



# OFFICE OF THE STATE CORONER

## FINDINGS OF INQUEST

CITATION: **Inquest into the death of Timothy James McPhee**

TITLE OF COURT: Coroner's Court

JURISDICTION: Bundaberg

FILE NO(s): 2011/1323

DELIVERED ON: 30 September 2013

DELIVERED AT: Mackay

HEARING DATE(s): 11 September 2013

FINDINGS OF: David O'Connell, Coroner

CATCHWORDS: CORONERS: Inquest – Workplace accident, House removal, building collapse when the jack was released, cause of collapse, whether reasonable precautions were taken

### REPRESENTATION:

Counsel Assisting: Mr John Aberdeen

Office of Fair and Safe Work, Qld: Ms D Heelan

Mr Herbener Mr M Treherne, Aitkin Wilson  
Lawyers

- [1]. On Tuesday 19 April 2011, Timothy James McPhee, just 23 years of age and on only his second day of work with this employer as a 'house re-stumper'<sup>1</sup>, was working on a relocated building at a site at the Bundaberg Airport. As the building was being lowered by a hand operated jack (known as 'trewhella jacks'), the operator lost control of the jacking handle, and the jack, under the weight of the house<sup>2</sup>, immediately dropped its full length of 600mm. The house then, with uncontrolled inertia, sprung on its timber girders, then 'bounced' on its timber supports (known as 'pig stys'), and finally collapsed to the ground. It happened very quickly.
- [2]. Mr McPhee attempted to escape from under the collapsing structure but was trapped, and seriously crushed. He was transported by ambulance to the Bundaberg Hospital where he died from his injuries later that morning.

### ***Tasks to be performed***

- [3]. My primary task under the Coroners Act 2003 is to make findings as to who the deceased person is, how, when, where, and what, caused them to die<sup>3</sup>. In Mr McPhee's case there is no real contest as to who, when, where, how or what caused him to die. The real issues are directed to the system of work employed.
- [4]. Accordingly the List of Issues for this Inquest are:-
1. The information required by section 45(2) of the *Coroners Act 2003*, namely: who, how, when, where, and what, caused Mr McPhee's death,
  2. What caused the failure of the Trewhella jack engaged in the lowering of the building at the Bundaberg Airport on 19th April 2011?
  3. Were reasonable safety precautions taken to either prevent or limit the collapse of the building on 19th April 2011?, and
  4. What improvements (if any) could be made to the system of work in place at Mr McPhee's workplace at Bundaberg Airport on 19th April 2011, with a view to preventing deaths in similar circumstances in the future?
- [5]. The second task in any inquest is for the coroner to make comments on anything connected with the death investigated at an inquest that relates to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future<sup>4</sup>.

---

<sup>1</sup> This term may be used to cover the differing processes of house raising/lowering/re-stumping and house removal and relocation

<sup>2</sup> estimated total weight of approximately 25 tonnes

<sup>3</sup> Coroners Act 2003 s. 45(2)(a) – (e) inclusive

<sup>4</sup> *ibid* s.46(1)

- [6]. The third task is that if I reasonably suspect a person has committed an offence<sup>5</sup>, committed official misconduct<sup>6</sup>, or contravened a person's professional or trade, standard or obligation<sup>7</sup>, then I may refer that information to the appropriate disciplinary body for them to take any action they deem appropriate.
- [7]. In these findings I address these three tasks in their usual order, section 45 Findings, section 46 Coroners Comments, and then section 48 Reporting Offences or Misconduct. I have used headings, for convenience only, for each of these in my findings.

### ***Factual Background & Evidence***

- [8]. The work at the site involved the lowering and re-stumping of a large house which had been re-located to a position within the airport complex.
- [9]. The principal contractor engaged to perform this work was Jeff Lennox Builder Pty Ltd. Lennox subcontracted for the movement and re-stumping with Herbener Bros House Removalists<sup>8</sup>. Mr McPhee was employed by Herbener Bros. He had undertaken some casual work in this industry many years prior<sup>9</sup> and he commenced work with Herbener Bros the previous day, ie Monday 18 April 2011. Mr McPhee's step-father, Mr Ricky McMullen, also worked for Herbener Brothers on the same jobsite.
- [10]. At 8.30am on the 19th April, the house was sitting on six (6) structures known as "pig sties" - two (2) located under each end of the house, and two (2) others in the centre of the house<sup>10</sup>. Each pig sty consisted of a number of heavy pieces (of approximately 150mm square cross-section) of timber placed in a "criss-cross" pattern<sup>11</sup>, to a height of about 1.6m. Each pig sty was slightly inset from the edge of the house, so as to be accessible only by a person who was actually under the house.
- [11]. Prior to 19 April 2011 the house was sitting evenly on the six pig sties, and holes had been dug for the new house stumps. The task to be faced on the morning of 19 April 2011 was the lowering of the house to a height close to the final 600mm stump height.
- [12]. The process of lowering the house is best explained by reference to the persons and their positions indicated in exhibit D2. Mr McPhee was positioned at Sty 6, Mr McMullen was positioned at Sty 5, and Mr Henry Herbener, one of the proprietors of the employer, was positioned

---

<sup>5</sup> Ibid s.48(2)

<sup>6</sup> Ibid s.48(3)

<sup>7</sup> Ibid s.48(4)

<sup>8</sup> The status of Herbener Bros House Removalists was a partnership.

<sup>9</sup> Evidence was that it was over five years prior

<sup>10</sup> See exhibit D2 for a 'Hand Drawn Plan and Elevation'

<sup>11</sup> See exhibit E2 for photographs of comparable pig-sty arrangements

as Sty 4. At both Mr McPhee's (Sty 6) and Mr McMullen's (Sty 5) positions, a 20t capacity hydraulic jack was placed on top of each sty. At Mr Herbener's position, a 6t capacity Trewhella® manual (or geared) jack was placed on top of each centre sty.

[13]. Each of the jacks were positioned under a large timber "girder" (a log, with flattened sides on top and bottom) running almost the length of the house.

[14]. The lowering process as explained by Mr Herbener was as follows:

a. Mr Herbener would disengage the pawl on the first Trewhella jack, and lower it a short distance<sup>12</sup>;

b. Mr McPhee would then take the weight on his sty on the hydraulic jack, and remove the top row of timber from his sty;

c. Mr Herbener would then move to the second Trewhella jack, on Sty 3, and do the same;

d. Mr McMullen would then take the weight on his hydraulic jack, and remove the top row of timber from his sty;

e. Mr McPhee and Mr McMullen would then move to Sty 2 and Sty 1 respectively, and repeat the lowering process on each;

f. At this point, the house would again be level, and would be lower by the thickness of a layer of sty-timbers (about 150mm);

g. The process would then be repeated until the final desired height was achieved.

[15]. At this time an explanation of the 6t Trewhella jack is of value. The Trewhella jack is described<sup>13</sup> as a 'rack and pinion type' jack with 'a mechanical linear actuator'. It is 'intended only for exerting force along the axis of the rack' and 'the jack is not intended to resist lateral forces' and 'any object supported by the jack must be restrained from sideways movement by stays or other means'<sup>14</sup>.

[16]. To operate the jack you can raise it by positioning the pawl so that it engages in the ratchet, turn the handle, and the jack will rise. The pawl engages in the ratchet under gravity every one sixth of a revolution of the handle, preventing the handle from reversing or lowering the load. This ratchet system permits the jack to be held at intervals of just 1 mm. Most significantly the pawl only works by engaging in the ratchet automatically (as it was gravity, not spring, activated) when the load is being raised.

---

<sup>12</sup> 'Just a few inches' was Mr Herbener's description

<sup>13</sup> Exhibit D19 includes mechanical specifications of the jack

<sup>14</sup> See exhibit D19 which is a technical brochure of the jack from the manufacturer

- [17]. To lower the jack the handle is to be held firmly to take the load and rotated slightly until the pawl can be flipped out of contact with the ratchet, then carefully lower the load by allowing the handle to rotate whilst retaining a good grip on it. To hold the rack in a new position, halt rotation of the handle, hold the load, then flip the pawl into contact with the ratchet<sup>15</sup>.
- [18]. Of great interest is that the pawl is simply completely disengaged from the ratchet whilst the load is being lowered using the handle. The pawl must be physically re-engaged by the operator, or an assistant, as there is no spring mechanism or other device to automatically re-engage the pawl. It is something which must be re-engaged by the operator, or their assistant, themselves. The pawl is located on the jack in a position behind the winding handle.
- [19]. The failure of the system of work occurred at the very outset of the process described in paragraph [14] above. Mr Herbener, who was positioned at Sty 4, with the Trewhella jack, released the pawl which served to hold the jack at about a 600mm extension. He then went to grasp the handle of the jack with both hands, but the handle, possibly due to the weight which was on the jack, slipped from his grasp<sup>16</sup>.
- [20]. Upon loss of control of the jack handle, the jack handle spun wildly, and significantly the jack bottomed, that is it dropped its full 600mm instantly then fell sideways out from under the load.
- [21]. The girder which had been sitting on the Trewhella jack, immediately bowed down. Being made of timber, it might have been more prone to movement in this way than would a steel RSJ<sup>17</sup>. In any event, the girder then "sprang back" to a near-straight profile. In doing so, it "threw" the house off Sties 5 and 6, and also threw the house forward by four to six feet<sup>18</sup>. There was both uncontrolled vertical and lateral movement of the building.
- [22]. Both Trewhella jacks were displaced. The sudden dropping of one end of the house suddenly tipped the jacks on top of Sties 1 and 2, at the opposite end of the house but they were not extended. However, these sties nevertheless managed to retain the weight of the house at that end, perhaps due to an absence of significant lateral movement there.

---

<sup>15</sup> See Exhibit D19

<sup>16</sup> At interview on 8 June 2011, Mr Herbener was still unclear as to how the jack handle came to slip from his hand; he had done the same manoeuvre countless times before, without mishap, but this is how he described it occurring in his evidence at inquest.

<sup>17</sup> Evidence by Mr Herbener and Mr McMullen is that steel has its limitations and that timber girders are preferred

<sup>18</sup> The forward movement of the house might have been due to the second Trewhella jack initially maintaining its position after the initial drop of the other Trewhella jack.

- [23]. When the house was thrown up and forward, by the spring action of the girder, the house passed over Mr McMullen's, at Sty 5. Mr Herbener noticed the house moving and so, even though he was then approximately 70 years of age, he dived out from under the building. Mr Herbener said it all happened very quickly but that his experience told him to keep low and dive out from under the building<sup>19</sup>.
- [24]. It seems probable to me that Mr McPhee whilst under the structure, and realizing that the house was in motion, moved to the side and to the rear, trying to avoid the dropping building. Regrettably he was trapped by the falling building, and was pinned to the ground, across his hips and lower back, by the corner of the building closest to Sty 5.
- [25]. The injuries suffered by Mr McPhee proved fatal and he died approximately two hours later in hospital.

### **Investigations into the incident:**

- [26]. Police were advised of the incident immediately it had occurred. They attended and commenced investigation.
- [27]. Inspector Brian Drake, from the then WHSQ (now termed Office of Fair and Safe Work Queensland, 'OFSWQ'), also attended. It was Mr Drake who assumed the role of lead investigator.
- [28]. During the course of his investigation, Mr Drake obtained technical data on the Trehwella jack and, very appropriately, systems of work utilized by other house removalist contractors in the Wide Bay area of Queensland. Mr Drake also interviewed two of the principals of Herbener Brothers, Henry Herbener and Francis Herbener at length, on 8 June 2011.
- [29]. On 17th April 2012, a summons issued to Mr Henry Herbener, a partner in the business, and the operator of the Trehwella jack at the time in question, for failing to observe a workplace safety obligation by which death was caused. Mr Herbener pleaded "Guilty" to that offence on 28th November 2012. He was fined \$10,000 plus legal costs

### **Identified shortcomings in the system of work:**

- [30]. The primary cause of the incident was the failure of the operator of the Trehwella jack (Mr Henry Herbener) to maintain control during the lowering phase. It is important to note that the jack itself did not fail, rather the operator's correct use of it 'failed' (at this time I leave aside the suitability of this style of jack for the task).
- [31]. This is a potential danger which was the subject of a specific warning by the manufacturers<sup>20</sup>. Under heavy load, it is recommended that lowering the jack be a two-person operation. It is not suggested that

---

<sup>19</sup> This process of staying low and diving out appears to encompass the entire safety plan

<sup>20</sup> See exhibit D19 at sheet 4 of the 34 page exhibit

the Herbeners had ever seen this information from the manufacturer. Their jack, in fact, certainly pre-dates publication of the manufacturer data sheet dated 22 October 2009 but still this was known well prior to the incident.

- [32]. The Herbeners indicated in their recorded interview with Mr Drake that as a result of this incident, the Trehwella jack was no longer used in this (centre position) application. Since the incident they only used hydraulic jacks for lowering.
- [33]. The cessation of use of Trehwella jacks in the centre position is a useful starting point. With hydraulic jacks, the only way in which they could "bottom" would seem to be through a total failure of the jack itself (which did not happen in this case - this case involved operator failure) and importantly the hydraulic jack only allows a load to fall 150 mm, rather than 600 mm (Trehwella jack), as 150 mm is the total extension height of the hydraulic jacks used.
- [34]. But the matter goes substantially further than that step alone (of where the jack should be located in lifting/lowering operations).
- [35]. During the course of his investigations, Mr Drake observed the system of work used by a similar business, conducted by Mr David Hose<sup>21</sup>. Mr Hose's system of work was characterised by the use of "safety sties" - additional pig sties, which provide a static back-up protection in the event of a sudden drop in height by the building.
- [36]. Evidence provided by Mr Drake, and by Mr Herbener, were that whilst Mr Herbener no longer used the Trehwella jack for lowering operations, the practices employed by persons in the industry in the Wide Bay area of Queensland have not altered at all since this incident in April 2011.
- [37]. I note that the OFSWQ have not issued any safety notice, industry alert, recommendation, guideline, or regulation, whether into the use of Trehwella jacks or appropriate practices within the house removal industry.
- [38]. Evidence provided to this inquest was that Mr Drake of OFSWQ could find no regulations, or laws, for this industry whether in Queensland or Australia wide. Mr Drake confirmed that this industry remains largely unregulated (this is by no means a criticism of Mr Drake, rather the lack of regulation of the industry itself). To his knowledge there are no relevant Codes of Practice. He advised that individuals need only hold a limited Building Services Authority licence to undertake this work.
- [39]. There was identified during the course of the inquest a generic "Safe Work Method Statement" pertaining to house restumping and published by Master Builders Victoria.

---

<sup>21</sup> Exhibit E2

- [40]. This aspect of a lack of industry regulation was very disconcerting to the family of Mr McPhee as the evidence provided to the inquest showed that there had been a number of deaths in the house removal industry relating to structures ‘dropping’ and crushing workers. There were reported such incidents in Victoria in the months of March 2002 and August 2004.
- [41]. Significantly an inquest was held after each of these incidents and recommendations were made for changes to be made in the industry. It appears very little has been implemented, whether in Victoria or elsewhere. The family of Mr McPhee indicated that a further death occurred in Victoria February 2011.
- [42]. The family of Mr McPhee were able to advise that in May 2007 Worksafe Victoria produced a ‘Guidance Note’ regarding the stability of buildings during construction and further a ‘Safety Alert’ was issued in April 2013 regarding preventing structural collapse with respect to incidents including houses being re-stumped.
- [43]. At the inquest the inspector called from OFSWQ was unable to point to any actual knowledge within the Queensland industry of such safety alert or guidance note in Queensland. The information provided to me at the inquest was that any guidance note or safety alert is more in the way of a suggested practice and certainly does not reach the threshold of an industry law.

### ***List of Inquest Issues Answers***

#### **Coroners Act s. 45(2): ‘Findings’**

- [44]. Dealing with the list of issues for this inquest the answers are as follows:-
- [45]. Issue 1. My primary task is the information required by section 45(2) of the *Coroners Act 2003*, namely:
- a. Who the deceased person is - Timothy James McPhee<sup>22</sup>,
  - b. How the person died – Mr McPhee died due to operator failure of a Trehwella jack leading to the sudden collapse of a building structure then being supported, which fell and crushed him,
  - c. When the person died – 19 April 2011<sup>23</sup>,
  - d. Where the person died – Bundaberg Hospital, Bundaberg, Queensland<sup>24</sup>, and
  - e. what caused the person to die – Multiple injuries, due to Industrial trauma<sup>25</sup>

---

<sup>22</sup> See exhibit A1 QPS Form 1

<sup>23</sup> See exhibit A2 Life Extinct Form

<sup>24</sup> See exhibit A2 Life Extinct Form

<sup>25</sup> See exhibit A3, Form 3 Autopsy Certificate

- [46]. Issue 2. What caused the failure of the Trewhella jack engaged in the lowering of the building at the Bundaberg Airport on 19th April 2011?
- [47]. It is clear that the Trewhella jack did not itself fail, rather the failure associated with the jack during its lowering operation was simply operator error.
- [48]. The error by the operator was a failure to control the jack handle, in that the operators' hands slipped off the handle. There was also the failure to have a second person available to operate the jack's pawl to engage it into the ratchet when required.
- [49]. Issue 3. Were reasonable safety precautions taken to either prevent or limit the collapse of the building on 19th April 2011?
- [50]. Clearly reasonable safety precautions were not taken to either prevent or limit the collapse of the building. Mr Herbener did not follow the manufacturer's recommendation of having a second person operate the pawl, and he should have used two hands at all times to operate the jack's handle as it was under significant load.
- [51]. More importantly the Trewhella jack is an inappropriate jack to be used for the lowering process. Mr Herbener himself has recognised this fact and now only uses hydraulic jacks for any lowering under load. The Trewhella jack has no ability to use the pawl for lowering in a loaded operation because if the handle slips from the operator's control, as occurred here, the handle will simply spin wildly and the operator cannot put their hand through this spinning metal handle to engage the pawl.
- [52]. Significantly hydraulic jacks are lowered by turning a handle inserted into the jack to operate a valve. This allows the operator to control the lowering speed. There is no particular pressure on the handle (as opposed to the Trewhella jack) and it is a twisting operation which can even be done at an extended distance<sup>26</sup>. This will be explored further under the section 46 Coroners Comments.
- [53]. Issue 4. What improvements (if any) could be made to the system of work in place at Mr McPhee's workplace at Bundaberg Airport on 19th April 2011, with a view to preventing deaths in similar circumstances in the future?
- [54]. This is dealt with below under the section 46 Coroners Comments heading.

---

<sup>26</sup> Mr Herbener and Mr McMullen confirmed this

**Coroners Act s. 46: 'Coroners Comments'  
(Recommendations)**

- [55]. This incident does provide the opportunity to recommend important improvements aimed at reducing the risk to workers in similar operations.
- [56]. The present situation is that there is simply no Queensland regulations, guidelines, or industry accepted practices uniformly used throughout the house restumping, house relocation or house raising/lowering industry<sup>27</sup>.
- [57]. Evidence presented to the inquest was that there are no enforceable regulations Australia wide, and the best that could be identified that there was only one Guideline and one Safety Alert issued in Victoria. In my opinion, with the deaths that have occurred in Victoria and the two coronial inquests<sup>28</sup> which have occurred, it is very surprising that regulation of the industry practices has not yet occurred.
- [58]. The OFSWQ suggested that with the recent harmonisation of workplace laws across Australia meant that there would need to be consultation Australia wide before regulations or work practices could be implemented. What I wish to highlight to regulators is that Mr McPhee died on 19 April 2011, and the inquest occurred on 11 September 2013. In the nearly two years and five months which have passed there has been no change within the industry; not even so much as a Safety Alert has occurred in Queensland. That situation cannot be allowed to continue. Regulators must take appropriate action to implement laws to prevent deaths such as Mr McPhee's.
- [59]. With the limited information available at the inquest, which is only based on the opinions and work practices of persons in the Wide Bay area, what it did highlight was that there are readily available steps which can be implemented promptly, firstly to eliminate dangerous work practices<sup>29</sup>, and secondly to implement safer work practices.
- [60]. At the inquest I was not presented with sufficient information to formulate what appropriate regulations, or work practices, should be. This is an area for regulators and industry to consult together.
- [61]. What I can recommend is that the regulatory authority commit to a review of the industry work practices in consultation with industry. They need to take submissions, prepare regulations, and most importantly then implement them. I appreciate this process will take time but it cannot be an endless timeframe. I envisage that 12 months

---

<sup>27</sup> evidence at the inquest was that there is a discrete difference between restumping and house removal. Both aspects of the one industry involve workers operating under a temporarily supported structure and so need to be considered together

<sup>28</sup> See paragraphs [40] and [41] above

<sup>29</sup> As to one such example Mr Herbener ceased using the Trewhella jack for house lowering immediately and now only uses hydraulic jacks for lowering

is adequate time for initial consultation, preparation of regulations, consultative review, and then the implementation of regulations to occur.

- [62]. I would like to see regulations implemented by 1 October 2014. I appreciate that the regulations which may be implemented by that time may not be ideal, but they will be a vast improvement on the unregulated and varying industry practices presently operating in Queensland. No doubt after a period of time, with industry input, those regulations can be reviewed and refined. It is a simple matter to have a continuous improvement program in place but, in the plainest of terms, the talk must stop and the action must commence. At the inquest no party expressed any dissention with this approach. All agreed that the unregulated industry must have appropriate work practices implemented and doing this by regulations will assist in their enforcement.
- [63]. The regulations need to include, and focus attention upon, the discrete processes of raising and lowering of a building. It is on these occasions when the building is in motion which encompasses the times of greatest danger.
- [64]. The challenge is to obtain a useful cross-section of opinion, which could be examined by the regulatory authority, to lead to appropriate industry regulation. It is acknowledged that the house relocation, house removal/re-stumping/raising/lowering industry is largely operated by small businesses. Accordingly any regulations must be practical and cost-effective. Of note at the inquest was that even Mr Herbener, who appeared to me to favour a high level of fiscal responsibility, conceded that certain safety aspects could be implemented readily, and in a very cost-effective way, even though they would add some more time and expense to the house raising/lowering process. Importantly he also saw that these practices could be implemented very promptly without departing greatly from present work practices.
- [65]. Whilst it is a matter for the regulatory authority to review, what was able to be identified at inquest were the following safety steps.
- [66]. The safety sty concept is relatively affordable. It is not a "high-tech" alternative. It would necessarily involve costs in obtaining and cutting the 150 x 150 timbers required, and necessary time and labour in assembling/disassembling, and in transport. Against the possibility of loss of life, it seems a reasonable safeguard. Mr Herbener saw benefits with it, and did not consider it an unreasonable cost.
- [67]. There was no indication that there is anything preventing the possibility that the pig sties, including safety sty, themselves be positioned outside the alignments of the building in question. This will obviously require longer girders. It will still require safety sties under the building to reduce flex or other vertical movement in the girders. Engineering

advice would determine appropriate spacing. In such a case, the girder would necessarily protrude past the extremities of the building at every external pig sty.

- [68]. The Trehella jack should simply not be used for the lowering of houses. Its design does not permit any level of appropriate safety when it is lowering under load. Where the load permits they may be a suitable jack for raising<sup>30</sup>. Mr Herbener says he does still use the Trehella jack in circumstances where he wishes to simply raise a corner of a house, such as for replacing a single stump, but it is only that corner of the house which is unsupported, the remainder of the house is supported on all of its other stumps.
- [69]. Hydraulic jacks, such as bottle jacks, should be used for raising and lowering. Hydraulic jacks have the important feature of being able to control their lowering rate by the controlled release of the hydraulic fluid within the jack. In addition the handle controlling the opening and closing of the release valve is not under any load. Clearly the valve could be a readily implemented 'restrictor valve' so that no matter how 'open' the operator releases the valve the restriction valve controls the lowering rate.
- [70]. Put at its most simple, it would appear obvious that to reduce the time workers spend under the house, particularly during times when the house is in motion by way of being lowered, or raised, will in and of itself, reduce risk to those workers.
- [71]. Appropriate training and qualifications of licensed personnel needs to be considered. At present it appears that one need only hold a Building Services Authority licence, presumably based upon a carpentry licence<sup>31</sup>, to become a house removalist.
- [72]. The process of house removal/restumping/raising/lowering necessarily requires the knowledge of engineering principles involving static and dynamic loads. Clearly an appropriate formal education course would teach and train these skills to allow person to hold an appropriate qualification. Any industry review needs to look at how this can be implemented and whether it applies for all persons, or simply new applicants, with existing licensed persons having their licence 'grandfathered' exempting this educational requirement for a limited period (for example three years) to allow those existing licensed persons time to successfully complete the course or exit the industry.
- [73]. The regulatory authority will need to identify and determine the appropriate issues for review and regulation.

---

<sup>30</sup> And in this instance a 6t jack was being used, in conjunction with other jacks, for an estimated 25t load

<sup>31</sup> in view of the qualification Mr Herbener had

[74]. I am confident that with the correct motivation this can be completed within 12 months. At the inquest the OFSWQ offered to keep me informed as to the progress of this review and its' implementation. I very much welcome this offer and I look forward to being informed of the timetable proposed for the review and implementation, and in turn, notification as progress is made towards implementation by 1 October 2014.

***Coroners Act s. 48: 'Reporting Offences or Misconduct'***

[75]. The Coroners Act section 48 imposes an obligation to report offences or misconduct.

[76]. It is observed that the employer was prosecuted for failing to observe a workplace safety obligation by which death was caused. That prosecution was concluded on 28 November 2012.

[77]. It was not suggested, nor recommended, to me by any party at the inquest that any further person or entity should be referred for investigation of an indictable or other offence.

[78]. Accordingly I make no such referrals under section 48.

**Magistrate O'Connell**

Central Coroner

Mackay

30 September 2013