thorPre	AuthorFirstName	AuthorLastName	BusinessCompany	Other Comments
Mr	Stephen	Myatt	Ai Group	
[redacted]			South Australian Wine Industry Association Inc.	
Mr	David	Place	SA Ambulance Service	SAAS does not own or operate any EWPs. In cases where patients are moved from heights, this is governed by SA Metro Fire Service at the time of rescue. SAAS supports any recommendations with the aim of providing safer systems of work.

12

Discussion Session

Elevating work platform safety and Recommendations of the Coroner in the Jorge Castillo-Riffo Inquest

Agenda

Meeting Date:	Friday 5 July 2019
Meeting Time:	9:00am – 11:00am
Meeting Location:	Office of Hon Rob Lucas MLC, Treasurer Boardroom Level 8, 200 Victoria Square, Adelaide
Chair:	Martyn Campbell, Executive Director, SafeWork SA
Attendees:	Hon Rob Lucas MLC Glenn Farrell, SafeWork SA Frank Keough, Health and Safety Operations Manager, McConnell Dowell Constructors (Aust.) Lex Hanegraaf, HSEQ Manager, Built Environs Pam Gurner-Hall Michael Ats, Lieschke and Weatherill Tim Nuttall, Vice President, Elevating Work Platform Association Peter Davis, Technical Director, Elevating Work Platform Association Angas Story, Secretary, SA Unions Erin Sneath, SafeWork SA

The Department of Treasury and Finance acknowledges Aboriginal people as the State's first peoples, nations and Traditional Owners of South Australian land and waters. We recognise that their unique cultural heritage, customs, spiritual beliefs and relationship with the land are of ongoing importance today, and we pay our respects to Elders past, present and future.

1. Meeting Procedures

- Welcome by Martyn Campbell
- Background of the Coroner's recommendations
- Outline the structure of the discussion session

2. Discussion on Coroner's recommendations

Recommendation 38.2

That the Elevating Work Platforms document dated September 2016 should be distributed on an annual basis electronically and in hard copy to all relevant building industry participants in South Australia. In addition, electronic links to the information sheet should be displayed permanently on SafeWork SA's webpage and be kept current. The associated minimum standard of training document should be brought into line to include references to clear lines of sight.

Recommendation 38.3

That the question of standardising scissor lift controls be given far greater impetus at a State and National level and that it be elevated to COAG for the commissioning of a project to pursue the standardisation of controls in scissor lifts.

Recommendation 38.4

That until the implementation of a system of effective standardisation of scissor lift control configuration across the country, that scissor lifts not be operated unless there is a person on the ground operating as a spotter who is available at all times to take steps to activate the emergency lowering mechanism should that be necessary.

Recommendation 38.5

That SafeWork SA consider whether the balance in the WHS Act and Regulations between safety being managed by risk assessment as opposed to express mandatory rules about what must occur in particular circumstances should be shifted in favour of more express mandatory rules and take that matter up with Safe Work Australia for consideration.

Recommendation 38.6

That SafeWork SA should investigate, consider and report upon the world's best practice engineering solutions to protect workers against the risk of crushing due to overhead surfaces, including the availability and design of secondary protective systems including operator protective alarms and operator protective structures and the options for reform to require that all scissor lifts in use in South Australia have a secondary protection system.

Recommendation 38.7

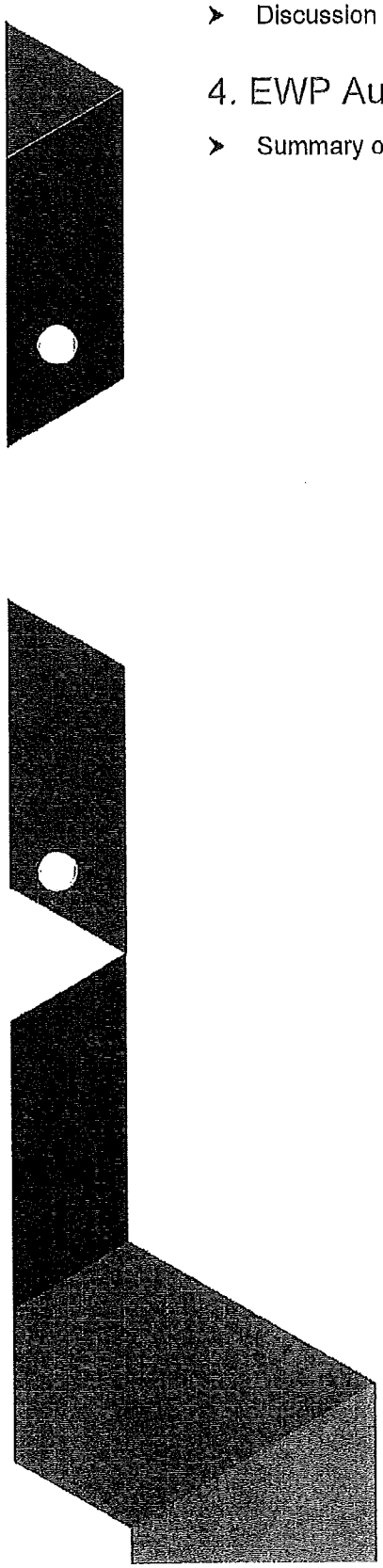
That the Government provide, through the Legal Services Commission, funding to enable families to be legally represented in Inquests, for deaths in custody, and generally. I direct this recommendation to the Attorney-General.

3. EWP Safety

- Discussion on safety

4. EWP Audits

- Summary of audits by Martyn Campbell



Lex Hanegraaf

161 Wakefield Street Adelaide SA 5000
P +61 8 8232 1882 | M +61 438 739 746
lex.hanegraaf@builtenvirons.com.au

20 December 2018

Mr. Martyn Campbell
Executive Director
SafeWorkSA
Level 4, World Park A, 33 Richmond Road
Keswick SA 5035

Ref: 18SWSA0657 letter dated 3 December 2018

Dear Mr. Martyn Campbell:

Thank you for the opportunity to provide feedback in relation to the recommendations handed down by the Coroner's court. This tragic incident has greatly affected the construction industry both locally and abroad. My firm position is that the health and safety of all workers on site must be held in the highest regard. As such, I am pleased to provide my feedback and trust the outcomes will assist industry promote workplace health & safety and raise industry standards regarding the use of scissor lifts.

I have responded to recommendations 38.2 – 38.6 below.

38.2. I recommend that the Elevating Work Platforms document dated September 2016 should be distributed on an annual basis electronically and in hard copy to all relevant building industry participants in South Australia. In addition, electronic links to the information sheet should be displayed permanently on SafeWork SA's webpage and be kept current. The associated minimum standard of training document should be brought into line to include references to clear lines of sight.

I agree with the importance of education, information and training. The information outlined in the guidance document provides industry with a great reference point for workers to use when planning work (in addition to competency training).

38.3. I recommend that the question of standardising scissor lift controls be given far greater impetus at a State and National level and that it be elevated to the Council of Australian Governments (COAG) for the commissioning of a project to pursue the standardisation of controls in scissor lifts.

I have carried out various site assessments and surveys of scissor lift controls and agree that discrepancy between models has been reality on all building sites. Many work processes become 'automatic' due to the repetitive nature of operations. Standardising controls would help with operators 'automatic' muscle functions avoiding controls being activated incorrectly or in the wrong direction. In the meantime, I have seen various efforts to highlight control direction using high-vis stickers etc. this could also be considered.

38.4. I recommend that until the implementation of a system of effective standardisation of scissor lift control configuration across the country, that scissor lifts not be operated unless there is a person on the ground operating as a spotter who is available at all times to take steps to activate the emergency lowering mechanism should that be necessary.

This point should be assessed with great caution as the introduction of a mandatory spotter may present additional risks (to the spotter). There have been many incidents where a spotter located in proximity to mobile plant has resulted in significant injury or fatality. A dedicated spotter who is totally focused on a single scissor lift may; become complacent/ distracted by the task and be struck by another item of mobile plant, approach the scissor lift to closely and be struck during inadvertent/ unexpected movement, or, provide the operator with a false sense of control and reliance on another person who may become complacent or distracted.

I do however feel it is essential that all mobile plant (including scissor lifts), is only operated in areas that are not isolated from other workers. Although a dedicated spotter may not be the most appropriate control, there should always be another person on the ground within range to offer assistance if required.

38.5. *I recommend that SafeWork SA consider whether the balance in the WHS Act and Regulations between safety being managed by risk assessment as opposed to express mandatory rules about what must occur in particular circumstances should be shifted in favour of more express mandatory rules and take that matter up with SafeWork Australia for consideration.*

Having the ability to meet the intent of legislation through risk assessment and applying reasonably practicable controls is something that is of value and typically done well amongst large and mature organizations. Businesses that do not have the organizational maturity to adequately controls risk through their independent assessment will benefit from guidance notes provided by SafeWorkSA. This further reinforces the importance of education and information.

38.6. *I recommend that SafeWork SA should investigate, consider and report upon the world's best practice engineering solutions to protect workers against the risk of crushing due to overhead surfaces, including the availability and design of secondary protective systems including operator protective alarms and operator protective structures and the options for reform to require that all scissor lifts in use in South Australia have a secondary protection system.*

This sounds like a great idea as technology continues to advance rapidly.

In addition to my responses to the recommendations, it has become apparent to me through my experience in the industry that the expected safety standards around scissor lifts if applied correctly, do offer a good level of control. The emphasis should be on businesses striving to meet or exceed the standards that are currently in place, rather than lifting expectations whilst performance remains substandard.

SafeWorkSA could consider the licensing requirements for the use of mobile elevated work platforms (below 11m) and include in the High-Risk Work framework. SafeWorkSA could also consider the penalties for workers and PCBU's that are imposed for breaches of work practices relating to the use of mobile elevated work platforms.

Note: This position is based on my personal views only. I will table this matter for consultation and feedback at the next SACSA meeting scheduled for 19 February 2019.

Sincerely,

Lex Hanegraaf
Chairperson
South Australian Construction Safety Alliance

EWPA

ELEVATING WORK PLATFORM ASSOCIATION OF AUSTRALIA INC

PO Box 1304 Mona Vale NSW 1660 **P:** 02 9998 2222 **F:** 02 9998 2299
E: info@ewpa.com.au **W:** www.ewpa.com.au ABN 32 545 830 419

18 December 2018

Mr Martyn Campbell
Executive Director Safework SA

Dear Mr Campbell,

We have reviewed the coronial report in relation to the death of Mr Jorge Alberto Castillo-Riffo and make the following comments:

GENERAL OBSERVATIONS

- The task being performed was to rework patching of post tensioning pockets on a level above the floor where access could be gained. The work area was limited in space and involved working underneath an overhead obstruction.
- Although there was a SWMS for patching from formwork or scaffolding there was no SWMS for undertaking the same work from a MEWP.
- The employment of a MEWP introduced an overhead crushing hazard that did not exist when patching from formwork or scaffolding.
- The MEWP that was used for the task was not ideal as:
    - The available work space was limited by the size and position of the MEWP and the surrounding structure.
    - The MEWP had to be repositioned in order to access all the pockets – therefore increasing exposure to the risk of crushing.
    - The small work space resulted in the platform controls being repositioned which may have increased the possibility of control error due to impaired visibility and/or orientation relative to the operator and the direction of operation.
    - When in position access to the emergency controls was obstructed by a barrier fence. It appears however that access to the normal ground controls was available but at the time, they were not used.
- The risk from crushing could have been controlled by:
    - Selecting an appropriate MEWP which optimized the work space and reduced the frequency of exposure to the crushing hazard – it is possible that a more suitable MEWP may have been available, but this was not fully explored. (Fig1)
    - Ensuring that the emergency controls were accessible before the work commenced.
    - Providing adequate support in the form of an observer at ground level tasked to identify potential crushing risks and to be readily available to execute an emergency plan if required.
- There was no emergency plan, it wasn't documented or rehearsed.
- Although personnel on site held licenses to operate scissor lifts, this proved to be inadequate because no-one other than Mr Castillo-Riffo was suitably familiar with the MEWP being used at the time.

Procedures relating to Risk Assessment, Planning, Selection, Siting, Operation and Emergency procedures are detailed in AS2550.10 Mobile Elevating Work Platforms –Safe Use. The EWPA is of the opinion that had these procedures been followed:

- The risk of crushing would have been identified;
- Control measures could have been devised to mitigate the risk;
- The selection of a suitable MEWP would have been considered;
- An emergency retrieval plan would have been established.

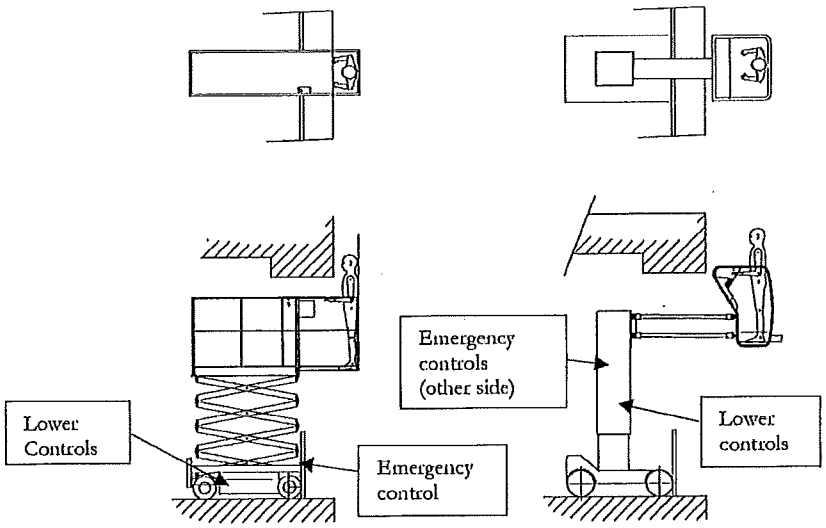


Fig 1

CORONER'S RECOMMENDATIONS

38.3 *"I recommend that the question of standardising scissor lift controls be given far greater impetus at a State and National level and that it be elevated to the Council of Australian Governments (COAG) for the commissioning of a project to pursue the standardisation of controls in scissor lifts"*

Work is already well underway at an international level through ISO TC214 in the development of a new International Standard ISO 21455 Mobile Elevating Work Platforms — Operator's controls — Actuation, displacement, location and method of operation. Upon finalisation it is intended to propose that this standard is referenced in a revision of AS/NZS 1418.10 Cranes, hoists and winches – Mobile elevating work platforms.

38.4 *"I recommend that until the implementation of a system of effective standardisation of scissor lift control configuration across the country, that scissor lifts not be operated unless there is a person on the ground operating as a spotter who is available at all times to take steps to activate the emergency lowering mechanism should that be necessary."*

The EWPA supports the employment of a spotter in situations where a risk of crushing exists, not only to perform emergency lowering should that be necessary, but to assist the operator in identifying a crushing hazard. However, to require a spotter in every situation (even where a risk of crushing doesn't exist) is problematic:

- There is a risk of employing inexperienced and untrained personnel simply to fulfil a need for a spotter;
- It detracts from the need to adequately identify hazards and manage risks accordingly – the primary objective should be to mitigate any crushing risk - not rely on emergency retrieval after the event;
- It could lead to a perception that any crushing risk is managed simply by the deployment of a spotter instead of taking steps to eliminate or mitigate the risk by proper planning and machine selection.
- It is an ineffective use of resources; and
- It could lead to personnel using ladders, which in some circumstances would create more risk.

Notwithstanding the above, support personnel, trained and familiar with operation of the lower (ground) and emergency controls should be available to perform an emergency retrieval. We do not believe however that personnel need to be assigned solely for the purpose of executing emergency retrieval.

38.5 *"I recommend that SafeWork SA consider whether the balance of the WHS Act and Regulations between safety being managed by risk assessment as opposed to express mandatory rules about what must occur in particular circumstances should be shifted in favour of more express mandatory rules .and take that matter up with SafeWork Australia for consideration."*

The EWPA supports mandatory rules for managing risk in the workplace at a high level such as that already expressed in the Work Health and Safety Regulation 2012 and the work Health and Safety Act 2012.

The EWPA does not support the introduction of detailed mandatory rules relating to specific circumstances or

activities as, in our experience:

- Mandatory rules detract from the general duty to identify hazards, eliminate risk or implement specific risk control measures.
- Mandatory rules cannot cover all circumstances where occupational risk may exist.
- Persons who have a duty under the Act may tend to abrogate their responsibilities to those expressed by mandatory rules.
- There is a perception, that where detailed mandatory rules exist, their very existence implies that workplace safety is controlled even beyond the scope where such rules would apply.
- Mandatory rules tend to lag world best practice and can inhibit the introduction of new methods to manage risk.

The introduction of mandatory rules as expressed by the coroner will tend to undo much of the progress that has been made in educating all stakeholders with respect to managing occupational safety over the last 20 years. These principles are not only imbedded in law but also in codes of practice, standards and industry guidelines.

With respect to the tragic incident that occurred at the Royal Adelaide Hospital, the only mandatory rule that could have been practically implemented would have been to mandate a spotter to perform emergency rescue. However, we have already noted that this is a reactive measure and proper risk management (using AS2550.10 as a guideline for example) would have identified the crushing risk and should have caused appropriate control measures to be implemented before the task commenced. It would be difficult to conceive low order mandatory rules that could have prevented the risk of crushing. We also note that there is already a duty under the Regulations to ensure that an emergency plan is prepared and maintained (R43).

38.6 *"I recommend that SafeWork SA should investigate, consider and report on the world's best practices engineering solutions to protect workers against the risk of crushing due to overhead surfaces...."*

OEMS are currently in the process of developing engineering solutions to control the risks of crushing hazards and such systems are being introduced into the market.

Further information is available on the EWPA website including:

Guidance on commonly provided emergency retrieval systems:

https://www.ewpa.com.au/uploads/Information%20Sheets/Emergency%20Lowering%20Procedures.pdf

Guidance on planning, selection and assessment of MEWPS:

https://www.ewpa.com.au/uploads/Information%20Sheets/EWP%20Safe%20Use%20Info%20Pack%20-%20Issue%2003%20-%20March%202013.pdf

Guidance on Crushing Risks:

https://www.ewpa.com.au/uploads/Information%20Sheets/Strategic%20Forum%20Best%20Practice%20Guide%20for%20MEWPs%20-%20avoiding%20trapping%20-%20crushing%20injuries.pdf

The EWPA Yellow Card training program includes machine selection, identification of overhead hazards, risk assessments, control measures and emergency retrieval within its course content:

https://www.ewpa.com.au/yellow-card

The EWPA also provides a MEWP Supervisors course, developed specifically for management of MEWP operations:

https://www.ewpa.com.au/uploads/Information%20Sheets/MEWP%20Supervisor%20Course%20overview%20v1.1.pdf

Regards

J. Oxenham

James Oxenham
EWPA CEO

File No; 18419

31 January 2019

Mr Martyn Campbell
Executive Director
SafeWork SA

BY EMAIL ONLY: Martyn.Campbell@sa.gov.au

Dear Mr Campbell

CFMEU & AWU & CEPU submission to SA Government
Coroner's Recommendations
Jorge Castillo-Riffo Coronial Inquest

1. We confirm that we act for the Construction, Forestry, Mining, Maritime and Energy Union (**CFMEU**), the Australian Workers Union (**AWU**) and the Communications, Electrical and Plumbing Union (**CEPU**) (collectively, **the Unions**) in relation to your invitation to make submissions in relation to the SA Government's consideration of the Coroner's recommendations in the Inquest into the death of Mr Jorge Castillo-Riffo.

2. Thank you for allowing the Unions until now to provide this submission.

3. The Unions support all of the Coroner's recommendations.

4. This submission is endorsed by Ms Pam Gurner-Hall, Mr Jorge Castillo-Riffo's widow.

5. We understand that the SA Government may wish to meet with Ms Gurner-Hall about this matter.

6. Ms Gurner-Hall would be grateful for the opportunity to do so and may raise matters beyond the content of this submission, given the opportunity.

CONTEXT

7. The inquest into the death of Mr Jorge Castillo-Riffo was necessarily about that particular event, rather than Elevating Work Platform (**EWP**)[1] related injuries and deaths more generally.

[1] In some of the evidence in the Inquest mentioned in the submissions and other documents, the acronym "MEWP" is used, referring to **mobile** elevating work platforms. Both MEWP and EWP are categories of machinery which include scissor lifts which are of course mobile.

9 MARKET STREET, ADELAIDE
SOUTH AUSTRALIA 5000
DX 52201 GOUGER STREET
P +61 8 8211 8662
F +61 8 8211 8282
E office@lieschke-weatherill.com

8. To provide some broader context, and without seeking to be exhaustive, in Australia, in addition to Mr Castillo-Riffo's death, EWP use has caused death and serious injury in incidents such as the following.

   8.1. On 5 December 2017, a 22-year-old construction worker was **crushed** between the top rail of an EWP basket and the roof above him at a Gold Coast construction site, **killing him.**[2]

   8.2. On 8 February 2017 a contractor for Renderworks Australia Pty Ltd was **crushed** between the cage of a scissor lift and a steel beam of a veranda while undertaking rendering work. The employer had **not conducted a risk assessment** or prepared a Safe Work Method Statement.[3]

   8.3. On 26 October 2016, Ivaca Andrijasevic **died** after being **crushed** between the basket of an EWP and an exterior surface.[4]

   8.4. On 30 August 2016 an employee was **crushed** between an EWP and an overhead steel beam. He signalled for help with the horn and was rescued by other staff members. He suffered **broken ribs, a collapsed lung, and damage to his liver, spleen and kidneys.** There was **no Safe Work Method Statement** or training provided in relation to the crush risk.[5]

   8.5. On 9 August 2016 an employee was **killed** after the EWP he was using collided with overhead power lines while fruit picking. There was **no spotter** assigned to the employee.[6]

   8.6. On 22 February 2016, 63-year old Mr Steve Wyatt was **killed** when his head hit a doorway while travelling on the platform of a scissor lift at the New Royal Adelaide Hospital.[7]

   8.7. On 15 May 2015, 28-year old Mr Josh Martin was **killed** at a Telfer mining site when he was **crushed** between the roof and the basket of the EWP he

---

[2] Amy Mitchell-Whittington and Toby Crockford, 'Young worker dies after cherrypicker accident at Gold Coast construction site', *The Brisbane Times*, 5 December 2017.

[3] Result Summaries and Enforceable Undertakings, 'Renderworks Australia Pty Ltd', Worksafe Victoria, 7 September 2018 < https://www.worksafe.vic.gov.au/prosecution-result-summaries-enforceable-undertakings>.

[4] Cassie Zervos, 'Tributes to Ivaca Andrijasevic, worker killed at Melbourne Convention and Exhibition Centre construction site', *The Herald Sun*, 28 October 2016.

[5] Result Summaries and Enforceable Undertakings, 'Vicrig Pty Ltd', Worksafe Victoria, 17 April 2018 < https://www.worksafe.vic.gov.au/prosecution-result-summaries-enforceable-undertakings>.

[6] Court summaries, 'Details of successful prosecution against E231365', Worksafe Queensland, 23 November 2018 <https://www.worksafe.qld.gov.au/laws-and-compliance/prosecutions/court-summaries>.

[7] Jordanna Schriever and Andrew Hough, 'Steve Wyatt becomes second man killed on new Royal Adelaide Hospital construction site', *The Advertiser*, 22 February 2016.

was using. The accident appeared to occur because of **confusion over the controls** for raising and lowering the EWP.[8]

8.8. On 21 May 2014, Mr Mark Galton was **killed** when he was **crushed** between the basket of an EWP and the roof above at Boggabri Coal Mine. While the ultimate cause of the accident could not be determined, it appeared that Mr Galton may have inadvertently caused the EWP to rise by using the wrong control switch or applying pressure in the wrong direction.[9]

8.9. On 11 September 2013, a 44-year old worker was **killed** when he was **crushed** by a scissor-lift at a BGC Cement plant in Perth.[10]

8.10. On 15 May 2013, Mr Peter Mackenzie suffered an electric shock while installing a length of steel railing from an EWP, when the railing came into contact with overhead power lines. The employer did not provide a safe work method identifying the risks from contact with these power lines.[11]

8.11. On 12 March 2013, a worker suffered **severe facial injuries** after her head collided with an overhead beam while manoeuvring an EWP through an underground car park in Queensland. There was **no spotter** present.[12]

8.12. On 24 May 2010, two workers suffered injuries after the EWP they were using to prune trees tipped over. The employer did not use stabilising spread plates, interfered with the safety interlock switch to override its function, failed to ensure employees wore a safety harness, and did not perform a pre-start check of the EWP.[13]

8.13. On 9 August 2009, a 52-year old diesel fitter, Mr Christopher Wagg, was **killed** after he was **crushed** between the basket of an EWP and an overhead access walkway at a Nyrstar site in Tasmania. A Coronial Inquest found the pro-forma **risk assessment** completed by Mr Wagg's employer was **insufficient** and did not direct appropriate attention to the risks of the job.[14]

---

[8] Ben Hagemann, 'Telfer accident linked to EWP controls', *Australian Mining*, 22 May 2015.

[9] NSW Mine Safety Investigation Unit, 'Worker crushed while using mobile elevated work platform', 21 May 2014; NSW Mine Investigation Union, 'Report into the death of Mark Daniel Galton at Boggabri Coal Mine on 21 May 2014', August 2015.

[10] Kaitlyn Offer, 'Man crushed in scissor lift at BGC plant', *PerthNow*, 12 September 2013.

[11] *Boland v Gogoll t/as SA Quality Sheds* [2015] SAIRC 35.

[12] Court summaries, 'Details of successful prosecution against E179617', Worksafe Queensland, 26 November 2014 <https://www.worksafe.qld.gov.au/laws-and-compliance/prosecutions/court-summaries>.

[13] Prosecution Summaries, 'Gerald James Shields', Worksafe Western Australia, 6 September 2012 < https://prosecutions.commerce.wa.gov.au/prosecutions/view/>.

[14] Record of Inquest into Death of Christopher William Wagg, 23 May 2014.

8.14. On 9 August 2008, Mr Majid Alaee suffered injuries to his coccyx and back after he collided with a pipe inside the basket of his EWP.[15]

8.15. On 29 July 2008, a 52-year old cable fitter, Mr Andrew McLaughlin, was **killed** when the basket of a scissor lift he was repairing descended on top of him and **crushed** him. There was **no spotter**. The employer did not enforce requirements for a job risk analysis to be completed and did not follow its own procedures on the supervision of employees.[16]

8.16. On 2 February 2007, Mr Colin Todd was **killed** when an EWP he was operating rolled backwards and **crushed** him. He was not given any induction or a copy of safety procedures. The employer's OHS Manager was aware that Mr Todd was not complying with these procedures but did nothing to enforce compliance.[17]

8.17. On 24 November 2006, a worker in Western Australia became **trapped** on an EWP after accidentally hitting the emergency stop button. **No spotter** was assigned and he had to telephone another worker for help to restart the engine. When the engine was restarted the machine began to wobble violently, and the worker fell approximately 6 meters. He suffered **severe brain injuries**. The EWP was in a poor condition, including a corroded pivot section and insufficient water ballast in the wheels.[18]

8.18. On 24 August 2005, a worker suffered **spinal injuries** after being **crushed** between the platform of a scissor lift and the bottom slab of a building he was working on in Gladstone.[19]

8.19. On 3 June 2005 Mr Mark Gallace was **killed** when he was **crushed** between the safety rail of his EWP and a roof purlin. The safe work method statement did not identify any risks associated with working underneath overhead structures. There was **no dedicated spotter** on the ground; an employee would simply walk between the various EWPs every 10 or 15 minutes.[20]

8.20. On 27 August 2003, Mr John Shevlin and Mr John Walsh were electrocuted in the basket of an EWP after an instrument they were using contacted overhead power lines. Mr Walsh **died** after suffering an electric shock and falling from the basket of the EWP; he was not wearing the mandatory safety

---

[15] *Eptec v Alaee* [2014] NSWCA 490.

[16] *BHP Billiton Iron Ore Pty Ltd v Capon* [2014] WASC 267.

[17] *DPP(Vic) v Coates Hire Operations Pty Ltd* [2012] VSCA 131.

[18] Prosecution Summaries, 'Hyde Park Management Limited', Worksafe Western Australia, 8 February 2010 < https://prosecutions.commerce.wa.gov.au/prosecutions/view/>.

[19] 'Man airlifted after scissor lift accident', *The Gladstone Observer*, 24 August 2005.

[20] *Inspector Melissa Chaston v Sacco Builders Pty Ltd* [2010] NSWIRComm 100.

harness. The company failed to perform any risk assessment of the work performed by Mr Shevlin and Mr Walsh. There was **no spotter**.[21]

8.21. On 13 October 1999, 30-year old Mr Barry Bullock was **crushed** between a doorway and the safety bar of a scissor lift while installing air-conditioning units, causing **total and permanent incapacity** including physiological damage to his heart.[22]

8.22. On 28 July 1998, Mr Keith Marshall suffered **severe head injuries** after colliding with an overhead rail while manoeuvring an EWP. Mr Marshall had very little experience using EWPs. **No risk assessment** was performed by Mr Marshall's employer. There was **no spotter**.[23]

8.23. On 6 December 1996, Mr Jordan Trajkovski and Mr Acko Dimovski were seriously injured when the EWP they were working on tipped. Mr Dimovski suffered **permanent incapacitating brain damage** as a result. **No risk assessment** was performed and no instruction was provided to the employees on the safe use of the EWP.[24]

9. **The impact on families and the economic and societal costs of these deaths and injuries are <u>totally unacceptable</u>.**

10. The impact on the workers killed or injured, their children, parents and partners and workmates makes **urgent action an absolute necessity.**

11. In March 2016, the ACTU wrote (in the same terms) to the following manufacturers of scissor lifts.

11.1. Skyjack.

11.2. Snorkel.

11.3. Genie.

11.4. Haulotte.

11.5. JLG.

12. The ACTU's letter to each manufacturer included the following.

---

[21] *Inspector Hugh Corner v Hastings Hire Pty Ltd and Inspector Hugh Corner v John Avalon Barrie Shevlin* [2008] NSWIRComm 63.

[22] *Bullock v Return to Work SA* [2018] SAET 208.

[23] *Inspector Brett Jurmann v Kevin R Sheather Services Pty Ltd* [2002] NSWCIMC 51.

[24] *WorkCover Authority of NSW v Ken's Painting & Decorating Services Pty Ltd* [1998] NSWIRComm 461

You will be aware that Australia has recently experienced two workplace fatalities involving scissor lifts.

The ACTU is of the view that more workers will be killed unless manufacturers introduce new engineering controls, which eliminate or substantially reduce the potential for scissor lifts to crush those using them.

The ACTU and its union affiliates are urging Australia's OHS regulators to mandate such new engineering controls.

Whilst these discussions are continuing, we are urging the manufacturers of scissor lifts to voluntarily introduce the appropriate engineering controls.

For this reason, we would be keen to learn from you what steps, if any, you are taking to modify scissor lifts manufactured by you, following the two recent fatalities in Australia.

Given the lives of Australians and other workers around the world are at stake, I expect you will give this correspondence your urgent attention.

13. Not one manufacturer took the trouble to respond.

14. Since then, at least three more Australian workers have been killed by EWPs.

15. The costs associated with preventing further tragedies pale into insignificance compared with the impact and costs of allowing more deaths and crippling injuries.

16. **The Unions urge all decision-makers to hear directly and in person from Ms Gurner-Hall** to assist them gain some insight into the real cost of these tragedies, and the abysmal failure of the existing safety regime for EWP's.

THE CORONER'S FIRST RECOMMENDATION; SAFEWORK SA INFORMATION

17. The Coroner recommended that:

    17.1. SafeWork SA's EWP document dated September 2016 be distributed annually to all relevant building industry participants in South Australia and electronic links to it be displayed permanently on SafeWork SA's webpage and kept current; and

17.2. the associated minimum standard of training document be brought into line with it to include references to clear lines of site.[25]

18. At the inquest, the CFMEU and Ms Gurner-Hall requested that recommendation.[26]

19. The Unions support that recommendation.

20. However, the CFMEU and Ms Gurner Hall also requested a recommendation that *the Treasurer introduce a mandatory regulatory requirement to ensure that the information sheet or any updated version is displayed at all commercial building sites.*[27]

21. Implementing such a requirement would assist in ensuring that important safety information reaches a critical audience for it.

22. However, whilst improved information provision could be helpful, the Unions' experience is that difficulties accessing safety information are rarely if ever the cause of deaths and serious injuries.

23. It is obvious from the proceedings of the Inquest and its findings that Jorge's death was not due to any difficulty accessing information. A critical safety actor in that matter (Mr Mark Evans, the senior Hansen Yuncken Leighton Contractors (**HYLC**) safety official on the New Royal Adelaide Hospital site) was well aware of pertinent safety information which, if adhered to, would have prevented Jorge's death. Mr Evans knew that:

23.1. there were significant risks in operating a EWP working alone or remote from assistance from at least mid-2014;[28]

23.2. the Australian Standard said that it *is important that there is a ground-based person who is aware of and adequately trained in how to use the ground controls on the immediate including the emergency descent controls as these are the controls that would be used to lower the platform during an emergency situation.*[29]

---

[25] Finding of Inquest, paragraph [38.2].
[26] CFMEU written submissions paragraph [40] & proposed recommendation 1 (page 35). Ms Gurner-Hall written submissions at [16].
[27] CFMEU written submissions, proposed recommendation 1 (page 35). Ms Gurner-Hall written submissions at [16].
[28] Transcript, page 2328, lines 8 – 12.
[29] Transcript, page 2328, lines 13 – 31.

24. Mr Evans, HYLC's Senior Safety Officer on the NRAH site, was in a key leadership position in terms of HYLC's approach to safety on the site. Mr Evans evidence gives substantial insight into HYLC's approach to safety.

25. Mr Evans initial position on what it meant to be working alone illustrates HYLC's approach to safety in practice, notwithstanding the concessions Mr Evans was obliged to make in response to questions from the Coroner.

> Coroner: ... You maintain that Jorge was not working alone, don't you; that's obvious from what you said.
>
> Mr Evans: ... Yes, your Honour.[30]
>
> .....
>
> Coroner: ... So are you saying ...[that someone is working alone] ... only if there is no activation of a response, are you saying that that means... [to be working alone]... that the person remains permanently trapped and no one ever comes and finds them.
>
> Mr Evans: Yes,...[31]

26. If Hansen Yuncken Leighton Contractors had adhered to their own "safety Bible" Jorge would not have died.

27. The HYLC "safety Bible" on the New Royal Adelaide Hospital site was the "HYLC safety essentials" document. All personnel on site were inducted into it and all personnel were supposed to follow it.

28. Even long after Jorge's death, in giving evidence at the inquest, a HYLC safety official[32] was advocating reliance on competent operators not making mistakes, rather than a systemic approach to minimising risk, completely at odds with basic work health and safety principles and the "HYLC safety essentials" document.

---

[30] Transcript, page 2328, lines 20 – 23.

[31] Transcript, page 2330, lines 1 – 5.

[32] Mr Lynch, at the time of Jorge's death, HYLC Senior Health Safety and Environment Coordinator at the New Royal Adelaide Hospital.

Mr Ats:[33] [page 14 of the safety essentials document]... "Human behaviour cannot be the primary risk control, it's an administrative control"

Mr Lynch: Yeah.

Mr Ats: That's at odds with what you've been putting forward about relying on competent operators not to make mistakes. All of those things I've taken you to [they are] relying on human behaviour on the operator not making mistakes aren't they.

Mr Lynch: Yeah.

Mr Ats: And that's completely inconsistent with the safety essentials document isn't it.

Mr Lynch: Yeah, the way you put that, but at the end of the day we try to eliminate, substitute, isolate the hazards and we shouldn't be relying on human error.

Mr Ats: But that's what happened in this case isn't it.

Mr Lynch: There was failures.[34]

29. HYLC emphasised its paperwork and written rules about safety practices.

30. What actually happened was, in critical respects, the polar opposite of what HYLC said it would do in writing.[35]

31. The HYLC Workplace Health and Safety (HSE Management Plan)[36] said

> *HYLC HSE Policy applicable to this project is to operate by the nRAH safety essentials supported by minimum standards guidelines....*
>
> *The Essentials do not address all critical risks – they are the minimum standards...*

[33] Counsel for Ms Gurner Hall in the Inquest.
[34] Transcript, Mr Lynch, page 1829 line 23 – page 1830 line 2.
[35] See generally, for example, transcript of Cartledge, page 642, line 3 – page 643 line 1 and page 720 lines 17 – 27.
[36] Exhibit C84

The nRAH safety essentials apply to all aspects of the nRAH project.

AS AN MEMBER OF THE PROJECT TEAM, EVERYONE MUST ADHERE TO THE REQUIREMENTS OF EACH OF THE ESSENTIALS AT ALL TIMES – THEY ARE NON-NEGOTIABLE.

...

Critical risks covered by the nRAH Safety Essentials cannot have administrative or Personal Protective Equipment (PPE) selected as the principal control except under exceptional circumstances which must be approved in writing by the Project Manager or above.

...

Critical risk activities require a higher level of supervision.

...

The appropriate emergency response to a critical risk activity must be planned, known by all involved in the activity and ready to be implemented. [37]

32. HYLC's *Safety Essentials*[38] document for the NRAH building site identified *work at heights* and *working in and around mobile plant* as *critical high risk activities*[39] and included the following.

    32.1. *Not focused on having people behave safely within a hazardous environment!*[40]

    32.2. *SAFE PLACES NOT SAFE PEOPLE.*[41]

    32.3. A hierarchy of control of risks to the effect that *reliance on human behaviour* was not an acceptable means of controlling risk.[42]

33. The contradiction between what HYLC said in its safety paperwork and what happened is exemplified by the fact that the work method that resulted in Jorge's death, in terms of safety, relied on Jorge not making the merest mistake, an approach totally inconsistent with HYLC's *Safety Essentials*[43] documentation.

Mr Ats:	... the **only** risk control against overhead crushing was relying on Mr Castillo-Riffo not to make a mistake...
Mr Kerpiniotis:	I accept that.[44]

[37] Exhibit C84, pages 53 – 54, section 21.1. Capitalisation emphasis in the original.
[38] Exhibit C11D.
[39] Exhibit C84, see heading on page 24 and content on page 25.
[40] Exhibit C11D, page 5.
[41] Exhibit C11D, page 6.
[42] Exhibit C11D, page 8 – 16, and in particular page 14.
[43] Exhibit C11D.
[44] Transcript, page 2085, lines 22 – 25. Bolding and underlining is our emphasis.

34. Mr Kerpiniotis was, at the time of Jorge's death, the HYLC operations Director, the third most senior HYLC official associated with the construction of the hospital.

35. There is no reason to think that HYLC's approach to safety as exposed in the Inquest is uncommon amongst employers. There was evidence in the Inquest that HYLC's approach to safety – not following its own written rules – is commonplace.

36. One of Jorge's workmates gave the following evidence about his observations on the new Royal Adelaide hospital building site, and in the construction industry generally (including at the time of the Inquest – 2018), in relation to the stark difference between what employer documentation says will occur in relation to safety, and what actually occurs.

Mr Cox:[45]	You mention...that things that you were told in the induction [weren't] the same as what was happening on-site.
Mr King:[46]	Correct.
Mr Cox:	And there'd be crane loads going over you even though there was a policy that... Was supposed to have warned workers underneath to get out of the way; that wasn't being complied with.
Mr King:	Correct.[47]
	.....
Mr Ats:	...what you were told and I suggest what the paperwork said, the safety paperwork, and what actually happened were two very, very different things, do you agree with that.
Mr King:	Correct.
Mr Ats:	Just because this inquest might be provided with a piece of paper that says, these are the safety rules about this, this court should not accept that that's how it actually went down, should it.

[45] Senior Counsel for SafeWork SA.
[46] One of Jorge's workmates.
[47] Transcript, King, page 270 lines 23 – 31.

Mr King:	Correct.
Mr Ats:	That was widespread.
Mr King:	Even today, yeah, correct.
Mr Ats:	**I think you must mean even on other jobs today...**
Mr King:	**Yes**, on all jobs, throughout the hospital, yes, correct.
Mr Ats:	I think in fairness to what you're saying, you continue to experience that very frequently in your work as a construction worker.
Mr King:	Correct.[48]

37. Whilst it has its place, improved provision of safety information in no way alleviates the need to implement other more important and effective recommendations made by the Coroner.

38. The core problem is not lack of knowledge.

39. Employers and head contractors frequently do not follow even their own rules let alone guidance material published by the regulator.

THE CORONER'S SECOND RECOMMENDATION; STANDARDISING SCISSOR LIFT CONTROLS

40. The Coroner recommended that:

    40.1. the question of standardising scissor lift controls be given far greater impetus at a State and National level;

    and

    40.2. that the question of standardising scissor lift controls be elevated to the Council of Australian Governments (COAG) for the commissioning of a project to pursue the standardisation of controls in scissor lifts.[49]

41. The Unions support that recommendation.

---

[48] Transcript, King, page 294 line 34 page 295 line 15.
[49] Findings of Inquest, paragraph [38.3].

42. The evidence in the Inquest, and even a cursory common-sense consideration, makes clear that the lack of standardisation in scissor lift controls is a recipe for disaster.

43. The extremely common industry practice of workers frequently moving between scissor lifts with differently configured controls severely exacerbates the inherent risks of a lack of standardisation.

44. It seems incomprehensible that any Australian Government (Commonwealth, State or Territory) would allow cars or trucks to be sold with some responding to "left-hand down" on the steering wheel with a left turn, and some responding to "left-hand down" on the steering wheel with a right turn. Why is it allowed for EWPs? It shouldn't be.

45. Common experience shows that errors in operating indicator stalks on cars when changing between European models (with indicator stalks on the left side of the steering column) and other models (with indicator stalks on the right side of the steering column) are common. Drivers may be focusing on other matters, or unconsciously revert to habits formed in driving vehicles with a different configuration.

46. It is unacceptable that EWP's, a prolific, powerful and crushingly deadly feature of modern Australian workplaces, are lawfully operated with controls that mean a forward joystick input on one EWP will bring the platform/cage down, and on another bring it up.

47. The Coroner found that a *worker such as Mr Castillo Riffo may find himself operating different scissor lifts on different days on the same site.*[50] In the Unions' experience, workers may operate different scissor lifts on the same day on the same site. It is a recipe for disaster. It cannot be allowed to continue.

48. Control boxes on many EWP's, and probably the vast majority of scissor lifts, are "plugged in" and detachable.

49. Whilst further work on the matter is appropriate, at face value a simple solution would be to mandate a particular control configuration, with any EWP's not complying with that control configuration in original manufactured specification to be either fitted with a converter mechanism or retired from use. The Unions' understanding is that all scissor lifts are imported into Australia – scissor lifts without the mandated configuration could be banned from import.

[50] Findings of Inquest, paragraph [29.2].

50. As EWP's may be transported between States and Territories as the need arises, and operators move between States and Territories (often to work on large projects), National control standardisation is necessary.

51. Associate Professor Dell was an extremely impressive expert witness at the Inquest. The Coroner noted his evidence that *this lack of consistency is a significant problem for operators... "beyond a shadow of a doubt".*[51]

52. This issue was an obvious concern even before the evidence commenced, and was identified by counsel assisting the Coroner in her opening address.[52]

53. Mr Steele was one of Jorge's workmates and uses scissor lifts in his work. His evidence included the following.[53]

Q.	... having differences in the controls on the scissor lifts ... creates a bigger risk of an accident, doesn't it.
A.	Definitely.
Q.	And it would therefore be much safer if all of the controls on every scissor lift, by law, were uniform.
A.	That's one great recommendation, yeah, **we've been saying that.**
Q.	Who's 'We'.
A.	Most users would generally come across that, hey, like we've got to standardise certain stuff. Certain legislation in New South Wales... compared to us, you know, like, I think it's standardisation across, like, the board you know, especially when it comes to those controls, you know.
Q.	And I'm putting it to you that's not only the joystick orientation, that's everything, the toggles, the whole kit, it needs to be standardised.
A.	You've got it, same as a car. Generally speaking the same as a car.
Q.	Same as a steering wheel, of course, we've had some evidence about hopping between European and non-European cars but we're not talking about the critical control mechanisms of the steering wheel and the brakes.
A.	That's right.
Q.	- the accelerator.

[51] Coroner's findings, paragraph [29.1].
[52] Transcript, page 30 line 22 – page 31 line 28.
[53] Transcript, page 389, line 5 – page 390 line 2.

A. Car accelerator and a brake, you switch them around and I think we'll all have a few issues.

54. Mr King, another of Jorge's workmates and another scissor lift operator gave evidence including the following.

Q. There was a moment ... when [you were asked]... questions about the direction in which you would move the joystick when – you ... said something like 'I don't know, I have to stop and think', ... you thought about it and gave an answer. I ... suggest that the reason that a very experienced and no doubt competent scissor operator like you wasn't able to just go ... here's the answer, is that the controls are different from machine to machine, they don't work in the same way.

A. Correct.

Q. Because if you had have been operating controls that operated in the same way throughout all your time operating a scissor lift you'd just know, wouldn't you.

A. Yes. If you're using the same – how do I put it? If you're operating the same machine, the same company brand machine well then you get to know it, you know you still make mistakes.

Q. Yes, sure.

A. But then if you go to a different brand [things] are [different].

Q. And ... on that... same brand, same thing all the time, you don't have to think about it in the end, it's a bit like you're driving a car, you don't think that to pull right-hand down that's necessary to turn right, you just do it, it's the same every time.

A. Basically, yes.

Q. That's the sort of thing you're explaining, isn't it.

A. Yes. If you drive a European car the windscreen wipers are on one side, if you drive an Australian car it's on the other.

Q. And it's only when you have the [change] that you really have to engage the brain and think about it for a while.

A. Exactly, and it's the same thing here.

Q. That's right. And if you change and stick with it after a while you've just got it, but if you're changing backwards and forth that complicates things a lot, doesn't it.

A. It does.

Q. Especially if you've got other things on your mind like ducking under a slab, for example.

A. Correct.

Q. That makes it harder to get it right every time, doesn't it.

A. It does.

Q. It creates a greater risk that you'll make a mistake, doesn't it.

A. There's a risk in everything, but yes.
Q. But it escalates that risk.
A. Yes.
Q. As compared to every single machine [having] the same mechanism of operation.
A. Correct.
Q. Now, I don't know what others would say, but based on what I've seen of your experience, by virtue of your experience you seem to me to be pretty expert in operating these scissor lifts, bearing in mind your long experienced in operating these scissor lifts, would it make it safer if every machine operated in the same way. Would it reduce the risk of accidents.
A. What? If all scissor lifts had the same controls?
Q. If uniform identical joystick forward does this, joystick back does this, identical, everyone.
A. Yes, it probably would.
Q. Make it safer, that's what you mean?
A. I think so, yes, my personal view.
Q. Do you know why they are not made to be like that?
A. It's the same as why aren't cars all the same.
Q. Do you know of any downside, other than changing things already built, why it's not a good idea to do that in future.
A. I can't comment on that, I wouldn't know.
Q. So, you can see it's a good idea to do it, you're not aware of any reason not to do it, is that the case.
A. In my [personal] view, yes.

55. Mr Hales, an experienced scissor lift operator, gave the following evidence.

Q. Does a difference in controllers create any confusion for you.
A. Yeah, sometimes, yeah it does.[54]

56. Mr Glover, gave evidence at the inquest as an expert witness, and had the following extremely extensive EWP experience.

56.1. Maintenance fitter with over 26 years' experience servicing, repairing and providing technical advice on MEWPs.

56.2. Considerable experience developing safety devices for MEWPs.

[54] Transcript, page 681.

56.3. Considerable experience as a technical advisor evaluating major safety incidents involving MEWPs.

56.4. Former member of the National Executive Team and National Service Manager at Australia's largest specialist supplier of MEWPs.

56.5. President of the New South Wales Elevating Work Platforms Association.[55]

56.6. Regular advisor to the world's major MEWP manufacturers.[56]

57. Mr Glover gave the following evidence.

Counsel for HYLC	... what engineering controls would you propose for the future?
Mr Glover	... That the functionality of all scissor lifts, direction of control of the joystick the ... function would be the same across all manufacturers.[57]
	.....
Mr Glover	... [operators]... being in there and thinking "what machine am I in?".... Move the joystick and he thinks it's going to go one way and it goes another.
Counsel for HYLC	... That is a problem, isn't it.
Mr Glover	... I think it's a problem.
Counsel for HYLC	... it seems reasonable to me. It's because it could create confusion and it can therefore result in injury, correct.
Mr Glover	Yes.
Counsel for HYLC	have you ever expressed that view in the [Elevated Work Platforms Association].
Mr Glover	Yes..... [the Elevated Work Platforms Association has asked international standards bodies]... to have standardised controls. There's been a trial unit that has been in Australia

[55] Exhibit C65, page 6.
[56] Exhibit C65, appendix a.
[57] Transcript, page 531, lines 27 – 32.

> and other places of the world... the [Elevated Work Platforms Association] would like to see standardised controls.[58]

58. The problem is obvious.

59. No matter how experienced the operator, mistakes will inevitably be made.

60. The heightened risk of mistakes in operation of scissor lifts due to differences in functionality from machine to machine is clear.

61. Section 17 of the *Work Health Safety Act 2012 (SA)* requires that risks be firstly eliminated so far as is reasonably practicable, and if it is not reasonably practicable to eliminate risks, to minimise those risks so far as is reasonably practicable. That principle must be followed in relation to scissor lift controls; which requires standardisation.

62. Whilst the Unions are firmly of the view that standardisation must occur, as soon as possible, the Coroner's recommendation is only that greater national focus be given to the issue and that a project for pursuit of the issue be commissioned by COAG. There is no good reason for the SA Government, or COAG, to decline that recommendation.

THE CORONER'S THIRD RECOMMENDATION; SPOTTERS REQUIRED TO OPERATE SCISSOR LIFTS

63. The Coroner recommended that until scissor lift control configurations are standardised, scissor lifts should only be operated if there is a person on the ground operating as a spotter, available at all times to activate the emergency lowering mechanism if necessary.[59]

64. In the short to medium term (or in the long-term if standardised controls are not implemented), **this is by far the most important recommendation** made by the Coroner.

65. **Implementing this recommendation would do more than any other to reduce serious injuries and deaths associated with the use of scissor lifts.**

66. Fundamentally, requiring spotters when scissor lifts are used would avoid serious injuries and deaths and reduce the severity of serious injuries by:

---

[58] Transcript, page 538 line 29 – page 539 line 17.

[59] Findings of Inquest, paragraph [38.4].

66.1. spotters warning operators of risks before they eventuate; and

66.2. when accidents happen, providing immediate assistance to trapped or injured workers (which almost certainly would have saved Jorge's life).

67. Jorge's case proves that assuming that because a scissor lift is being used in what is thought to be a busy work area provides adequate monitoring of scissor lift operators is a fatal mistake.

68. Construction sites in particular impede casual observation of scissor lift operators by physical obstructions and noisy operating environments. A dedicated observer trained in the operation of the particular machine being used is necessary.

69. Jorge's case demonstrates that even after a worker trapped by crushing is found by chance, if the person who happens upon the trapped worker is not trained in the operation of that particular scissor lift they may not be able to help; potentially the difference between life and death.

70. Mr Hales, a plasterer who was the first to find Jorge, gave the following evidence about why he was unable to lower the machine and release Jorge's head from being crushed between the basket of the scissor lift and the slab above:

"I looked for the emergency handle on the scissor lift and could not find it ....."[60]

71. Mr Hales was an experienced EWP operator. His evidence was that "...I operate an EWP on a daily basis and am familiar with the controls."[61]

72. Mr Hales was examined about why he, an experienced operator, could not locate the emergency release.

Ms Waite:[62] How is it that you've used a scissor lift and you didn't know where the emergency release was?

Mr Hales: ... they're different on scissor lifts... they're all in different spots. And the one that Jorge was on was at the front of the scissor which he drove all the way close to the barrier and we can't find - that's why we couldn't find it because it was right up against the barrier and we couldn't see it ....[63]

---

[60] Exhibit C03a, page 3.
[61] Exhibit C03a, page 4.
[62] Counsel assisting the Coroner.
[63] Transcript page 686 line 20-28.

73. Mr Haig, who was second on the scene, gave the following evidence:

> "I immediately ran to the back of the EWP to look for the emergency release. I could not find it so I panicked and ran around it a couple of times before locating the release at the front of the EWP."[64]

74. The adoption of this recommendation would be either a minimal evolution of the existing requirements of Australian Standards or the practical articulation of the requirements of the existing Australian Standard.

75. The existing Australian Standard for the operation of MEWPs[65] includes the following requirement.

> **5.14 ASSISTANCE FROM SUPPORT PERSONNEL**
> Prior to operation, a system of communication shall be established between people working on the platform and nominated support personnel.
>
> Arrangements shall be made for rescue in the following events:
> (a) Failure of the elevating mechanism.
> (b) Disabling injury or sickness of the operator.
> (c) The MEWP coming into contact with overhead powerlines.
> (d) The operator being suspended in a safety harness after being expelled from the MEWP.
>
> Ground personnel shall be trained in the use of emergency retrieval systems.

76. A proper system for the rescue of an operator disabled by injury or sickness requires that the operator be constantly monitored because a disabling injury or sickness could easily prevent the operator initiating any communication themselves (e.g. because they are trapped by crushing or are unconscious).

77. Viewed in the context of the existing Australian Standard, a mandatory requirement for a spotter trained in the use of the relevant emergency retrieval system cannot be regarded as any significant extra requirement to operate scissor lifts.

78. The Unions consider that the above aspect of the Australian Standards is routinely flouted by employers, as exemplified by Jorge's case. In Jorge's case:

---

[64] Exhibit C04d, page 2.
[65] Australian Standard 2550.10 – 2006, Cranes, Hoists And Winches – Safe Use, Part 10: Mobile Elevating Work Platforms.

78.1. no arrangements were made for rescue whatsoever;

78.2. the first person who stumbled upon Jorge, unconscious and trapped by crushing, could not find the emergency release mechanism (notwithstanding that they were an experienced scissor lift operator themselves); and

78.3. the second person to attempt to assist Jorge took some time to locate the emergency release mechanism.

79. Workplaces associated with persons or bodies who suggest that there would be any radical change in implementing the Coroner's recommendation that spotters be mandatory should be inspected (without any advance notice) to assess their compliance with Australian Standards and safe work practices in relation to Scissor Lifts and EWPs generally, as such a position suggests a failure to comply with the Australian Standard and a failure to safely operate Scissor Lifts.

80. It is difficult to see how a mandatory statutory requirement for a spotter trained in the operation of the particular machine (presumably in the WHS regulations) would impose additional costs on employers who were complying with the existing Australian Standard.

81. The risk of crushing between EWPs and other structures is well known. The risks of failing to continuously monitor operators are, sadly, also well-known as a result of Jorge's case and it appears recognised by the Australian Standard. The risks associated with not having a person who knows how to lower the machine if need be are obvious. In that context, it is difficult to see how an employer who fails to provide a trained spotter to assist in EWP operator can discharge their obligation to provide a safe system of work.

82. To the extent that spotters trained in the operation of the relevant machine are not being provided, that appears to contravene both the Australian Standard and the employer's ordinary duty to provide a safe system of work. Notwithstanding that, scissor lift operators working without a spotter is commonplace. It cannot be allowed to continue.

83. This recommendation must be implemented, and must be implemented quickly.

THE CORONER'S FOURTH RECOMMENDATION; BALANCING RISK ASSESSMENT AND EXPRESS MANDATORY RULES

84. The Coroner recommended that:

84.1. SafeWork SA consider whether the balance in the WHS Act and Regulations between safety being managed by risk assessment as opposed to express mandatory rules about what must occur in particular circumstances should be shifted in favour of more express mandatory rules; and

84.2. take that matter up with SafeWork Australia for consideration.[66]

85. This is an extremely important recommendation, with a far broader scope and significance for workplace safety than the Coroner's other recommendations. Whilst this recommendation is not in conclusive terms, it identifies a fundamental failure of the current system of workplace health and safety regulation.

86. In short, the present system of WHS regulation is failing because it is premised on considered risk assessment, which often does not happen. Jorge died because of a failure to properly assess the risks of his work.

87. The Unions' common experience is that risk assessment is not taken seriously by many employers and "template" safe work method statements are used without any consideration of the particular circumstances at hand. Employers often focus on "paper compliance" – having a document that says risk assessment has been done – without actually performing a proper risk assessment.

88. Jorge's case also demonstrates that in a practical context, "hard and fast" rules are often retained and remembered from training, and followed, but "fuzzy" or diffuse notions of risk assessment in busy workplaces are ineffective.

89. At the Inquest there was evidence of confusion about the rationale for safety harnesses being required in all boom lifts, but not being required (e.g. by mandatory hard and fast rule) for scissor lifts - even when used extended out into a void in a building site – multiple floors from the ground.

> *In a boom lift... I've got to wear a safety harness and you have to clip-on – that's law... In a scissor lift you don't have to have a safety harness. I don't know why, I don't make the rules... I wish someone would tell me...*[67]

[66] Findings of Inquest, paragraph [38.5].
[67] Mr King, transcript, page 310, line 16 – 22. Other evidence was given to the effect that some scissor lifts lacked an engineered anchor point to attach a harness to. That did not however address the apparently equivalent risk of falling out of the basket of a scissor lift and a boom lift.

90. In telling evidence about the failure of risk assessment and "hard and fast" rules being remembered and taken seriously, Jorge's supervisor gave the following evidence in relation to spotters and EWPs.

Ms Holt:[68]	Do you understand that a spotter was legally required for the work that Jorge was undertaking at the time.
Mr Traeger:	No.
Ms Holt:	Did you **consider** whether to put a spotter in at the time.
Mr Traeger:	**No**, spotters are used for when you're working near powerlines.[69]
	.....
Mr Ats:	.... You said that spotters were used when working near powerlines. What you were talking about was your understanding of the regulatory regime, wasn't it.
Mr Traeger:	Yes.
Mr Ats:	Not some independent assessment of what the safest work practice might be.
Mr Traeger:	No.[70]
	.....
Mr Ats:	Was Jorge wearing a safety harness fixed to the scissor lift when you observed him doing his work that day.
Mr Traeger:	No.
Mr Ats:	Did you ask him to.
Mr Traeger:	Not required.
Mr Ats:	Why is it not required given that he was working over a void in the order of two storeys and there was the possibility that he could topple backwards out of the platform.
Mr Traeger:	It's not a requirement legally I believe.
Mr Ats:	So -
Mr Traeger:	It's only a requirement in a boom lift or a - yeah, boom lift.
Mr Ats:	So I think you're telling us that your understanding was there was no clear mandatory obligation for there to be a harness.
Mr Traeger:	That's correct.

[68] Counsel for SRG, Jorge's employer.
[69] Transcript, page 751, lines 27 – 34. Highlighting and bolding are our emphasis.
[70] Transcript, page 800, lines 13 – 20.

Mr Ats:	And therefore you didn't turn your mind independently to the question of whether it was appropriate to mitigate risk.
Mr Traeger:	I don't understand your question.
Mr Ats:	Because of your understanding that there was no mandatory legal requirement to have a harness attached to the machine you did not then make your own assessment about whether that was an appropriate step to mitigate the risk associated with falling out of the basket.
Mr Traeger:	I don't believe it was required.
Mr Ats:	By law.
Mr Traeger:	By law. ... - I don't know of a law in South Australia, definitely no law in Victoria.
Mr Ats:	I'm accepting what you say, that was your understanding of the law. I'm asking you to leave that question behind. You did not independently consider the merits of a harness did you.
Mr Traeger:	No.[71]

91. The complete failure to take steps to minimise risk in the absence of an express mandatory rule about what to do was also tragically highlighted by Jorge's supervisor's evidence.

Mr Ats:	How did you factor the risk of inadvertent operation of the joystick into your assessment that that work method was safe given the extremely restricted working area and the lack of guarding against inadvertent operation.
Mr Traeger:	I don't believe if the machine and the operator had have operated it correctly the risk would be nil. It's always a risk in operating machinery.
Mr Ats:	It's always a risk of inadvertent operation isn't there.
Mr Traeger:	Yes.
Mr Ats:	And that risk is heightened when there is no guard against inadvertent operation isn't it.
Mr Traeger:	Yes.
Mr Ats:	And that risk is heightened by work in confined spaces isn't it.
Mr Traeger:	Yes.

[71] Transcript, page 789, line 9 – page 790, line 6.

Mr Ats:	How did you factor those increased risks into your assessment that the work was safe.
Mr Traeger:	The work was safe if the operation was carried out correctly.
Mr Ats:	So there was no margin for error allowed, was there.
Mr Traeger:	No. if you operate it correctly, you would be safe.[72]
	...
Mr Ats:	You answered a question earlier about spotters and you said that spotters were used when working near powerlines. What you were talking about was your understanding of the regulatory regime, wasn't it.
Mr Traeger:	Yes.
Mr Ats:	Not some independent assessment of what the safest work practice might be.
Mr Traeger:	No.[73]
	...
Mr Cox:	Well you've told us that a boom lift would have required legally a safety harness. That was your evidence.
Mr Traeger:	That's correct.
Mr Cox:	That's your understanding.
Mr Traeger:	That's my understanding.
Mr Cox:	If he'd been using a scissor lift as he was, that wasn't required, the use of a safety harness.
Mr Traeger:	That's my understanding.
Mr Cox:	Although he was working at the same height, which was the reason for the requirement to have a safety harness with the boom lift, is that right.
Mr Traeger:	That's right. I can't add any more to that, that's the law ...[74]

92. Risk assessment assumes careful consideration.

93. The above evidence demonstrates that experienced supervisors may consider that if there is no mandatory rule to follow a given safe work practice, the possibility of following it as an outcome of risk assessment does not arise.

94. Experience shows that expecting that careful consideration to occur all of the time is unrealistic, and that clear hard and fast rules have a better chance of being remembered and followed.

---

[72] Transcript, page 790, line 37 – page 792 line 2
[73] Transcript, page 800, lines 13 - 20
[74] Transcript, page 869, lines 1 – 14

THE CORONER'S FIFTH RECOMMENDATION; ENGINEERING PROTECTIONS AGAINST CRUSHING

95. The Coroner recommended that SafeWorkSA investigate, consider and report upon the world's best practice engineering solutions to protect workers against the risk of crushing between EWPs and overhead surfaces, including the availability and design of secondary protective systems including operator protective alarms and operator protective structures and the options for reform to require that all scissor lifts in use in South Australia have a secondary protection system.[75]

96. It is obvious from Jorge's case and the other examples of deaths and injuries given above that engineering solutions are highly desirable.

97. It appears that there is significant complexity in determining the most appropriate engineering solution, for reasons including the variety of overhead structures and materials which are commonly proximate to scissor lift platforms and the risks of alarms not being heard in noisy environments or disregarded if they are unnecessarily activated too often.

98. Whilst the Unions strongly support work on this topic, it is not obvious that Safe Work SA's internal resources are most suited to performing this work.

THE CORONER'S SIXTH RECOMMENDATION; SUPPORTING BEREAVED FAMILIES IN INQUESTS

99. The Coroner recommended that the Government provide, through the Legal Services Commission, funding to enable families to be legally represented in Inquests generally.[76]

100. This is a very important recommendation.

101. Opportunities for bereaved families to ask hard questions of employers and others involved in workplace deaths, in circumstances where the questions must be answered, are rare indeed.

102. The sheer scale of the documentary material involved in this inquest would make it nigh on impossible for a bereaved family without representation to properly engage in the inquest.

---

[75] Findings of Inquest, paragraph [38.6].
[76] Findings of Inquest, paragraph [38.7].

103. The Principal Contractor, Hansen Yuncken Leighton contractors, was represented at the enquiry by Senior Counsel, Special Counsel, a Partner and another lawyer.

104. The employer retained a QC to appear (although that ultimately did not occur due to a scheduling clash), and was represented by two Partners and another lawyer.

105. SafeWorkSA was represented by Senior Counsel, Junior Counsel and solicitors from the Crown Solicitors' Office.

106. The hearing itself took about 5 weeks.

107. The notion that a bereaved family could fairly participate in such an inquest without legal representation is unrealistic and unfair.

108. It was obvious during the inquest that the Coroner's Court is seriously under resourced. Given the deficit in resourcing, it is unrealistic to expect counsel assisting to adequately engage with the bereaved family so as to represent them. In any event, that is not the role of counsel assisting.

109. As a matter of basic justice, families of deceased workers must be provided with funding to be adequately represented.

110. Further, conducting a coronial inquest should be a legislated mandatory requirement for all workplace deaths.

OTHER MATTERS

Workers should not be punished for speaking up about dangerous work

111. Barriers to workers speaking up about dangerous work are one of the most significant factors that make South Australian workplaces dangerous.

112. Ms Gurner Hall gave the following evidence.

    112.1. She is *convinced that the casualisation of work in the building and construction industry is a major issue workplace safety and has not been adequately investigated;*[77]

    112.2. She *asked Jorge the night before he died why he was going to keep working despite his concerns about safety on site.* [Jorge said]... *" Mi Amore, I've got one more*

[77] C59B, affidavit of Gurner Hall, paragraph [39].

week of work ... If I do a good enough job then they might hire me back. And I like working for this company."[78]

112.3. *Casual workers can lose their job and their livelihood if they raise concerns about safety and particularly if they refuse to perform work because of those safety concerns.*[79]

112.4. *Casualisation of the workforce in the construction industry is a major risk. It needs to be very seriously...reconsidered. It puts workers in a much more vulnerable position. They are at the whim of the employers with respect to... the safety of the workplace.*[80]

112.5. *Jorge made it clear to me that he and other workers were very cautious about speaking up about safety problems. Employers and head contractors like HYLC didn't like that because doing things safely is often perceived as slower or more expensive.*[81]

112.6. *The nature of the construction industry means that many workers jobs finish as a project finishes and they seek employment on the next project that comes along. It is too easy for employers to informally "blacklist" workers who stand up for safe workplaces. It is just too hard to prove that this is what is happening, when the workers know it is. There must be a better way to prevent "payback" from bosses when workers raise safety concerns.*

112.7. *Casualisation in the labour force ... is one of the big issues around why Jorge actually got onto that machine...* [Jorge] *... was frightened of not having work and I think casualisation of the labour force is something that really needs to be considered.*[82]

112.8. [Jorge] *was really nervous about being too vocal... He refused to* [work as a safety officer]... *Because he felt that they were... So unsupported.*[83]

113. The former SA Branch Secretary of the CFMEU, who spoke to Jorge before Jorge started work on the day Jorge was crushed, gave the following evidence.

---

[78] C59B, affidavit of Gurner Hall, paragraph [46].
[79] C59B, affidavit of Gurner Hall, paragraph [47].
[80] C59B, affidavit of Gurner Hall, paragraph [48].
[81] C59B, affidavit of Gurner Hall, paragraph [48].
[82] Transcript, Ms Gurner Hall, page 115, lines 24 – 26, page 116 lines 24 – 27.
[83] Transcript, Ms Gurner Hall, page 126, lines 23 – 30.

113.1. On the morning that Jorge was crushed Jorge told him about the work method. Jorge said *it makes me very nervous.*[84]

113.2. He suggested to Jorge that Jorge's concerns should be raised, and in response, Jorge said *it's a good company and I don't want to cause trouble.*[85]

113.3. [Jorge]... *Struggled over the years through labour hire companies and because he was such a strong advocate for safety, he had a lot of trouble continuing in full-time work.*[86]

113.4. Jorge wasn't afraid to speak up when he needed to, *but he had been battered around a fair bit in the industry because of it too and it takes its toll on you, particularly if you're the breadwinner in the family... You can only do that so long in the South Australian building industry before you find it increasingly difficult to get work, so it can wear you down doing that role. I know myself, that's why I ended up with the union.*[87]

113.5. [Jorge] ... *was tired of being outcast from the industry* [for speaking up about safety].... *it just wears people down particularly in a small industry like Adelaide is... he didn't want to jeopardise his employment...*[88]

113.6. *Workers are far more hesitant in the industry now than say a decade ago to raise safety issues. Casualisation is part of that and also litigation through the Australian Building and Construction Commission through legitimate safety issues that workers have had and have found themselves being prosecuted in the Federal Court.*[89]

114. Part of Mr Traeger's evidence emphasises the dangers of workers feeling unable to speak up when combined with an inappropriate approach from supervisors.

Dr Gray:	I want to suggest to you that it wasn't Jorge's sole responsibility to advise you if he felt unsafe and that you had a responsibility to ensure that he wasn't working in a space...that was so confined that it wasn't safe.
Mr Traeger:	I disagree with that.

[84] C20C, affidavit of Cartledge, paragraph [218].
[85] C20C, affidavit of Cartledge, paragraph [221].
[86] Transcript, Cartledge, page 663 lines 18 – 21.
[87] Transcript, Cartledge, page 665 line 35 – 666 line 5.
[88] Transcript, Cartledge, page 673 line 36 – page 674 line 22.
[89] Transcript, Cartledge, page 717 lines 23 – 30.

115. Mr King, one of Jorge's workmates, gave the following evidence.

Mr Ats:	Your evidence has been that you observed the difference between what was said and what was done.
Mr King:	Correct.
Mr Ats:	Did you ever talk to anyone about that.
Mr King:	We only talk amongst ourselves.... we talk amongst ourselves but a lot of people are afraid to speak up because if you speak up, **they're afraid they're going to lose their jobs, so people keep their mouth shut. People die.**[90]
	...
Mr Ats:	Did you ... [speak] ... up, about this gap between what was said and what was done on this building site.
Mr King:	No.
Mr Ats:	Why not.
Mr King:	Because it doesn't get you anywhere.
Mr Ats:	Do you mean by that that when you do speak up, it just carries on the same.
Mr King:	Basically, yes.... it's up to HYLC to ensure its enforced, if they don't do that, well then you're just banging your head against the wall and that's on all construction sites.
Mr Ats:	.... was your thinking that because HYLC is allowing this, no point me speaking up.
Mr King:	My personal view, yes.

116. To address this problem, at the inquest Ms Gurner-Hall sought the following recommendation,[91] which should now be pursued by the South Australian Government.

> *The Premier should institute a Judicial Inquiry, with provision for protection of the identity of witnesses, to report on measures to stamp out employment practices that deter construction workers from raising concerns about workplace safety. The Inquiry should commence within 6 months, report within a year from its commencement with its report being tabled in Parliament on the next sitting day after it is delivered, and with the Government's response to that report being tabled in Parliament 6 months thereafter. The Premier should request that the desirability of a Commonwealth Judicial Inquiry of that nature be placed on the agenda for the next Council of Australian Governments meeting. If a Commonwealth Judicial Inquiry of that nature is instituted, a South Australian Judicial Inquiry would be unnecessary.*

[90] Transcript, Mr King, page 297, lines 6 – 17.
[91] Written closing submission of Ms Gurner-Hall, 2 October 2018, paragraphs [20], [77] – [79].

WHS law enforcement

117. The Unions acknowledge and welcome SafeWorkSA's public statements about its intention to significantly improve its investigation/prosecution practices and outcomes.

118. An aspect of that improvement should be prosecution of breaches of the obligation to provide a safe system of work in appropriate circumstances when there is no injury or death as a result.

119. Prosecuting such failures would assist in driving better workplace health and safety outcomes.

All EWP's should be classified as high risk plant

120. Presently, scissor lifts are not classified as "high risk plant" under the WHS regulatory regime. They should be, as is plain from the examples of deaths and serious injury given above.

121. Mr Glover, with his extremely extensive expertise in relation to MEWPs generally and scissor lifts gave the following evidence.

Q. My understanding – please correct me if I'm wrong – is the scissor lift in question is not considered under the relevant regime to be high-risk plant.

A. Yes, that's correct.

Q. So did you mean to exclude the scissor lift when you said high-risk plant.

A. No, I was including them in the MEWP's. Under the regulations a high-risk plant is MEWPs, boom lifts, over 11m.

Q. And the reason you included it is that in your own personal expert opinion, not applying the regulatory regime, you know that that scissor lift is high-risk plant, don't you.

A. I think **any MEWP is high-risk plant**.

Q. And **it would be safer if they were all classified as high-risk plant, wouldn't it.**

A. **I believe so. I cannot understand why they have an over 11m and an under 11m rule for boom lifts. I can't even understand why the regulations have now excluded, I think other than Victoria, that scissor lifts don't require design registration. But these are the regulators.**

Q. Yes. All right, I think it's plain from that that you think they should be categorised in that way and be covered by the regime that applies to what is now recognised as high-risk plant.

A. Yes. .....[92]

122. Jorge's employer's senior workplace safety officer (Mr Parker) gave the following evidence.

Q. I think you said ... that you considered this construction work to be high-risk construction work.
A. It is because we're using an EWP.
Q. So we're using mobile powered plant.
A. Yes.
Q. Where there's a risk of falling above 3m.
A. Yes.
Q. And therefore given that we're dealing with a high-risk construction work environment, would it not have been appropriate for a spotter to be in place.
A. In hindsight I would say yes.[93]

CONCLUSION

123. The CFMEU, the AWU and the CEPU thank you for inviting them to make this submission.

124. Workers must be better protected from being seriously injured or killed by being crushed between mobile elevating work platforms and other structures. The present regulatory arrangements have failed.

125. An absolute requirement for trained spotters when scissor lifts are used is urgent and necessary.

---

[92] Transcript, page 565, lines 7 – 33. Our emphasis.
[93] Transcript, page 1884, lines 23 – 33.

126. There has been too much focus on risk assessment, and not enough focus on clear mandatory rules.

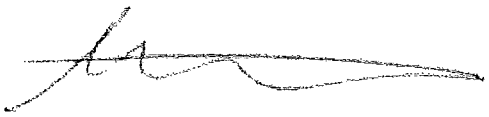
127. Risk assessment is too reliant on human behaviour and fails for that reason.

128. The balance must be shifted in favour of clear mandatory rules.

129. Please let us know if the CFMEU, the AWU or the CEPU can further assist in this matter.

130. Please let us know, as soon as possible, what action SafeWork SA and the SA Government will take in this matter.

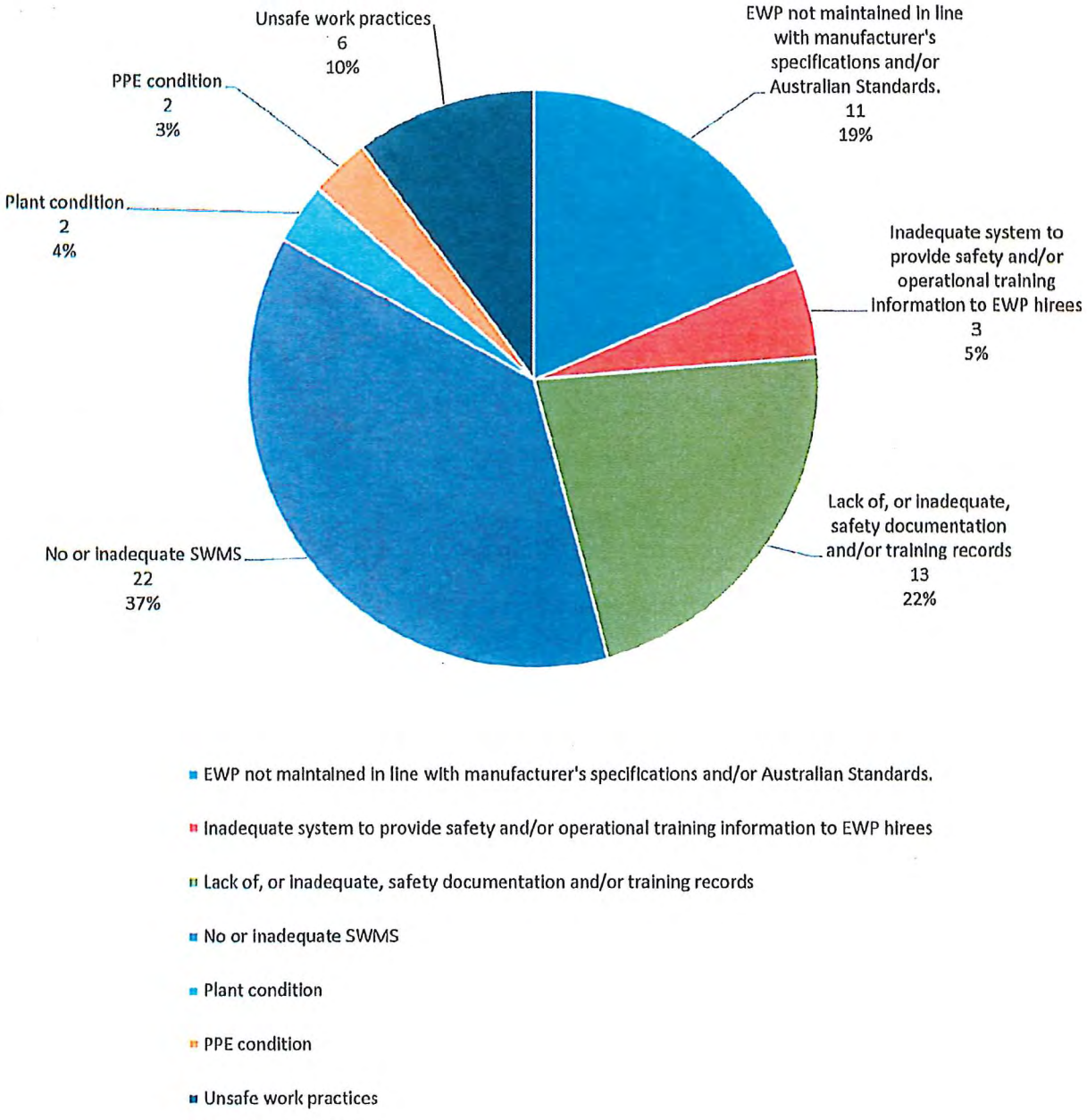
Yours faithfully
LIESCHKE & WEATHERILL

Per: 

MICHAEL ATS
Principal

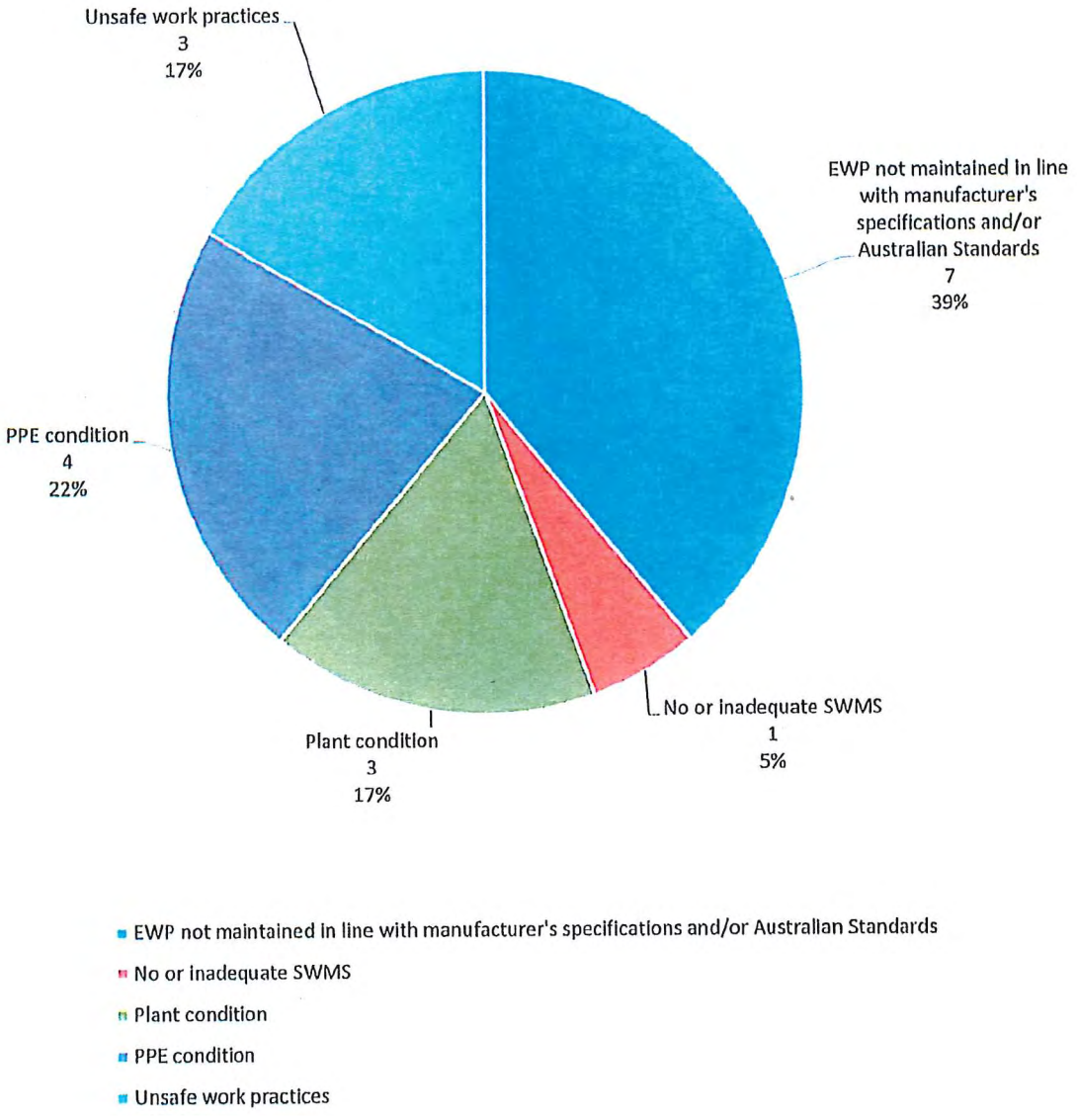
D

Improvement Notices - core reasons for notice issue



Attachment D

Prohibition Notices - core reasons for notice issue



Marciano, Nino (DTF)

From: Mesisca, Luigi (DTF)
Sent: Monday, 24 June 2019 3:36 PM
To: Marciano, Nino (DTF); De Gennaro, Gino (DTF)
Subject: FW: TRS18D2385 - Final 19SWSA0089 Coroner's Recommendations, Inquest into death of Mr Castillo-Riffo

FYI

From: Sneath, Erin (DTF)
Sent: Monday, 24 June 2019 3:35 PM
To: Mesisca, Luigi (DTF) <Luigi.Mesisca2@sa.gov.au>
Cc: Campbell, Martyn (DTF) <Martyn.Campbell@sa.gov.au>
Subject: RE: TRS18D2385 - Final 19SWSA0089 Coroner's Recommendations, Inquest into death of Mr Castillo-Riffo

Hi Luigi

I did speak to Belinda about this issue last week, and advised that I have followed up numerous times with the remaining group and sent another email on Wednesday last week and have not received a response. I will keep trying.

The following persons have been confirmed as attending to EWP Session on 5 July 2019:

- Frank Keough, Health and Safety Operations Manager, McConnell Dowell Constructors (Aust.)
- Lex Hanegraaf, HSEQ Manager, Built Environs
- Pam Gurner-Hall (partner of Jorge Castillo-Riffo) and her legal representative Michael Ats, Lieschke and Weatherill
- Tim Nuttall, Vice President and Peter Davis, Technical Director, Elevating Work Platform Association
- Angas Story, Secretary SA Unions - noting we did also receive an email from the CFMMEU providing us with a list of names of persons they wanted to attend the discussion session. We have responded advising that SA Unions has been invited to represent all their unions including the CFMMEU. They have not responded to that email as yet.

Master Builders Association have declined the invitation.

Thanks

Erin Sneath
Project Officer
Review and Reform
Available: Monday - Thursday

SafeWork SA

Level 4, World Park A, 33 Richmond Road, Keswick
P +61 8 846 34957
W safework.sa.gov.au **P** 1300 365 255

Government of South Australia
SafeWork SA

From: Campbell, Martyn (DTF) <Martyn.Campbell@sa.gov.au>
Sent: Monday, 24 June 2019 3:12 PM
To: Sneath, Erin (DTF) <Erin.Sneath@sa.gov.au>
Subject: FW: TRS18D2385 - Final 19SWSA0089 Coroner's Recommendations, Inquest into death of Mr Castillo-Riffo
Importance: High

Hi Erin,

Please can you respond to Luigi?

Thanks

Martyn Campbell
Executive Director | SafeWork SA

Level 5, 33 Richmond Road, Keswick, SA 5035
t 08 8303 0230 | **m** [redacted] | **e** martyn.campbell@sa.gov.au | **w** www.safework.sa.gov.au

From: Mesisca, Luigi (DTF) < >
Sent: Monday, 24 June 2019 2:46 PM
To: Campbell, Martyn (DTF) <Martyn.Campbell@sa.gov.au>
Cc: Marciano, Nino (DTF) <Nino.Marciano@sa.gov.au>; Signorelli, Belinda (DTF) <Belinda.Signorelli2@sa.gov.au>
Subject: RE: TRS18D2385 - Final 19SWSA0089 Coroner's Recommendations, Inquest into death of Mr Castillo-Riffo
Importance: High

Hi Martyn,

Are you able to provide a priority update on access to the submissions made, which were mentioned in the minute to the Attorney-General as per the below email trail?

Kind regards,
Luigi

Luigi Mesisca
Ministerial Adviser
Office of the Treasurer
The Hon Rob Lucas MLC
Level 8 | 200 Victoria Square ADELAIDE SA 5000
t 822 62708 [redacted] **e luigi.mesisca2@sa.gov.au**

SOUTH AUSTRALIA

Government of South Australia
Department of Treasury and Finance

From: Sneath, Erin (DTF) <Erin.Sneath@sa.gov.au>
Sent: Wednesday, 22 May 2019 12:43 PM
To: Signorelli, Belinda (DTF) <Belinda.Signorelli2@sa.gov.au>
Subject: RE: TRS18D2385 - Final 19SWSA0089 Coroner's Recommendations, Inquest into death of Mr Castillo-Riffo

Hi Belinda

As discussed this morning, I have received permission from one group to share their submission with the Attorney-General, however the remaining group have advised that they will be providing further correspondence in relation to my request as soon as possible.

As soon as the correspondence is received, I will update you.

Thanks

Erin Sneath

Project Officer
Review and Reform
Available: Monday - Thursday

SafeWork SA

Level 4, World Park A, 33 Richmond Road, Keswick
P +61 8 846 34957
W safework.sa.gov.au **P** 1300 365 255

Government of South Australia
SafeWork SA

From: Sneath, Erin (DTF)
Sent: Thursday, 2 May 2019 2:11 PM
To: Signorelli, Belinda (DTF) <Belinda.Signorelli2@sa.gov.au>
Cc: Brown, David (DTF) <DavidL.Brown@sa.gov.au>
Subject: FW: TRS18D2385 - Final 19SWSA0089 Coroner's Recommendations, Inquest into death of Mr Castillo-Riffo

Hi Belinda

In relation to the below note, the only attachment that should be included is the the Inquest findings.

We are unable to provide a copy of the submissions without the author's permission, so the minute is seeking the Attorney-General's views on whether she would like this to occur.

I am happy to contact the groups today and seek their permission if you like, prior to writing to the Attorney-General.

Thanks

Erin Sneath

Project Officer
Review and Reform
Available: Monday - Thursday

SafeWork SA

Level 4, World Park A, 33 Richmond Road, Keswick
P +61 8 846 34957
W safework.sa.gov.au **P** 1300 365 255

Government of South Australia
SafeWork SA

From: DTF:SWSA Policy And Governance <SWSAPolicyAndGovernance@sa.gov.au>
Sent: Wednesday, 24 April 2019 1:37 PM
To: Sneath, Erin (DTF) <Erin.Sneath@sa.gov.au>; Jewell, Nicole (DTF) <Nicole.Jewell@sa.gov.au>
Subject: FW: TRS18D2385 - Final 19SWSA0089 Coroner's Recommendations, Inquest into death of Mr Castillo-Riffo

FYI Treasure signed on 14 April.

Kim

From: DTF:Treasurer <treasurer.dtf@sa.gov.au>
Sent: Wednesday, 24 April 2019 12:45 PM
To: DTF:SWSA Policy And Governance <SWSAPolicyAndGovernance@sa.gov.au>
Cc: Sneath, Erin (DTF) <Erin.Sneath@sa.gov.au>
Subject: TRS18D2385 - Final

Good afternoon

Please find attached TRS18D2395 signed minute from the Treasurer approving the sessions to commence.

Luigi has stated the following: *the Attorney-General's minute notes a copy of submissions in relation to the recommendation. Are you able to amend the minute to the Attorney in absence of the submission or provide the submission?* I have been advised that Luigi has discussed the action of this matter with Erin. If you have any queries please contact Luigi on his mobile [redacted]

Kind Regards

Toni Fletcher
A/Parliamentary Liaison Officer to the
Hon Rob Lucas MLC
Treasurer

Phone: 8204 1496
Department of Treasury & Finance
Level 8, 200 Victoria Square | ADELAIDE SA 5000

SOUTH AUSTRALIA **Government of South Australia**

Marciano, Nino (DTF)

From: Campbell, Martyn (DTF)
Sent: Monday, 24 June 2019 3:13 PM
To: Marciano, Nino (DTF); Sneath, Erin (DTF)
Subject: RE: Meeting re EWPs

Hi Erin,

Please can you share with Nino who is attending next week?

Nino,

I'm meeting with the Treasurer this Friday to discuss this meeting and answer any questions he may have.

Thanks

Martyn Campbell
Executive Director | SafeWork SA

Level 5, 33 Richmond Road, Keswick, SA 5035
t 08 8303 0230 | **m** [redacted] | **e** martyn.campbell@sa.gov.au | **w** www.safework.sa.gov.au

From: Marciano, Nino (DTF) <Nino.Marciano@sa.gov.au>
Sent: Monday, 24 June 2019 2:52 PM
To: Campbell, Martyn (DTF) <Martyn.Campbell@sa.gov.au>
Subject: Meeting re EWPs

Good afternoon Martyn,

I would greatly appreciate it if you could please provide an update in relation to who will be attending the discussion session with the Treasurer on 5 July 2019 regarding elevating work platforms and the recommendations of the Coroner in the Jorge Castillo-Riffo Inquest.

Thank you for your assistance.

Kind regards,

Nino Marciano
Ministerial Adviser
Office of the Treasurer
The Hon Rob Lucas MLC
Level 8 | 200 Victoria Square ADELAIDE SA 5000
t 846 33192 m [redacted] nino.marciano@sa.gov.au

SOUTH AUSTRALIA

Government of South Australia
Department of Treasury and Finance