QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

NON-INQUEST FINDINGS

CITATION:	**Investigation into the death of Wayne George MAPPERSON**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Southport
FILE NO(s):	2012/3489
FINDINGS OF:	James McDougall, Coroner
CATCHWORDS:	Coroners: head injury, fall, employment, Office of Fair and Safe Work Queensland, available evidence, concerns.

General Circumstances

Mr Wayne Mapperson was born on 21 November 1953, and died just short of his 59th birthday, on 25 September 2012 at the Gold Coast Hospital. Mr Mapperson was employed as a truck driver and forklift operator at a premises occupied by Australian Work and Leisure Canopies (AWL) that manufactured vehicle canopies.

I have received a letter from Mr Mapperson's daughter Melinda, written on behalf of herself, her mother Mrs Susan Mapperson, and her brother Mr Michael Mapperson. It is clear to me that Mr Mapperson was dearly loved by his wife and children, and that he is keenly missed. He had been married to Mrs Mapperson for 39 years. I have carefully considered the concerns expressed in this letter, and those concerns have substantially guided my coronial investigation.

In the circumstances which will be described below, Mr Mapperson suffered a severe head injury, and several other injuries, in the course of his employment, on 29 August 2012. He was taken to the Robina Hospital and later, once the extent of his injuries became known, he was transferred to the Gold Coast Hospital, where he was treated in the intensive care unit until it became clear that he was not recovering from his injuries. He was removed from the intensive care unit on the afternoon of 25 September, and died some hours later.

On my instructions, and at the request of Mr Mapperson's family, a full autopsy was not carried out. I am satisfied that the results of the external autopsy conducted by pathologist, Dr Little are sufficient to enable me to confidently make these findings. An investigation into this incident has been carried out by the Office of Fair and Safe Work Queensland (OFSW). The OFSW report has been made available to me, and has been of assistance. Ultimately, OFSW has determined not to commence criminal proceedings against AWL.

A key difficulty associated with the investigation of Mr Mapperson's death is that there are a number of important factors which are simply not known, as Mr Mapperson was alone at the time of the incident which ultimately led to his death. Consequently, in these findings, I will begin by outlining those matters which are known with reasonable certainty regarding this incident. I will then outline those matters which are not known, and indicate the implications of these gaps in our knowledge. Finally, I will set out the substantial concerns which arise in my mind on the facts presented in relation to Mr Mapperson's death.

Matters which are clear on the available evidence

It is clear to me, as a starting point, that Mr Mapperson had a fall while working at the AWL premises at 2/12 Hampton Road, Burleigh Heads, and that this fall caused his injuries. This was a finding of the autopsy report, and it is a convincing finding. The head injury was a fractured skull, with a multifocal bleed onto the brain. In addition, however, Mr Mapperson had fractured ribs, a fractured wrist, and bruising to his leg. I consider it implausible that anything other than a fall could have caused this collection of injuries. A falling object might, for instance, have caused the head injury alone, but would have been unlikely to cause the other injuries.

Second, it is clear to me that the injuries sustained in the fall led to Mr Mapperson's death. While Mr Mapperson was not otherwise in perfect health (he had, for instance type 2 diabetes) there is no suggestion that any underlying medical condition caused his death. His death arose principally from the pressure in his brain associated with the subarachnoid and subdural haemorrhage caused during his fall.

Third, it is clear to me that the medical intervention in relation to Mr Mapperson's injuries was appropriate, once he reached the Robina Hospital (I consider the issue of First Aid below). I have reviewed Mr Mapperson's medical records, and I see nothing to suggest that any different course of clinical intervention might have increased his chances of survival.

Finally, it is clear to me that the decision to palliate Mr Mapperson was properly taken once it became clear that Mr Mapperson was not going to recover from his injury. This decision was taken following appropriate consultation with Mr Mapperson's family.

Matters which are not clear on the available evidence

First, it is not entirely clear where Mr Mapperson fell from. The premises at Hampton Road include a mezzanine storage area, and immediately prior to his death Mr Mapperson had been engaged in lifting large items onto that mezzanine using the forklift. If this was the intended use of the mezzanine, then it was appropriate that the mezzanine had no barriers along its edge (as these would have prevented access via the forklift). It appears, however, that Mr Mapperson may have used a long ladder (which was not supplied by AWL, but located outside the premises) to access the mezzanine floor, perhaps to check the loads which he had just placed there by forklift.

On this basis, I find it is equally likely that Mr Mapperson fell from the mezzanine floor, or from the ladder itself. Nothing in his injuries, and no physical evidence at the scene, allows me to definitely understand which of these is more likely to be the case. I am satisfied that Mr Mapperson climbed the ladder to gain access to the mezzanine, and that he did so whilst alone. He may have fallen while climbing the ladder; he may have fallen from the mezzanine itself; and he may have fallen while descending the ladder.

Second, and perhaps most importantly, it is not clear what made Mr Mapperson fall. A number of possibilities exist. The three most likely are as follows:

a. The ladder may have slipped while Mr Mapperson was climbing. The ladder in question was a very tall, rigid ladder which (based on the photographs attached to the OFSW report) would have reached well past the mezzanine, and likely to the roof. It was not designed, and not suitable, for accessing the mezzanine, particularly by a worker doing so alone. The floor of the storage area, furthermore, had recently been painted and was regarded by AWL workers as being slippery.

b. Mr Mapperson may simply have slipped or lost his balance while moving around the mezzanine area. Photograph 3 attached to the OFSW report

suggests that there is little room for a person to move about, once the canopy moulds are moved onto the mezzanine by the forklift operator.

c. Mr Mapperson may have lost consciousness due to some other cause, whilst either climbing the ladder or whilst on the mezzanine. A range of medical conditions might cause a person to faint.

In addition, of course, the fall may have been caused by some further, unknown factor. Sadly, there is simply no way to tell what actually caused the fall.

Finally, it is not clear precisely when Mr Mapperson fell. It is clear that Mr Joel Frankham, who had been working with Mr Mapperson, left the warehouse to return to the AWL main premises for "smoko" but no specific time is indicated. Mr Mapperson was then discovered by Mr Robert Frankham around 11am. At that time he was dazed, but standing on his own. From this I infer that the fall had not occurred immediately before Mr Frankham's arrival. It may have occurred just a few minutes before, and it may have occurred perhaps thirty minutes prior to Mr Frankham's arrival.

I am concerned about this timing issue because the delay in learning that Mr Mapperson had fallen obviously led to a delay in him obtaining medical support.

This combination of circumstances – the matters which are, and are not known, lead me to a number of serious concerns in relation to the operations of AWL. I outline these concerns below.

Concerns emerging from these circumstances

a. *Why was this particular ladder in use?*

I am particularly troubled by the ladder which Mr Mapperson was using to access the mezzanine. This was clearly not the right ladder for the job. It was far too long, and there is no indication that it was properly secured at either the base or the top, as is necessary for a rigid or extension ladder. The ladder was, in fact, not even the property of AWL, but was found nearby. It had therefore clearly not been inspected or safety tested in any way.

It is clear, however, from the statement of Mr Joel Frankham, that the ladder had been used on several occasions to access the mezzanine floor. Mr Frankham stated *"while we were moving stuff into the new factory at Hampton Court we put some stuff up on the mezzanine floor. We had to climb a ladder which was at the factory and when I was there I would hold the ladder whilst Wayne climbed up and then he would hold the top of the ladder whilst I climbed up and vice versa when we got down."*

From this I infer that there was a regular need for workers to access the mezzanine floor, either to *"put stuff up on the mezzanine"* (Mr Joel Frankham's words) or to check on materials which had been lifted there by forklift. And yet, at the same time the Managing Director of AWL Robert (Bob) Frankham stated that *"there was no reason to get up on the*

mezzanine floor. All the property could have been fork lifted onto the floor."

Another witness, Bret Ireland, states that on the morning of the fall, he witnessed a conversation between Mr Mapperson and several other people, including Bob Frankham, and that in the course of that conversation Mr Mapperson stated that he was using a ladder to access the mezzanine floor. Mr Ireland also stated that there were other ladders available at the other AWL premises.

On the basis of this evidence, I do not accept Mr Bob Frankham's statement. I accept Mr Ireland's evidence that Mr Mapperson stated his intention to use a ladder to access the mezzanine. At this point, Mr Frankham should have either specifically directed Mr Mapperson not to access the mezzanine floor, or alternatively should have instructed him to obtain a suitable ladder and exercise appropriate safety measures for working at heights. It is clear that neither of these things occurred.

This is not to suggest that Mr Bob Frankham was responsible for the fall. However I do not accept that Mr Mapperson was engaged in unauthorised activity using unauthorised equipment.

b. Why was a staff member engaged in potentially dangerous work while alone?

The use of forklifts is a high-risk workplace activity in itself; the use of ladders to access the mezzanine floor, and activity on the mezzanine floor were also high risk activities. In my view, workers at AWL should have been forbidden to engage in this activity while completely alone. When Mr Joel Frankham left to return for "smoko" the implication should have been that Mr Mapperson must cease work until his return. Mr Mapperson's statement that *"he could manage by himself"* should not have been accepted.

Had another person been present at the time of the fall, Mr Mapperson could have received more immediate medical attention, and the treating medical staff would have had far superior information about the precise cause of his injuries.

I note the statement by Mr Ireland that Mr Mapperson was strong-willed and adamant that tasks should be done his way. I do not accept this statement. Mr Mapperson's bosses at AWL had a responsibility to maintain a safe workplace, and their responsibility was not vacated by their sense that Mr Mapperson was strong-willed. Simply put, they should have directed Mr Mapperson to comply with appropriate safety procedures, or they should not have continued to employ him. It is not acceptable for employers to tolerate unsafe work practices simply because an employee is regarded as strong willed.

c. Were sufficient first aid resources available?

On the basis of the injuries sustained by Mr Mapperson, it is difficult to be certain that timely first aid could have assisted. In addition, for inexperienced first aiders (even those with appropriate training) it can be difficult to identify traumatic brain injuries in the absence of external signs (such as external bleeding).

I note Mrs Susan Mapperson's specific concerns about why an ambulance was not immediately called for Mr Mapperson. On the evidence available to me, when Mr Mapperson was discovered by Mr Bob Frankham, he had no obvious injuries but was complaining about his shoulder. I accept that there was nothing in Mr Mapperson's condition to suggest to Mr Frankham that he had suffered a life-threatening injury. Mr Fankham's action in taking Mr Mapperson to the emergency room at Robina was appropriate in all the circumstances.

However this incident emphasises the importance, in workplaces engaged in dangerous activities such as the use of forklifts, or working at heights, of having sufficient trained first aiders, whose training is refreshed on a regular basis.

Should further action occur?

Under section 45(5) of the Coroners Act 2003, I must not include in these findings any statement that a person (which includes a corporation) is, or may be, guilty of a criminal offence, or civilly liable for any action.

Under section 48(2)(b) of the Coroners Act 2003, if I reasonably suspect that a person has committed an offence, I must give information about my suspicions to (in this case) the Chief Executive Officer responsible for OFSW Queensland.

I have noted the specific concerns of Mr Mapperson's wife, Mrs Susan Mapperson, to the effect that AWL should be held accountable for not having a safe work place. In response to Mrs Mapperson's concerns, it is appropriate that I carefully consider whether this matter is one which I should refer under s.48(2)(b), and clearly set out my reasoning.

A starting position is the fact that OFSW has already investigated this matter. This in itself is not determinative, and if I form the view that OFSW has not sufficiently considered relevant factors, then it remains open to me to refer the matter back to OFSW for further consideration of charges.

It is convenient for me to focus on the conclusions of the OFSW report, which are appropriately consistent with the reasoning in the rest of the report. In essence, the reasoning for not preferring charges is that there is no clear evidence to establish the cause of the head injuries which led to Mr Mapperson's death.

In making this assessment, the investigator would inevitably have been considering the criminal standard of proof: in other words, for charges to proceed the investigator would have to be convinced that every element of the charge could be proven beyond reasonable doubt. If it is even reasonably possible that Mr Mapperson's head injuries could have been caused by something other than

unsafe work practices, then any charges would be unsustainable.

In these findings I have found that Mr Mapperson's head injuries were caused by a fall. I am not required to apply the criminal standard of proof, but rather the civil standard of proof. In other words, I am only required to be convinced that it is more likely than not that my conclusions are accurate. It will be appreciated that this is a lower standard than is required in criminal proceedings.

And yet, even applying this lower standard of proof, I have been unable to satisfy myself as to key aspects of Mr Mapperson's injury. I have been unable to determine whether he fell from the ladder or the mezzanine. I have been unable to determine the cause of his fall. Without answers to these questions, I agree with OFSW that any charges would ultimately be bound to fail.

That being the case, I do not reasonably suspect that any person has committed an offence for which there is any prospect of a conviction. I will not be making a referral under section 48(2)(b). I recognise that this will cause substantial disappointment to Mr Mapperson's family; however their disappointment would not be lesser if charges were laid, and an acquittal followed (as it almost certainly would).

Formal findings

In accordance with section 45(2) of the *Coroners Act 2003* I find:

a. The deceased person is Mr Wayne George Mapperson.

b. Mr Mapperson died from a multifocal bleed into his brain, the effects of which could not be controlled despite surgical intervention.

c. Mr Mapperson died on 25 September 2012.

d. Mr Mapperson died in the Gold Coast University Hospital in Southport in the State of Queensland.

e. Mr Mapperson died from injuries caused in a workplace fall on 29 August 2012. The broader circumstances of his death are outlined in my reasons above.

James McDougall
Coroner
Southport
20 February 2015