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

RETBE CHIDE NEGGA

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Retbe Chide Negga, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

12 April 2021, with final written submissions received 24 May 2021.

Representation

E Bill – Counsel Assisting the Coroner
K Read SC, N Munting – SD Reid Holdings Pty Ltd
J Bourke – Mr Negga's family

Introduction

1. On 9 January 2015 Retbe Chide Negga was working as part of a pickup crew in a cherry orchard in Tasmania's Derwent Valley. He suffered terrible injuries in an accident at the orchard and died a few hours later in the Royal Hobart Hospital.

2. Born in Ethiopia, probably in 1965, Mr Negga came to Australia in 2008 with his family, seeking a better life. He left behind a widow and four children. He was much loved by them and loved them deeply in return.

3. At the time he suffered the injuries which caused his death, Mr Negga was employed by SD Reid Holdings Pty Ltd. The *Coroners Act* 1995 provides that where a person dies as a "result of an accident or injury that occurred at his or her place of work, and the coroner is not satisfied that the death was due to natural causes" an inquest is mandatory. Mr Negga's death was not the result of natural causes. If the Senior Next of Kin of a deceased person who died as a result of injuries suffered at work asks a coroner not to have an inquest then, provided the coroner is satisfied that it would "not be contrary to the public interest or the interest of justice", an inquest can be dispensed with. No such request was made in this case. Accordingly an inquest was held into Mr Negga's death. An inquest is a public hearing.[1]

[1] See section 3 of the *Coroners Act* 1995.

What a Coroner Does

4. As I noted above, a coroner in Tasmania has jurisdiction to investigate any death that "occurs at, or as a result of an accident or injury that occurs at, the deceased person's place of work, and does not appear to be due to natural causes".[2] Self-evidently, Mr Negga's death meets this definition. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case.

5. When conducting an inquest a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[3] The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.[4] The role of the coroner in making recommendations has frequently been acknowledged as especially important in the context of workplace deaths.[5]

6. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. I note that by the time the inquest commenced criminal proceeding arising out of Mr Negga's death were complete. Those proceedings involved a charge against SD Reid Holdings Pty Ltd for a breach of section 32 of the *Work Health and Safety Act* 2012. The complaint (at least in part) against SD Reid Holdings Pty Ltd was found proved and the company convicted and fined by a magistrate. The transcript of the evidence at that hearing was tendered at the inquest and informed these findings.

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[2] *Supra.*
[3] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.
[4] This function is important in Australia and overseas. As to the latter see 'Coroners' Courts- A Guide To Law And Practice', Third Edition, Dorries, at paragraph 10.13.
[5] See for example 'Death Investigation and the Coroner's Inquest', Freckleton and Ransom page 675.

7. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[6] 'How' has been determined to mean "by what means and in what circumstances",[7] a phrase which involves the application of the ordinary concepts of legal causation.[8] Any coronial inquest 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.

8. The standard of proof at an inquest 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 inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*[9], that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.

Issues at the Inquest

9. In advance of the inquest a number of issues, in addition to those mandated by the *Coroners Act* 1995, were identified as being matters to be particularly considered at the hearing. Those matters included:

    a) Why did Mr Negga run onto the side step of the trailer?

    b) What caused Mr Negga's leg/foot to become trapped, including:

        i. Did he slip and if so, why?
        ii. Were there any environmental factors?
        iii. What parts or movement of the trailer caused the injuries to Mr Negga?

    c) What were the general practices of the workers around the use of the side step of the trailer?

    d) The existence and adequacy of SD Reid Holdings Pty Ltd's workplace supervision, instruction, training and policies including:

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[6] Section 28(1)(b).
[7] See *Atkinson v Morrow* [2005] QCA 353.
[8] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.
[9] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

i. The training, supervision and instruction provided to Mr Negga, and other employees, regarding the safe work practices around the trailer, and in particular the use of the side step.
ii. The practices, including risk assessment, around the installation of the side step on the trailer.
iii. Processes and procedures to ensure Mr Negga, and other employees, complied with safe work practices around the trailer, and in particular the side step.

10. The list of issues, or 'scope', was distributed to all interested parties before the inquest. The evidence at the inquest was directed towards these issues, as well as answering the questions in section 28(1) of the *Coroners Act* 1995.

Evidence at the Inquest

11. At the inquest evidence was heard from:

a) Mr Craig Sault – WorkSafe Tasmania Inspector;
b) Mr Thomas Heyward – pickup crew member;
c) Mr Anthony Hawkins – pickup crew member;
d) Mr Dallas Lovell – tractor driver;
e) Mr Nicholas Owen – Production Manager – SD Reid Holdings Pty Ltd; and
f) Mr Tim Reid – Managing Director – SD Reid Holdings Pty Ltd.

12. In addition, a significant amount of documentary evidence was tendered including the complete Worksafe Tasmania investigation file and the file associated with the prosecution of SD Reid Holdings Pty Ltd.

The System of Work

13. Much of the evidence about Mr Negga's death was not in dispute. He started work at the cherry orchard at Glenora in Tasmania's Derwent Valley on 2 January 2015. The orchard was, and still is, owned and operated SD Reid Holdings Pty Ltd. He was employed as a member of what was described as a 'pickup crew'. It was not the first time that he had been employed by SD Reid Holdings Pty Ltd in seasonal employment. There was evidence that he had worked for SD Reid Holdings Pty Ltd four or five seasons earlier.

14. The evidence was that the role of the pickup crew, which comprised six or seven workers (including a tractor driver and data entry worker) was, in essence, to load

trailers with boxes (or as they are known in the industry 'lugs') of cherries. Each lug, when full, weighed in the order of eight or so kilograms.

15. The lugs were filled by pickers and then stacked at the end of the rows of cherries. The pickup crew moved through the orchard collecting the full lugs and putting them in a trailer towed by a tractor. When full, the trailer was taken to a central point to be emptied and the process continued.

16. The equipment in use by the pickup crew was a blue Landini tractor towing a trailer. The trailer had fitted to it, aftermarket, steps on both sides, immediately in front of the wheels. The trailer had a single axle that was able to be raised and lowered by means of hydraulics.

17. The steps were installed approximately two years prior to Mr Negga's death. Mr Owen said in his evidence at the inquest that he modified two of the trailers by including a fabricated metal platform at the front. Mr Owen said that approximately two years prior to Mr Negga's death he modified the trailer in question by including fabricated metal side steps. The steps were made from checker plate steel and were welded onto the trailer. Checker plate steel is a mild, lightweight metal which is covered with a raised pattern of either diamonds or lines (in this case lines). It is usually used as a material for flooring and steps – and is not uncommonly used as part of trailers.

18. Both steps were positioned in front of unguarded trailer wheels. A gap, which varied depending on the height of the trailer above the ground, provided an opportunity for someone to slip into it, as Mr Negga did. When half raised hydraulically, the gap between the step and the unguarded trailer wheel was approximately 150 mm. Relevantly, in the context of what happened to Mr Negga, there was no non-slip coating on the step.

19. The rationale for fitting the steps to the sides of the trailer was to assist workers loading the lugs of cherries into bins on the trailer. Mr Owen said that it was his intention that the steps would only be used whilst the trailer was stationary. He did concede, however, that there would be a temptation for workers to use these steps while the trailer was mobile. There was ample evidence that this is how they were in fact used.

20. The steps created an entrapment point due to the gap between the wheel and the step. That entrapment point was the direct cause of Mr Negga's death.

21. It is apparent that no assessment of the safety of the aftermarket steps appears to have been carried out by anyone at SD Reid Holdings Pty Ltd. No one appears to have turned their mind to whether, in an attempt to make things easier for the pickup crews, a danger had been created.

Induction and Training

22. Most employees at the orchard were, generally speaking, seasonal. Every employee was required to complete an induction before commencing work. Mr Owen, gave evidence that he was responsible for carrying out the induction of employees. He described in his evidence at the inquest the inductions involved a verbal briefing in which prospective employees had explained to them, in a group, what the job involved and how it was to be performed.

23. Mr Negga participated in such an induction. The evidence was that Mr Owen and Mr Lovell carried out the induction. In summary, the induction apparently involved a practical demonstration of procedures and safety issues. It is evident that one matter in particular that was emphasised in the induction; namely the need for workers to stay away from the wheels. Mr Owen said that he gave this message and several witnesses including Mr Hawkins, Mr Newbon, Mr Anderson and Mr Lovell all recalled being told to keep away from the wheels and keep clear of the trailer.

24. Mr Owen said:

> *"On the day that [Mr Negga] started Dallas [Lovell] and I gave him an induction in relation to safety around the tractors and trailers.*
>
> *I specifically included not travelling on the side step when the trailer was in motion.*
>
> *I even mimed it to him in front of the step on the trailer and [Mr Lovell] uses this form of instruction as well to ensure that workers who don't speak English perfectly, understand.*
>
> *I was satisfied that [Mr Negga] took this information in and that he understood it."*[10]

25. I am afraid that I do not share Mr Owen's confidence that Mr Negga "took this information in and that he understood it". There was much evidence at the inquest that in fact, rather than avoiding the trailer when it was in motion, many workers rode on the steps of the trailer throughout the orchard. Mr Owen himself said at the inquest that this was so. It is also apparent to me that supervisory staff at the orchard

[10] Exhibit C17A, Affidavit of Nicholas James Owen, sworn 5 May 2015, page 4 of 4.

were well aware that employees were riding on the trailer, and its steps, but did nothing about it. This alone must have given rise to an understandable level of confusion about what was, and was not, permitted in terms of riding on the trailer and its steps. The fact that Mr Negga died as a result of attempting to mount the trailer when it was moving, rather suggests to me that he may not have fully understood the substance of the induction he received.

26. Returning to the issue of that induction, it seems to be the case that following induction most workers (but not Mr Negga) were asked to sign an induction form. Mr Negga was not asked to sign the induction form because it was considered, apparently because he had poor verbal English skills, he would not understand what he was being asked to sign. It is unclear to me, on the evidence, whether anyone actually checked to see what Mr Negga's ability with written English was.

27. I have to say that an induction programme that cannot, or does not, take account of the varying capacity of employees, by reason of linguistic ability to actually understand what they were being instructed about, and relies upon the art of mime (as Mr Owen apparently did), seems, to say the least, somewhat lacking. Simply 'going through the motions' or 'ticking boxes' is of no assistance to any employee and cannot hope to discharge an employer's obligations to provide a safe system and place of work.

28. In addition, the apparent lack of supervision and correction of workers riding on trailers towed by tractors in the orchard must have diminished the effectiveness of Mr Negga's training and induction – assuming he even understood it.

Circumstances of Death

29. On the day of his death Mr Negga was in a pickup crew which consisted of eight employees (including himself). Those employees were Mr Dallas Lovell, the tractor driver, Mr Peter Anderson, Mr Aaron Newbon, Mr Benjamin Hurst, Mr Anthony Hawkins, Mr Thomas Heyward and Mr Joshua Maddox.

30. Mr Anderson (and possibly Mr Maddox – the evidence about this was unclear, but nothing turns on it) was performing the role of 'data operator'. The role of the data operator was to record the number of lugs moved by the crew. The other members of the crew, including Mr Negga, were involved in the actual physical task of picking up lugs full of cherries and placing them in the trailer. Supervision of the crew, and how the duties were carried out by them, appears to have been shared, informally, between Mr Lovell and Mr Anderson.

31. The job itself was straight forward. The method of communication was also straight forward. It was not prescribed anywhere (in the sense it was not written down in a SOP or similar) but seems to have involved giving a 'thumbs up' or a nod of the head or a verbal 'okay' to the driver, Mr Lovell, to indicate that it was safe for the tractor to move off.

32. Mr Hayward, Mr Hawkins and Mr Lovell all gave evidence at the inquest. Mr Hurst was excused from giving evidence on medical grounds. The other members of the pickup crew were either unavailable or not considered likely to provide any evidence different to those that gave evidence. The evidence of Mr Hayward, Mr Hawkins and Mr Lovell confirmed the method of work I have set out immediately above.

33. At around 11.30-11.45 am on 9 January 2015 the crew had just placed one lot of picked cherries into the trailer and were about to move to the next pickup point. Witnesses gave different times for the accident. Those times varied from as early as 10.00 am to as late as 12 noon. Little, if anything, turns on the different times. Objective evidence in the form of Ambulance Tasmania records indicate that the 000 call was made at 11.50 am.[11]

34. In any event, the evidence was that Mr Anderson gave Mr Lovell an all clear 'thumbs up' sign. Mr Anderson, in his affidavit, said that, when he did so all workers were clear of the trailer, although some were standing in the general area. Mr Lovell said that "once [he] got the okay, [he] was [*sic*] turned around in the driver seat, looking at them to check for [himself] – get a visual."[12] Although he did not say it in his affidavit, it is implicit in that evidence that everything was, to Mr Lovell's mind, safe to commence the tractor moving forward. He said he turned back and faced the front, engaged the clutch, selected the forward gear, and moved off at a slow walking pace.

35. Based on the evidence at the inquest I find the following is the sequence of events. As the tractor and trailer began to move slowly forward, Mr Negga was a distance of approximately 10 metres away. Mr Anderson was riding on the trailer, but no other member of the pickup crew was. Mr Negga ran towards the trailer and jumped onto the step on the left side of the trailer. I cannot determine why he ran and jumped on the step. The only person who could cast any light on that issue was, of course, Mr Negga.

[11] Exhibit C5.
[12] Exhibit C9 Affidavit – Dallas Arch Lovell, sworn 24 March 2015, page 2 of 3.

36. As Mr Negga mounted the step, his right foot slipped off the step and into the gap between it and the wheel. The wheel, which was slowly turning forward, caught hold of Mr Negga's foot and leg and pulled him into the area in front of, and underneath, the wheel. His lower abdomen, pelvis and legs were all crushed. Several members of the pickup crew shouted at Mr Lovell to stop.

37. Unsurprisingly, there was a variation between the evidence of witnesses, particularly in relation to who was standing where when Mr Negga was crushed beneath the wheels of the trailer. I do not consider that those variations were of any importance. To my mind, they are the natural result of eye witness evidence and especially evidence relating to something as shocking as Mr Negga's accident. The differences between witnesses are certainly not indicative of anyone trying to mislead the inquest.

38. Specifically, I am not satisfied that anyone was riding on the trailer (apart from Mr Anderson as I have already said) and in particular there was no one on the steps when Mr Negga slipped and fell. I am also affirmatively satisfied that no one pushed, tripped or in any other way caused Mr Negga to slip from the step.

39. Returning to the sequence of events, I find that Mr Lovell, as he said, felt a 'bump' at essentially the same time as he heard other workers screaming at him to stop. He stopped and looked back. He could not see Mr Negga but another worker, Mr Newbon, told him that Mr Negga was under the trailer or the wheel – Mr Lovell said in his evidence at the inquest he could not remember precisely what was said (which is hardly surprising and I do not consider that it matters). Accordingly, Mr Lovell reversed the tractor and trailer back a distance of three or four feet.

40. Meanwhile, 000 was called and supervisors advised of the incident. Efforts were made to provide Mr Negga, who was terribly injured, with first-aid. The first emergency responders, ambulance paramedics, arrived at the scene at 12.02 pm. Paramedics observed that Mr Negga had suffered massive trauma to his pelvis and legs. He was administered painkillers and fluid IV to attempt to stabilise him before he was airlifted to the Royal Hobart Hospital (RHH) by helicopter.

41. Mr Negga was admitted to the RHH urgently and assessed. Desperate efforts were made to try to save Mr Negga but the injuries he had sustained was so extensive as to be unsurvivable. He died at 10.25 pm that evening.

Investigation – Forensic Pathology Evidence

42. After being pronounced deceased, Mr Negga's body was formally identified[13] and then taken to the mortuary at the RHH. At the mortuary, experienced forensic pathologist, Dr Donald Ritchey, externally examined Mr Negga's body. He expressed the opinion that the cause of Mr Negga's death was blunt trauma of his abdomen, pelvis and legs.[14]

43. Dr Ritchey was shown a photograph of the trailer involved in the accident. He expressed the opinion that the crush injuries he observed at the mortuary were consistent with Mr Negga having been crushed between the step and the wheel of the trailer shown in the photograph.[15]

44. I accept Dr Ritchey's opinion, which he is well qualified to express.

45. Samples taken from Mr Negga's body were subsequently analysed at the laboratory of Forensic Science Service Tasmania. In an affidavit tendered at the inquest forensic scientist, Ms Miriam Connor, said that apart from ketamine, no alcohol or drugs (prescription or illicit) were identified as being present.[16] The presence of ketamine, a non-barbiturate anaesthetic, is explained by it having been administered as part of Mr Negga's treatment prior to his death at the hospital.

46. I am satisfied, to the requisite legal standard, that neither alcohol nor drugs played any role in Mr Negga's death. Particularly, I am satisfied that neither influenced his decision to run and mount the step of the trailer nor caused his loss of balance and fall.

Investigation – System of Work

47. An investigation by Tasmania Police commenced at the scene. A parallel investigation by WorkSafe Tasmania also took place. I received evidence at the inquest from both sources. I was particularly assisted by the evidence Mr Sault, the WorkSafe Tasmania investigator, gave at the inquest.

48. I have to say that the initial police investigation was of a poor standard. The initial investigation and report provided to the Coronial Division did not even address issues as basic as whether any drug and alcohol testing had been conducted. At my request, Mr Negga's death was investigated further by detectives. That investigation, of a far more appropriate standard, did not reveal any evidence, at all, of foul play.

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[13] Exhibit C3.
[14] Exhibit C6.
[15] Exhibit C6A.
[16] Exhibit C7.

49. The fundamental issue, to my mind, that arose from both investigations was that there had been a failure to recognise and ameliorate the risk posed by the step of the trailer creating a 'pinch point'. In addition, it is apparent to me that there was inadequate instruction, supervision and training of workers generally, and Mr Negga in particular. There is little doubt that there was a general practice of workers riding on trailers around the orchard, something inherently dangerous but about which SD Reid Holdings Pty Ltd apparently did nothing.

Changes since the Accident

50. Both Mr Owen and Mr Reid gave evidence in relation to changes to work, health and safety practices at the orchard in the wake of Mr Negga's death. I accept that SD Reid Holdings Pty Ltd have made significant improvements in that regard. Those improvements include, but are not limited to, covering gaps in trailers and the like, as well as the use of buses for transportation of workers in and around the orchard.

Formal Findings

51. On the basis of the evidence presented at the inquest, I make the following findings pursuant to section 28(1) of the *Coroners Act* 1995:

    a) The identity of the deceased is Retbe Chide Negga;
    b) Mr Negga died as a result of injuries sustained in the course of his employment when he was crushed by a trailer;
    c) The cause of Mr Negga's death was blunt trauma of the abdomen, pelvis and legs; and
    d) Mr Negga died on 9 January 2015 at the Royal Hobart Hospital, Hobart in Tasmania.

Conclusions and Comments

52. Mr Negga's death is a stark example of the inherent dangers associated with working in and around machinery. It is, to my mind, essential that employers are vigilant about those dangers and take all reasonable steps to stop employees riding on moving machinery such as tractors and trailers.

53. I do not consider it is necessary or appropriate to make any formal recommendations or comments pursuant to section 28 of the *Coroners Act* 1995.

54. I wish to extend my sincere and respectful condolences to the family of Mr Negga on their tragic loss.

Dated 9 August 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner