QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Walter Robert Greenfield**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2011/1892
DELIVERED ON:	26 August 2014
DELIVERED AT:	Cairns
HEARING DATE(s):	19 August to 21 August 2014
FINDINGS OF:	Jane Bentley, Coroner
CATCHWORDS:	Coroners: inquest, Cairns Regional Council, road work, line marking, Traffic Guidance System, Manual of Uniform Traffic Devices.

REPRESENTATION:

Counsel Assisting:	Ms Nerida Wilson, Counsel
Cairns Regional Council:	Mr Douglas McKinstry instructed by Williams, Graham, Carmen, Solicitors
Office of Fair and Safe Work Queensland:	Mr Paul Waltham
Mrs Lorna Greenfield:	Mr Bebe Mellick

Introduction

Section 45 of the *Coroners Act 2003* provides that when an inquest is held the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to officials with responsibility over any areas the subject of recommendations. These are my findings, comments and recommendations in relation to the death of Walter Robert Greenfield. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

These findings and comments:

- Confirm the identity of the deceased person, the time, place and medical cause of his death;

- Consider whether the actions or omissions of any third party, in relation to workplace safety, contributed to his death; and

- Consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Summary of the circumstances of Mr Greenfield's death

At the time of his death, Walter Robert Greenfield was 66 years old and lived with his wife, Lorna Greenfield. Mr Greenfield was an employee of the Cairns Regional Council and had been for approximately 23 years. He was the ganger (supervisor) of a road crew that conducted line marking on roads in the City area.

On 7 June 2011, Mr Greenfield and the other two members of his crew, along with a traffic controller, were working night shift. They were carrying out line marking of a turning lane leading from Pease Street into Jensen Street at Manoora. They were laying 'thermo lining' (thick paint with added glass shards) to indicate the start of the turning lane.

Traffic could travel north up Pease Street unimpeded and traffic cones only stopped traffic moving left into the turning lane until it got closer to the traffic lights.

At about 10.50pm Ms Mailee Sayaxang was driving her silver Toyota Rav 4 in a northerly direction on Pease Street. She had turned north from the Anderson Street roundabout into Pease Street. She failed to keep right and struck the traffic cones. Mr Greenfield saw the vehicle driving towards him and started to run to the edge of the road but Ms Sayaxang struck him with the centre front of her vehicle.

Police and Queensland Ambulance Service paramedics attended. Mr Greenfield was pronounced deceased at the scene at 10.59pm.

Investigations

Autopsy

Dr Paull Botterill, Specialist Forensic Pathologist, conducted an autopsy on 9 June 2011 and concluded that Mr Greenfield died from multiple injuries sustained when he was struck by the vehicle.

Dr Botterill noted:

Post mortem examination showed breaks of the pelvis, right thigh bone, breastbone, many ribs, neck and abdominal spine, collections of blood in the chest cavities, tears of the lungs and major chest blood vessels.

Testing for drugs and poisons was negative for drugs, including alcohol.

Witness Statements

Charles Scorey

Mr Scorey is an employee of the Council. On Tuesday 7 June 2011, Mr Scorey was rostered to work from 9.48pm until 7am the following day. Mr Scorey has been a Line Marking Operator for 15 years and worked with Mr Greenfield for the entire time. Giovanni Furnari had worked with them for about five years. Stephen Guignon had been their permanent traffic controller for at least six months prior to the accident.

Mr Scorey told investigators that there was no hand written plan in regard to set up procedures at the work site – they used a generic plan which is kept at the depot. They always set up the same way and using the same procedures. They discuss the set up at the site before they start. The traffic controller always put out signage before they started setting up the site. When the signs were out the traffic cones were put out.

Mr Scorey said there was plenty of lighting from the pole opposite Halligan Street and a second light pole two houses down from Halligan Street. The night was very clear.

After they had discussed the procedure for setting up, Mr Guignon set up the signs. Mr Furnari parked his truck on the shoulder of the North bound lane. The truck was facing the oncoming traffic. The amber rotating lights, on either side of the headboard behind the cab, and the hazard lights, were on. The arrow board on the truck was not turned on as it was their practice to turn it on only when they started work.

Mr Greenfield was putting out the traffic cones and Mr Scorey heard a car hit one of the cones and then looked up and saw Mr Greenfield as he was hit by the car. Mr Greenfield was facing the roadway and he jumped backwards just before he was hit.

Mr Scorey said that the foreman makes decisions about when they have traffic control on a job. The foreman is Chris Glynn and has been for about seven years.

Mr Scorey said that the team always discussed the job at the depot and then again at the site when they would reassess it. The signage is the first thing that is set up and the team checks the signage before they go onto the roadway. The cones would always be put out before the start of the job. They were put out from the start of the job so that drivers could see them from the beginning of the site. The person putting out the cones would stand facing the road so that they could move backwards off the road if required.

On the night of the accident there was no traffic at all so the crew set out the cones while the traffic controller went to the end of the job to continue with the signage. If there was traffic, the traffic controller would have stayed at the start of the job and directed the traffic whilst the cones were put out.

Mr Scorey said that during the day they have more traffic controllers on jobs. At night they are paid an extra 15% and have been told by the foreman that this means there is no money in the budget for an extra traffic controller.

Mr Scorey stated he believes that Mr Greenfield's death may have been averted if there had been another traffic controller on duty that night.

Mr Scorey said that it is extremely rare for their supervisor to come to their work sites. He has told the team not to call him at night. On the night of the accident Mr Scorey tried to contact the supervisor four times but he did not answer his work phone.

Giovanni Furnari

Mr Furnari was also rostered to work from 9.48pm on 7 June to 7am on 8 June 2011.

Mr Furnari parked the Council truck under the light post opposite Halligan Street.

Mr Furnari said that the traffic controller puts out the signs before they go onto the road. On the night of the accident Mr Guignon put out a '40 km/h' sign south of their location. Mr Greenfield put the cones out.

Mr Furnari was getting something out of the truck when he heard the cones being hit by a car. He turned and saw the SUV hitting the cones and driving towards Mr Greenfield and then he heard the car hit Mr Greenfield.

Mr Furnari thinks that Mr Greenfield was facing the road when the car struck him. He said that he cannot understand how the driver did not see the cones. There was plenty of room for her to drive past the job site and to have taken evasive action.

The traffic controller was setting up other signage when the accident took place.

Mr Furnari is a trained traffic controller. He said that the team had a meeting before going to the job site about what had to be done and how to do it. They also looked at the safety aspects of each job. They would discuss whether they needed more than one traffic controller and if they decided they did Mr Greenfield would make that request of Mr Glynn. Mr Glynn would usually agree.

Mr Furnari is of the opinion that they need two traffic controllers and better equipment including flashing traffic cones. He thinks that all safety decisions are made based on resources. Mr Furnari never saw their site supervisor on site at night.

Stephen Guignon

Mr Guignon has been a traffic controller with East Coast Traffic Control for about nine years. The Council sources traffic controllers from ECTC.

Mr Guignon is a qualified Level II controller – a qualification he has held for about nine years. He was on night shift on 7 June 2011 and engaged to conduct traffic control for the Council night line marking crew. He had worked with the crew for over six months.

Mr Guignon and the crew arrived at the site at about 10.30pm.

Upon arrival he discussed with the team the work to be carried out and the signage required. Mr Greenfield requested that the speed limit be reduced to 40 km/h. Mr Guignon said that he drew a mud map of the layout of the site. He then put the signs out:

- WORKMEN REDUCE SPEED 40 KM/H at the southern end of the job, under a street light about 50 metres from the work site;
- A small WORKMEN sign on Halligan Street;
- WORKMEN REDUCE SPEED 40 KM/H and END ROADWORKS 60 DRIVE SAFELY in Jensen Street;
- WORKMEN REDUCE SPEED 40 KM/H at northern end of work site and about 500 metres from work site;
- END ROADWORKS 60 DRIVE SAFELY opposite above sign.

When Mr Guignon finished putting out the signs he intended to go back to the work site and assist with traffic control and watch for cars. As he was returning he saw Mr Furnari waving and shouting. He parked his vehicle in front of the truck and saw that Mr Greenfield had been struck by a car.

Mr Guignon stated that he believes there should have been two traffic controllers on the work site at the time of the accident and that there should be at least two controllers on every work site.

Michael McFadden

At the time of the accident, Mr McFadden worked for the Council as the Manager, Cairns Works, and had done so since 1987.

Mr McFadden was responsible for supervising the coordinators of the work units including Paul Johnson. Mr Johnson was the coordinator for 'Maintenance Central' and within this unit; Chris Glynn was the person responsible for line marking and signage.

Mr Glynn is responsible for two line marking crews – he provides instructions to all of those under his control about what to do and how to do it.

The Council has Job Safety Analysis procedures (which have been reduced to documentation) for line marking that was developed in 2010. It refers to the Manual of Uniform Traffic Control Devices re signage and also refers to the use of warning devices and high visibility clothing.

The procedures for laying out thermo plastic are addressed on page 11 of the JSA. How to 'cordon off' a work site is addressed at page seven.

Every Council employee working on the roads has a Level 2 Traffic Management Certificate. Mr Greenfield, as the ganger on the job, was in charge of the site and would decide, with the traffic controller, where the signage would be put and who would put out the cones.

Mr McFadden said that the signage should be put out first, then the truck put in place and then the cones put out.

The complexity and size of the job determines the number of traffic controllers required. The decision is made on site and may change during the job.

Mr Glynn and Mr Johnson are responsible for monitoring the work crews.

Paul Johnson

At the time of Mr Greenfield's death Mr Johnson was the Acting Central District Maintenance Co-ordinator for the Council. He was Mr Glynn's supervisor.

Mr Johnson stated that Mr Glynn's duties included ensuring that all work sites were set up and controlled in compliance with the MUTCD.

He and Mr Glynn met once per week to discuss issues including workplace health and safety issues, budget issues and programmed works.

Mr Johnson regularly saw Mr Greenfield, whom he held in high regard, and his crew, at the depot.

Mr Johnson said that although Mr Glynn did not work night shift he was available to the night crew, at any time, via his mobile phone.

Since Mr Greenfield's death, there have been no line marking crews working at night.

Chris Glynn

Mr Glynn is the District Supervisor for line marking, signage and miscellaneous. He is qualified in Front Line Management and MUTCD Part 3 training level 1. Mr Glynn supervises 17 employees including two line marking crews.

Mr Greenfield, Mr Furnari and Mr Scorey were the dedicated long line crew. That crew carried out edge lines and centre line marking.

The JSA re line marking was developed in 2010 in consultation with a Workplace Health and Safety officer and the line marking crews.

Mr Glynn stated that he left it to Mr Greenfield to determine the number of traffic controllers required on jobs. If Mr Greenfield determined he required further traffic controllers he would contact Mr Glynn so that he could arrange it. Mr Greenfield, as ganger, was in charge of the site and the traffic controllers.

Mr Glynn doesn't work night shift. He doesn't know how the crew set up on the night of 7 June 2011.

Luke Boniface

Mr Boniface is a maintenance ganger with the Council and has been for about 18 years. He stated that he has always been able to obtain the number of traffic controllers that he considers are needed on a job.

Stephen Dry

At the time of the accident, Mr Dry was the Operations Manager, East Coast Traffic Control. At 11.16pm on 7 June 2011, he received a call from Mr Glynn who informed him that there had been a death on site and asked him to attend to assist investigating officers.

Mr Dry arrived on site at about 11.30pm. He spoke to Stephen Guignon and investigators and assisted with traffic control and securing the site. He marked the location of signage with paint so that the signs could be removed.

Bruce Gardiner

Mr Gardiner is the General Manager, Infrastructure Services, for the Council. He prepared a report summarising the work practices of the Council line marking crews.

Council utilises the MUTCD as the guideline for management for all such works. At the time of the accident Council had in place a generic Safe Work Method Statement (SWMS) for working on roads. The Central and Northern line marking crews had separate JSA processes which were recorded in documentation. There were two JSA – one for night work and one for day work.

All crew were trained in the SWMS and the JSA which had been developed in consultation with them. The JSA as at 7 June 2011 specified the steps to be taken prior to starting work:

- Pre-start briefing;
- Pre-start equipment check;
- Wear adequate hearing protection and PPE;
- Comply with MUTCD, traffic management plan and complete daily report and checklist of signage;
- Vehicles to have flashing lights;
- Workers and supervisors to wear high visibility garments in poor light;
- Undertake a visual inspection to check hazards and determine PPE and be aware of changes to work area and other plant and equipment working in the area.

There is currently a single SWMS for line marking works. The JSA are no longer utilised.

Council has also, since the accident, employed two dedicated Traffic Safety Offices to assist and advise staff, review traffic management practices, advise staff and management on latest developments and traffic safety related matters.

There are no limits on the number of traffic controllers that can be engaged for any job and it is up to the site supervisor to identify the number required.

If staff members wish to raise a safety issue they can do so with their direct supervisor, the elected Workplace Health and Safety Officer, the Departmental Workplace Health and Safety Officer, the Traffic Safety Officer or their other supervisors.

Council has a Workplace Health and Safety Committee and a Corporate Safety Committee which meet regularly and review all workplace incidents, hazards and rectification action plans. Safety issues can be tabled at these meetings and agendas and minutes are published broadly.

Council holds regular toolbox meetings with all staff where safety issues are discussed.

Bob Carnaby

After Mr Greenfield's death the Council commissioned a review by Mr Carnaby, an independent consultant, in relation to the provision of road marking services. The review examined Council road marking management practices and made recommendations for changes identified to improve efficiency, improve road marking conditions standards, increase life cycle, reduce risk to personnel and reduce the cost of maintaining markings.

Mr Carnaby recommended that line marking not be carried out at night. He also recommended that road markings activities be outsourced by the Council which would limit personnel's exposure to traffic by utilising vehicle mounted long line marking technology and therefore substantially reduce the risk to personnel working on the roads and the hazards to drivers that may be associated with road works.

Joy Bond

Ms Bond was the passenger in the vehicle which struck Mr Greenfield. She told police that the driver was not intoxicated and that they were talking at the time of the accident. She saw the truck and the 40km/h sign but did not see any flashing lights. She said it was dark at the location of the accident and she thinks that the driver did not see the cones. She said she saw Mr Greenfield and his orange shirt was the same colour as the cones. Mr Greenfield stood up as he saw the car approaching and moved off the road but the driver also drove in that direction and struck Mr Greenfield.

Ms Bond said that the radio was on low and the driver was not using her phone. Ms Bond said that the driver sometimes wore glasses but was not wearing them that night.

Record of Interview – Cindy Mai Lee Sayaxang

Ms Sayaxang told police that she turned right at the Anderson Street roundabout. She was talking to Ms Bond and then heard her car drive over the cones. She then went to pull over and she suddenly saw Mr Greenfield in front of the car. He was in a crouching run in front of her and she slammed on the brakes but she hit him.

Ms Sayaxang told police that she was not on any medication, she had not been drinking alcohol or taking illicit drugs and she was feeling fine at the time of the accident. She said that she sometimes wore glasses as she was short sighted but she was not wearing them at the time of the accident. She said that she was not aware that it was a condition of her driver's licence that she was to wear glasses when driving.

Ms Sayaxang estimated that she was travelling at about 50 km/hour when she was on Pease Street and slower than that when she hit the cones.

She told police that she saw the 40km/h sign but thought that it was left there from previous road works. She saw the truck with the flashing lights but didn't

realise that it was a work truck and thought it was a fire truck. She saw the reflectors of the traffic cones but they didn't really register before she hit them.

She saw some workmen at the truck and she was pulling over to apologise for hitting the cones when she saw Mr Greenfield in front of her.

Ms Sayaxang said that she thought the fact that she wasn't wearing her glasses contributed to the accident.

Report of the Forensic Crash Unit

The FCU of the Queensland Police Service investigated the death of Mr Greenfield and investigators concluded:

- Ms Sayaxang's vehicle had no defects which could have contributed to the accident;
- The accident did not involve the use of alcohol, drugs or excessive speed;
- Ms Sayaxang was travelling at a speed of between 46 and 52 km/h prior to braking;
- As she was travelling along Pease Street, Ms Sayaxang moved into the turn left lane;
- She collided with several of the traffic cones;
- She immediately applied her brakes but collided with Mr Greenfield who was attempting to get out of her way;
- Ms Sayaxang failed to observe the speed restriction signs, truck and traffic cones correctly and/or failed to understand their significance.

The investigating officer made the following recommendations:

- Setting up of such work sites should be done systematically:
    - Warning signs put out first;
    - Vehicles placed correctly with warning boards illuminated;
    - Traffic cones and items for use at the site placed last;
- Once signs are placed a traffic controller should man the approach points applicable for that site – that person should have the appropriate safety equipment and be in a position to warn the personnel working on the site of impending danger;
- A traffic controller could be required to protect workers setting up the site;
- No worker should be setting up vehicles, cones, tools or working prior to correct signage being placed and at least one traffic controller supervising approaching traffic.

Workplace Health and Safety Report

The Office of Fair and Safe Work Queensland conducted an investigation into the death of Mr Greenfield.

The Council was the principal contractor and in charge of the work site. East Coast Traffic Control Pty Ltd is a company which specialises in providing

companies and government departments with traffic control, labour hires and contract work. ECTC was engaged by the Council to conduct traffic control at the site of the accident.

The Council crew involved in the job consisted of Mr Greenfield, Charles Scorey and Giovanni Furnari. Stephen Guignon was the ECTC traffic controller.

Scene of the occurrence

All three council employees were wearing reflective clothing which is standard council issue. The traffic cones utilised on the night were fairly new, orange in colour with a reflective strip.

Inspectors concluded that the area was well illuminated, the night was clear and visibility was reasonable, even late at night. There was no other traffic on the road at the time of the incident. There is a set of traffic lights approximately 128 metres from the incident and another two street lights in the immediate area. There was a further street light near where the speed sign was erected. The road was in good condition.

The site set-up was as follows -

- A standard road sign had been erected on Pease Street, about 200 metres from the roundabout at the intersection of Pease Street and Anderson Road, Manoora, facing traffic coming from the roundabout which indicated that road works were being undertaken and that the speed limit was 40km/hr. This was the southern end of the work site.
- A Council work truck with an arrow board on it was parked near the speed sign and under a street light.
- Signage warning of the reduced speed limit had been set up along Jensen Street leading to the traffic lights at the intersection of Jensen and Pease Streets.
- At the time of the incident, Mr Greenfield was about 300 metres from the roundabout and 130 metres from the traffic lights at the intersection of Jensen and Pease Streets.
- Two other Council workers were in the vicinity of the work truck.
- All workers were wearing high visibility clothing with night reflection.
- The distance from the first safety sign to the first traffic cone was 78.24 metres and the distance to the site of the incident was 107.1 metres.

Investigators checked Council documentation and found:

- All the employees on site at the time of the incident had undertaken the appropriate training in relation to traffic management.
- The Council SWMS for work on or adjacent to a road was followed.
- One of the relevant JSA steps for line marking had not been undertaken prior to Mr Greenfield being struck i.e. a manual task risk assessment had not been completed as outlined in the procedures.

- Although there was only one traffic controller on the job that night, had Mr Greenfield, as ganger, considered that more were required he could have requested that and additional controllers would have been allocated.

In regard to the failure by the Council employees to comply with the JSA procedure in relation to the manual task risk assessment, OFSWQ issued an Improvement Notice to the Council.

The Notice required the Council to provide adequate supervision and monitoring of line marking activities on roadways to ensure compliance with formal systems of work to ensure workers are free from the risk of injury. Following the issue of the Notice, on 29 September 2011, the Council implemented a Rectification Action Plan for risk assessments to be carried out both before and after controls are implemented in relation to identified hazards.

The SWMS for Line Marking dated 20 October 2011 now specifies:

- That there must be site specific inductions for all workers and contractors prior to every job;
- There must be compliance with the MUCTD which is issued by the Department of Transport and Main Roads;
- Workers must be aware of changes to the work area and make appropriate modifications to operations;
- Incidents must be reported immediately to a supervisor;
- The site supervisor is responsible for ensuring that all control measures are adhered to;
- The site supervisor or ganger must conduct the on-going monitoring of the work area;
- A new Activity Plan for working on or near roads;
- The site supervisor must conduct a review process.

Further, the Council developed and prepared a Risk Management Worksheet identifying the manual task hazards associated with line marking activities and nominating control measures.

The Council workers have been trained in the new procedures.

It was noted that it was unclear whether the arrow board was operating at the time of the incident and it was recognised that it was possible that this was a contributing factor.

Further, the provisions of the MUCTD at the time of the incident did not require the traffic controller to have been in place with a “slow” batt prior to the Council workers setting out the traffic cones. It is now Council procedure that the traffic controller to be in place, with a “slow” batt, at the start of such jobs.

The investigation was concluded on the basis that the cause of the accident was the manner in which the vehicle that struck Mr Greenfield was driven and that the Council should not be prosecuted in relation to the incident.

Criminal investigation and prosecution

Mailee Sayaxang was charged with Dangerous Driving Causing Death and Failing to Comply with a Condition on her Licence (i.e. wearing prescriptive glasses).

Ms Sayaxang entered a plea of guilty to that charge and was sentenced in the District Court at Cairns on 25 September 2013 to two years imprisonment, suspended after six months for an operational period of two years and was disqualified from holding a driver's licence for a period of three years.

The Learned Judge sentenced Ms Sayaxang on the basis that she had failed to keep a proper lookout and drove dangerously for some distance. She had driven without wearing her glasses, failed to pay regard to the 40 km/h sign, didn't see the traffic cones, proceeded through them and continued until she hit Mr Greenfield who she did not see until it was too late to stop.

Mrs Greenfield's concerns

Following Mr Greenfield's death, Mrs Greenfield told police that the Council had reduced the number of traffic controllers allocated to jobs during the night shift and that Mr Greenfield and other employees were of the opinion that this placed them in danger and it was only a matter of time until someone was hit by a vehicle.

On 26 April 2012, Mrs Greenfield sent an email to the Council in which she raised the following concerns:

- The Council had cut costs by reducing the number of traffic controllers available to line marking crews;
- The fact that only one traffic controller was working on the site on the night of Mr Greenfield's death contributed to his death;
- The exit from Anderson Street roundabout should have been completely blocked off;
- A site safety plan procedure was not completed prior to work on site being commenced;
- On many occasions Mr Greenfield's manager would call him and direct him to reduce the number of traffic controllers on a job;
- Some time before 4pm on 6 June 2011 Mr Greenfield received a phone call at home, from a supervisor who told him he could only have one traffic controller on site that night – at that time Mr Greenfield had already arranged to have more than one traffic controller on the job site.

In May 2014, Mrs Greenfield sent an email to the Office of the Northern Coroner in which she stated:

- Mr Greenfield arranged for two traffic controllers to be present on the night of 7 June 2011 but his foreman, Mr Glynn, phoned him at about 4.30pm that afternoon and told him that he had cancelled one of the traffic controllers;
- Mrs Greenfield is aware of this conversation as Mr Greenfield activated the speaker on his phone and she heard the conversation. Mr Glynn stated, 'Mate, we've had to cancel one of your traffic controllers and you're only entitled to one.'
- Such conversations were a common occurrence;
- Mr Greenfield continually expressed his concerns in regards to safety and breaches by drivers to his supervisors and he was told not to report these incidents to police but to his supervisors and he was told that it was all part of the job and he should get over it.

The Inquest

A pre-inquest directions hearing was held on 23 June 2014. The parties appeared. Counsel Assisting advised that the issue to be explored at the inquest was the safety management for line marking crews at the Cairns Regional Council at the time of Mr Greenfield's death and at present. The inquest was listed to commence on 19 August 2014.

Ten witnesses gave evidence at the inquest and their evidence is summarised below.

Lorna Greenfield

Mrs Greenfield stated that for some time before his death Mr Greenfield regularly received phone calls from Mr Glynn at 4.30pm during which Mr Glynn would say that Mr Greenfield could not have the number of traffic controllers he wanted for various jobs.

On 7 June 2011, Mr Greenfield received a phone call from Mr Glynn at 4.30pm and Mrs Greenfield overheard the conversation as he put it on speaker phone. Mr Glynn told Mr Greenfield that he could only have one traffic controller that night as it was a quiet night and only one was needed.

Mrs Greenfield referred to the above phone call in her email to my office in May 2014 but did not in earlier correspondence. In earlier correspondence she stated that Mr Greenfield had received a call before 4pm on 6 June 2011 and afterwards Mr Greenfield told her that Mr Glynn had reduced the number of traffic controllers.

Mrs Greenfield stated that she believes that the Council reduced the funds available to pay for traffic controllers because of budgetary constraints.

Mrs Greenfield stated that she believes that the traffic controller should have been standing at the start of the job when the cones were put out.

Giovanni Furnari

Mr Furnari said that when he arrived on site on 7 June 2011 the traffic controller was not on site – he was already putting out signs further north.

Mr Furnari said that the arrow board on his truck was not activated when Mr Greenfield was hit. The traffic controller was still out placing the signage at that time. When he was struck Mr Greenfield was laying the thermo plastic. There were 10 to 15 metres to be laid out that night and they had completed about 12 to 14 metres. Before they started laying out the thermo plastic Mr Greenfield had put out the traffic cones. There was about 15 metres of cones laid out.

It would have taken Mr Greenfield about 15 to 20 minutes to lay out the cones and the plastic.

Mr Furnari said that when the traffic controller had finished putting out the signs he would stand at the front (southern end) of the job site with his slow batt. He should have been in place before they started work. They started work before he was there as they thought it was safe to do so.

Although that was not in accordance with procedure, Mr Furnari considered that what they did was safe.

Mr Furnari said that the night of Mr Greenfield's death was the only time the crew had started work without having the traffic controller in place.

Mr Furnari said that the crew generally had sufficient traffic controllers for their work sites. One was generally sufficient. He stated that he would not have started work if he thought that they needed more traffic controllers.

Charles James Scorey

Mr Scorey said that he and the crew discussed the job on site and at the depot before going on site. He said that the traffic controller, Mr Guignon, met them outside the depot and then they had a further meeting with him on site. He said that Mr Furnari arrived on site directly behind them. They had a generic site plan.

Mr Scorey said that the arrow board on the truck was not on but the hazard lights and rotating lights were.

Mr Guignon had put the signs up for the northbound traffic and they asked him to to go and put the signs out for the next part of the job which was to take place further down Pease Street.

The Traffic Guidance System (a map to be drawn by the traffic controller at the start of the job) was at the shed, it was not signed on site. He said if there was a map drawn up by Mr Guignon it would have been done at the site.

Mr Scorey said that the traffic controller would draw up the map of the site and they would sign off on it at the end of the night.

Mr Scorey said that their crew did not complete the Site Specific Induction Plan as Mr Glynn would not give them the documentation.

Mr Scorey believes that the crew complied with the JSA except for the fact that they sent Mr Guignon to work on the next part of the job.

Mr Greenfield had put out the cones and then they made the decision to start the work before the traffic controller came back on site. They made that decision because it was a clear night and there was little traffic.

Mr Scorey stated that he believes a second traffic controller could have averted Mr Greenfield's death. He said that they sent Mr Guignon to the other end to save time but it there had been two traffic controllers the second one would have been in place on the work site.

Mr Scorey said that it was common practice for that crew to commence work without having the traffic controller in place.

Mr Scorey said that Mr Glynn told him that as the night crew were paid a loading of 15% they could only have one traffic controller on their jobs.

Mr Scorey said that when they were at the depot Mr Greenfield had told him that Mr Glynn had phoned him that afternoon and told him that they could only have one traffic controller that night.

Mr Scorey said that he could not recall the last time he raised any safety issues with his superiors at the Council.

Mr Scorey agreed that his crew regularly failed to comply with safety procedures in order to save time on jobs. He stated that they did not want to stand around 'twiddling their thumbs' for half an hour waiting for Mr Guignon to return but then agreed that, in fact, they would have only had to wait 10 to 15 minutes for Mr Guignon to finish setting up the signs for that site. Mr Scorey could give no reason why the crew had not utilised the truck with the arrow board by placing that at the beginning of the job site before setting out the cones and starting work.

Stephen Guignon

Mr Guignon said that he usually drew the TGS after he had put out the signs and he would give that to the ganger at the end of the shift when he handed in his time sheet. He didn't have time to do that on 7 June as the accident had happened before he had finished putting out the signs.

He said that the crew should not have started work until he had put out the signage and returned to the site. It would have taken him about 15 to 20 minutes to put out all six signs. Mr Guignon could see when he was putting

out the signs that the crew had started work but he didn't say anything as he didn't think it was unsafe for them to do so.

At no time did Mr Greenfield tell Mr Guignon that he considered there should have been more traffic controllers on a job. If Mr Guignon had considered that there should have been more he said he could have ordered extra men through his boss, Mr Dry, and he could have done so without getting approval from any other person.

Mr Guignon said that it would have been safer that night had there been more two traffic controllers rather than only one as there would have been 'more eyes on the road'. Mr Guignon also said, however, that had there been another traffic controller that person would have been in the truck with him putting out the signs.

Chris Glynn

Mr Glynn stated that he had never refused a request for more traffic controllers. He said that Mr Greenfield was very safety conscious and had an excellent knowledge of the JSA and MUTCD.

Mr Glynn set out the procedures that should have been followed that night:

1. the crew would discuss the job with the traffic controller at the depot;
2. they would attend on site and the traffic controller would develop the Traffic Guidance System (a hand drawn map);
3. the crew should have completed the Site Specific Induction Plan (although this was never done by his crews as he was unaware of the requirement);
4. the traffic controller would put out the signs as per the TGS and then the cones;
5. the traffic controller would position himself at the start of the job;
6. the crew would commence work.

Mr Glynn said that if the crew were putting out the cones he would expect the traffic controller to be in place with his batt.

Mr Glynn denied that he had called Mr Greenfield on the afternoon of 7 June 2011 and produced his work mobile phone records which showed there were no calls made that afternoon. He said that he could not recall the last time he spoke to Mr Greenfield but that it was not in the immediate period before 7 June 2011.

Mr Glynn said that when he had heard that there were suggestions that he had cancelled a traffic controller on 7 June 2011 he asked Mr Dry if ECTC had any record of any traffic controllers being cancelled that day and there was no such record.

Mr Glynn said that he had never received requests from the crews or the union for more traffic controllers on job sites.

Mr Glynn said that although he was the supervisor of the night crew he had never done a site inspection at night. He agreed that such inspections probably should have been done but said that he had never raised the issue with his superiors.

Mr Glynn said that the TGS should have been signed off by both the traffic controller and the ganger before work commenced. That was not done on 7 June 2011.

Mr Glynn said that he did not answer his work phone at night as he finished work at 4pm.

Mr Glynn said that he had never been told by Mr McFadden that there was no money in the budget for traffic controllers, in fact, the line marking budget was underspent towards the end of the 2011 financial year and that is why the Council had decided to initiate night work.

Mr Greenfield's crew had never been criticised for under-performance – they achieved more work than the day crew. There was no pressure put upon them to work faster.

Paul Johnson

Mr Johnson stated that there were no budgetary constraints put on any safety measures. Neither he nor any other managers had ever questioned expenditure on traffic controllers.

Mr Johnson said that he had a good relationship with Mr Greenfield and his crew and would stop and talk to them in their shed at the depot. They knew they could phone him at any time. On one occasion Mr Greenfield phoned him and requested more traffic controllers on a job. That was some time ago and on a day job and there ended up being seven controllers on that job. He believed Mr Greenfield phoned him directly on that occasion instead of going through the usual channels because of the large number of controllers requested.

He said that Mr Greenfield and Mr Scorey were very safety conscious and if they had any concerns he would expect that they would have raised them with him. They had never complained to him about Mr Glynn refusing or cancelling traffic controllers.

Mr Johnson said that it was his opinion that the site of Mr Greenfield's death could have been adequately controlled by one traffic controller. He said the crew should not have commenced work until he was in place.

Surprisingly, considering his position and responsibilities at the Council, Mr Johnson stated that he was unaware of the Improvement Notices issued to the Council, how Mr Greenfield's death occurred and the level of supervision that Mr Glynn exercised over Mr Greenfield's line marking crew.

Mr Johnson said that random site inspections have increased since the Council employed two Traffic Management Officers, subsequent to Mr Greenfield's death.

The SWMS in regard to line marking, developed by the Council and reviewed since Mr Greenfield's death, now mandates that no traffic cones are to be placed on the road until the traffic controller has put out all signage and returned to the work site and is in place.

Michael McFadden

Mr McFadden said that gangers could order traffic controllers for a job themselves and didn't need any authorisation to do so. As at 7 June 2011 the road works budget was significantly underspent.

Mr McFadden said that, although the MUTCD and the JSA as at 7 June 2011 did not require a traffic controller on site, as Mr Guignon was there the crew should not have started work until he was in place with his slow batt or night wand. He is of the opinion that the traffic controller should have been in place prior to the cones being put out.

He said that Mr Glynn should have been supervising the crew and if they had not communicated for a lengthy period that would not be best practice. He believes that Mr Glynn did not have a good relationship with the crew but that Mr Johnson was very conscious of that and he would have endeavoured to address any issues which arose due to the conflict.

Mr Johnson said that the Council suspended night work after Mr Greenfield's death.

He thinks that it would be a very good idea to photograph or video sites when they are set up and before work commences.

Stephen Dry

Mr Dry was employed as Operations Manager by ECTC at the time of Mr Greenfield's death and he was Mr Guignon's supervisor. He said there was a standing order of one traffic controller for Mr Greenfield's crew. If extra controllers were required for a job they would be ordered. Mr Scorey would sometimes ring him and arrange for extra traffic controllers and sometimes Mr Glynn would do so but such requests usually came from the traffic controller on site.

Mr Dry had no requests for extra traffic controllers for the night of 7 June 2011 and there were no cancellations of traffic controllers for that evening.

Mr Dry said that, to his knowledge, there were no cutbacks in the Council budget in regard to road works and, in fact, he was told by other supervisors that there was an unrestricted budget for traffic controllers.

Mr Dry, a qualified Level 4 Traffic Controller, and now employed as the Traffic Safety Officer with the Council, set out the steps that Mr Greenfield's crew should have followed:

- TGS drawn up and agreed upon by the ganger and the traffic controller;
- Signs put out;
- Crew go on road.

Mr Dry said that whilst the signs were being put out the crew could be making preparations for the job off road but should wait for the traffic controller to return before going onto the road. The documentation (i.e. the TGS and the Site Specific Induction Plan) should be completed and agreed upon before work commences.

Mr Dry was aware that neither document was completed on the night of 7 June 2011. Mr Guignon told him that he hadn't done it as he wasn't back on site at the time of the accident.

Mr Dry said that, at the time of Mr Greenfield's death it was not unusual for crews to start work before the traffic controller had finished up but it was not best practice.

Bruce Gardiner

Mr Gardiner gave evidence that the SWMS which has been put in place since Mr Greenfield's death now mandates that no work is to be carried out and no cones are to be placed on the road until the traffic controller is in place.

Luke Boniface

Mr Boniface is a ganger in charge of a line marking team which works on the Northern Beaches. That team does not work at night due to lower levels of traffic in that area.

Mr Boniface stated that he has worked for the Council for 29 years and during that time has received much training in relation to line marking including traffic control and risk assessment.

Mr Boniface said that, as ganger, he is in charge of the work site and responsible for requesting traffic controllers. He said he has never had a request for controllers rejected by his supervisor. He is unaware of any budgetary restraints which have impacted on safety measures including availability of traffic controllers.

Mr Boniface said that prior to starting on a job, he and his supervisor draw up a plan and work out how many traffic controllers are needed. He said they usually come in pairs but sometimes he only has one on a job.

Mr Boniface is aware of the set up of the job site on which Mr Greenfield died and is of the opinion that one traffic controller would have been sufficient on

that site. However, Mr Boniface said that no work should have been commenced and no cones put out before the traffic controller had finished putting out the signage.

In relation to procedure, Mr Boniface said that the traffic controller draws up a plan of the site and then the ganger signs off on it. The signs are laid out then the cones are used to close off the lane and then the truck is put in place at the start of the job. The traffic controller should be in place with a bat before any work is undertaken.

Leisa Vagg

Senior Constable Vagg was a member of the Forensic Crash Unit that investigated Mr Greenfield's death. She said that the driver saw the signs at the southern end of the site and she saw that there was a truck with flashing lights and some people standing around but their significance did not register with her.

Snr Const Vagg said that had the traffic controller been in place with a slow batt it may have heightened her awareness that roadwork was taking place.

Snr Const Vagg said that the FCU investigators concluded that the following should be recommended:

1. the traffic controller should be in place before any workers go onto the roadway;
2. photographs or video footage should be taken when a work site is set up so that if there is an accident there will be an accurate record of the site for investigators. In this case the site was altered to make way for the ambulance, etc before police arrived.

Submissions

Ms Wilson submitted that the following recommendations were appropriate:

1. Ensure that line marking gangs do not commence work on the road way (including delineation set up) until all signs and safety measures have been put in place and the traffic controller returns to act as a spotter/ safety number.

2. Line marking operations are not to commence until the traffic controller gives approval.

3. Photographs or video of the work site are taken after all signage and safety measures are agreed between the ganger and the traffic controller, and prior to work on the road way commencing.

4. Spot checks or safety audits be conducted on line marking work sites to ensure compliance with relevant safety procedures and set up (including during night work if reinstated).

Ms Wilson noted that the first recommendation has already been implemented by the Council in that the new SWMS has incorporated that procedure. She submitted that I should make the remaining recommendations.

Mr McKinstry agreed with Ms Wilson.

Mr Waltham submitted that I should also consider the following recommendation:

1. That the Council engage an Occupational Health and Safety Officer to undertake risk assessment to clearly outline in one document the procedure to be adopted by line marking gangs (site specific risk analysis), including that signage and traffic cones are to be put out and the traffic controller be in place before any work on the road commences.

Comments, recommendations and findings

The scope of the Coroner's inquiry and findings

An inquest is not a trial between opposing parties but an inquiry into a death. The scope of an inquest goes beyond merely establishing the medical cause of death.

The focus is on discovering what happened; not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and, in appropriate cases, with a view to reducing the likelihood of similar deaths.

As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.

A coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable.

Proceedings in a coroner's court are not bound by the rules of evidence. That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

A coroner should apply the civil standard of proof, namely the balance of probabilities. However the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven.

If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner

must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant department. A coroner may also refer a matter to the Criminal Misconduct Commission or a relevant disciplinary body.

Comments

Mr Greenfield died at 10.59pm on 7 June 2011 from injuries he sustained when he was struck by a car. At the time he was struck he was working on the road on Pease Street at Manoora. He was putting out thermo plastic for line marking.

Mr Greenfield was the supervisor of a line marking crew which consisted of himself, Mr Scorey and Mr Furnari. Their traffic controller that night was Mr Guignon. He had been their regular traffic controller for about six months.

The crew met up at the Council depot before starting work that night. They didn't see Mr Guignon at the depot but met up with him at the work site. It is unclear whether they had any lengthy discussion in relation to the setting up of the work site but they had worked at that site together in the recent past and they may have already agreed on how it was going to be set up.

Mr Guignon put out the initial sign at the southern end of the job which warned drivers of the roadworks and reduced the speed limit to 40 km/hour. He then left, in his truck, to put out the six other signs required.

Whilst Mr Guignon was gone, Mr Greenfield placed about fifteen metres of traffic cones onto the road and then he and Mr Furnari started laying down the thermo plastic on the road. They had completed about 12 of the 15 one metre strips to be put down when Mr Greenfield was struck by a car.

The driver saw the initial sign but thought that it may have related to previous road works, she failed to see the traffic cones, veered into the left lane, hit the cones and then failed to see Mr Greenfield in front of her and struck him. When he was hit Mr Greenfield was moving towards the left, trying to get off the road.

The Council truck was parked off the side of the road. It was fitted out with an arrow board but that had not been turned on. The truck did have flashing lights and hazard lights activated. The driver saw the truck and some flashing lights and thought it may have been a fire truck.

At the time Mr Greenfield was struck Mr Guignon was returning to the site in his truck. He was waved down by Mr Furnari.

Before this inquest commenced it had been suggested by some of the witnesses that Mr Greenfield's death had been significantly contributed to, and/or caused by a lack of safety measures for Council line marking crews working on roads. In particular, allegations were made that Council had cut back on the number of traffic controllers that were available to such crews

and, on the night of 7 June 2011, a second traffic controller that was to be allocated to the job had been cancelled by Mr Greenfield's supervisors.

The evidence heard in this inquest does not support any of those contentions.

There were at the time, and are now, no budgetary constraints in relation to traffic controllers. Mr Greenfield, Mr Scorey and Mr Guignon had the authority to order more traffic controllers if they had believed that more were required. They could have done so before or after starting work on the site. They had worked at that site in the recent past and had a good knowledge of it and the safety requirements.

Neither Mr Greenfield nor Mr Scorey had, at any time, complained to supervisors, Mr Furnari, workplace health and safety representatives or union representatives about safety issues or lack of safety resources including traffic controllers. Mr Greenfield and Mr Scorey did not, any time, tell Mr Furnari that they had been refused extra traffic controllers.

The evidence has revealed that there was a standing order for one traffic controller on all of Mr Greenfield's jobs and none were ever cancelled. Certainly, there was no cancellation of a traffic controller on the night of 7 June 2011.

Mr Scorey, Mr Furnari and Mr Guignon all said, during the investigation and the inquest, that they believed the accident could have been averted if there was another traffic controller on site. This is not so. Firstly, they did not properly utilise the traffic controller they had on site. Secondly, the evidence revealed that one traffic controller was sufficient for that site. The work was not impacting on traffic on the other side of the road. If there had been a second traffic controller on site he or she would have been in the truck with Mr Guignon putting out the signs and then would have stood nearby the men working on the road.

Mr Greenfield's death was primarily caused by the driver who failed to comply with the road safety signs, failed to see the traffic cones and struck him. She admitted her guilt and has served a period of imprisonment.

Mr Greenfield, Mr Scorey, Mr Furnari and Mr Guignon failed to follow the Council policies and procedures for setting up and commencing work on line marking work sites and failed to utilise the safety measures that were available to them on site on 7 June 2011. These failures may well have contributed to Mr Greenfield's death.

The procedures were set out in the JSA which was current at that time and which had been developed in consultation with Mr Greenfield and other line marking staff. They provided for safety measures which were over and above the minimum requirements of the MUTCD.

The JSA required that a Traffic Guidance Scheme be completed by the traffic controller either before or after the signage had been put out and it be signed

off on by both the traffic controller and the ganger. That document was not completed and signed off on that night because Mr Greenfield had started work, and was struck, before the traffic controller returned to the site.

If the crew had waited for Mr Guignon to return and not started work until the proper documents had been completed and signed, Mr Guignon would have been in place at the time the car which struck Mr Greenfield drove into the site. Mr Guignon would have been standing in front of the cones, between the first road works sign and the traffic cones. He would have been standing in position before the point where the driver started to change lanes. It is unlikely therefore, as has been suggested, that she would have struck Mr Guignon.

The driver said that although she saw the first sign she did not know if it was current. If she had then seen Mr Guignon standing on the roadway, waving an illuminated batt, it is very likely that she would have realised that the sign was current and road works were underway which would have caused her to slow down and pay more attention.

Further, had the Council truck with the illuminated arrow board been on the road before the location where the work was being carried out, this would have served as a further warning to the driver and one which would have been difficult to ignore or misinterpret.

The truck was available to the crew and could easily have been moved onto the road. The crew did not think that such safety methods were required that night.

Had Mr Greenfield and Mr Scorey complied with the JSA and utilised the resources available to them it is likely that Mr Greenfield would not have been struck by the car.

It is clear that the Council is a responsible employer which takes workplace health and safety issues very seriously and does its best to protect its workers. Council line marking staff were more than adequately trained and had available to them safety equipment and measures over and above that required by the MUTCD.

However, it is also clear from the evidence adduced at this inquest that the Council did not ensure that Mr Greenfield's crew was following those procedures or implementing their training.

On 7 June 2011 Mr Greenfield and his crew did not comply with best practice and the JSA. One can be reasonably satisfied that this was not the first time they had worked in this manner. Their supervisors were not aware that they were not complying with the JSA for two reasons.

Firstly, Mr Glynn was not aware of the requirement that the Site Specific Safety Induction be completed. His lack of knowledge in that regard, however, did not contribute in any way to the accident. Had he enforced the

completion of that document it is unlikely that it would have been signed off before the end of the shift, as was the practice with the TGS which was being completed but signed at the end of the shift by Mr Greenfield's crew.

Secondly, there was no real supervision of Mr Greenfield's crew. Mr Glynn could not recall the last time he spoke to Mr Greenfield. Information about work was exchanged between Mr Glynn and the crew by the use of 'in' and 'out' trays. Mr Glynn, although directly responsible for supervising the crew, never visited their work site as he worked day shift and they worked night shift. Mr Glynn's supervisor, Mr Johnson, gave evidence that Mr Glynn was always available to the night crew. This was clearly not the case. Mr Glynn was not paid to be on call and finished work at 4pm.

Mr Johnson must have known that Mr Greenfield's crew were not subject to any supervision whilst working at night.

Had Mr Greenfield's crew been appropriately supervised including being subject to random on site inspections, which the day crews experienced very regularly, it is likely that they would have been more compliant with procedures in relation to documentation and better utilised the resources they had on site.

The Forensic Crash Unit investigators noted that, when they arrived at the scene, it had been disturbed to make way for the emergency services personnel. This made it difficult to establish exactly how the scene had been set up prior to the accident. I agree with their recommendation that sites should be photographed or video recorded prior to work commencing. As well as providing an accurate presentation of any scene at which an accident occurs, this will help to ensure that work is not commenced whilst the site is being set up and made safe for workers.

Recommendations

I make the following recommendations:

1. Photographs or video of the work site are taken after all signage and safety measures are agreed between the ganger and the traffic controller, and prior to work on the road way commencing.

2. Spot checks or safety audits be conducted on line marking work sites to ensure compliance with relevant safety procedures and set up (including during night work if reinstated).

3. The Council consider engaging an Occupational Health and Safety Officer to undertake risk assessment to clearly outline in one document the procedure to be adopted by line marking gangs (site specific risk analysis), including that signage and traffic cones are to be put out and the traffic controller be in place before any work on the road commences.

Findings required by s. 45

Identity of the deceased – Walter Robert Greenfield

How he died – Mr Greenfield was struck by a car whilst line marking on the road at night time, as an employee of the Cairns Regional Council.

Place of death – Corner of Pease and Jensen Streets, Manoora, QLD 4870

Date of death– 7 June 2011

Cause of death – Multiple injuries due to motor vehicle collision (pedestrian) against a background of coronary artery atheroma.

I close the inquest.

Jane Bentley
Coroner
Cairns
26 August 2014