castillo-Riffo<sup>221</sup>. Mr Lynch said he did not have an opinion on whether Mr Castillo-Riffo's system of work was a safe system. He said there were probably numerous ways the activity could have been undertaken. He said that for a five minute exercise such as patching:

'If it was a five minute exercise you wouldn't build a scaffold from the ground up and you probably wouldn't have had the room and you've just got to be reasonably practicable within your approach if it's only a short task if it takes three, four men by four days to build something and half that time to take it down; you've just got to - that's a part of our job, risk assess and find out what the best suitable item of platform or plant you use for that particular activity.'<sup>222</sup>

## 22. SRG's safety system – there was no SWMS

- 22.1. Mr Bradley Parkinson gave evidence at the Inquest. He was in November 2014 employed by SRG as its quality safety environmental manager covering Victoria, South Australia and Tasmania. In that role he offered advice to quality, safety and environmental managers on the site teams. He conducted formal inspections and audits of sites<sup>223</sup>. He was involved in the nRAH project by supporting SRG's project team<sup>224</sup>. Mr Parkinson was taken to a document in the course of his evidence. It is a SWMS and

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<sup>217</sup> Transcript, page 1757

<sup>218</sup> The system was known as ACONEX

<sup>219</sup> Transcript, page 1758

<sup>220</sup> Transcript, page 1758

<sup>221</sup> Transcript, page 1760

<sup>222</sup> Transcript, pages 1761-1762

<sup>223</sup> Transcript, page 1851

<sup>224</sup> Transcript, pages 1852-1853

MPS

is entitled 'Delivery, installation, stressing and grouting of post-tension tendons'<sup>225</sup>. Mr Parkinson was asked what sort of work this document applied to. He said:

'You start with the formwork then this document goes through the tasks of installing the post-tensioning tendons onto the formwork then moves onto the initial stressing of the post-tensioning tendons after the concrete is poured, then that follows on to the post-tensioning or final stressing of the post-tensioning tendons followed by cutting and sealing of the post-tensioning tendons and then finally grouting them.'<sup>226</sup>

The SWMS named the relevant project as the nRAH project. It was prepared by Shane Leef, SRG's supervisor on the project<sup>227</sup>. Mr Parkinson said that it was then submitted by Mr Laudato, SRG's site engineer and administrator through to HYLIC via ACONEX. Mr Parkinson said that Mr Leef consulted with him on many occasions on many subjects. In particular Mr Leef spoke to him when preparing this SWMS and would have used as precedents SWMS that Mr Parkinson had looked at in the past on different post-tensioning projects. He said:

'Most of the time the post-tensioning work doesn't change a great deal from project to project.'<sup>228</sup>

- 22.2. In SRG's submissions it was conceded that there was no documented SWMS in place for the task that Mr Castillo-Riffo was performing. It was acknowledged that this was contrary to SRG's requirement and expectation that a risk assessment will be undertaken and a SWMS completed for all high risk work<sup>229</sup>. In its submissions SRG acknowledged that this was unacceptable.
- 22.3. In particular SRG acknowledged that it became clear during the Inquest that the SWMS for delivery, installation, stressing and grouting of post-tension tendons<sup>230</sup> applied to post-tensioning work being conducted by SRG employees while the formwork for the concrete pour was still in place and that it did not envisage work being undertaken in a scissor lift in the manner that the rectification work was performed by Mr Castillo-Riffo.

<sup>225</sup> Exhibit C64, page 1 and Exhibit C48i

<sup>226</sup> Transcript, page 1855

<sup>227</sup> Transcript, page 1855

<sup>228</sup> Transcript, page 1856

<sup>229</sup> Transcript, page 1857

<sup>230</sup> Exhibit C64, page 1

MPS

- 22.4. SRG's concessions with respect to that SWMS<sup>231</sup> was correctly made on a review of the document. It is apparent from the document that it envisages a system of work at a point before the concrete has been poured for the slab. Obviously the rectification work being performed by Mr Castillo-Riffo could only take place after the slab had been poured. A SWMS for Mr Castillo-Riffo's work would not have required any mention of the work required to be done prior to the pouring of the concrete such as can be seen on page 12 of the SWMS. It is notable also that that page contains a reference to the formwork collapsing when a coil is landed on the deck. Clearly there was no formwork in place when Mr Castillo-Riffo was performing his task. The document also goes through the actual tensioning process by use of the hydraulic jacks. Again, this is something that occurs as part of the main process, and is not relevant to the sort of rectification work being performed by Mr Castillo-Riffo. Another example is to be found at page 19 where the SWMS refers to overseeing the concrete pour to ensure cables are not damaged and ducts/anchorages are not displaced. It is notable that Mr Castillo-Riffo and the other workers from SRG have signed the SWMS acknowledging that they have read it and understood it<sup>232</sup>.
- 22.5. There was in evidence a second SWMS document<sup>233</sup>. This SWMS was entitled 'Cut and seal strands from slab edge from a boom EWP'<sup>234</sup>. Clearly enough the reference to a boom EWP is a reference to a different kind of elevating work platform from a scissor lift. The SWMS does not apply to a scissor lift on its face. This SWMS was prepared by Mr Parkinson in relation to aspects of the rectification or defect work<sup>235</sup>. Mr Parkinson said that returning to perform rectification work of the nature that was required in this case occurred very rarely. He said that generally speaking the grouting and clean-up occurs before the removal of the formwork<sup>236</sup>.
- 22.6. Mr Parkinson prepared the SWMS in response to a request from Mr Leef for a SWMS covering work in zone 4 which involved removing some sand and cement from pockets and replacing it with a high strength product. Mr Parkinson met with Mr Leef at the

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<sup>231</sup> Exhibit C64, page 1

<sup>232</sup> See pages 31-33

<sup>233</sup> Exhibit C64, page 38 and Exhibit C48j

<sup>234</sup> EWP = Elevated Work Platform and includes a boom lift and also a scissor lift

<sup>235</sup> Transcript, page 1859

<sup>236</sup> Transcript, page 1859

MPS

site and inspected the area where the work was to be performed<sup>237</sup>. Mr Parkinson understood that a scissor lift would be used on flat ground in zone 4 and a boom lift would be used on the ramp<sup>238</sup>. He said that it was never his intention that this SWMS should be used for work undertaken in a scissor lift over a void<sup>239</sup>.

- 22.7. Mr Parkinson was asked about the rarity of the performance of rectification work of this nature. It was suggested that that may have been a reason why there was no SWMS for that kind of work and he replied:

'Yes, very rarely do you work off EWPs for monostrand post-tensioning. In fact I had a word with our construction manager in Victoria on Saturday and in the last three and half years that's only occurred twice ... in my area, South Australia, Victoria and Tasmania.'<sup>240</sup>

He said that was the reason why SRG did not have a template SWMS available for the type of work Mr Castillo-Riffo was performing<sup>241</sup>.

- 22.8. Had a SWMS been prepared for the proposed use of a scissor lift for the patching work being performed by Mr Castillo-Riffo it would, of necessity, have forced the author of the SWMS to address the risks of performing work in a scissor lift over a void. Two of the obvious risks that would have been considered in that process would have been the risk that too small a scissor lift would not afford sufficient room for the worker to perform his tasks. It would have been apparent to the author of the SWMS that the extension platform on a scissor lift may be at the same end of the scissor lift as the emergency lowering safety lever, as was the case with Mr Castillo-Riffo's scissor lift. Presumably a properly prepared SWMS for the task would have proscribed the use of a scissor lift whose safety release lever would have to be against a guard rail fence in order for the extension platform to protrude into the void. There may have been other scissor lifts on the market apart from the Snorkel scissor lift used by Mr Castillo-Riffo where that problem might have been obviated. However, a properly constituted SWMS would have considered other risks involved in the use of a scissor lift such as the adequacy of the work space which I have already mentioned.

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<sup>237</sup> Transcript, page 1861

<sup>238</sup> Transcript, pages 1860-1861

<sup>239</sup> Transcript, page 1861

<sup>240</sup> Transcript, page 1911

<sup>241</sup> Transcript, page 1912

MPS

### **23. The experts engaged by SafeWork SA**

23.1. SafeWork SA engaged three experts in the course of its investigation. There were strong attacks upon the process of briefing the experts engaged by SafeWork SA. Each of the three experts gave evidence at the Inquest.

#### **23.2. John Glover**

Mr Glover is the National Service Manager for the On-Site Rental Group. He is a qualified maintenance fitter by trade and is the current State President of the New South Wales Elevated Work Platform Association. He started work in the EWP industry in 1988. Initially he was fixing and repairing equipment in the field. He then progressed to becoming a leading hand and service manager and ultimately the National Service Manager<sup>242</sup>. Mr Glover prepared several reports for SafeWork SA which were admitted<sup>243</sup>. It seems that initially SafeWork SA engaged Mr Glover as a mechanical expert. Clearly he is appropriately skilled and qualified to assess the mechanical condition of the scissor lift. Indeed, he did carry out a mechanical inspection of the Snorkel scissor lift that was used by Mr Castillo-Riffo. The evidence of his inspection is relevant and admissible for this Inquest. He found that the scissor lift was in appropriate working order and was working as intended by the manufacturer. In particular Mr Glover confirmed that apart from the defective horn and broken glass in the charging indicator, the machine functioned as it was supposed to. In particular he found that the emergency release lever, the lower controls and the controls in the box all functioned correctly<sup>244</sup>. I accept that evidence.

23.3. It seems that SafeWork SA's engagement of Mr Glover was then extended to seek his opinion as to whether the scissor lift being used by Mr Castillo-Riffo was 'the appropriate machine to use at that site and report on whether a more appropriate piece of plant would be applicable to use'<sup>245</sup>.

23.4. Mr Glover expressed the opinion that a Haulotte Star 10 boom machine would be a better option for the task than the scissor lift that was in fact used by Mr Castillo-Riffo<sup>246</sup>. Indeed, Mr Glover took a photograph of a Haulotte Star 10 in situ at the nRAH site in April 2015 when he was doing a site visit for the purposes of his reports. It

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<sup>242</sup> Transcript, page 485

<sup>243</sup> Exhibits C65, C65a, C65b and C65c

<sup>244</sup> Transcript, page 515

<sup>245</sup> Transcript, page 488

<sup>246</sup> Transcript, pages 535-538

MFS

appeared to be being used for the same task, or a similar task to that carried out by Mr Castillo-Riffo<sup>247</sup>. It is useful at this point to note that the photograph of the Haulotte Star 10 appears in Exhibit C65a at page 13. In his report dated 13 September 2016<sup>248</sup> Mr Glover provided some detail in relation to the photograph of the Haulotte Star 10. He said that it was taken at the nRAH construction site on 29 April 2015 ‘on the same level as the incident (adjacent to crane 3A on the northern side of level 2 within zone 3). The Haulotte Star 10 was accessing a similar area 90 degrees adjacent to where the incident occurred’ (the underlining is mine). It is apparent from this clarification that the Haulotte Star 10 was not in an identical position to the position occupied by the scissor lift that was being used by Mr Castillo-Riffo at the time when he had his accident.

23.5. I was not satisfied that Mr Glover was appropriately qualified to express an opinion about the relative merits of the Haulotte Star 10 and the scissor lift for the task being carried out by Mr Castillo-Riffo. That said, I note that a number of witnesses expressed opinions about the relative merits of the two machines, and indeed some of them expressed a preference for a boom lift such as the Haulotte Star 10. Notably, Mr Traeger’s original intention for the job was to use a boom lift, and it was that boom lift that was the subject of his discussion with Mr Kinsman as I have already outlined. Clearly Mr Traeger had a preference for a boom lift for the task to be carried out by Mr Castillo-Riffo. I will return to that matter later in this finding.

23.6. Professor Caple

Professor Caple is a Management Consultant specialising in health, safety and ergonomics. He prepared reports on behalf of SafeWork SA. Both reports were admitted in these proceedings<sup>249</sup>. Professor Caple also gave evidence.

23.7. Ms Croci was a Senior WHS Inspector employed by SafeWork SA. Ms Croci attended the scene of the incident on 27 November 2014. After that she had no further involvement in the investigation of Mr Castillo-Riffo’s death until 31 August 2016 when she was requested by her employer to assist Professor Caple to operate the scissor lift during his inspection at Ottoway on that date. Ms Croci admitted that she

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<sup>247</sup> Transcript, pages 540-541

<sup>248</sup> Exhibit C65b

<sup>249</sup> Exhibits C79 and C79a

MFS

considered it appropriate to discuss with Professor Caple her own theory on how the incident occurred:

- 'Q. Did you understand that you could tell him what your observations were.  
 A. Yes.  
 Q. Did you think that you could tell him what your inferences were from what you observed that day.  
 A. Yes.  
 Q. Did you think that you could tell him what your theory was about how the accident had happened.  
 A. Yes.' <sup>250</sup>

Shortly after that passage of evidence the following was elicited:

- 'Q. So when you were out there with Professor Caple, you did identify to him your understanding of how the accident happened.  
 A. From what I seen (sic) on the day, yeah.  
 Q. Were you able to tell him what your source of information was that enabled you to come to the hypothesis that you came to.  
 A. Just from the discussion I'd had with Brett and Dave on the day.  
 Q. Can you tell us what those discussions were.  
 A. We were just trying to figure out how Mr Riffo (sic) was caught in the position he was caught in; the possibilities of how, what had occurred.  
 Q. Because none of the three of you knew at that point, did you.  
 A. No.  
 Q. And the only way you were ever going to find out is by talking to the eyewitnesses who had seen.  
 A. Yes.  
 Q. You nevertheless had formed a pretty clear view about what had happened, hadn't you.  
 A. I wouldn't have called it a clear view.  
 Q. You had a defined hypothesis.  
 A. A rough idea of how it could've occurred.' <sup>251</sup>

Shortly after that passage of evidence the following was elicited:

- 'Q. The assumption that you've made there is that he's reaching back with his left arm using the control box without actually being able to see it and at the same time reaching down to get some product from his bucket.  
 A. That was one theory we had.  
 Q. Well, that was the theory that you suggested to Professor Caple, wasn't it.

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<sup>250</sup> Transcript, page 1677

<sup>251</sup> Transcript, page 1679

MPS

- A. Yes.
- Q. It's the one you acted out.
- A. Yes.
- Q. And the one he photographed.
- A. Yes.
- Q. Did you tell him that that's what you thought had happened.
- A. Yes.
- Q. Just turn to p.13, you appear to have had some theory about Mr Castillo-Riffo's head being on the bar facing back into the building and away from the void, do you see that.
- A. Yes.
- Q. Do you now know that's wrong, do you.
- A. Yes, as of yesterday.
- Q. But there were in fact eye witnesses who could have told you and Professor Caple exactly which way Mr Castillo-Riffo was facing and where his head was caught.
- A. That would have been handy.'<sup>252</sup>

23.8. It is apparent from the above passage of evidence that Ms Croci performed a crude reconstruction of her interpretation of the incident for Professor Caple when he was inspecting the Snorkel scissor lift at Ottoway. Indeed, the caption to one of the photographs<sup>253</sup> states 'this photograph shows the Inspector, Cathy Croci, simulating this posture'. Page 11 of the report shows Ms Croci adopting what is described as a 'potential posture when fatality occurred' in which she can be seen bending over with her head side on to the top of the guard rail. Her torso and body are facing towards the rear of the scissor lift. By contrast, the eyewitness Mr Haig described Mr Castillo-Riffo's torso and body oriented in the direction of the void, in other words the opposite direction to that demonstrated by Ms Croci.

23.9. Not surprisingly this caused SafeWork SA to concede that Professor Caple's hypothesis of how the incident occurred must be disregarded as it was on a factual basis inconsistent with eyewitness accounts as to Mr Castillo-Riffo's positioning. As a result those opinions would never have been admissible evidence in any prosecution as the opinions were irrelevant, and secondly as a reconstruction, would be inadmissible:

'...unless it is shown that they are identical with the earlier event which is reconstructed. Where this identity cannot be shown, the "reconstruction" does not satisfy a distinct rule of admissibility. Hence the reasoning in that case, more exactly put, would have been: "if the reconstruction was identical with the actual event (a matter for proof by the

<sup>252</sup> Transcript, pages 1684-1685

<sup>253</sup> Exhibit C79, page 10

MPS

prosecution, and decision by the judge, on the voir dire), then it should have been left to the jury; if not, not.” (Heydon, Cross on Evidence, [1490] (last updated August 2018; see further [1290]: "reconstructions" have generally been rejected as their admissibility depends on their being sufficiently similar to the original event).'

23.10. Perhaps less appropriately SafeWork SA submitted that its:

'.. then solicitors ought to have ensured that any evidence from Mr Caple was in an admissible form. SWSA's solicitors should have instructed Mr Caple in writing clearly setting out the factual assumptions he was required to make and not relied on inadmissible reconstruction evidence (which would have been likely inadmissible regardless of who instructed Mr Caple). It should not have been left to Inspector Croci to brief Mr Caple.'<sup>254</sup>

23.11. The criticism of SafeWork SA's then solicitors may well be justified. However one would expect expert investigators to know better than to participate in a reconstruction, particularly without the most meticulous care being taken in ensuring its accuracy. This aspect of the investigation was incompetent and inept and it may be completely unfair to blame the then solicitors for SafeWork SA who may have had no idea that a person held out as an inspector, and therefore as having some idea about the gathering of evidence for courts, would know better than to engage in the farcical process adopted by Ms Croci.

23.12. Associate Professor Dell

Finally, SafeWork SA engaged Associate Professor Dell who is an expert in occupational hazard management, assessment of workplaces, work practices and the safe use of plant. Associate Professor Dell is also the Discipline Leader, Accident and Forensic Investigation Department, Central Queensland University where he holds the position of Associate Professor. Associate Professor Dell said that he did not think at the time he expressed his opinions, and still did not think at the time of giving evidence, that he was able to say exactly how Mr Castillo-Riffo met his accident 'because of a lack of validated evidence from the scene'<sup>255</sup>. He said that for the purposes of his report it was neither necessary nor possible to work out exactly how the accident happened from the material he was provided with<sup>256</sup>.

23.13. Associate Professor Dell was an astute and intelligent witness who gave his evidence in a straightforward, frank and helpful manner. I have no hesitation in accepting his

<sup>254</sup> See closing submissions of SafeWork SA

<sup>255</sup> Transcript, page 2433

<sup>256</sup> Transcript, page 2433

MPS

evidence and I particularly note that he was at pains to acknowledge the limitations upon his ability to express opinions.

- 23.14. Associate Professor Dell said the difficulty that he had was that some of the information that might have shed light on the circumstances of how Mr Castillo-Riffo was trapped was not captured at the time of the event. He said that some set of circumstances arose that had Mr Castillo-Riffo in a position he was not expecting to be in. He said that if he had been investigating the incident at the time it occurred, he would have been looking at the operation of the scissor lift 'a lot more closely', comparing it to other scissor lifts that were in use at the site. He particularly noted that there are significant variations in the operating geometry of scissor lifts and that there is no standard for the way control configurations are presented to operators. In effect, manufacturers seem to do what they like. He said it was possible that may have had some impact on the event<sup>257</sup>.
- 23.15. Associate Professor Dell remarked that the photographs that were taken at the scene<sup>258</sup> were inadequate. He said there was parallax error in trying to make any measurements from the photographs. The photographs did not establish the exact geometry of the scene. He noted that there was no accurate measurement taken at the scene of the relationship between the hand rail and the edge of the concrete slab<sup>259</sup>.
- 23.16. Associate Professor Dell said he could not say what Mr Castillo-Riffo was exactly doing when the accident happened and to do so would be conjecture. When pressed he offered the following:

'So that raises a question of was he activating it in the direction he was intending or in another direction? Given the close proximity to the slab there was virtually - if it was an inadvertent activation, you know, the entrapment would have occurred really quickly and you know, clearly he didn't have the opportunity to reverse it - '<sup>260</sup>

Associate Professor Dell acknowledged that at the time of the accident Mr Castillo-Riffo was not actually carrying out the work that he had been doing (in other words the patching)<sup>261</sup>. Associate Professor Dell said that he did ask to see the machine and also

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<sup>257</sup> Transcript, page 2434

<sup>258</sup> Photographs were taken at the scene by Inspectors Croci and Pfeffer - they were taken on their respective mobile telephones

<sup>259</sup> Transcript, page 2439

<sup>260</sup> Transcript, page 2441

<sup>261</sup> Transcript, page 2443

MPS

visit the site scene of the accident. He said that SafeWork SA did not allow him those opportunities<sup>262</sup>.

- 23.17. Associate Professor Dell said that he was asked to look at all of the risks associated with the method of work. He then noted that that was his brief:

'... even though that wasn't part of what - you know, as you said earlier, you know, he wasn't doing the job at the time of the event. In responding to the brief, I had to consider the workspace.'<sup>263</sup>

- 23.18. In short, Associate Professor Dell was critical of the confined nature of the workspace that Mr Castillo-Riffo had available to him to perform the work in question. In particular, Associate Professor Dell said that the workspace available to Mr Castillo-Riffo is not a matter of whether he used a boom lift or a scissor lift simpliciter, but whether he had sufficient workspace<sup>264</sup>. He frankly acknowledged that from the point of view of what actually happened to Mr Castillo-Riffo, the amount of workspace he had available to him at the time he was doing the patching task was irrelevant and would not have made any difference. He responded by saying that the method of work posed a risk, but it was not a risk that caused Mr Castillo-Riffo's incident<sup>265</sup>.

- 23.19. Associate Professor Dell offered as an alternative form of work method, the use of a cantilevered scaffold which would have required the input of a scaffolding engineer<sup>266</sup>.

- 23.20. Associate Professor Dell acknowledged that there were two possibilities as to how Mr Castillo-Riffo came to be underneath the slab. He acknowledged that one possibility was that Mr Castillo-Riffo had stopped doing his work and had crouched down to move back into the machine under the concrete slab. Another possibility was that he may have finished working on the face, lowered the machine and was then actually coming back up at the time he was trapped. Associate Professor Dell said that it is simply not known which of these occurred<sup>267</sup>. In his report<sup>268</sup>, Associate Professor Dell did nominate a number of alternatives including the use of a boom lift such as the Haulotte Star 10. He also significantly referred to the absence of a SWMS for the task being undertaken by Mr Castillo-Riffo. He said had a SWMS been developed it would have eliminated the risks involved in using the Snorkel in the way it was being used at

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<sup>262</sup> Transcript, page 2445

<sup>263</sup> Transcript, page 2455

<sup>264</sup> Transcript, page 2463

<sup>265</sup> Transcript, page 2463

<sup>266</sup> Transcript, page 2468

<sup>267</sup> Transcript, page 2478

<sup>268</sup> Exhibit C98

MPS

the time of the incident and an alternative method of access would likely have been sourced and implemented to ensure a safe method of work. He also noted that a spotter should have been assigned to assist Mr Castillo-Riffo.

**24. Boom lift or scissor lift?**

- 24.1. As I have noted, it was Mr Traeger's view that a boom lift ought to have been used initially. For example he said it would have been more convenient because the telescope goes out and you can slew left or right from one position. By contrast, the scissor lift required you to reset your machine underneath each pocket, which in this instance involved repositioning the machine seven times<sup>269</sup>.
- 24.2. Mr Yuckich also expressed a preference for a boom lift<sup>270</sup>. Mr King's evidence was that he did not perform patching over a penetration. Mr Steele's evidence appeared to be that he had no preference one way or the other between a scissor lift and a boom lift.
- 24.3. Finally it must be noted that the SWMS that was most nearly suited to the task that Mr Castillo-Riffo was undertaking was entitled 'Cut and seal strands from slab edge from a boom EWP'<sup>271</sup>. That in itself is indicative of a preference, at least on the part of the author of the SWMS for the use of a boom in carrying out the task.
- 24.4. The preponderance of the evidence would seem to favour the boom. However, I do not regard it as part of my task to make a finding as to which of a boom or scissor lift was the appropriate machine to use on this occasion. Indeed, given that the incident did not occur while Mr Castillo-Riffo was in the course of carrying out the patching task, and did not occur while he was extended out into the penetration, the preferable method for performing the patching task in the penetration is not particularly relevant.

**25. Exclusion zone permit**

- 25.1. Mark Evans was the HYLIC health, safety and environment adviser. He gave evidence that around the site HYLIC might establish exclusion zones where there was a risk of someone being struck by falling objects from persons working above them. He said that on each level around the open edge of the building HYLIC demarcated two metres

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<sup>269</sup> Transcript, page 739

<sup>270</sup> Transcript, page 1546

<sup>271</sup> Exhibit C64, page 38

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out from the edge of the building as an exclusion zone. He said that if anyone needed to work within that two metres they were required to obtain an exclusion zone permit<sup>272</sup>.

- 25.2. An exclusion zone permit had been obtained for the work being performed by Mr Castillo-Riffo<sup>273</sup>. The document is in a standard form and is headed 'exclusion zone permit' with the HYLC Joint Venture logo. The permit start date was 20 November 2014 and the finish date was 23 November 2014, but that was amended to 28 November 2014. The permit was issued by Mr Ray Plant who was the site structure manager for HYLC. The applicant for the permit was Mr John Traeger of SRG. The permit contained a requirement that the person accepting the permit had to ensure that he or she had read, explained, or otherwise understood the requirements of 'the SWMS and any associated permits'<sup>274</sup>. This imposed an obligation upon Mr Traeger to turn his mind to the existence of a SWMS and it would appear that he did not.

**26. Who was the health, safety and environment officer assigned to the rectification works?**

- 26.1. There was confusion amongst the witnesses as to which of the HSE officers within HYLC had responsibility for the rectification works being done by SRG. Accordingly, in the course of the Inquest HYLC made the following concession:

'It is conceded that when Structural Systems Limited (SSL)<sup>275</sup> rectification works got to zone 3 of the nRAH structure in November 2014, HSE resources were being reassigned from structure duties to the fitout tasks but did not sufficiently accommodate the SSL rectification works in adjacent areas. No HYLC HSE resource therefore required SSL to produce a SWMS in accordance with their obligations.'

Mark Evans, Health, Safety And Environment adviser for HYLC, gave evidence at the Inquest acknowledging that the rectification work at the time 'wasn't on our radar'<sup>276</sup>.

**27. Minimum standard 28**

- 27.1. Following Mr Castillo-Riffo's tragic death HYLC issued what was known as Minimum Standard 28 in respect of the nRAH site. It concerned elevated work platforms and

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<sup>272</sup> Transcript, page 2368

<sup>273</sup> Exhibit C87

<sup>274</sup> Exhibit C87

<sup>275</sup> Also SRG

<sup>276</sup> Transcript, page 1978

MPS

contained a number of measures designed to prevent a repetition of Mr Castillo-Riffo's tragic accident. The following measures are noteworthy:

- An emergency retrieval plan must be established. Nominate a person on the ground that is familiar with and has practised the emergency lowering controls.
- When the platform is elevated and stationary, ensure that the emergency ground controls are accessible in case of an emergency.
- No lone work is permitted when operating an EWP.

## **28. SafeWork SA's information sheet**

28.1. There was a PDF document dated September 2016 which is referred to in Exhibit C101. It is entitled 'Elevating Work Platforms'. It is a document that the CFMEU has submitted should be distributed on an annual basis electronically and in hard copy to all relevant building industry participants in South Australia. The CFMEU also recommended that electronic links to the information sheet be displayed permanently on SafeWork SA's webpage and be kept current. The associated minimum standard of training document should be brought into line to include references to clear lines of sight. These are sensible measures and I intend to recommend accordingly. It is notable that the document states that a SWMS must be developed and followed for operating an EWP if there is a risk to people from its movement, including those working on it.

## **29. The problem of non-standard controls in scissor lifts**

- 29.1. This Inquest has heard from many witnesses acknowledging that scissor lifts of different manufacture have different sets of controls. Obviously all scissor lifts have a function that enables them to raise and lower and they all have a function which allows them to drive forwards or backwards and to steer. I have described in great detail the control box which was fitted to the Snorkel scissor lift being used by Mr Castillo-Riffo. Other scissor lifts of other brands are configured very differently. It was certainly Associate Professor Dell's opinion that this lack of consistency is a significant problem for operators. Indeed he agreed with that proposition 'beyond a shadow of a doubt'<sup>277</sup>.
- 29.2. Associate Professor Dell noted that in very large projects such as the nRAH it is likely that there will be large numbers of scissor lifts operating on the site because of the

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<sup>277</sup> Transcript, page 2480

MPS

vastness of the project and its capacity to absorb all of the local resources such as scissor lifts from whatever sources may be available. The result is a large variety of scissor lifts from a large variety of different sources. A worker such as Mr Castillo-Riffo may find himself operating different scissor lifts on different days on the same site.

- 29.3. It would clearly be desirable to introduce a system of standardisation for scissor lift controls. It is also clear that this would impose a burden on the owners and operators of existing scissor lifts which do not happen to fit the chosen standard configuration.
- 29.4. It is not for this Court to specify what the standard configuration for the controls of a scissor lift should be. That is obviously a matter for SafeWork SA and its counterparts in the various States and Territories, industry groups and manufacturer representatives.
- 29.5. Another confounding element is the ability for an operator to move the upper control box from one part of the machine to another. It will be recalled that the control box for Mr Castillo-Riffo's Snorkel scissor lift was portable and could be hung from the guard rail of the scissor lift on any of its sides. It was connected to the machine by a cord. This obviously has the potential to confound any attempt to standardise the configuration of the operating controls of a scissor lift because the standard configuration is only as useful as the orientation of the control box in relation to the machine. It seems to me therefore that a necessary concomitant of the imposition of a set of standard control configurations would be the imposition of a requirement that the control box be fitted in one place in all scissor lifts and not be movable. That may have the capacity to adversely affect the flexibility of a scissor lift as a tool for working at heights. I note that other elevated working platforms do not have portable control devices, or at least the ones examined in this Inquest did not<sup>278</sup>.
- 29.6. For that reason I am loathe to make recommendations that are too narrowly framed in this respect. Unfortunately, the best that I can do is to recommend that the question of attempting to standardise scissor lift controls be given far greater impetus at a State and National level and that it be elevated to the Council of Australian Governments (COAG) for the commissioning of a project to pursue the standardisation of controls in scissor lifts.

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<sup>278</sup> The Haulotte Star 10 had a fixed control box

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**30. Spotters**

30.1. While Australia continues to have a proliferation of scissor lifts with non-standard control configurations it is necessary to have a secondary safeguard. In my opinion that necessitates the implementation of spotters. I therefore recommend that until the implementation of a system of effective standardisation of scissor lift control configuration across the country, that scissor lifts not be operated unless there is a person on the ground operating as a spotter and who is available at all times to take steps to activate the emergency lowering mechanism should that be necessary.

**31. Criticisms of SafeWork SA's investigation**

31.1. There were a number of criticisms of SafeWork SA's investigation. Unsurprisingly, many of these came from HYLC. In fairness to SafeWork SA the scene of the incident was necessarily changed by the activities of first responders. For example the scissor lift was lowered, albeit after some delay caused by Mr Haig being unable to locate and then readily operate the safety lowering mechanism. The fact that the safety lowering mechanism was hard up against the safety rail clearly did not aid in that endeavour and I have discussed that elsewhere. The placement of the safety lever hard up against the railing was a clear failure in the system of work and would have been avoided by the use of a proper SWMS.

31.2. Amongst the many criticisms that were made of the SafeWork SA investigators, I mention a few:

1. Ms Croci's reconstruction with Professor Caple. This was a gross error of investigation and expert witness briefing and clearly should never have happened. It raised the possibility that the later expert, Associate Professor Dell, was tainted by the possibility that he had seen some of the photographs of Ms Croci and assumed them to be accurate descriptions of what had occurred. The evidence was not completely clear as to whether Associate Professor Dell did in fact see those photographs. Nevertheless, he was aware of Professor Caple's reports and he may have been indirectly affected by these errors. Of course, the actions of Inspector Croci meant that the entire exercise of briefing and paying for Professor Caple was entirely wasted.

2. Inspector Moss was the initial principal officer for the investigation. He attended the site on the day after the incident. A week later he took annual leave for a period of some five weeks. It was his evidence that his plan was to leave the investigation to SAPOL investigators during that period with a view to seeing what they managed to ascertain once he had returned from annual leave. Even when he returned from annual leave he was not immediately able to devote himself to the investigation. That does not reflect well upon SafeWork SA.

In the result, SAPOL officers did collect a significant number of witness statements and these were extremely helpful. In my opinion however it is inappropriate for SafeWork SA to make the assumption that SAPOL will bear the main burden of responsibility for an investigation such as this. In my opinion there must be better coordination between SAPOL and SafeWork SA in these situations. By saying that I imply absolutely no criticism of SAPOL in its work in connection with Mr Castillo-Riffo's death. The investigators (Detective Sergeant Truesdale and Detective Brevet Sergeant Nikolic) did excellent work. They would no doubt have been assisted if extra resources had been available from SafeWork SA. They would have particularly been assisted if SafeWork SA had made available whatever expertise it could assemble and procure at a very early stage to determine what the investigational priorities were and to coordinate the efforts of SafeWork SA and SAPOL together. That did not happen. Instead SafeWork SA effectively abandoned the field for SAPOL to pursue the investigation for a period of some six weeks within a week of the incident occurring. That is unsatisfactory.

3. Exhibit C50a, photograph 22, is a close-up photograph of the upper control box in the machine being used by Mr Castillo-Riffo. The photograph reveals the presence of a rubber band at the base of the joystick. This issue was never identified or inquired about by SafeWork SA and appeared only to become apparent in the course of the Inquest. I do not know, nor does anyone else, what role if any the rubber band played in relation to the incident. It is however a line of inquiry that should have been explored very thoroughly. The rubber band was plainly present on the joystick on the day of the incident and after the incident. It should have been observed by the inspectors in what Inspector Croci described as her 'initial investigation', whatever that was. However, it was not recorded, the rubber band was not seized and its presence was not brought to the attention of the experts when

MPS

briefed. Both experts Associate Professor Dell and Professor Caple accepted that the presence of a rubber band on the joystick was relevant and was something they would have been extremely interested in. It was a matter that required investigation. When asked whether the presence of the rubber band would be a source of concern for somebody analysing the safe use of the scissor lift if the matter was drawn to their attention, Professor Caple stated:

'Yes, yes, it raises a whole lot of scenarios that might take you down a different journey.'<sup>279</sup>

On the same topic Associate Professor Dell stated:

'If I'd have known about, if I'd have been investigating it in the first place that would have been a line of inquiry to take - I would have interviewed as many people as I could on site till I got somebody who would talk to me about what they used the elastic band for.'<sup>280</sup>

31.3. Without analysing the evidence of each of the inspectors in detail I am content to merely record that I was not impressed by the SafeWork SA investigation as a whole.

## **32. Helmet not immediately seized**

32.1. Mr Kerpiniotis was the operations director for HYLIC at the nRAH project as at November 2014. He said that between 3pm and 4pm on 27 November 2014 he was informed that a helmet, which was presumed to be Mr Castillo-Riffo's, was still on the ground near the accident site and had not been taken either by SAPOL or SafeWork SA officers<sup>281</sup>. Mr Kerpiniotis very properly gave instructions for the helmet to be bagged and brought to his office. Later that afternoon Mr Kerpiniotis noticed an unmarked SAPOL car at the site and approached the officers who informed him that they had returned to the site to collect the helmet. Mr Kerpiniotis informed the officers that the helmet was in his office and they followed him to his office where they took photographs of the helmet on his desk and took possession of it<sup>282</sup>.

32.2. It is a matter of considerable concern that neither the SafeWork SA officers nor the SAPOL officers who attended that day seized the helmet before leaving the site. In the event, it was not apparent that anything flowed from this omission and that is fortunate.

<sup>279</sup> Transcript, page 1502

<sup>280</sup> Transcript, page 2485

<sup>281</sup> Exhibit C91

<sup>282</sup> Exhibit C91, paragraphs 34 and 35

MPS

### 33. SafeWork SA's claim that it is not responsible for investigating cause of death

33.1. In its closing submissions, SafeWork SA made the following remark:

'No suggestion has been made by Counsel Assisting or any interested party that SWSA<sup>283</sup> had any role in causing or contributing to the death of Mr Castillo-Riffo. Nor should there be. The circumstances of Mr Castillo-Riffo's death, as summarised in paragraph 5 below, clearly establish that there was no such SWSA involvement. As a result ... no findings or recommendations ought to be made with respect to SWSA ... SWSA respectfully submits that this Court lacks jurisdiction to make either findings or recommendations concerning SWSA given that SWSA played no role in the circumstances of Mr Castillo-Riffo's death.'

33.2. I find that to be a startling proposition. Of course it goes without saying that SafeWork SA did not play any role in causing or contributing to the death of Mr Castillo-Riffo. It is bizarre that SafeWork SA would feel the need to make such a self-evident and self-serving statement. However, the reason for the making of the statement becomes clearer as the submission is developed.

33.3. The next stage of the reasoning was that a number of the criticisms in the Inquest of SafeWork SA's investigation were 'misguided' because they failed to appreciate that a SafeWork SA investigation is 'different in nature and purpose to a criminal investigation or a "cause of death" investigation'.

33.4. The submission proceeded to set out in some detail the legislative and regulatory framework which I have summarised previously in this finding. The submission provided an example of the operation of one of the provisions: the WHS Act says that a person commits a Category 2 offence if that person has a health and safety duty, fails to comply with that duty and the failure '*exposes an individual to a risk*' of death or serious injury or illness (the emphasis comes from the submissions of SafeWork SA). SafeWork SA next reasoned that whether any injury materialises is irrelevant to the question whether or not an offence was committed. The submission was that it is the **risk** of injury which compromises an element of the offence. Offences against the WHS Act turn on whether or not there was a wrongful exposure to risk of injury not on whether or not the work practice caused an injury. The submission proceeded to assert a number of propositions each constituting an asserted breach of the WHS Act, Regulations and Codes of Practice on the part of HYLC and SRG which are asserted to be clear and obvious and unanswerable contraventions.

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<sup>283</sup> Acronym for SafeWork SA

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33.5. The submission stated that the SafeWork SA investigation:

'.. was for the purpose of preparing a brief of evidence to enable SWSA to take advice from its lawyers as to whether any PCBU on the nRAH site had ensured, so far as reasonably practicable, the health and safety of Mr Castillo-Riffo in performing the subject patching work. It was an investigation to determine whether the duty of care imposed by s 19 of the WHS Act was complied with so as to ascertain whether Mr Castillo-Riffo was exposed to the risk of death or serious injury so as to establish a category two offence within the meaning of s 32 of the WHS Act.'

33.6. The submission continued:

'The SWSA investigation only had to identify evidence, for assessment by SWSA's solicitors, of breaches of that Act and the relevant legislative instruments.'

33.7. The submission continued:

'The SWSA investigation was not a broader inquiry into the cause and circumstances of Mr Castillo-Riffo's death. It was not an investigation to assist this Court. Whilst SWSA voluntarily provided its file to this Court, it was the South Australia Police ("SAPOL"), principally Detective Sergeant Nikolic, who conducted the coronial investigation.'

33.8. The submission asserted that the object of a SafeWork SA investigation is significantly different from a coronial or criminal investigation. The following is SafeWork SA's summary of the above submissions:

'In accordance with this summary, SWSA submits:

- 62.1. crime scene investigation is primarily and properly the role of the police who have highly-trained, specialist crime scene examiners;
- 62.2. while the police and the Coroner conduct "cause of death" investigations, that is not a focus of investigations of possible contraventions of the WHS Act. The police and the Coroner properly deal with autopsies and forensic pathologists;
- 62.3. as submitted above, SWSA investigations are considerably narrower in focus to criminal / cause death investigations as they review the general work that was being done and look backwards to review the processes that led up to that work.'

In my opinion that analysis is narrow, artificial and wrong. As I have previously noted, the structure of SafeWork SA and its relationship with the WHS Act 2012 is that that Act defines 'Department' to be the administrative unit of the public service that is ... responsible for the administration of the Act<sup>284</sup>. 'Executive Director' means the person for the time being holding or acting in the position of Executive Director of that part of

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<sup>284</sup> Section 4 WHS Act 2012

MPS

the Department that is directly involved in the administration and enforcement of the Act<sup>285</sup>.

The 'part of the Department' directly involved in the administration and enforcement of the WHS Act 2012 is known as SafeWork SA. It has been placed in various administrative units, most recently the Attorney-General's Department, and now the Department of Treasury. The responsible Minister has been the Attorney-General, and most recently the Treasurer.

33.9. It scarcely needs to be stated that SafeWork SA is responsible for the administration of the whole of the WHS Act 2012, and not just those parts that focus on prosecutions and the delivery of briefs to solicitors. For example, s 3 of the Act states:

- (1) The main object of this Act is to provide for a balanced and nationally consistent framework to secure the health and safety of workers and workplaces by –
- (a) protecting workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from work or from specified types of substances or plant; and
  - (b) providing for fair and effective workplace representation, consultation, co-operation and issue resolution in relation to work health and safety; and (c) encouraging unions and employer organisations to take a constructive role in promoting improvements in work health and safety practices, and assisting persons conducting businesses or undertakings and workers to achieve a healthier and safer working environment; and
  - (c) encouraging unions and employer organisations to take a constructive role in promoting improvements in work health and safety practices, and assisting persons conducting businesses or undertakings and workers to achieve a healthier and safer working environment; and
  - (d) promoting the provision of advice, information, education and training in relation to work health and safety; and
  - (e) securing compliance with this Act through effective and appropriate compliance and enforcement measures; and
  - (f) ensuring appropriate scrutiny and review of actions taken by persons exercising powers and performing functions under this Act; and
  - (g) providing a framework for continuous improvement and progressively higher standards of work health and safety; and
  - (h) maintaining and strengthening the national harmonisation of laws relating to work health and safety and to facilitate a consistent national approach to work health and safety in this jurisdiction.

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<sup>285</sup> Section 4 WHS Act 2012

MPS

- (2) In furthering subsection (1)(a), regard must be had to the principle that workers and other persons should be given the highest level of protection against harm to their health, safety and welfare from hazards and risks arising from work, or from specified types of substances or plant, as is reasonably practicable.'

33.10. It can be seen from the above objects of the Act that the Act is about far more than just preparing briefs for prosecutions. For example, protecting workers against harm through the elimination or minimisation of risks arising from work may involve, and does involve, activities that are not solely related to prosecuting offences under the WHS Act. Promoting the provision of advice, information, education and training in relation to work health and safety is another example.

33.11. Section 152 of the Act sets out the functions of the regulator (the regulator is the Executive Director – see s 4). It is as follows:

**'152—Functions of regulator**

The regulator has the following functions:

- (a) to advise and make recommendations to the Minister and report on the operation and effectiveness of this Act;
- (b) to monitor and enforce compliance with this Act;
- (c) to provide advice and information on work health and safety to duty holders under this Act and to the community;
- (d) to collect, analyse and publish statistics relating to work health and safety;
- (e) to foster a co-operative, consultative relationship between duty holders and the persons to whom they owe duties and their representatives in relation to work health and safety matters;
- (f) to promote and support education and training on matters relating to work health and safety;
- (g) to engage in, promote and co-ordinate the sharing of information to achieve the object of this Act, including the sharing of information with a corresponding regulator;
- (h) to conduct and defend proceedings under this Act before a court or tribunal;
- (i) any other function conferred on the regulator by this or any other Act.'

Out of nine functions enumerated in s 152, only one is the conduct and defence of proceedings under the Act before a court or tribunal. It is quite plain that in order to carry out its functions of advising and making recommendations to the Minister, reporting on the operation and effectiveness of the Act, collecting, analysing and publishing statistics relating to work, health and safety and engaging in promoting and coordinating the sharing of information to achieve the objects of the Act, one would

MPS

expect the regulator, the Executive Director, and the whole of SafeWork SA, to be intensely interested in establishing the cause and circumstances of a workplace fatality.

33.12. To suggest that the establishment of cause of death is a matter for the Coroner and SAPOL and none of SafeWork SA's business is an alarming proposition. The Coroner and the Coroners Court rely entirely upon external agencies for investigations. The principal such agency is SAPOL. However, it is hardly to be expected that SAPOL will be expert in every field of potential investigation. It is true that SAPOL does contain some specialist investigational services, for example the Major Crash Investigation Unit, which has particular expertise in the investigation of the cause and circumstances of motor vehicle collisions. SAPOL has other specialist resources. However, SAPOL does not have special expertise in the conduct of industrial accidents. It appears to me that the State of South Australia has organised its affairs, for better or for worse, on the assumption that expertise in the area of industrial accident investigation resides in SafeWork SA, and not in SAPOL. While that does not mean that SAPOL has no responsibility in the conduct of investigations relating to industrial fatalities, it is plain that SAPOL would benefit from advice, assistance and collaboration with SafeWork SA or a body with like functions when SAPOL is called upon to investigate on behalf of the Coroner an industrial fatality. I am dismayed that SafeWork SA would effectively wipe its hands of any responsibility to assist in the process of establishing the cause and circumstances of the death of a worker at a fatal industrial accident.

33.13. These submissions demonstrate that there is a need for a clear protocol between SAPOL and SafeWork SA under which SafeWork SA commits to working collaboratively with SAPOL to obtain the best possible evidence as to the cause and circumstances of the death of a person involved in an industrial accident. This raises the question of SafeWork SA's submissions in relation to whether or not I may make any recommendation affecting SafeWork SA in this case.

#### **34. Recommendations in relation to SafeWork SA**

34.1. SafeWork SA made submissions about the Court's jurisdiction to make recommendations. SafeWork SA referred to the case of **Saraf v Johns** [2008] SASC 166 where the Supreme Court said there had to be 'an obvious and close connection between the findings made by the Coroner's Court and any recommendation. In some

MPS

cases, the recommendation will depend on the findings that have been made. The recommendations might fairly be considered to be a subset of the findings'<sup>286</sup>. Reference was also made to the observations of Kelly J in **Onuma v Coroner's Court** (2011) 111 SASR 382 where Her Honour said at [72]:

'the recommendation which the court is empowered to make is one which, in the opinion of the court, might prevent or reduce the likelihood of a recurrence of an event similar to the event that was the subject of the inquest.'

And at [79]

'any recommendation made by the Coroner must be for the purpose of, and only for the purpose of, the matters set out in s 25(2), namely, for the purpose of preventing or reducing the likelihood of an event similar to the event that was the subject of the inquest.'

34.2. In that context, SafeWork SA made the following submission:

'Any recommendations concerning SWSA could not directly or indirectly relate to the prevention or reduction of the likelihood of a death recurring in similar circumstances to Mr Castillo-Riffo's. General recommendations as to SWSA investigatory practices would be outside this Court's power in a manner similar to the impugned recommendations in **Saraf** which concerned matters, including the actions of regulatory agencies, following the subject death.'

34.3. I would in any event have refrained from making a recommendation about SafeWork SA's investigatory practices because it is well-known that the Independent Commission Against Corruption is currently carrying out a review that will undoubtedly contain recommendations on that subject in addition to those already made in the legal advice provided to the Chief Executive of the Attorney-General's Department which has previously been referred to. It would be undesirable for a further set of recommendations on that topic to be advanced by this Court. It would raise the possibility of a conflict between the various recommendations.

34.4. However, it seems to me unlikely that the Independent Commission Against Corruption would be aware of the very narrow position that SafeWork SA has taken in these proceedings in relation to its role in investigating the cause of an industrial accident and thus its capacity to assist this Court in determining the cause and circumstances of a death in an industrial setting. As I have explained above, I do not accept SafeWork SA's submissions on that topic. While SafeWork SA has been at pains to emphasise

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<sup>286</sup> Saraf v Johns [2008] SASC 166

MPS

the need for this Court to refrain from making any recommendation in relation to SafeWork SA, I nevertheless feel the need to make a comment which I hope will be noted by the Treasurer, the Minister responsible for SafeWork SA, when this finding is published. Indeed, a copy of this finding will be forwarded to the Treasurer for his information.

- 34.5. My comment is that given the vehemence of SafeWork SA's closing submissions about its lack of a role in determining the cause of a workplace fatality, the Treasurer should consider whether it is necessary to amend the Work, Health and Safety Act 2012 out of an abundance of caution, to make it absolutely clear that SafeWork SA is required to ascertain, to the extent reasonably practicable, the cause and circumstances surrounding a workplace fatality, and to provide the fruits of that investigation to the State Coroner. Furthermore, I make the comment that SafeWork SA should collaborate with SAPOL under an arrangement intended to ensure that their efforts when investigating a workplace fatality complement each other. In this respect I am not to be taken to suggest that the SAPOL officers involved in this case, Detective Sergeant Truesdale and Detective Brevet Sergeant Nikolic, have been guilty of any lack of diligence in their investigation. In fact the contrary is the case. Without the efforts of SAPOL while Inspector Moss was on annual leave and other activities for six weeks, there would have been major deficiencies in the evidence.
- 34.6. This comment is not a recommendation. It may be suggested that there is little difference in substance between a comment about a matter of public administration affecting whether an agency with expertise in industrial accidents should assist the police in investigating industrial fatalities on behalf of the coroner and a recommendation pursuant to s 25 of the Coroners Act to like effect. Certainly it is to be hoped that a Minister of the Crown who becomes aware of a matter that is clearly of pressing concern to this Court would give consideration to addressing the matter. Thus, the effect of a comment is similar to the effect of a formal recommendation. Perhaps that is true. If so, it does not prevent the making of a comment by this Court about a matter of public administration going to the integrity and quality of a coronial investigation. It has long been accepted that courts in general, not just the Coroners Court, make comments and suggestions directed at the Legislative and Executive about public administration or law reform. Indeed, it is not without some irony that one might

MPS

observe that the Court in *Saraf*<sup>287</sup> while quashing a recommendation of this Court on a matter of law reform, itself made a recommendation about a different law that should be reformed<sup>288</sup>.

### **35. The proposed recommendations of Ms Gurner-Hall**

35.1. Ms Gurner-Hall was represented throughout the Inquest and in her closing submissions she requested that the Court make certain recommendations. Out of deference to Ms Gurner-Hall's unique role in this Inquest I have decided to set out the recommendations she proposes and my reasons for adopting or not adopting them.

35.2. Proposed recommendation 1:

'The Premier should institute a Judicial Inquiry, with provision for protection of the identity of witnesses, to report on measures to stamp out employment practices that deter construction workers from raising concerns about workplace safety. The Inquiry should commence within 6 months, report within a year from its commencement with its report being tabled in Parliament on the next sitting day after it is delivered, and with the Government's response to that report being tabled in Parliament 6 months thereafter. The Premier should request that the desirability of a Commonwealth Judicial Inquiry of that nature be placed on the agenda for the next Council of Australian Governments meeting. If a Commonwealth Judicial Inquiry of that nature is instituted, a South Australian Judicial Inquiry would be unnecessary.'

As to this proposed recommendation I respectfully decline to adopt it. There was no evidence to support the contention that Mr Castillo-Riffo's tragic accident was caused as a result of employment practices that deter construction workers from raising concerns about workplace safety. Furthermore, I would generally be reluctant to recommend, as a result of an inquiry by this Court, an inquiry by a Royal Commission.

35.3. Proposed recommendation 2:

'SafeWork SA's practice of failing to commence any prosecutions and any civil penalty proceedings for breaches of workplace safety laws that do not result in injury or death should cease.'

I respectfully decline to make this recommendation. This case examined only the cause and circumstances of Mr Castillo-Riffo's death. It did look at some elements of SafeWork SA's investigation of the incident. However, it did not traverse the general

<sup>287</sup> *Saraf v Johns* [2008] SASC 166

<sup>288</sup> See *Saraf v Johns* [2008] SASC 166 at para [43]

MPS

practice of SafeWork SA in relation to commencing proceedings and it would be inappropriate of me to reach any conclusion on that subject.

35.4. Proposed recommendation 3:

'The provisions relating to WHS management plans<sup>1</sup> should be amended such that:

- 3.1 WHS management plans include an obligation on the principal contractor to conduct a thorough investigation into all deaths, serious injuries and near misses at the workplace and to make available all material gathered in that investigation to the regulator, all relevant workers and their unions and in the event of a death, to the family of the deceased;
- 3.2 WHS management plans include an obligation on the principal contractor to make available written advice about the changes implemented (if any) to avoid the recurrence of any incident resulting in a death, serious injury or near miss at the workplace to the regulator, all relevant workers and their unions and in the event of a death, to the family of the deceased;
- 3.3 WHS management plans must specify how the principal contractor will ensure that all high risk construction work is identified and how the principal contractor will ensure that an appropriate SWMS (suitably adapted to the task at hand) is in place for all high risk construction work; and
- 3.4 Each failure to comply with a WHS management plan be punishable by prosecution or the imposition of a civil penalty with penalties equivalent to category 3 offences under the WHS Act.<sup>2</sup>

<sup>1</sup> Presently, *Work Health And Safety Regulations 2012*, regulations 309 – 311 & 312

<sup>2</sup> *Work Health and Safety Act 2012*, section 33. '

I respectfully decline to make this recommendation. There was no evidence to suggest that the conduct of investigations into all deaths, serious injuries and near misses by the principal contractor would have prevented the tragic death of Mr Castillo-Riffo. Furthermore, I am mindful of the nationally consistent framework of workplace safety laws and it would be undesirable for South Australia to depart from uniformity.

35.5. Proposed recommendation 4:

'Compliance with enforceable undertakings under Part 11 of the WHS Act be actively and carefully monitored and in respect of failures to comply with those enforceable undertakings, serious consideration be given to prosecutions or civil penalty proceedings.'

This is not a recommendation that would be appropriate. It would add nothing to the obligations that already exist under the WHS Act which already require the monitoring of enforceable undertakings.

MPS

## 35.6. Proposed recommendation 5:

'Having regard to HYLIC's decision to intentionally breach its obligation to conduct an investigation in accordance with its WHS management plan, Hansen Yuncken and Leighton Contractors (now known as CPB contractors) should not be awarded any new South Australian Government contract for at least 10 years.'

I decline to make this recommendation. A recommendation in that form would have a punitive effect upon HYLIC and its corporate successors. It is not within the jurisdiction of this Court to recommend the imposition of a penalty of that nature.

## 35.7. Proposed recommendation 6:

'The balance in the WHS Act and Regulations between safety being managed by risk assessment as opposed to express mandatory rules about what must occur in particular circumstances should be shifted in favour of more express mandatory rules about what must occur in particular circumstances because adequate risk assessment is not occurring in practice.'

There may well be merit in the notion that safety is better managed by express mandatory rules than by risk assessment. On the other hand, I do not necessarily accept the proposition that adequate risk assessment is not occurring in practice if it is intended to suggest that that is a conclusion directed to the industry as a whole rather than the circumstances of this particular case. There may well be merit in the proposal. On the other hand it might be suggested that the introduction of more express mandatory rules would reduce flexibility, and that in itself would be undesirable. It is a matter that warrants consideration by SafeWork SA and I will recommend to that effect.

## 35.8. Proposed recommendation 7:

'The families of workers killed at work should receive funding to be represented at Coronial Inquests and should be assigned a caseworker to act as a single point of contact for the family with all relevant government agencies (for example, SafeWork SA, SAPOL, Return to Work SA, Births, Deaths and Marriages Registry). Consideration should be given to the costs of that representation and that caseworker being funded from the Victims of Crime fund.'

I have recently had cause to make a recommendation about representation in coronial Inquests to the Attorney-General. That recommendation was made following the Inquest into the death of Chrystal Jessica Ross<sup>289</sup>. I am happy to repeat the

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<sup>289</sup> Inquest 03/2018

MPS

recommendation in this case bearing in mind Ms Gurner-Hall's particular and personal concern and interest in the matter.

35.9. Proposed recommendation 8:

'The Treasurer should seek to amend the *Workplace Health and Safety Act 2012 (South Australia)* to make it consistent with the *Fair Work Act 2009 (Commonwealth)* in terms of who may commence proceedings for the imposition of civil penalties for breaches of the *Workplace Health and Safety Act 2012 (South Australia)*, with such variations as may be necessary to ensure that the next of kin or family of workers killed at work can commence such proceedings.'

I decline to make a recommendation in these terms. In my opinion a properly resourced and managed regulator is the appropriate entity, in conjunction with the Director of Public Prosecutions, to make decisions about whether prosecutions should be commenced and, once commenced, whether they should be continued. The introduction of what would amount to private prosecutions would inevitably raise the question of the award of costs in the event that prosecutions were not successful and a variety of considerations would follow. I do not consider such a recommendation would be appropriate.

**36. Industrial manslaughter – mandatory Inquests be held**

36.1. One of the recommendations pressed upon me by the CFMEU in its submissions was that consideration should be given to the introduction of a new offence of industrial manslaughter in the WHS Act 2012 and that Inquests should be mandatory. The present case has demonstrated that the present laws relating to prosecution for workplace injuries cause defensive litigious strategies on the part of employers and regulators. To raise the stakes even higher by the introduction of an indictable offence such as manslaughter would only exacerbate those tendencies. Those tendencies are not conducive to the public exposure and bringing to light of the full facts surrounding an industrial tragedy such as Mr Castillo-Riffo's.

36.2. The introduction of an offence of industrial manslaughter is, to my mind, the antithesis of the notion that there should be mandatory Inquests into workplace deaths. An Inquest cannot under the existing provisions of the Coroners Act 2003 proceed until the completion of the criminal process. Under the law in this State, the privilege against self-incrimination operates in coronial proceedings. The WHS Act now provides that proceedings for an offence against the Act may be brought within the latest of the period of two years after the offence comes to the notice of the regulator, or one year after a

MPS

coronial Inquest ended<sup>290</sup>. These factors render it more likely that any mandatory Inquest would be inhibited by the existence of criminal proceedings. In short, Inquests do not sit easily with criminal proceedings, and for that reason, I repeat the comments I made in the Madeley Inquest<sup>291</sup>:

'As a matter of law reform, I suggest that the Government consider a major reform of the current system of criminal prosecution for fatal industrial accidents. In my opinion it is just wrong that the prosecution of Diemould took 5 years to arrive at a plea of guilty. There must be a way to improve that. It seems to me that the family of a person killed in a workplace accident may be better served by seeing an open public inquiry convened within 12 to 18 months of the accident, than a criminal prosecution which might never result in the public hearing of any evidence, and which takes more than three times that long to even start. I suggest that consideration be given to a reform of the law which would enable the following things to happen:

- 1) Coroner intimates that, were no charges to be laid against any person in connection with the accident, an Inquest would be held;
- 2) Family elects whether they would prefer that the matter be the subject of an Inquest, or the subject of the usual criminal process;
- 3) If the family elects that they would prefer that there be an Inquest, the prosecuting authorities (including the DPP) would be empowered to intimate that no person or company would be prosecuted under the Occupational Health, Safety and Welfare Act or any other law. Such an intimation would then operate as a bar against future prosecution and, accordingly, no person would be exposed to the risk of self-incrimination in answering questions at the Inquest, with the result that the Court could insist that answers be given, notwithstanding that they might otherwise be refused on that ground.

This is a suggested law reform, not a recommendation under section 25(2) of the Coroners Act. That is because of the way section 25(2) is framed, being limited to recommendations that might prevent or reduce the likelihood of events similar to the event the subject of the Inquest. If section 25(2) permitted recommendations concerning the administration of the law, as the corresponding provision in the Coroners Acts of some other jurisdictions do, I would have made this suggestion a recommendation<sup>292</sup>.

### **37. Summary**

- 37.1. The Snorkel scissor lift being used by Mr Castillo-Riffo was working as designed. There were no relevant faults in the machine. The defective horn and cracked glass on the meter were not the cause of the incident.

<sup>290</sup> WHS Act 2012, Section 232(1)(b)

<sup>291</sup> Inquest into the death of Daniel Nicholas Madeley – 14/2010

<sup>292</sup> See generally *Saraf v Johns* (2008) 101 SASR 87 where Debelle J noted the limitation on the recommendation making power in the Coroners Act, but made his own suggestion for reform of the law, a practice that has long been adopted by courts of law

MPS

- 37.2. Mr Castillo-Riffo's entrapment preceded and induced the cardiac arrest and the ultimate hypoxic-ischaemic encephalopathy.
- 37.3. The work method was not safe because the primary safety feature to deal with entrapment, namely the safety lowering lever – was located in a position that the work method rendered very difficult to access by any rescuer. It was very difficult for two reasons:
1. Firstly it was difficult to see the lever because it was on the front end of the scissor lift which was up against the fence; and
  2. Secondly, the closeness of the fence to the front of the scissor lift meant that the rescuer would find it difficult to access the emergency lowering lever and to activate it if and when they located it. The evidence shows that is exactly what happened in this case.
- 37.4. HYLIC's health, safety and environment officers were being reassigned from structure duties to the fitout tasks. They did not sufficiently accommodate the SRG rectification works in adjacent areas, such as the area where Mr Castillo-Riffo was working. Therefore, no HYLIC health, safety and environment officer required SRG to produce a SWMS for the work being done by Mr Castillo-Riffo.
- 37.5. There was no SWMS for the performance of patching work from a scissor lift as being performed by Mr Castillo-Riffo on the day of his death.
- 37.6. Had there been a SWMS developed for the performance of the patching work from a scissor lift as being performed by Mr Castillo-Riffo on the day of his death, the risks involved would have been properly assessed. One of the risks of the proposed method was the inaccessibility of the safety lowering lever. That by itself would have rendered the proposed method unacceptable. Another method would have to have been devised. A number of alternatives were available.
- 37.7. It is not for this Court to say what the appropriate method would have been.

### **38. Recommendations**

- 38.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the

MPS

likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

- 38.2. I recommend that the Elevating Work Platforms document dated September 2016 should be distributed on an annual basis electronically and in hard copy to all relevant building industry participants in South Australia. In addition, electronic links to the information sheet should be displayed permanently on SafeWork SA's webpage and be kept current. The associated minimum standard of training document should be brought into line to include references to clear lines of sight.
- 38.3. I recommend that the question of standardising scissor lift controls be given far greater impetus at a State and National level and that it be elevated to the Council of Australian Governments (COAG) for the commissioning of a project to pursue the standardisation of controls in scissor lifts.
- 38.4. I recommend that until the implementation of a system of effective standardisation of scissor lift control configuration across the country, that scissor lifts not be operated unless there is a person on the ground operating as a spotter who is available at all times to take steps to activate the emergency lowering mechanism should that be necessary.
- 38.5. I recommend that SafeWork SA consider whether the balance in the WHS Act and Regulations between safety being managed by risk assessment as opposed to express mandatory rules about what must occur in particular circumstances should be shifted in favour of more express mandatory rules and take that matter up with SafeWork Australia for consideration.
- 38.6. I recommend that SafeWork SA should investigate, consider and report upon the world's best practice engineering solutions to protect workers against the risk of crushing due to overhead surfaces, including the availability and design of secondary protective systems including operator protective alarms and operator protective structures and the options for reform to require that all scissor lifts in use in South Australia have a secondary protection system<sup>293</sup>

<sup>293</sup> In the present case it is known that Mr Castillo-Riffo had the guard rails of the machine in very close proximity to the under surface of the third floor slab. I would expect that any effective engineering solution to prevent crushing risk from a scissor lift would have precluded him from being able to get the scissor lift that close to the slab in the first place, thus obviating the use of the scissor lift for the purposes that Mr Castillo-Riffo was using it for on the day. However, that does not mean that I should not recommend the implementation of engineering solutions to protect workers against the risk of crushing from overhead surfaces bearing in mind that is precisely what happened to Mr Castillo-Riffo in this instance.

MPS

38.7. I recommend that the Government provide, through the Legal Services Commission, funding to enable families to be legally represented in Inquests, for deaths in custody, and generally. I direct this recommendation to the Attorney-General.

*Key Words: Industrial Accident; Industrial Fatality; SafeWork SA; Scissor Lifts*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 1<sup>st</sup> day of November, 2018.*



Inquest Number 9/2018 (2071/2014)