CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Simon James Poxon**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Toowoomba
FILE NO(s):	2013/738
DELIVERED ON:	8 July 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 November 2015, 19 January 2016, 29 March-1 April 2016, 4 April 2016
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, workplace death, identification of hazard and management of risk of moving vehicles, adequacy of investigations, adequacy of process adopted for decisions to prosecute

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis, Coroners Court of Queensland
Counsel for Office of Industrial Relations (WHSQ):	Mr B McMillan I/B Crown Law
Counsel for the Poxon family:	Mr C van der Weegen I/B Shine Lawyers
Counsel for Sherrin Rentals Pty Ltd:	Mr A Scott I/B Holding Redlich

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Introduction

1. Simon James Poxon was aged 47. Simon had been employed with Sherrin Rentals Pty Ltd for a period of two days. Sherrin Rentals Pty Ltd was a company, which hired construction equipment including travel towers, height access equipment, scaffolding and earthmoving equipment.

2. On 26 February 2013 Simon and a co-worker were at Sherrin Rentals' Toowoomba depot. They were standing in between a knuckle boom and a bucket truck when the bucket truck suddenly reversed. The co-worker managed to get out of the way in time, however Simon became trapped between the two vehicles and suffered significant injuries to his lower torso. These injuries were nonsurvivable.

3. The incident was reported to the Queensland Police Service (QPS) and Workplace Health and Safety Queensland (WHSQ), with both agencies attending the scene on the day of the incident and thereafter conducting investigations to identify whether anyone may be responsible for an offence under the Criminal Code/Traffic legislation or Workplace Health and Safety legislation.

4. Following those investigations, the QPS investigator formed the opinion that there was insufficient evidence to successfully prosecute the driver of the vehicle for driving offences under the *Criminal Code* or the *Transport Operations (Road Use Management) Act 1995*. No charges were considered against the company.

5. WHSQ commenced a prosecution action under its legislation against the driver of the vehicle, Mr Jameson Boon, but not the company, Sherrin Rentals. Mr Jameson Boon subsequently pleaded guilty to the charge and was sentenced.

6. The family expressed a number of concerns as to the circumstances of the tragic incident, the quality of the investigations and the prosecution decisions that had been made. A decision was made to hold an inquest.

Issues for inquest

7. At pre-inquest conferences held on 16 November 2015 and 19 January 2016. It was made clear at the outset that this court would not be reviewing issues of penalties imposed at sentence by the Industrial Magistrate or whether an appeal should have been lodged.

8. The following issues for the inquest were determined:

- The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death;

- The circumstances surrounding the death, including identification and management of the risk of persons being struck by vehicles or machinery at the workplace; and

- Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.

- The response of the Queensland Ambulance Service, the Queensland Police Service and the Office of Fair and Safe Work Queensland to the death, including the basis for decisions about prosecution actions

9. The following witnesses were called to provide evidence at the inquest:

- Matthew Hunter, Flight Critical Care Paramedic, QAS (QAS first response officer)
- Senior Constable Natalie BROWN, Toowoomba Police Station (QPS first response officer)
- Senior Constable Alvyn SERVIN, Toowoomba Forensic Crash Unit (QPS Investigating Officer)
- Scott MUNRO, Inspector (Investigations), WHSQ (WHSQ Investigating Officer)
- Bruce Matthews, Principal Inspector (Investigations), WHSQ (WHSQ Investigating Officer from September 2013)
- Neil Alfred STEGER (Float Driver, Sherrin Rentals,)
- Marvin GEIST (Field Service Mechanic, Sherrin Rentals)
- Jarod BOON (Field Service Maintenance Supervisor, Sherrin Rentals)
- Jeffrey CAMPBELL (Auto Electrician, Sherrin Rentals)
- Matt William WOODS (Diesel Fitter, Sherrin Rentals)
- Mark SYMONDS (Mechanic, Sherrin Rentals;)
- Jameson Nathan BOON (Labourer/Yard Hand, Sherrin Rentals; driver of the tower truck)
- Kevin BARRY (Operations Manager, Sherrin Rentals)
- Grant SHERRIN (General Manager, Sherrin Rentals)
- Tahnee WINNING (Administration and Property Manager)
- Quinnton NEWITT (workshop mechanic)
- Lenard COTT (worker with Sherrin Rentals)

Autopsy results

10. An autopsy examination found the cause of death was due to hypovolaemic shock due to exsanguination and from traumatic rupture of the femoral artery and vein on both the left and right side. This was due to a massive groin injury involving fracture of the pubic rami, severing of prosthetic urethra, lower rectum and degloving injuries to genitals caused by a crushing injury between two items of machinery.

The circumstances surrounding the death

11. Simon Poxon was a carpenter and qualified builder for over 21 years. He had established his own successful house removing, restumping and levelling business in Toowoomba. Financial impacts on his business following a long wet season meant that Simon had to look for other means of income. This is what led him to being in the employ of Sherrin Rentals Pty Ltd as a tilt tray driver.

12. On 26 February 2013 Simon was at Sherrin Rentals depot and workplace at 17 Hillman Street, Torrington, Toowoomba. Earlier that morning Simon and a co-worker Neil Steger had driven to Esk to retrieve a “knuckle boom” (a mobile elevating work platform) and return it to Sherrin Rentals’ Toowoomba depot.

13. The weather was overcast and there had been intermittent rain. The incident occurred onsite at the depot, in an area described as the red tagging/refuelling area. Because of the rain, there was more activity than usual at the depot as many workers who were usually operating in the field, were present at the depot performing maintenance.

14. A Hino bucket truck (the truck had a cherry picker tower fitted and is also referred to as a travel tower or tower truck) had been parked near the red

tagging/refuelling area earlier. It was moved from the wash bay pit area adjacent to the wash bay shed to make room for another vehicle in the workshop. The company's auto electrician, Geoffrey Campbell still had work to do on the passenger side of the bucket truck's dashboard and requested Mark Symonds to move it there so that he could later work on it out of the rain, but to ensure the fuel bowser was still accessible. Mr Campbell did not feel comfortable moving the bucket truck himself, as it required reversing, and asked Mr Symonds to do so because he had a truck licence.

15. According to Marvin Geist he was working on a dump truck and had to reverse it into the workshop, but was blocked by the position of the bucket truck and another dump truck. Mr Geist sought permission from the supervisor Jarod Boon to move these trucks. Mr Geist was at the time also discussing a pole borer with Jarod Boon, so Mr Geist asked if Jameson Boon could move the two trucks. Jarod Boon is Jameson Boon's uncle. Jameson Boon was a young man aged 19 and had been employed as a yardsman for about 11 months.

16. Once permission was given, Mr Geist says he told Jameson Boon to move the bucket truck "directly forward to the fence, to a space in the fence". Mr Geist told WHSQ he made sure Jameson Boon understood what he was to do and Jameson Boon said it was all good and Mr Geist left it at that.

17. This direction by Mr Geist was considered by WHSQ investigators as significant, on the basis it was a specific direction given by Jameson Boon's employer through Mr Geist, being a more senior employee, to Jameson Boon who was considered a junior employee. WHSQ's contention is that for reason or reasons uncertain, Jameson Boon, instead of driving forward as directed, reversed the bucket truck, which then impacted with the knuckle boom and Simon Poxon.

18. Geoffrey Campbell told WHSQ that he could not see how any logical reasoning person would need to reverse, given the vehicle needed to be driven forward to remove it from the area. Geoffrey Campbell recalls this particular bucket truck as he had been working on the shutdown circuit, which related to the operation of the bucket. He had been asked by Jameson Boon if the truck could be moved safely. Mr Campbell had no concerns with it being driven safely. In his evidence at inquest Mr Campbell stated he did not instruct Jameson Boon to move the bucket truck under cover as there was really no room under cover.

19. Jameson Boon told the inquest that he was told to put the dump truck in the wash bay and the bucket truck under cover for the electrician to do more work. Moving the bucket truck under cover would have involved a more complicated manoeuvre including reversing at some point. Although Jameson Boon conceded he had been warned by his employer to use a spotter when reversing plant he did not do so on this occasion. I will deal with Mr Boon's evidence in more detail shortly.

20. Simon and his co-worker Neil Steger were standing in between the knuckle boom and the bucket truck going through the refuelling process. Neil Steger recalls hearing the truck start up but does not recall any person getting into the cabin. He does not recall hearing the reversing beeper. He noticed the truck reversing out of the corner of his eye and jumped out of the way. He yelled out for the driver to stop. Simon was pinned between the knuckle boom and bucket truck.

21. Mark Symonds recalls hearing the sound of the reversing beeper and as a result recalls looking towards the bucket truck and seeing it move backwards. He recalls that Simon was looking at Neil Steger, who in turn was looking back to the truck. Neil Steger was seen to put his arms up and yelled out to stop and

as the truck got closer, Neil jumped out of the way but Simon was not quick enough. Mr Symonds considered the truck moved backwards quickly.

22. Matt Woods was talking to Mark Symonds. He heard someone yelling out from inside the workshop and they both spun around to look towards the wash bay. He saw the bucket truck was reversing and could see Neil Steger and Simon standing near the back of the knuckle boom. They both started yelling out to the driver and at the last moment Neil Steger jumped out of the way as the truck reversed back but Simon became pinned.

23. Several staff at the worksite witnessed the incident and many individuals rushed to help Simon, providing first aid and calling Queensland Ambulance Services (QAS). Another witness ran over to the driver of the bucket truck, whose window was up and told him to move the vehicle forward. The driver had to wind the window down to hear. It is apparent he also had the truck radio on.

24. QAS officers provided emergency medical care at the scene and then transported Simon to Toowoomba Base Hospital, however despite these medical efforts Simon died from his injuries.

Evidence of Jameson Boon

25. Jameson Boon provided a sworn statement to Senior Constable Servin on 8 March 2013. He was not questioned via an electronic record of interview. Senior Constable Servin stated that he did not specifically warn Jameson Boon of his right to remain silent at the time of taking the statement. He says Senior Constable Natalie Brown as first response officer at the scene, had previously warned him of his right to silence at the scene on the day of the incident.

26. Senior Constable Brown did not give any evidence that confirmed she gave a warning to Jameson Boon and makes no reference to this in her statement. As well, she told the inquest that apart from making Jameson Boon return to the scene (he says he was sent home) and take a Random Breath Test (RBT), she did not otherwise speak to Jameson Boon about the incident as he was very upset. She said she would have warned Jameson Boon if she was going to question him.

27. Senior Constable Servin stated in his evidence he simply reminded Mr Boon of the previous warning given by Senior Constable Brown. None of this information is contained in Senior Constable Servin's statement or report to the coroner and no reference to this warning is contained in Jameson Boon's statement. This is quite concerning. It does not impact on me in making findings about what happened, given I do not need to rely on the Rules of Evidence. It may impact on what can be done with his statement and his evidence generally in other places, given the lack of a warning.

28. I was also aware from previous evidence, that Jameson Boon had declined to provide a statement to WHSQ unless he was required to under their coercive powers and given some immunity. That indication had been given to WHSQ by his lawyer shortly after the incident. WHSQ declined to interview Mr Boon on that basis, although it is apparent he was given other opportunities by WHSQ to voluntarily speak to them at other times, which he declined.

29. Accordingly when Jameson Boon gave evidence at the inquest I also warned him that he could decline to give evidence if he felt that evidence may incriminate him. I also provided him with information about the protection provided by s 29 of the *Coroners Act 2003*. Mr Boon stated he was happy to give evidence. He was not legally represented. I was not sure he completely understood everything I said. Given all of the matters referred to above, I

decided that notwithstanding his apparent willingness to provide evidence at the inquest, in doing so this would be on the basis of the protections provided by s 29 in that this evidence, if incriminatory, could not be used against him in any subsequent proceeding, other than for perjury.

30. Mr Boon's evidence was not altogether satisfactory. At times it was rambling and confusing, at other times he provided contradictory evidence and on occasions self-serving evidence. I had some uneasiness about the extent of his understanding of some of the questions being asked. I am not sure he was deliberately being evasive as a court room can be a strange environment for a young person without any noticeable support.

31. Jameson Boon's statement noted that part of his duties were to clean the equipment, do yard work and do some minor maintenance on the machines. He was also required on occasion to drive equipment around the yard, mainly when they were being washed or worked upon. That much is uncontroversial.

32. Jameson Boon said he did not have any "tickets" or licenses for the equipment. He was the holder of a P1 provisional driver's license. He did not hold a truck license. He had no formal training other than on-the-job training. He had spoken to the company about an apprenticeship as a diesel fitter or mechanic but was not able to get one. There were clearly some concerns expressed by the company about his progress and his performance and he seemed to concede this.

33. Jameson Boon said he had driven trucks similar to the bucket truck he drove that day, but had not driven that particular truck. He had never been given any training for driving the bucket truck. I deal with training and competency issues later in this decision.

34. Jameson Boon's statement to QPS contained a passage where he stated that when he moves equipment he always has a "spotter" with him to make sure he does not cause damage or injury. He qualified this assertion in his oral evidence by saying he "mostly but not always had a spotter". On 27 July 2012 Mr Boon was given a formal warning notice after an incident at work. He did not recall the notice but agreed his signature was on it. The notice required him to have a spotter in future when he was loading equipment onto a trailer.

35. Jameson Boon says he was asked by Marvin Geist if he could move a dump truck and bucket truck. He says he moved the dump truck from outside into the undercover wash bay. Jameson Boon's statement also stated that Geoffrey Campbell had said it was okay to move the bucket truck but to move it somewhere under cover. In evidence he said it was one of the two who said he should move the bucket truck under cover.

36. It was put to Mr Boon that Marvin Geist had given evidence that Marvin told Jameson Boon to move the bucket truck forward to the fence line. Jameson Boon's response was equivocal. In short compass he first said he believed so; then he said he did not recall; and then he was not 100% sure.

37. It was also put to him that Geoffrey Campbell had not told him to move the bucket truck under cover but Geoffrey had told someone else this earlier in the day. The response was he did not know if Geoffrey spoke to someone else but he just did what he was told.

38. Jameson Boon said he was not always comfortable moving trucks but he did what he had to do.

39. In his oral evidence he stated using a spotter just did not come into his head. It was put to him the contents of his statement suggested he did not request someone to spot for him because Marvin Geist or another person would have been watching him. He was quite hesitant and unconvincing in his oral evidence and suggested they would be involved in their own work. He mentioned on a number of occasions in his oral evidence there were other "eyes and ears" in the yard.

40. It was further put to Mr Boon that when he pleaded guilty to the charge brought by WHSQ, the facts and particulars set out in the Complaint and Summons included the allegation that he had been directed by Mr Geist to move the truck forward to the fenceline. Mr Boon could not really explain or respond to this suggestion. He was shown a copy of the Complaint and Summons. He appeared genuinely quite confused when reading it.

41. On that issue I do not think too much can be placed on the plea of guilty, although it was a valid forensic exercise to be put to Mr Boon. Clearly a sentencing court is entitled to rely on a guilty plea as an admission of guilt to the particulars stated in the charge and sentence accordingly. However, defendants can and do plead guilty to offences and particulars of those offences for a variety of reasons, and I do not think it can be assumed that his acceptance of the facts being dealt with in one court should necessarily follow to be an acceptance of the facts in a quite different jurisdiction.

42. Jameson Boon says he then climbed into the cabin of the bucket truck. He could not see any equipment behind him as he climbed into the truck and said it was very difficult to see out the back with the bucket on the back of the truck. He stated the mirrors have a limited view but he did check them.

43. Jameson Boon said it had been his intention to drive the bucket truck around the wash bay building and into the undercover area. There had been a dump truck parked near the wash bay and he had to decide whether he would go around the dump truck or go in front of it to enter the wash bay from the other end. He remembers that the hand brake was on. The gear indicator showed that he was in either neutral or park, but he cannot remember which. He said the gear indicator was similar to an automatic car gear shift.

44. Jameson Boon says he started the truck and stayed still for about thirty seconds whilst he thought about what he had to do to move it to the wash bay. He then put his foot on the brake and released the hand brake. He then moved the truck a metre forward and then put his foot on the brake and stopped. He was considering what was in front of him, the size of the vehicle he was driving and the route he would take. He had not made his mind up and decided to back the bucket truck and start again.

45. CCTV footage of the incident was obtained. Simon Poxon and Neil Steger can be seen at the fuel bowser attending to paperwork and about to refuel the knuckle boom. This footage shows the bucket truck reversing into the knuckle boom but does not show it being driven forward as claimed by Jameson Boon. However, it is apparent the CCTV is motion responsive and it may have only activated for the period when the incident occurred.

46. Jameson Boon says he then placed the gear selection into reverse, checked his mirrors, saw nothing behind him and took his foot off the brake. He says he did not hit the accelerator and the truck moved backwards. He does not recall the reversing alarm sounding. He felt the truck hit something and recalls workers yelling at him to move forward, which he did. In his evidence at the inquest he admitted he had turned on the truck's radio.

47. At the inquest Mr Boon denied the suggestion put to him on a number of occasions that he applied the accelerator pedal. Eventually during cross examination he conceded he did apply some accelerator but "not to the floor". It was never suggested he applied the accelerator hard or to the floor, but clearly the CCTV footage shows the bucket truck reversing at a speed consistent with some application of the accelerator pedal.

48. Jameson Boon says in his statement he then ran to get the first aid box near the office and was told to sit in one of the rooms. He said he was very upset. His statement also stated an ambulance officer came and spoke to him and took his pulse and told him he should go home. In his evidence at the inquest he said his uncle, Jarod Boon, told him to go home. Mr Jarod Boon denied this.

49. Matthew Gribble from QAS recalls Jameson Boon was very distressed and was crying. He took his vital signs, which gave him no concern, gave him some advice on how to deal with emotional distress and he told a male person someone should stay with Mr Boon. He says he did not direct Mr Boon to leave the scene nor did he tell him to stay, as that is not part of his role as a paramedic. I accept this was the case.

50. Jameson Boon stated a friend came and picked him up, but as they were about to arrive at his friend's house he was asked to come back to the office. He spoke to a police officer. A number of witnesses also recall Jameson was very upset and crying.

51. It is apparent Senior Constable Natalie Brown requested Jameson Boon return. When he did she could see Mr Boon was distressed and upset. A specimen of breath was negative for any alcohol. No saliva drug testing was requested. Senior Constable Brown says she did not otherwise discuss the incident with him.

52. Jameson Boon stated that he was unsighted and unable to see behind the truck. However, it is clear he did not physically check around the truck before moving it and he easily could have done so. In evidence he agreed he should have got out of the vehicle to check and that reversing was inherently dangerous.

53. Jameson Boon also agreed that having a spotter would have avoided the incident occurring. Jameson Boon stated he did not recall an induction dealing with safe work procedures and hazard awareness. He agreed an incident involving him moving a water truck in 2012 occurred as a result of him having no spotter.

54. One of the critical issues for determination was the nature of the direction given that day to Jameson Boon. Mr Boon's statement was provided on 8 March 2013. His version at that time was he intended to move the bucket truck into the undercover wash bay area. It is unclear if he was aware of the version of events being alleged that he had been informed to move the truck forward to the fenceline. It is likely he has at some stage heard discussion around the yard that morning about the bucket truck needing some further electrical work done on the dashboard and the preference by Mr Campbell to do that out of the rain. A decision was later made that the truck needed to be moved and the only position available was at the fenceline. I accept the instruction given by Mr Geist to Jameson Boon was to move it to the fenceline and it is most likely Mr Geist also said to move it forward. Jameson Boon appeared to accept this proposition and then he became less certain.

55. For reasons that are unclear Jameson Boon decided to reverse. Perhaps he was wanting to be helpful and decided he would still move it under cover and

out of the rain. Perhaps he had not listened carefully to the instruction. Perhaps he simply decided to ignore the instruction. Whatever is the case, Jameson Boon then made the inexplicable decision to reverse the truck. Inexplicable not so much as to the manoeuvre itself, but inexplicable in that he must have seen the knuckle boom behind the bucket truck as he went over to get into the truck. It was patently obvious to anyone. He then did not do a further check as to what was behind when he could not see out to the rear of the vehicle. He then did not request a spotter. Any one of those actions would have identified the hazard and the consequences of reversing and would have stopped the truck reversing into Mr Poxon. The incident was completely avoidable.

Training and competency of Jameson Boon

56. The training provided to workers including at induction as well as concerns relating to the competency of Jameson Boon and how Sherrin Rentals handled this became relevant, because one of the reasons why WHSQ determined that the company should not be prosecuted was that "*Jameson Boon was given an induction, part of which related to driving or moving of plant, hazard awareness (Hazard identification, assessing and managing risk), safe work procedure (including assessing and managing risk for each task).*"[1]

57. The evidence to support that determination largely comes out of the statement and evidence of the General Manager Grant Sherrin when he asserted that Mr Jameson Boon commenced employment on 5 March 2012. Mr Sherrin stated Jameson Boon underwent the employee induction, which includes a number of work place health and safety related topics including hazard awareness/incident reporting and safe work procedures. Jameson Boon's duties included the daily moving of all heavy equipment and Jameson Boon had done this on numerous occasions over the 11 month period of his employment.

58. The totality of the evidence suggests unsurprisingly that all employees received a form of induction. An Induction Checklist documented that the induction included a component on "*Hazard awareness/Incident reporting and Safe Work Procedures*".

59. Rather than accept at face value that the induction included all of the matters noted on the checklist it became instructive at the inquest to examine what that induction process actually provided to individual workers and in particular about hazard awareness in relation to the moving of plant and vehicles.

[1] Evidence of Mr Peter Matthews

Exhibit 55 - Statement of Grant Sherrin GS-1

SHERRIN Rentals

INDUCTION CHECKLIST

EMPLOYEE NAME: JAMESON BOON

	Tick if present
COMPANY HISTORY	☑
COMPANY VALUES	☑
MANAGEMENT STRUCTURE	☑
DRUG AND ALCOHOL POLICY	☑
PROTECTIVE EQUIPMENT	☑
EMERGENCY PROCEDURES	☑
ASSEMBLY POINT	☑
FIRST AID	☑
FIRE	☑
HAZARD AWARENESS/INCIDENT REPORTING	☑
SAFE WORK PROCEDURES	☑
MENTOR	☑
REVIEW PERIOD	☑
PAY	☑
JOB/ROLE TASKS	☑

Has the employee been given access to a copy of the Company Policy Manual? Yes/No

Employee signature: [signature] Date 05 / 03 / 12

Manager signature: [signature] Date 05 / 03 / 12

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Training/Induction Provided to Workers

60. Neil Steger said in his statement to QPS that he did not receive any specific "safety" training from Sherrin Rentals but recalls an induction session where there was an evacuation safety drill. Training/Induction was not raised by WHSQ in their interview with him. At inquest Mr Steger was unable to expand on this by very much. He was unsure if he has seen the company policy manual or the induction checklist but conceded, when shown, that he had signed one. He stated that safety around machinery was largely common-sense and he had been around machinery for a long time. Safety issues were raised at toolbox meetings. He could not recall the risks of moving plant being raised specifically. There had however, been changes to traffic flow through the depot put in place since the death.

61. Mark Symons started work at Sherrin Rentals on the same day as Simon. He says in his QPS statement there was a tour of the work area and layout and a tool box meeting was held that morning, which was basically an introduction to the daily workings of the yard. He does not recall there being a specific "safety" lecture about working within the yard. Training was not raised in his interview with WHSQ. At the inquest he recalled an induction in the form of an orientation of the layout of the yard. It was fairly quick to his recollection and given by Kevin Barry. There was also a quick tool box meeting. He does not recall a specific safety lecture or instructions about how to move a vehicle. Subsequent to the incident there were more specific instructions including traffic flow in one direction, where to park and not to park, the yard was provided with more signs and they needed to travel at a reasonable speed. He agreed he had seen an induction checklist and signed it but was dismissive of the process generally in so far as many companies use them as legal protection. He also stated safety issues were common-sense. He was not critical of Sherrin Rentals. He also said individuals have a responsibility to show common-sense.

62. Matt Woods gave a statement to QPS. He was not interviewed by WHSQ. He said he was employed as a diesel fitter for three months and commenced work on 25 February 2013. He stated he had a general site induction, which took about twenty minutes. Areas included were general things such as toilets, areas that were off limits, speed limits on site, emergency procedures and assembly point. At the inquest he said he could not recall any instructions being given about how to move vehicles around the yard and only about parking trucks at specific spots. Traffic flow through the yard changed after the incident. He was not sure if he signed an induction checklist. At the inquest he stated he may have. He recognised the company policy manual as it was kept in the trucks. He could not recall the company Safe Work Procedures document.

63. Quinnton Newitt provided a statement to Police. He was not interviewed by WHSQ. He did not see the incident that day. He stated in his statement he did not receive any training for safety and was just shown how to operate and drive machinery. He was told who the safety officer was. He compared Sherrin Rentals to subsequent employers who had provided a safety course. At inquest he was unable to expand upon this evidence other than that his current employer has a process whereby employees are trained and encouraged to consider how to make things safe when conducting each task. At the same time he said he felt safe at Sherrin. He did not recall any specific instructions about how to prevent people being hit by vehicles or reversing. He thought the induction checklist looked familiar and had seen the company manual. He was not sure about the Safe Work Procedures document.

64. Philip Tuesley also did not see the incident. He provided a statement to Police. He was not interviewed by WHSQ. He does not recall any particular safety course. When he first joined the company someone followed him around for a

couple weeks to ensure he was doing the right thing and showing him the machinery. He said the policy now within the yard is to sound the horn and ensure that it is clear around the machinery that has to be moved within the yard. At the inquest he stated that safety around the yard was a matter of common-sense and he felt safe at Sherrin. He does not recall discussions about managing the risk of reversing vehicles. He said as a matter of common sense you would check the area or use a spotter. He had been there over 5 years and quite reasonably could not recall induction checklists or manuals and safe working procedures. Since the incident there had been traffic flow imposed in a one way direction and warning horns are to be utilised with 2 to indicate going forward and 3 for reverse. The refuelling area is now a clear way for refuelling only.

65. Jason Zeller gave a statement to QPS in February 2016. He was not interviewed by WHSQ. In his statement he stated that when he first started working at Sherrin Rentals, workplace safety on the equipment was explained with a site induction handbook by management, which was read and signed, but there was nothing really official in place for the operation of each piece of equipment. Most of the workers had been working around heavy equipment for some time and it was all common sense stuff. He told the inquest workers are responsible for their own safety. Since the incident workers are required to operate machinery and vehicles in front of management, who then signed off that you were competent on that piece of equipment. There was a requirement to sound the horn of machinery before you move it. There was no specific instructions about reversing before the incident but after the incident the use of spotters became more common.

66. Leonard Cott stated in his QPS statement that after the incident the company changed their procedure so that two people had to be moving trucks around, with one person driving and one person outside ensuring the safety of the work yard. The company also changed the direction you could drive around the yard to a one-way direction. He was not interviewed by WHSQ.

67. In his interview with WHSQ Grant Sherrin was asked about whether the induction provided to Jameson Boon was in relation to the driving or moving of plant around the depot. He replied it was and then was asked how this was conducted. His answer was this training took place over a period of time by showing Boon how to move equipment into the wash bay. He was asked who provided this training and the response was either Jameson Boon's mentors or staff present at the time. He nominated Kevin Barry as the mentor and agreed that none of this training process was documented in any way. There was no further examination conducted in the WHSQ interview on this topic.

68. At the inquest Mr Sherrin agreed he was not present at the induction of Jameson Boon. He said the training about moving vehicles in the yard took place at induction and also over a period of time showing workers how to move equipment. He said Jameson Boon's mentor was Kevin Barry and he relied on Mr Barry to ensure Jameson Boon had been trained appropriately. Mr Sherrin was taken to a *Training Log for a water cart*[2] which certainly seemed to be a document that indicated a more formal and specific equipment instruction but he was unsure if it had been in use in 2013. He was unable to say how the company ensured Jameson Boon had been given appropriate instruction about how to use equipment at the depot other than a general answer that people at the depot would have done it. When asked who would have provided training to Jameson Boon for plant he repeated he believed Kevin Barry showed him. Mr Sherrin was vague in his knowledge of some fairly significant matters such as the *Plant Code of Practice*. Mr Sherrin nominated Mr Ben Hill as the person

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[2] Exhibit C2 page 46

who could provide more detail on the company's health and safety management strategies.

69. Mr Hill told the inquest that although he has more of a role now in relation to formulating workplace health and safety procedures and changes that were implemented, he did not seem to have specific involvement in formulating them before or at the time of the incident. After the death, the company engaged a consultant to review policies and provide advice on changes to procedures at the depot and these are reflected in the changes to traffic workflow and other practices that had been introduced and identified consistently by the workers at the inquest.

70. Kevin Barry was not interviewed by WHSQ until 3 April 2014. By that time he had left the employ of Sherrin Rentals. He gave a version of the events of the day of the incident from his perspective (he was present but did not witness the incident), which is uncontroversial. He gave evidence about the induction for Simon Poxon and identified the induction checklists for Mr Poxon and Jameson Boon. He told WHSQ that supervision responsibility for Jameson Boon were a combination of the mechanics, himself and Ms Winning from the office staff. He was unaware of Jameson Boon's licences or tickets. He could not recall who had given instruction to Jameson Boon on how to move vehicles around but then queried if Jarod Boon may have. Mr Barry was aware of the various warning notices given to Jameson Boon.

71. At the inquest Mr Barry did not recall the induction given to Jameson Boon although his signature is on the checklist. He said during the induction they would go through the checklist and tick it off. He seemed to suggest they would look at the Company manual and flick through the headings and they were given a copy to read later. He could not recall what was said about Safe Work Procedures but said employees could access it on the computer and print out pages if needed. He could not recall who Jameson Boon's mentor was. He repeated that Jameson Boon's supervisor could have been any number of persons including Jarod Boon. Mr Barry stated that after the warning incident he made sure Jameson Boon did not move anything unless someone was with him and recalls asking Jarod Boon or Marvin Geist to manage this. He said Jameson was under instruction to use a spotter and relied on people in the yard such as Jarod and Marvin to make sure that happened.

72. Jarod Boon provided an interview with WHSQ on 26 February 2013. He did not provide a statement to QPS. Jarod was largely asked about the events of the day and the interview lasted 5 minutes. At the inquest Jarod was asked if he was Jameson Boon's supervisor. He stated that when Jameson was first employed, he was out in the field but then became the field service supervisor and was based in the depot. He said he supposed he then was the supervisor. He could not recall any discussions about Jameson moving trucks but that was Jameson Boon's job. He does not recall any discussions about the dangers of moving trucks or equipment in the yard. He said most of those experienced in the industry would know when they needed help or needed a spotter. He said the induction he received was mainly related to orientation of the yard. He had seen the company manual and possibly had seen the Safe Working Procedures. He had left the company 2 years ago but recalled a number of changes had been introduced after the incident.

73. In my view the totality of this evidence would support a conclusion that determining the induction process included *Hazard awareness/Incident reporting and Safe Work Procedures* well overstates the evidence. WHSQ did not sufficiently investigate the induction process to be able to objectively come to that determination and appears to have accepted the version provided by the company without testing the assertion.

Issues relating to competency of Jameson Boon

74. The issue of the driving and work behaviour of Jameson Boon and any company response to concerns was also raised as an issue at the inquest.

75. The general manager Grant Sherrin stated in his statement that Mr Jameson Boon commenced employment on 5 March 2012. He stated that Jameson Boon did a variety of jobs from gardening to washing down vehicles and very basic mechanical repairs. He was past his probation period but had not been put on as an apprentice. He had been given another six months probationary period. On 6 February 2013, in response to a request regarding a potential apprenticeship, Jameson Boon was advised by the general manager to press on in his current capacity as a yard person and show the company he had the drive and commitment to complete an apprenticeship. He referred to the various warning notices provided to Jameson Boon. Other than those incidents he was not aware of other concerns about Jameson Boon.

76. Mr Sherrin was asked in his interview with WHSQ as to his knowledge of Jameson Boon's experience in moving large vehicles. His response was he did not know if he had that experience.

77. Tahnee Winning was the rental coordinator. She recalls Jameson was trying to get an apprenticeship but he needed to show that he was more conscientious and careful about his job. He had a few minor mishaps and would arrive late to work on occasions. To her knowledge he was tolerated by other staff but he was not well liked due to his poor attitude about work and poor efforts in his attempts to learn when other staff tried to show him procedures. He had run over ladders in the wash bay and almost tipped a water tank off a truck.

78. Neil Steger was asked about this issue in his police statement and he said he recalls Jamieson Boon was a young man who drove trucks and equipment in the yard. He did not have that much to do with him. He was not asked about this issue by WHSQ. At the inquest he was unable to expand upon this issue.

79. Quinnton Newitt recalls in his police statement that Jameson Boon had a bit of a poor attitude and almost rolled a water truck because he did not listen to the experienced workers. Mr Newitt was not interviewed by WHSQ. At the inquest he added that Jameson Boon was very cocky and was reluctant to accept help and advice. He was aware or heard about a few incidents and that Jameson Boon drove around the depot yard a bit fast.

80. Jason Zeller stated in his police statement, only taken in February 2016, that Jameson Boon was young and quite cocky. He personally never really saw him do anything unsafe in the yard, apart from driving equipment at unnecessary speed around the depot. He was not interviewed by WHSQ. He repeated this evidence at the inquest. He said Jameson Boon liked to show off and never got pulled up about it. Mr Zeller does not remember if he told management of his concerns and assumed someone did but was not aware who.

81. Phillip Tuesley was not interviewed by WHSQ. In his police statement he simply said he did not have much to do with Jameson Boon other than he used to help load gear occasionally. All he could say was that like any young person you have to watch them to ensure they are acting safely in the work environment. At inquest he said that he was out of the yard a lot and did not have much to do with Jameson Boon. He does not recall any problems with Jameson Boon's driving or other staff expressing concerns about speed. He stated that he was young and just out of school and everyone needs help from

time to time and you needed to keep an eye on the young ones as they were not used to heavy machinery.

82. Leonard Cott did not provide any information about this issue in his police statement. He was not interviewed by WHSQ. At the inquest he commented that Jameson Boon was young and he would try to teach Jameson Boon but he sometimes would not listen. Sometimes Jameson Boon appeared to be in his own world and you would have to tell him to pay attention. Mr Cott also saw Jameson Boon sometimes drive around the yard more quickly than necessary and he had told him to slow down. Mr Cott did not raise this further up the chain of management.

83. Geoffrey Campbell was not asked about the Jameson Boon's competency in his police statement, other than making a comment that he was past his probation period but had not been put on as an apprentice, perhaps to wait to get his mechanical skills up to par. He repeated as much in his record of interview with WHSQ. Mr Campbell also said he did not have a high regard for Jameson Boon's level of maturity or approach to things and his mechanical aptitude and skills were very limited. Mr Campbell was reminded by his family that he had once said to them he considered Jameson was reckless and was going to kill someone someday. At inquest he said Jameson Boon was accident prone, careless and would not listen. He recalls he almost rolled a truck off a trailer. He said that there is a need to move equipment slowly but this was not the case with Jameson who would not listen and was not cautious. He did not raise concerns with company management up the line.

84. Kevin Barry was the former operations manager. He told WHSQ that Jameson Boon had received a verbal warning for an incident involving loading of an item of plant without using a spotter and that he had been instructed to use a spotter on different occasions he would be moving equipment. There had been disciplinary action taken in respect to Mr Boon. On 14 July 2012 he was given a verbal warning for driving a water truck without a spotter present. It was asserted he was also provided with additional training in respect to the operation of equipment although it is unclear what that training involved.

85. The evidence would support a conclusion that Jameson Boon was young, inexperienced and "a bit cocky" and he had been careless on two occasions. These incidents were appropriately dealt with by the company. There was some vague evidence Jameson Boon would move equipment in the yard a bit quickly but this does not seem to have been brought to the attention of management. Jameson Boon's behaviour was no doubt sufficient to bring into doubt his long term role at the company but it would be unfair to suggest it should have raised a red flag to Sherrin Rentals that he was unsuitable to carry out the basic tasks he was employed to do, or that he was a danger to himself or other workers.

The response of the Queensland Ambulance Service, the Queensland Police Service and the Office of Fair and Safe Work Queensland to the death, including the basis for decisions about prosecution actions

First responses by emergency and investigative services

86. Queensland Ambulance Services (QAS) received an emergency call at 12:47 and a single officer arrived at 12:52. Second and third units of paramedics arrived at 12:58 and 13:10 respectively. After stabilising Simon, he was taken to Toowoomba Base Hospital and arrived at 13:25. On arrival at Toowoomba Base Hospital he was unconscious with an un-recordable blood pressure. The

response by QAS was well within appropriate response guidelines. Death appears to have occurred on the way to Hospital rather than at the work site.

87. First response officers from Toowoomba police station were first in attendance having been advised by QAS. The call to Police was logged at 13:36 and first response officers were assigned at 13:58 and arrived at 14:11. QAS had left the scene by this time and were on the way to hospital. Senior Constable Natalie Brown and Constable Aaron Fitzpatrick were first Police officers on the scene. A Forensic Crash Unit (FCU) investigator arrived after them at around 14:30. Senior Constable Servin of the FCU was the investigating officer.

88. QAS policy was that QPS should be advised immediately of any major incident and all road traffic crashes. QAS agrees a delay of 49 minutes to contact QPS was disproportionate. Contact with QPS is by telephone whereas notification to QAS and Queensland Fire and Emergency Service (QFES) is through a shared computer aided dispatch platform and is automatic on receipt of predetermined incident types. A QFES unit was the second unit to attend the scene and assisted the first QAS officer.

89. The inquest has been informed a project has since commenced to implement an Inter CAD Emergency Messaging System to start in late 2016 between QAS, QFES and QPS. This system will alleviate for the future the problem of a delayed report to QPS.

90. By the time Senior Constable Brown arrived at the site QAS had already left, the driver had left and the vehicles had been moved. She thought the scene had been hosed down, although it is apparent this was not the case. She was not aware there had been a death or serious injury until she arrived. She did not take any notes of her actions and after securing the scene waited for the Forensic Crash Unit.

91. WHSQ arrived at 14:21 with Inspector Alison Cummings and Scott Munro attending. They had been tasked about the incident at about 13:50. FCU officer Senior Constable Servin was present when they arrived. The investigation was led by Principal Inspector Alison Cummings. The investigation report was finalised by Inspector Bruce Matthews after Ms Cummings took an extended period of leave for personal reasons.

Mandatory Drug Testing

92. Concerns were raised by family that Jameson Boon was not the subject of a mandatory drug test. He had been breath tested for alcohol with a negative result. There is no evidence to suggest Jameson Boon was affected by anything else. This is simply raised as a process issue relevant for future cases.

93. The issue of mandatory drug testing of drivers where death or serious injury has occurred has been the source of some concern to coroners.

94. The policy current at the time of the incident appears to have been that a decision to test for other substances other than alcohol is subject to the officer observing indicia that suggests the person is otherwise under the influence of a drug. The Operations Performance Manual sets out a number of criteria to assist a police officer to make such assessment.

95. Coroners have been concerned there may be considerable difficulties for police officers to make fine assessments of impairment based on indicia. It is accepted there may be resource implications, however recommendations have

been made by coroners that the Queensland Police Service ensure there is performed alcohol and drug testing of all potentially culpable surviving drivers involved in motor vehicle accident where serious injuries or death occurs.[3]

96. Since this incident there have been legislative changes introducing drug saliva testing.

97. The authority for police officers to require specimens of breath for breath test or specimens of blood for blood tests is based on the *Queensland Police Service Traffic Manual* and the *Transport Operations (Road Use Management) Act* (TORUM).

98. Section 80(2A) of TORUM provides that an officer may require a person to provide a specimen of breath for a breath test or a specimen of saliva for a saliva test or both where a motor vehicle was involved in an incident resulting in injury to or the death of any other person on a road or elsewhere if the police officer suspects, on reasonable grounds, such person was driving the vehicle at the time of the incident.

99. Under section 80(8) where those tests are positive a police officer may require the person to provide a specimen of breath, saliva or blood for further analysis.

100. It is apparent from a QPS perspective there have been a lack of qualified drug testers to ensure saliva tests occurs at all incidents. In an earlier response to requests from QPS to respond to family concerns on this issue, it was stated that there was an expectation that training of FCU officers was being attended to in the first half of 2016 so that FCU officers were able to conduct roadside drug tests of uninjured drivers involved.[4] Otherwise, although FCU officers could request a *Random Drug Testing Unit* to attend, depending on the location of the incident and the availability of the specially trained drug testing officers, this at times may not occur.

101. That training expectation may now be uncertain. QPS are still considering if all FCU personnel should be drug test trained and there are a number of considerations to be rationalised including the benefit if an FCU officer does a drug test at a serious crash and if it is positive the FCU officer will be required to leave the scene, the further test requires two officers, consideration of priority blood testing and trainer resources.

102. In order to be clear and to place the position beyond any doubt I intend to recommend to QPS as I have previously that sufficient resources and training are made available to ensure there is alcohol and drug testing of all potentially culpable surviving drivers involved in motor vehicle accidents where serious injuries or death occurs.

Prosecution Decisions

General Principles

103. One of the issues raised for the inquest was the basis for decisions about prosecution actions taken by WHSQ and QPS. There is a long-standing principle that, generally speaking, the exercise of the executive's decision whether to prosecute or not is not susceptible to judicial review.

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[3] Recommendation of Coroner Lock in Inquest into the death of Roslyn Law, 1 March 2012; Recommendation of Coroner Previtera in Inquest of the deaths of Brett McKenzie, Abigail Ezzy, Nicholas Nolan & Maxwell Thorley, 3 April 2012

[4] Exhibit B15 QPS response to family concerns

104. The question whether a coroner can investigate the reasoning of a decision not to prosecute pursuant to section 45 of the Act, and/or comment on a decision not to prosecute pursuant to section 46 of the Act, was the subject of a decision of the Supreme Court of Queensland in *Goldsborough v Bentley*4] QSC 141.

105. The general principle established by that case is that a coroner does have the power to investigate at inquest, and comment upon, a decision whether or not to prosecute an individual or entity in connection with the death, including any policy basis for this decision, provided any findings or comments do not include any statement that a person is or maybe guilty of an offence or civilly liable for something.

106. At the pre-inquest hearing conducted on 19 January 2016 it was agreed by those appearing including for WHSQ that the basis for decisions about prosecution actions, was capable of being added to the issues to be determined at inquest. I determined that a coroner could not investigate or comment upon decisions about whether an appeal should be lodged on any sentence.

107. A secondary issue was raised during the course of the inquest as to whether I should receive submissions from the legal representatives of possible affected parties as to whether I should exercise my duty to refer any person or organisation under section 48 of the *Coroners Act* 2003 ("the Act") and further whether any decision to refer or not to refer should be recorded in my published decision arising from this inquest.

108. I published my decision that it is my view proper for submissions to be received by Counsel Assisting and those potentially affected by a referral and that the decision of the coroner in that regard could be set out in any written decision. My decision and reasons are attached to this finding as Annexure A.

QPS investigation and prosecution decision

109. An examination of the various equipment identified was made by FCU and WHSQ. The equipment had been moved from their relative positions at the time of the incident so that first aid could be administered before the arrival of QPS or WHSQ. No criticism is made of this decision even though it compromised the scene for later forensic examination. The effective ability to provide first aid and the safety of those providing first aid is always paramount.

110. It was not until 13 March 2013 that the knuckle boom and Hino bucket truck were placed approximately in the positions they were at the time of the incident. At the time of this inspection officers Alison Cummings and Scott Munro from WHSQ as well as Senior Constable Servin from QPS were in attendance.

111. A mechanical inspection of the Hino bucket truck by QPS mechanical inspectors found no defects, which would have contributed to the cause of the incident and the bucket truck vehicle was in a satisfactory mechanical condition. Inspection noted the singular reverse light and reversing beeper on the Hino bucket truck was functional.

112. There was no reversing camera fitted to the Hino bucket truck. The investigators, when sitting in the driver's seat as the vehicles were placed at the

reconstruction[5], said the knuckle boom could not be seen due to the tower and bucket on the back of the Hino bucket truck.

113. Senior Constable Servin told the inquest that he believed the matter was more a concern for a WHSQ prosecution. Arguably this approach by Senior Constable Servin impacted on the subsequent investigation and could have impacted on his consideration of the evidence and prosecution decision.

114. Mr Peter Matthews, Director, Legal and Prosecution Services of WHSQ noted that QPS did not charge Jameson Boon with any offence and considered that, on the available facts it was also equally open for QPS to initiate a charge against Jameson Boon. In a prosecution notification signed by Mr Matthews he noted that "*in this case it may have been a better result had the Queensland Police Service investigated and considered enforcement action under either the criminal code or transport operations legislation if relevant. The incident, although falling into jurisdiction under the WHS Act, appears more appropriate to police investigation and enforcement. It was considered that the QPS showed little interest and took the more simplistic approach of identifying the matter as purely "workplace related" and referred it to WHSQ."*

115. Senior Constable Servin says he considered charges of dangerous driving and due care and attention charges and was of the view there was insufficient evidence for either. As well, Senior Constable Servin's report to the coroner noted he was of the opinion that Sherrin Rentals had not provided suitable training for Jameson Boon in the safe operation of vehicles within the work yard.

116. Senior Constable Servin then also made the surprising remark at the inquest that he regarded the report to the coroner as somewhat of a "safety net" for him on whether the correct decision had been made. That approach clearly is not supported by an underlying policy forming the basis for the *Coroners Act 2003* by separating from coroners altogether, the functions of determining criminality.

117. It is quite evident that Senior Constable Servin formed a view early on that the driver should not be charged and the fault lay with the employer. QPS are always the lead agency where a death occurs yet much of the responsibility for gathering of information was left to WHSQ. Senior Constable Servin did not obtain any versions from witnesses that day at the scene. Many of the statements were taken some months later. Hence, when Jameson Boon was interviewed, Senior Constable Servin did not have other versions to put to Jameson Boon. Senior Constable Servin appears to have delegated responsibility to WHSQ to map and reconstruct the scene, to take any measurements and to obtain the CCTV footage on the basis the area was a workplace and not a road. In fact these were matters that should have been attended to by Police.

118. Senior Constable Servin agreed that by 8 March 2013 when he took a statement from Jameson Boon, he had already formed the view there was insufficient evidence to charge him, hence the interview took the form of a statement rather than a recorded Record of Interview.

119. In his evidence Senior Constable Servin placed a lot of weight on the fact the incident occurred on private property and not a road related area, even though offences of dangerous operation and due care and attention can occur in "a place" and are not limited to a road.

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[5] The CCTV footage may support a suggestion the bucket truck was not directly in front of the knuckle boom and was a little to one side, thus possibly giving some view in the rear mirrors. I am unable to conclude this issue one way or the other.

120. The test for whether a particular driving offence has been made out relates to the manner of driving. In this case it appears from the above that Senior Constable Servin may have approached the decision to prosecute or not, by taking into account an extraneous criteria being the alleged deficient training by the employer. For that reason alone I will be referring the information received in the course of this coronial investigation to the Director of Public Prosecutions for its consideration. In doing so I make it clear there is no finding of any criminal culpability. The threshold for referral is a low one.

121. There was in place no formal review process for prosecution decisions being made by Forensic Crash Unit officers. FCU officers individually had developed a number of informal approaches utilising mentors or speaking to other officers. The law in relation to identifying the relative limits for where charges of driving without due care and attention and dangerous operation starts and ends, is notoriously difficult and complex. In my experience the decisions are often confounding for victim's families.

122. Counsel representing the family appropriately did not make any submissions on the issue of referrals but did provide some useful information concerning the law on the relevant driving offences, to bring some context to the difficult decisions that officers need to make. It is quite complex. I was provided with an analysis of the law contained in the December 2015 edition of Hearsay, the Journal of the Bar Association of Queensland. [6]The writer of that article proposed that "in order to achieve the uniformity in the exercise of discretion there needs to be a policy direction. Section 11 of *Director of Public Prosecutions Act 1984,* empowers the Director to furnish guidelines to the Commissioner of the Police Service with respect to prosecutions in respect of offences." This may be one avenue that can be considered by the Director if it has not already been done.

123. As well, the Commissioner of Police should also consider whether some form of a formal/informal review process, of these difficult decisions should be set up to provide oversight and support to those officers in making these difficult decisions. I understand such a review process would receive support from Forensic Crash Unit officers and they may be best placed to assist in determining how such a review process would look.[7] Acting Senior Sergeant Nicole Fox of the Brisbane Forensic Crash Unit gave evidence at the inquest that there have been some changes to the review of such decisions, and the policy is that a FCU report does not leave the station until it has been overviewed by senior officers. As well, all FCU officers now come under one command. Acting Senior Sergeant Fox advised there had been informal discussions about a Panel Review process, which she said was great in theory but would require resources.

The Queensland Ombudsman Workplace Death Investigations report

124. In September 2015, the Queensland Ombudsman published his report on workplace death investigations.[8] The Ombudsman's investigation analysed 20

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[6] Hearsay, Issue 74, December 2015 *"When does driving without due care and attention become dangerous"*

[7] As a matter of transparency, shortly after the inquest concluded, I raised this issue at a conference of Forensic Crash Unit officers from around the State when I was invited to. provide a short address on a number of matters of mutual interest to FCU and coroners and I raised this general proposition.

[8] Exhibit G1, *The workplace death investigations report–an investigation into the quality of work place health death investigations conducted by the Office of Fair and Safe Work Queensland*

workplace death investigations which occurred between 1 January 2012 and 30 June 2013. This occurred in the context of the Queensland Ombudsman receiving complaints regarding the quality of investigations by WHSQ into serious workplace incidents.

125. The investigation identified both positive and negative features of workplace death investigations undertaken by WHSQ. The processes for notification and referral, triage, responding to a workplace death and additional investigation activities were assessed as generally appropriate. However, deficiencies were identified in investigation planning, issue identification and evidence gathering, and the sufficiency of advice provided by legal officers to support prosecution decisions.

126. It is not intended to refer to all of the opinions reached by the Ombudsman in the report as many of these relate to liaison and communication with next of kin. These issues have been the subject of consultation with advocacy groups, WHSQ, government stakeholders and various processes have been put in place to address some of those concerns.

127. The report did conclude that investigative planning by WHSQ was inadequate, often of a poor quality and contributed to unsatisfactory investigations, and the regulatory outcomes in many of the investigations reviewed. It also considered that case management of many investigations reviewed was inadequate and record-keeping did not demonstrate the case management processes that had occurred in many cases. Timeliness in completing some investigations were also considered poor.

128. The report also noted that memorandums of advice prepared by legal officers did not provide clear and sufficient reasons to allow the Director, Legal and Prosecution Services, to make an informed decision about whether to commence a prosecution.

129. The report relevantly found that in one case there was no evidence of any information sharing or collaboration by police and WHSQ regarding the investigation of workplace deaths occurring in a serious traffic incident.

130. Fifteen recommendations were made for consideration by the government.

131. It is against that background and context that I will consider the WHSQ investigation and its prosecution decisions. I also consider the evidence referred to earlier concerning training and induction of Sherrin Rentals employees and evidence concerning Jameson Boon's competency.

WHSQ investigation and prosecution decisions

Identification and management of the risk of persons being struck by vehicles or machinery at the workplace

132. The *Workplace Health and Safety Act 2011* requires that all people are provided with the highest level of health and safety protections from hazards arising from work, so far as is reasonably practicable. The primary duty of care rests with the business or undertaking, in this case that was clearly Sherrin Rentals Pty Ltd. While at work, workers have a duty to take reasonable care for their health and safety as well as that of others who may be affected by their acts or omissions.

133. WHSQ received a copy of the FCU report and statements taken of witnesses. They also conducted a number of interviews with witnesses who had given statements to QPS.

134. WHSQ investigators identified that the hazard requiring management at the workplace was *"powered mobile plant being moved in and around the yard in areas shared by pedestrian workers".*

135. WHSQ found that the risk that may result from the hazard was "*the risk of bodily harm, or grievous bodily harm or in this case, fatal injuries to workers at the workplace, including the risk of a worker being crushed between items of powered mobile plants."*

136. The identified plant being the knuckle boom and Hino bucket truck were registered to the company Sherrin Rentals Pty Ltd. WHSQ found that the company owed a primary duty of care and Jameson Boon also held a duty of care as an employee.

137. The risks to health and safety from the hazard of powered mobile plants are highlighted in the *Workplace Health and Safety Regulation* 2011 and the *Plant Code of Practice 2005.* Sections 214 and 215 of the regulations makes specific reference to managing the risk of plant colliding with any person or thing and must also ensure that the plant has a warning device to warn persons who may be at risk from the movement of the plant.

138. Section 5.8.1 of the Code makes specific reference to reversing powered mobile plant, in that all powered mobile plant should be fitted with a warning device such as a reversing alarm and/or flashing Amber light. The Code makes specific reference to the dangerous activity of reversing powered mobile plants.

139. The Code notes that due to noise and activity on the work site, it could be difficult for workers to see a reversing vehicle or hear the reversing alarm. A risk assessment may indicate that a spotter should be appointed who was responsible for directly observing both vehicles and personnel movement within the working zone. The Code also states that mobile plant should not be reversed if it is practicable to drive a vehicle forward.

140. A record of interview under coercive powers was conducted with the general manager Grant Sherrin. The interview was concluded after 25 minutes. WHSQ was also provided copies of employee documentation and the Company Policy manual. Grant Sherrin stated that Sherrin Rentals did not have a specific risk assessment for the moving of plant or vehicles at the depot, other than it was general practise and everyone was aware of the zones in which equipment should be manoeuvred onsite. There were no exclusion zones around the refuelling area. There was no documented traffic management plan for the site. There is one now.

141. When asked about the spotter policy Grant Sherrin said it was simply that where it is necessary that a spotter is required, that workers should seek assistance to have a spotter. Grant Sherrin was asked if a spotter should have been present on this occasion. He said he did not believe a spotter was required in the direction Jameson Boon was instructed to take. Grant Sherrin stated that Jameson Boon was directed to move the truck forward and in a direct line to the fence. There was no requirement for him to reverse the truck.

142. Mr Sherrin was not asked if the policy about a spotter was documented, although it is evident it had not been documented.

143. Inspector Alison Cummings conducted the initial investigation until handing over to Inspector Bruce Matthews. Ms Cummings was questioned about what appeared to be little consideration given to whether there was a case to answer by Sherrin Rentals, and to examining Sherrin Rentals' policies in the context of their compliance with the *Plant Code of Practice*. Ms Cummings appeared to be unsure of the relationship and relevance of the *Plant Code of Practice*. Ms Cummings stated she was not going to investigate the company policies in a case where the facts and evidence of witnesses, concluded that Jameson Boon had simply backed into a worker.

144. Mr Bruce Matthews finalised the investigation and prepared a coronial report. He agreed that in relation to the induction of Jameson Boon he relied on the information provided by Grant Sherrin and the induction checklist. He agreed he did not go into any detail as to how the induction was carried out by Kevin Barry or to understand the quality of the induction. He stated he considered the incident was an act of an individual and any induction had not much to do with that.

145. Mr Bruce Matthews also did not consider that understanding the level of supervision provided to Jameson Boon was relevant to the investigation. Mr Matthews did not look into the workplace environment as it was not a potential causation factor, and not relevant to the individual act of Jameson Boon. Mr Matthews was asked if he assumed that having signed the induction checklist and being given the Company Policy manual, that this satisfied the employer's responsibilities under the Act. His response was that he was not able to say what happened in each case, but on face value there was no evidence to suggest otherwise. He stated on a number of occasions when questioned about why he did not explore with employees their knowledge of policies and Codes of Practice that he did not see the relevance given this was an act of defiance by Jameson Boon.

146. Mr Matthews stated that he did not have any information that gave concern that Jameson Boon could not operate the machinery, or that lack of training was contributory and that this was a deliberate reversal, as distinct to accidental.

147. WHSQ found that by his act of reversing the Hino bucket truck into the knuckle boom, Jameson Boon breached his duty to take reasonable care and this action adversely affected the health and safety of other persons, namely Simon Poxon. Further that he did not comply as he was reasonably able with the reasonable instruction given by Sherrin Rentals, namely to move the truck forward.

148. WHSQ noted that Jameson Boon had no history or prior convictions under workplace health and safety legislation, but had been given a verbal warning for attempting to load an item of plant onto a trailer without the use of a spotter to guide him.

149. Mr Peter Matthews is the Director, Legal and Prosecution Services of WHSQ. He approved the decision to prosecute Jameson Boon as well as approving private counsel to be briefed at any trial/sentence and the provision of opinion on the prospect of success of any appeal from the sentence imposed.

150. Consideration was also given at the time of commencing the drafting of the complaint against Mr Jameson Boon for a breach of s 32, as to whether a breach under s31 was available. It was determined the evidence was insufficient to prove the element of "recklessness" required under the WHS Act.

151. Mr Matthews stated a prosecution action was considered by the principal legal officer against Sherrin Rentals. Those considerations took into account whether

there was sufficient evidence to charge a duty holder with an offence under s 31 and 32. The outcome of those considerations was that no further action be taken against Sherrin Rentals. It was conceded that internally there had been some discussions between officers from WHSQ and there had been some difficulty in making a recommendation as to whether Sherrin Rentals should be prosecuted.

152. It is evident in this case that there was consideration as to whether a prosecution against the company should be considered. A *Recommendation for Matter to be Prosecuted* [9] recommending the company be prosecuted noted that an internal company guideline, provided minimum requirements for the safety of all drivers, which set out a number of factors including competency, licenses/tickets or certification, qualifications, and training. The Recommendation noted that Jameson Boon confirmed he did not have any license to operate the bucket truck but was required to drive the truck and others like it. It also provided that he had no training on that particular truck. In addition it suggested that Sherrin Rentals had previous knowledge that Jameson Boon's driving was not up to the appropriate safe standard and made reference to the warning given with respect to the use of a spotter. Ultimately this recommendation did not proceed. In fact a subsequent *Recommendation for No Further Investigation* submitted there was insufficient evidence to demonstrate beyond reasonable doubt that the company had a case to answer. This document repeats the issues raised in the earlier document but then considered some mitigating facts, which largely dealt with Jameson Boon's actions and which it was said were outside the control of the company.

153. Mr Peter Matthews stated that based on the material the decision to not prosecute was for the following reasons:–

a. Mr Jameson Boon was given an induction, part of which related to driving or moving of plant, hazard awareness (Hazard identification, assessing and managing risk), safe work procedure (including assessing and managing risk for each task);
b. Mr Jameson Boon had a mentor allocated to him and at the time of the incident his supervisor was on site;
c. Mr Jameson Boon was aware that the area behind the truck was a refuelling area and that he should have checked around the truck prior to reversing, if required;
d. Mr Jameson Boon was given a clear and simple instruction on how and where to move the truck;
e. There was no reasonable explanation as to why Jameson Boon reversed the truck;
f. It was reasonable for Sherrin Rentals to expect Jameson Boon to perform a simple task safely;
g. Mr Jameson Boon had moved equipment around the yard on many occasions and the movement of such equipment was part of his duties (although he had not driven this particular truck before);
h. Mr Jameson Boon did not ensure he had a spotter to assist him in contravention of warnings and further training provided to him;
i. Mr Jameson Boon had access to the company manual which dealt with safety when operating equipment.

154. After having considered all of the evidence, if issues (a) and (b) above were important matters to be factored into the decision to not prosecute, then I would have to say the investigation by WHSQ was insufficient to establish their veracity. The evidence in relation to Jameson's Boon mentor, supervisor and

[9] Exhibit B22.3 p5

supervision generally was uncertain at best, so how it could be factored in is unclear.

155. Of more significance is the induction process. The evidence does not establish that the induction process included a qualitative component which in fact related to *"driving or moving of plant, hazard awareness (Hazard identification, assessing and managing risk), safe work procedure (including assessing and managing risk for each task."* I accept inductions took place, and checklists were ticked off, but there is really no evidence that these matters were considered in the induction or any later training.

156. I accept WHSQ were hindered by Jameson Boon's reluctance to provide an interview, so the content and quality of the induction/training on *the hazards of driving or moving of plant* could not be explored with him. However, this does not seem to have been explored with other employees either, other than in a very cursory sense. I do not suggest there were in fact concerns about the induction process and there was something to be seen, because WHSQ just accepted the company's position and did not further investigate, let alone robustly. A more thorough investigation at the time may have found there was nothing for the company to answer and reason (a) was able to be made out.

157. At the same time factors (c) to (i) were more or less made out and on their own may have been sufficient to justify the decision to not prosecute. The instruction on how to move the vehicle may have been elevated to a level that I may have some uneasiness about, but I accept the instruction was given. I make it clear I am not critiquing the decision to not prosecute itself, but critique that part of the investigative process adopted in reaching that decision. I am not critical of Mr Peter Matthews in reaching his conclusion as he would have relied upon the advice of other legal officers. It is unreasonable to suggest he should read the whole of the evidence gathered in every investigation. That is why there are professional staff employed to review such matters and to advise him.

158. The inquest endeavoured to make some headway in gathering more evidence on the issues raised about induction and training. This was expectedly unsuccessful largely due to the passing of time reducing the reliability of memories. No further advantage would be reached in re-investigating those issues. I have considered the helpful submissions of Counsel for the company and WHSQ as well as Counsel Assisting submissions, and certainly agree that based on the evidence as it currently stands there is no basis to give information to WHSQ to reconsider the issue under s 48 of the *Coroners Act 2003*.

Conclusions

159. Simon Poxon's death was completely avoidable.

160. Investigations conducted by QPS and WHSQ came to different conclusions as to the relative responsibilities of the driver of the bucket truck and the employer for Mr Poxon's death, in the context of their respective legislative investigation responsibilities.

161. The QPS/FCU investigation was based around the premise the incident was primarily workplace related. Senior Constable Servin therefore delegated aspects of the investigation usually conducted by Police to WHSQ. The QPS investigation should have focused on a consideration as to whether the manner of driving was such that offences under the Criminal Code or transport legislation were made out or should be considered. In forming an opinion that the evidence did not support such consideration, Senior Constable Servin also

concluded the company had not provided suitable training to Jameson Boon in the safe operation of vehicles within the work yard. There are two problems with that conclusion. Firstly, an objective view of the evidence gained by the QPS investigation could not conclude the evidence was clear or robust enough to be able to come to that opinion. Secondly, the lack of or quality of training may be an issue that could be raised in mitigation to charges brought, but training is not an issue that should be considered when examining the manner of driving, which should be the primary focus.

162. For that reason it is my view the evidence obtained relating to the manner of driving should be considered by the Director of Public Prosecutions. I make it clear that in coming to that conclusion I am not suggesting the evidence is sufficient to bring any charges. My referral power is based on a low threshold and is much lower than establishing a prima facie case or a finding there is sufficient evidence to ground a charge. As well, in this case there are clearly problems with aspects of how the evidence was obtained from the driver. The position is that it is simply not a matter for me to determine but for others to do so.

163. WHSQ did bring a charge under its legislation against the driver. WHSQ considered the evidence in relation to the company and concluded no prosecution would be successful against the company. I have found there were aspects about the WHSQ investigation, which accepted at face value an assertion by the company that the induction and training of workers included a component with respect to *driving or moving of plant, hazard awareness (Hazard identification, assessing and managing risk), safe work procedure (including assessing and managing risk for each task.* There was little if any further investigation testing that assertion. What a further investigation would have revealed at the time is somewhat speculative. Due to the passing of time memories have faded and in any event a further investigation may have made no difference to the outcome. Although the evidence from Mr Sherrin and Mr Hill did not imbue me with a lot of confidence, the evidence gathered in a further investigation may well have supported the assertion that the induction included that component. However, based on the evidence as it currently stands after the inquest, there is no basis to give information to WHSQ to reconsider the issue under s 48 of the *Coroners Act 2003*.

164. I have noted submissions from counsel representing the family concerning recommendations relating to amendments to the QPS Traffic Manual and to the QPS Operation Procedures Manual to reflect the legal tests that should be applicable in these cases. In my view issues relating to the legal tests applicable for charges laid under the Criminal Code or traffic legislation are best suited for consideration by the Director of Public Prosecutions in a guideline issued pursuant to s 11 of the *Director of Public Prosecutions Act 1984.* An informal approach to the Director's office by my office in the last few days notes this could be considered later in the year when the guidelines are reviewed.

165. I have also formed the view that some assistance should be provided to support FCU officers and others making decisions concerning these often complex factual scenarios. This could be in the form of a Review Panel or some other process, which I recommend be considered by the Commissioner of Police in consultation with FCU officers.

Findings required by s45

Identity of the deceased – Simon James Poxon

How he died – Simon Poxon was crushed between two pieces of plant when one of those pieces of plant, a bucket truck reversed into the other. The driver of the bucket truck should have noticed the other piece of plant and that two workers were standing immediately to the rear of the bucket truck. The driver should not have reversed without first checking behind the bucket truck or utilising a spotter.

Place of death – 17 Hillman Street TORRINGTON QLD 4350 AUSTRALIA

Date of death– 26 February 2013

Cause of death – 1(a) Hypovolaemic shock due to exsanuination from traumatic rupture of femoral artery & vein on both left & right side
1(b) massive groin injury involving fracture of pubic rami, severing of prostatic urethra, lower rectum & degloving injuries to genitals
1(d) crushing injury between two items of machinery

Comments and recommendations

I recommend to QPS that sufficient resources and training are made available to ensure there is alcohol and drug testing of all potentially culpable surviving drivers involved in motor vehicle accidents where serious injuries or death occurs.

It is recommended the Commissioner of Police consider, in consultation with Forensic Crash Unit officers, whether there should be some form of a formal/informal review process, including consideration of forming a Review Panel, to assist FCU officers and QPS officers generally in the making of prosecution decisions for driving offences of vehicles or plant under the Criminal Code or TORUM, and to otherwise provide oversight and support to those officers in making these difficult decisions.

It is further recommended that the Director of Public Prosecutions issue a guideline pursuant to s 11 of the *Director of Public Prosecutions Act 1984,* directed to the Commissioner of Police Service relating to prosecutions for driving offences of vehicles or plant under the Criminal Code or TORUM.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
08 July 2016

Inquest into the death of Simon James Poxon

Decision on s 48 referral

The issue for determination is whether I should receive submissions from the legal representatives of possible affected parties as to whether I should exercise my duty to refer any person or organisation under section 48 of the *Coroners Act* 2003 ("the Act") and further whether any decision to refer or not to refer should be recorded in my published decision arising from this inquest.

Section 48 essentially states, that if a coroner reasonably suspects that a person has committed an indictable offence from information obtained whilst investigating a death (not limited to an inquest) the coroner must give that information to the Director of Public Prosecutions (DPP), or for any other offence (and relevantly to this case under workplace health and safety legislation) to the chief executive of the department administering the *Workplace Health and Safety Act 2011*.

What constitutes reasonable suspicion is well established in the case law and it is considered to be a low threshold and certainly a much lower threshold than commenting on or forming a belief that a prima facie case has been established.

This duty or responsibility of the coroner to form a reasonable belief and make a referral in appropriate cases must be balanced by virtue of the prohibition contained in ss. 45 and 46 of the Act that a coroner may not make a statement that a person is or may be guilty of a criminal offence.

It was submitted there is a conflict in these provisions of the *Coroners Act* 2003 whereby, on the one hand a coroner can make a referral under s 48, and on the other must not make any comment or finding that a person is or may be guilty of a criminal offence. It was submitted that where a conflict appears these should be reconciled so far as is possible *"by adjusting the meaning of the competing provisions to achieve that result which will best give effect to the purpose of and language of those provisions while maintaining the unity of all the statutory provisions."*[1]

The submission followed that to reconcile these sections there should be no submissions received on whether or not a referral should be made and there should be no reference to the decision contained in any publically available written decision.

There is currently no Queensland case law directly on point referring to s 48 although there has been a single judge decision of the Supreme Court of Tasmania considering analogous legislation in Tasmania and Victoria. The conclusion reached in that decision is that coroners should not hear submissions from any party relating to the exercise by the coroner of similar referral powers nor make any reference to a referral in the written judgment.[2] This is distinct

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[1] See discussion on statutory interpretation contained in *Project Blue Sky v ABA* 194 CLR 355 at pp 381 -382

[2] *R v Tennent; ex parte Jager*, 9 TAS R 111

from the right under the rule of natural justice of a person to address a coroner where a potentially adverse finding may be made against them.[3]

There has been discussion in case law to the effect, that a referral by a coroner to a prosecuting authority is not a decision which affects legal rights or interests, and therefore the principles of natural justice do not require that a person who may be the subject of a referral be permitted to make submissions in that regard.[4] In Queensland there is particular authority on point that a decision to refer or not to refer information to a prosecuting authority is not a reviewable decision under the *Judicial Review Act* 1991 as it was not a decision which affected legal rights and obligations.[5]

By contrast *The State Coroners Guidelines* in section 9.13 examines the principles guiding such referral decisions and essentially concludes that where a coroner is considering whether a referral should be made then the subject of such a referral should be heard, preferably in open court.[6]

The Guideline further states that given the principle of openness and transparency it is also proper that the decision on whether a referral has been made, be set out in the decision incorporating the findings.

The Guideline also states that the right to make submissions is to be confined to Counsel Assisting and counsel for the person or organisation subject to possible referral. Counsel for the Poxon family, who was given leave to appear, concedes that given the contents of the Guideline his client is not entitled to address on the issue of a referral but of course is otherwise entitled to make submissions on the general subject matter of the inquest.

I accept that the Guideline is not binding on a coroner to follow and I am aware of differing views by coroners on this vexed issue.

It must be accepted that in general, proceedings conducted by a coroner should be open to the public and transparent. There is a specific responsibility of a coroner under s 48 to make referrals where the coroner reasonably suspects a prosecuting authority should consider whether information obtained during an investigation is sufficient to bring a charge. In general that information would be in the form of the brief of evidence, and transcript of proceedings, less anything which clearly is inadmissible or directed evidence obtained under s 39 of the Act.

Consistent with the reasoning of the State Coroner's Guideline, it is my view that it is proper for submissions to be received by Counsel Assisting and those potentially affected by a referral and that the decision be set out in any written decision.

Any perceived conflict in the legislation can be ameliorated, as the Guideline states, by making clear the low threshold on which the obligation to refer arises and referring to the particular role of the prosecuting authority to determine if any charges should be brought. It would be inappropriate for the coroner to express an opinion on the strength of any case and it may also be prudent to not even identify the suspected offence or the person the subject of a referral. In most cases that will be evident from the narrative contained in the finding, but simply saying

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[3] *Annetts v McCann* (190) 170 CLR 596

[4] *Ainsworth v Criminal Justice Commission* (1992) 175 CLR 564; *Attorney-General v Maksimovich & Anor* (1985) 4 NSWLR 300

[5] *Nona & Anor v Barnes* [2012] QSC 35, decision of Justice P McMurdo; *Nona & Anor v Barnes* [2012] QCA 346, decision of Court of Appeal

[6] This section of the Guideline generally follows the reasoning of the decision of former State Coroner Barnes in *Re Bornen*, 16 July 2010

nothing one way or the other does not sit well with open and transparent justice, particularly when there is specific legislative responsibility for the coroner to consider those matters.

In particular cases where there is potential for prejudice of a future trial or where a significant risk to reputation may arise, my practice has been to withdraw any published decision from the court's website until the matter is resolved. The use of a non-publication order[7] in relation to submissions, either written or oral, or closing the court[8] when submissions are made could also be entertained in such cases.

Accordingly I will permit Counsel Assisting and counsel for any potentially affected person to make a written submission on the issue of referrals for my consideration.

John Lock

Deputy State Coroner

12 April 2016

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[7] s 41 *Coroners Act* 2003

[8] s 43 *Coroners Act* 2003