QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Laurence Edwin Rowe** |
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Southport |
| FILE NO(s): | 2008/628 |
| DELIVERED ON: | 11 December 2014 |
| DELIVERED AT: | Southport Courts Complex, Southport |
| HEARING DATE(s): | 6 August 2012 – 10 August 2012,<br>22 October 2014 |
| FINDINGS OF: | James McDougall, South Eastern Coroner |
| CATCHWORDS: | CORONERS: Inquest – industrial accident, forklift, system of work. |

REPRESENTATION:

Counsel Assisting: Ms M Zerner, Ms Rhiannon Helsen

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Mr Kevin Parrott, Crown Law I/B WH&S

Mr Martin Carey, Counsel, WH&S

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## INTRODUCTION

The inquest was held over six days from 6 August 2012 - 10 August 2012 and 22 October 2014.

## BACKGROUND

1. Laurence Edwin Rowe was a 68 year old male. He died on 18 August 2008 at 156 Eastlake Street, Carrara. This is the address of Belle Maison Properties Pty Ltd ('BMP'), which is owned and operated by Mr. Brian Curtis. BMP is a trucking/haulage business. Mr. Rowe was a long-standing friend of Mr. Curtis.

2. Mr. Rowe was crushed in a forklift at BMP and sustained a fatal head injury ('the incident').

3. The Queensland Police Service ('QPS') Forensic Crash Unit undertook an investigation into the incident. Sergeant Garth Crank initially performed the investigation. Following Sergeant Crank's retirement, Senior Constable ('SC') Kyle Hutchinson continued the investigation. Workplace Health and Safety ('WH&S') also investigated the incident. The primary investigator was Mr. Zoran Durdev.

4. Dr Frank Grigg an expert engineer, and Sergeant Rasmussen, a QPS forensic scientist, provided additional assistance in the investigation into Mr. Rowe's death.

5. The persons who were present at the premises on the day of the incident included Mr. John Curtis, Mr. Brian Curtis, Mr. Rowe, Mr. Lowry and Mr. Whitelock. Mr. John Curtis is Mr. Brian Curtis' son. Whilst not an employee of BMP, or actively engaged in assisting his father with work that day, he

was residing at the premises. Mr. Brian Curtis was working with Mr. Rowe in removing a large aluminum beam from a truck trailer.

6. Mr. Lowry, a qualified mechanic was at BMP working on one of the BMP trucks. He is a self-employed mobile mechanic who had been servicing BMP trucks for approximately 12 months prior to the incident. His business is called, Outcall Mechanics.

7. Mr. Whitelock was an employee of BMP. He had only recently started employment as a truck driver/maintenance. In his interview with WH&S of 20 August 2008, he said the incident had occurred on his third day. In evidence, he said it happened on his first day.

8. There are some inconsistencies in the evidence between Mr. Jason Lowry and Mr. John Whitelock. The inconsistencies concern not only the version of events, but also internal inconsistencies in their recollection of some critical facts. This can be put down in part to the number of versions of events they were asked to provide and the period of time over which they were required to provide their versions. I consider the evidence of Mr. Brian Curtis supports the general propositions put forward by Mr. Lowry and Mr. Whitelock as to what occurred at or around the time of the incident, and shortly thereafter.

**CORONIAL ISSUES**

9. The issues to be canvassed at the inquest were:

a) the identity of Mr. Rowe including when, where and how he died, and the cause of death;

b) determine the surrounding events and circumstances leading up to the death;

c) examine any/all safety management standards in operation at BMP at the time of the death, and if applicable, the adequacy of those safety management standards;

d) examine any/all safety management standards relating to the use and operation of the forklift;

e) to examine and review any/all formal/informal staff training undertaken by BMP to any/all staff operating the forklift during the course of their employment.

**MR ROWE**

10. Mr. Rowe had been born in Christchurch, New Zealand and immigrated to Australia in 1987. He had been married to his wife, Loise Rowe for forty-seven years. They both retired in 1998 and had been engaged in regular travel. Mr. Rowe was a fitter and turner by trade.

11. Mr. Rowe was fit and active for his age. The only health issue he had was high blood pressure which was controlled with medication. He wore glasses for reading and for 'close work'. He was left-handed. Mr. Rowe had renewed his driver's license for five years prior to his death.

12. Mr. Rowe was an experienced forklift operator. He obtained qualifications to operate a forklift in New Zealand. Mr. Curtis' lawyers advised they had been instructed Mr. Rowe's New Zealand Drivers License authorized him to operate a forklift. WH&S confirmed Mr. Rowe had a valid forklift license at the time of the incident.

13. In the eighteen months leading up to Mr. Rowe's death, Mr. Rowe had worked at BMP for about a total of three weeks. Mr. Curtis, through his lawyer, advised Mr. Rowe was not an employee during the period of time WHS investigators sought documentation. However, in consultation with

WorkCover, WHS investigators sourced a number of invoices dating back to 2002 that appear to have been between Mr. Rowe and Mr. Curtis, which suggested he was employed by BMP.

14. In evidence, Mr. Curtis was reluctant to answer questions concerning the working arrangement between himself and Mr. Rowe. He eventually conceded he paid Mr. Rowe for work he undertook for Mr. Curtis. He was shown the invoices, which document payment between the two dating back to 2002, with some invoices being as recent as August 2008. Mr. Curtis advised the invoices were completed by Mr. Rowe and issued to him for payment.

**BMP**

15. A component of BMP's operations is based at a residential property at 156 Eastlake Street, Carrara, the storage of trucks and machinery. The registered address for the company is Mr. Brian Curtis' residential address. There are a number of large parking areas in the front where trucks are parked. The residence is split-level. At the back of the property is the workshop where a number of truck bodies are located.

16. The incident occurred adjacent to the workshop area at the back of the residence on a flat gravel/dirt surface. This area was adjacent to the double garage at the base of the house, which was used as the workshop. Access to the area through the residence, is down a flight of stairs between the back section of the dwelling and the swimming pool. Alternatively, access to the workplace is down the side of the residence. In the immediate vicinity of the incident, there was a truck and trailer; a trailer with an aluminum beam, an excavator, work bench and the forklift.

**THE FORKLIFT**

17. The forklift is a TCM Series 700 Model FG20N5. It is a grey import, which is a second hand machine, brought to Australia through channels other than the importer and distributor of new machines. As a result, grey

imports are not required to meet the relevant Australian Standards. Often buyers are not aware the machine they are purchasing is a grey import.

18. The warning stickers on the grey imports are usually in Asian writing. The load rating is less than that in Japan, the difference being the rating plate, not the machine. There is no regulation preventing the import of these grey imports.

19. Mr. Curtis does not recall when he purchased the forklift, or from whom he purchased it. He confirmed he did not have an operating manual for the forklift.

20. The forklift had a three metre upright vertical mast and therefore did not have a tilt stop. In sitting in the cabin of the forklift, there are three levers to the right and two levers to the left.

21. The levers on the right operate the hydraulic mechanisms of the forklift. The closest to the operator controls the mast, pushing forward raises it and pulling back lowers it. The centre lever controls the tilt, pulling it towards the operator, pulls (luffs) the mast in towards the cabin, and pushing it away, pushes (luffs) the mast away from the cabin. The third lever, which is furthest away from the operator, controls the tines.

22. The only lever, which works when the forklift is turned off, is the lever to release the mast to the ground. The tilt and tines do not work. It is possible to move one lever forward and one lever back at the same time. The levers return to neutral when they are let go. Whilst there is a distinct neutral position, it does not take much to push it either way. If pushing against a lever being obstructed, it would be difficult to have a sense of where the neutral position is. The levers cannot be moved forward by foot, and are moved forward by hand. The longer handled lever on the left of the operator's cabin is the reverse lever. The other is the handbrake.

23. SC Hutchinson (of the FCU) confirmed when the forklift engine is off; the

only operation of the three levers to the right is for the sliding mast to be lowered. This is due to the effects of gravity, without any hydraulic flow from the machine, the other mechanisms of the forklift will not operate. The maximum rate of the drop of the sliding cross member is a metre per second. However, it can be decreased slowly, inch by inch, using the lever.

24. Mr. Smith, the national operations manager of NTP Forklifts (an importer and distributor of TCM products) explained how the forklift works, he said, "*Effectively you have a hydraulic pump which is driven off, off the engine. The hydraulic pump takes oil from the hydraulic reservoir and it feeds it first to a priority valve. The primary purpose of the priority valve is to give the braking and the steering systems, the safety systems, priority in case of a – an issue with the hydraulic system*". He advised the forklift uses pressure in one direction to operate it and is lowered with gravity and weight. Therefore, the only function that can be used when the engine is not operating is to lower the forks. Mr. Smith said the mast could not be pushed forward towards the centre without power.

25. Mr. Smith undertook an inspection of the forklift. He found the battery clamps for powering the machine were damaged, with a G clamp fitted instead of the standard battery clamp. He did not consider this a safe attachment. He also observed on the 2008 video the hoses were perished. Further, that the hydraulic hoses had run off the pulley. He was not able to say how this occurred or how long ago it had occurred. Mr. Curtis was not able to recall if there was a problem with the hoses prior to the incident.

26. Sergeant Crank (FCU) on his inspection, formed the opinion there was no mechanical defect in the forklift that was a contributing factor to the incident.

27. Mr. Smith was critical of the cover over the operator's cabin. He says the one they supply has a solid infill at the back half and a clear vinyl front half so the operator can see through it. He advised unfortunately in his

experience he has seen lots of alternatives used on top of the operator's cabin, which limits a driver's vision. Including wood, wool packs and pallets. Mr. Curtis thought at some stage he had put the canvass on top of the operator's cabin to provide some shade.

28. Mr. Smith indicated the full extent of the mast tilt or luff was 12 degrees and whilst it will take the mast a fair way back it should not touch the operator cabin. Dr Grigg measured the tilt on the forklift to be 13 degrees. With the mast fully tilted, there is a small gap between the mast and the top bar of the operator's cabin.

29. Mr. Smith explained in order for the forklift to reverse, the engine has to be on, the handbrake off and then the forward reverse lever is engaged. This will cause the forklift to move slowly back. If the handbrake is on and the forward reverse lever is engaged, the forklift will not move.

30. Both Mr. Lowry and Mr. Whitelock had forklift licenses and had used the forklift at BMP prior to the incident. Both deny receiving any instruction on using the forklift at BMP. Mr. Whitelock was generally critical of the workplace and Mr. Brian Curtis' work practices. He does not recall any changes to any work practices after Mr. Rowe's death.

31. Mr. John Curtis confirmed he had driven the forklift prior to the incident but did not hold a license. Likewise Mr. Brian Curtis confirmed he had driven the forklift prior to the incident and that he also did not hold a license. Mr. Brian Curtis confirmed he did not provide any instruction to Mr. Rowe. He was of the view Mr. Rowe was a very experienced operator with over 40 years experience. He did not consider it necessary or appropriate.

## CIRCUMSTANCES LEADING UP TO MR ROWE'S DEATH

32. Mr. Lowry had been asked by Mr. Curtis to attend BMP to quote on an insurance job. Mr. Lowry arrived in the morning with one of his mechanics

and then proceeded to quote on the job. During this time Mr. Lowry met Mr. Whitelock who had been tasked to repair a Horton fan on one of the BMP trucks in the front yard. Mr. Lowry provided some assistance to Mr. Whitelock but had to leave to go to his next job. Mr. Curtis asked Mr. Lowry to return in the afternoon to rebuild the Horton fan. Mr. Lowry estimates he arrived back to BMP at around 2pm.

33. On his return, Mr. Lowry and one of his mechanics set about rebuilding the Horton fan. Mr. Lowry had to go down the back of the residence at one stage to use the oxy torch to cut a piece off the Horton fan. He briefly spoke with Mr. Rowe who was standing out the back. Once the Horton fan had been completed he handed it back to Mr. Whitelock to install into the truck. Mr. Lowry then sent his mechanic to the next job, which was just down the road.

34. Whilst Mr. Whitelock was predominantly working at the front of the house, when he went down the back earlier in the day he recalls seeing Mr. Brian Curtis move Mr. Rowe around on the forklift. He says he saw Mr. Curtis driving the forklift with Mr. Rowe on the tines. He says once Mr. Curtis got to the position he was working; Mr. Curtis would raise the tines to the level required. He estimates this was eight to 10 feet high. He was unable to confirm whether the mast was tilted but thought it would have been, as it would have been steadier for Mr. Rowe.

35. Once Mr. Lowry had cleaned up, he had some parts, which could be reused and went out the back of the residence to discuss those parts with Mr. Curtis. As he was approaching Mr. Curtis, Mr. Lowry says he saw Mr. Rowe standing on the forks of the forklift, elevated above the air, leaning across, putting the beam where it sits. Mr. Rowe was high enough to lean over to get the rope off the beam.

36. Mr. Lowry was not able to say how high Mr Rowe's head was at that stage, as he was not taking much notice. He was more focused on getting onto

his next job. In evidence he confirmed Mr. Rowe was high enough that he would not just step off the tines to the ground. In his statement to WH&S of 20 August 2008 he thought the fork tines were approximately level in height, with the top of the front trailer tyre but qualified this by saying he was uncertain of the exact height. Mr. Lowry assumed someone would have had to operate the forklift to put Mr. Rowe at the height and someone would need to bring him down from that height. Mr. Lowry was of the view the tines were at such a height that Mr. Rowe would not jump down. He denied putting Mr. Rowe up on the forklift and leaving it running.

37. Mr. Lowry observed Mr. Curtis operating the excavator. He waited until Mr. Curtis had finished what he was doing and had unlocked the hydraulics. Mr. Lowry recalls Mr. Curtis turning to face him to talk to about the left over parts he had. SC Hutchinson confirmed from the photographs the excavator appeared to be closed in. He suggested if the engine had been turned to an idle it is possible Mr. Rowe could not get the attention of Mr. Curtis or Mr. Lowry. It is possible Mr. Curtis was not in Mr. Rowe's line of sight as he had turned to speak with Mr. Lowry. Mr. Lowry says he could not see Mr. Rowe from where he was speaking with Mr. Curtis.

38. As Mr. Lowry was speaking with Mr. Curtis, he received a phone call from his wife. He says just as he answered the phone, he heard a noise like someone really in pain. He said the noise he heard was like when someone gets a severe winding, like they are trying to scream but cannot. Mr. Lowry recalls saying something like, "*whoa, who, whoa*" as he looked over and saw Mr. Rowe trapped in between the boom and the cab. Mr. Lowry did not hang up from his wife but dropped his phone. This call was received at 4.16pm.

39. Mr. Lowry says in an instant he and Mr. Curtis went to the forklift. He says Mr. Curtis got out of the excavator and went one way, and he went the other. Mr. Whitelock was not present when the incident occurred.

40. Mr. John Curtis recalls having lunch with Mr. Rowe on the day of the

incident. He said as he had just returned from America, he was telling Mr. Rowe about his travels. Mr. John Curtis recalls being at the incident scene about five to ten minutes prior to the incident occurring. He says he was just engaged in general chatter and then left to return to the residence.

41. Mr. Brian Curtis recalls working with Mr. Rowe on the morning prior to the incident. They were working in the back of a trailer to loosen a bent aluminium structural beam, which was part of the trailer. He says he and Mr. Rowe had climbed inside the trailer using a ladder and were both removing the 40 or so bolts from the beam. He recalls they had detached the beam and moved it on an angle on top of the trailer ready for removal after lunch. Mr. Brian Curtis denied he or Mr. Rowe had used the forklift prior to lunch.

42. Mr. Curtis says after lunch, he and Mr. Rowe returned down to the workshop area with a view to moving the beam from the trailer to the ground. He says they had planned to tie a rope over the beam and use the excavator to lower the beam to the ground. Mr. Curtis confirmed the rope was already on the end of the excavator when the incident occurred.

43. Mr. Curtis said prior to the incident the forklift was positioned forward of where it finally came to rest (this is likely to have been close to under where the beam was located).

44. Mr. Curtis denies operating the forklift at anytime that day. He says Mr. Rowe was on the ground when he went to get into the excavator. He was not able to elaborate on what Mr. Rowe did after that.

**THE INCIDENT**

45. Mr. Lowry is unable to confirm if the forklift was on when he was talking with Mr. Curtis but says it was running at the time of the incident. He says it was slowly moving backwards and that Mr. Rowe was getting squashed in the position he was in. Mr. Lowry says he says as he was trying to get

on the forklift, one of his feet got stuck as it was rolling back. Mr. Lowry said he did not look at Mr. Rowe again because all he was concentrated on was stopping the forklift from crushing Mr. Rowe.

46. Mr. Lowry recalls the mast being closer to the cabin then when the tines were on the ground. In evidence, he did not remember whether the mast was moving as the forklift was going backwards or how far back the mast was tilted. In his original statement to WH&S of 20 August 2008, he said he saw the mast tilting back towards the cabin into Mr. Rowe. In his addendum statement to the QPS of 21 August 2009, he said he didn't actually see the mast tilting back but had assumed that was the case as Mr. Rowe was trapped in between the mast and the roof of the driver's cage.

47. Mr. Lowry recalls Mr. Rowe having one leg stuck on the reverse lever and the other leg on the apparatus handles. He could not move either leg. Mr. Lowry cannot recall if Mr. Rowe's leg was against one or more of the levers, but stated, "*His foot was definitely jammed against at least one of them*". The ball of his foot was on the dash. Mr. Lowry says Mr. Rowe's legs were stretched out straight. He could not see if Mr. Rowe was bent over above his waist. In his original statement to WH&S of 20 August 2008, he said Mr. Rowe had his right foot pushed hard against the operational control levers and his left against the reverse lever.

48. Mr. Lowry described the events as he arrived to the forklift, "*First of all I tried to push down near his shoes and that didn't work, so I decided to go a little bit higher on the levers and push against them to try and get some leverage on his shoes to centralize them, and then within that instant, realized I was getting nowhere here and, yeah, put the foot on the brake and Brian turned the engine off and then it just all stopped…"* Mr. Lowry recalls pushing on two levers but could not get any leverage from Mr. Rowe. He recalls having aching arms the following day due to the weight he was putting on the levers. Mr. Lowry did not think it was possible he was pushing the levers more forward than he thought.

49. In his statement to the QPS of 12 January 2009, Mr. Lowry says one of Mr. Rowe's feet was on the reversing lever, with the top of his toes on the dashboard to the left of the instrument cluster. Mr. Rowe's other foot was jammed on the other three levers on the right side. All three levers were fully backward. He put his feet on the brakes to stop the forklift moving in reverse. Mr. Rowe was facing forward and he could see the back of his legs. Mr. Lowry says despite putting one hand on the left lever and his right arm on the right lever and applying as much weight as he could, he was unable to move Mr. Rowe. Mr. Lowry said he could not see past the roofline because of the white vinyl cover.

50. Mr. Lowry says the pressure got taken off and Mr. Rowe fell to the side. He says he is certain he moved the middle lever forward to release Mr. Rowe. He thinks he probably centralized everything because that is something he would usually do but cannot recall what he did on that occasion. He explained even though the engine was off, he understood the mast came forward due to the weight Mr. Rowe's body would have had on the mast. After pushing the lever forward, he blacked out. He says he woke up behind the bush and the first thing he did was call triple 0. Mr. Lowry recalls a rush of fluid, which was nearly simultaneous with everything stopping. He could only see the back of Mr. Rowe's legs up to his thighs due to the vinyl roof cover.

51. In relation to the sequence of events, Mr. Lowry said He could not recall when the engine was switched off. He conceded it was possible Mr. Rowe's body went limp before the engine was turned off but says the motor was not running when he released him. He says he struggled with how the mast could go forward when the engine was off and had his mechanic demonstrate to him that if you put a weight on the front of the mast it dips forward with no power. Mr. Lowry would not concede it was possible he lowered the mast prior to the engine being switched off. He does not recall Mr. Whitelock being present whilst he was attempting to move the levers. However, he acknowledged Mr. Whitelock could have

been there.

52. In his original statement to WH&S of 20 August 2008, he says he recalled Mr. Curtis coming over to the forklift and reaching into the cabin and switching it off. He says he then saw a big gush of blood and noticed Mr. Rowe's legs stop pushing against the controls and his body going limp and lifeless. He says it was then possible to operate the forklift control levers. In his addendum QPS statement of 21 August 2009, he says he could not recall whether he had first moved the levers forward, or Mr. Curtis had turned off the ignition. He could not recall if the big gush of blood occurred before or after Mr. Curtis turned the ignition off. However, the gush of blood occurred before he moved the levers forward. He was unable to explain how the mast went forward after the ignition turned off.

53. In Mr. Lowry's interview with WH&S on 20 August 2008, he was clearly distressed when he was talking about the incident. He says he thinks he blacked out for a few seconds and that Mr. Curtis was calling out to him to go and hold the body up but that he physically could not go over there. He says after the incident Mr. Curtis told him he had been screaming but he cannot remember what he was doing. In his QPS statement of 12 January 2009, he says before making the triple 0 call he ran off screaming and crying for about 30 seconds. He says he was behind the pool fence. Once he got hold of himself he rang triple 0 and handed his phone to Mr. Curtis. The Call Charge Records confirm a 000 call was made from Mr. Lowry's mobile phone at 4.17pm.

54. Mr. Brian Curtis said he was in the excavator at the time the incident occurred. The engine was off and he was talking to Mr. Lowry. He confirmed Mr. Lowry was standing on the left side of the excavator where the excavator door was located. They were talking about the work Mr. Lowry had done. Mr. Curtis says he vaguely recalls Mr. Lowry receiving a phone call from his wife but was uncertain if that was before or after the incident. Mr. Curtis says as he was talking with Mr. Lowry he heard Mr. Rowe call out. When he looked over from the excavator the forklift was

moving backwards and Mr. Rowe was trapped against the front of the operator's cabin by the mast. He says Mr. Rowe was bent over with his head in the mechanism of the forklift.

55. Mr. Lowry went to the right and he went to the left of the forklift. Mr. Curtis recalls Mr. Lowry getting his foot caught, as the forklift was moving backwards. He said his natural instinct was to immediately turn the forklift off so they could assess what needed to happen. He recalls a gush of blood coming from Mr. Rowe and is not sure if that was before or after he turned the forklift off. He was not able to advise where Mr. Rowe's foot was on the right side or what was happening with the controls as Mr. Lowry was there. Mr. Curtis confirmed Mr. Rowe's head was crushed between the fixed mast cross member and the sliding mast cross member.

56. Mr. Curtis says he restarted the forklift in order to release Mr. Rowe from the forklift. As he did, Mr. Rowe fell down into the forklift with his legs over the mudguard and slumped towards the ground.

57. Mr. Whitlock was walking down the yard to where the others had been working. He saw Mr. Lowry about 15 metres in front of him and heard Mr. Curtis yell out that Mr. Rowe had been hurt. He says Mr. Curtis was on the phone at this stage pointing to the forklift. When he looked over he saw Mr. Rowe pinned between the forklift mast and the cabin of the forklift. He says the mast was tilted about two thirds back towards the dashboard. Mr. Whitelock recalls Mr. Rowe's feet hanging out one side and his head out the other. Mr. Rowe's legs were across the mudguard of the forklift. Mr. Rowe's body was over the top of the hydraulic rams. He went to the side where Mr. Rowe's head was to hold it up and then yelled to Mr. Lowry to come and help.

58. Mr. Whitelock says Mr. Rowe was wedged into position. He had tried to gently pull Mr. Rowe down when he was holding him but could not budge him. Mr. Curtis does not recall helping get Mr. Rowe to the ground. He thought Mr. Rowe eventually fell to the ground after slumping forward.

59. Mr. Whitelock originally said he ran over to the forklift and saw Mr. Lowry inside, he subsequently changed this to, "*I then ran over to the forklift and called Jason Lowry to come to the forklift...*". When he called out to Mr. Lowry, Mr. Curtis was still on the phone. He had to yell and use expletives to get Mr. Lowry to respond and assist. In evidence he thought he told Mr. Lowry to push the middle lever forwarded but conceded if he had said in his statement he told Mr. Lowry to push all the levers forward he would have said that. Mr. Whitelock could not recall if the engine was on when he arrived but conceded if he had said the engine was off in his statement, it more than likely was off. In evidence, Mr. Whitelock conceded it was possible nobody assisted him and that it was he who released the mast in order to get Mr. Rowe out (it seems the further maneuvering of the controls was in relation to getting Mr. Rowe from where he was lying across the hydraulic rams onto the ground).

60. Once the pressure was relived; Mr. Whitelock was able to pull Mr. Rowe out and place him on the ground. He recalls yelling out to Mr. Curtis that he could feel a weak pulse and could feel air coming from Mr. Rowe's mouth and that through phone instructions from Mr. Curtis he was told to keep giving Mr. Rowe resuscitation. Mr. Whitelock continued resuscitation for about 10 minutes and when the ambulance arrived he told them Mr. Rowe was dead.

61. In evidence, Mr. Curtis says he did not know what happened prior to Mr. Rowe being trapped but when reporting the incident to the QAS and to Mr. Rowe's family he made an assumption as to what he thought Mr. Rowe was doing. He says he thought Mr. Rowe was on the tines and had climbed around the mast and stepped onto the mudguard and dash to get down. He then said he really did not know what Mr. Rowe was doing and conceded Mr. Rowe could have been standing on the dash. Whatever the scenario he agreed Mr. Rowe had adopted an unsafe work practice and that he should not have been in the position he was in. Mr. Curtis does not recall seeing Mr. Rowe's glasses on the forklift canopy and was not

able to provide an explanation as to how they got there.

62. Mr. Rowe was declared deceased at 17.27hr. QPS arrived at 17.00hrs and the QAS directed the QPS to Mr. Rowe who was covered by a blanket. On this basis it seems likely the paramedic has recorded the incorrect time Mr. Rowe was declared dead and it should be 16.27hrs, and similarly the time of arrival should have been 16.24hrs. The QAS Incident Information, which is a document completed by the QAS Communications Centre indicate the arrival time to the scene as being 16.24.54hrs.

63. QPS arrived to the scene at approximately 5pm. Two legal representatives for Mr. Curtis were already present and would not assist police or the WH&S investigators. Mr. Brian Curtis says the legal advice he received was not to provide a statement or to speak with investigators. He denies telling Mr. Whitelock or Mr. Lowry not to provide statements or to speak with investigators. He also denies speaking with Mr. Whitelock and Mr. Lowry about the events that occurred and what was likely to have been the cause of the incident.

64. On the day after Mr. Rowe's death, BMP through its lawyer faxed an incident notification form to WH&S. The time of the incident is recorded as begin at 1516 (3.16pm) [this time is incorrect as it does not accord with the phone records and other evidence].

65. WH&S served two prohibition notices on BMP following the incident. One was concerning a grinder that was located at the scene, which did not have a guard. The other was in relation to the forklift.

66. WH&S formed the view there were poor systems of work and poor supervision concerning the forklift and the forklift operation. This included finding that Mr. Rowe had no up to date license to operate a forklift (this turned out to be incorrect); that BMP did not have any policies and procedures in place concerning the operation of the forklift or traffic management; and that there was no adequate training, supervision or

instruction in relation to the operation of the forklift.

## THE INJURIES

67. The autopsy of Mr. Rowe was limited to an external autopsy. It was performed by Dr Aartsen and Professor Hansford. A number of signs of recent injury were identified. They are described fully in the Autopsy Report. They generally include an extensive facial injury involving the collapse of the right orbit with complex comminute fractures of the facial skeleton. The right side of the jaw was collapsed. The posterior aspect of the skull showed no external evidence of a fracture. There was an abrasion over the posterior aspect of the neck.

68. Other bodily injuries included a ovoid shaped bruised over the right sided epigatstrium; abrasion over the pubic symphysis; an abrasion over the anterior shoulder and extending down the upper arm; gaping laceration over the palmer aspect of the thumb; an abrasion over the left anterior upper arm and antero-lateral aspect of the forearm; left little finger had a band aid with a crusted laceration; the mid and distal phalanx of the index finger had a palmar laceration with mild tissue loss and soft tissue loss over the tip of the finger; two small abrasions over the right knee; three lacerations over the lower right shin; and one abrasion on the left knee, and one below.

69. In evidence, Professor Ansford opined Mr. Rowe's facial injury had been caused by a flat surface or an edge causing a flattening out of the face. He explained the facial bones are the weakest part of the skull and that if there is pressure applied to the back of the head and the face is on a flat surface, like a metal bar, the facial bones are the likely part to collapse first. Professor Ansford explained the back of the neck is fairly robust with the spine and some muscles whereas the front of the face is very fragile. He said any damage would depend on the degree of compression and how long it lasted and how much movement there was. Professor Ansford confirmed the front of the skull has certain integrity and it would resist

being crushed to a point but would all of a sudden collapse once the pressure gets to a certain point.

70. Professor Ansford thought it was possible dropping the sliding mast cross member caused the injury to Mr. Rowe's neck and the facial injuries occurring with Mr. Rowe's face on an angle against the fixed mas cross member.

71. Professor Ansford is of the view Mr. Rowe's injuries on his right arm and shoulder are consistent with the pulleys and chains on the right hand side when looking from the operator's seat. This would have Mr. Rowe placed facing out away from the operator. He believes the injury on Mr. Rowe's left shoulder marries up with the pulley and chain on the left hand side of the forklift. Professor Ansford is of the view the injuries to Mr. Rowe's arms would have occurred, as the pulley was moving. He felt they were unlikely to have been caused by falling against the structures after Mr. Rowe was released from the mast.

72. Professor Ansford was unable to say how Mr. Rowe injured his fingers but confirmed they were caused by a crush injury. He could not say when the injury to the fingers occurred. He conceded they could have been entrapped in the chains or pulley but said he would have expected to see blood in the area. Professor Ansford thought it more likely than not Mr. Rowe's arms were outside the mechanism at the point when the fatal crush injury to Mr. Rowe's face occurred.

73. Professor Ansford was unable to say whether the crushing injury causing Mr. Rowe's entrapment or the sudden force, possible of a few seconds, caused Mr. Rowe's fatal injury.

74. Professor Ansford was unable to confirm when the injuries to Mr. Rowe's abdomen; or to his knees occurred. He says the parallel injuries across the top of Mr. Rowe's bottom are consistent with him being pinned up against the front bar of the operator's cabin.

## PHYSICAL EVIDENCE

75. There was some critical evidence obtained at the scene of the incident. The evidence included shoe prints on the dashboard of the forklift, scuff marks on two of the right hand operating levers; and blood at different locations on the forklift.

76. Sergeant Crank originally found Mr. Rowe's shoes were not a match for the imprint of shoe marks on the dashboard of the forklift. Sergeant Rasmussen, a QPS forensic scientist confirmed that was a reasonable assumption based on the methodology used by Sergeant Crank at the time he completed his investigation. Sergeant Rasmussen completed his own assessment of the shoe print and is of the opinion there is a potential the patterns on Mr. Rowe's shoes do match those on the dash of the forklift.

77. Sergeant Rasmussen determined the mark from the front to the back or vice versa, on the right hand side of the dash was a sliding mark. He was unable to establish the direction of the slide. He was of the opinion the mark was probably caused by Mr. Rowe's right shoe. The bloodstains in the area would have been deposited after the sliding mark. Sergeant Rasmussen was not able to determine when it was put there.

78. Sergeant Rasmussen confirmed there had been some forceful contact in the area of the levers. He came to this conclusion, as there was dust on the surrounding areas. He was not able to confirm or exclude that there had been forceful contact with the third lever, which was covered in electrical tape.

79. Mr. Rowe's facial wound and the open wounds to his left index finger and right thumb were all sources for bloodshed. The photograph of Mr. Rowe's T-shirt did not allow full assessment of the blood loss on to Mr. Rowe. Further, without the shirt, testing could not be undertaken to determine the nature of the blood loss. The same applied to Mr. Rowe's shorts.

80. There was projected blood on to the canopy cover of the operator's cabin. Sergeant Rasmussen concluded the direction of the blood had come somewhere forward of the cabin. He was not able to confirm or exclude where the blood came from. He though thought it probable it had come from the fixed mast cross member.

81. There was blood across the top and the leading edge of the fixed mast cross member but none on the top of the sliding mast cross member. Sergeant Rasmussen was of the view this was because the fixed mast was exposed to a blood source and the sliding mast had not. He reported there was body tissue on the leading edge of the fixed cross member, blood underneath it, which is projecting away, and blood on top of it. He explained his reference to the 'leading edge of the fixed cross member' is the side of the cross member which cannot be seen from the operator's cabin. Sergeant Rasmussen suggests the body tissue on the fixed mast cross member leads him to suspect that is the surface, which is involved in causing the injury to Mr. Rowe's face.

82. There was passive drip and projected blood on the sloping front of the operator's cabin frame. The distribution of the blood was consistent with secondary splatter associated with blood dripping into blood or ricocheting during fall. Sergeant Rasmussen concluded the distribution of the blood pools, possible dripped blood, associated splatter, and the majority of the other projected blood was consistent with originating from the general area of the fixed mast cross member. He was not able to determine from his blood splatter analysis whether Mr. Rowe was in front or behind the mast at the time his injury occurred.

83. Except for two small droplet stains on the top right tine, there were no obvious bloodstains in the area forward and inclusive of the front of the backrest frame to the tines.

84. There was blood staining consistent with Mr. Rowe's head being over the

mudguard and wheel. There was also evidence some of the blood drops might be altered by contact in that area. This is consistent with Mr. Rowe being suspended for a period over the mudguard with his head out to the side.

## THE THEORIES

85. The investigating officers from the QPS and WH&S have canvassed a number of theories as to the immediate circumstances leading to the fatal injury and the mechanism of that injury. Further theories were developed throughout the first five days of the inquest.

86. SC Hutchinson took over the investigation from Sergeant Crank. SC Hutchinson did not attend the scene and did not personally interview any of the witnesses. This was his first investigation of an industrial accident involving a forklift. He had no training in forklift operation and did not ever operate the forklift concerned in this incident. He did not have any scientific input on developing his theories. Sergeant Crank was not called to provide evidence at the inquest.

87. Sergeant Crank developed two possible scenarios as to how the incident occurred, SC Hutchinson, three. SC Hutchinson's second and third theories are consistent with Sergeant Crank's theories. SC Hutchinson's theories include:

    A. That Mr. Rowe was standing with his head oriented backwards to 180 degrees to his body with his head on the fixed mast cross member;
    B. That Mr. Rowe's head was resting on the fixed mast cross member whilst he was standing between the mast and the operator's cabin, pinned by the mast - his body and head were pulled down by the sliding mast cross member so that he was bending over to touch his toes (Sergeant Crank's scenario 2); and

C. That Mr. Rowe is standing on the tines with either Mr. Curtis or Mr. Lowry operating the tines – as they are lowered Mr. Rowe reaches through the mast to retrieve his glasses from the top of the operator's cabin – as he does the operator lowers the sliding mast cross member – Mr. Rowe's face rests on the leading edge of the fixed mast cross member and the sliding cross member is lowered on to Mr. Rowe (Sergeant Crank's scenario 1).

88. Sergeant Crank formed the view the evidence supported his Scenario 1 but the witness versions supported his Scenario 2. Sergeant Crank was concerned the statement of Mr. Lowry and Mr. Whitelock were similar and questioned whether they had been 'bundled' up to the house and told not to speak with anyone, and a version had been fabricated between the parties. He then reported ultimately it was his opinion both were honest witnesses and it may have been the case they subconsciously filled in the blanks to join other component parts to have their version make a logical sequence of events.

89. SC Hutchinson conceded his theories may change somewhat or could be affected by scientific evidence that was to be provided to the inquest. SC Hutchinson conceded his scenario A really had no logic to it and said whilst it was a thought he now believed it was not possible and that it should be eliminated. SC Hutchinson believed on the evidence there was an argument for scenario B and C.

90. At the conclusion of his report he leaned towards scenario C as the most plausible explanation for what had occurred but following discussions with Sergeant Rasmussen, a scientific officer, reviewing autopsy photos and Dr Grigg's further evidence, weight could be attributed to scenario B. The scenario being more consistent with the witness statements.

91. SC Hutchinson advised if Mr. Rowe's feet were pushing back against the controls, he could not cause the compression injury because pushing

against those levers would not cause the sliding inner mast cross member to lower. He thought as a result there had to be the intervention of another person and that that intervention could have been in good faith.

92. Mr. Durdev of WH&S posed three theories in his report:

a) Mr. Rowe operated the forklift controls himself, by leaning and extending through the forklift mast components, and has been inadvertently crushed whilst doing so; or

b) Mr. Rowe initially operated the forklift controls by himself by leaning and extending through the components, before inadvertently becoming partially trapped, before someone else has come to his aid who has tried to help, but accidentally inflicted further and ultimate fatal crush injuries by lowering the tines rather than raise them which would have most probably released the pressure being inflicted onto Mr. Rowe; or

c) Some other person has operated the forklift, causing the tines to descend, whilst Mr. Rowe had his head and torso within the subject area of entrapment.

93. In evidence, Mr. Durdev advised he had formed the view the physical evidence did not marry up with the witness statements. He thought Mr. Rowe had to be standing on the tines and protruding through the mast when the injury occurred. He postulated that Mr. Rowe was reaching through to the cabin and somehow operating the levers. He advised he was approaching the scenario from a layperson, not an expert in blood splatter. He qualified his thoughts by saying the witnesses were quite forthright in ways that they did see Mr. Rowe in the area between the mast and the cabin.

94. During Dr Grigg's investigation he attempted to reinact SC Hutchinson's Scenario C. He said whilst it was probably possible to reach through to retrieve the spectacles he found it much more difficult, if not impossible to place his eyes on the rear edge of the fixed mast cross member.

95. Dr Grigg is of the opinion there is a low possibility the incident occurred as proposed by SC Hutchinson's Scenario C. He is of the opinion the incident occurred essentially as described in Scenario B, which is consistent with the statements of Mr. Lowry and Mr. Whitelock. Dr Grigg said the principal reasons being:

a) the blood on the underside of the fixed mast cross member and the rub markings and fabric prints can be seen on the back and bottom side of the sliding mast cross member are consistent with Mr. Rowe's head being forward of his neck when the sliding mast descended;
b) the mechanism of injury is consistent with Mr. Rowe's face on the fixed mast cross member and the sliding mast cross member contacting Mr. Rowe's neck;

c) the wiped area on top of the dash and the scrape marks on the fronts of the mast tilt and fork tilt levers are consistent with Mr. Rowe's shoe having slid down into the region between the dashboard and the control levers causing the mast to tilt backwards;
d) the wiped area on top of the dash and the scrape marks on the front of the forward-reverse lever, are consistent with Mr. Rowe's left foot having made contact with that lever causing the forklift to move backwards;
e) when standing on the forks facing backwards, leaning against the top rail of the fork backrest guard, a person with a stature similar to Mr. Rowe could not place their head in a position where their eyes would be near the front edge of the fixed mast cross member when the sliding mast was near the fully lowered position, as necessary for the head to be crushed;
f) when standing on the dash (or with the feet jammed between the levers and the dash) it is not difficult for a person with a stature similar to Mr. Rowe to place their head in the trapping space; and

g) It would be expected that if rendered unconscious, the blood and Mr. Rowe would fall down between the mast and the canopy of the forklift. It could also be possible for the blood to fail to fall on the front of Mr. Rowe's shirt.

96. Dr Grigg says due to no scrape marks on the front of the sliding mast control lever it is possible Mr. Rowe's foot did not make significant contact with the lever. He suggests in attempting to relieve the pressure from the other levers Mr. Lowry may have inadvertently caused the sliding mast control lever to move forward.

97. Dr Grigg is of the view the evidence strongly supports the theory that Mr Rowe was was standing on the dashboard of the forklift facing forwards immediately prior to his head being crushed. Sergeant Rasmussen says the evidence suggests the injury to Mr Rowe's face was caused on the front side of the fixed cross member. In his report, Dr Grigg concluded:

*a) There is a very low or negligible probability that the deceased was standing on the tines and reaching back through the mast when his head was crushed.*
*b) There is a very high probability that the deceased was standing on the dashboard of the forklift facing forwards immediately prior to his head being crushed.*
*c) The switching off of the engine of the forklift had nothing to do with the causation of the injuries but it must have occurred after the deceased was released from the trapping space.*
*d) The descent of the sliding mast may have occurred as a result of inadvertent forward movement of the sliding mast control lever when efforts were being made to push the other control levers forwards to prevent the mast tilting backwards.*
*e) The available evidence does not include any explanation for the presence of the deceased on the dashboard of the forklift, however the impression is gained that the forklift was being used as a mobile work platform associated with grinding and movement*

*of an aluminium beam.*

98. Dr Grigg was present during the evidence of Mr. John Curtis and Mr. Brian Curtis. He was recalled to clarify whether his conclusions were consistent with the version of evidence provided by Mr. Brian Curtis. Dr Grigg was of the view all but point three in his conclusions remained accurate and that the conclusions he reached were consistent with the version of events provided by Mr. Brian Curtis. He advised point three of his conclusions was no longer accurate because he was not aware the engine had been turned off and then restarted in order to release Mr. Rowe. Dr Grigg said it made sense. He says Mr. Brian Curtis' evidence does not change his view as to what he says most probably occurred.

99. Based on his assessment of the physical evidence and reviewing the witness statements Sergeant Rasmussen also had a theory. He surmised Mr. Rowe was positioned between the operator's cabin and the mast and his body is bent over the fixed mast cross member. His face would have been positioned so that his face from his denture to his eyebrow is over the fixed mast cross member. With the mechanism of the sliding mast coming down pressure is applied to the back of his right head so his head is making contact over the top of the leading edge of the fixed mast cross member. As the sliding mast cross member comes down it pushed his head down around and onto the mast that would have skewed his body up at the same time taking his left eye where there is a release of energy causing the blood splatter on to the back of the canopy on the operator's cabin. His torso would have been positioned to the right creating a barrier. This theory is generally consistent with that of Dr Grigg.

**WHICH THEORY IS MOST PLAUSIBLE**

100. A number of suggestions arise in the evidence concerning what Mr. Rowe was doing, and where he was attempting to position himself on the forklift immediately prior to the incident. Mr. Whitelock recalled earlier in the day

Mr. Rowe was standing on the tines with Mr. Curtis driving the forklift (an assertion Mr. Curtis denied). In the minutes prior to the incident, Mr. Lowry recalls seeing Mr. Rowe standing on the forklift tines. Whilst it is likely Mr. Rowe was on the tines shortly prior to the incident, on the evidence it has not been established as to how he came to be on the dash of the forklift.

101. However, as to the mechanism of injury. I find that it is more probable than not that:

a) immediately prior to the incident:
    i. the forklift was located under the aluminium beam close to the trailer;
    ii. the forklift was on, without the brake engaged;
    iii. Mr. Rowe was using the forklift with a view to moving the alumimium beam;
    iv. Mr. Brian Curtis was sitting in the excavator speaking with Mr. Lowry;
    v. Mr. Brian Curtis was facing away from where Mr. Rowe was located;
b) Mr. Rowe placed his feet on the dash of the forklift and they slipped down, causing:
    i. the forklift to go into reverse;
    ii. the tilt lever to engage; and
    iii. the mast to move towards Mr. Rowe trapping his body between the operator's cage and the mast;
c) the force of the mast against Mr. Rowe's body caused Mr. Rowe to bend over around the torso and his head to be placed in between the fixed mast cross member and the sliding mast cross member;
d) in a desperate attempt to free Mr. Rowe by pushing against the tilt control to release the mast, Mr. Lowry inadvertently also moved the control closest to the steering wheel which lowered the mast, causing the sliding fixed cross member to come into contact with Mr. Rowe's head;
e) at or around the same time Mr. Brian Curtis turned the forklift off;

f) there was a gush of blood which coincided with Mr. Rowe no longer moving; and
g) Mr. Brian Curtis turned the forklift back on to release the tilt and raise the mast in order to free Mr. Rowe.

## ANALYSIS OF THE CORONIAL ISSUES

### *The identity of Mr Rowe including when, where and how he died, and the cause of death*

102. In accordance with section 45 of the *Coroners Act 2003* ('the Act'), I make the following findings:

a. the identity of the deceased person was Laurence Edwin Rowe;

b. the deceased person died as a result of being trapped in a forklift between the mast and operator's cage, with his head becoming crushed between the sliding mast cross member and the fixed mast cross member;

c. the date of death the deceased person died was 18 August 2008;

d. the place of death the deceased person died was 156 Eastlake Street, Carrara, Queensland; and

e. The cause of death was head injury.

### *Determine the surrounding events and circumstances leading up to the death*

103. The events and circumstances leading up to Mr. Rowe's death have been canvassed in detail above.

### *Examine any/all safety management standards in operation at BMP at the*

***time of the death, and if applicable, the adequacy of those safety management standards***

104. The safety management standards at BMP have been examined. It has been established that BMP had no safety management standards to speak of in operation at the time of the incident. Some observations include that BMP had:
    a) no operating manual for the forklift;
    b) no risk management procedures in place;
    c) no induction manual or training;
    d) no maintenance records for the forklift;
    e) allowed consumption of alcohol by Mr. Curtis at lunchtime prior to the incident; and
    f) had a general disregard for safety.

***Examine any/all safety management standards relating to the use and operation of the forklift***

105. It has been established there were no safety management standards in place in relation to the operation of the forklift.

***To examine and review any/all formal/informal staff training undertaken by BMP to any/all staff operating the forklift during the course of their employment***

106. It has been established there was no formal or informal staff training undertaken by BMP to any/all staff operating the forklift during the course of their employment. Mr. Brian Curtis and Mr. John Curtis both admitted to operating the forklift without the relevant license.

**RECOMMENDATIONS IN ACCORDANCE WITH S46**

107. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to:

a. public health and safety,

b. the administration of justice, or

c. ways to prevent deaths from happening in similar circumstances in the future.

108. In this case there were no systemic specific industry issues identified. BMP had poor work practices and did not promote a safe workplace. Mr. Rowe a very experienced operator engaged in what can only be described as dangerous work activities, putting himself at risk of significant injury and death. I make the following comments or recommendations.

## DISCRETION OF THE CORONER TO REFER IN ACCORDANCE WITH S48(2)

109. Section 48(2) of the Act provides if, from information obtained whilst investigating a death, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the director of public prosecutions or the chief executive of the department in which the legislation creating the offence is administered.

110. I do not consider there is any evidence to suggest the actions taken by Mr Brian Curtis and Mr Jason Lowry were carried out with anything but good faith. They reacted quickly and were desperate to try and free Mr Rowe in what was a very distressing situation. I am of the view there is no information obtained which suggests a criminal offence was committed.

111. A question for this Inquest is whether, given the evidence that has been heard in relation to the actions by BMP and Mr. Brian Curtis, charges under the WH&S Act ought to be considered. I find there is evidence which requires the consideration of the chief executive of Workplace Health and Safety Queensland.

**James McDougall**
**South Eastern Coroner**