CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 5th, 6th, 7th, 10th, 11th, 12th, 13th, 14th and 21st days of May 2010, the 8th day of July 2010 and the 9th day of February 2010 , by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Daniel Nicholas Madeley.

The said Court finds that Daniel Nicholas Madeley aged 18 years, late of Lot 3 Bayliss Road, McLaren Vale, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 6th day of June 2004 as a result of respiratory failure secondary to closed chest trauma. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Daniel Madeley was 18 years of age when he died on 6 June 2004 as a result of horrific injuries sustained when he was caught in a horizontal boring machine he was operating while employed as an apprentice by Diemould Tooling Services Pty Ltd. Once he became entangled in the machine he was spun around the machine violently with the result that his feet were amputated by the force involved when they came into contact with non-moving parts of the machine. He was transferred to the Flinders Medical Centre where he died the following day as a result of respiratory failure secondary to closed chest trauma.

1.2. An autopsy was conducted by Professor Byard[1] who gave the cause of death as respiratory failure secondary to closed chest trauma, and I so find. Professor Byard

[1] Exhibit C3a

noted that Mr Madeley's anatomical injuries including flail chest with multiple bilateral fractures of the ribs and significant bruising of the lungs. There was significant pulmonary fat embolism and bleeding into the pleural spaces. There was bruising of the heart and bruising and laceration of the liver and spleen. As I have said, there was bilateral amputations of the feet with long bone fractures. There was contusion of the kidneys.

1.3. The horizontal boring machine by which Mr Madeley was entangled was an old machine that was probably built between 1960 and 1970. It was manufactured in the USSR as it was then known, probably in Russia. The machine had no guarding or other safety devices that might have prevented the occurrence of an event such as that which took Mr Madeley's life. Indeed, the only safety device incorporated into the machine, if one could describe it as a safety device, was the 'emergency stop' button. The emergency stop button did not operate any differently from the ordinary stop button on the machine. Its only distinguishing feature was that it was a larger, more obvious button than the ordinary stop button[2]. I will describe the machine in greater detail later in this finding.

1.4. Mr Madeley's death was entirely preventable. This much is obvious from the fact that the machine by which Mr Madeley was killed was replaced shortly after his death by Diemould Tooling Services Pty Ltd with a machine manufactured in approximately 2002. That machine was equipped with appropriate modern safety interlock devices that prevented a person coming into contact with the moving parts of the machine. I will return to this later in this finding.

2. Background

2.1. Mr Madeley was formally an employee of an association known as the Engineering Employers Association Group Training Scheme, or EEAGTS. He was an apprentice toolmaker and was undertaking the first year of his apprenticeship at Diemould Tooling Services Pty Ltd (Diemould) where he had been placed by EEAGTS pursuant to an arrangement between EEAGTS and Diemould. His placement commenced in June 2003, so Mr Madeley had been working at Diemould for almost 12 months at the time of his death. Diemould's business was the manufacture of injection moulds for

[2] Transcript, page 74

the manufacture of plastic products. For the purpose of this Finding, I regard Mr Madeley as having been employed by both Diemould and EEAGTS.

2.2. Diemould was at that time run by the Managing Director, Mr Neville Grose. Mr Grose's son, Jim Grose, was also employed at Diemould at that time. Sometime between Mr Madeley's death and the hearing of this Inquest, Mr Neville Grose died and the position of Managing Director was assumed by Jim Grose, who gave evidence at the Inquest.

2.3. EEAGTS has, since Mr Madeley's death and prior to the commencement of this Inquest, ceased to operate under that name. Instead, the same function is now being performed by the Australian Industry Group Training Scheme (AIGTS). I heard evidence from Mr Robert Drysdale who was employed as a Training Coordinator at EEAGTS at 2004 and is now Training Manager with the Australian Industry Group Training Scheme.

2.4. Following Mr Madeley's death an investigation was conducted by Workplace Services, a South Australian State Government department with responsibility for investigating breaches of the Occupational Health, Safety and Welfare Act 1986. Workplace Services is now known as SafeWork SA. I will refer to both entities under the latter name hereafter. Following the investigation, a complaint was laid by an authorised officer of SafeWork SA against Diemould and also against EEAGTS. The complaint was not laid until 3 May 2006, only one month short of two years after Mr Madeley's accident. I note that the time for laying such a complaint under the Occupational Health, Safety and Welfare Act was two years from the date of the offence.

2.5. EEAGTS pleaded guilty on the first return date of the complaint, 8 September 2006, and on 29 September 2006 was convicted and fined $60,000. Diemould raised certain arguments, which I will describe more fully later in this finding, about the manner in which the complaint was worded which resulted in a consideration of the matter by the Full Court of the Industrial Relations Court, the Full Court of the Supreme Court of South Australia and an application for special leave to appeal to the High Court of Australia which was dismissed. Finally, Diemould pleaded guilty to an amended complaint on 23 April 2009 and was convicted and fined $72,000 on 26 June 2009,

just over 5 years after Mr Madeley's death. This Inquest could not be held until the finalisation of those criminal proceedings[3].

3. The horizontal boring machine

3.1. The horizontal borer was manufactured in the Soviet Union, possibly Russia, in the 1960s. The borer was an extremely heavy piece of machinery and was roughly the size of a motor vehicle[4]. It consisted of a bed on which the steel dies could be placed while they were being machined. The bed enabled the work to be moved into different positions. It did this by means of a frame to which the work could be attached which would move on the bed. At one end of the bed the main part of the machine rose vertically from the bed. That part of the machine contained the electric motor that drove the machine and the gears, gearboxes and associated equipment that drove the spindle and chuck of the machine. The spindle and chuck protruded from this vertical structure horizontally above and parallel to the bed that I have previously referred to. The spindle or chuck would rotate and might be fitted with a drill bit or other boring tool that would be used to bore holes into the die being worked upon.

The height of the spindle in relation to the bed was adjustable and lateral adjustments

[3] Coroner's Act 2003, S21(2)
[4] See photograph below

across the bed were also possible. Furthermore, the angle of the work in relation to the bed, and therefore in relation to the spindle, was also adjustable. As it happened, the particular piece of work on which Mr Madeley was working on 5 June 2004 was required to be setup to enable holes to be bored into it at an angle to the surface of the work itself. This required a complex and careful setup procedure with which Mr Madeley required assistance from one of the toolmakers, Mr Sandeep Chalil, who gave evidence at the Inquest and whose account I will come to in due course.

3.2. The evidence of Mr Brian Butterworth established that there was no regular maintenance program for the horizontal borer[5]. Mr Butterworth was a machine tool fitter who undertook repair work on an 'as needed' basis on the horizontal boring machine prior to the accident involving Mr Madeley[6]. Parts were not readily available for the machine and would often have to be specially manufactured if required[7]. The horizontal boring machine, when tested by Mr Allan McLean, who was engaged by SafeWork SA to give an expert report on the risks associated with the horizontal boring machine, took 8 seconds to slow from full speed to stationary.

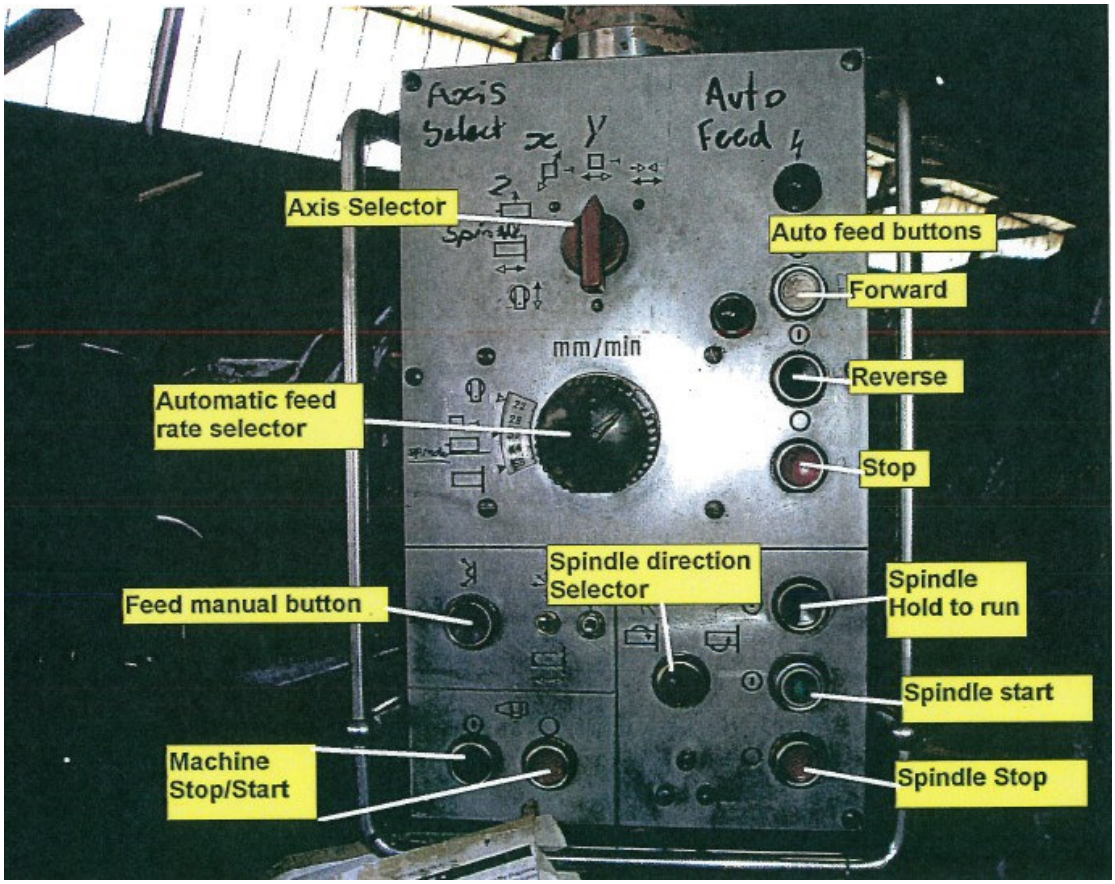
3.3. Mr McLean gave evidence in the course of the Inquest and produced a report for SafeWork SA which was admitted and Exhibit C32. Mr McLean has been practising as a risk consultant on the safety of machinery for 25 years. I accept him as a witness of expertise in this area.

4. The method of operation of the horizontal boring machine

4.1. The evidence showed that the operator of the horizontal borer would use his right hand to operate the control panel[8]. In most operations, including the operation that Mr Madeley was performing when he had his accident, the operator would use his left hand to squirt coolant (a mixture of water and oil) on the cutting device being rotated by the boring machine at the point where it entered the object being drilled. The coolant was applied by means of plastic bottles with a screw top and a nozzle which, when squeezed, would squirt coolant a sufficient distance, or so it was thought, to keep the operator safety out of reach of the rotating spindle and cutting device. The evidence of the various employees and former employees of Diemould as to how

[5] Transcript, page 63
[6] Transcript, page 60
[7] Transcript, pages 62-63
[8] See photograph below

close to the moving parts the operator would have to have his hand and the bottle in order to achieve this process varied.



The witness, Mark Remfrey, who was a more senior apprentice at the time of Mr Madeley's accident and who had instructed Mr Madeley in the use of the machine, said as follows:

> 'Myself, normally I would have been approximately between 30 and 40 cm, 20 to - at closest 20, 15-20 cm at absolute closest, but on a normal occasion it would be more like 30-40.' [9]

Mr Remfrey said it was not practical to stop the machine in order to apply the coolant. He said the coolant needed to be applied continuously during the operation[10]. Mr Remfrey said that for the operation that Mr Madeley was performing, it would be necessary to be adding coolant either constantly in a fine stream or at least once every 15 to 30 seconds[11].

[9] Transcript, pages 114-115
[10] Transcript, page 117
[11] Transcript, page 113

4.2. The witness Sandeep Chalil, who was a tradesman at the time of Mr Madeley's accident, said that the distance would be 'more than 30 - yeah, a bit more than 30' and ultimately suggested that it would be around 40 centimetres[12].

4.3. This matter of the need to apply coolant by means of the plastic bottles is significant. The evidence showed that it was an essential part of the process that the coolant had to be applied. Without it the drill bit would overheat and the operation could not properly be carried out.

4.4. The evidence also showed that other horizontal boring machines are equipped with systems for the automatic application of coolant at the right place and in the correct quantities.

4.5. Significantly Mr Butterworth, who it will be recalled carried out maintenance on the machine, had not been aware that the machine was not fitted with an automatic coolant system[13]. In fact it appears that he had assumed that it was fitted with an automatic coolant system. Similarly, Mr McLean had not appreciated until giving his evidence, that the machine was not fitted with an automatic lubrication system. He said:

> 'You would normally expect to see the lubricant automated.' [14]

As a result, he had to make a modification 'on the fly' during his evidence to his estimate of the cost of rendering the horizontal boring machine safe to operate. I will return to his evidence in more detail in due course. I am not making any criticism of Mr McLean for not appreciating that the coolant system was not automated. I have merely pointed out that both Mr Butterworth, who was familiar with the machine having performed repairs on it on several occasions, and Mr McLean, an expert in the area, had a natural expectation that the machine would have been fitted with an automatic lubrication system. In my opinion, it is reasonable for me to infer that an automatic lubrication system would be sufficiently common to justify that assumption by both of these experienced men. That the horizontal boring machine being operated by Mr Madeley did not have something as rudimentary as an automated lubrication system is a further indicator of the poor standard of the machine.

---

[12] Transcript, pages 158-159
[13] Transcript, pages 74-75
[14] Transcript, page 506

5. The steps that could have been taken to render the machine safe

5.1. I return to the evidence of Mr McLean. Mr McLean was asked to summarise the risks associated with the horizontal boring machine as he perceived them. He responded that the machine needed to be guarded because it was too risky not to be guarded. When asked what the hazard presented by a failure to guard the machine was, he responded:

> 'Everything that you could imagine actually. There's rotating, there's swarf, there's coolant, there's slippery floors, there's drawing in shearing - even just being hit by the traversing tables you could be crushed, particularly if it's close to a wall and it closes to zero against the wall and you happen to be standing there. The machine's more powerful that what your leg is, I bet you.' [15]

5.2. Mr McLean said that because the machine took 8 seconds to stop when it was running at full speed it was necessary to prevent access to the machine until it was stopped. He said it would be necessary to fit a device to check to see that no motion was present before a person could approach the vicinity of the danger area. He talked about devices for scanning the dangerous parts of the machinery in this connection. He said that the introduction of an automated lubrication system was itself a hazard reduction enhancement simply because it would reduce the risk of people coming close to the machine with the risk of entanglement[16]. Mr McLean said that it would be possible to change the control system to give the machine a braking effect so that it would brake and stop very quickly. He referred to a machine that he had been involved with that was of a similar age to the Diemould horizontal boring machine. He said:

> 'They're very similar in construction and style of construction. They're very old. They're very old compared to the new machines nowadays. Its ability to - it was a complete retrofit. What we had to do was basically rebuild the control systems to accommodate fast stopping and to accommodate failsafe, dual-redundant circuits into it to bring it up to what the company considered was a less-risky state, they minimised the risk by doing that.' [17]

5.3. Mr McLean said that his estimate of the cost of retrofitting the Diemould machine in the same manner as the machine referred to in his evidence and in his report[18], which was a machine operated by a company called Southern Machinery Services, or

---

[15] Transcript, page 502
[16] Transcript, page 507
[17] Transcript, page 510
[18] Exhibit C32

Siemens, would be in the order of $15,000 to $17,5000[19]. He added that the cost of fitting an automated lubrication system would have to be added to that estimate. His position was that it would not be a difficult or unduly costly exercise to render the machine safe to operate.

5.4. I have no hesitation in accepting the evidence of Mr McLean. I note that he was not cross-examined by counsel for Diemould. His evidence was not challenged.

5.5. To summarise my conclusions to this point, I turn to the outline of submissions provided by Diemould Tooling Services Pty Ltd as to the condition of the horizontal boring machine.

a) A primary cause of the accident was the condition of the horizontal borer. It was an inherently dangerous item of plant;

b) There were a number of things Diemould could have done to this machine to reduce the risk of entanglement or to improve the ability to stop the machine quickly if entanglement occurred:

i) Installed guarding (fixed, interlock fence, sensor);

ii) Relocation of hold to run and continuous run buttons;

iii) Relocation of emergency stop button;

iv) Restrict mobility of pendant / restrict simultaneous access to danger area and start button;

v) Install emergency braking (reduce rundown time);

vi) Provide longer coolant nozzles / install automated cooling[20];

vii) Remove the potential of loose clothing being near moving parts;

c) The controls are on a pendant and can be brought into the danger area, that is the area close to the spindle. It is possible for an operator to be in close proximity to the spindle and to switch the machine on;

d) It was a very dangerous situation whereby an employee had to be close to a rotating spindle which could operate on a continuous basis;

[19] Transcript, page 511

[20] In my opinion it would only be by means of automated cooling that the machine could be rendered safe. To that extent I do not accept this submission.

e) Even if the employee was operating the machine on a hold to run basis and let go of the button it would take too long for the machine to slow down and stop. There was no emergency braking system fitted to the machine;

f) One way to improve safety would have been to relocate the continuous run button from the pendant control so that it could only be pressed once the operator was out of the danger zone. That would leave only the hold to run button on the pendant for use in close proximity work;

g) There was a real risk that an employee, concentrating on the close work, could accidentally press the continuous run button instead of the hold to run button. The buttons are so close to each other and the continuous run button is not shrouded, capped or protected in any way;

h) The emergency stop button did no more than cut power to the spindle. It was possible and reasonable to fit emergency braking devices which would stop the machine in under a second. Products were available on the market enabling a machine to be brought to a complete stop by feeding direct current into an AC motor;

i) The location of the only emergency stop button was on the bottom of the pendant control. Entanglement in an unguarded rotating spindle is the most obvious hazard presented and the existence of the emergency stop button on the pendant control would be of no assistance to an entangled employee;

j) There should have been an emergency braking system triggered by a probe switch or proximity switch. Such measures may not prevent the initial entanglement but may prevent the extent of injuries.

5.6. These frank concessions speak for themselves. By and large I agree with them, but would add that the machine required a physical guard interlocked with the motor of the machine such that it would not be possible to open the physical guard to gain access to the machine while the machine was moving.

6. The witnesses

6.1. I propose to discuss the evidence of some, but not all, of the witnesses.

6.2. Mark Remfrey

Mr Remfrey is a toolmaker and he continues to be employed by Diemould. He was employed at Diemould at the time of Mr Madeley's accident and was still an apprentice, although became a toolmaker shortly after Mr Madeley's accident. Like Mr Madeley, Mr Remfrey was actually engaged by EEAGTS and was placed at Diemould. He said that he commenced his career with a 3 month block of training at Regency TAFE and was then placed with Diemould as his host company. His period of apprenticeship was 4 years although he finished 6 months early on the basis of his assessments by TAFE, EEAGTS and by Diemould. During his 3.5 years as an apprentice he continued to work at Diemould apart from periods of training at TAFE. When he started at Diemould the Apprentice Master was a Thomas Volk whose role was to look after first year apprentices.

6.3. Mr Remfrey said that he worked on the horizontal borer during the first year of his apprenticeship. He was trained on the horizontal borer by Daniel Rothe. Mr Rothe was another apprentice in his third year at that time. Mr Remfrey confirmed that there was a practice at Diemould that a more experienced apprentice would train the next apprentice on the horizontal borer[21]. Mr Remfrey spent 9 months working on the horizontal borer[22]. He said that experience on that machine was useful for an apprentice because it required the apprentice to look at drawings and interpret them from a two-dimensional drawing into a 3D steel object. He said it was a good learning tool for people to have to do a number of different operations[23]. He said that his induction to the horizontal borer consisted of a two week period of one-on-one instruction. There were no written safety procedures or safe operating procedures that he was aware of. The instruction was verbal and physical demonstration[24]. He did not recall any specific information as to appropriate clothing to wear whilst operating the horizontal borer[25]. Mr Remfrey said that there was a practice at Diemould that employees, including apprentices, would be issued with dust coats if they requested them. A dust coat is an overcoat to be worn over other clothing to protect the other

[21] Transcript, pages 99-100
[22] Transcript, page 101
[23] Transcript, page 101
[24] Transcript, page 104

clothing from dirt and metal. He did not recall having been given any safety instructions in relation to the manner of wearing a dust coat or as to the appropriateness of wearing one when operating the horizontal borer[26]. Indeed, he confirmed that he himself wore a dust coat when he operated the horizontal borer[27]. He said that his practice was to roll up at least the left sleeve of the dust coat to avoid it getting tangled in anything[28]. However, he had no recollection of having been specifically instructed to roll up his sleeve[29].

6.4. Mr Remfrey commented that there would be times when the platform next to the horizontal borer would become slippery by virtue of the spilling of coolant on the floor and the platform next to it[30]. Mr Remfrey said that it was he that instructed Mr Madeley in the use of the horizontal borer in much the same fashion as he himself was instructed by Mr Rothe[31]. He said that he had told Mr Madeley that he should be careful not to get his clothing caught in the machine and had explained to Mr Madeley how powerful the machine was[32].

6.5. Mr Remfrey was present at the Diemould premises on the Saturday of the accident and described what he observed and the actions he took after becoming aware of the accident. My impression of Mr Remfrey as a witness was that he is an intelligent and articulate person. He was adept in his use of language and clearly understood the questions that were asked of him and the significance of his questions and answers. Indeed, he is now studying a Diploma of Business Management and Human Resources and is looking to move into a management role 'rather than just working on the tools'[33]. In this connection, he has performed some quality management work for Diemould as a result of which he has some knowledge of the company's governance and structure[34].

6.6. Quite early in Mr Remfrey's evidence, which started immediately after lunch in the afternoon of the first day of the Inquest, he produced some papers which he described

---

[25] Transcript, page 104
[26] Transcript, page 106
[27] Transcript, page 106
[28] Transcript, page 106
[29] Transcript, page 117
[30] Transcript, page 120
[31] Transcript, pages 121-122
[32] Transcript, pages 122-123
[33] Transcript, page 736
[34] Transcript, page 734

as notes that he had made at the time of the incident[35]. The notes were produced and were ultimately admitted as Exhibit C24a. The notes contain a statement at the top of the first page that the notes are a statement made in contemplation of legal proceedings and that 'professional legal privilege' applies to them[36]. Mr Remfrey was questioned about the circumstances in which the notes came into existence. According to the notes they were a statement taken at Diemould Tooling Services at 10am on 11 June 2004.

6.7. Mr Remfrey was asked whether he typed his own 'notes' himself. He responded that he 'aided' in typing them up. He was asked who he aided and responded that it was a lawyer whose name was Rosey. He claimed that he could not recall her last name. When asked if her last name was Batt, he responded that it may have been but that he could not recall. He was asked if the lawyer was assisting the company Diemould and he responded 'I believe so'. He was then asked if he was involved in the preparation of the document and responded as follows:

> 'What this document refers to is what I said without having other influences placed upon me. More accurately, I believed than my statement that was made to SafeWork SA.' [37]

6.8. Approximately a third of the way through Mr Remfrey's evidence that afternoon, I had cause to ask him the following questions and he responded with the following answers:

> 'Q. Just before Ms Cacas goes on, is there anyone in court today from Diemould.
>
> A. No.
>
> Q. Thank you.
>
> A. That is employed at Diemould?
>
> Q. Yes.
>
> A. No.' [38]

6.9. Mr Remfrey displayed some reluctance to agree that the account he provided to Inspector Oaten of SafeWork SA was a true and accurate account, although ultimately, with some qualifications I will proceed to deal with, he did so[39]. That statement was accordingly admitted as Exhibit C24. The qualifications were that, according to Mr Remfrey, Inspector Oaten was insistent in her questioning that Mr

[35] Transcript, page 92
[36] See Exhibit C24a
[37] Transcript, page 92
[38] Transcript, page 102

Madeley was wearing overalls underneath his dust coat. He claimed that he had said that Mr Madeley was NOT wearing overalls on the day of the accident. Furthermore, he said that Inspector Oaten asked him about a birthday party that she thought was happening on the premises at Diemould. Mr Remfrey told her that there was no party happening. It appears that Inspector Oaten persisted in this suggestion and that Mr Remfrey, according to his account, was somewhat indignant about that. In the result, the statement he provided to Inspector Oaten wrongly conceded that, according to Mr Remfrey, and for that matter according to the objective evidence, Mr Madeley was wearing overalls. On the other hand, the statement quite clearly stated that he was not aware of any birthday celebration taking place at the premises that day.

6.10. Neither of these matters is of any particular significance and neither of them bears any sinister connotation. It was difficult to see why Mr Remfrey was as indignant about these matters as he claimed to be in his evidence. He did raise one further quibble with the SafeWork SA statement. That was that Inspector Oaten had apparently suggested to him that Mr Madeley may have been standing on the table of the machine. In the statement Mr Remfrey says Mr Madeley 'couldn't have been on the table and operating the controls of the machine'. In other words, the statement accorded with what he said he had told Inspector Oaten. It makes no sense to complain about it. As I said, Mr Remfrey is not slow witted. He was at ease in the witness box. Confusion or discomfort were no justification for this oddity in his evidence.

6.11. His explanations of the reservations he had about his statement to Inspector Oaten were underwhelming and did not match his claim that he felt that Inspector Oaten influenced his statement to her thus rendering it less accurate that the statement he gave to Ms Batt. This claim of 'influence' echoes similar claims made by other Diemould witnesses as to their SafeWork SA interviews. In Mr Remfrey's case, I reject his claims. He was an intelligent, articulate witness who was more than able to state his position when challenged. I have no doubt he would have been more than capable of resisting any 'influence' that Inspector Oaten may have brought to bear. In saying this I do not imply that I accept Mr Remfrey's evidence that Inspector Oaten did attempt to influence his account. In fact, in this respect I find Mr Remfrey's evidence unreliable, and I do not accept it.

---

[39] Transcript, page 98

6.12. After the completion of Mr Remfrey's evidence that day, I heard evidence from a number of other Diemould witnesses. I need to deal with certain aspects of their evidence before returning to that of Mr Remfrey.

6.13. Sandeep Chalil

Mr Chalil was a toolmaker employed at Diemould in 2004 and was the leading hand in the tool room. At the time of giving his evidence he was no longer working at Diemould.

6.14. Mr Chalil had nothing much to do with the horizontal borer and had not trained anyone to work on it. Indeed it appears that he had not had much to do with the horizontal borer in the course his employment with Diemould[40]. However, on the day of Mr Madeley's accident, Mr Chalil was supervising Mr Madeley's work and assisted Mr Madeley in setting up the work for the various operations that Mr Madeley was required to undertake that day[41].

6.15. Mr Chalil asserted, in relation to a general question about safety manuals for machinery at Diemould, that on every machine there was a safety procedures document[42]. He claimed that such a document was attached to every machine including the horizontal borer. This was unusual because Mr Chalil had never worked on the horizontal boring machine and admitted that he had no knowledge of whether safe operating procedures existed for that machine or not[43].

6.16. I formed the opinion that Mr Chalil was guarded in his evidence and appeared to be reluctant to make concessions about matters which seemed reasonably obvious. For example, Mr Chalil was asked about his understanding of how Mr Madeley would have been required to apply coolant for the purposes of the operation he was carrying out. He was asked to give an estimate of the distance that Mr Madeley would have had to have been from the work in order to achieve that. His response was 'a safe distance'[44]. Mr Chalil displayed great reluctance to offer an estimate of the proximity one would have to have to the machine in order to use the coolant bottles effectively. After much effort he reluctantly offered a suggestion of 40 centimetres[45].

[40] Transcript, page 140
[41] Transcript, page 150
[42] Transcript, page 141
[43] Transcript, pages 144-145
[44] Transcript, page 155
[45] Transcript, page 159

6.17. When Mr Chalil was asked if he accepted the truth and accuracy of a typed statement taken from him by Inspector Oaten on 10 June 2004, and signed by him on that day, he appeared reluctant to do so. He said that he had made a 'note' and that there were a 'few areas I was actually concerned about'[46]. Following this exchange Mr Chalil produced a two page document that was ultimately admitted as Exhibit C25b. It is dated 16 November 2004 and simply states that he has now had the opportunity to read his statement provided to SafeWork SA on 16 June 2004. It goes on to say that there are several sentences in the statement that he believes to be misleading and to not accurately reflect the true position. It says that his interview with SafeWork SA occurred only 5 days after the accident whilst he was in a state of shock, had no legal representation and did not notice the inaccuracies on the day due to his emotional state.

6.18. After lengthy questioning it emerged, somewhat reluctantly, that Mr Chalil had prepared this document after speaking with the lawyer, Ms Batt. He appeared very reluctant to elaborate about any of this[47].

6.19. Significantly, Mr Chalil's document dated 16 November 2004 contains the following quote:

> 'There were safe operating procedures in place about safety when using the horizontal borer or the radial drill that state 'don't get too close to the spindle' and 'be aware of moving spindle'.' [48]

Mr Chalil was questioned about that aspect of Exhibit C25b. He claimed that there was a safe operating procedure in respect of the horizontal borer[49]. He was unable to explain how it was that when he was interviewed by Inspector Oaten he stated:

> 'There is not an instruction about how close they can get to the spindle and drill.'

He was asked if anyone had prompted him in relation to the words he purportedly quoted from a safe operating procedure for the horizontal borer but he denied this[50].

6.20. In the result the evidence showed, and it was conceded in the written submissions of Diemould itself, that there were no written safe operating procedures for the

[46] Transcript, page 163
[47] Transcript, pages 160-180
[48] Exhibit C25b
[49] Transcript, pages 189-190
[50] Transcript, page 192

horizontal boring machine. As a result I approach Mr Chalil's evidence with considerable caution.

6.21. Robert Shaw

Mr Shaw was a fitter and turner when he gave his evidence. In 2004 he was a second year apprentice toolmaker employed by EEAGTS and placed at Diemould. He was asked whether he accepted the truth and accuracy of a typed record of interview taken from him by Inspector Oaten on 28 June 2004. He said that he had another document which included changes to that statement which he had prepared in conjunction with Ms Batt. After further questioning about the circumstances in which that material came into existence, Mr Shaw revealed that he and other witnesses had attended at Diemould two weeks prior to the Inquest to discuss the Inquest[51]. This was the first occasion on which the Court became aware that a number of the witnesses had had a meeting prior to the Inquest that was convened on the premises of Diemould. Mr Shaw revealed that, amongst other people, Mr Remfrey and Mr Chalil had been present at this meeting. At that stage of the Inquest, the evidence of Mr Remfrey and Mr Chalil had been completed and neither had mentioned any such meeting.

6.22. It then became apparent that Mrs Sam Grose was in the body of the Courtroom. She was identified by Mr Shaw as the wife of Mr Jim Grose, a proposed witness at the Inquest and the Managing Director of Diemould. Mr Chalil was asked whether Mr Remfrey would know Mrs Grose and he said that Mr Remfrey would know her[52]. At that point it was drawn to my attention that Mrs Grose had been present during the evidence of Mr Remfrey when he had been questioned about the presence of anyone from Diemould in the Courtroom. As a result of this information coming to hand it was decided that Mr Remfrey at least would need to be recalled.

6.23. Mr Shaw claimed to have had concerns with the interview he gave to SafeWork SA as soon as he read the transcript sometime after the interview took place[53]. However, he did not raise the matter with SafeWork SA[54]. In the SafeWork SA interview he was asked whether there were any safe operating procedures for the horizontal borer. He said in his evidence that at the time of the interview he could not recall anything. He claimed that after reading the statement he went and saw sheets of paper on the wall

[51] Transcript, page 259
[52] Transcript, pages 270-271
[53] Transcript, page 319
[54] Transcript, page 319

near the horizontal borer bearing written safe operating procedures[55]. He claimed that as a result of reading these sheets he subsequently told the solicitor, Ms Batt, in a statement which was admitted as Exhibit C28b, the following:

> 'P6. In relation to the questions relating to my training on the Horizontal Borer, I wish to add that the name of the person who trained me was Adrian Maddin. Adrian trained me in the Safe Operating Procedures of the Horizontal Borer as follows:-
>
> If in doubt ask - don't use machine without instruction/training
>
> Ensure work area is clean and tidy
>
> Eye protection and foot protection must worn at all times
>
> Do not operate machinery with any loose clothing, long hair or jewellery
>
> Report any faults or breakages to supervisors immediately
>
> Ensure job is securely fastened
>
> Stop machine prior to making measurements
>
> Ensure rotary table is locked while machine is in use
>
> Know where the emergency stop device is located
>
> Be aware of surroundings.'

He acknowledged that those words in the statement he provided to Ms Batt[56] were from the text of the safe operating procedure that he claimed was on the sheet of paper attached to a wall near the horizontal borer[57].

6.24. Mr Shaw was repeatedly challenged in relation to this claim which, on the evidence, could not be true as it was accepted by Diemould itself and by almost all other witnesses that there were no safe operating procedures for the horizontal borer at the time of Mr Madeley's accident.

6.25. Furthermore, it is instructive that Mr Shaw made a statement to Ms Batt even before he was interviewed by SafeWork SA. The statement was taken at Diemould on 17 June 2004, and was admitted as Exhibit C28a. The SafeWork SA interview was taken on 28 June 2004, some two weeks later. It was admitted as Exhibit C28.

6.26. In the first statement to Ms Batt, the following appears:

> 'I do not recall ever having safety of machine ever pointed out to me. I knew not to go near the spindle because of common sense. I remember Paul telling me about safety issues such as sweeping up swarf, machining so that swarf does not touch you, ie to stand back. He would often tell me to put my safety glasses on and to leave them on.'

[55] Transcript, page 321
[56] Exhibit C28b
[57] Transcript, page 322

6.27. When Mr Shaw was interviewed by Inspector Oaten some two weeks later, she asked him this question and he provided the following answer:

> 'Inspector Oaten — Were you provided with written safe operating procedures for the borer?
>
> Mr Shaw — No, well, not that I can remember. I don't remember if there was anything on the wall. I believe there was something on the wall. It may have been like how you go about doing a job though. I'm not quite sure about that.' [58]

When Mr Shaw refers at that point to something on the wall which may have been 'how you go about doing a job', he was not asserting that there was a document on the wall in the nature of a safe operating procedure. An instruction as to how a job should be done is an entirely different thing from a document dedicated to dealing with safe operating procedures. In any event, as I have said, the overwhelming evidence was that there were no safe operating procedures written or unwritten in relation to the horizontal borer, although the evidence did suggest that there may at times have been instructions as to how jobs should be done.

6.28. It is highly significant that Mr Shaw would tell Ms Batt on 17 June 2004 that he did not recall 'ever having safety of machine ever pointed out to me'[59] and that he provided an answer to similar effect to Inspector Oaten two weeks later. Yet, he claimed in a later statement given to Ms Batt, to be able to recall a detailed statement of safety procedures for the borer in what amounted to a verbatim quote. He vehemently denied having been prompted in relation to the claimed safe operating procedures. He was asked whether he may have been mistaken as to the timing; whether the claimed safe operating procedures were in existence prior to Mr Madeley's accident. He conceded that he could possibly be mistaken on that[60]. In any event, there was no evidence to support the proposition that safe operating procedures were erected for the horizontal borer after Mr Madeley's accident. Indeed, common sense would suggest the contrary, as the borer was never again used by Diemould after Mr Madeley's accident. A prohibition notice was placed upon the borer by SafeWork SA on the day of Mr Madeley's accident. It was never lifted prior to the removal of the machine from the premises of Diemould. It seems to me to be most unlikely that a safe operating procedure might have been devised for the

[58] Exhibit C28, page 6

[59] It can safely be concluded from that statement that he was not asserting at that time that there were written safe operating procedures for the horizontal borer

horizontal borer and placed near it on a sheet of paper attached to the wall at any time after Mr Madeley's accident and prior to the removal of the borer from the premises. I find that Mr Shaw was untruthful in his evidence about this claimed safe operating procedure bearing in mind the overwhelming weight of evidence, and admissions by Diemould, that no such document ever existed.

6.29. Mr Shaw was not an employee of Diemould at the time he gave his evidence. He denied that he was tailoring his evidence with a view to pleasing or currying favour with Diemould. He did admit that he maintains a 'working relationship' and chats to Mr Grose now and then for 'future workplacing'[61] and that he maintained an ongoing social relationship with Mr Grose 'for prospective work purposes'[62].

6.30. Despite Mr Shaw's denials, I do consider that he tailored his evidence in an effort to assist Diemould by claiming the existence of a safe operating procedure that simply did not exist. The genesis of his claim was the document, Exhibit C28b, prepared sometime in 2004 after his original statement to Ms Batt and his interview with SafeWork SA.

6.31. <u>David Welling</u>

Mr Welling was a first year apprentice working at Diemould in 2004. At the time of giving evidence at the Inquest he was employed at BAE Systems Australia. Like the witnesses, Mr Remfrey and Mr Shaw, Mr Welling also cavilled at the accuracy of his interview with SafeWork SA. By the time he gave that interview he had already made a statement to Diemould's solicitor, Ms Batt[63]. He had also been interviewed by a police officer on the day of Mr Madeley's accident[64].

6.32. Like Mr Remfrey and Mr Shaw, Mr Welling claimed that the interview given to SafeWork SA was unsatisfactory:

> 'I … wasn't really happy with the way the interview was conducted and didn't feel I got a chance to put forward what happened on the day, so we made this statement.' [65]

It was then pointed out to Mr Welling that he made his statement to SafeWork SA after, and not before, the statement he made to Ms Batt. Thus his explanation that the

---

[60] Transcript, page 337
[61] Transcript, page 257
[62] Transcript, page 258
[63] Exhibit C27a
[64] Exhibit C27
[65] Transcript, page 217

statement to Ms Batt was made because he 'wasn't really happy' with the SafeWork SA interview made no sense.

6.33. In his first statement, that which he gave to Ms Batt, no mention was made of safe operating procedures for the horizontal borer. Consistent with this, in his interview with Inspector Oaten, he said that he was not provided with written safety instructions in relation to the horizontal borer[66].

6.34. I have read the interview conducted by Inspector Oaten and there is no sign that she was overbearing or attempted improperly to influence Mr Welling. In fact, Mr Welling did not point to any aspect of the interview with Inspector Oaten concerning a substantive issue with which he disagreed.

6.35. I note that Mr Welling was asked by Inspector Oaten whether he had been asked to discuss the accident with anybody else for an accident investigation or any other reason and he denied having done so apart from his statement to the police. He was asked again whether he had been involved in a company accident investigation at all and he replied 'no'. This was untruthful because, at the date of the interview with Inspector Oaten on 25 June 2004, Mr Welling had made a statement to the solicitor, Ms Batt[67]. Far from being overborne or intimidated by Inspector Oaten, Mr Welling was prepared to lie to her. Despite this, in his evidence, he returned to his claim about feeling uncomfortable about the SafeWork SA interview[68]. He also claimed that the police officer who interviewed him on the day of the accident made him feel really 'bad'[69]. He claimed that both the police officer and Inspector Oaten 'kept trying to put words in our mouths all the time, the way they asked questions'. He went on to say that when he read the statement from SafeWork SA:

> 'I have read the way, you know, she asked me questions and it just doesn't feel right, the way they're pushing us to, you know, instead of letting us try and say what happened on the day.' [70]

I reject Mr Welling's claims that he was in any way pushed or dealt with improperly by Inspector Oaten. I further express considerable doubt that the police officer who took a statement from Mr Welling on 5 June 2004 was inappropriate in his dealings

[66] Exhibit C27b
[67] The statement to Ms Batt, Exhibit C27a, was made on 17 June 2004
[68] Transcript, page 251
[69] Transcript, page 251
[70] Transcript, page 251

with Mr Welling. There is certainly nothing in that statement[71] which would suggest that there was any lack of volition or any undue pressure brought to bear in the obtaining of that statement.

6.36. I am at a loss to see why Mr Welling has constructed this elaborate claim that he was overborne by Inspector Oaten and by the police officer. Certainly, there was no connection between the police investigation on 5 June 2004 - the day of the accident - and the subsequent investigation by SafeWork SA. There is nothing to suggest that the police officer concerned would ever have had cause to discuss the matter with Inspector Oaten.

6.37. Mr Remfrey is recalled

As a result of the belated revelation that Mr Remfrey had been part of a meeting at Diemould only a matter of weeks before he gave evidence in this Court, and that he had made no reference to that fact, and further as a result of him not having disclosed that Mrs Grose was present in Court whilst he was giving his evidence in circumstances where I believe he should have done so had he been entirely frank and open with the Court, Mr Remfrey was recalled.

6.38. Mr Remfrey denied knowing Mrs Grose well[72]. He was asked if he had lunch with her the previous week on the day he gave evidence in the Court and he denied having done so. When pressed as to whether they met for coffee, he conceded that they had spent the lunch break together, first on a trip to Coles supermarket and then at the Crown and Sceptre Hotel adjacent to the Court. Furthermore, after Mr Remfrey left Court on that day, he accompanied Mrs Grose and walked with her part of the way down Gouger Street. They were even filmed by television crews walking together[73].

6.39. Mr Remfrey disclosed that although Mrs Grose was not working for the company at the time he gave his evidence, he knew that she had previously been an employee of the company[74].

6.40. I find that Mr Remfrey was keen to present himself in a manner that would curry favour with the management of Diemould. In that endeavour his evidence to the Court was less than frank. When he was questioned as to whether there was anyone

[71] Exhibit C27
[72] Transcript, page 717
[73] Transcript, page 732
[74] Transcript, page 733

from Diemould present in the body of the Court at Transcript, page 102, he answered, initially, 'no'. He then sought to obtain further information from the Court to qualify his answer: 'that is employed at Diemould?'. When the Court responded in the affirmative, he answered that there was no-one from Diemould present. Thus, his final answer was technically accurate in that there was no person presently employed by Diemould present in the Court. However, he was well aware of the fact that the Managing Director's wife, who was intimately involved in the affairs of the company (having been present at the meeting of all of the witnesses only two or three weeks prior), and who had previously been an employee of Diemould, was in fact present in the body of the Court. His initial response to the question was to deny that there was anyone from Diemould in the body of the Court and, in my opinion, his initial response was one of dishonesty. However, he corrected himself by employing the device of seeking to clarify whether the question was directed at any employee of Diemould. Having received an affirmative response from the Court he proceeded to deny that there was an employee present. In my view this shows a reluctance to be cooperative with the Court and a desire to assist Diemould.

6.41. Mr Chalil is recalled

Mr Chalil was also recalled and was questioned about his failure to disclose the meeting of Diemould witnesses that was convened at Diemould and addressed by the solicitor, Ms Batt, several weeks prior to the Inquest commencing. Mr Chalil responded that he did not think he was required to make any mention of that. It was pointed out to him that he was asked a number of questions about how he came into possession of the statement which he made to Ms Batt, and that it might have been natural to have disclosed that he was presented with it after the meeting. His response was:

> 'There wasn't any question about that, wasn't asked anything about it.' [75]

In my view it is unnatural that Mr Chalil refrained initially from identifying the circumstances in which he came into possession of the statement he had given to Ms Batt when it had happened so recently and as a direct result of the meeting convened at Diemould and addressed by Ms Batt. It appears to me that Mr Chalil was at pains to avoid disclosing any information that might cause any harm or detriment to Diemould.

[75] Transcript, page 748

7. The Diemould witnesses, Mr Remfrey, Mr Chalil, Mr Welling and Mr Shaw - reluctance to be fully open and frank with the Court

7.1. As a result of the way in which the evidence unfolded, I formed a preliminary view that certain of the Diemould witness, in particular Mr Remfrey, Mr Chalil, Mr Welling and Mr Shaw, were guarded in some of their responses to the Court. When it became apparent that there had been a meeting of those witnesses and a number of other witnesses[76], I was concerned that there may have been coaching or other inappropriate influences brought to bear upon prospective witnesses. This resulted in the need to closely question all of the witnesses about what was said at that meeting and, in particular, whether they were in any way coached. I am satisfied, as a result of the answers given by all of the witnesses, that no overt attempt was made to coach them in relation to the evidence they should give at the Inquest. It was clear from the answers given by many of the witnesses that there was a general expression of surprise that there was to be an Inquest at all. Apparently a view was expressed at the meeting that it would have been 'normal' to have held the Inquest prior to the completion of the criminal proceedings. Of course this view, if expressed, would have been misconceived by virtue of the prohibition in the Coroners Act against commencing or continuing an Inquest when criminal proceedings are on foot or in contemplation. As I have already noted, the Inquest could not be conducted until those proceedings came to a conclusion, more than 5 years after Mr Madeley's accident.

7.2. A considerable amount of time was spent in examining the matter of the meeting and what transpired at it. In the result, I was satisfied that nothing improper occurred at the meeting. Needless to say, it was unwise on the part of all concerned to have held such a meeting of all potential witnesses immediately prior to the Inquest, gathered all together in one place, particularly the premises at Diemould, to discuss the Inquest. However, it may have been misguided, and it may have been indicative of poor judgment on the part of those convening the meeting, but I am satisfied that nothing improper transpired in relation to coaching or otherwise tampering with witnesses.

[76] The accounts of various witnesses show that at least the following persons were present at the meeting: Mr Jim Grose, Mrs Sam Grose, Ms Rosey Batt, Mr Paul Barber, Mr Robert Shaw, Mr Chalil, Anant, Mr Remfrey, Mr Armando Baker, Mr Paul Barlow, Mr Jason Malec, Mr Dave McMinn, Anant, Mr Fred Hull, Mr John Mitchell

7.3. Nevertheless, I am left with misgivings as to the pattern of behaviour exhibited, at least by the witnesses Mr Remfrey, Mr Chalil, Mr Welling and Mr Shaw, all of whom were principal actors on 5 June 2004. Each of them was present on that day. One might have expected that their sympathies would lie with their deceased former colleague. Instead, each of these witnesses exhibited, to a greater or lesser degree, an unwillingness to cooperate with the Inquest and a desire to look to the interests of Diemould. I have concluded that this attitude did not originate in the meeting to which I have referred. In my opinion, that attitude is more likely to have grown out of a culture that I find was prevalent at Diemould in the period up to 2004 and following. A culture that was led by Mr Neville Grose, the then Managing Director of Diemould.

7.4. Neville Grose died sometime after the events of 2004 and prior to the commencement of the Inquest. Accordingly, he could not be called to give evidence. However, there is in existence a record of an interview of Mr Grose which was conducted by Inspector Oaten on 19 November 2004 and continued on 24 November 2004[77]. In that record of interview Mr Grose displayed an attitude that was, to say the least, unhelpful. For example, at the outset of the interview the solicitor for Mr Grose noted that she had that day sent a letter objecting to Inspector Oaten conducting the interview that day and, secondly, claiming that Mr Grose was not well and had been advised by the solicitor that he was not well enough to continue with the interview. Nevertheless, Mr Grose wished to proceed with it in any event. As a result of that intimation the interview was suspended and Inspector Oaten obtained legal advice. When returning she stated to Mr Grose that she was concerned about his health and asked whether he wished to continue with what was likely to be a lengthy interview that day. Mr Grose said that he did wish to do so. In the result, there was an objection made by the solicitor to the interview occurring at all, followed by a statement by the solicitor that the interviewee was sufficiently unwell that the solicitor had recommended the interview not continue. Yet there was also an intimation that Mr Grose wished the interview to go ahead. The position overall is self contradictory. It only served to lay a foundation for a subsequent objection of some kind to the admission of the evidence should that be convenient.

[77] Exhibit C18aaaaar and C18aaaaas

7.5. Mr Grose asserted that there were safe operating procedures for the horizontal borer, notwithstanding the fact that there were none.

7.6. He asserted that it would have been utterly impractical to install adequate safety devices on the machine, notwithstanding that the evidence clearly shows that it would have been practical and notwithstanding that the machine was replaced by another machine which performed the same function and did feature safety devices necessary to prevent a repetition of Mr Madeley's fatal accident. Furthermore, Mr Grose asserted that it would have been impossible to install brakes on the machine that would have caused it to stop quickly when the evidence showed that it would have been feasible to do so - see the evidence of Mr McLean.

7.7. I think it likely that the witnesses employed at Diemould took their lead from Mr Neville Grose in relation to their attitude in relation to SafeWork SA. That attitude continued through the Inquest, notwithstanding a change of management at Diemould and a far more conciliatory approach on behalf of the company by Mr Jim Grose.

7.8. I base my conclusions about the culture at Diemould on the following:

a) Mr Daniel was employed at Diemould in a senior position in 2004 and he had been working at Diemould since 1998 in the position of Business Development Manager. In around 2003 when Neville Grose became ill and took time off, Mr Daniel was the acting General Manager[78]. Upon Neville Grose's return from sick leave, Mr Daniel continued in a sales and marketing role but with a slow continual progression to the General Manager role which he assumed after Neville Grose's death[79]. Mr Daniel was in a senior role at Diemould and was in a position to observe Neville Grose's interactions with staff and his reaction to Mr Madeley's accident and the SafeWork SA investigation which ensued. Mr Daniel said that he did not think that Neville Grose liked the SafeWork SA inspectors being on the factory floor. He said that Neville Grose had described Inspector Oaten as 'an aggressive bitch'[80]. He agreed with the proposition that

[78] Transcript, page 397
[79] Transcript, page 938
[80] Transcript, page 968

Neville Grose's attitude in relation to SafeWork SA would have been plainly apparent to the other workers, employees and general staff at Diemould[81].

b) Mr Jim Grose was Neville Grose's son and he gave evidence at the Inquest[82]. Jim Grose was very frank in his evidence and conducted himself in the witness box in a commendable manner considering that the experience would have been unpleasant. I accept his evidence. Jim Grose said that the culture of the workplace at Diemould changed when he became the boss after his father's death[83]. He said that a much higher emphasis was placed on safety under his leadership than was the case under his father's[84]. Jim Grose conceded that Neville Grose was not happy about SafeWork SA's involvement in the Diemould workplace following the accident[85].

c) Jim Grose was asked about his father's response in the records of interview to which I have made reference about modifications that could have been made to the horizontal borer to render it safe. He frankly acknowledged that he 'could see that we could have done better'[86].

d) Jim Grose said that it was his understanding that the replacement of the horizontal borer was entirely prompted by the accident and Mr Madeley's death[87].

e) Jim Grose said that the feelings that Neville Grose had about SafeWork SA and Inspector Oaten personally were made known by Neville Grose to workers at Diemould[88]. He conceded also that it was possible that as a result of Neville Grose's attitude, the staff at Diemould might themselves have taken a negative attitude to SafeWork SA inspectors[89].

f) Jim Grose conceded that no safe operating procedures existed for the horizontal boring machine prior to or at the time of Mr Madeley's death[90].

---

[81] Transcript, page 969
[82] His actual Christian names are Mark James but he is known as Jim
[83] Transcript, pages 984-985
[84] Transcript, page 985
[85] Transcript, page 985
[86] Transcript, page 988
[87] Transcript, page 1047
[88] Transcript, page 1052
[89] Transcript, page 1053
[90] Transcript, page 1076

In the result, it seems to me that Neville Grose's attitude to the SafeWork SA investigation was influential in the attitude subsequently displayed by the witnesses Mr Remfrey, Mr Shaw, Mr Chalil and Mr Welling and, to a lesser extent, some of the others. Their complaints about the manner in which they were questioned by Inspector Oaten had a hollow ring to them when one actually considered the content of the records of interview and the nature of the questions asked by Inspector Oaten. It was clear that Neville Grose had a belligerent and combative attitude to Inspector Oaten, having described her to Mr Daniel as 'an aggressive bitch'. In all likelihood he made the same or similar observations to other employees at Diemould, including the witnesses to whom I have referred. There is nothing in the record of interview of any of those witnesses that would justify the assertions made by some witnesses that Inspector Oaten had attempted to put words in their mouth or to influence their answers improperly.

7.9. I have felt it necessary to resolve this issue because of the meeting held at Diemould in the weeks prior to the Inquest. It would be a serious matter to conclude that the witnesses had been coached or influenced at that meeting in a way which led to a consistent pattern of evidence being given about the way in which SafeWork SA allegedly placed pressure on witnesses to respond in particular ways. On a close reading of the records of interview, those allegations did not stack up. It might have been open to conclude that the pattern of evidence emerging from these witnesses was a result of a discussion of their proposed evidence at the meeting held at Diemould in the weeks prior to the Inquest. Having examined the matter thoroughly I am satisfied that is not the case and that the true explanation for this pattern of evidence lies in the poor example set by Neville Grose in relation to the SafeWork SA investigation.

7.10. Finally, I note that I invited Jim Grose to comment on the possibility that I might ultimately find that Diemould was not cooperative with SafeWork SA in fully and frankly answering questions of Inspector Oaten and had rather a combative attitude to SafeWork SA immediately following Mr Madeley's death. I asked him whether he had anything to say to me that might cause me to think otherwise and he replied that he did not[91].

[91] Transcript, pages 1048-1049

8. The SafeWork SA prosecution - legal proceedings relating to the wording of the complaint

8.1. The following is a chronology of the prosecution under the Occupational Health, Safety and Welfare Act 1986:

Date	Event
5.6.04	Date of accident
3.5.06	Complaint laid
8.9.06	Return date of complaint EEAGTS pleads guilty before Mr Lieschke IM
29.9.06	EEAGTS sentenced - fine of $60,000 (maximum penalty $100,000) with a reduction of the penalty that would have otherwise been imposed of $15,000 (ie.20%) for an early plea of guilty
1.3.07	Questions of law reserved as to duplicity of charges
21.5.07	Argument before Special Bench of five Judges of Industrial Relations Court
24.8.07	Judgment by Full Court of IRC - [2007] SAIRC 44
5.5.08	Argument before Full Court of Supreme Court
17.7.08	Reasons published by Full Court - (2008) 101 SASR 339
28.8.08	Application for Special Leave to High Court
13.11.08	High Court refuses special leave to appeal
20.3.09	Agreement reached between prosecution and Diemould for plea of guilty to be entered on amended Complaint.
23.4.09	Defendant pleads guilty before Mr Hardy IM
26.6.09	Diemould convicted and fined $72,000 (maximum penalty $100,000) after allowance for a reduction of $8,000 (ie 10%) of what would otherwise have been the penalty of on account of the plea of guilty

8.2. Diemould objected to the form in which the summons was drafted and that objection was the focus of the litigation outlined in the above chronology. The complaint on its face only laid one charge for one breach of Section 19 of the Occupational Health, Safety and Welfare Act 1986. The charge was in the following terms:

> 'On 5 June 2004 at Edwardstown in the State of South Australia, the first defendant, being an employer, failed to ensure so far as reasonably practicable that its employee Daniel Madeley was while at work safe from injury and risks to health.'

After this there followed particulars of the charge including a statement that Mr Madeley was fatally injured while operating the horizontal borer and further particulars divided into three categories, namely plant, safe systems of work and

information instruction, training and supervision. Under each of those categories further sub paragraphs were included totalling 15 altogether.

8.3. The gravamen of Diemould's argument was that the complaint breached the rule against duplicity. Diemould submitted that the prosecution should elect to proceed on one count only of what it said were the several separate counts contained in the complaint. On the other hand, the prosecutor said that there was only one complaint, that the charges were not duplicitous and that even if they were, the prosecution could amend each relevant count to allege multiple counts to avoid duplicity. Diemould contended that it was not possible for the prosecution to amend the complaint because the time limit for laying new charges had expired[92]. The Chief Justice noted that provisions similar to those contained in the South Australian Occupational Health, Safety and Welfare Act 1986 can be found in legislation in New South Wales, Victoria and Western Australia. He said that cases in those jurisdictions have considered issues similar to those that were argued by Diemould and that the case law has given rise to apparently conflicting views, 'and to fine distinctions leading to different results'[93].

8.4. I will not attempt to outline the legal argument that was considered by the various courts in the history of the litigation. It is sufficient to say that because the proceedings against Diemould were criminal proceedings, an argument about the precise nature of the charge it faced duly arose, and it having arisen, needed to be resolved by the courts. As was its right, Diemould argued the case through the appellate hierarchy, ultimately failing to obtain leave to appeal to the High Court. In the end it was unsuccessful in the litigation. However, the prosecution did make some substantial changes to the complaint and summons resulting in the deletion of 8 of the 15 particulars that had been argued by Diemould to properly be the subject of an individual count. While the litigation itself was unsuccessful, it can fairly be said that Diemould had some success in reducing the number of particulars alleged as evidencing the single charge, namely a failure to ensure so far as reasonably practicable that Mr Madeley was safe from injury and risks to health while he was at work.

---

[92] The time limit being 2 years after the occurrence of the accident - expiring 5 June 2006
[93] [2008] SASC 197 para 7

8.5. However, it may also be observed that all of the amendments that were made by the prosecution and agreed by Diemould could have been made whether or not the appellate litigation had been engaged in. I have no information before me as to the basis on which Diemould and the prosecution agreed upon the amendments to the complaint and so cannot reach any conclusion as to the reasons why that did not happen at a much earlier stage. However I would observe that, even as amended, there were still 7 particulars and Diemould's duplicity argument would have been just as applicable to 7 particulars as it was to 15. In all probability, Diemould would have wished to agitate the duplicity argument even if the prosecution had offered an amendment of the kind ultimately made at an earlier stage.

8.6. Although as a matter of legal principle, the arguments about the drafting of the complaint and whether it was duplicitous in nature or not, were important matters worthy of the attention of the various appellate courts in a criminal proceeding, the arguments had nothing to do with the central issue that Mr Madeley was clearly exposed to a risk of injury as a result of which he died.

8.7. Furthermore, it can be fairly said that although Diemould was prosecuted under an amended complaint, which on its own argument remained a duplicitous complaint, it was only found guilty of the one offence at the completion of the proceedings. The Court did not, for example, find it guilty of 7 different offences. Furthermore, a single penalty was imposed which in no way rested on any suggestion that Diemould had been guilty of multiple offences. The penalty was imposed in relation to Diemould's guilt of only one offence.

8.8. I do not wish it to be thought that I am criticising Diemould for taking advantage of rights that were clearly available to it as a defendant in a criminal prosecution. Any other defendant would have been at liberty to assert the same rights and, indeed, the litigation was conducted in tandem with litigation raising the same point by a second employer, namely Santos Ltd.

8.9. However, the fact remains that the criminal prosecution of Diemould took more than 5 years to be finalised from the date of Mr Madeley's accident. None of the judgments of the appellate courts considered the substance of the charges but merely their form. No court considered the evidence which the prosecution asserted would prove the charge. Indeed, neither Diemould nor EEAGTS ever faced a full hearing of

the charges against them on account of their pleas of guilty. Thus, the actual facts leading up to Mr Madeley's fatal accident were never aired in any of the criminal courts.

8.10. It was only when the criminal proceedings were finally completed that this Inquest could be held and all of the facts and circumstances surrounding the tragic accident could be publicly aired.

8.11. The penalty imposed upon Diemould of a fine of $72,000 was ⅓ of the cost of the replacement horizontal boring machine that was purchased by Diemould in August 2004[94]. Thus, the penalty imposed was significantly less than the cost to Diemould of replacing the horizontal boring machine. I do not suggest that an economic decision was ever made by Diemould that it would be cheaper to pay a fine in a prosecution under the Occupational Health, Safety and Welfare Act 1986 (the maximum penalty being $100,000) than invest in a new horizontal boring machine, the cost of which would be 230% higher than the maximum penalty available under the Act. However, it might be considered a matter of public concern that in an operation such as Diemould's, the cost of acquiring safe plant and equipment far outweigh the likely penalty in a criminal prosecution.

8.12. It seems to me that a criminal proceeding is ill suited to air the issues arising from an industrial accident. The criminal process is not designed to arrive at a full consideration of all of the facts and circumstances. Much of the evidence that was admissible in this Court would have been inadmissible in the criminal jurisdiction. Certainly, the criminal court would never have heard evidence as to the cost of the replacement horizontal boring machine.

8.13. Following the close of the Inquest I indicated that I would request counsel assisting me, Ms Cacas, to write to SafeWork SA asking for information about what they had done to look into the prevalence of similar horizontal borers in the South Australian industrial environment. As a result of correspondence forwarded by Ms Cacas, a replay was received[95].

8.14. That letter reveals that SafeWork SA commenced a compliance project to identify the number of horizontal and vertical borers at South Australian workplaces in May 2010.

---

[94] Transcript, page 1045 - The actual cost of the replacement machine was $229,904.92

[95] See Appendix A - Letter dated 29 September 2010 from Mr Brian Russell, Director Strategic Interventions, SafeWork SA

It happens that May 2010 was the month in which the Inquest into Mr Madeley's death commenced. Mr Madeley died in June 2004 and the compliance project was not commenced for almost 6 years thereafter. It could have been commenced in June 2004, but it was not until this Inquest was about to commence that a compliance project was actually conducted. By September 2010 SafeWork SA had visited 7 business premises and had issued a total of 3 prohibition notices and 5 improvement notices. This is an indication that the process of inspection was bearing fruit, and the preventative aspect of SafeWork SA's function was being deployed, possibly with the result that further injury to employees may have been prevented. The letter states as follows:

> 'While SafeWork SA is the Government agency responsible for administering OHS laws in South Australia, the primary statutory duty to assess the risks associated with borer machines and to implement appropriate control measures to ensure their safe use is vested in the owners of such machines and/or the employers who are controlling their use.'

8.15. This seems to imply that the primary responsibility for ensuring the safety of workers rests with employers rather than SafeWork SA.

8.16. The difficulty with that approach is that, as here, a horizontal boring machine had been operated at Diemould for years in a condition which could only be described as deplorably unsafe. It could have been guarded, but was not. It could have had a braking system, but did not. It could have had an automated lubrication system, but did not. Employees using the machine could have been prohibited from wearing dust coats, but were not. Many other things could have been done, but any one of these would have been sufficient to save Mr Madeley's life. For example, even if the machine had been appropriately guarded, Mr Madeley would not have been entangled and would not have died.

8.17. Mr Madeley's death was preventable. A regime of proper inspection by SafeWork SA and the issuing of improvement notices and prohibition notices might, if conducted prior to June 2004, have identified such an obviously unsafe machine as the horizontal borer and prevented its further use until it was rectified.

8.18. It is extremely disturbing that SafeWork SA failed to carry out an audit following Mr Madeley's death for nearly 6 years, and only then at the same time as an Inquest was

started. The Inquest could not, as I have previously said, be commenced until the completion of the prosecution proceedings.

8.19. SafeWork SA undertook to provide a further update on the outcome of the compliance project. As at the date of this finding however, no further information has been provided to the Court.

8.20. In my opinion, the system of leaving industrial safety compliance to employers and then simply prosecuting them once an employee is fatally injured, is inadequate and insufficient. A rigorous system of inspection and a full use of the range of improvement notices and prohibition notices would be a far more effective way of preventing accidents such as Mr Madeley's.

8.21. In my opinion, the prosecution process should be reviewed. A better system of accountability could and should be arrived at. I suspect that a public airing of the circumstances of an industrial fatality would be far more beneficial if it occurred soon after the occurrence of the accident. That way any systemic failures could be identified before further employees are exposed to similar risks. The present case is a good example. For one reason or another it took 6 years before a compliance project was instituted in relation to horizontal boring machines. I believe that the relevant Minister should consider whether an alternative process could be offered to the families of victims of industrial accidents. Such a system might involve an invitation to the State Coroner to consider, at an early stage, whether it is necessary or desirable that an Inquest be held; if the State Coroner were to intimate that in his opinion it was necessary or desirable that an Inquest be held, the family of the deceased might be offered the opportunity to elect whether they would prefer that the matter be the subject of an Inquest, or the subject of the usual criminal process. In that event, the prosecuting authority would be empowered to intimate that no person or company would be prosecuted in order to avoid the risk of self incrimination at the Inquest. In this manner families might be able to obtain a full understanding of the circumstances that led up to the death of their relative at a much earlier stage than is likely if a prosecution is pursued.

9. EEAGTS

9.1. EEAGTS had, for many years, been placing apprentices at Diemould. It had placed a number of apprentices there. EEAGTS did complete rudimentary checks of occupational health and safety at Diemould premises, as it did with other host employers. I heard evidence from Mr Robert Drysdale who had been employed by EEAGTS as a Training Coordinator and who had a pastoral role in relation to the training of Mr Madeley. He was, at the time of giving evidence, an employee of AIGTS. He was a sincere witness who gave his evidence in an open and frank manner and I have no hesitation in accepting his evidence. He said that his knowledge of Diemould was that its general reputation was good and that reputation was relied upon by him and others within the EEAGTS[96]. Mr Drysdale and EEAGTS had no negative information in relation to Diemould's practices[97] and Mr Drysdale was not aware of any Workcover claims for EEAGTS employees who had been hosted at the Diemould site[98].

9.2. It was submitted on behalf of AIGTS and EEAGTS, and I accept, that the idea that apprentices might be training other apprentices was something that neither Mr Drysdale or EEAGTS were aware of and had not anticipated. It was frankly acknowledged by counsel for AIGTS that EEAGTS had failed to have systems in place to ensure that such a situation did not occur and, furthermore, to check whether safe operating procedures existed for machinery at Diemould, including of course the horizontal boring machine. Mr Drysdale and EEAGTS both properly conceded that the horizontal boring machine was not safe and, further, that the wearing of dust coats was unsafe[99].

9.3. Very properly, EEAGTS entered a plea of guilty to the complaint laid against it as an employer of Mr Madeley, being a charge of failing to ensure so far as was reasonably practicable that Mr Madeley was, while at work, safe from injury and risks to health (contrary to section 19 of the Occupational Health, Safety and Welfare Act 1986). The plea of guilty was entered on 8 September 2006 in the Industrial Court at the first available opportunity. EEAGTS was convicted and fined $60,000.

---

[96] Transcript, page 534
[97] Transcript, page 540
[98] Transcript, page 541
[99] Transcript, page 555

9.4. Following the death of Mr Madeley, EEAGTS conducted an internal analysis of its operations. As a result radical changes were made. The Court was provided with a copy of each of the following documents which are now used by AIGTS for the purposes of discharging its responsibilities:

a) The host company manual[100];

b) The apprentice training and work experience handbook[101];

c) A flowchart detailing the process which was explained by Mr Drysdale in his evidence[102];

9.5. AIGTS' processes are now subject to an occupational health and safety audit at a state and national level and they include mandatory visits to the host employer with 7 visits within the first 12 months of an apprentice's placement and a site inspection and evaluation as contemplated by Exhibit C21f. This system has been implemented directly as a result of Mr Madeley's death[103].

9.6. AIGTS submitted that the lessons learned from the death of Mr Madeley have not just been applied in South Australia but now form part of the national system in place through the AIGTS and its 550 apprentices in 4 states. I have no hesitation in finding that AIGTS responded appropriately to the tragic death of Mr Madeley, and has implemented systems and procedures which are appropriate and suitable. There response was commendable. Mr Drysdale was, as I have said, a truthful and sincere witness who was obviously very distressed about Mr Madeley's tragic death. I do not doubt that the diligence displayed by him in the course of giving evidence is applied by him in his daily interactions with apprentices.

10. Diemould following the death of Neville Grose

10.1. As I have noted, following the death of Mr Madeley, Diemould replaced the horizontal boring machine with a new machine which was appropriately guarded. Furthermore, it is apparent that there has been a change in the culture of the company since the death of Neville Grose. I accept that the company has become more proactive in identifying, assessing and attending to issues of safety.

---

[100] Exhibit C21d
[101] Exhibit C21e
[102] Exhibit C21f, Transcript, page 564
[103] Transcript, page 567

11. Conclusions

11.1. Mr Madeley's tragic death was entirely preventable. Diemould was operating a horizontal boring machine which, on any view, was clearly unsafe. It is inexplicable in an age in which occupational health, welfare and safety is so much a part of the modern workplace, that a workplace could have existed so recently as 2004 with a machine that was so obviously unsafe. One would not have needed to be an expert to conclude that the machine was totally unguarded and had many other unsafe features. The system of work employed in its operation, namely the need to lean in towards the work with the plastic bottle of lubricant and squirt it on the work, was a major accident waiting to happen. The horizontal boring machine and the method of its operation might have been something one could have expected to see in a workplace in the 1950s, but certainly not in 2004.

11.2. I simply cannot understand how such a workplace existed in South Australia in 2004 bearing in mind the existence of SafeWork SA and its various predecessors, and the Workcover Corporation which, I understand, also takes an interest in occupational health, welfare and safety.

11.3. I would have thought that an intelligent 'strategic intervention' by SafeWork SA might have decided to target small manufacturing businesses in possession of heavy machinery such as the horizontal borer. I certainly would have thought that such a 'strategic intervention' would have been taken very soon after Mr Madeley's death. However, it was not until more than 6 years after Mr Madeley's death that the 'strategic interventions' section of SafeWork SA finally commenced a compliance project to identify the number of horizontal and vertical borers at South Australian workplaces and ensure that they are appropriately guarded, amongst other things. In my view this is completely unacceptable. The letter from the Director, Strategic Interventions, dated 29 September 2010 to which I have already made reference, refers in a passage I have quoted, to the fact that the 'primary statutory duty' to assess the risks associated with boring machines rest with employers and/or owners of such machines. This may be technically true, but it seems to me that it does not absolve SafeWork SA from an obligation to fully utilise the powers available to it under the Occupational Health, Safety and Welfare Act 1986, including the power of inspection. When an inspector attended at Diemould in response to Mr Madeley's accident, a

prohibition notice was issued immediately for the horizontal boring machine. It is reasonable to assume therefore that had an inspector attended at Diemould at any time prior to that, a prohibition notice would have been issued. As I have already said, any person of moderate intelligence would quickly appreciate the hazards posed to the safety of a worker by that particular machine, and the more so if the inspector were to observe the system of work employed with the plastic squirter bottle of lubricant.

11.4. I note that there is in existence an advisory committee established under the Act and known as the SafeWork SA Advisory Committee. I propose to refer this finding to that committee and also to the Minister having the administration of the Act to consider the matters raised herein.

11.5. I am particularly disturbed that some 6 years expired from the date of Mr Madeley's accident, and the first evidence of the potential danger of machines of this kind, and the eventual institution of a program of inspection targeting these machines. It would have been reasonable to assume that if such a machine was in operation at a workplace such as Diemould, which was a supposedly reputable workplace with a good record of safety and recognised high standard of product, that such machines would also be in operation in other workplaces. Indeed, the letter from SafeWork SA states that there are 78 South Australian workplaces with such machines on site but, as at 29 September 2010, only 7 of the businesses had been visited and 6 horizontal borers and 3 vertical borers identified. A total of 3 prohibition notices and 5 improvement notices were issued.

11.6. I do not know whether any further progress has been made by SafeWork SA in this project. Despite the author of the letter undertaking to provide me with an update upon completion of the project, no update has been provided as at the date of this finding. It is reasonable to assume therefore that work is continuing. Given that the project started in May 2010 and it is not yet complete in February 2011, it is fair to say that the project is hardly proceeding expeditiously. In my opinion, some greater sense of urgency should be applied to this project and I propose to recommend accordingly.

12. Recommendations

12.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

12.2. I recommend pursuant to section 25(2) of the Coroners Act that the SafeWork SA Advisory Committee, established under the Occupational Health, Safety and Welfare Act 1986, examine the practices of SafeWork SA in the period preceding 5 June 2004 in order to consider the adequacy of the inspection regime that was then in place.

12.3. I recommend pursuant to section 25(2) of the Coroners Act that SafeWork SA Advisory Committee examine the practices of SafeWork SA in the period after 5 June 2004 in order to consider the adequacy of the inspection regime that has been in place since then.

12.4. As a matter of law reform, I suggest that the Government consider a major reform of the current system of criminal prosecution for fatal industrial accidents. In my opinion it is just wrong that the prosecution of Diemould took 5 years to arrive at a plea of guilty. There must be a way to improve that. It seems to me that the family of a person killed in a workplace accident may be better served by seeing an open public inquiry convened within 12 to 18 months of the accident, than a criminal prosecution which might never result in the public hearing of any evidence, and which takes more than three times that long to even start. I suggest that consideration be given to a reform of the law which would enable the following things to happen:

1) Coroner intimates that, were no charges to be laid against any person in connection with the accident, an Inquest would be held;

2) Family elects whether they would prefer that the matter be the subject of an Inquest, or the subject of the usual criminal process;

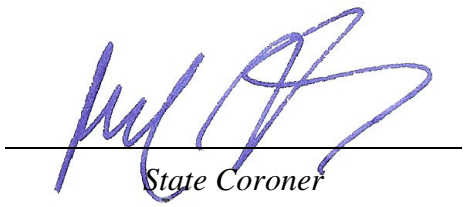
3) If the family elects that they would prefer that there be an Inquest, the prosecuting authorities (including the DPP) would be empowered to intimate that no person or company would be prosecuted under the Occupational Health, Safety and Welfare Act or any other law. Such an intimation would then

operate as a bar against future prosecution and, accordingly, no person would be exposed to the risk of self incrimination in answering questions at the Inquest, with the result that the Court could insist that answers be given, notwithstanding that they might otherwise be refused on that ground.

This is a suggested law reform, not a recommendation under section 25(2) of the Coroners Act. That is because of the way section 25(2) is framed, being limited to recommendations that might prevent or reduce the likelihood of events similar to the event the subject of the Inquest. If section 25(2) permitted recommendations concerning the administration of the law, as the corresponding provision in the Coroners Acts of some other jurisdictions do, I would have made this suggestion a recommendation[104].

Key Words: Workplace Injury; Industrial Accident

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 9th day of February, 2011.



State Coroner

Inquest Number 14/2010 (1637/2004)

[104] See generally Saraf v Johns (2008) 101 SASR 87 where Debelle J noted the limitation on the recommendation making power in the Coroners Act, but made his own suggestion for reform of the law, a practice that has long been adopted by courts of law

Appendix A Letter dated 29 September 2010 from Mr Brian Russell, Director Strategic Interventions, SafeWork SA

Government of South Australia
SafeWork SA

Department of the Premier and Cabinet
Office of the Executive Director

Level 4, 1 Richmond Road
Keswick SA 5035

GPO Box 465
Adelaide SA 5001

DX 715 Adelaide

Contact Bryan Russell
Phone (08) 8303 0232
Fax (08) 8463 4978
Email russell.bryan@dpc.sa.gov.au

ABN 50-560-588-327
www.safework.sa.gov.au

Your ref :
Our ref : 10SWSA0517

29 September 2010

Ms Amy Cacas
Senior Counsel Assisting the State Coroner and
Deputy State Coroner
South Australian Coroner's Court
302 King William Street
ADELAIDE SA 5000

Dear Ms Cacas

Thank you for your letter dated 25 August 2010 requesting additional information in relation to the industrial accident that occurred on 6 June 2004 that resulted in the unfortunate death of apprentice toolmaker, Mr Daniel Madeley. I am pleased to provide you with the following information

In May 2010, SafeWork SA commenced a compliance project to identify the number of horizontal and vertical borers at South Australian workplaces. Vertical borers were included within the scope of this project as they are very similar in operation to horizontal borers and, therefore, give rise to similar risks.

The compliance project involves auditing identified workplaces, specifically targeting the borers to ensure that any risk to health and safety is eliminated or minimised by ensuring that:

- the machines are appropriately guarded;
- procedures are in place for the safe operation of the machine and the protection of workers;
- workers required to operate the machine have been trained in all aspects of the machine;
- apprentice workers are adequately trained and supervised; and
- appropriate personal protective equipment is issued to workers.

So far, the project has identified a total of 78 South Australian workplaces that have horizontal and/or vertical borers on site. As the project has not yet been completed, I am unable to advise at this stage as to the percentage of machines within this total that are in use.

Information about the location of these borers is provided (Attachment A).

As part of the compliance project, an audit tool has been developed, a copy of which is also provided (Attachment B). The tool is in the form of a questionnaire that focuses on:

- the existence and scope of general occupational heath and safety (OHS) procedures;
- the nature and extent of training, information and instruction provided concerning the borer(s);
- the nature and extent of personal protective equipment provided to workers;
- the use of the borer(s) by apprentices;
- the amount of supervision provided to apprentices; and
- the guarding of each machine, and other features of the borer(s) and their surrounding environment that impact on safety.

You will be aware that SafeWork SA does have the power to issue statutory notices requiring the repair of machines that are considered, in the opinion of a SafeWork SA inspector, to contravene the *Occupational Health, Safety and Welfare Act 1986* and/or the *Occupational Health, Safety and Welfare Regulations 2010*.

In cases where a SafeWork SA inspector is of the opinion that a machine represents an immediate risk to health and safety, the inspector can prohibit the use of the machine until such time as adequate measures have been taken to avert, assess, eliminate or minimise any risk.

To date, SafeWork SA has visited seven of the identified business premises, locating six horizontal borers and three vertical borers. A total of three prohibition notices and five improvement notices have been issued.

This project is scheduled to be completed by the end of 2010, but may be extended depending on the findings as the project progresses.

While SafeWork SA is the government agency responsible for administering OHS laws in South Australia, the primary statutory duty to assess the risks associated with borer machines and to implement appropriate control measures to ensure their safe use is vested in the owners of such machines and/or the employers who are controlling their use.

A further update on the outcomes will be provided to the South Australian Coroner's Court upon completion of the project.

I trust this information is of assistance. Please do not hesitate to contact me should you have any further queries.

Yours sincerely

Bryan Russell
DIRECTOR
STRATEGIC INTERVENTIONS
SAFEWORK SA