OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Katherine Alison Jones**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Maroochydore
FILE NO(s):	COR 3019/05(5)
DELIVERED ON:	4 December 2006
DELIVERED AT:	Maroochydore
HEARING DATE(s):	29 & 30 November 2006
FINDINGS OF:	Coroner Killeen
CATCHWORDS:	CORONERS: Inquest – automatic sliding gates, workplace health & safety

REPRESENTATION:

Assisting the Coroner	Snr Sgt A J Hurley
Savills Lawyers	Mr G P Long i/b Gadens
Perpetual Limited as trustee for Macquarie Group	Mr A A J Horneman-Wren i/b Hall Payne Lawyers
Magic Door Industries	Mr David A Jesser (McInnes Wilson Lawyers)
Family	Mr Gerard O'Driscoll (of Hall Payne Lawyers)
Imperial Protection Service and Kevin Rynne	Mr Peter G Boyce (Butler McDermott & Egan Nambour)

Introduction

In respect to this matter, I propose today to deliver my findings into an inquest into the death of Katherine Alison Jones.

Brief facts

On the 10th of December 2005 Katherine Alison Jones was employed by Robert James Duggan and Rosemary Duggan trading as Duggan's Cleaning Service as a cleaner at the Nambour Plaza Shopping Centre situated Howard Street, Nambour, in the State of Queensland.

Duggan's Cleaning Service is contracted by Macquarie Country-wide Management Limited and Savills Queensland Pty Ltd was the superintendent and supervisor of the cleaning contract. Macquarie Country-Wide Management Limited was the responsible entity, managing the day-to-day operations of the Macquarie Trust properties, including the Nambour Plaza Shopping Centre.

Macquarie Asset Services Limited supply services to Country-Wide Management Limited and manages and oversees the financial operational aspects of the Nambour Plaza Shopping Centre. Savills Queensland Pty Ltd has a contract with Macquarie Asset Services Limited to manage the Nambour Plaza Shopping Centre. KMB Investments Pty Ltd trading as Imperial Protection Services was the security firm appointed by Savills Queensland Pty Ltd to protect the Nambour Plaza Shopping Centre.

Part of the security firm's employees' duties included closure of the Howard Street security gates in the evening. Magic Doors Industries Queensland Pty Ltd installed the control circuitry components for the Howard Street gates and conducted maintenance on the gates on a continual basis after installation.

The incident

On the morning of the 9th of December 2005 the eastern gate of the Howard Street security gates at the Nambour Plaza Shopping Centre could not be fully opened and became jammed. CCTV security footage reveals about 9.40pm on 9 December 2005 Luke James Campbell, a security officer from KMB Investments Pty Ltd, unsuccessfully attempted to close the eastern gate. He contacted his employer, Mr Rynne, by mobile telephone. The eastern gate was left in a partly open position, until Mr Rynne arrived at 11.37pm on 9 December 2005, and attempted to close the eastern gate by various means including the use of a steel pipe. His actions are recorded on CCTV security footage, see Exhibit 5.

On 10 December 2005 Katherine Alison Jones was rostered to work a shift commencing at 5.30am at the Nambour Plaza Shopping Centre, Howard Street, Nambour. Katherine's work duties included opening the Howard Street security gates before commencing her cleaning duties. At about 5.40am on 10 December 2005 Katherine, in the performance of her work duties, activated the Howard Street entrance security gates with a key that was placed in the Magic Eye activation control box, located on the eastern concrete pillar.

When operating in a proper manner each of the two gates is programmed to open from the centre to the sides, retracting into the inside of the façade of the concrete side walls. After removing the key from the control box, the gates were activated and they commenced to move. Katherine then commenced to walk in a westerly direction that was parallel to the gates. Both gates were meant to move outward from the centre. Instead of the eastern gate opening by moving back behind the concrete wall the eastern gate moved forward in the same direction as the western gate, which was opening in a proper manner by retracting behind the concrete wall.

As the eastern gate travelled past the centre of the driveway opening and past the retaining rollers attached to the eastern concrete wall pillars, the eastern gate fell inwards from its track onto the concrete driveway. The eastern gate fell onto Katherine, knocking her to the ground and causing fatal injuries. The autopsy certificate, see Exhibit 2, issued states that the cause of death to be severe multi trauma, due to gate falling on top of Katherine.

The automated galvanized gates were 6.2 metres long and 4.4 metres high. The gates were constructed by using steel box frame members and the frame was sheeting with heavy galvanized mesh. Each gate weighed approximately 900 kilograms.

Scope of the inquest

In addition to making findings pursuant to section 45 of the *Coroner's Act 2003*, as to the cause and circumstances of death a Coroner may make comments on anything connected with the death investigation that relates to public health or safety or the administration of justice, or ways to prevent death from happening in similar circumstance in the future.

Section 46. In order to make such comments it is necessary for the Coroner to identify those factors that contributed to the accident.

Section 45, subsection 5, states that a Coroner must not include in the findings any statement that a person is or may be guilty of an offence or should be liable for something.

Section 48 states, if, from the information obtained while investigating a death a Coroner reasonably suspects a person has committed an offence, the Coroner must give the information to - for an indictable offence, the Director of Public Prosecutions, or for any other offence, the Chief Executive of the Department in which the legislation creating the offence is administered.

I note that the relevant regulatory body for Workplace Safety is the Department of Industrial Relations, Workplace Health and Safety Queensland Division.

Section 32D of the *Acts Interpretations Act 1954* states that a reference to a person generally includes a reference to a corporation as well as an individual.

Findings under section 45 of the Coroner's Act: Following my investigation and evidence presented at the inquest, in accordance with section 45 of the Coroner's Act, I make the following findings:

1 I find that the deceased person was Katherine Alison Jones.

2 I find that the deceased died whilst carrying out her employment duties at the Nambour Plaza Shopping Centre when a large galvanized steel gate fell on top of the deceased, crushing her beneath it.

3 I find that the deceased died at the Nambour Plaza Shopping Centre Nambour on the 10th of December 2005.

4 I find that the cause of death was severe trauma due to the gate falling on the deceased.

Cause of the eastern gate falling: Considerable evidence has been presented to the inquest as to why the gate fell on 10 December 2005. In reaching my findings I accept the conclusions reached by Dr Grigg, who I accept as an expert witness on the issue before the inquest.

I am satisfied the following facts caused or contributed as to why the eastern gate fell:

1 The eastern gate fell over due to the lack of a safety stop to prevent it travelling beyond where it could be supported by its top guide rollers situated in the concrete pillars.

2 A safety stop and extension arm had been fitted to the eastern and western gate in about May 2004. The safety stops and extension arms were not incorporated in the original design of the gates.

3 The stop of the eastern gate had broken off some considerable period of time before 10 December 2005 and had not been repaired. A regular system of inspection of the gates would have detected the missing stop on the eastern gate.

4 A system for controlling the movement of the gates was not programmed to sense the positions of the gates and relied on the continued engagement of a rack on a pinion on the drive.

5 The eastern gate electric motor including the engagement of the rack on the pinion of the drive malfunctioned as a consequence of any or all of

(a) an interference by persons with the electronic programming of the electric motor

b) being derailed on the morning of 9 December 2005, or

(c) as a consequence of the forceful manipulation of the gate by a security officer using a steel pole about midnight on 9 December 2005 which caused the electric motor to lose track of the positioning of the

eastern gate causing it to move forward rather than to open backwards in the proper manner when key activated by the deceased.

6 The security officer who forcefully closed the eastern gate about midnight on the night of 9 December 2005 failed to subsequently test the operation of the gate and did not detect its fault operation. The security officer failed to place any warning or danger tag on or near the eastern gate which he knew or should have reasonably known was defective.

7 The design and attachment of the extension arms and metal stops to the gates were inadequate and deficient. Mr Fratus, who erected the arms and stops, said in evidence that they were, to quote, "A temporary measure only to stop the gates falling if moved past the centre point prior to installation of the motor." These temporary stops were never replaced by more sturdy and appropriate constructed extension arms and stops.

8 The design and installation of the extension arms and stops were not carried out in accordance with the John Holland instruction dated 12 May 2004: Exhibit 6 and 9 refer.

9 The deficiencies of the extension arm and stop should have been readily apparent to any - on any close inspection by a qualified person or quality test. No proper structural or safety assessment appears to have been ever made, as to the adequacy of the design implemented, and of its compliance with the instruction required.

10 The accident on 10 December 2005 would not have occurred if the gates had been designed:
(a) to include a suitable stop on the overhead truss at the centre of the opening which would have prevented the gates from passing beyond the centre point of the gate opening. Or,
(b) if there had been guide rollers attached to the top rail of the gate engaging the sides of the bottom member of the truss over the gateway.

11 There was a failure to place on or near the gate any danger tag or similar system of warning of the occurrence of and possible dangers arising from malfunctioning equipment.

12 Access to the electric motor control box by non-qualified persons without proper instructions and/or training and interfering with the controls and mechanism governing the operation of the motor.

13 Employees were not properly or adequately instructed or trained on the correct operational procedures in the event of a malfunction of the gates.

Section 48, the reporting of offences or misconduct. Senior Inspector Raymond Kickbusch of the division of Workplace Health and Safety

Queensland has given evidence to this inquest that criminal proceedings under the Workplace Health and Safety Act shall be shortly commenced against three corporations that I have determined had a sufficient interest in the inquest; the three corporations being Macquarie Asset Services Limited; Savills Queensland Pty Ltd and KMB Investments Pty Ltd, trading as Imperial Protection Services.

I confirm my view, stated in Court at the end of the evidence, that I agree with the conclusion reached by Senior Constable Church, that there is no evidence of criminal negligence on the part of any person that caused or contributed towards the death of the deceased.

I do not reasonably suspect that any person, including a Corporation has committed an indictable offence.

In respect to section 48, subsection 2 of the Act, and without considering whether there is a reasonable suspicion that the three corporations last stated have committed any non-indictable offence, on the evidence I do not reasonably suspect that any other person including a corporation has committed any non-indictable offence.

Section 46 comments: In accordance with section 46 I inform the State Coroner of the following recommendations: A copy of these findings be sent to the Australian Building Codes Board.

On my investigation to date it appears that there may not be any National Standard Code in place for automatic sliding gates for vehicular ingress and egress. See Australian Standard 4085.

It is recommended that an appropriate standard for such gates should include the provisions of stops including a central stop where gates meet at a central point on all sliding gates as a safety feature to be incorporated in the design and manufacture of such gates. All electronically operated gates above a minimum weight should have some form of mechanical backup system so that in the event of any electronic malfunction the gates do not have to be moved manually in order to operate.

The occupier of premises be required by legislation including WorkCover to keep and maintain a register of malfunctions of any automatic sliding gates, and that on a regular basis certification from a suitably qualified person that the gates have been inspected and are in good working order.

By these findings my duties under section 45 and other sections of the Coroner's Act are discharged and I now close the inquest.

Coroner Killeen
4 December 2006