MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Andrew McKee, Coroner, having investigated the death of Richard Carl Barker with an inquest held in Launceston in Tasmania make the following findings:

Hearing Dates

15, 16, 17 and 19 August 2016, at Launceston in Tasmania

Representation

Counsel Assisting the Coroner: Ms Maricia Duvnjak
Counsel for Mrs Jemma Barker: Mr Dexter Marcenko
Counsel for BIS Industries: Mr William Griffiths

Jurisdiction

Pursuant to s 24 of the *Coroners Act 1995* (as Mr Barker's death occurred as a result of an accident or injury at his place of work, and his death was not due to natural causes) it was mandatory that an inquest be held.

Introduction

1. On 23 April 2013 Mr Richard Carl Barker died as a result of head, neck and chest injuries he sustained after removing a number of bolts attached to a metal wing from a piece of decommissioned equipment stored at BIS Industries situated at 108 Bell Road, Bell Bay in Tasmania.

2. At the time of his death Mr Barker was 43 years of age. He was born in Launceston. He was educated at Hagley Farm School. He commenced and completed an apprenticeship as an A-Grade Wood Machinist in 1986. After an industrial accident

he retrained and commenced as a Boner with Blue Ribbon. He then returned to employment as a Wood Machinist with Gunns Pty Ltd.

3. He married at the age of 22. That marriage ended in divorce. It produced two children. He married Jemma Barker in 2012. The marriage produced one child. At the time of his death he was happily married to Mrs Barker. The couple were building a home at Hillwood.

4. He was an industrious individual, maintaining employment for the majority of his adult life.

5. At the date of his death Mr Barker was engaged as a contractor by Hall's Family Trust, trading as ATH Engineering and Maintenance (hereinafter referred to ATH). A business operated by Adam Craig Hall and his wife.

6. ATH provided to BIS Industries contractors and employees to undertake works which included the servicing and maintenance of equipment located at the Temco/BHP site.

7. BIS Industries supplied mobile plant and labour to Temco. The Temco site was situated near the BIS Industries site. The two sites were separated by a road of some 700 metres.

8. Mr Barker was sub-contracted to BIS Industries. His primary role was as a "greaser". A greaser undertakes basic preventative maintenance of plant and equipment. This maintenance would either occur at the Temco site or at the BIS Industries site.

9. The maintenance of the plant and equipment could only occur when it was not being operated. Such maintenance usually occurred when the plant operators were taking breaks. Such breaks usually occurred between 9:30 to 9:45, 12:00 to 12:30 pm and between 2:30 and 4:00 pm. Mr Barker's usual hours of work were between 7:00 am and 4:00 pm.

10. During the period that he was not performing maintenance on the plant and equipment he performed other duties. Shortly prior to his death he was involved in the collection of scrap metal from the BIS Industries site.

11. That task required him to collect and cut up scrap metal and place it in bins. He utilised a forklift to move some scrap metal to the bins.

Management Structure of ATH, BIS Industries and the Relationship between Employers and Sub-Contractors of ATH and BIS Industries

12. Mr Barker was not the only contractor or employee of ATH that was sub-contracted to BIS Industries.

13. The following persons were also engaged at the site:

    (a) Mr David Pearce (an apprentice Diesel Mechanic);
    (b) Mr Jason Chorley (a Boilermaker);
    (c) Mr Tom Martello (a Trade Assistant);
    (d) Mr Jonathan David Johnson-Graauw (Motor and Diesel Mechanic).

14. Mr Adam Hall was the Manager of ATH. He confirmed in his evidence that he occasionally attended the BIS Industries site. He was not responsible for the allocation of work to the ATH employees or sub-contractors. He had not participated in or undertaken any risk management assessments associated with the specific tasks undertaken by ATH employees or sub-contractors.

15. There was no necessity for Mr Hall to supervise the tasks undertaken by ATH workers.

16. Mr Grantley Hamilton was employed by BIS Industries as a Manager. He was responsible for managing the BIS Industries site. His duties included overseeing the site, financial management and overseeing the operational and safety responsibilities of the work site.

17. Mr Brian Fitch was employed by BIS Industries as the Operation Manager.

18. Both Mr Hamilton and Mr Fitch's evidence was that they had no supervisory role in relation to ATH employees/contractors.

19. Mr Hamilton's evidence was if he observed any unsafe work practices he would act on them.

20. The evidence discloses that prior to ATH workers/contractors commencing work at BIS Industries, or at the Temco site, they were required to undergo an induction.

21. BIS Industries had appropriate safety procedures in place. Tasks to be performed required *"Take 5 mini-risk assessment"* or a *"Job Safety Analysis"* (JSA) which was a more detailed risk assessment to be conducted.

22. All ATH employees/contractors were provided with a *"Take 5"* booklet. The booklet comprised tear out pages. The clear intent of the *"Take 5"* assessment process was to require the individual completing a task to consider various safety aspects of the given task. If the risk rating was above 3 a JSA was required to be completed.

23. Once completed, *"Take 5"* assessments were placed in a box located in the office at the BIS Industries site. There was no evidence regarding what became of JSAs.

24. There was no evidence before me that the *"Take 5"* assessments or the JSAs were regularly monitored or considered.

25. Whilst the situation regarding the monitoring of the *"Take 5"* assessment or JSAs appears to be less than ideal, I am satisfied that the lack of monitoring of *"Take 5"* assessments or the JSAs did not in any way contribute to Mr Barker's death.

Allocation of Work to ATH Employees and Contractors

26. ATH employees and contractors were allocated work by way of a work order. Work orders were issued by Mr Brian Fitch. The work orders were issued at a pre-start meeting held at approximately 7:00 am each morning. The meeting occurred at the BIS Industries site.

27. No work order was tendered in evidence regarding the scrapping of steel.

28. On the evidence before me I find that Mr Barker was required when not performing maintenance work on plant or equipment to collect scrap steel from around the BIS Industries site and deposit it in bins. He was also required to clean the site generally.

29. There is no evidence as to the existence of any JSA or *"Take 5"* risk assessments with respect to the cutting of metal/scrap metal other than the evidence of ATH workers to the effect that *"there would have been".*

30. Mr Hamilton's evidence was that he, along with Mr Barker and Jon Johnson-Graauw, walked around the yard and identified scrap steel by spray painting a yellow cross on

it. Some of the steel was of sufficient size and weight to require the use of a forklift to transport it to the bins.

31. Mr Hamilton's evidence was that the steel to be scrapped was located on the south and west boundary of the BIS Industries site.

32. Near the western boundary of the site decommissioned plant from the Temco site was being stored.

33. The following decommissioned items were on the BIS Industries site:

    (a) A grizzly;
    (b) A crusher; and
    (c) The hopper for another crusher.

34. Photographic evidence tendered through Constable Midson clearly shows the hopper with a yellow cross on it, and the words *"all go"* spray painted on it in yellow. Mr Barker was working on the hopper at the time of his death.

35. Mr Hamilton denies spray painting the cross on the hopper, or the words *"all go".* It was his belief that that would have occurred when the hopper was to be transported from Temco to the BIS Industries site.

36. His evidence was that the hopper was not to be scrapped. I accept that evidence.

37. Even if allowance is made for the fact that Mr Barker may have identified the yellow cross on the hopper as an indication that it was to be scrapped, and that he had some implied permission to commence that process, there is no evidence that he performed a *"Take 5"* prior to commencing that task.

38. The completion of a *"Take 5"* may have identified risks associated with the task that ultimately led to his death. There is, however, insufficient evidence to reach that conclusion.

39. I note that the decision by Mr Hamilton to place an *"X"* on materials to be scrapped by utilising yellow spray paint is less than ideal when it should have been obvious that yellow paint marks appeared on the decommissioned plant from TEMCO. However, I am satisfied that the use of yellow paint to mark materials to be scrapped in no way contributed to Mr Barker's death.

40. Mr Hamilton's evidence was that he was not aware that Mr Barker was cutting up scrap steel with oxyacetylene equipment.

41. His evidence was that Mr Barker had in fact asked if other persons were permitted to cut steel up so that he could transport it to the bins.

42. His evidence is to be contrasted with the evidence of Mr Johnson-Graauw and Mr David Pearce. Their evidence was clear that they had observed Mr Barker utilisiting oxyacetylene equipment to cut up steel.

43. Whilst it is accepted that Mr Hamilton may not have been aware of that Mr Barker was utilising oxyacetylene equipment to cut up steel, there is a clear body of evidence that Mr Barker was involved in the collecting and cutting up of scrap steel material utilising the oxyacetylene equipment at the BIS Industries site. I accept that evidence.

44. I accept the evidence of Mr Hamilton that he was unaware Mr Barker was utilising oxyacetylene equipment to cut up steel. His evidence was that he never observed Mr Barker performing that task.

45. The evidence of Mr Fitch in relation to this issue is contained in his affidavit. In his affidavit he makes reference to Mr Barker cutting up steel. It is clear from his affidavit that Mr Fitch was aware that Mr Barker had been cutting up steel. His affidavit, however, was silent as to the manner in which Mr Barker was cutting up the steel.

46. I therefore find that the Operation Manager of BIS Industries was aware that Mr Barker was utilising oxyacetylene equipment to cut up steel. However, I am satisfied that Mr Fitch's knowledge that Mr Barker was engaged in the cutting up of steel in no way contributed to Mr Barker's death due to a direction given by Mr Hamilton at a meeting on the 23rd April 2013.

Meeting of the 23 April 2013

47. On 23 April 2013 Grantley Hamilton called a meeting as the result of observing Mr Thomas Martello, the Trades Assistant, working at height on top of a piece of the decommissioned plant known as *"the crusher".*

48. The plant was identified in photograph number 6 tendered as part of C12. Mr Martello was working without a safety harness and without safety rails in place.

49. Mr Hamilton, upon observing these work practices, directed Mr Martello to immediately cease work.

50. The meeting was held. Present at the meeting were Mr Barker, Tom Martello, David Pearce, Brian Fitch and Jason Chorley.

51. Mr Hamilton produced notes after the meeting. Those notes are in the following terms:

> *"On the 23rd of April at approximately 11:15 am I walked to the rear of the yard to view a piece of scrap steel. When I arrived at the rear of the yard I observed Tom Martello on top of the crusher walk way. He was sitting on the walk way with the oxy/acetyne. I asked Tom what he was up to. He said cutting some steel. Tom was about 2-2.5 metres off the ground with no hand rail.*
>
> *I told Tom to come down and put some danger tape accross the walk way to prevent others entering this area. I also asked Tom to come back to the workshop.*
>
> *I then talked back to the office and called his manager Adam Hall. I advised Adam of what happened with Tom and Adam told me he would keep him back at the workshop in Scottsdale. I then called Brian Fitch and asked him to get all the ATH employees together in our crib room. At about 11:50 am all the ATH employees were in the crib room with Brian Fitch. Present were, Jason Chorley, Tom Martello, David Pearce, Brian Fitch and Richard Barker. I started by telling all of them that 'while they are on my site they follow BIS Industries policies and procedures'. I said that 'what I just saw down the back was not acceptable'. I asked them who knew Tom as working down the back? Richard and Jason both said they knew he was there. I banged my hand on the table and said, 'You two should know better than to have an apprentice working by himself'. I also asked them if they knew what he was doing? They both said they did and admitted it was not good enough.*
>
> *I told them that although I am not their manager they need to follow the site rules. I also told them that they need to look out for each other.*
>
> *I mentioned PPE, and said, If you see someone without there safety glasses on they should tell them. I said 'I' would rather be called a dickhead, than have someone lose an eye. They all agreed and again said it wasn't good enough. I then calmed down and said to them that we wasn't going to go back down there. (refering to the scrap steel). I said we will leave everything down there and do the job properly, JSA, boom lift and crane. I said 'Do not touch any more scrap steel, we will do it properly'. I asked everyone in the room if this was clear and if they had any questions. They all said no except David who asked if we could arrange a boom lift, and if they would require a licence. I said, 'don't worry about that now', and reiterated, that we would do it later and I didn't want anyone touching it".*

52. Mr Hamilton's recollection of the meeting and the notes he made of the meeting are supported by the ATH employees or contractors recollection of what occurred at the meeting.

53. The direction he gave at the meeting is abundantly clear, he said:

> *"I then calmed down and said to them that we wasn't going to go back down there. (refering to the scrap steel). I said we will leave everything down there and do the job properly, JSA, boom lift and crane. I said 'Do not touch any more scrap steel, we will do it properly'. I asked everyone in the room if this was clear and if they had any questions. They all said no except David who asked if we could arrange a boom lift, and if they would require a licence. I said, 'don't worry about that now', and reiterated, that we would do it later and I didn't want anyone touching it".*

The direction was clear in its terms and was not open to misinterpretation.

54. Mr Pearce and Mr Chorley's evidence was that they both understood that all work in relation to the decommissioned equipment at the rear of the yard was to cease immediately and not recommence until a proper risk assessment had been undertaken.

55. The evidence of Mr Chorley and Mr Pearce is that after the meeting Mr Barker approached them (both independently) and enquired if he should continue cutting up the steel.

56. Mr Chorley's evidence was that he told Mr Barker he should not.

57. Mr Pearce's evidence was that he advised Mr Barker that he should seek further clarification from Mr Fitch.

58. As a result of Mr Hamilton's instructions and the discussion with Messrs Pearce and Chorley, it is difficult to see how Mr Barker could have misconstrued or misunderstood the instruction. The discussion with Pearce would have left him with a clear understanding he had to check with Mr Hamilton or Mr Fitch prior to recommencing scrapping works on the hopper. Chorley's evidence was clear, he told him he should not continue cutting up the steel.

59. The unchallenged evidence is that the direction to cease work on the decommissioned plant was given, Messrs Pearce and Chorley understood that direction to mean that no further work was to be undertaken on the decommissioned plant without authorisation from Mr Hamilton or Mr Fitch.

60. No further direction was given by Mr Fitch or Mr Hamilton to recommence work on the decommissioned plant.

61. There is no evidence to support the proposition that the storing of the hopper, along with the other decommissioned plant, posed a safety risk.

62. The evidence supports a finding that once Mr Hamilton became aware works were being performed on the hopper that he deemed to be unsafe, he acted immediately and appropriately by issuing a direction to ATH contractors and employees not to undertake any further works until a risk assessment had been undertaken.

63. The evidence supports a finding that the majority of the ATH employees/contractors present at the meeting understood the direction. When Mr Barker questioned the direction with other employees, it was reinforced by one he should cease cutting up the steel unless otherwise directed, and one directed him to Mr Fitch.

64. The totality of the evidence leads to the conclusion that Mr Barker, contrary to a direction given to him by Mr Hamilton on the day prior to his death, proceeded to the area the hopper was stored at and cut steel bolts from the hopper. The removal of the bolts resulted in the steel wing of the hopper falling onto him resulting in his death.

65. There is no evidence to explain why Mr Barker acted in the manner he did. No finding can be made as to why Mr Barker acted in the manner that he did.

66. An issue has arisen as to whether s 28(1)(f) of the *Coroners Act 1995* remains applicable.

67. I repeat and agree with the comments of Coroner McTaggart in her finding into the Inquest of Jasmine Rose Pearce at page 5:

> "However, on 21 April 2015, the *Coroners Amendment Act 2015* repealed section 28(1)(f).
>
> A question arises in this inquest regarding whether I am required to specifically make a finding under section 28(1)(f) given that both the death occurred and the inquest was held when the provision was in existence.
>
> In the joint judgment of the High Court in *Rodway v R* [1990] HCA 19; (1990) 169 CLR 515 at 518 the court stated:

> *"The rule at common law is that a statute ought not be given a retrospective operation where to do so would affect an existing right or obligation unless the language of the statute expressly or by necessary implication requires such construction. It is said that statutes dealing with procedure are an exception to the rule and that they should be given a retrospective operation. It would, we think, be more accurate to say that there is no presumption against retrospectivity in the case of statutes which affect mere matters of procedure. Indeed, strictly speaking, where procedure alone is involved, a statute will invariably operate prospectively and there is no room for the application of such a presumption. It will operate prospectively because it will prescribe the manner in which something may or must be done in the future, even if what is to be done relates to, or is based upon, past events. A statute which prescribes the manner in which the trial of a past offence is to be conducted is one instance."*
>
> Section 16 of the *Acts Interpretation Act 1931* provides that where an Act repeals any other enactment then, unless the contrary is expressly provided, such repeal shall not affect any right, privilege, obligation, or liability acquired, accrued, or incurred under any enactment so repealed.
>
> In *State of Tasmania v Thorpe* [2011] TASSC 18, Evans J applied the principles in *Rodway* in respect of a change to the provisions of the *Sentencing Act 1997* relating to the activation of breaches of suspended sentences. His Honour held that a person did not have a right to the proceedings brought against him for breaching the condition of his suspended sentence being conducted in any particular way. His right was for these proceedings to be conducted in accordance with the practice and procedure prevailing at the time of the hearing. His Honour stated that had the legislature intended otherwise when it amended the *Sentencing Act* it could have so provided.
>
> In a similar vein, the former section 28(1)(f) of the *Coroners Act* is a procedural provision relating to matter for mandatory inclusion in a coroner's finding. Its repeal does not affect any right, privilege, obligation, or liability acquired, accrued, or incurred by any person.
>
> I note that there is no provision that provides for the retrospective operation of section 28(1)(f) of the *Coroners Act.*
>
> I therefore conclude that the repeal of s. 28(1)(f) operates prospectively from the date of the repeal, and that I am not required to make a specific finding as to the identity of any persons who contributed to the death".

The repeal of s 28(1)(f), operates prospectively from the date of the repeal, and that as such I am not required to make a specific finding as to the identity of any persons who contributed to the death.

Section 28 Findings

68. The following findings are made pursuant to s 28 of the *Coroners Act 1995*:

    (a) The identity of the deceased is Richard Carl Barker;

(b) How Mr Barker died is addressed in detail in these findings;

(c) The cause of Mr Barker's death was head, neck and chest injuries when crushed by a metal plate;

(d) Mr Barker died on 23 April 2013 at the BIS Industries industrial site situated at 108 Bell Bay Road, Bell Bay in Tasmania; and

(e) *Birth Deaths and Marriages Registration Act 1999* provides no guidance as to the particulars required to register a death under the Act, something which has been commented upon several times in the past; I am unable to make a finding under s 28(1)(e) of the Act.

Conclusion

69. The circumstances of Mr Barker's death do not require me to make any recommendations.

70. I express my particular thanks to Ms Duvnjak, Counsel assisting.

71. I extend my condolences to the family and loved ones of Mr Barker on their loss.

Dated: 28 July 2017 at Launceston in the State of Tasmania

Andrew McKee
Coroner