



## **FINDING OF INQUEST**

*An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 19th day of July, the 3rd, 10th, 22nd, 23rd, 24th and 26th days of August, the 5th, 6th, 8th and 9th days of September, the 3rd, 15th, and 16th days of November, the 8th, 12th and 13th days of December 2022 and the 8th day of August 2024, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Peter Kevin Howard.*

*The said Court finds that Peter Kevin Howard aged 59 years, late of 43 Bungarra Street, Hillbank, South Australia died at Glenroy Street, Athol Park, South Australia on the 28<sup>th</sup> day of August 2018 as a result of inhalation of products of combustion and effects of heat. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction**

- 1.1. Mr Howard was a decent and hard working member of the South Australian community. He had a long and successful marriage with his wife that resulted in a family with three sons. Mr and Mrs Howard had brought them up well. They are law-abiding and productive men.
- 1.2. Mr Howard had worked for more than 27 years at a factory at Athol Park<sup>1</sup> owned by Orora Packaging Australia Pty Ltd, a packaging company<sup>2</sup>. He was a reliable and loyal employee, predominantly working as a forklift driver.

---

<sup>1</sup> Athol Park or the Athol Park site

<sup>2</sup> Orora

- 1.3. During his many years working there, Mr Howard had experienced some inappropriate behaviour at the hands of his co-workers. Mr Howard was described as a '*very sensitive guy*'<sup>3</sup> and '*popular*'<sup>4</sup>. The inappropriate behaviour can be described at the very least as consistent with or bordering on bullying.
- 1.4. On 28 August 2018, Mr Howard left the Athol Park site unannounced after being upset following a verbal altercation with a fellow worker, Mr Craig Reid.
- 1.5. Evidence of his movements in the minutes before his death was obtained from closed circuit TV<sup>5</sup> cameras set up at businesses near Athol Park. This evidence suggested that once Mr Howard left work that morning after the dispute, he acted decisively and rapidly in obtaining three 20 litre capacity yellow plastic petrol containers.<sup>6</sup>
- 1.6. He then filled all the jerry cans with unleaded petrol over their capacity at a nearby service station and stored them inside his Hyundai sedan.<sup>7</sup> He was seen on CCTV footage placing them into the back seat of the Hyundai and driving off in a calm manner towards the Athol Park site. The available CCTV footage showed him paying for the petrol and the jerry cans by Visa card. He obtained a stapled receipt from Paramount Browns' that he placed in his wallet.
- 1.7. The receipt and computer records of the service station showed he purchased 64.61 litres of petrol. Therefore, the petrol in each jerry can was on average above the recommended maximum storage level by 1.57 litres. This was against the warning etched on each jerry can. Further, the storage of these containers in the Hyundai's cabin created a very dangerous situation for him according to scientific evidence at the Inquest.
- 1.8. Mr Howard's Hyundai was next seen about six minutes later by a fellow Orora employee, Mr Niedeck, who was outside the Athol Park factory in the loading bay area. He was loading a truck with goods on his forklift. Mr Niedeck described hearing '*an almighty bang*' and saw the Hyundai rolling slowly down the road engulfed in smoke and flames. There were no CCTV cameras that covered this area where he stopped.

---

<sup>3</sup> Transcript page 412

<sup>4</sup> Transcript page 429

<sup>5</sup> CCTV

<sup>6</sup> jerry cans or yellow jerry cans

<sup>7</sup> Hyundai

- 1.9. Mr Niedeck raced to the fence then back to loading bay area to retrieve a fire extinguisher before running back to the Hyundai. He crouched down about a metre away and used the extinguisher.
- 1.10. It caused the smoke to clear briefly and allowed him to see an arm on the steering wheel. He believed it was Mr Howard's left arm.<sup>8</sup>It became a hopeless situation for Mr Niedeck who assessed that the fire was too intense to put out. He had to retreat for his own safety.
- 1.11. By this time many of Mr Howard's fellow workers had come outside. It was quickly realised that it was Mr Howard's car, and he must have been inside it. They correctly assumed he had perished in the blaze. SA Police<sup>9</sup> and Metropolitan Fire Service arrived to deal with the fire and investigations. This terrible situation caused Athol Park to shut down for the day. The workers were sent home.
- 1.12. Mr Howard's death was totally unexpected to those that knew him at work as well as his family and his friends. He was 59 years old.

## **2. Cause of death**

- 2.1. The cause of Mr Howard's death was determined by forensic pathologist Associate Professor<sup>10</sup> Neil Langlois, of Forensic Science South Australia<sup>11</sup> who conducted a post-mortem examination on Mr Howard on 30 August 2018.
- 2.2. AP Langlois found Mr Howard's death was caused by 'inhalation of products of combustion and the effects of heat'.<sup>12</sup>
- 2.3. This finding was not challenged at the Inquest. I am satisfied that Mr Howard's cause of death was as expressed by AP Langlois and make a finding accordingly.

## **3. Reason for inquest**

- 3.1. The death of Mr Howard was a 'reportable death' for the purposes of the *Coroner's Act, 2003 (SA)*<sup>13</sup> as it occurred due to an "unexpected, unnatural, unusual, violent or

---

<sup>8</sup> Exhibit C5a

<sup>9</sup> SAPOL

<sup>10</sup> AP

<sup>11</sup> FSSA

<sup>12</sup> Exhibit C1a, Post-mortem report

<sup>13</sup> The Act

unknown cause”. The circumstances of his death were such that the State Coroner found it necessary or desirable to conduct an Inquest pursuant to the Act.<sup>14</sup>

- 3.2. The issues raised for consideration at the Inquest were:
- 3.2.1. What caused Mr Howard to leave his work shift so suddenly and unexpectedly that morning?
  - 3.2.2. Why did Mr Howard purchase so much petrol and drive with it in his car back towards his workplace?
  - 3.2.3. Why did Mr Howard pull over his car in the bus zone?
  - 3.2.4. How did the petrol ignite?
  - 3.2.5. Did Mr Howard take his own life? That is, did he commit suicide by deliberately igniting the petrol he obtained in the jerry cans and causing his death by self-immolation in the confines of his Hyundai?
- 3.3. The standard of proof to be applied in making coronial findings is the civil standard, the balance of probabilities. In considering making findings which imply or express criticism of individuals, I am guided by the principles enunciated in *Briginshaw v Briginshaw*<sup>15</sup> and I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made.

#### **4. Evidence at Inquest**

- 4.1. At the inquest I heard from the following eight witnesses:
- 4.1.1. Dr Nicholson –Mr Howard’s general practitioner<sup>16</sup> since 1990.
  - 4.1.2. Professor David Crompton OAM, Consultant Psychiatrist as an expert witness on suicide.
  - 4.1.3. Associate Professor Tak Kee, Interim Head of the School of Chemistry at the University of Adelaide.

---

<sup>14</sup> Section 21(1)(b) of the Act

<sup>15</sup> (1938) 60 CLR 336

<sup>16</sup> GP

- 4.1.4. Professor Derek Abbott, Professor of Electrical Engineering at the University of Adelaide.
  - 4.1.5. Ms Genevieve Evans, People and Culture Manager. At the time of Mr Howard's death, she was the Human Resources Manager of Orora Athol Park.
  - 4.1.6. Mr Darren Lowe, Health and Safety Advisor at Athol Park.
  - 4.1.7. Mr Adrian Wright, day shift supervisor at Athol Park from 2016.
  - 4.1.8. Mr Colin Spencer, Site Manager at Orora Athol Park.
- 4.2. In addition to the oral evidence, the Court received into evidence numerous affidavits, statements and documents relevant to issues at the Inquest. I will not set them all out in this Finding but highlight a few including:
- i. Exhibit C3 - affidavit of Mrs Howard. This details her personal life with Mr Howard including his expressions of frustration with work issues and colleagues. She believed that he was subject to extensive bullying at Athol Park.
  - ii. Exhibit C6 – A co-worker, a forklift driver at Athol Park who played a practical joke on Mr Howard in 2014 by placing chilli flakes within his water bottle.
  - iii. Exhibit C8 - Mr Mark Hoskin, leading hand at Orora Athol Park who dealt with Mr Howard on the morning of his death.
  - iv. Exhibit C11- Mr Carrol, Production Manager at Athol Park who outlined incidents in February 2018 and May 2018 between Mr Howard and fellow co-worker Mr Craig Reid.
  - v. Exhibit C12 - Mr Clifford Badcock, co-worker at Athol Park who was one of the last people to see Mr Howard alive.
  - vi. Statements concerning the investigation into the death of Mr Howard by SAPOL.
  - vii. Dr Schrippa, Psychiatrist.
  - viii. Professor Tuckey, Psychiatrist.

ix. Mr Vuong, Mental Health Clinician.

4.3. In this finding I shall not summarise all the evidence tendered or heard at the inquest but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

4.4. With the leave of the Court, the following counsel appeared to represent witnesses and interested parties:

i. Mrs Howard, widow of Mr Howard was represented by Ms Maddeley, solicitor and Mr Saies of counsel. I am grateful for their assistance to Mrs Howard especially in circumstances of representing her 'pro-bono'. Their efforts and willingness to assist the Inquest and Mrs Howard in these circumstances was much appreciated.

ii. Mr Howard's employer Orora was represented by senior counsel Dr Gray KC with Ms O'Keeffe as her instructing solicitor.

iii. Dr Barry Nicholson was represented Mr Bullock of counsel, with Mr Black as his solicitor.

iv. Mr Longson appeared as Counsel Assisting.

4.5. Following the conclusion of the Inquest, I received comprehensive oral submissions from all counsel, in addition to thorough written submissions from Mr Saies, Dr Gray and Mr Bullock.<sup>17</sup>

## **5. Mr Howard's employment history at Orora**

5.1. It had been assumed by many people for many years in the lead up to this Inquest that Mr Howard's death was an intentional suicide in direct response to bullying that he had been subject to at his workplace. There is no doubt he was involved in a workplace altercation on the morning of his death that impacted his mental state that morning. The true impact of that event needed to be considered in the context of his many years of

---

<sup>17</sup> The last of which was in January 2023

employment at Orora, and the events that Mr Howard had experienced in that workplace over the years.

- 5.2. For that reason, Mr Howard's history of workplace complaints whilst working at Orora was relevant. Orora produced copies of all the documentary records it held about workplace incidents involving Mr Howard to the Inquest.<sup>18</sup> A number of Orora employees were called to give evidence.
- 5.3. An analysis of these documentary records, together with the evidence given at the Inquest, indicates that between 2013 and 2018 four incidents in relation to Mr Howard were recorded as being reported to management at the site.
- 5.4. The first recorded incident will be referred to a number of times in this finding as the "chilli flakes" incident. The evidence revealed the following:
  - 5.4.1. The incident occurred on 16 April 2014.
  - 5.4.2. A co-worker, acting alone, decided to put chilli flakes in Mr Howard's drink bottle without his knowledge. Mr Howard was extremely upset by this prank. He reported it to Orora.
  - 5.4.3. Orora held a meeting with the co-worker involved on 17 April 2014.
  - 5.4.4. Orora then held a further disciplinary interview with the co-worker on 22 April 2014 where he was officially warned for a breach of both the Respect for People in the Workplace policy and the Athol Park site rules.
  - 5.4.5. The co-worker was issued with a first written warning and warned that further instances may lead to termination of his employment.
  - 5.4.6. The co-worker involved apologised directly to Mr Howard in a meeting and was always mindful about how he conducted himself around Mr Howard after that day. He never behaved inappropriately again towards Mr Howard. I believe his response to this situation was genuine and remorseful.
  - 5.4.7. Mr Howard did not raise any further concerns about the manner in which the employee involved engaged with him in the workplace. However this event

---

<sup>18</sup> Exhibit C18b, tabs 38 to 62

caused a detrimental long term effect on him which he documented and discussed at times for years, including shortly before his death.

5.5. The next incident documented within the Orora records occurred in 2015. The evidence revealed the following:

5.5.1. There was an incident on Thursday 18 March 2015 where Mr Howard's forklift seat was tampered with by someone.

5.5.2. Mr Howard reported this to Mr Ferdinand on 19 March 2015 who then emailed the Site Manager Mr Sunnasy, the HR Manager Ms Evans and the Head Union Delegate Mr Travis that morning asking them to follow up and investigate.

5.5.3. Ms Evans spoke to Mr Howard on 20 March 2015 despite the fact he was off work. She spoke again to him on the Monday morning when he returned to work. She told Mr Howard she would speak with the offender to determine what if any further action would be taken.

5.5.4. On 24 March 2015 Mr Sunnasy requested that Ms Evans get formal statements from Craig Reid and Adam Bourne about the incident reported by Mr Howard. Ms Evans took statements from both workers later that day during which Mr Reid admitted that he had moved Mr Howard's seat.

5.5.5. On 27 March 2015 Mr Reid was issued with a counselling note which he signed. This note recorded that his behaviour was a form of bullying and against company policy. He was told not to interfere with Mr Howard's seat again or make remarks to him that he knew would upset him.

5.6. The next incident recorded in the Orora documents occurred in 2017. The evidence revealed the following:

5.6.1. On Thursday 18 August 2017 Mr Howard left the workplace during his shift after an altercation with Mr Ryan;

5.6.2. Mr Wright spoke to Mr Howard on the phone shortly after he had left the workplace to see if he was ok and to check if he was safe to drive;

- 5.6.3. Mr Wright asked Mr Howard to call him again when he got home so that Mr Wright knew that he was ok. Mr Howard subsequently left a voice mail for Mr Wright at 8:16am confirming he had arrived home safely;
- 5.6.4. Ms Evans rang Mr Howard either later that day to see if he was ok and find out what had happened. During the discussion Ms Evans spoke to Mr Howard about coping strategies and Mr Howard indicated he was going to see his doctor on Monday;
- 5.6.5. Mr Howard returned to work on Monday 22 August 2017 and met with Mr Wright and Mr Travis to talk about what had occurred. Mr Wright then held a meeting with Mr Ryan to obtain his account of the incident;
- 5.6.6. On 25 August 2017 Mr Sunnasy and Mr Travis met with Mr Howard and Mr Ryan separately to talk about the incident. During the discussion with Mr Howard he admitted that he had overreacted. It was agreed that the parties would meet together on the following Monday;
- 5.6.7. On Monday 28 August 2017 Mr Wright met with Mr Howard, Mr Ryan and Mr Badcock. During this meeting the records of this meeting indicated that Mr Howard stated he shouldn't take things so much to heart and should raise issues with the leading hands, shift supervisor or union delegate if they arise. Mr Ryan acknowledged that he needs to be more aware about how he speaks to people. Both Mr Ryan and Mr Howard agreed the issue was resolved. They shook hands and agreed to work together in the future.
- 5.6.8. Mr Wright gave evidence to the Inquest that from a management perspective this was the best possible outcome. The two employees had resolved the issues themselves through a joint meeting.

#### Orora's Witnesses

- 5.7. Ms Genevieve Evans
- 5.8. The first former Orora employee from whom I heard oral evidence was Ms Genevieve Evans. Ms Evans was Orora's HR Manager for South Australia and

Western Australia between January 2015 and mid-September 2018. Ms Evans' duties included dealing with any reports of bullying and harassment in the workplace.<sup>19</sup>

5.9. Ms Evans' evidence was to the effect that:

5.9.1. there were a few occasions when Mr Howard raised issues which were brought to her attention. This resulted in her having a conversation with him to understand the issue so that the right corrective action could be taken;<sup>20</sup>

5.9.2. during these conversations Mr Howard indicated to Ms Evans that he would sometimes overreact to things said or done by his colleagues, and that his reaction being upset or angry was not warranted;<sup>21</sup>

5.9.3. Ms Evans built a rapport with Mr Howard over time and Mr Howard knew he could approach her;<sup>22</sup>

5.9.4. during their conversations Mr Howard would often revisit historical things which he had noted in his notebook and would say that he would revisit his notebook fairly regularly and this would increase his angst;<sup>23</sup>

5.9.5. Ms Evans offered to help Mr Howard by going through his notebook with him if he wanted to and encouraged him to seek professional help and support because he said that revisiting his notebook kept things at the forefront of his mind;<sup>24</sup>

5.9.6. On every occasion that she spoke to Mr Howard when he raised an issue she would remind him of the availability of the Employee Assistance Program;<sup>25</sup>

5.9.7. Mr Howard advised her that he was seeking his own professional support;<sup>26</sup>

5.9.8. Mr Howard never raised any concerns to her about what she had done in relation to managing the complaints he brought to her attention.<sup>27</sup>

---

<sup>19</sup> Exhibit C18a, tab 14

<sup>20</sup> Transcript, page 180

<sup>21</sup> Transcript, page 194

<sup>22</sup> Transcript, page 195

<sup>23</sup> Transcript, page 195, 217

<sup>24</sup> Transcript, page 199

<sup>25</sup> Transcript, page 199

<sup>26</sup> Transcript, page 199

<sup>27</sup> Transcript, page 220

- 5.10. During cross-examination Ms Evans' evidence was to the effect that she:
- 5.10.1. did not have any sense that there was bullying and harassment on the factory floor that wasn't coming to her attention;<sup>28</sup>
  - 5.10.2. did not consider that she needed assistance from a psychologist or psychiatrist in relation to Mr Howard because Mr Howard had told her that he was seeking that advice himself;<sup>29</sup>
  - 5.10.3. was not trying to indicate to Mr Howard that he needed to '*harden up*'. She emphasised she would never do that. She took her work very seriously and cared about her employees including Mr Howard;<sup>30</sup>
  - 5.10.4. did not identify a pattern of bullying and harassment of Mr Howard;<sup>31</sup>
  - 5.10.5. did not accept that there was too much focus on the alleged offender and not on the victim. Whilst that was part of the process she was also checking in with Mr Howard as were his manager and supervisors and she did encourage him to seek professional help.<sup>32</sup>
- 5.11. Ms Evans referred to the policies and procedures in place at Orora which dealt with inappropriate behaviour. She identified Respect for People in the Workplace training that she herself delivered to the workers at the Athol Park. Ms Evans explained the training was aimed at raising employees' awareness about what is appropriate and inappropriate workplace behaviour and also provided employees with information on what they should do if they experienced inappropriate behaviour or witnessed it being directed towards another.
- 5.12. I accept Ms Evans as a witness of truth concerning her genuine attempts to make Mr Howard comfortable at Athol Park. I believe that she treated him well and realised his character led him to tend to dwell on matters in the past that were beyond his and her control. She impressed me as a kind person well suited to her role as HR Manager.

---

<sup>28</sup> Transcript, page 272

<sup>29</sup> Transcript, page 284

<sup>30</sup> Transcript, page 287-288

<sup>31</sup> Transcript, page 311

<sup>32</sup> Transcript, page 313

She was genuinely upset about Mr Howard's death. She struggled at times talking about him in her evidence.

- 5.13. She accepted that bullying and harassment allegations that were not raised with her would mean that she was not aware of them. She admitted that she was not aware of any '*element*' of bullying and harassment at the Athol Park site.<sup>33</sup>
- 5.14. Despite being pressed on policy issues concerning bullying and harassment such as risk assessment, managers' knowledge of Orora's policies and their discretion not to elevate complaints to her, she no longer had a memory of them given the passage of time. I accept her answers on that topic. She confirmed Mr Howard had complaints against Mr Reid in 2015, 2017 and 2018. She had no independent memory of whether she liaised with Mr Travis, the Union representative, to deal with workplace issues affecting Mr Howard.
- 5.15. As stated earlier denied there was too much focus placed on the alleged offender rather than the victim at Orora for workplace issues. She referred to her actions and words with Mr Howard in denying this proposition.<sup>34</sup>
- 5.16. She believed the preferred way of dealing with a dispute would be at the '*workplace level*'<sup>35</sup> rather than further escalation.
- 5.17. In general, when she checked in on Mr Howard in the factory he did not 'provide me any feedback to say that he was dissatisfied with how things had been dealt with'.<sup>36</sup>
- 5.18. Mr Adrian Wright
- 5.19. The Court also heard evidence from Mr Adrian Wright, the day shift supervisor at Orora. Mr Wright was basically responsible for maintaining the machinery, crewing levels and workplace safety issues at Athol Park for the day shift. He would manage about 25-30 people per shift.<sup>37</sup> He began working at Orora in October 2016. Mr Howard was one of the workers he was responsible for on shift.

---

<sup>33</sup> Transcript, pages 272-273; 277-278

<sup>34</sup> Transcript, pages 314-315

<sup>35</sup> Transcript, page 315

<sup>36</sup> Transcript, page 317

<sup>37</sup> Transcript, page 349-350

5.20. Mr Wright was inducted by Orora in to programmes concerning workplace culture and duty of care. He explained the availability for workers under his direct care to deal with grievances as well as pastoral care support such as the monthly toolbox meeting. These meetings were for workers to discuss and deal with wide ranging workplace topics including mental health care. He believed Mr Howard was a willing and engaging participant at these meetings.<sup>38</sup> He was aware of Mr Howard's particular ongoing issues with fellow workers Mr Ryan and Mr Reid.

5.21. He described Mr Howard's reaction to these situations, noting that he would:

'get frustrated, very temperamental. Yeah, frustration I think, and emotional. Never really angry, just an emotional person, I think is the best way to put it.'<sup>39</sup>

5.22. These reactions would happen once every two months on average.<sup>40</sup> He classified Mr Howard's role at the Athol Park site included driving a forklift and dealing with pallets manually.

5.23. He referred to a dispute between leading hand Mr Ryan and Mr Howard concerning a remark made when Mr Howard returned from some leave. Mr Howard eventually accepted that he may have misinterpreted comments made by Mr Ryan to the effect of it was good to see him return to the workplace. This occurred in August 2017 and was documented in the Orora records.<sup>41</sup>

5.24. The last issue with Mr Howard before his death was on 1 August 2018 concerning Mr Howard and Mr Reid. This was documented in the Orora records<sup>42</sup>. However, Mr Wright did not have any independent recollection of that matter.

5.25. His response to a proposition that was a culture of bullying at the Athol Park site when he arrived in 2016 up to the time of Mr Howard's death was as follows:

I don't think there was a bullying culture, it was more an old school culture, a lot of the employees there were long-term, still are, I'm talking in excess of 20, 20/30 year employees. The culture that they had there is a very matey thing, just like they'd worked together for a long time, a culture that was just - they did what they thought was okay,

---

<sup>38</sup> Transcript, page 359

<sup>39</sup> Transcript, page 361

<sup>40</sup> Transcript, page 361-362

<sup>41</sup> Exhibit C18b

<sup>42</sup> Exhibit C18b, page 677

that's probably the best as I can put it. Old school culture, old school mentality that everything is okay, we're okay, they worked together, ... there wasn't a bullying culture, no.'

5.26. Mr Wright made a series of further general comments about the nature of the majority of the employees at the Athol Park site and Mr Howard namely:

5.26.1. 'It's a very old school mindset there and people are set in their ways about what they've been doing for 20 or 30 years. People just think that what they did at work was what they could do and they're fine doing that.'<sup>43</sup> This comment was made to investigators on the background that it was hard to invoke change.

5.26.2. Mr Howard continually brought up the chilli flake incident with Mr Wright, ('25 times')<sup>44</sup> on the basis it had not been properly investigated.

5.26.3. Mr Howard was a '*very sensitive guy*'.<sup>45</sup> He discovered that during meetings with him and Ms Evans.<sup>46</sup>

5.26.4. Mr Howard was popular and always worked on the morning shift.<sup>47</sup> He never asked to change to the afternoon shift which would have been possible.

5.26.5. In describing Mr Howard's relationship with Craig Reid he said '*they just didn't see eye to eye*'.<sup>48</sup>

5.26.6. When Mr Wright was asked to assume that Mr Howard took his own life, he agreed in hindsight that he '*totally never saw that coming*'.<sup>49</sup>

5.27. Mr Colin Spencer

5.28. Mr Spencer was the Site Operations Manager at Athol Park from January 2018 to November 2021. He was '*the most senior person on site*'.<sup>50</sup> Among his responsibilities in managing the Athol Park site were safety and quality. He outlined his relationship

---

<sup>43</sup> Transcript, page 403, 33-37

<sup>44</sup> Transcript, page 412

<sup>45</sup> Transcript, page 416

<sup>46</sup> Transcript, page 416-417

<sup>47</sup> Transcript, page 429

<sup>48</sup> Transcript, page 437

<sup>49</sup> Transcript, page 438

<sup>50</sup> Exhibit C29, paragraph 8

with safety advisor at the Athol Park site, Mr Darren Lowe and production team leader, Mr Mark Hoskin.

- 5.29. He also provided an assessment on Ms Evans, the HR Manager. He found her to be ‘*a very caring and dedicated manager who always made time for workers at this site*’.<sup>51</sup>
- 5.30. He had very little involvement with Mr Howard directly other than to say hello to him on the factory floor and at group meetings. Mr Spencer was present at the Athol Park site at the time of Mr Howard’s death. He organised for the shut down of the factory for the day.
- 5.31. Mr Spencer reviewed the previous incidents reported to Orora involving Mr Howard.<sup>52</sup> He concluded that the incidents reported to Orora between 2014 and 2018 ‘*appeared to be isolated and relatively minor, except potentially the chilli flake incident.*’<sup>53</sup> The incidents appear to have all been addressed promptly and appropriately by management on each occasion.
- 5.32. He believed that the incidents reported in this time period ‘indicated an underlying pattern of behaviour towards Peter or indicated a risk management strategy for Peter was required.’<sup>54</sup>
- 5.33. Mr Howard did not report any concerns from August 2017 until August 2018. Further he stated that ‘management responded quickly’ and the incidents (save for the last one in August 2018) were addressed in accordance with the required procedures (in my view appropriately).<sup>55</sup>
- 5.34. These statements were supplemented by his oral evidence.<sup>56</sup>
- 5.35. He believed there was no risk of Mr Howard being subject of immediate concern based on the reported incidents.
- 5.36. He was ‘*saddened*’<sup>57</sup> by the chilli flake incident in 2014 but believed it was handled appropriately with a written warning to the offender and the direct apology to

---

<sup>51</sup> Exhibit C29, paragraph 14

<sup>52</sup> Exhibit 18A and 18B

<sup>53</sup> Exhibit C29, paragraph 69

<sup>54</sup> Exhibit C29, paragraph 69

<sup>55</sup> Exhibit C29, paragraph 73

<sup>56</sup> Transcript, pages 667-801

<sup>57</sup> Transcript, page 680

Mr Howard which he noted was rare in his '*experience in the manufacturing sector*'.<sup>58</sup> His evidence was thoroughly tested by Mr Saies on behalf of Mrs Howard.

- 5.37. Mr Spencer confirmed that he never saw Mr Howard in his office but that was '*not unexpected*'<sup>59</sup> due to the line of management for Mr Howard. Mr Howard never approached him directly about any '*personal concern*'.<sup>60</sup>
- 5.38. He accepted that a reported conversation between Mr Reid and Mr Howard in the carpark of Orora on 7 August 2018 when Mr Reid said threatening words should result in investigation as it was on its face contrary to the Code of Conduct of Orora.<sup>61</sup>
- 5.39. He contrasted this to the general culture of the manufacturing environment where often there would be 'a little bit of sarcasm and a little bit almost of what you would call low level humour or something that you would typically find in a fairly male dominated industrial workforce. But if there was anything that sort of crossed the line, I believe that there was many people that would come and see me'.<sup>62</sup>
- 5.40. He believed that up to early August 2018, there was nothing to indicate that the Athol Park site of any acute problem between Mr Howard and any employee.
- 5.41. He accepted that should any complaint be made by Mr Howard to his managers that it would be inappropriate to advise him that he was '*overreacting*' or should '*harden up*'.<sup>63</sup>
- 5.42. Unsurprisingly, he expected the Code of Conduct to be complied with by employees.
- 5.43. He expressed confidence in Mr Adrian Wright and noted that in general his belief was '*when things needed to be reported they were reported*'.<sup>64</sup> He accepted that employees at the Athol Park site were '*old school*' about their work which was consistent with the average age of the workforce being 55 and predominately male.<sup>65</sup>
- 5.44. He realistically accepted that employees would '*swear or get frustrated with one another*' and given the cross section of personalities of the manufacturing workforce

---

<sup>58</sup> Exhibit C29, paragraph 55

<sup>59</sup> Transcript, page 684

<sup>60</sup> Transcript, page 685

<sup>61</sup> Transcript, page 692-694, see also paragraph 5.49 of this Finding

<sup>62</sup> Transcript, page 696

<sup>63</sup> Transcript, pages 702-703

<sup>64</sup> Transcript, page 718

<sup>65</sup> Transcript, page 719

community is inevitable some people can cope with comments and frustrations better than others. However, he emphasised *'if they said something that wasn't right it would be followed up and in some cases documented, and in some cases there would be a warning, and in some other cases there were some people who actually lost their employment if they failed to remedy what they were doing within the time of their assigned warning period'*.<sup>66</sup>

- 5.45. He disagreed that Orora's policies had failed in respect to Mr Howard emphasising that Orora could only act on matters reported to them. He confirmed that he was not aware of any complaints of bullying or harassment made by Mr Howard. He conceded that such complaints may have been handled and managed at a lower level than senior management.
- 5.46. However, when the outcome of the investigation into an incident involved a formal warning up to dismissal then that would *'usually that would require my sign-off...on behalf of Orora.'*<sup>67</sup>
- 5.47. Mr Spencer gave answers on two key topics that encapsulated the important issues regarding Mr Howard's workplace. In fairness I will set out these answers in full namely:

Q. Do you think, Mr Spencer, that even accepting for current purposes that apart from the chilli flakes in the water bottle incident, were relatively minor, that the significance of these different incidents lay in the pattern of behaviour that might have been directed towards Mr Howard.

A. I do think pattern is relevant, I also think time frame is also relevant, as well as I guess the input from the concerned party, and we have sort of acknowledge, I've acknowledged from my experience how these incidents are perceived by different people needs to be taken into account, but the one thing I made mention in my statement was that I understand that these incidences, the ones that were recorded, the four that I'm aware of, occurred over four years. So, I'm not sure whether I would have been able to necessarily link those together, or at least the significant amount of time that happened between those incidences.

Q. I think you agree with my proposition yesterday that if there were other lower level transgressions of the code of conduct in terms of swearing, abusive language generally, demeaning or belittling comments directed to Mr Howard in between

---

<sup>66</sup> Transcript, page 722

<sup>67</sup> Transcript, pages 733-734

those other incidents, that might fit with a broader pattern of behaviour, might it not.

A. If there was a broader pattern of behaviour, as you propose, you know Orora and management would have to be aware of it in order to make that connection. I probably would use the analogy of a physical hazard to explain the way I would view this, as you know I was responsible for safety on site, and there was obviously many physical hazards that we would have to manage, so if there was near misses, if there was a risk assessment done and hazards were identified, and there was incident reports, then we would be expected as a management group and as a company to respond to those within a reasonable type of action and time frame. So, when you come to something that is of a nature of like systemic bullying, which is alleged, then you would need to see similar sorts of near misses and similar sort of risks present for us to be able to act reasonably with those.<sup>68</sup>

'Q ...is there any sense on your part that with the older members of the workforce, that they might have been reluctant to make complaints or to provide information about inappropriate behaviour.

A. My general experience is that it really depends on the individual. I would have young employees, say under 30, that maybe wouldn't feel confident enough, especially to speak up against a more experienced or senior operator; but then I'll have another younger person that would be more than happy to speak up because, you know, they're confident, and also feel that they're to say what they're going to say; and same goes for someone that's older. The comment about whether some of the older - we say the terminology 'older school people', again there would be a percentage of people that would say, you know 'I'm just going to get on with it' you know 'that doesn't affect me. It's not worth complaining about something minor', you know, to put some words in the scenario. But my general experience is that I don't think age necessarily has a large part to do with that. I think it sort of depends on someone's individual personality because I've had people at both ends of the spectrum. It's just at Athol Park, as we said yesterday, the average age was quite high, so we had more people that were older than younger.<sup>69</sup>

5.48. Orora submitted that Mr Spencer's evidence about the manner in which the 2014, 2015 and 2016 documented matters were managed by them ought to be accepted. Mr Spencer's evidence was that:

5.48.1. he considered all of the above incidents were managed in accordance with the Guiding Principles and the Enterprise Agreement Procedure;

---

<sup>68</sup> Transcript, pages 739-740

<sup>69</sup> Transcript, pages 748-749

- 5.48.2. the incidents appeared to all have been addressed promptly and appropriately by management on each occasion;
- 5.48.3. the incidents all appeared to be isolated and relatively minor, apart from potentially the chilli flake incident; and
- 5.48.4. he did not consider that those incidents and the 6 August 2018 incident were matters he would have necessarily linked together and considered they indicated an underlying pattern of behaviour directed towards Mr Howard or indicated that a risk management strategy was required.
- 5.49. Orora submitted that all their policies and procedures concerning management of their employees at the Athol Park site were appropriate including the policy known as the Orora Code of Conduct.<sup>70</sup>
- 5.50. Orora's position was that the supervisors of Mr Howard on a day to day basis and at higher levels within the hierarchy of oversight of operations and employees always acted properly and promptly concerning any issues reported by or concerning Mr Howard. Orora submitted that the death of Mr Howard was totally unexpected and unforeseeable based on his previous behaviour in dealing with situations that upset him at Athol Park.
- 5.51. I believe the evidence from Orora concerning their dealings with disputes and issues brought to their attention showed its reaction was appropriate, timely and gave Mr Howard his chance to explain the effect on him.

## **6. Other workplace issues noted by Mr Howard**

- 6.1. Mr Howard's diary was tendered at the Inquest. In a bundle of documents tendered by Mrs Howard<sup>71</sup> there is a chart of Mr Howard's transcribed notes in this diary. Some entries are dated others are not. Some entries refer to earlier events and are repeated throughout the diary. In particular the "chilli flake" incident from 2014 was mentioned by him on numerous occasions. Some of Mr Howard's note demonstrate anger, some sadness and some frustration. I have studied his diary entries and in doing so acknowledging the powerful considerations of hindsight and outcome bias.<sup>72</sup> I also

---

<sup>70</sup> Exhibit 18a, which applied to all work places of Orora. "Code of Conduct"

<sup>71</sup> Exhibit C27

<sup>72</sup> As defined in the Australasian Coroner's Manual, page 10

acknowledge that during a 27 year career at one workplace there are bound to be difficult times, disputes and personality clashes for any employee.

- 6.2. I also note Mrs Howard's evidence that Mr Howard 'discussed the issues over the years. I know that each incident frustrated him. I know this because Peter kept a diary which he used to record all the times he was bullied or when an incident occurred at work'<sup>73</sup>
- 6.3. I do not see the utility in setting out each situation of the approximately thirty issues raised in his diary notes. However I will mention examples of behaviour that caused him to react by leaving the Athol Park site. Where possible, I will also set out the dates that he has documented.
- 6.4. Pre April 2008 (undated) - Wet rags were left on his forklift seat early into his shift causing his pants to be saturated.
- 6.5. Cream on handle levers of his forklift which he documented made him see 'red' and 'had rest of week off'.
- 6.6. A pattern at lunchtimes of his cup or bag going missing which caused him to note 'one day I saw red'.
- 6.7. Another co-worker 'continually' poked him in the ribs and when asked to stop laughed at him.
- 6.8. An employee writing on his new uniform.
- 6.9. 15 April 2008 - An employee writing 'I love you' on cardboard cutouts.
- 6.10. 21 April 2008 - A discussion with Management. Mr Howard recorded that he was 'not into mucking around I can see funny side of things but when it gets constant it pisses me off. I am a very quite (sic) person. Just want to come to work to do his job and go home. We get good money. Always on edge what they will do next.'
- 6.11. 24 November 2008 - Key to his forklift taken and hidden under his seat.
- 6.12. 4 June 2009 - Hit in head with rolled up tape when it was thrown towards a bin, everyone laughed.

---

<sup>73</sup> Exhibit C3, paragraph 8

- 6.13. 1 November 2010 - 'Place is fucked too many clicky (sic) groups.'
- 6.14. 18 January 2012 - Reference to the shoulder injury and rehabilitation 'told to stay home and come in when do full time work'.
- 6.15. June 2012 - On Workcover- arguments about working.
- 6.16. 16, 17 and 24 April 2014 - 'The Chilli Flakes' reference to offender and reaction of his 'disgust he got a written warning. No Satisfaction, No Trust, No Hope, Total Disgust. Lunch-anyone want chilli sauce?'
- 6.17. 13 February 2017 - Numerous incidents of people turning off gas tank for forklift just after he started using it. 'totally pissed off'. 'had next day off.'
- 6.18. March 2017 - Issue regarding stacking of pallets. Offered by Management to go home for 2 days (Peter Hoskin).

## 7. **Professor Michelle Tuckey**

- 7.1. Professor Tuckey's area of expertise is in work and organisational psychology which she teaches at the University of South Australia. Her qualifications are set out in her expert report.<sup>74</sup> She has been involved in this area since obtaining her PhD in psychology from Flinders University in 2004.
- 7.2. As she said a focus of hers since 2013 'has been advancing the risk management of bullying as a work health and safety hazard'<sup>75</sup>. Her expertise was unchallenged.
- 7.3. In her report she gave helpful comments on general issues of workplace bullying and examined Orora's policies and procedures on this topic.
- 7.4. As she stated, the process for responding to reports of bullying behaviour through informal resolution and formal complaints investigation is a core bullying policy component. When implemented effectively,<sup>76</sup> incident resolution and complaints investigation have the potential to re-establish fairness and send a signal that bullying behaviours is taken seriously in the organisation and will not and (sic) be tolerated.<sup>77</sup>

---

<sup>74</sup> Exhibit C27, page 85

<sup>75</sup> Exhibit C27, page 85

<sup>76</sup> My emphasis

<sup>77</sup> Exhibit C27, page 93

- 7.5. I have read her report carefully including the assumed facts she relied on in particular that Mr Howard died due to suicide.<sup>78</sup>
- 7.6. She referred to the ‘workplace bullying’ definition from Safe Work Australia’s guide for preventing and responding to workplace bullying (2016) as ‘repeated and unreasonable behaviour directed towards a worker or a group of workers that creates a risk to health and safety.’<sup>79</sup>
- 7.7. Unreasonable behaviour was further defined as behaviour ‘that a reasonable person, having considered the circumstances, would see as unreasonable, including behaviour that is victimising, humiliating, intimidating or threatening’. She concluded that Mr Howard was subject to unacceptable behaviour from April 2014 (the chilli flake incident) to August 2018. Professor Tuckey was not called. This was due to a decision I made after hearing argument from counsel<sup>80</sup>.
- 7.8. I have read Professor Tuckey’s report carefully and accept that many incidents recorded in Orora’s records, and some recorded in Mr Howard’s diary but not reported to Orora, do constitute unacceptable workplace behaviour. However, I also find that it seems Orora were not made aware of many of the incidents recorded in Mr Howard’s diary, and in relation to the incidents of which they were aware, they were dealt with reasonably and in compliance with company policy at the time. In saying that, I am not minimising the impact that those incidents may have had on Mr Howard’s mental state, which I will turn to now.

## **8. The impact of workplace incidents on his mental state**

- 8.1. Dr Barry Nicholson attended to give evidence in this Inquest. As well as hearing his oral evidence, the Court has received into evidence his affidavit sworn on 7 January 2019,<sup>81</sup> his statement to Safework SA dated 17 April 2020<sup>82</sup> and his case notes in relation to Peter Howard from the Elizabeth Centre Clinic.<sup>83</sup>
- 8.2. Dr Nicholson was an obviously co-operative and forthright witness. It was clear that he was doing his best to assist the Court in relation to matters which, at the time they

---

<sup>78</sup> Exhibit C27, pages 94-101

<sup>79</sup> Exhibit C27, page 96

<sup>80</sup> Transcript, pages 805-829; in particular submissions at 808, 826 and 828

<sup>81</sup> Exhibit C19

<sup>82</sup> Exhibit C19a

<sup>83</sup> Exhibit C19b

occurred, were not particularly remarkable and, in part, occurred many years ago. He made clear the limits of his recollection and the fact that he was reliant on refreshing his memory from his case notes. The fact that he had little specific memory of what were mostly uneventful consultations with one of his many patients is unsurprising.

- 8.3. I formed the view that Dr Nicholson is a very competent and dedicated GP. He has been working at the Elizabeth City Centre Clinic since 1989. He began looking after Mr Howard in 1990. He was eminently qualified to speak about Mr Howard's work and mental health issues. It had been a significant and ongoing topic during their professional relationship. He summarised that these issues '*were on going stress issues that frustrated him. He wouldn't show his anger however he would be red in the face and if Peter was angry it was quite controlled*'.<sup>84</sup> He also described Mr Howard as a man that '*internalised a great deal*'.<sup>85</sup>
- 8.4. From time-to-time Mr Howard raised concerns with Dr Nicholson about issues in his workplace in his attendances. Workplace issues were raised on 21 out of 102 attendances over the course of 28 years. Dr Nicholson's responses and management decisions upon those matters being raised were timely, appropriate and considered. He was experienced in treating patients exhibiting symptoms of anxiety and was aware of the healthcare resources available for such patients.
- 8.5. Dr Nicholson described Mr Howard as being mildly anxious. The effect of it created a scope of behaviour by Mr Howard to range from being functional to being disabled by it.<sup>86</sup> He had come to the reasonable conclusion that there was no clinical need for his anxiety to be referred to a psychiatrist.<sup>87</sup>
- 8.6. In relation to the relatively minor single vehicle accident first reported to Dr Nicholson by Mr Howard in September 1992, Dr Nicholson was belatedly informed by Mr Howard in November 1993 that the accident had been a suicide attempt. The initial report of that motor vehicle accident was the subject of a Workers Compensation Certificate from Dr Nicholson dated 4 September 1992.<sup>88</sup> Dr Nicholson's response to

---

<sup>84</sup> Exhibit C19, paragraph 13

<sup>85</sup> Exhibit C19a, statement of Dr Nicholson to Safe Work SA 17 April 2020, page 9 lines 272-273

<sup>86</sup> Transcript, page 87

<sup>87</sup> Transcript, page 92

<sup>88</sup> Exhibit C19e

that information was to refer Mr Howard to a psychologist, Dr Joe Magliaro. This was appropriate and proportionate.

- 8.7. While the Court does not have the benefit of the Mr Magliaro's records the letters sent by him to Dr Nicholson coupled with the absence of any further indication of any subsequent suicidal ideation on the part of Mr Howard meant that there was no call for any more significant intervention by Dr Nicholson.
- 8.8. The consultations relevant to workplace issues can be summarised as follows:
- 8.8.1. 2002 Referral Letter to Dr Magliaro by Dr Nicholson indicating Mr Howard reports that he stresses and takes things to heart.<sup>89</sup>
- 8.8.2. A detailed letter by Dr Nicholson in 2019 to a legal firm to where Dr Nicholson believed that there was '*interplay of his particular personality and personal traits, as well as contribution of stress contributed by the workplace*'. Secondly, that workplace bullying contributed as well as his obsessive personality style to create '*extreme frustration at the continual harassment and abuse*'.<sup>90</sup>
- 8.8.3. 30 April 2002: Mr Howard indicated that after a months holiday he returned to his work. His boss told him '*don't stress don't panic*'. This had the opposite effect and he '*can't stop thinking about what he said*'. Mr Howard admitted that he '*stresses and takes things to heart. Has always tended to stress about things*'.<sup>91</sup> As a result of this Dr Nicholson issued a sick certificate for that day and wrote a referral letter to Dr Joseph Magliaro.
- 8.8.4. A further referral letter was written to Dr Magliaro, to provide Dr Nicholson '*an opinion and management*'. The referral also noted Mr Howard had seen Dr Magliaro in the past for '*similar problems*'.<sup>92</sup>
- 8.8.5. 1 May 2002: Mr Howard reported poor sleep, seeing '*Joe on Friday week. Still feels worried splitting headache*'.<sup>93</sup> Dr Nicholson issued Mr Howard a sick certificate for that day and 2 May 2002.

---

<sup>89</sup> Exhibit C19b, page 138

<sup>90</sup> Exhibit C19b, pages 172-175

<sup>91</sup> Exhibit C19b, page 14

<sup>92</sup> Exhibit C19b, page 138

<sup>93</sup> Exhibit C19b, page 15

- 8.8.6. 11 November 2004: Mr Howard reported that he had '*constant ridicule from someone at work, almost hit him*'.<sup>94</sup> A sick certificate was issued to Mr Howard for that day.
- 8.8.7. 18 April 2005: Mr Howard reported a '*severe headache*'. This was assessed by Dr Nicholson as a tension headache. Mr Howard reported he had '*some worries, he has chronic anxiety*'.<sup>95</sup> I have taken these comments to be a self-diagnosis by Mr Howard of anxiety.
- 8.8.8. 30 October 2006: Mr Howard reported '*problems at work*', including repetitive practical jokes and '*digging him in the ribs*'.<sup>96</sup> The offending worker would not stop when requested. Mr Howard indicated he might see Dr Magliaro again.
- 8.8.9. 19 March 2015: A complaint in general that there are '*a lot of idiots doing practical jokes*'. There was reference back to the chilli in his drink bottle. He was about to jump on his forklift and the seat had been adjusted '*out of wack*'. Acknowledgement that he had been working there for 25 years and that does '*tend to react*'. He had complained to management but '*that nothing happens*'. A medical certificate was given.<sup>97</sup>
- 8.8.10. 11 August 2016: Mr Howard reported an incident at work on 10 August 2016. He was reprimanded by his boss for pile of stock on the floor. '*Couldn't sleep last night*'. A medical certificate was given.<sup>98</sup>
- 8.8.11. 23 March 2017: Consultation at 10:47am. Mr Howard reports '*meltdown*' at work this morning. On 22 March 2017 he had a slow motion collision with another forklift whilst reversing. He believed that other forklift driver took no evasive action deliberately to purposely cause an accident. This morning got there to find stock all over the floor at the start of his shift that he believed was left there by the forklift driver to annoy him. He admitted being '*very emotional and left*'. A medical certificate was given.<sup>99</sup>

---

<sup>94</sup> Exhibit C19b, page 31

<sup>95</sup> Exhibit C19b, page 33

<sup>96</sup> Exhibit C19b, page 44

<sup>97</sup> Exhibit C19b, page 55

<sup>98</sup> Exhibit C19b, page 61

<sup>99</sup> Exhibit C19b, page 64

- 8.8.12. 11 August 2017: He reported that he could not sleep, was awake after 1am with worries from work and a headache. He expressed there was no '*no culture of concern at his workplace. Team leaders not helpful*'<sup>100</sup>. Mentions of surveys where he repeats his complaints every year and nothing changes. He didn't think he could get another job at age 58. He was a butcher by trade but not worked in that industry for over 20 years. A medical certificate was given.
- 8.8.13. 5 February 2018: Progress note by Northern Wellbeing Program recorded a workplace incident with another worker deliberately trying to '*stuff me up*'. Mr Howard went straight to line manager to complain and took rest of day off. Still annoyed. Author encouraged him to think of therapy to let go of negative thoughts.<sup>101</sup>
- 8.8.14. 2 August 2018: Medical visit but work issues mentioned. Co-worker '*purposely mucked up 2 palattes (sic) to annoy him. He has as meeting tomorrow with them ... seriously thinking of taking stress leave*'.<sup>102</sup>
- 8.8.15. 8 August 2018: Meeting was '*Ok*' but coworker not spoken to yet. Verbal abuse. Has URTI<sup>103</sup>. A medical certificate was given.
- 8.8.16. Report of Mental Health Clinical Intern at Northern Wellbeing Program. Mr Howard '*up and down*' over the last two weeks. Mr Howard had understanding '*mindfulness practice*'.<sup>104</sup> Assessment by the author: that work and career holds great value and sentiment to him.
- 8.9. Dr Nicholson's later referral of Mr Howard to Northern Wellbeing, Northern Health Network for psychologist's treatment was appropriate in the circumstances. Mr Howard's presentation had not changed significantly over many years and there had been no further presentation suggestive of suicidal thinking ideation since the 1993 report of thinking ideation in September 1992.
- 8.10. I find that on appropriate occasions he had referred Mr Howard for psychological counselling/treatment. He always reacted promptly to the more serious presentations of his anxiety such as in November 1993 when Mr Howard confessed to him that a car

---

<sup>100</sup> Exhibit C19b, page 65

<sup>101</sup> Exhibit C19b, page 110

<sup>102</sup> Exhibit C19b, page 81

<sup>103</sup> Exhibit C19b, page 82 upper respiratory tract infection

<sup>104</sup> Exhibit C19b, page 108

accident the previous year was a suicide attempt. These intermittent referrals for mental health care continued up to 2017 when he arranged for Mr Howard to attend at the Northern Wellbeing Centre.

- 8.11. I find Dr Nicholson was entitled to conclude what he did about Mr Howard's mental health based on all the evidence and consultations with him. I find that there is no indication given to Dr Nicholson of anything like suicidal tendencies that he failed to act upon. On the contrary, the treatment and care of Mr Howard was exemplary.
- 8.12. His concern for Mrs Howard after his death demonstrated the caring attitude for his long-term patient who died so unexpectedly. He did everything he could for Mr Howard to try and help develop coping techniques for confrontation and/or unjustified behaviour to him by work colleagues.
- 8.13. In a further insightful observation he said the following:

'He was just a very nice person and kept complaining about so much of the same thing over many, many years, workplace issues. So, he wasn't histrionic, he was fairly measured in everything that he did. I think that he thought a great deal about other people, and I think that he wanted other people to treat him as they wanted to be treated by other people, like he's treated them. And the impression that I got was that he was frustrated and annoyed that nothing ever seemed to change really. I mean, that that's the theme looking through the entries, is the frustration that despite efforts nothing seems to change. And we were trying to help him deal with what couldn't be changed, I suppose. That's what we were trying to do, to give him tools to deal with it and that was the aim.

I didn't think he was at risk of committing suicide. He didn't say to me that he had suicidal ideations. Looking through the notes I didn't specifically ask him. Perhaps I should have done but he didn't ever come in saying that he was distressed. We see people often who you worry about their demeanour and how they present in terms of their suicidal ideation, non-verbal cues. He never seemed like that. He always seemed to be temporarily frustrated again by what was happening to him.

I'm terribly sorry for all him and all his family and I can't imagine the awful scene when all this happened, and terrible for his workmates as well for them to deal with all of this.'<sup>105</sup>

- 8.14. This observation was made when Dr Nicholson assumed that Mr Howard died due to suicide. I acknowledge that this assessment is a hindsight review based on Dr Nicholson wondering what more he could have done himself to try and prevent Mr Howard's death on the basis it was suicide. It supports the impression I had of Dr Nicholson regarding his care and professionalism towards Mr Howard.
- 8.15. Overall, Dr Nicholson's evidence enabled me to draw the following conclusions:
- 8.15.1. Mr Howard was significantly impacted by workplace issues over a number of years;
- 8.15.2. Dr Nicholson had assisted Mr Howard by providing tools to try and manage his anger and frustration, and referring him to other agencies when necessary;
- 8.15.3. Mr Howard never gave any indication that he was at risk of committing suicide after his admission in 1993 of a previous attempt via a car accident.

**9. Did a workplace incident, or the culmination of a history of workplace incidents, cause Mr Howard to leave work on the morning of the 28 August 2018?**

- 9.1. There were, clearly, some incidents of inappropriate workplace behaviour that came to the attention of Orora management over the years. Orora did not suggest that there were no incidents of inappropriate workplace behaviour. Orora submitted that its records demonstrate that inappropriate incidents did occur however those records also show that when such incidents were reported to management they were addressed. That submission was clearly supported on the evidence.
- 9.2. There were also a number of incidents Mr Howard had detailed in his diary. I note that several of the complaints noted in Mr Howard's diary seemingly never came to attention of Orora management. Accordingly and logically, they cannot be criticised for taking no action in relation to matters of which they were not aware.

---

<sup>105</sup> Exhibit C19a, pages 9-10

- 9.3. I have also considered that there were a great number of long-term male employees at the Athol Park site. There was a strong union presence and many workers like Peter Howard chose to stay in the workplace for an extended period. I repeat that in such circumstances it is not surprising that on occasions personal conflicts could and did arise.
- 9.4. Counsel for Orora has submitted that the evidence does not support a finding that there was any failure by Orora to deal with reported incidents. I agree with this submission.
- 9.5. Nevertheless, my acceptance of that submission that does not negate the impact that those reported incidents had on Mr Howard, nor his perception of what was occurring when the other unreported incidents occurred in the workplace. Whether his perception was reasonable or objective was not really an issue to decide at the Inquest. The real issue was whether his perception of what was occurring caused or contributed to his decision to purchase the petrol and transport it in his car on the date of his death. Clearly those purchases were not explicable in the context of a comparison with his reactions on the other occasions to workplace incidents, particularly when he left the Athol Park site.

## **10. The events of 28 August 2018**

- 10.1. According to Mrs Howard, she had spent an uneventful evening on 27 August with her husband. Mr Howard retired to bed about 10pm. He had not talked about work or said anything ‘*out of the ordinary*’ that night.<sup>106</sup> The following summary shows the timing of events immediately preceding his death.
- 10.2. 5:15am: Mr Howard left for work to begin at 6am.
- 10.3. 5:42am: Mr Howard arrived at work.
- 10.4. 6:50am: Mrs Howard sent an SMS to Mr Howard to tell him that she had been called in to work. He did not reply.
- 10.5. At 7am Mr Howard spoke to leading hand Mark Hoskin who asked how he was going. Mr Howard replied with words along the lines of “the c\*\*\* is back today.” This was taken as a reference that morning to fellow employee Craig Reid who had made a

---

<sup>106</sup> Exhibit C3, paragraph 12

passing remark about Mr Howard completing a task by saying to him *'good job with that smart arse'*. Mr Howard was advised *'to take it easy and keep calm'*.<sup>107</sup> This situation did not overly concern Mr Hoskin as he had seen this type of reaction before from Mr Howard.

- 10.6. At approximately 7:15am, Mr Cliff Badcock and Mr Hoskin saw Mr Howard in an upset and *'flustered'* state outside the factory floor. He was sitting on the ground next to a tree, *'breaking tree leaves up'*.<sup>108</sup> Mr Badcock described him as *'a bit emotional and seemed to be holding back tears'*.<sup>109</sup> He described to Mr Badcock a workplace task had gone wrong where he broke a pallet and admitted fault. However, Craig Reid *'started yelling at him'*.<sup>110</sup> Mr Badcock trying to change the subject *'as I was trying to pull him back out of the daze he seemed to be in'*.<sup>111</sup> This tactic did not work as Mr Howard kept referring back to that morning's incident. He then raised the *'chilli flakes'* incident from 2014. It was at about that time that Mr Hoskin joined the group and made his own observations of Mr Howard.
- 10.7. Sometime between 7:30am and 7:45am Adrian Wright, the day shift supervisor became aware of Mr Howard's state and went outside to speak with him.
- 10.8. Mr Wright had arrived at work between 06:45am to 7am.<sup>112</sup> He went to his desk, switched on his computer and was preparing for the daily shift meeting on the factory floor with all staff. Shortly after the meeting he spoke with Mr Howard indicating that there was a lot of packaging material concerning their client Pernod and the large amount of wine boxes to deal with that day. He described Mr Howard as *'fine at the time, I wouldn't have known any different'*.<sup>113</sup> He then continued his normal duties ending up back at his desk at 7:30am in preparation for a 9:15am meeting.
- 10.9. He described Adam Ryan coming to him and saying *'have you spoken to Howie, he seems very flustered'*.<sup>114</sup> He went to find Mr Howard. In doing so, he encountered Mr Hoskin who informed him Mr Howard was outside. As he made his way outside he crossed paths with Mr Howard who was walking back towards the factory floor. He

---

<sup>107</sup> Exhibit C8, paragraph 11, Mr Hoskin who described Mr Howard driving off in his forklift *'in a huff'*

<sup>108</sup> Exhibit C8, paragraphs 15-16

<sup>109</sup> Exhibit C12, paragraph 7

<sup>110</sup> Exhibit C12, paragraph 7

<sup>111</sup> Exhibit C12, paragraph 8

<sup>112</sup> Transcript, page 385

<sup>113</sup> Transcript, page 386

<sup>114</sup> Transcript, page 387

asked him if he was ‘okay’<sup>115</sup>. Mr Howard replied ‘no I’m not’ and was according to Mr Wright very ‘hyped up’.<sup>116</sup>

- 10.10. He and Mr Howard went to the canteen where they spoke further. Mr Howard complained about the ‘*that bloody idiot Craig Reid*’ but after a few minutes including having a coffee he had settled down. Mr Wright told him that when Ms Evans arrived they would go and see her.<sup>117</sup> In the meantime he asked Mr Howard to work in a separate area known as the hand strapping area. He agreed. As noted, Ms Evans was on a flight to Perth and was not going to be in at her normal time of 8:30am.
- 10.11. At 8:32am Mr Howard drove the Hyundai out of Orora. He had not notified anyone of his decision to leave.
- 10.12. At 8:54am Mr Howard arrived at the business Paramount Browns’ situated at 99 Cavan Road, Gepps Cross.
- 10.13. At 8:57am Mr Howard left Paramount Browns’ having purchased three jerry cans.
- 10.14. At approximately 9am Mr Howard is noted to be missing at Orora.
- 10.15. At 9:05am Mr Howard began filling the jerry cans with unleaded petrol at Coles Express Service Station situated 452 Grand Junction Road, Mansfield Park.<sup>118</sup>
- 10.16. At 9:08am Mr Adrian Wright called Mr Howard, almost certainly from his work phone. CCTV footage at Coles Express shows Mr Howard looking at his phone but declining to answer.
- 10.17. At about 9:15am the Hyundai exploded into fire on Glenroy Street, Athol Park, outside Orora. The Hyundai was stationary in a designated bus zone. Mr Howard, the sole occupant in the driver’s seat, was killed.

## **11. Why did he leave the workplace on that day?**

- 11.1. Mr Howard’s perception of what was occurring in the workplace, and indeed his response to the events of that morning, seemingly did cause or contribute to his decision to purchase the petrol and transport it in his car. That in itself was dangerous. In making

---

<sup>115</sup> Transcript, page 390

<sup>116</sup> Transcript, page 390

<sup>117</sup> Transcript, pages 390-391

<sup>118</sup> Coles Express

this finding I am not implying that there was anymore, on that morning, that could have been done from Orora's perspective to prevent the catastrophe that unfolded. I accept that on that morning, the supervisors' reactions to Mr Howard's distress demonstrated the level of support Mr Howard received from Orora as soon as an issue was raised by him. The supervisors were immediately concerned about his welfare and implemented a strategy to relieve his distress and to allow him to regain his composure.

- 11.2. Although I am not suggesting that there was more that could or should have been done on that particular morning to change the course of events, it is an undeniable circumstance of his death that operating on Mr Howard's mind at the time he purchased the petrol was distress and/or anger as a result of the interaction at work that morning.

**12. Why did Mr Howard purchase the petrol?**

- 12.1. In particular, did he purchase this petrol with the intention of ending his life?
- 12.2. This topic focused on the uncontested evidence of what Mr Howard did once he left the Athol Park site in his car. The circumstances regarding his behaviour and in particular his reaction to the workplace issue prior to leaving must also be considered in analysing the uncontested evidence in particular, of the collection of the three jerry cans, the over filling them with petrol and storing them within the cabin of his Hyundai.
- 12.3. What he intended to do with it is another question. I am satisfied he had no legitimate purpose for purchasing that petrol. It is not helpful to speculate about what he may have been contemplating doing at the time he purchased the petrol. But the mere act of purchasing that amount of petrol and putting it in his car placed him at extreme risk.
- 12.4. Why did he initially store the jerry cans within the back seat area of the cabin rather than attempting to store them within the boot of his car? After the fire, the front passenger seat contained the remnants of one of the jerry cans on the passenger seat<sup>119</sup> and remnants of another jerry can in the front passenger footwell. Those jerry cans must have been moved by Mr Howard after the Coles Express visit and prior to the car igniting. There is barely any evidence of the third jerry can in the rear of the cabin which may have been completely consumed by the fire, unlike the other two.

---

<sup>119</sup> Exhibit C16, Brevet Sergeant Pearson dated 30 October 2018

- 12.5. In considering the purchase of the jerry cans and petrol, I have taken into account the careful and detailed submissions on behalf of Mrs Howard urging a finding of fact that he committed suicide due to factors that include:
1. Mr Howard was completely unaffected by alcohol or drugs.
  2. The evidence of CCTV footage before his death showed him in a calm manner dealing with employees at Paramount Browns' and Coles Express.
  3. Mr Howard did not take his work bag with him when leaving the Athol Park site that morning which is what he did if he left.<sup>120</sup>
  4. Relying on AP Kee's evidence, petrol vapour and or liquid petrol must have been released into the interior of the Hyundai by Mr Howard compared with escaping the jerry cans without his assistance. This is coupled with the likely need for an independent ignition source such as a cigarette lighter or a match.
- 12.6. I pause here to note that Mr Howard was not a smoker and nor was there any evidence of purchasing an ignition source of any type from Paramount Browns' or Coles Express. This does not exclude him using a cigarette lighter from the car, nor obtaining an ignition source such as matches or a cigarette lighter from within the Athol Park site before he left that morning. He also may have made a cash purchase elsewhere of matches or a cigarette lighter before returning to the bus zone.
- 12.7. It was also submitted the background and cumulative effects of Mr Howard's workplace incidents over a long period of time, as documented and undocumented manifested itself into self-inflicted tragedy that day. Reliance was placed on '*the daze*' he was in that day, a description by Mr Badcock that he '*knew something wasn't right...he was a bit emotional and seemed to be holding back tears*'.<sup>121</sup> This was the result of a confrontation that occurred between him and Craig Reid that morning up to Mr Howard had admitted making an error which resulted in being yelled at and chastised by Mr Reid.
- 12.8. An expert report was received from eminent Consultant psychiatrist Adjunct Professor Crompton OAM that stated 'it does appear that his actions that day are linked to the

---

<sup>120</sup> Exhibit, C27

<sup>121</sup> Exhibit, C12

recurrent experiences in the workplace and his belief that the response to these events was inadequate. Ultimately the build-up of internalised distress in a man who experiences significant anxiety, particularly in the context of the workplace events, may be perceived as linked to his actions.’<sup>122</sup>

12.9. I have taken into account the medical evidence, the expert evidence on suicide, the workplace evidence concerning Mr Howards character, behaviour and previous reactions. I have also taken into account the significance of where the car ignited, Mr Howard’s long and loyal history with Orora and the scientific evidence of combustion of the highly flammable unleaded petrol and its storage in such a confined space.

**13. Why did he pull over in the bus zone?**

13.1. There is a question mark about why the car was pulled over into the bus zone. Could it be that he had abandoned any plans he had contemplated with that petrol? Had he pulled over to move the jerry cans? Did he pull over to be close enough to the work site such that an impact of his actions would not risk the lives of others? These are all questions which unfortunately were unable to be answered. Did he simply want to set his car on fire as a protest and spread petrol inside the car but something happened by accident to cause the explosion and fire?

**14. How did the petrol combust?**

14.1. The only two credible propositions about the combustion of the petrol when in the Hyundai at the bus zone was due to a deliberate act by Mr Howard to set fire to his car or spontaneously due to properties of petrol and the dangerous situation he placed himself in by his earlier actions.

**14.2. Scene Evidence and subsequent SAPOL investigation for the State Coroner**

14.3. I will deal with investigation by SAPOL both at the scene and following in their capacity as reporting the result of their investigation to the State Coroner.

---

<sup>122</sup> Exhibit C28 page 6

14.4. Examination of the Scene

14.5. There are features of this scene that need to be expressed in this Finding despite the graphic nature of it. I will only set out what is necessary in the circumstances.

1. The car doors were all closed.
2. The interior of the car was extensively melted and fire damaged.
3. The engine block and bonnet was extensively damaged but not to the extent as the rest of the Hyundai. This indicated to SAPOL that “the fire did not start in the engine”.
4. The ignition source is unknown.
5. SAPOL were ‘unable to establish how the fire started due to the extent of fire damage’<sup>123</sup> to the Hyundai.
6. SAPOL could not say if the car was on or off when the fire started.

The SAPOL scene examiner concluded that:

*‘Due to the presence of an odour of petrol inside the vehicle this death appears to have been a deliberate act to self-harm. It has occurred as a result of the deceased igniting an accelerant that had been contained in the two(2) plastic yellow fuel containers found within the passenger section of the vehicle.’<sup>124</sup>*

7. SAPOL does not refer to a third jerry can at the scene. This means it was removed by Mr Howard prior to arrival or was totally subsumed in the fire, perhaps leaving the barest of traces of it in the back seat.
8. A toolkit was found in the rear passenger seat footwell. This was a possible place where matches or a lighter may have been.

---

<sup>123</sup> Exhibit C16, paragraph 51

<sup>124</sup> Exhibit C16, paragraph 53

14.6. Detective Mitchell, Western District Criminal Investigation Branch

14.7. Detective Mitchell was tasked to the scene by SAPOL and arrived at 9:27am. He saw the Hyundai alight and heard “effusions” from it when he approached. He described a “strong” smell of petrol.

14.8. His subsequent enquiries and investigations showed Mr Howard had arrived at Athol Park at 5:42am and leaving at 8:42am. He obtained the CCTV footage of the purchase of the jerry cans and petrol. He obtained Mr Howard’s credit card statement showing his last two purchases were of those items. The SAPOL investigation concluded that the circumstantial inferences from the purchases of the jerry cans and petrol meant the fire in the Hyundai resulted from Mr Howard’s “self inflicted act whereby he took his own life by igniting his vehicle alight using fuel contained in jerry cans he purchased as an accelerant.”

14.9. I heard evidence from two experts as to possible methods of ignition in this instance. They were both engaged by this Court after SAPOL had completed their investigation.

14.10. Associate Professor Tak Wi Kee

14.11. At the time of giving evidence Associate Professor<sup>125</sup> Kee was interim head of the School of Chemistry at the University of Adelaide. His qualifications were not in dispute but I set them out in any event. He graduated from Iowa State University in 1997 with an undergraduate degree in science then studied at the University of Texas to obtain a PHD in 2003 concerning the properties of water under intense laser radiation. From 2003 to 2006 he worked in the United States at the American National Institute of Standards and Technology before accepting a position at the Adelaide University in 2006. He lectured undergraduates, postgraduates and supervised PHD candidates. In addition he was involved in a number of research projects including studying renewable energy.

14.12. AP Kee provided a report<sup>126</sup> to the Inquest and gave oral evidence. His evidence covered basic features of petrol that are generally known in the community but also subject of his specific expertise.

---

<sup>125</sup> AP

<sup>126</sup> Exhibit C23

14.13. He was asked to make a number of assumptions as he set out in his report and evidence concerning the purchase of the petrol, namely:

1. The three jerry cans were filled to capacity.
2. Mr Howard did not smoke nor possess cigarette lighter or matches.<sup>127</sup> This assumption was strictly followed for his evidence and does not cover he may have had or somehow obtained an ignition source.
3. The fire started in the cabin of the car which had a volume of approximately 3.2 cubic metres.

14.14. By virtue of his evidence, the following properties of petrol were explained, namely:

1. It gives off vapour.
2. The vapour is heavier than air.
3. Petrol vapour is highly flammable due to its makeup of complex hydrocarbons.
4. Petrol vapour will, in a large space, tend to 'cover the ground'. This compares with a confined space where it will 'cover the ground first and then...begin to accumulate upward. Given sufficient time, a confined space can be filled with petrol vapour.'<sup>128</sup>
5. To ignite petrol vapour without an ignition source, a temperature of greater than 350°C is required.
6. Below the temperature of 350°C, an ignition source is required to ignite the vapour.
7. Petrol vapour will not explode in a confined space unless it sits between a figure of 1.4% of the volume up to 7.6% of the volume. Assuming a 3.2 cubic metres space, the minimum level (1.4%) equates to 44.8 litres of petrol vapour.
8. The maximum level of 7.6% with the same cubic dimensions equates to 243 litres of petrol vapour. As AP Kee stated 'Petrol is an explosive between the minimum and maximum explosive limits. Below the minimum limit, the oxygen content is too low

---

<sup>127</sup> Exhibit C23

<sup>128</sup> Exhibit C23

for an explosion. Above the maximum limit, the fuel content is overly high to result in an explosion'.<sup>129</sup>

9. Given the presence of the three jerry cans within the cabin, all of which were overfull against recommendation, an amount of 'an average of 128 mL of petrol would be needed to have been spilt and evaporated on each container to reach the minimum explosive limit'.<sup>130</sup>
  10. By logic if petrol is spilt it will fall to the bottom of the cabin where, if small in volume it would be expected to evaporate fully in ten minutes.
  11. The evidence of the CCTV footage<sup>131</sup> shows evidence of a spillage in the containers on the ground after Mr Howard has loaded them into the jerry cans into the car. However, the evidence of the petrol on the ground made it '*unlikely that that ...spill could account for 38mL of petrol needed to reach the minimum explosive limit*'.<sup>132</sup> The car doors on the driver's side were open during the filling of the jerry cans. It was not possible to see how Mr Howard screwed the caps back on after filling the jerry cans.
  12. AP Kee came to the opinion in his report that 'in the absence of any defects in the petrol containers, it is unlikely that there would be sufficient spilt petrol to evaporate in the internal cabin to reach the minimum explosive limit'.<sup>133</sup>
- 14.15. Yellow jerry can
- 14.16. A yellow jerry can of the type purchased by Mr Howard was tendered in evidence.<sup>134</sup> Features of the jerry can include two caps attached to the top and a nozzle clipped in to allow easy pouring. I refer back to my earlier summary where each jerry can was filled beyond recommended capacity by an average of 1.57 litres. The importance of concentrating on this exhibit is because of the expert evidence of AP Kee that airspace is needed within each jerry can.
  - 14.17. Before analysing AP Kee's evidence on this topic I will set out the applicable warnings engraved on Exhibit C30 namely:

---

<sup>129</sup> Exhibit C23

<sup>130</sup> Exhibit C23

<sup>131</sup> At time 9:05:44

<sup>132</sup> Exhibit C23

<sup>133</sup> Exhibit C23

<sup>134</sup> Exhibit C30

- Flammable – vapour may cause – fire.
- Keep out of reach of children.
- Keep container away from source of ignition.
- Not suitable for all racing fuels.
- Store away from direct sunlight.
- Place containers on ground when filling and ensure filling nozzle contacts the container during filling.

14.18. On Exhibit C30 the filling line is clearly marked with as follows ‘20L’.

14.19. I have closely examined this exhibit. The relevant 20 litre line to fill to its recommended limit leaves considerable space for air as planned for by the manufacturer of the jerry can.

14.20. Significance of need for air within jerry can

14.21. This topic was commented on and explained by AP Kee. He nominated two reasons why petrol containers such as the yellow jerry can should not be ‘*filled to the brim*’<sup>135</sup> namely:

‘One is that the petrol would evaporate and it would create a positive pressure, and that pressure, if the level of the petrol is too high, could actually begin to expel the petrol from the container through the cap. That’s reason No.1.

Reason No.2 is that you would not want to have too much of a head space in the container, because a head space would encourage evaporation, and you would have a lot of petrol vapour, and - within the container - and petrol vapour is very dangerous because they’re very flammable.’<sup>136</sup>

14.22. A third or related factor was explained. In the case of reduced headspace in a jerry can full of petrol when the petrol evaporates within a container it generates pressure. That pressure created by the vapour has to go somewhere and:

---

<sup>135</sup> Transcript, page 460

<sup>136</sup> Transcript, page 460-461

‘... escape from the petrol container, in order to be able to release that pressure: and unfortunately, when the petrol is filled too high, then the amount of – then is the petrol, the liquid petrol being expelled from the container itself in that case.’<sup>137</sup>

- 14.23. It was consistent with an uneducated conclusion by any reasonable person that transporting significant litres of petrol, with car windows up, such as Mr Howard did could result in the vapour being exposed within the cabin to reach the minimum explosive limit as well as spillage of petrol.
- 14.24. What is beyond argument is an ignition source, such as cigarette lighter from within the car structure, that was readily accessible to Mr Howard was sufficient source to generate the situation needed for the explosion within the car that occurred.
- 14.25. Naturally, if was deliberately orchestrated by Mr Howard by splashing petrol around on or near him and exposing the cigarette lighter such an explosion would occur. He must have realised that extensive self-harm or death would follow as a result.
- 14.26. The important factors that can now never be properly ascertained through this expert evidence alone is whether Mr Howard did deliberately set up such a dangerous situation with the intent to end his life or whether the scientific formula for ignition happened accidentally. AP Kee cannot assist us on that topic as he quite correctly acknowledged.<sup>138</sup>
- 14.27. Finally, further logical evidence about the headspace within the yellow jerry can was briefly touched upon. He explained in simple terms that if there is more space then there will be more petrol vapour and correspondingly less vapour if there is less space.
- 14.28. He re-emphasized that the pressure within the container would be exactly the same in either situation. I quote further from him:

'So in the big head space for instance, the amount of pressure is exactly the same. The danger there is that you have a lot of petrol vapour within that container, and that's the danger itself. However, if the head space is very small, the extra pressure that's built up could potentially push the liquid into the other caps and then the liquid may actually flow out of the cap.'

---

<sup>137</sup> Transcript, page 461

<sup>138</sup> See cross-examination of Mr Saies, pages 477-481: and Dr Gray KC page 481-482

- 14.29. Finally, the only spillage we saw with certainty occurring was that at the Coles Express. There was no evidence of what he did with the containers, other than having to move at least two of them from the rear seat to the front passenger seat prior to the explosion. This factor is also certain based on the photos taken by SAPOL at the scene showing remnants of two jerry cans in the front passenger seat as previously described.
- 14.30. Why were these jerry cans moved? One answer is they may have been unstable as initially stored and perhaps spillage occurred. This heads to a reasonable line of thought that if he had planned to suicide by self-immolation, spillage of some petrol would not matter. Another is that he planned to stop there and had moved them there to suicide in that unusual manner outside the Athol Park site. No-one saw him stop there and there were no CCTV cameras to capture his movements at that point.
- 14.31. Just as he did at Paramount Browns', Mr Howard paid for his petrol purchase by Visa card. CCTV evidence from both businesses showed that he was impassive and behaved normally.
- 14.32. Importantly another feature was that at 9:08am, during filling the jerry cans at Coles Express, Mr Adrian Wright called. Mr Howard looked at his phone<sup>139</sup> presumably knowing who was calling but declined to answer. The jerry cans full of petrol were put into the back passenger seat area, looking like they were stored on the driver's side due to the manner Mr Howard was leaning in to the car with the jerry cans. The refusal to take that call meant he did not want to engage with Orora at that time.
- 14.33. At 9:15am, he died outside the Athol Park site when the Hyundai exploded into fire sitting stationary, in a designated bus zone. His actions in those seven minutes are not known except for the fact he must have moved the jerry cans from their original position.
- 14.34. Professor Abbott
- 14.35. Professor Abbott was also called to give evidence on this topic of how the petrol may have ignited due to static electricity. I note that there were some objections to his evidence.

---

<sup>139</sup> 9.08am and 44 seconds

- 14.36. According to the evidence provided by Professor Derek Abbott, static electricity can serve as an ignition source. In its simplest form, static electricity is the accumulation of charge on a surface, which can be discharged and result in arcing. This accumulation of charge can occur on surfaces like clothing, particularly synthetic fabrics, which are known to be more prone to static electricity. When synthetic fabrics rub against each other or against another surface, such as a car seat, there can be an accumulation of positive or negative charge. This can lead to the creation of a spark, which is caused by high voltage breaking down the air and creating visible arcing.
- 14.37. The presence of static electricity is influenced by environmental factors such as humidity and temperature. Higher humidity can make the incidence of static electricity and sparks less likely, as it helps to discharge the charge away faster. On the other hand, lower humidity increases the likelihood of sparks occurring. Temperature itself does not directly affect the presence or absence of static electricity, but it can indirectly impact humidity levels. For example, air conditioning systems that reduce humidity can make static electricity more likely in certain circumstances.
- 14.38. In terms of structures, the ability of a material to dissipate a charge affects the likelihood of sparks occurring. Wood, for example, is less conductive than steel, so it is less likely to accumulate a charge. When it comes to getting in and out of a car, the accumulation of charge on the outside of the car can result in a jolt when touching the car door. This discharge occurs as electrons flow through the person, discharging the accumulated charge. The presence of static electricity in cars is primarily caused by clothing rubbing against the seat.
- 14.39. It is important to note that static electricity can serve as an ignition source for petrol. However, it is not a common occurrence in cars because people generally do not have a significant amount of petrol inside the car. Electrical system failures, such as overheating or damaged wiring, are more common causes of vehicle fires. Static electricity igniting petrol is more commonly associated with incidents at petrol stations, where static can be generated while filling the tank.
- 14.40. In summary, while static electricity can serve as an ignition source, it is not a common occurrence in cars due to the lack of a combustible material like petrol. Other factors, such as electrical system failures, are more likely to cause vehicle fires.

14.41. The state of the evidence on this topic does not allow me to make any meaningful finding about static electricity as an ignition source concerning Mr Howard's death. Although it is very unlikely, I cannot entirely exclude the remote possibility that static electricity was the ignition source.

**15. Was this an act of suicide by self-immolation?**

15.1. I have deeply considered whether Mr Howard finally but unexpectedly reached a saturation point or tipping point about his ability to cope with the workplace issues that had from time to time greatly affected him in his long career at Athol Park. If that is correct, he may have chosen this location, just outside the boundary fence to emphasise a link between his suicide and what happened to him at work that morning and in the past.

15.2. In my decision as to whether I could be satisfied on the balance of probabilities that this was an intentional suicide, I have taken into account a number of factors, including the evidence received about self-immolation as a means of suicide. Many of those factors are listed in paragraph 12.9 of this Finding.

15.3. Professor Crompton OAM, a consultant psychiatrist, gave evidence relevant to this issue. Prior to obtaining a Fellowship in Psychiatry in 1990 he worked as a general practitioner for a number of years preceding 1990. He subsequently worked in private psychiatric practice for 12 years before obtaining leadership roles and mental health in New South Wales and Queensland.

15.4. At the time of giving evidence he was a Professor at Griffith University in the School of Applied Psychology and the Institute for Glycomics as well as Queensland University of Technology in the Health faculty. He was also a member of the National Research Committee for Suicide Prevention Australia. Professor Crompton's curriculum vitae<sup>140</sup> was tendered<sup>141</sup> that outlined his extensive research in the area of suicide.

15.5. Self-immolation is rare in Western society. Studies in USA, South Australia and Victoria indicate a very low percentage of suicides occur in this manner. For instance in a 13 year span in USA, 0.43% of all suicides were by this method.<sup>142</sup> Given such a

---

<sup>140</sup> CV

<sup>141</sup> Exhibit C28A

<sup>142</sup> Exhibit C8 and Transcript, page 565

small number of suicides in this manner, he explained it was difficult to draw any inferences as to the common features between any of the people that died this way. This was especially emphasised by him given the research in Victoria where 75% of people who died in this manner did not leave any final communications as to why this method was chosen.

- 15.6. I am wary to publicise detail concerning his evidence any more than is necessary to satisfy my task under the Act in conducting this Inquest.
- 15.7. However, Professor Crompton OAM did refer to research that indicated that ‘use of self-immolation as a form of protest for political reasons, as a way to end intense personal suffering or to emphasise that they have experienced individual maltreatment’ are reported reasons for suicide in this manner.<sup>143</sup>
- 15.8. Assuming Mr Howard did die in this manner, Professor Crompton OAM agreed it was likely that his death ‘*reflected a culmination of experiences rather than just one event*’.<sup>144</sup>
- 15.9. He talked in general terms about the link between bullying, suicidal ideation and actual suicides. Understandably he suggested increased ‘*risk of suicidal ideations in that population that experiences bullying*’<sup>145</sup> was supported by research.
- 15.10. He further linked that ‘peer victimisation and bullying are associated with suicidal ideation’.<sup>146</sup> He referred to a study that ‘demonstrated a significant association between victimisation from bullying and subsequent suicidal ideation, suggesting that bullying may cause suicidal ideation...findings highlighted the importance of preventative measures against due to the risk “bullied “employees may have an increased probability of considering ending lives’.<sup>147</sup>
- 15.11. The attitude and reaction by the receiver of comments or actions done to someone that many would consider innocuous is important. That is, even a comment made with an innocuous intent can be perceived by the receiver to being a piece of bullying.

---

<sup>143</sup> Exhibit C28

<sup>144</sup> Transcript, page 609

<sup>145</sup> Transcript, page 586

<sup>146</sup> Exhibit C28, page 6

<sup>147</sup> Exhibit C28, pages 6-7

- 15.12. He agreed with a proposition that ‘one person’s practical joke could be another person’s bullying’.<sup>148</sup>
- 15.13. He agreed it is possible to be ‘*worn down*’ with respect to a psychological defence or barrier to the effects of bullying, even to the point of Mr Howard ‘*not being able to cope any longer*’.<sup>149</sup>
- 15.14. He was referred to the description by Mr Badcock of ‘*fiddling with sticks*’<sup>150</sup> as he sat under the tree that morning and was seen to be emotional with a sign of ‘*distress*’. He believed it would be ‘*drawing a great deal of speculation*’ to suggest he was in a dissociative state at that point.<sup>151</sup>
- 15.15. He commented on Mr Howard’s reported reaction to the work incident with Mr Craig Reid that morning was ‘causing him considerable distress and he was finding it difficult to cope with, and then at some stage, he decided to leave the workplace.’<sup>152</sup>
- 15.16. He continued. ‘But as to what then the next step was between him leaving work and then making that decision to purchase the petrol etc., and his life ending, again there may have been other things other than just that, that was occurring in his mind.’<sup>153</sup>
- 15.17. In the setting of the assumption of suicide, Professor Crompton OAM was asked this question:
- Q. Is there a possibility in this case that Mr Howard's making some sort of protest to the workplace given the location of where this occurred.
- A. If one speculated the answer is yes, that's possible, but that's really - again we have no knowledge of whether that is the case or not. We don't know what the meaning of him driving back to the workplace is. One could speculate the answer is yes, but it is speculative.
- 15.18. Further Professor Crompton confirmed that he had prepared his report and answered questions in oral evidence on the ‘*assumption most likely he took his own life*’ rather than any consideration of an accidental death.<sup>154</sup>

---

<sup>148</sup> Transcript, page 586

<sup>149</sup> Transcript, pages 588-589

<sup>150</sup> Exhibit C12

<sup>151</sup> Transcript, page 596

<sup>152</sup> Transcript, page 597

<sup>153</sup> Transcript, page 597

<sup>154</sup> Transcript, page 611

- 15.19. The other proposition about Mr Howard's death was that it was unintended. The purchase of over 64 litres of unleaded petrol into three jerry cans with a cavalier approach to the storage within his car tended to suggest that he was going to use the petrol to do something in the near future after its purchase. His return towards his worksite tended to suggest he planned to do something with the petrol at or around his worksite. I do not believe that he would have contemplated consciously putting anyone lives at risk by using the petrol in any place at the Athol Park site he thought could have harmed someone directly. The evidence suggested that Mr Howard was not that type of person.
- 15.20. All the evidence demonstrated expert medical clinicians, family, friends and co-workers did not believe Mr Howard was at risk of self-harm on 28 August 2018. I take that into account with the lack of direct evidence of the identifiable source of the ignition, the possibility (albeit it remote) of spontaneous ignition or ignition from static electricity, the lack of evidence of what spillage may have occurred with the car after leaving Coles Express and no evidence of what happened when he pulled up in the bus zone prior to the explosion and fire.
- 15.21. After a great deal of thought, in the end I am unable to find on the balance of probabilities whether or not Mr Howard deliberately ignited the petrol in that location at that time. Neither can I find what exactly his intention was when he purchased all of that petrol and placed it in his car. Further, it is plausible that his pulling up in the bus zone indicated a change of intention and/or an abandonment of any thoughts of potentially harmful behaviour of a protest involving the petrol.
- 15.22. I am confident that Mr Howard would not have deliberately placed anyone else in harms way by his intended actions if suicide was not his motive to buy the petrol.

## **16. Findings on the circumstances of Mr Howard's death**

- 16.1. Mr Howard was a loyal and well-respected employee of Orora at Athol Park. He had devoted 27 years of his working life to Orora at that site.
- 16.2. A number of incidents involving Mr Howard had come to the attention of Orora management over the years. These known incidents were appropriately dealt with by Orora. As said earlier in making that finding, I am not minimising the impact those

incidents may have had on Mr Howard's mental state. Similarly I do not minimise the impact of unreported incidents and a belief that they would continue in the future.

- 16.3. On the morning of 28 August 2018, soon after he began work Mr Howard became significantly upset over the dispute with a co-worker. Mr Howard was approached by his supervisors in an effort to assist him with the aim of returning to work in a different area. After some discussion he regained his composure and returned to the factory floor for a short time.
- 16.4. At 8:32am Mr Howard left in his Hyundai without providing any notice to his superiors or co-workers at the Athol Park site.
- 16.5. I find that the action of leaving and obtaining the petrol was connected to what occurred at work that day and reflected a culmination of experiences that he could not put to one side rather than one event.
- 16.6. Mr Howard purchased three jerry cans between 8:45am and 8:57am at Paramount Browns' Cavan, only a short drive away from the Athol Park site.
- 16.7. Mr Howard drove to Coles Express on Grand Junction Road and filled the three jerry cans with 64.61 litres of petrol.
- 16.8. In filling the jerry cans on the outside of the car next to the pump, it is evident that some spillage was caused, perhaps through overfilling one or more of the jerry cans past their absolute capacity.
- 16.9. I cannot positively find, nor would it be helpful to speculate what he intended to do with the petrol. However, Mr Howard was in a dangerous situation having that petrol in the car with him that day as a result of the stressors he had been experiencing at work. To that extent, his work stress was a circumstance relevant to his death.
- 16.10. He pulled over into the bus zone well away from the factory floor of Orora but still in potentially a dangerous position for other members of the public that may have used that road or footpath. At the time of the start of the fire no other members of the public nor employees of Orora were placed in immediate danger. I tend to believe he knew or believed the street was quiet when he pulled up.

Ultimately, the evidence does not leave me comfortably satisfied to find that he died from suicide or spontaneous ignition.

- 16.11. In confirming this finding. I have carefully considered all the evidence of people who knew him, at work and socially, the SAPOL investigation, the evidence of Dr Nicholson and the experts.
- 16.12. I have deliberately concentrated to separate speculation from allowable inferences on the evidence. It was not an easy task. I still find the quick turn of events that morning to be almost incomprehensible given Mr Howard's long work history at Orora, his family life and his social life.
- 16.13. I also have to acknowledge that people can reach a breaking point, essentially as Professor Crompton's evidence described and the uncontested evidence of that morning meant he had decided on a very different and unpredictable course of events once he left the Athol Park site compared to his previous behaviour in an upset state.
- 16.14. The rejection of a phone call from Orora at 9:08am followed by no contact with anyone tended to suggest he was determined to follow through on a course of events at that time.
- 16.15. As said earlier, speculation may lead to many conclusions about his intended outcome of his actions. I repeat that whatever his intent, I believe he was not seeking deliberately to put anyone else in harm's way when he pulled up outside Orora in that bus zone.

## **17. Recommendations**

- 17.1. Pursuant to Section 25(2) of the *Coroners Act* 2003 I am empowered to make recommendations that 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. I was informed throughout the inquest of a number of significant developments that have occurred at Orora since Mr Howard's death. I will not repeat them here. I have taken each of those developments into account when considering any recommendations I should make.
- 17.2. I was urged at the close of evidence to make recommendations for South Australia to adopt new regulations to help workers and employers manage the risk of psychological injuries and illnesses in the workplace.

17.3. It was submitted that I should urge the South Australian Government to adopt the Commonwealth Model of Code of Practice for Managing Psychological Hazards at Work (2022) into industrial relations law.<sup>155</sup> New workplace regulations came into effect in South Australia on 25 December 2023. The changes to the regulations under the *Work Health and Safety Act 2012* adopting the Code will help provide better guidance to workers and employers. There is no need in these circumstances to make recommendations on this important workplace issue.

17.4. I therefore make no recommendations.

*Key Words: Combustion - inhalation of products of; Suicide; Workplace*

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

*Seal the 8<sup>th</sup> day of August, 2024.*

Inquest Number 22/2022 (1647/2018)

---

*Deputy State Coroner*

---

<sup>155</sup> Transcript, pages 955- 956 'the Code'