Findings of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Shane Anthony Masters

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Shane Anthony Masters with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Dates

27 April 2022

Representation

Counsel Assisting the Coroner – C Lee

Counsel for Wendy Masters and family – R Grueber

Introduction

1. Shane Anthony Masters was born on 25 December 1980 and was aged 40 years at his death on 11 February 2021. He lived in Geilston Bay with his mother, who was his carer. He has two children, Dekoda and Blaine. He maintained a close friendship with his former partner, Casey Howlett, the mother of his children.
2. On 19 May 2008, Mr Masters suffered a significant brain injury in an accident at the premises of his employer, Aprin Transport Pty Ltd ("Aprin"). His injury occurred whilst he and other employees were working in the workshop service pit repairing airbags on a fully laden log truck. At this time, a jack being used to lift the trailer of the log truck became dislodged and struck another employee in the pit who, in turn, fell backwards hitting Mr Masters. As a result, Mr Masters fell into the concrete side of the pit, causing a severe head injury.
3. Because of the head injury, Mr Masters was no longer able to work. He also commenced to suffer seizures and these continued to occur over the next 12 years until his death. He was under the care of specialists and his general practitioner. He was also prescribed medication for his seizures.
4. On 10 and 11 February 2021, Mr Masters suffered two separate seizures, the second of which resulted in his death.

Coroner's jurisdiction, functions and scope of inquest

5. Mr Masters' death was a "reportable death" for the purpose of section 3 of the *Coroners Act* 1995 because it occurred as a result of an accident or injury at his place of work, even though the death occurred 12 years after he sustained the injury.
6. Section 24(1)(ea) of the Act requires an inquest to be held[1] where a person dies as a result of an accident or injury that occurred at his place of work and the coroner is not satisfied that death was due to natural causes. It might be thought that Mr Masters' cause of death, being sudden unexpected death in epilepsy (SUDEP), is in the category of natural causes and a mandatory inquest in such a case is not required. However, given that the epilepsy was post-traumatic in origin, being directly linked to his brain injury of 2008, I am satisfied in the absence of contrary argument that a public inquest is mandated.
7. Under section 28(1) a coroner investigating a death must find, if possible:

    (a) the identity of the deceased;

    (b) how death occurred;

    (c) the cause of death; and

    (d) when and where death occurred.

8. Further, by section 28(2), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
9. By section 28(3), a coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
10. Within section 28 of the Act, this inquest focused, in particular, upon the following matters:
    a) The circumstances of Mr Master's accident on 19 May 2008;
    b) The standard of best practice at the time of the incident in terms of replacing an airbag on the particular truck;
    c) The nature of the investigation undertaken by Workplace Standards Tasmania (WST), any remedial action requested of Aprin and the nature of the remedial action; and
    d) The circumstances leading to Mr Masters' death on 11 February 2021.

[1] Subject to s26A, which is not applicable in this case.

Evidence in the investigation

11. The documentary evidence tendered at inquest comprised exhibits C1 to C18. The exhibit list is annexed to this finding.
12. At inquest, the following witnesses provided oral testimony:
    - Mrs Wendy Masters, mother of Mr Masters and his primary carer;
    - Mr Timothy Masters, younger brother of Mr Masters, also a former employee of Aprin;
    - Mr Bradley Parker, Director of industry Safety, WorkSafe Tasmania, who provided comments upon the investigation; and
    - Mr Michael Clark, WorkSafe Tasmania Inspector, who investigated the incident occurring on 19 May 2008.

Workplace incident 19 May 2008 causing injury to Mr Masters

13. Aprin operated from the premises of 352 Midlands Highway in Brighton. Its principal business was log cartage for three large companies. Mr Masters was a permanent employee of Aprin, occupying the position of workshop assistant. He was a trained tyre fitter.
14. In the early evening of Sunday 18 May 2008, Mr Jamie Burden, workshop supervisor of Aprin, was notified of a log truck requiring repair the following day to aspects of its airbag suspension.
15. Mr Burden started work at 7.00am on Monday 19 May, earlier than Mr Masters, and backed the trailer of the truck over the pit ready for repair. In his interview with WST, Mr Burden said that he identified the issue as being a broken spring associated with the front right airbag on the trailer (possibly due to bolts which had broken or snapped off) as well as a fault in the front left airbag (likely a hole or holes).
16. Mr Burden was then assisted in the work by two Aprin employees: Mr Masters and Mr Lyall Huxley, a welder. The evidence indicates that the work task was to replace the broken spring on the right airbag and then to fully replace the faulty left airbag. Upon the evidence, such tasks were undertaken regularly upon Aprin's trucks in the workshop and there had been no previous safety incidents associated with performing these tasks.
17. At the time of undertaking the work on the truck, the trailer was fully loaded with the logs, a practice that was not uncommon for Aprin but was unsafe due to the vastly increased weight of the trailer if it was required to be raised.

18. Mr Masters and Mr Huxley were working in the service pit at the time of the incident. The pit is depicted in the photographs as long, deep, and narrow, although the precise dimensions are not specified in the evidence. A seven-step ladder/stair access provided entry from ground level into the pit.
19. At the time of the incident, Mr Burden was on top of the trailer. Of the three workers, only Mr Burden and Mr Huxley were able to provide an account of the work due to the effects of the injuries suffered by Mr Masters. Both were interviewed by WST shortly after the incident. The sequence of the work and the tasks carried out are somewhat unclear in their accounts.
20. Mr Burden described in his interview that they had replaced the broken spring and had then placed one bolt in the spring. He said that they were unable to insert the required second bolt properly and therefore the trailer needed jacking and then an axle stand placed between the axle and the chassis rail. This process would create free movement in the airbag to allow the work on the bolt to be completed.
21. It is apparent from all of the evidence that a 16 tonne hydraulic jack was therefore placed upon a metal stanchion bar removed from the side of the trailer and positioned across the pit. The dimensions of the bar were 100mm in width and 75mm in depth. The top of the jack was positioned under a metal component of the suspension that cannot be precisely identified on the evidence.
22. Mr Burden went on to say in his interview that, as they were raising up the trailer with the jack to attend to insert the bolt, he heard air gushing or leaking out, apparently from holes in the front left airbag. He said that this fact caused them to "*change plans altogether*". Mr Burden said that he then decided to block off the air to the broken left airbag by laying on top of the trailer and disconnecting the airline. It appears that a decision was also made at this time to inflate the other three airbags of the trailer to enable replacement of the left airbag. Mr Burden said that whilst he was disconnecting the air line, Mr Huxley and Mr Masters were in the pit operating the jack, although he did not have direct vision of them. He did not witness the jack then dislodging from under the trailer and striking Mr Huxley.
23. In his interview after the incident, Mr Huxley said that he and Mr Masters were working in the pit at this time and lifting the trailer with the jack with the inflation of the other three airbags having been completed. He then said that the right airbag slipped from its springs and "*shot out*" with the jack also being dislodged. He said that he was hit by both the airbag and the jack. He described that the airbag cracked his collarbone and the jack caused a fracture of his scapula. Mr Huxley fell back onto Mr

Masters, whose head impacted with the side wall of the pit, likely a metal light guard or a protruding metal compressed air fitting.

Injuries and consequences of injuries

24. As a result of his head strike, Mr Masters suffered multiple skull fractures, subarachnoid haemorrhage, subdural haematoma, bilateral frontal and temporal contusions to the brain, severe cerebral oedema and a resultant sub-tentorial herniation of the brain. He required extensive life-saving neurosurgery and spent 13 days in the Intensive Care Unit of the Royal Hobart Hospital. He was a patient at the hospital for a period of six months and came under the care of a rehabilitation physician who helped him learn to walk and talk again. He was left with a severe acquired brain injury, with significant scarring of the left frontal and temporal lobes of the brain.
25. In the months following his injury, Mr Masters developed epileptic seizures secondary to the brain scarring from his injuries. He also suffered memory loss, headaches, permanently impaired balance and hearing, impaired gait and a permanent and profound speech impediment.
26. His seizures were persistent over the years, despite multiple specialist reviews, medication changes and maximal doses of some medications. In general, however, he managed his medications well and had strategies in place to do so. His long time general practitioner, Dr Danny Rimmer, said that Mr Masters' memory impairment from his injury was almost certainly a significant contributing factor in him missing doses of medications at times. Dr Rimmer said that Mr Masters' brain trauma and scarring left him with a very low seizure threshold, such that missing only one dose of his medication could lead to a seizure.
27. His mother, Mrs Wendy Masters, gave helpful and compelling evidence about her son's condition. It is very clear that her patience and unconditional support assisted Mr Masters to regain many positive aspects of his life.
28. Mrs Masters described how her son's personality changed after his injury. She described him as behaving "*like a 16-year-old*", and said that he could not interact well with other people and was very difficult to be around. Because of his changed personality, his relationship with his own children suffered greatly. His relationship with Ms Howlett ended for the same reasons.
29. Mrs Masters said that in 2010, about two years after his injury, Mr Masters trialled living on his own. He occupied a unit by himself and was provided with assistance. However, he was unable to live independently due to an inability to be organised,

perform household chores or manage his medications. He therefore returned to live with his mother and, with her care and support, progressed to being able to cook and do household chores.

30. Mrs Masters described that, after a number of years, Mr Masters learnt to interact with others more appropriately and less impulsively. He was able to resume a good relationship with his children and Ms Howlett. Before his injury, Mr Masters had been a champion in judo. Mrs Masters said that, in the several years before his death, he became involved in judo coaching which was a positive development for him. He had also been able to obtain his driver's licence.
31. The evidence indicates that, over time, Mr Masters' seizures became more frequent and were of longer duration. Mrs Masters described in evidence how her son managed his seizures by lying on the floor so that he was safe.
32. For about two months before his death, Mr Masters had been dating Ms Blair Darby and was looking forward to the prospect of a longer relationship with her.
33. In the last few days before his death, Mrs Masters noticed that Mr Masters had suffered more frequent migraines than was normal.

Circumstances surrounding death

34. On 10 February 2021, Mr Masters was told by Ms Darby of her wish to have some space in the relationship. Mr Masters became very upset and went to discuss the situation with Ms Howlett that same evening. They spoke at length.
35. At approximately 10.30pm, Mr Masters told Ms Howlett that he could feel a seizure coming on and laid on the lounge room floor. Ms Howlett telephoned for an ambulance once his seizure commenced. When the ambulance attended, the seizure had stopped. Mr Masters was assessed by the paramedics and advised that he did not require hospitalisation but if he had any more seizures within a short period of time, he should call again and be transported to hospital. Mr Masters then went to sleep on the couch and "slept off " the effects of the seizure. It was normal for Mr Masters to sleep after a seizure and then to feel better in the morning.
36. At approximately 6.00am on 11 February, Mr Masters woke and was walking around when he felt another seizure coming. He immediately laid on his back on the lounge room floor. Ms Howlett heard Mr Masters awake and went to check on him. She observed he was about to have another seizure. Ms Howlett then asked their daughter, Dekoda, to call 000 whilst she stayed with Mr Masters. The seizure lasted for approximately 2-3 minutes before he gasped and ceased breathing.

37. With assistance over the phone from the ambulance operator, Ms Howlett started CPR and continued until paramedics arrived and took over resuscitation. Mr Masters was in asystole (no cardiac output) when they arrived and they continued CPR and medical intervention by intubating him and inserting a catheter in his left shin to deliver adrenaline and fluids. At 7.17am, after approximately 45 minutes of medical treatment, Mr Masters was pronounced deceased.

Comments

38. The company, Aprin Transport Pty Ltd, was deregistered on 9 August 2017. It is nevertheless appropriate to make comments upon safety issues applicable to the work being performed at the time Mr Masters suffered his injury.
39. After the incident, WST was notified and attended the site. The investigator appointed was Mr Michael Clark. Fortunately, the full workplace investigation file from 2008 had been retained and was tendered in evidence. Apart from the audio recordings of witness interviews, it contained CCTV footage of the incident, relevant Aprin documents, photographs taken at the site and an investigation report by Mr Clark.
40. It is clear from the CCTV footage, which was not at close range, that there was a sudden dropping of the trailer height immediately before Mr Masters and Mr Huxley were injured. In his investigation, Mr Clark concluded that the height drop was caused by dislodgement of the jack, which had been elevating the trailer. With the trailer fully loaded and the airbags being inflated, the pressure on the jack was very great. Mr Clark explained in evidence that, with such pressure, any angularity or instability of the jack would predispose it to slipping. Similarly, metal-on-metal surfaces also increase the chance of slipping, due to a low co-efficient of friction.
41. I am satisfied that, at about the same time, the right front airbag slipped off its springs as it was inflated. This may have been because the bolts had not been correctly fitted at that stage but this is speculation. It is also possible that the cessation of the inflation process resulted in deflation and dislodgement of that airbag. In any event, Mr Huxley believed that the airbag displacement dislodged the jack and he was hit by both. I cannot make a finding on the precise sequence of events, although safe placement of the jack would have prevented its dislodgement, which was the primary, or at least a significant, cause of the injuries to Mr Huxley and, in turn, Mr Masters.
42. Again, I particularly emphasise that the trailer should have been unloaded before the work began. Jacking a loaded trailer is a dangerous practice and should never occur in a controlled work environment. I am unable to comment whether the weight of the

trailer exceeded the capacity of the jack, but it may well have done and this fact may have contributed to the incident.

43. Having regard to Mr Clarke's analysis, I find that the dislodgement of the jack was likely caused by several factors – being one or more of the following;
    a. Taking the pressure of a fully loaded trailer repair work;
    b. Misalignment of the jack whilst the suspension system was being inflated;
    c. The stanchion bar upon which the jack sat was not sufficiently flat and was narrower than the jack base;
    d. There was no friction material used between the jack base and the trailer stanchion bar;
    e. There were no blocks placed next to the jack or under any other part of the trailer as protection in case the jack failed; and
    f. A system of work not guided by documented safety procedures.
44. In respect of the final point above, the operations manager of Aprin said in his interview that there were no documented safety procedures for undertaking repairs in the workshop. He conceded that, in hindsight, this was an oversight on the part of the company. In this regard, Regulations 17, 18 and 19 of the *Workplace Health and Safety Regulations* 1998 ("the regulations") placed an obligation on the company to identify its particular workplace hazards, assess the risks of the identified hazards and implement controls to minimise the risk.
45. Aprin had not complied with its statutory duties under the regulations at the time of the incident. If it had done so, there may well have been a safer approach to the task of repairing more than one defective airbag and a safer approach to the use of the jack. In this case, the injury to Mr Masters may have been avoided.
46. On 29 October 2008 , WST issued Aprin with a notice under section 38(1) of the *Workplace Health and Safety Act* 1995 directing it to take the following steps;
    a. Document procedures for both workshop and field based trailer repairs as required by the regulations;
    b. Ensure housekeeping in the pit area is maintained to a suitable standard so as to remove all trips/slip hazards;
    c. Assess the suitability of the light guards used in the pit area; and
    d. Ensure that all metal to metal jacking blocks have anti-slip or friction material on them or between the surfaces.
47. A follow-up visit to Aprin's premises on 1 December 2008 by WST confirmed that there had been satisfactory compliance with the notice.

48. Finally, I accept the evidence given by Mr Bradley Parker, Director Industry Safety, WorkSafe Tasmania, that there have been no known similar incidents involving Aprin or in any other Tasmanian workplaces.

Formal findings required by section 28(1) of the *Coroner's Act* 1995:

a) The identity of the deceased is Shane Anthony Masters;

b) Mr Masters died in the circumstances set out in this finding;

c) The cause of Mr Masters' death was Sudden Unexpected Death in Epilepsy resulting from a brain injury suffered on 19 May 2008 in the course of his employment with Aprin Transport Pty Ltd; and

d) Mr Masters died on 11 February 2021 at Hobart in Tasmania.

Recommendations

49. I do not consider that it is appropriate to make recommendations.

Dated 18 May 2022 at Coroners Court in Hobart in the State of Tasmania

Olivia McTaggart
CORONER

Annexure

C1	**Police Report of Death**	**Constable Joshua Tringrove**
C2	**Life Extinct Affidavit**	**Dr Zachary Robinson**
C3	**Affidavit of Identification**	**Constable Joshua Tringrove**
C4	**Affidavit of Identification**	**Anthony Cordwell, Mortuary Ambulance**
C5	**Autopsy Report**	**Dr Andrew Reid**
C6	**Toxicology Report**	**Neil McLachlan-Troup, FSST**
C7	**Affidavit – dated 11.02.2021**	**Wendy Masters**
C7A	**Affidavit – dated 20.02.2021**	**Wendy Masters**
C8	**VACIS Electronic Patient Care Record (331) – 10.02.21**	**Ambulance Tasmania**
C9	**VACIS Electronic Patient Care Record (35) – 11.02.21**	**Ambulance Tasmania**
C10	**WorkSafe Tasmania Folder**	**WorkSafe Tasmania**
C11	**WorkSafe Compliance Notice Documents (in C10 WorkSafe Folder)**	**WorkSafe Tasmania**
C12	**Medical Records (USB)**	**Royal Hobart Hospital**
C13	**Medical Records (USB)**	**Churchill Avenue Medical Centre**
C14	**Medical Report**	**Dr Rimmer**
C15	**Affidavit**	**Brad Parker, WorkSafe Tasmania**
C16	**ASIC Company Search - Aprin Deregistration**	**ASIC**
C17	**Additional Aprin compliance notice**	**WorkSafe Tasmania**
C18	**Email on Post Investigation Information**	**Michael Clark, WorkSafe Tasmania**