MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Maxwell Jones

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Maxwell Jones;

b) Mr Jones died as a result of head and neck injuries whilst operating a bulldozer;

c) Mr Jones' cause of death was head and neck injuries; and

d) Mr Jones died on 21 March 2022 at Campania, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Jones' death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Opinion of the forensic pathologist regarding cause of death;
- Toxicology Report of Forensic Services Tasmania;
- Medical records for Mr Jones;
- Affidavit of Anthony Maxwell Jones, son of Mr Jones;
- Affidavit of Barry Turnbull, owner of the property where Mr Jones was working;
- Affidavits of five attending and investigating police officers, including body worn camera footage, crash analysis report, video recordings and photographs;
- Affidavit of Transport Safety and Investigation Officer, Jason Armstrong, regarding the condition of the bulldozer;
- WorkSafe Tasmania investigation report, including all investigative materials and reports held by WorkSafe; and
- Specifications of the bulldozer.

Background

Mr Maxwell Jones was born on the 12 November 1936 and was aged 85 years at the time of his death.[1] He was married to Emily Margaret Rose Harrison and, together, they had five children.[2] In November 2021, Mr Jones' wife passed away.[3] Since her death, Mr Jones was reported to be recovering well and in good spirits'.[4] At the time of his death, Mr Jones was physically healthy with no significant medical history.[5]

From a young age, Mr Jones worked with heavy vehicles. His first job involved driving tip trucks for Australian Newsprint Mills on private land coups.[6] Throughout his working life, Mr Jones was self-employed, operating log trucks as a local contractor in the New Norfolk area.[7] Mr Jones was considered an experienced operator of heavy machinery,[8] holding a valid Tasmanian heavy rigid vehicle licence at the time of his death.[9] Throughout his career, Mr Jones had developed experience operating bulldozers and heavy machinery in bush areas.[10]

At the time of his death, Mr Jones was retired but would often undertake work for his eldest son, Anthony Jones ('Tony'), who owned the business Tony Jones Repairs.[11]

The work arrangement was not recorded in writing and Mr Jones did not accept payment from Tony for the work he did.[12] Mr Jones was enthusiastic in his wish to perform work for clients of Tony Jones Repairs and often would work independently of Tony.[13] Tony would receive payment from clients for the work conducted by Mr Jones.

The work undertaken by Mr Jones often involved the use of a bulldozer, a Komastu D65E Crawler Dozer ('the dozer'), owned by Tony since about 2014.[14] In his statement for the investigation, Tony said that the work helped keep his father busy, especially since the death of his wife.[15] Because of Mr Jones' experience, Tony said that he did not give advice to his

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[1] Police Subject Report to Coroner, 1.
[2] Ibid 2.
[3] Ibid 4.
[4] Ibid 4; also see C5: Medical record 3 December Consult with Dr Tim W Lickiss.
[5] C4: Post Mortem Affidavit.
[6] Police Subject Report to Coroner, 1.
[7] Police Subject Report to Coroner, 2.
[8] See File 2 Correspondence to WorkSafe from DMA: 'information for WorkSafe Tasmania' by Tony Jones.
[9] See File 2: Tab 5 Photos, photo of license from scene.
[10] File 2 Correspondence to WorkSafe from DMA: 'information for WorkSafe Tasmania' by Tony Jones.
[11] Police Subject Report to Coroner, 2.
[12] See File 2 Correspondence to WorkSafe from DMA: 'information for WorkSafe Tasmania' by Tony Jones.
[13] See File 2 Correspondence to WorkSafe from DMA: 'information for WorkSafe Tasmania' by Tony Jones.
[14] Ibid.
[15] Ibid.

father on operating bulldozers and that his father would not have taken such advice if provided.[16]

Prior to his death, Mr Jones was working on a 500-acre property owned by Mr Barry Turnbull located at 1530 Colebrook Road, Campania.[17] Mr Jones had worked intermittently for Mr Turnbull in the 3-4 weeks prior to his death.

Mr Turnbull said in his coronial affidavit that he engaged Mr Jones to push an access track through the property for the purpose of establishing fencing and access to check on stock. The work was scheduled to take place on 21 March 2022. [18] Mr Turnbull said that he was aware that Mr Jones was 85 years of age and that he was the operator of the dozer.[19] Mr Turnbull previously had a discussion with Mr Jones to the effect that Mr Jones should stop work at any time if he felt unsafe. On a previous occasion, work was stopped by Mr Jones due to the risk of shifting rocks.[20]

Circumstances leading to death

On 21 March 2022, Mr Jones arrived at Mr Turnbull's property at 8.00am and he worked for about two hours on a smaller job near the house. At 10.00am, Mr Turnbull took Mr Jones with the dozer to the worksite.[21] Mr Turnbull then returned to his home with Mr Jones to obtain Mr Jones' vehicle to return to the worksite where Mr Jones was required to push a track through a steep hill on Mr Turnbull's property (approximately longitude 42.60S and latitude 147.44E).[22] This was about 100 metres from an area where Mr Jones had previously worked.[23] The gradient of the hill which required the track was very steep, varying between 24.3 degrees and 48 degrees.[24] Towards the eastern side of the track created by Mr Jones on the day was a deep gully.[25]

At 11.30am, Mr Turnbull arrived at the worksite to assist Mr Jones and to keep a look out whilst Mr Jones was operating the dozer. [26] Mr Turnbull was concerned about leaving Mr Jones at the worksite by himself. Mr Turnbull observed that Mr Jones was working at a rapid pace. Mr Jones had pushed through a track of approximately 400 metres in a period of 90 minutes.

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[16] Ibid.
[17] C8: Turnbull affidavit, 1.
[18] Ibid.
[19] Ibid.
[20] Ibid 2.
[21] Ibid 1.
[22] C11: Collision Analysis Report Senior Constable Cordwell, 3
[23] C8: Turnbull Affidavit 2.
[24] C11: Collision Analysis Report Senior Constable Cordwell, 3.
[25] C11: Collision Analysis Report Senior Constable Cordwell, 5; C8: Turnbull Affidavit 2.
[26] C8: Turnbull Affidavit 2.

Whilst continuing to push through the track with his dozer, Mr Jones encountered a large boulder which prevented him from continuing to create the track. The boulder was approximately 2 cubic metres in size.[27]

It appears from markings and the track created that Mr Jones attempted to remove the rock before continuing onwards. It appears that he tried unsuccessfully to dislodge the rock by using the dozer's blade. Mr Jones then "squared up" to the rock using the dozer's blade to either push in or pull out the rock. It is likely that Mr Jones reversed to make a right turn down to square up the dozer to the face of the rock. While reversing, the dozer came close to the edge of the track.[28] The weight of the dozer appears to have been too much for the edge of the track, which caused the ground to depress.[29] The dozer rolled down the gully, travelling approximately 80 metres and rolling at least four times before coming to a stop on its right hand side.[30].

At the time of the accident, Mr Turnbull was approximately 20 metres ahead of the dozer.[31] He had initially turned his back on the dozer but turned back around after hearing a loud noise.[32] It was then that he saw the dozer rolling down the gully.[33] After the dozer came to a stop, Mr Turnbull immediately made his way down to the dozer and called emergency services. He observed Mr Jones motionless and did not feel any movement when he placed his hand on Mr Jones' chest.

Sometime between 1.06pm and 1.50pm, police officers arrived at the property. Paramedics and a doctor arrived at the property by helicopter. The doctor examining Mr Jones determined that he was deceased. [34]

Subsequent investigations

Examination of scene

Mr Jones was found inside the cabin of the dozer. Mr Jones appeared to have suffered wounds to his back, had swelling on his face and had what appeared to be a badly broken arm.[35] I find, upon the evidence of the forensic pathologist, that Mr Jones died from the head and neck injuries sustained when the dozer rolled over. He did not have any drugs or alcohol in his system at the time of the accident.

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[27] Police Subject Report to Coroner 3.
[28] Police Subject Report to Coroner 3.
[29] Police Subject Report to Coroner 3.
[30] C11: Collision Analysis Report Senior Constable Cordwell, 5; C8: Turnbull Affidavit 2.
[31] C8 Turnbull Affidavit.
[32] Ibid.
[33] Ibid.
[34] C10 Sergeant Taylor, 2; C3: Affidavit Cordwell.
[35] C13: Senior Constable Swinton Affidavit 2.

The engine of the dozer was still running at the time Mr Jones was found. The dozer appeared to be in neutral of the forward side direction. [36] Items located in the dozer included a ruptured fire extinguisher, a log book which only had two entries, and a hard helmet.[37] The helmet was not attached to Mr Jones' head and did not contain straps that would have secured it. [38] Based upon the location of the helmet, I find that Mr Jones either did not wear the helmet or the helmet was dislodged when the dozer rolled over.[39] It was noted that the interior of the cabin consisted of multiple hard steel surfaces.[40]

Dozer Inspection

An inspection of the dozer was conducted by Mr Jason Armstrong, Transport Safety and Investigation Officer with the Department of State Growth. He is a qualified auto mechanic with over 30 years of experience in the automotive industry. Inspection of the dozer revealed two main defects.

Firstly, Mr Armstrong found that the fuel control lever was non-compliant but that this did not contribute to the accident. Secondly, he found that the transmission displayed non-engagement of the neutral position after shifting from either forward or reverse positions into the neutral position.[41] Mr Armstrong was unable to conclude whether the defect existed before the accident or was a result of the damage sustained to the dozer when it rolled over.[42] This issue meant that when the transmission was shifted from either forwards or backwards into the neutral position, the dozer would continue to remain in motion instead of stopping.[43]

Mr Armstrong also noted that the dozer with was not fitted with a seatbelt.

Soil Analysis

Analysis of the condition of the track was conducted by Dr Richard Doyle and Evan Langridge, of Doyle Soil Consulting. Dr Doyle holds a PhD in Soil Science and is a Certified Professional Soil Scientist of the Australian Society of Soil Science. Evan Langridge is a soil scientist at Doyle Soil Consulting.

Testing of the soil was conducted 9 days after the incident. Dr Doyle and Mr Langridge formed the view that the condition of the soil was comparable to conditions on the day of

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[36] Ibid also see pictures.
[37] Ibid see pictures.
[38] Ibid.
[39] C11: Collision Analysis Report Senior Constable Cordwell, 7.
[40] Ibid.
[41] C14: Armstrong Affidavit 3.
[42] Ibid.
[43] Tab1: WorkSafe investigation.

the accident.[44] They stated that the strength of the roadway created varied depending on the distance from the inner cut into the hill. From 0-3.3metres from the inner cut, the road was considered to be of suitable strength for working a bulldozer for typical road construction operations.[45] From 4.0-4.3m from the inner cut, the ground was of more variable strength but able to hold the weight of the dozer. From 4.6m beyond the inner cut, the soil would not have supported the weight of the dozer.[46]

Dr Doyle also commented that the site appeared stable in relation to land-sliding and that the road constructed appeared to be of a high standard.[47]

WorkSafe Investigation

WorkSafe Tasmania conducted an investigation into the death of Mr Jones and I have available to me the WorkSafe investigation file completed by Senior Investigator Matthew Conway. Mr Conway considered that the dozer was suitable for conducting the type of work Mr Jones undertook.[48] I accept that this was the case. I also accept Mr Conway's conclusions that, on the face of it, Mr Jones had sufficient skill and experience to undertake the work. I also agree that weather conditions did not contribute to the accident. [49] Mr Conway considered that it would have been reasonable for the vehicle to have had a seatbelt, and one could have been purchased from Komatsu, the maker of the dozer.

Ultimately, Mr Conway formed the view that a range of factors that could have contributed to Mr Jones' accidental death. This included the uneven and rough terrain, the load-bearing strengths of the track, the defect in the gearbox (if it existed before the accident), the lack of a seatbelt and operator error (potentially due to Mr Jones' age).[50]

Comments

I find that Mr Jones was at his "workplace" when he died of unnatural causes. In coming to this conclusion, it is immaterial in this case that he was working for his own enjoyment without being paid. He was, in fact, working on behalf of the business operated by his son, Tony Jones Repairs. Tony was being remunerated for Mr Jones' work with the dozer. In finding that this is a workplace death, I have considered, but not accepted, the submissions of counsel for Mr Tony Jones received on 30 June 2023.

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[44] Tab 7: Road Stability Assessment, Dr Doyle 3.
[45] Ibid 5-6.
[46] Ibid.
[47] Ibid 6.
[48] Ibid 13.
[49] Tab 1: WorkSafe Investigation 9.
[50] Ibid 12.

Mr Jones' workplace death would ordinarily be required to be the subject of a public inquest pursuant to section 24 of the *Coroners Act* 1995 ("the Act"). I have received a representation from the senior next of kin, Mr Tony Jones, under section 26A(2) of the Act, that he does not seek an inquest be held. Additionally, I am satisfied that not holding an inquest under section 26A(3) of the Act, is not contrary to the public interest. I have therefore decided not to do so. However, I make the following comments.

Mr Jones was a competent operator of the dozer. Having regard to the evidence, it seems likely that Mr Jones operated the dozer too close to the soft edge of his recently formed track when attempting to dislodge the obstructing rock. This caused the dozer to roll over the edge and come to rest in the gully. It is possible that a pre-existing transmission defect caused the dozer to continue reversing whilst purportedly in neutral gear. It is not clear whether the transmission defect in the dozer existed before or after the accident, and I am unable to conclude that it contributed to Mr Jones' death. Weather conditions, drugs and alcohol did not play any part in the accident. It is possible that Mr Jones' age may have been a factor in his manoeuvring of the dozer, because of deteriorating faculties, but I cannot make a positive finding to this effect.

His injuries were exacerbated by the fact he did not wear a seat belt. I am unable to say whether he had worn his helmet, but consider that it may also have reduced the severity of his injuries if it was able to be properly secured to his head.

In its investigation, WorkSafe considered that the relationship between Mr Jones and Tony was one where Tony owed duties to Mr Jones to provide safe work systems and safe plant.[51] I agree with this assessment. WorkSafe therefore made the valid criticism of Tony that, as a person conducting a business undertaking, he did not create a Safe Work Method Statement (SWMS) for the high risk construction work undertaken by his father. Such a statement must, *inter alia,* identify the work, specify the hazards and risks, describe the measures to be implemented to control the risks and describe how the control measures will be implemented.[52]

Further, Tony Jones did not issue any other instructions to his father relating to the work. He did not consider that he should be categorised as an employee or contractor and therefore allowed him to work completely autonomously. Mr Jones was not subject to any policies or procedures (including relating to safety) imposed by the business. He did not have any discussion with Tony regarding the risks or safety precautions to be taken for the work. There were no set policies or procedures imposed by the business for the dozer operation.

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[51] Ibid 3. s 19(3) of the *Work Health and Safety Act 2012* (Tas).
[52] Reg 299 *Work Health and Safety Regulation 2022*

The dozer's logbook/maintenance schedule had not been kept up to date and there is no evidence it had been serviced as required.[53] I accept that Tony relied upon his father's vast experience, but he should have documented and implemented appropriate risk management and safety strategies as the person conducting the business undertaking.

It is not possible to say that Mr Jones' death would have been avoided if more attention had been given by Tony to the required safety aspects of the work, including the servicing of the dozer.

Perhaps a Safe Work Method Statement shared with Mr Jones may have alerted him to potential hazards of this high-risk work, despite his long experience.

I extend my appreciation to investigating officer Constable John McGuinness for his investigation and report.

The circumstances of Mr Maxwell Jones' death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Jones.

Dated: 23 July 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart

Coroner

[53] Ibid 14.