QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of** **Olivier Max CARAMIN**
TITLE OF COURT:	Coroners Court Queensland
JURISDICTION:	CAIRNS
DATE:	20 August 2021
FILE NO(s):	2017/4872
FINDINGS OF:	Nerida Wilson Northern Coroner
CATCHWORDS:	CORONERS: overseas national; working holiday; Visa; farm work; labour hire; pumpkin picking; death as a result of heat stroke; failure to implement adequate controls; *Work Health and Safety Act* 2011; Magistrates Court prosecution; Safe Work Australia; Managing Risks of Working in Heat; Employer Obligations to Workers and Foreign Nationals; Harvest Trail Inquiry report.

Contents

1. The deceased, Mr Olivier Max Caramin was born on 18 January 1990 and died on 1 November 2017, aged 27 years.

2. On 22 January 2021 I issued written findings (20A Coroners Findings and Notice of Completion of Coronial Investigation)

3. As a result of submissions received on behalf of Mr Caramin's family and the conclusion of workplace prosecution proceedings I have determined that the coronial investigation should be re-opened for the purpose of updating my original findings. Accordingly, these are my revised findings.

Background

4. Mr Caramin, a Belgian national was travelling in Australia on a Working Holiday (Temporary) (class TZ) Working Holiday (subclass 417) Visa granted on 24 August 2017. Mr Caramin entered the country on 19 September 2017.

5. On 27 October 2017, Mr Caramin checked in to the Delta Back Packers, a Hostel, located on Queens Street at Ayr. On 28 October 2017 he commenced employment with Bradford Clark Rosten, a sole trader operating a labour hire contract business that coordinated and organized heavy produce harvests for clients.

6. On Sunday, 29 October 2017, Mr Caramin worked picking watermelons at Ayr between 6:30am and 2pm.

7. On Monday, 30 October 2017, Mr Caramin worked on a farm ("the Fredericksfield Farm") leased by Michael and Leigh Zabala as trustee for M&L Zabala Investments Pty Ltd (hereinafter referred to as Zabala) picking pumpkins between the hours of 7am and 2:30pm. The day was described as hot, with little shade available. Mr Caramin was observed to be tired and ill-prepared for the work, having limited food and drink with him.

8. On Tuesday, 31 October 2017, Mr Caramin returned to pick pumpkins at the Fredericks field farm at Home Hill. There was limited shade available and colleagues reported that the temperature and humidity on the day as "*extreme*". Mr Caramin was wearing a singlet and shorts but no hat.

9. The agreed statement of facts tendered in Magistrates Court proceedings describes the following:

Workers observed that from the outset of the day, Mr Caramin was struggling to keep up with the pace of the work, and at around 2.30 to 3 pm, he became delirious and commenced acting erratically, jumping on the trailer, running around the field, flaying his arms about, stumbling, staggering around, and that he ran across the paddock where they were working, subsequently collapsing, convulsing, and becoming unconscious. Mr Caramin did not appear to be sweating.

The workers attempted to render assistance to Mr Caramin and requested emergency services to attend. Attending ambulance officers noted that Mr Caramin was hot to touch, unconscious and his temperature was recorded as 48 degrees.

10. A call to Triple 0 was initiated and consequently Mr Caramin was transported by ambulance to the Ayr Hospital.

11. Mr Caramin was then transferred to the Townsville Hospital where was admitted at about 6:49pm. The clinical impression was consistent with heatstroke, diffuse cerebral oedema, likely secondary to hypoxic-ischaemic encephalopathy. CT imaging of the brain showed homogenisation of brain architecture and descent of the cerebellar tonsils, most likely reflecting heat stroke with collapse. Despite medical interventions, Mr Caramin's condition continued to decline. He was declared deceased at 4:52am on 1 November 2017.

Post mortem examination

12. A post-mortem examination performed on 7 November 2017, confirmed Mr Caramin's cause of death at multiple organ failure, due to or as a consequence of heat stroke.

13. I accept and adopt that cause of death for the purpose of these findings.

Office of Industrial Relations Investigation

14. The Office of Industrial Relations (OIR) investigated the circumstances of Mr Caramin's death.

15. The OIR investigation identified the following significant factors:

    i. For the period between 6:30am and 3pm on 31 October 2017the "average apparent temperature" was 32°C in the shade and 40°C in the sun. As at 10am the apparent temperature had reached 33°C. The rate

of work was considered "*moderate*" and the equipment being used for harvesting provided "*poor quality shade and inadequate protection from direct and indirect solar radiation*".

ii. The shifts Mr Caramin was working (7.5 hours), without physiological adaptation to the level of heat stress in the working environment, placed him at risk of a heat-related illness. The OIR further identified there was pressure being placed on the workers to continue picking and packing pumpkins notwithstanding a number of workers raising concerns about the environmental conditions on the day.

iii. There is no workplace exposure standard or limit for heat stress. Variability in the nature of the task, surrounding environment and individual physiological characteristics and capabilities, is such that it is not possible to set a standard or limit based on ambient air temperature.

iv. The employer's failure to adequately asses the environmental conditions and working in the direct sun with little to no shade was a significant contributing factor to Mr Caramin's death.

v. Mr Caramin was just three days into his fruit picking job during summer in Far North Queensland.

vi. Mr Caramin was not properly acclimatized or adapted to the heat at the time of his death, which was considered to be a significant contributing factor to his death. The OIR proposed an acclimatization plan so that workers can adjust to a new climate.

vii. There was no safe work procedures that addressed the risk of working in an outdoor environment "other than" to wear sunscreen, a wide brimmed hat and appropriate clothing for sun protection. No PPE was supplied to the workers; they would usually supply their own, including gloves, sunscreen and hats. The OIR also identified that there was no trained dedicated first aid officer on site amongst the work crew.

viii. That very little shade was available that day and no cool area where workers could take breaks.

ix. An absence of risk assessment or safe work procedure, and inadequate training provided to workers. Mr Caramin himself received no induction at the time he commenced employment from his employer.

16. Workplace Health and Safety Qld have since issued improvement notices.

17. I am satisfied, based on the OIR report to me that steps have since been taken to change workplace practices.

Workplace Health and Safety Prosecution

18. I am precluded from making any comment that a person is, or may be, civilly or criminally liable for something, however it is useful to provide a summary of the Workplace Health and Safety Prosecution and outcome below.

19. A Workplace Health and Safety Prosecution against Bradford Clark Rosten (Rosten), a labour hire contractor, concluded on 2 October 2020 when he entered a plea of guilty and was sentenced and ordered to pay a fine of $65,000.

20. Subsequent to that prosecution, an authorised family representative acting on behalf of Mr Caramin made a request under section 231 of the Work Health and Safety Act 2011 (**WHS Act**) to the Work Health and Safety prosecutor (**WHSP**) that he also consider prosecuting Michael D and Leigh Ann Zabala as trustee for the M & L Zabala Investments Pty Ltd (**Zabala**) for breaches of the WHS Act which lead to Olivier's death.

21. As a result the WHSP commenced a prosecution against Zabala for a category 2 offence under the WHS Act. The charge against Zabala alleged that it failed in its duty under s.20(2) of the WHS Act to ensure that the workplace (the farm that it operated) was without risks to health and safety of any person. In particular it was alleged Zabala failed to provide shade reasonably proximate to the workers (including Olivier) engaged by Rosten.

22. Zabala entered a plea of guilty to the offence of Failure to Comply with Health and Safety Duty and was sentenced in the Magistrates Court of Queensland on 3 June 2021. Zabala was fined $100,000 and no conviction was recorded.

23. The prosecution case relied on the Workplace Health and Safety Queensland (**WHSQ**) investigation which identified:

a) There was no nearby area provided for workers to rest and shade themselves from direct exposure to the sun, and
b) The trailer and conveyor attachment did not have shade structures installed thereon.

24. A report obtained from a heat related illness expert Dr Rosario Dr Corleto (for the purpose of the WHSQ prosecution) considered the potential of heat induced illnesses occurring if the conditions were not addressed. This report outlined

the safety controls that could have been implemented to address the risk including:

a) The provision of shade for rest areas;
b) A thermal risk assessment;
c) The provision of training in relation to heat stress management; and
d) Rescheduling picking to cooler parts of the day.

25. At the time of Olivier's death Zabala P/L was of the view that no duty was owed because of the labour hire arrangement with Rosten. Zabala subsequently admitted that it owed a duty to ensure that the workplace was without risk to the health and safety of any person.

26. The sentencing Magistrate had regard to the fact that Zabala was in exclusive control of the workplace and could not diminish his responsibility through the use of contractors. The Magistrate accepted that under the (*Work Health and Safety*) Act the duty to ensure the safety of workers cannot be delegated.

27. The Magistrate took into account steps Zabala had taken to improve workplace practices including improvements to the trailers to include shade and the company Director's closer contact with workers including organising additional training for all pickers on the defendant's farm.

28. Zabala's failure to provide shade areas for workers was a factor which directly contributed to Olivier's death.

29. The sentencing Magistrate also took into account (with reference to the transcript of proceedings) the following:

In addition to that (guilty) plea, I also take into account the cooperation of the defendant, the prosecuting authority, the significant remedial steps which would have been – which have been taken by the defendant, the amount of the fine as imposed upon his contractor Rostin, although acknowledging a significantly different maximum penalties applied between the two, the fact that the Directors are deeply remorseful, and the steps taken to assure something like this is never to happen again.

It is also noted the apology by the Director of the company through their counsel for the incident and any oversight is also noted and take into account the Directors are deeply upset that Mr Caramin in the circumstances, was left to work without a proper supervisor.

Balancing all of these matters together with the factors outlined by the prosecution, I am of the conclusion that although the seriousness of the

offence and its obvious tragic outcome would certainly warrant a fine in the vicinity submitted by the complainant, after considering all of the mitigating factors and balancing the issues giving due weight to the relevant sentencing guidelines, that a fine of $100,000 referred to SPER is appropriate and the defendant is accordingly fined that amount.

Soon after Olivier's death Safe Work Australia published information in December 2017 *Managing the risks of working in heat – Guidance Material*. It provides guidance to those with a duty to protect the health and safety of workers working in heat. The factors which have been found to have contributed to Olivier's death are identified as risks that must be managed by workplaces.

Expert report – Dr Rosario Di Corleto

30. I have the benefit of the report tendered in Magistrates court proceedings and extract below the summary and conclusions of Dr Di Corleto;

With the author's knowledge and experience and referral to photographs, detail supplied, and calculations based on the data available, it is clear on the basis of information provided that there was significant opportunity for the occurrence of a heat related illness to occur.

The report suggests that whilst some controls were provided on the day that may have mitigated the risk, there were a number of interrelated factors that contributed to the final consequence. It is necessary to give employees an appropriate skills and knowledge base so that they can demonstrate the appropriate behaviours in the workplace. This training must be supported where applicable by appropriate equipment, documented work methods and audit protocols to ensure that the desirable behaviours are sustainable over time.

Workplace Safety Assistance Unit

31. The Workplace Assistance Safety Unit attended the workplace and after assessment a Business Improvement Plan was developed with the employer (Bradford Rosten, Pumpkin Pickers). Mr Rosten has since engaged Act Safe to improve existing work practices and procedures.

Harvest Trail Inquiry

32. During the course of the coronial investigation I have had regard to the '**Harvest Trail Inquiry'** conducted by the Commonwealth Fair Work Ombudsman, the findings of which were published in 2018. I accept that young foreign nationals have a particular vulnerability in (Australian) agricultural workplaces.

33. The Harvest Trail Inquiry focused on non-compliance with Australian workplace laws rather than workplace health and safety. The findings of the inquiry included that there was a negative impact on workers where labour hire arrangements were used (as was the case here).

Findings required to be made by Coroner

34. Pursuant to section 46(3) of the *Coroners Act* 2003 I must not make any comment or statement that a person is or may be:

a) Guilty of an offence; or
b) Civilly liable for something.

35. Pursuant to section 45(2) of the *Coroners Act* 2003 I am required to make the following findings:

a) The identity of the deceased;
b) How the person died;
c) When the person died;
d) Where the person died;
e) What caused the person to die.

36. I find that Olivier Max Caramin a 26 year old Belgian national, whilst on a working Visa, died on 1 November 2017, at the Townsville Hospital, as a result of multiple organ failure, due to or as a consequence of heat stroke whilst lawfully engaged in work as a fruit picker on 31 October 2017.

37. The failure to properly identify the risk of heatstroke and the failure to implement adequate controls exposed Mr Caramin to the risk of death.

38. Mr Caramin's death was preventable.

Application for Inquest

39. By letter dated 29 January 2019 I was informed of concerns held by Mr Caramin's family regarding the circumstances of his death. His family requested that an Inquest be held. The family have since had the benefit of the OIR report, and the Work Health and Safety prosecution has concluded. Those proceedings have now concluded.

40. The family considered there public interest factors were enlivened in this case, particularly the ability of a Coroner to make recommendations that would address the failings identified by the OIR.

41. Ultimately I am satisfied with reference to the material and information before me including, the Office of Industrial Relations Fatality report; the WHSQ Prosecution; and ancillary material such as the Harvest Trail Inquiry Report that I have all the evidence I require to make findings pursuant to s.45 of the *Coroners Act* 2003 and as such an inquest would not assist this investigation further.

Publication of non-Inquest findings

42. The next of kin via their legal representatives, Caxton Legal Centre (Coronial Legal Service) submit that it is in the public interest to publish non Inquest findings on the Coroners Court website.

43. I accept those submissions and direct that these **8** page findings into the death Olivier Max Caramin be published on the Coroners Court of Queensland website.

Condolences

44. I extend my sincerest condolences to Mr Caramin's parents and his family for their devastating loss. It is an absolute tragedy that a young man on a working holiday in Australia died in circumstances that were wholly preventable.

Acknowledgements

45. I acknowledge Olivier's aunt Hilde Van Praag Byrne, who resides in Australia and who, on behalf of Olivier's parents (located in Belgium), has staunchly advocated for accountability and reform within the Australian horticultural industry relevant to employer obligations to foreign nationals on working visas during the seasonal harvest.

46. I acknowledge and thank Caxton Legal Centre (Coronial Legal Service) for the submissions provided to me on behalf of Ms Van Praag Byrne and for their assistance to the coronial investigation.

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Nerida Wilson
Northern Coroner
CORONERS COURT OF QUEENSLAND
NORTHERN REGION
20 August 2021 (revised).