FINDINGS, COMMENTS AND RECOMMENDATIONS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Terrence William Close

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Terrence William Close with an inquest held at Launceston in Tasmania make the following findings.

Hearing Date

22, 23, 24 and 25 October 2018 at Launceston in Tasmania

Representation

L Mackey - Counsel Assisting the Coroner

S Thompson for the Regulator, WorkSafe Tasmania

A D Halse for Venarchie Contracting Pty Ltd

M Jacques for Launceston City Council

Introduction

1. Terrence William Close, known as Terry, father, grandfather, motor sport fan and passionate North Melbourne Australian Rules Football Club supporter, died on 5 February 2013 as a result of injuries suffered by him whilst he was working as a traffic controller on Vermont Road in Launceston. While so working he was struck by a vehicle driven by Mr Murray Anthony Higgs.

2. Mr Close was born on 27 April 1950. A hard-working man, devoted father and grandfather, Mr Close loved his work and according to his son Trent had no intention of retiring. His health was, generally speaking, good.

3. Rushed by ambulance to the Launceston General Hospital (LGH) from the scene Mr Close was so terribly injured that despite the best medical care he died not long after arriving at hospital.

4. Mr Higgs was charged with, and pleaded guilty to, several offences arising out of Mr Close's death. Relevantly, he was convicted of one count of causing the death of another person by negligent driving contrary to section 32 of the *Traffic Act* 1925 and sentenced to a period of imprisonment for three months wholly suspended on conditions for a period of 12 months.

5. Prosecutions were also undertaken against Mr Close's employer Altus Traffic Pty Ltd ('Altus') and Venarchie Contracting Pty Ltd ('Venarchie'). Altus pleaded guilty to, and was convicted of, a breach of section 32 of the *Work Health and Safety Act* 2012 in respect of a failure to provide such systems of work, training and instruction necessary to protect persons from risks to their health and safety. Upon conviction Altus was fined $250,000.

6. Venarchie pleaded not guilty to the charge laid against it. After hearing, it was acquitted of a breach of section 32 of the *Work Health and Safety Act* 2012.

7. Because Mr Close died in the course of his employment an inquest, subject to an exception, was mandatory.[1] Mr Close's senior next of kin, his son Trent, did not request that an inquest not be heard. Accordingly, the inquest proceeded in Launceston, not far from the scene of Mr Close's death but only after all prosecution proceedings against Mr Higgs, Altus and Venarchie had been completed.

The Role of the Coroner

8. Before an analysis of the circumstances surrounding Mr Close's death is undertaken it is important to say something about the role of a coroner.

[1] See section 26A.

A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. An inquest is a public hearing.[2]

9. When investigating a death and an inquest is held, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Act* asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of the person's death and where and when the person died. This process requires the making of various findings of fact. It is important however to recognise that it is not part of the coroner's role to apportion legal or moral blame for someone's death. Other people of course may draw conclusions from the findings of fact that a coroner is required to make after hearing evidence at an inquest.

10. A coroner is also able, if she or he thinks fit, to make comments about the death.[3] If the circumstances are appropriate a coroner is required to make recommendations with respect to ways of preventing further deaths.[4] This is a particularly important function in the context of reviewing deaths arising from work.

11. It is important also to recognise that a coroner does not punish or award compensation – that is for other proceedings in other courts, if appropriate. Neither does a coroner charge people with crimes or offences arising out of the death the subject of investigation.[5] In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of an offence.[6] As was noted earlier, three separate prosecutions were undertaken arising out of the circumstances surrounding Mr

[2] See section 3.
[3] See section 28 (3)
[4] Section 28 (2)
[5] The circumstances were materially different in the past see for example section 16 of the *Coroners Act* 1957 (Tas)
[6] Section 28(4).

Close's death.

12. As was noted above, one matter that the *Act* requires is finding how the death occurred.[7] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[8] Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

13. The standard of proof in coronial inquests is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquiry reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved should be approached with great caution.[9]

Issues at Inquest

14. In addition to the matters that the *Act* requires consideration of at any inquest, in advance of the hearing the parties were advised that particular attention would be focussed upon the following issues:

    a) What rules and regulations control the operation of traffic control during roadworks?

    b) Were those rules complied with?
        i. If not why not?
        ii. If so, were the rules and regulations sufficient/fit for purpose?

    c) What were the roles of:

[7] See section 28(1) (b).
[8] See *March v E. & M.H. Stranmere Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[9] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

i. Venarchie - to ensure appropriate and safe traffic management at its roadworks?
ii. Altus - were the Altus measures adequate and if not why not?
iii. Workplace Standards - regarding the regulation and supervision of traffic management around roadworks?
iv. Launceston City Council; and

d) What, if any, behavioural implications arise as a result of the site set up leading up to and at the time of the death?

15. Much of the evidence at the inquest was directed to the issues set out above.

Roles of Venarchie, Altus and the Launceston City Council

16. It is necessary to say something of the respective roles of the Launceston City Council ('the Council'), Venarchie and Altus to understand the context in which Mr Close died. Vermont Road was (and presumably still is) a council managed road. The Council was responsible for its maintenance. The evidence was that in the past the council had carried out that maintenance itself utilising its own employees. At some stage prior to Mr Close's death the Council engaged Venarchie to carry out some or all of that maintenance.

17. The Council provided to Venarchie a list of streets requiring attention in the nature of sealing. The list had a priority regard rating regarding each street. Venarchie were required to undertake the works in accordance with the Council's allocated priority.

18. Venarchie contracted with Altus for the provision of traffic control to enable the works to occur. The evidence of the inquest was unclear as to the extent of the information provided by Venarchie to Altus ahead of time. There was uncertainty even as to whether information was provided as to the location where works were to be undertaken.

Events of 5 February 2013

19. On 5 February 2013 Mr Close was employed by Altus. The evidence was that Altus was a specialist traffic management provider. Mr Close was an experienced employee having worked for Altus as a traffic controller for five years or so prior to his death. He was popular with his colleagues.[10]

20. I observe that although well aware of the fact of the inquest and that it was concerned with the death, at work, of an apparently valued employee, his employer Altus choose not to appear at the inquest, a decision as insulting to Mr Close's family as it was unhelpful to me.

21. As has already been mentioned, Venarchie were at the relevant time contracted by the Council to carry out, as part of the Council's ongoing road maintenance programme, the sealing of cracks in various streets. All witnesses referred to the process as 'crack sealing'. So shall I.

22. The evidence was that crack sealing was a three person operation. One operator walked in front and cleared debris and contaminants from any cracks in a road with a blower. The second member of the crew drove a truck which towed a crack seal machine. The machine contained heated crack sealant. Both the truck and the crack seal machine were fitted with flashing amber lights.

23. The third member of the crew walked behind the truck using a wand (or as it was otherwise described 'lance') to insert the hot sealant into the cracks. The wand was connected by a hose to the crack sealing machine.

24. The evidence was that the pace at which the crack sealing was conducted (perhaps self-evidently) was just below walking pace.

[10] See affidavit of Harold Burgess sworn 11 February 2013 exhibit C18

25. On 5 February 2013 Mr John Vanson was the member of the crew operating the blower, Mr Stuart Wright was driving the truck and trailer and Mr Kevin Reynolds operating the wand. Each of those men gave evidence at the inquest.

26. On the last day of his life, 5 February 2013, Mr Close started work at about 7.30am at the Altus yard in George Town Road, Rocherlea. He was working with Mr Rex Purcell who gave evidence at inquest. Mr Purcell was less experienced than Mr Close but not significantly so. He and Mr Close were good friends. Neither man had any experience in relation to crack sealing works. Mr Purcell said in his evidence at the prosecution of Venarchie that he had done no crack sealing works prior to 5 February 2013 and it was his belief that Mr Close had not done any either. Given that historically the Council had carried out its own maintenance of its own streets, including crack sealing, Mr Purcell's evidence in this regard is inherently plausible and I accept it.

27. In charge at Altus on the day was the then Altus Tasmanian Northern Operations Supervisor, Mr Harold Burgess. As at 5 February 2013 Altus were providing traffic control services to Venarchie, who had workers operating in a crew crack sealing at Cimitiere Street in Launceston. The evidence at the inquest from Mr Burgess was that he organised the crews to go out and perform the particular duties on the day. He said that all the jobs for the day for Altus employees were listed on a whiteboard at the Rocherlea yard and that what he described as the 'relevant paperwork' relating to each job was attached to the whiteboard.

28. Having been assigned their job for the day, Mr Close and Mr Purcell left the Altus depot to start work. There was some dispute on the evidence as to whether they met with the crack sealing crew at the Venarchie depot or actually at the jobsite in Cimitiere Street. Although little turns on the issue, the preponderance of evidence from Mr Purcell and Venarchie crew members Mr Vanson and Mr Wright, all suggest that the meeting occurred in Cimitiere Street.

29. The evidence was that upon arrival at Cimitiere Street a Safe Work Method Statement (SWMS) was completed by Mr Close and signed off by Mr Purcell and Mr Reynolds.[11] In addition, a Venarchie risk assessment that had been completed in October 2012 was signed by both Mr Close and Mr Reynolds.

30. The apparent purpose of the SWMS and risk assessment was to alert workers engaged in tasks on 5 February 2013 to the various risks they faced. Counsel assisting submits, with significant force in my view, that that purpose was simply not achieved on this occasion. There are a number of reasons for reaching this conclusion.

31. First, the SWMS was concerned only with the Cimitiere Street works, noting that Mr Close died as a result of an accident which occurred at a completely different site.

32. Second, no further SWMS was completed in respect of the Vermont Road worksite once the Altus crew became aware that they would be moving to and working in that environment.

33. Third, even if an SWMS had been completed in relation to the Vermont Road worksite, the probability was that it would not have addressed at all the risk associated with the movement of the worksite from east to west of the railway crossing. I say this because this was a decision that appears only to have been communicated by the Venarchie team to the Altus workers immediately prior to the movement of the works.

34. The Risk Assessment was, Counsel assisting submits, wholly deficient in identifying risks that arose from traffic and the management of traffic in the context of the particular works being undertaken on 5 February 2013. I accept this submission.

[11] Exhibit C 28

35. I observe that the nature of the works being carried out was necessarily hazardous. Crack sealing required workers from both Venarchie and Altus to have ‘feet on the roadway’. Necessarily, unless a road was completely closed such workers were therefore vulnerable to being struck by a motor vehicle. In addition, although not directly relevant to Mr Close’s death, an additional significant risk was posed by the sealant on the trailer. Mr Reynolds in his evidence at the inquest said that if the trailer upon which the sealant was kept had been struck by a motor vehicle there was potential for an explosion to occur.

36. In any event crack sealing was carried out, apparently without incident, at Cimitiere Street. At about 11.30am the job having been completed, the Venarchie crew moved to a new worksite a few kilometres away from Cimitiere Street to Vermont Road. Mr Purcell and Mr Close packed up their equipment and signage and made their way to Vermont Road independently of the Venarchie crew.

The Vermont Road Worksite

37. In the vicinity of the fatal accident, Vermont Road runs in a general east-west direction from the road’s intersection with Wildor Crescent. It is a two-way street with a lane travelling in either direction. The lanes are separated by a painted white broken line. The road runs, generally speaking, through a suburban area and the edges of the road have concrete curbing and sealed footpaths.

38. Wildor Crescent runs to Vermont Road from the suburb of Ravenswood. The road surface of Vermont Road was (and still is) a coarse aggregate bitumen mix in a generally good condition (aside from cracks that needed sealing). There was no evidence of any surface defects. At the time of the fatal crash the road was dry and apparently free from any loose material.

39. The weather at the time of the crash was clear and fine. The evidence was that Tasmanian Bureau of Meteorology records recorded no rainfall for the day and a maximum temperature of 26.2°C.[12]

40. A railway line runs in a generally south-north direction in the area. Vermont Road crosses the railway line a few hundred metres west of the Vermont Road and Wildor Crescent intersection.

41. The crack sealing initially conducted was on Vermont Road in the section east of the railway bridge between the bridge and the intersection of Vermont Road and Wildor Crescent. The crew worked initially east and then returned in a westerly direction from the Wildor Crescent/Vermont Road intersection back toward the railway bridge.

42. Mr Close and Mr Purcell laid out signage to warn motorists of the Venarchie crack sealing crew as the men worked in the area described immediately above.

43. After the crack sealing east of the railway bridge was complete the Venarchie crew and Mr Close and Mr Purcell had lunch. The worksite was then moved to the west of the railway bridge along Vermont Road in the general direction of the Launceston racecourse towards the suburb of Mowbray.

44. The evidence at the inquest was that to accommodate this change of worksite Mr Close and Mr Purcell moved the signage on the western end of the road further west along Vermont Road. However, they did not move the signs on the eastern side of the worksite.

45. As a result, at the time Mr Close was hit by Mr Higgs the roadworks signage east of the place where Mr Close was struck was as follows:

[12] Exhibit C 16, page 4

- A yellow background with black writing ‘Roadwork Ahead’ sign at 1200 metres from the crash site;[13]
- A sign consisting of 3 parts including an orange background with a black human figure holding a sign, a blue background with white writing ‘Drive safely’ and a standard white, red and black 40 km/hr sign at 1100 metres from the crash site;[14]
- A red background with white writing ‘Prepare to stop reduce speed’ sign 900 metres from the crash site;[15] and
- A sign consisting of 3 parts including an orange background with a black human figure holding a sign, a white background with black writing ‘Do Not Overtake’ and a standard white, red and black 40 km/hr sign 750 metres from the crash site.[16]

46. The first 3 signs referred to above were on Wildor Crescent. The final sign was on Vermont Road. In addition to these signs 3 traffic warning signs were laid out on Vermont Road, east of the intersection with Wildor Crescent. However given that Mr Higgs drove along Wildor Crescent in the immediate lead up to the crash, those signs of course gave him no warning of the presence of workers on the road ahead.

47. Finally, in addition the speed limit signs in the area (the posted limit was 60 km/hr which was displayed on road signs of the normal type i.e. a white background with a red circle containing black numbers) had placed over them 40 km/hr signs. Relevantly, one such sign was a short distance east of the last sign referred to immediately above that is somewhere in excess of 750 metres from the crash site.

[13] C25 and C24 photographs 2 and 3
[14] C25 and C24 photographs 2-5
[15] C25 and C24 photographs 4-7
[16] C25 and C24 photographs 10 and 11

The Fatal Crash

48. At approximately 1.30pm Mr Close was managing traffic at the rear of the Venarchie crack sealing crew. He was behind Mr Reynolds, at the eastern end of the worksite. In that position he was controlling traffic heading west along Vermont Road toward Mowbray. He was holding what was described in evidence as a 'stop/slow' bat. The bat, familiar to any driver on Tasmanian roads, consisted of a round sign on top of a wooden pole roughly 175 cm long. One side of the sign had a yellow background with black writing and 'slow' on the sign. The other had a red background with the word 'stop' in white writing. He was wearing an orange high visibility vest.

49. Mr Close was working on the area of Vermont Road between Bill Grove and Clare Street roughly outside house number 168. There were no witches hats, no bollards or any other traffic barriers or delineation on the roadway.

50. The evidence satisfies me that Mr Close was standing toward the centre of Vermont Road. He was holding the 'stop/slow' bat described above with the red and white 'stop' side facing toward oncoming traffic. At the same time Mr Purcell, at the western (or Mowbray) end, was allowing the traffic heading east to progress through the works. Mr Close and Mr Purcell communicated by means of handheld UHF radios. This enabled them to coordinate the opening and closing of their respective ends of the worksite.

51. In addition to the road signage both the Venarchie truck and trailer had operational flashing orange lights. All workers, including Mr Close, were wearing high visibility clothing.

52. The Altus vehicle that Mr Close and Mr Purcell were using that day was also present in the vicinity of the workplace. The evidence from Mr Purcell was that it was parked near the railway bridge on the side of the

road and it too had flashing orange lights operating.

53. Just before 1.30pm Mr Higgs was driving his white 1998 Nissan Navara flat tray ute along Wildor Crescent heading toward Mowbray. He said he saw roadwork signage on Wildor Crescent being the first 3 signs referred to in paragraph 45 above. He entered onto Vermont Road. He said at the inquest that he did not see any roadwork signs facing him in Vermont Road. Mr Higgs has been, I note, consistent in this account. He therefore did not see the final sign referred to in paragraph 45 above.

54. Whilst driving along Vermont Road towards Mr Close, Mr Higgs was distracted by efforts to tune his vehicle's radio. In an interview conducted by Tasmania Police Crash Investigation Services officers Mr Higgs described how the accident occurred.[17] He said:

> *'I have a bet on the horses every day. It's just something to do and um, I had me radio on the ABC and on my radio it's got 3 fms on it and it's just a tiny little button you've got to push and I was just doing that, one eye on the road and one eye on, and it's really hard and when I went through it, the first time I missed it so I had to do it again and I turned it up and I went through it again and when I actually got on the station um, Mr Close was just, and I just froze, I just froze, normally I just swing, but I just froze.'*

55. Extremely helpful evidence was given by experienced crash investigator First Class Constable Nigel Housego. No challenge to Constable Housego's qualifications or expertise was made by any party and I accept him as an expert able to express the opinions that he did. Constable Housego's evidence was that Mr Higgs had approximately ten seconds of visibility of Mr Close in the immediate lead up to the accident. It follows, accepting this evidence as I do, that Mr Higgs' attention was diverted from the task of driving for a full 10 seconds. He had 10 seconds to appreciate the presence of workmen in high visibility clothing

[17] Exhibit C 7

on the roadway. He had at least 10 seconds to appreciate the presence of a truck and trailer with flashing orange lights on the roadway and did not do so. He had 10 seconds to take steps to avoid colliding with Mr Close.

56. The evidence was that Mr Higgs collided with Mr Close on a straight section of the road outside house number 168 Vermont Road. Mr Purcell described hearing a '*thump*' which was followed by '*the screeching of tyres*'. He said that he rushed back up towards where Mr Close was working and saw him lying on his back on the road more or less in the middle. He described his head pointing towards the Mowbray direction (that is west). It was immediately obvious to him that Mr Close was seriously hurt. He described blood on the back of his head and also his pelvis and said that Mr Close had his eyes open and was moaning.

57. Mr Wright actually saw the collision. He saw Mr Higgs' ute travelling at a speed he thought was in the order of 60 km/hr. He saw Mr Close slide on his back after Mr Higgs' ute had hit him and described seeing the 'stop/slow' bat snap to pieces on impact and land near the broken white centre line. He described seeing Mr Close's two-way UHF radio and hat being thrown onto the road. Like Mr Purcell, he described Mr Close lying on his back in the middle of the road with his head pointing in the general direction of Mowbray.

58. Like Mr Purcell, Mr Reynolds heard rather than saw the collision. He said that as soon as he realised what had happened he dropped his sealing wand and ran straight over to Mr Close, describing him as lying in '*about the middle of the opposite lane on his back*'. He also said that Mr Close's head was facing towards Mowbray. He also saw that Mr Close was badly injured and he used his work phone to call for an ambulance. Mr Purcell, Mr Reynolds and Mr Wright all tried to comfort Mr Close.

59. An ambulance and police were quickly on the scene. The first attending police officer, Constable David Eaton, said in his affidavit that because of the nature of the injuries apparently suffered by Mr Close he arranged for Crash Investigation Services officers to attend. As a consequence First Class Constable Housego was at the scene shortly after the happening of the crash where he commenced an investigation.

60. Meanwhile, Mr Close was rushed from the scene to the emergency department of the LGH. Despite the best efforts of medical staff Mr Close was so grievously injured that he died at approximately 6.20pm in the presence of family.

Forensic Pathology Evidence

61. After formal identification at the LGH Mr Close's body was transported by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital, experienced forensic pathologist Dr Donald McGillivray Ritchey performed an autopsy. Dr Ritchey's report following that autopsy was tendered at the inquest.[18] Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Close's death was blunt trauma of his chest and abdomen. At autopsy he found severe traumatic injuries of Mr Close's thorax, abdomen and pelvis all of which caused severe internal bleeding and death.

62. Samples taken at autopsy were analysed at the laboratory of Forensic Science Service Tasmania. The analysis report prepared by Ms Miriam Connor was tendered at the inquest.[19] No alcohol or illicit drugs were found in those samples. All that was found were therapeutic levels of drugs administered to Mr Close as part of resuscitation and treatment efforts following his accident as well as drugs prescribed for him by his GP.

[18] Exhibit C4
[19] Exhibit C5

63. I am satisfied that neither alcohol nor drugs played any role in Mr Close's death.

Initial Investigation

64. An investigation into the crash commenced at the scene. Mr Higgs was subjected to alcohol and drug testing. No alcohol or illicit drugs were found to have been present in his body at the time of the crash.

65. Constable Housego examined and photographed the scene. He photographed the signage which is referred to earlier in this finding. I note that the evidence is that the signage was not moved after the crash and before Constable Housego took those photographs.

66. Mr Higgs' motor vehicle was impounded by police and subsequently examined by a Transport Inspector employed by the Department of Infrastructure, Energy and Resources (DIER). That Transport Inspector, Mr Barry Spencer, identified 13 deficiencies with the vehicle. Those defects included:

- brake pedal rubber worn to metal on the right lower corner;
- left-hand exterior mirror cracked;
- speedometer display inoperative;
- rear suspension spring shackle bushes worn;
- seat backrest and locking mechanism damaged and bent;
- driver and passenger headrests insecure and broken;
- left passenger seat belt latch mechanism faulty;
- oil leak from the power steering box area;
- left-hand mudguard side indicator assembly missing entirely;
- rear numberplate light inoperable;
- an insecure battery; and
- an insecure right side shroud under the engine.

67. In addition, Mr Spencer reported that he found the right front headlight and park light assembly to be broken and inoperative. However this was damage caused by the impact with Mr Close and not a prior defect. Plainly many of these defects were not capable of either causing or contributing to the happening of the crash. However the inoperative speedometer display is a particularly relevant defect in the context of this matter given that I am satisfied on the evidence that excessive speed, along with inattention on the part of Mr Higgs, were the principal reasons for Mr Close's death.

68. Mr Higgs was, as has already been mentioned, interviewed after the crash by Crash Investigation Services officers. He was cooperative during that interview and made a number of admissions in relation to driving inattentively and speeding. In terms of speed Constable Housego carried out a speed analysis after the crash as part of his investigation. He calculated that Mr Higgs' speed at the time of the crash was in the order of 53 km/hr, i.e. 13 km/hr over the posted speed limit.[20] Mr Higgs also conceded to WorkSafe Tasmania (WST) investigators that he was driving too fast.[21]

69. I note the evidence that Mr Higgs accepted that he had seen the 40 km/hr sign in Wildor Crescent. There was no evidence that he saw another sign altering that speed limit (and indeed he could not have as there was not one). The only conclusion open is that he deliberately chose to ignore the speed limit to which he was subject.

70. It is recognised that Mr Higgs' distress and shock was evident immediately after the accident. Several witnesses described him as distressed and distraught in the aftermath of the accident.[22] His assistance to both police and WST investigators and his plea of guilty regarding the criminal prosecution of him are also acknowledged.

[20] Exhibit C 16, page 7
[21] Exhibit C 31, Tab 11, page 5
[22] See for example the affidavits of Kevin Reynolds (Exhibit C 13) and Stuart Wright (Exhibit C 15)

However it is an inescapable fact that the manner of his driving is the principal reason Mr Close died.

71. Counsel assisting submitted that this tragic incident should serve as a reminder to all drivers of all vehicles on our roads that momentary inattention can have disastrous, indeed fatal, consequences. I agree. It is critical to keep in mind that relatively mundane activities which divert the attention of a driver from concentrating on the dangerous task of driving a vehicle on a public street (such as in this case changing stations on a car radio) should only be carried out when a vehicle is stationary.

System of Work – Adequacy of Signage

72. Having made the findings of fact set out above as to the circumstances in which the fatal accident occurred it is necessary to consider them in the broader context of the system of work that was in place when Mr Close died.

73. As I have already said the speed at which Mr Higgs drove was a significant factor in Mr Close's death. Mr Higgs said he saw the speed limited to 40 km/hr on Wildor Crescent (and I note he was consistent about this in his account to police crash investigators as well as in his evidence at inquest). He said, again something he was consistent about, that he complied with that speed limit but sped up when he had entered Vermont Road as he did not see any roadworks and saw a sign on the other side of the road (not facing him) which he assumed stated that roadworks were ended.

74. Mr Higgs said he was travelling behind a vehicle in front of him which subsequently turned off before the roadworks and which also sped up after leaving Wildor Crescent. Mr Jeremy Fuller gave evidence at the inquest. He was driving behind Mr Higgs on Vermont Road on the day, having entered from old Vermont Road at the intersection of Vermont

Road and Wildor Crescent.

75. Mr Fuller said in his affidavit that he also did not see any signs of roadworks on Vermont Road at all. His evidence was that as he approached the worksite travelling behind Mr Higgs' ute, he saw the flashing lights on the Venarchie works truck and slowed his own vehicle.

76. Counsel assisting submitted that the circumstances outlined above and in particular the evidence from Mr Fuller along with that from Mr Higgs, raises the issue of the adequacy of the signage on the eastern end of the works. The issue of the adequacy of the signage of the eastern end of the worksite is highlighted if a comparison is made between the signage at the other (western) end of the worksite. The comparison is stark. It is quite apparent that the signage at the western end of the worksite was such that a clear warning of the presence of workers on the road was given to drivers travelling west to east.[23]

77. Evidence was heard at the inquest from 3 drivers - Ms Caroline Williams, Mr David Cox and Ms Angela Goodyer - who were all travelling on Vermont Road from west to east in the general vicinity of the accident at the time it occurred and actually saw it occur. All gave evidence of signage giving a clear indication of the presence of works requiring the need to slow and potentially stop. The point being that the signs at the western end of the worksite were placed much closer to where the actual work was being carried out than those of the eastern end.

78. It seems clear that the change of the worksite to the western side of the railway bridge and the failure to have moved the signage on the eastern end of the works to a position closer to the works led to a significant lengthening of the distance between the signage and the works. This in turn led to a situation where drivers could become confused as to

[23] See in particular photograph 1 in exhibit C 24

whether works were actually being undertaken and if so where. The closest warning sign was 750 m away from where the crash occurred.

79. The photographs tendered at the inquest show very clearly the complete lack of warning to drivers approaching from the east, for an extended period of time, that work would be taking place on the road in front of them.[24]

80. In all the circumstances of this case I am satisfied to the requisite legal standard that the significant distance between the last warning sign on Vermont Road (and in fact the other 3 signs on Wildor crescent), may have had the effect of contributing to Mr Higgs' quite erroneous assumption that he had passed through the roadworks and that the signs had been mistakenly left out.

81. A considerable amount of evidence was led at the inquest in relation to the adequacy or otherwise of the signage on the day in question. A good starting point in my view is Australian Standard 1742.3-2009 - the Manual of Uniform Traffic Control Devices ('the Traffic Control Devices Standard'). Part 3 of the Traffic Control Devices Standard deals with traffic control for works on roads. I note that the evidence was that AS 1742.3–2009 was not a mandatory code of practice in Tasmania. Nonetheless, it is apparent that both Altus and Venarchie used the Traffic Control Devices Standard as a reference point.

82. Having regard to that Standard it is quite apparent that the signage that was in place at the eastern end of the worksite did not 'measure up'. Table 4.7 of AS 1742.3–2009 recommends a maximum distance of 500 metres for the sign furthest away from the worksite of which it gives warning. In this case the closest sign was 750 metres away and the most distant sign well over 1 kilometre away.

[24] exhibit C 24 photographs 11 – 14

83. Even if the table in AS 1742.3-2009 is not applied then on any reasonable view of the circumstances the warning signs to the east of the worksite were simply too far away to provide adequate protection to the workers, including Mr Close, on the road.

84. Returning to the Traffic Control Devices Standard for a moment, it is quite clear that there were other deficiencies with the signage to the east of the crash site. These deficiencies included:

- The 'workers symbolic sign' was not used. This sign is used to warn approaching traffic of the presence of workers on the roadway;[25]
- Signage was not placed on either side of the road;[26] and
- The 40 km/hr zone was extended beyond 500 m.[27]

85. The first two (2) deficiencies set out above are perhaps not of a great deal of significance in the context of this case but the third one is important for reasons already highlighted.

Training and Qualifications

86. The investigation carried out by WST, the comprehensive results of which were tendered at the inquest, revealed in my view significant deficiencies in the training of Altus' employees Mr Burgess, Mr Purcell and Mr Close with respect to drawing a Traffic Management Plan. The records of each man were tendered at the inquest. Those records showed that Mr Burgess and Mr Close were qualified to control traffic with a 'stop/slow' bat and implement a Traffic Management Plan. Mr Purcell's only traffic management qualification was 'implement traffic management plan'. None of the Altus employees directly involved in traffic management activities on the day of Mr Close's death, nor the supervisor responsible for the allocation of those duties, had any other

[25] Exhibit C 21, paragraph 75 – 76
[26] Exhibit C 21, paragraphs 103 – 107
[27] Exhibit C 21, paragraphs 103 – 107

qualifications. Specifically, none of them had the qualifications to enable them to design or draw Traffic Management Plans.

87. The lack of qualification seems to me to be particularly important in the context of this case. It is difficult to escape the conclusion that had Mr Close or Mr Purcell (or for that matter Mr Burgess when he assigned the work) been qualified to draw a Traffic Management Plan, someone would likely have averted to the need to move the signage on Wildor Crescent once the workplace moved west of the railway bridge.

88. As has already been noted the Traffic Management Plan used and implemented made no use of a shadow vehicle, nothing in the nature of delineation or tapering by using lines of cones or bollards or any method of protection of the workers on the site. Mr Davis, an experienced safety consultant who gave evidence at the inquest said, and I accept, that the use of delineation or a shadow vehicle would have raised the level of protection for Mr Close (and the other workers present on the road) from approaching traffic.

89. WST investigator Mr Collins, who gave evidence at the inquest said, and I accept, that had a Traffic Management Plan for Vermont Road been *'…developed by an appropriately trained and qualified person, control measures such as the proper placement and correct usage of signage, the use of tapers, the use of cones to delineate the workers from traffic or use of shadow vehicle with vehicle mounted signs and devices (flashing lights or display board), may well have been implemented.'*

90. The final point about the adequacy or otherwise of the training of personnel, and in particular Mr Close, concerns his position on the road at the time of the fatal crash. Evidence at the inquest was to the effect that the training of a 'stop/slow' bat operator included a direction not to enter onto the middle of the road until the first vehicle had been halted. The effect of this positioning meant that the first vehicle stopped, in

effect became a protective barrier for the traffic controller.

91. Mr Purcell's evidence at the inquest was that he stood near the gutter of the road as he felt that it was safer to do so. In the same vein Mr Vanzon said in his evidence that the usual practice was to be near the curb when conducting traffic control.

92. I note also that the Venarchie generic plan placed the traffic controllers to the side of the roadway.

93. At the time of being struck by Mr Higgs' vehicle, however, Mr Close was located near the centre line of the roadway. Several witnesses said this was so and the position he came to rest after being hit on the roadway supports this finding. Positioned as he was he had no protection from the first oncoming vehicle (in this case Mr Higgs). He had to rely for his safety upon a hope that the first driver approaching him saw the warning signs some significant distance prior, saw the flashing lights on the Venarchie and Altus vehicles and saw him holding the 'stop/slow' bat. None of these measures of course provided a physical barrier to protect Mr Close.

94. Improved training, perhaps in the form of regular refreshers or the like, may have meant that Mr Close was better positioned on the road and thus helped avoid this tragic accident.

Traffic Management Plans

95. The evidence at the inquest disclosed that at the time of Mr Close's death there were three (3) discrete categories of Traffic Management Plans in operation that were relevant to the work he was carrying out. Set out below are the 3 categories with the features relevant to each and relevant to this case:

a) Site-specific - The evidence about site-specific plans was to the effect that site-specific plans were required for traffic management where that management was perceived to be complex or complicated.

b) Generic plans appeared to be very common. Generic plans were in use on the day of Mr Close's death. Generic plans formed part of the contract documentation between Venarchie and the Launceston City Council. Altus also used generic plans. The features of those plans in summary were as follows:

i. The Altus generic plan.[28] Features of that plan included:
   - Traffic control workers shown on the roadway;
   - No coning or bollards;
   - No delineation;
   - 45 m spacing between signs;
   - Signs both sides of the roadway;
   - Traffic controller ahead sign used;
   - Worker symbolic sign used.

ii. The Venarchie generic plan (urban).[29] Relevantly the plan showed:
   - Traffic control workers shown off the roadway;
   - Use of cones and/or bollards;
   - References Australian Standard 1742.3-2009 in relation to spacing;
   - Requires traffic control to be carried out in accordance with DIER traffic control at worksites code of practice June 2004;
   - Signage both sides of the road;
   - No worker symbolic sign.

[28] Exhibit C 27 tab 11
[29] Exhibit C 28 tab 21

c) A so-called ‘mud map’ was also in use on 5 February 2013.[30] Its features included:

- Rough not to scale drawing;
- No distances designated between signs and between signs and works;
- Signs not shown either side of road;
- 40 kilometre an hour repeater sign shown not placed;
- No coning or other delineation;
- The traffic controller is not depicted anywhere on the map.

96. It is apparent that there are obvious and critical differences between the three (3) plans. That level of difference can only lead to confusion. In my respectful view this should not ever be more than one Traffic Management Plan applicable to any traffic management operation.

97. The evidence in this case recognised that only a person holding a ‘prepare work zone traffic management plan’ qualification had the capacity to draw a Traffic Management Plan and while a worker on site not holding that qualification could make minor alterations or adjustments to allow a need for some onsite flexibility to account for the local conditions, any such alterations or adjustments should not deviate substantively from the plan.

98. When the standard of planning is considered there appears to have been a significant departure in practice from this position. No site-specific planning was done for Vermont Road almost certainly because neither Mr Close, Mr Purcell nor Mr Burgess were even aware that work was to be done in that location on that day.

[30] exhibit C 28 tab 21

99. Mr Andrew Vireaux, in the prosecution of Venarchie, gave the following evidence; (transcript 11.10.16):

- *'So at the time of doing this time, I had no idea where the roads were that led to the crack sealing. So that's why it's just generic with a sequence of signs. Once you actually know where the streets are, that's when it's a requirement to do a site specific traffic management plan.* (P233 l17-23)

- *'…the expectation, as I said, from that initial approach from their state manager was that they would be doing site specific plans for each site once they actually knew the location of works and you could actually do a site specific plan.*

Did you ask for any of those site specific plans from Altus?

'No, because they're done on site as part of – before you start work, they were actually - you're shown where the extent of the work is, they would be able to do a plan, a site specific plan to allow for that.' (p236 l33-16)

- In answer to a question if it was general practice that you provide the generic plan to workers on site…

  'No, because a generic plan is not really a good enough traffic management plan. It needs to be site specific. So if I had drawn up a plan that was site specific that our workers were to go and work on, then, yes they were given a site specific traffic management plan to work to.' (P236 l119-20)

100. In contrast when interviewed by WST Mr Burgess said the following:[31]

[31] Exhibit C 30 – lines 487 - 493

'…I don't, I didn't put a plan with every job, that's goes out of here, how can I… cause you don't know where they are going to be, you know you send them, was in Lawrence and whatever, Cimitiere Street, that's where I thought they was going. Didn't know they was going to Vermont Road.'

101. Counsel assisting submitted that the safety would be significantly enhanced for traffic controllers if at least the following methods were to be adopted:

- Sufficient notice be provided regarding the location of works to enable site specific planning;
- Site-specific planning be undertaken;
- Generic plans to be used only when the nature of the environment and the works require minimal planning input;
- Traffic management on site to be at the minimum level required by the site-specific or generic plan; and
- Mud maps not to be used.

102. In the case of Mr Close's death, all of the factors set out in the immediate preceding paragraph were present. As their immediate supervisor, Mr Burgess confirmed when Mr Close and Mr Purcell set out in the morning they did not know they were going to Vermont Road (neither did Mr Burgess). It follows from this that site-specific planning relating to Vermont Road was not able to be undertaken. Instead generic plans were utilised. Given the lack of qualifications of Mr Close and Mr Purcell, they had no alternative and no training to identify any inadequacies in those plans.

103. The evidence satisfies me when viewed as a whole that the traffic management planning utilised on the day of Mr Close's death was wholly inadequate. I am satisfied that that lack of proper planning contributed to Mr Close's death.

First Line of Defence

104. Counsel assisting submitted that no traffic controller should ever be placed in a position where he or she is the so-called first line of defence between road workers and traffic. There is, so far as I can see, no rational argument to the contrary. However on 5 February 2013 this is precisely where Mr Close found himself.

105. The inquest heard evidence of various options that could be employed to provide a protective barrier to a traffic controller. The first of those were cones and/or bollards. Neither were in use on 5 February 2013 on Vermont Road (even though the generic Venarchie crack sealing plan provides for their use). Had they been, then in my view it is unlikely that Mr Close would have died. There was no reason I could discern why neither cones nor bollards were not in use.

106. Concerningly, the evidence was that (at least at the time) neither cones nor bollards were ever used during crack sealing operations even though, as I have already mentioned, the generic crack sealing plan mandated their use.

107. There seemed to be some concerns expressed as to the practicality of the use of cones and bollards given the length of the worksite and therefore the number that would be required and the perceived risk posed in setting them down and moving them with the worksite. I do not accept these to be valid criticisms, let alone a rational reason for them not to have been used. And at the risk of repetition, the urban traffic plan Venarchie submitted to the Council provided for the use of tapers and cones around the roadworks and the amended Venarchie Traffic Management Plan places the controller within the coned zone.[32]

[32] Exhibit C 28 tab 21

108. The benefits of a coned system and most probably why they are used in a static worksite environment, is to clearly identify the worksite area and provide a barrier. As Mr Higgs stated in his record of interview with WST:[33]

> *'I'm not trying to excuse what I have done, I'm not I'm I know I stuffed up bad but I am telling you if that had of been a sign or a witches hat or something anything it would not have happened, anything if it had of been anything there would have just straight up and I wouldn't have been mucking around with my radio and it's no excuse*.'

109. A shadow vehicle could (and should in my view) have been employed to the rear of Mr Close. Mr Purcell, Mr Wright and Mr Reynolds all agreed in their evidence that there was no impediment to a shadow vehicle being employed. I am quite satisfied that had a shadow vehicle been employed it is almost certain that Mr Higgs would have struck it and not Mr Close.[34] I note that there was an Altus vehicle standing idle on the side of the road whilst the works were being conducted. That vehicle, for the sake of the cost of an extra worker to operate it, could easily have been employed as a shadow vehicle.

110. The only impediment to the use of a shadow vehicle appears to be financial considerations. In my respectful view as Counsel assisting submitted, the financial outlay of a shadow vehicle must be considered in light of the risk to human life and the cost to families and the community when a worker is killed or seriously injured in the course of his or her employment.

111. Another easy to use product designed to warn drivers, and thus provide protection to traffic controllers are ripple strips. While ripple strips do not provide a physical barrier as such, they do alert inattentive drivers who

[33] Exhibit C30 tab 11 page 3 line 140 - 4;
[34] Exhibit C19 para 50-51

may not have noticed the fact of roadworks and road workers in their path.

112. In fact the safest options are complete road closure, removal of traffic controllers or at least removing them from the road surface completely. But if none of these options are thought practicable then the use of bollards, cones, ripple strips and critically a shadow vehicle to create physical separation of traffic controllers from moving traffic must in my view always be used.

113. The inquest heard evidence from Constable Housego about how Tasmania Police conduct traffic crash investigation on roads. He described a practice of creating a 'corridor of safety'. This practice places a vehicle between the officer and the traffic as a level of barrier or protection from other road users. It is easily replicated by traffic controllers using the methods described above.

114. Relevant industry bodies should in my view consider the use of such devices on roads to improve safety for workers.

Code of Practice

115. Part 3 of Australian Standard 1742.2-2009 Traffic Control for Works on Roads (the Works Standard) gives detailed guidance to minimum safety standards for traffic control around static, mobile and frequently changing sites.[35] The evidence at the inquest was clearly that all traffic management planning in this case used the Works Standard as a reference or guide, referencing the need to comply with it. The planning and the traffic management in place on 5 February 2013 on Vermont Road did not comply with the minimum requirements provided for in the

[35] Exhibit C 32 Tab 1

Works Standard.[36]

116. The significance of the Works Standard in a general sense is illustrated by the fact that in 2011 DIER published a *Traffic Control for Work on Roads Tasmania Guide* 2011 (the Guide) to which it requires its contractors to adhere.[37] The Guide requires contractors to have in place traffic control at all worksites that complies with the Works Standard. It requires staff involved in 'installing and managing traffic controller worksites' to understand the requirements of the Works Standard and be trained and qualified in its use.

117. The Guide also requires as a minimum that Traffic Management Plans must be certified by a person who has satisfactorily completed the training course 'Prepare work zone traffic management plan' or equivalent.

118. Mr Cocker, the current Regulator, gave evidence in which he confirmed that the Works Standard has no regulatory force under the *Work Health and Safety Act* 2012 (the *Act*).[38]

119. WST are not involved in the supervision of traffic management around roadworks save for the enforcement of compliance with relevant laws and in the context of high risk construction work.[39]

120. The fact that the Works Standard is not an enforceable instrument means that the WST as Regulator is not, and cannot be, engaged in the enforcement of the minimum requirements of the Works Standard at worksites. The inclusion of traffic management in the definition of high risk construction work does not give rise to any specific powers of supervision and enforcement of practices of traffic management around

[36] Exhibit C 19 and C 21
[37] Exhibit C 32 tab 17
[38] see exhibit C 20 at paragraph 22
[39] Exhibit C 20 par 41

roadworks.

121. The inclusion of the Works Standard or a derivative providing for minimum requirements would be a relatively simple process of approval of that Works Standard as a code of practice pursuant to s274 of the *Act*.

122. By its inclusion, the Works Standard would provide a benchmark against which the conduct of traffic control on roadworks could be measured, supervised and enforced. In addition if the Works Standard is approved as a code of practice it would be admissible in proceedings as evidence of the compliance or otherwise with the duties and obligations imposed by the *Act*.

123. I note that Justice Porter in *Kent v Gunns* [40] concluded that the Works Standard was not an approved code of practice under the *Work Health and Safety Act* 2012 and as such did not *'…unless given legal force by statute, have any legal or evidentiary force'*. I observe that the Works Standard has regulatory force in other Australian jurisdictions.

124. Victoria's *Road Management Act* 2004 gives legislative force to Codes of Practice approved under that Act. Worksite traffic management is an approved Code of Practice under the Act and incorporates the Works Standard.

125. The situation in Queensland is much the same. In that state the *Traffic Management for Construction or Maintenance Work Code of Practice* 2008 is an approved code under the *Work Health and Safety Act* 2011 in that jurisdiction.

126. The Regulator agreed in his evidence that the regulation of traffic management would be enhanced by giving the Works Standard, or

[40] (2009) TASSC 30 at page 10

similar, regulatory force and could not identify any barrier to doing so. However he seemed to be opposed to an adoption of the Works Standard as an approved code of practice under the *Work Health and Safety Act* 2012. In adopting that position I did not understand him to point to any significant disadvantages were such a course to be adopted. I note that ultimately the adoption of the Works Standard as a code of practice is a matter for the Minister for Building and Construction.

127. Finally, I note that the evidence was that there has been no adoption of a code of practice setting out minimum requirements for the operation of traffic management on its roads by the Council. Evidence was provided at the inquest by Mr Collins as to his engagement with the Council regarding the development of just such a code but that it was yet to produce an outcome.

128. There would appear much to gain and no impediment to instituting a code similar to that adopted by DIER referred to above by not only the Council but all councils in the State. However were the Minister to adopt the Works Standard as an approved code of practice under the *Work Health and Safety Act* 2012, then the need for the adoption of separate codes or guides by councils individually or collectively would be obviated. The advantages are obvious particularly with regard to uniformity. The safety of road workers would in my respectful view be enhanced were the Works Standard to be adopted as a code under the *Work Health and Safety Act* 2012.

WorkSafe Tasmania Investigation

129. Some criticism was made of the WST investigation by Counsel for Venarchie. The investigation was in my estimation both comprehensive and thorough. It involved interviewing numerous witnesses, obtaining a very large number of documents, engaging an expert and a consideration of the respective roles of Altus, Venarchie and the Council

(as well as Metro Tasmania).

130. If there is to be any criticism it is because the WST investigator did not interview anyone from the Council, something the Chief Executive and Regulator Mr Cocker agreed should have been done.

131. That having been said it is impossible to conclude that this failure compromised in any meaningful sense the investigation or was the result of *mala fides*, bias or incompetence.

132. I observe that whilst it is within my power as a matter of law to comment on the investigation, I am precluded from offering any comment on why a person or entity was not prosecuted.[41] It is of course another thing to say that a failure to prosecute may diminish the general deterrence aspect of workplace safety legislation. In this case of course I observe that both Venarchie and Altus, along with Mr Higgs, were all prosecuted with offences arising out of Mr Close's death.

133. The other area of criticism related to the evidence from Mr Collins about an inspection he carried out on 23 October 2012 relating to works being performed on the Kings Meadows underpass at Connector Park, Launceston. Altus were providing traffic management. Mr Collins said he was off duty at the time but identified some significant deficiencies in traffic management and requested rectification. He said he was satisfied that rectification had occurred and continued on his way. He told the inquest that he followed up that spot inspection with telephone calls. However Mr Collins did not issue an improvement notice or send a documentary record to Altus (or to the principal contractor). In my view he should have done both. The role of WST is multifaceted and nuanced but at its heart is the safety of persons at work. This involves amongst other things proper record-keeping and formalisation of actions on the part of inspectors. Having said that I note the evidence of Mr Cocker as

[41] see section 28 (4) of the *Coroners Act* 1995

to the procedures now in place with respect to inspection procedures.

134. That evidence was that WST mandates the issuing of inspection reports, a practice consistent with similar models operating elsewhere in Australia. He described as ‘concerning’ any opting out by an individual inspector of that particular requirement.

135. Mr Cocker said that it was his expectation if an inspector identified a problem or deficiency, an improvement or prohibition notice was to be issued or at the very least a workplace inspection report completed.

136. I accept that the system described by Mr Cocker as now in place at WST, is a significant improvement on the system in place in 2013.

Findings – Issues and Scope of Inquest

137. Earlier in this finding I set out the questions posed before the inquest designed to refine the scope of the inquiry. I turn now to addressing those issues in light of the evidence heard and findings of fact made.

138. The first question was what rules and regulations control the operation of traffic control during roadworks? The answer seems to be very little. No documented controls existed over the operation of traffic management on Launceston City Council roads at the time of the accident.

139. Similarly, no code of traffic management or Standard had application over Council or State controlled roads at the time of the accident and no legislative controls incorporating specific minimum traffic control standards existed at the time of the accident.

140. The evidence was that DIER require compliance by its contracted roadworks and traffic management providers with its Code but otherwise unless and until the applicable Works Standard is incorporated into the DIER code then that Works Standard has no regulatory force within

Tasmania.

141. The next series of questions posed, namely:

- Were those rules complied with?
- If not why not?
- If so were the rules and regulations sufficient/fit for purpose?

do not fall to be answered in light of the absence of any real regulatory controls over the conduct of traffic management. I do note that the traffic management in use on 5 February 2013 on Vermont Road was not compliant with the applicable Works Standard.

142. I also observe that the so-called generic traffic management planning undertaken in the context of crack sealing works by both Altus and Venarchie were not strictly compliant with the Works Standard. As should be reasonably clear from earlier in this finding, I am satisfied that had there been strict, or even closer, compliance with the Works Standard then Mr Close may not have died.

143. Turning to consider the role of Venarchie in ensuring appropriate and safe traffic management at the roadworks, the evidence when viewed as a whole leads me to conclude that simply 'outsourcing' the provision of traffic management even to a specialist entity such as Altus, did not entitle it to 'wash its hands' as it were of all considerations in respect of that issue. At the very least Venarchie should have communicated early to Altus as to the location, timing and nature of the works to be conducted to enable site-specific planning to be undertaken by Altus. It did not do that. The evidence was that no one at Altus knew that Mr Close and Mr Purcell would be working at Vermont Road on 5 February 2013.

144. Venarchie ought to have taken steps to ensure that its Traffic Management Plan complied with the minimum requirements of the Works Standard. As has been seen it did not. In the same way

Venarchie was obliged, in my view, to ensure that the entity contracted to provide traffic management (in this case Altus) did so in a way which similarly complied at a minimum level with both Venarchie's own plan and therefore the applicable Works Standard. Again, I do not consider it did so.

145. In my view Venarchie ought to have ensured that meaningful, site-specific hazard identification, risk management and the like be undertaken. It did not do so. The lackadaisical and informal approach to the SWMS and risk assessment completed at the beginning of the day's work demonstrates that this was so.

146. Turning to consider Altus, I note that Altus was directly responsible as employer for Mr Close's safety. I am satisfied on the basis of the evidence that the measures it took to ensure Mr Close's safety on 5 February 2013 were completely inadequate. The training provided was of a poor level. Inadequate staff were provided for the task (no driver for a shadow vehicle even though one was available). No site-specific planning occurred at all. None of the workers associated with the task - Mr Burgess, Mr Close or Mr Purcell - had the necessary qualification to enable site-specific planning to be carried out.

147. The starkest example of the inadequacy of Altus' provision of traffic management was the fact that the traffic controller, Mr Close, found himself in a position where he was the 'first line of defence'.

148. In my view WST were prevented from effectively managing compliance with a minimum standard of traffic control in the absence of any regulatory force in the applicable Works Standard or alternative code.

149. I also note that WST procedures regarding the communication of issues of concern to worksites lacked documentary reinforcement. That procedure now appears to have been remedied by the implementation of formal procedures whereby issues following site inspections are raised

in writing in a timely manner to the worksites concerned.

150. The evidence leads to the conclusion that the Launceston City Council failed to have in place anything in the nature of a policy or a code providing a minimum standard of compliance for the conduct of traffic management on council controlled roadways. This is particularly significant given the attitude evidenced by the Council of being opposed to closing roads when work was being carried out on them.

151. Furthermore, I observe that it is apparent that the Council's process of auditing failed to detect issues with traffic control including the compliance of the Venarchie generic plan with the applicable Works Standard and the adherence to that plan by workers on site.

152. The driver behavioural implications that arise as a result of the site set up may be summarised as follows; the principal cause of Mr Higgs' failing to appreciate the presence of Mr Close on the roadway was him concentrating on trying to change stations on his car radio so he could listen to a horse race, rather than watching where he was driving.

153. However, I am also satisfied that the fact that Mr Higgs diverted his attention and the fact that he sped up from 40 km/hr was contributed to by the inappropriate placement of the signage to the eastern side of the roadworks. In my view the distance between the signage and the works created an environment in which it was possible for a driver to reach the mistaken belief that roadworks were no longer being conducted, noting that some distance had passed from the signs without evidence of the works being undertaken. The requirement in the applicable Works Standard for signage to be placed no further than 500 metres away from the works underscores this point.

Formal Findings

154. On the basis of the evidence at the inquest I find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Terrence William Close;
b) Mr Close died as a result of injuries suffered by him whilst working as traffic controller on Vermont Road in Launceston when he was struck by a vehicle driven by Murray Anthony Higgs;
c) The cause of Mr Close's death was blunt trauma of chest and abdomen; and
d) Mr Close died on 5 February 2013 at the Launceston General Hospital, Launceston in Tasmania.

Comments and Recommendations

155. As I explained at the beginning of these findings one aspect of the role of a coroner investigating the death of a person in the course of their employment is to make recommendations if justified or comments if warranted.[42]

156. For reasons which should, I hope, be clear I consider that the adoption of the applicable Australian Standard as a Code of Practice under the *Work Health and Safety Act* 2012 would enhance the safety of road workers. Accordingly, I **recommend** that the Minister for Building and Construction adopt the Standard as a Code of Practice pursuant to section 274 of the *Work Health and Safety Act* 2012.

157. It should also be clear that had there been compliance with the applicable Australian Standard then Mr Close would not have been killed. I therefore **recommend** that all roadworks be carried out in a

[42] see section 28 generally of the *Coroners Act* 1995

manner that complies as closely as practicable with the applicable Australian Standard.

158. Aside from Mr Higgs' criminal inattention and speeding, a significant reason why Mr Close was killed was because he had no barrier between him and the first car approaching him. Numerous methods were identified to ensure that no road worker need ever be the 'first line of defence'. I **recommend** that under no circumstances should any road worker be positioned on the road without a physical barrier between her or him and the first approaching vehicle.

159. Finally, I **comment** that it is the responsibility of all drivers on Tasmanian roads to ensure the safety of road workers.

Conclusion

160. I thank all counsel for their assistance in relation to this inquest but in particular Ms Mackey, Counsel Assisting.

161. I thank also Constable Stephen Anderson of the Launceston Coroner's Office for his work in coordinating the material for the inquest and liaising with witnesses. Finally, I thank Constable Nigel Housego for his thorough and professional crash investigation.

162. In conclusion, I offer my sincere and respectful condolences to Mr Close's family on their loss.

Dated 27 March 2019 at Launceston in the State of Tasmania

Simon Cooper
Coroner