TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

HILLAN Coroner

TOWN-COR-00000083/06

IN THE MATTER OF AN INQUEST INTO THE CAUSE AND CIRCUMSTANCES SURROUNDING THE DEATH OF PETER GABIOLA

TOWNSVILLE

..DATE 19/03/2007

FINDINGS

CORONER: Having had all the evidence adduced before me I have considered that evidence now and am prepared to hand my findings down.

My findings are as follows: I find that the name of the deceased was Peter Gabiola, a male, then aged 41 years, late of 4 Valencia Court, Kirwan.

The deceased was an employee of a labour hire company, namely Skilled Engineering Limited. The deceased was hired out to the Townsville City Council and worked as a plant operator and maintenance worker at the Citiwater Department, Cleveland Bay purification plant for the past nine to 10 months.

That he died on the 23rd of July 2003 at approximately 3.30 p.m. at the Cleveland Bay purification plant, 999 Racecourse Road, Cluden as a result of injuries sustained during the course of his employment as a plant operator.

On the 23rd of July 2003 the deceased was operating a tractor outside the treatment plant grounds. The tractor was a John Deere tractor 5300, with a front bucket and a slasher attachment. This machine was owned by Fleet Services at the Townsville City Council.

At approximately 3 p.m. on that date the deceased was observed driving the tractor back towards the water treatment plant. The slasher at that time was in the up position.

The deceased's supervisor, Mr Morris, returned to the plant at around 4 p.m. when he noticed that the tractor was parked in the shed. It was reversed in and the slasher was still connected and appeared to be up on blocks.

At first, Mr Morris could not locate the deceased. After a further check he found the deceased with part of his torso and his legs sticking out from under the slasher. Morris had called out to the deceased and received no answer.

Morris ran to the office to get help from another worker, Mr Luck, and called the ambulance. Mr Luck and Mr Morris ran back to the shed. A short time later the fire brigade and ambulance officers arrived together with officers from the police service, and Workplace Health and Safety.

Mr Luck started up the tractor and operated the hydraulics in order to lift the slasher off the deceased and move the tractor forward. Checks were made of the deceased, but unfortunately the injuries he suffered had caused his death.

I find that during the course of operating the tractor/slasher, barbed wire had become entangled around the shaft of the slasher.

I further find that the deceased had reversed the tractor/slasher back into the shed and lifted the slasher up so he could place blocks underneath it.

I find that the deceased lowered the slasher onto the cement blocks and timber, giving him some room to crawl under the slasher to remove the barbed wire with a pair of pliers.

After lowering the slasher, I find that the deceased had turned the tractor to the off position.

I find that as the deceased attempted to remove the offending barbed wire, the movement caused the blocks to become unstable and the slasher collapsed as a result, causing the deceased to be pinned, with the result that his chest was crushed under the weight of the slasher.

I find the cause of death was:

(a) traumatic asphyxia, due to;

(b) compression by slasher.

I find that the policy of the Townsville City Council was that all repairs or work on machinery needed to be reported to the supervisor, who would in turn report it to Fleet Services, that is a division of the Townsville City Council, for their attention. That maintenance of machinery was left to the operator's attention.

I find that, Mr Morris, of Citiwater, Townsville City Council had informed the deceased of the council's policy in this regard.

I find that the deceased had failed to inform his supervisor of the barbed wire problem, and that the deceased had proceeded to chock up the slasher himself, contrary to that instruction.

From the evidence, it has also revealed that the only tests carried out at the request of Mr Dare of Workplace Health and Safety on the hydraulics of the slasher was when Mr Luck of Citiwater performed a test shortly after the incident.

Mr Luck had started up the tractor and operated the hydraulics to lift the slasher to a mid position off the ground and left the slasher in that position for approximately 15 minutes. The hydraulics did not fail on that occasion.

Another test was requested by Mr Dare to be carried out which was carried out by a Mr Mulder and Mr Wilson of Fleet Services; bearing in mind these are employees of Townsville City Council who operate the machinery, and the result of that test was reported in Exhibit 10. I do not need to go into that exhibit, it speaks for itself.

However, there is no independent mechanical inspection carried out which may assist this Court. The only tests that were carried out were by city council employees, and the owner of the machinery was the Townsville City Council. So I do not have any independent mechanical inspections carried out.

Mr Dare informed the Court that his department does not have the facilities to carry out mechanical inspection. To my mind this does not assist the Court in any way. I recommend that in future where the Department of Workplace Health and Safety is investigating a death which resulted in the use of machinery, that independent mechanical inspections be carried out and reports prepared for the consideration of the Coroner.

From the evidence adduced, some of it is self-serving I might add, I am unable to find with any degree of certainty whether or not the hydraulic system of the tractor had failed on this occasion.

And from the evidence adduced before me, I find no evidence upon which to commit anyone for trial for an indictable offence.

The inquest is now closed. And I thank your attendances.
