FINDINGS, RECOMMENDATIONS and COMMENTS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Kurt Joshua Gorrie

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Kurt Joshua Gorrie with an inquest held at Currie and Burnie in Tasmania make the following findings.

Hearing Dates

18 June at Currie, King Island; and 19 and 20 June at Burnie in Tasmania

Representation

Ms S Taglieri SC Counsel assisting the Coroner
Mr N Sweeney for De Jong and Sons Constructions Pty Ltd
Mr I Guest for Mr Luke Gorrie

Introduction

1. Kurt Joshua Gorrie died as the result of injuries received when he fell approximately 6 metres from the roof of the airport extension at Currie, King Island onto a concrete slab, just after 9.00am on 8 December 2014.
2. Mr Gorrie was working as a roof plumber with his brother, Luke Gorrie, at the time of his fall.
3. Born on 4 September 1986 Kurt Gorrie was 28 years old when he died and the father of a young daughter. He was popular and well liked, good at his job and a valued member of the Penguin Australian Rules Football Team.
4. His death was a completely avoidable tragedy. The fall that caused it would not have occurred if some very basic safety precautions had been taken.

The Role of the Coroner

5. Before an analysis of the circumstances surrounding Kurt Gorrie's death is commenced it is important to say something about the role of a Coroner. A Coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. Because Kurt Gorrie died as the result of

an accident which occurred whilst he was at work the *Coroners Act* 1995[1] (the *Act*) makes an inquest mandatory. An inquest is a public hearing.

6. When investigating any death, whether or not an inquest is held, a Coroner performs a role very different to other judicial officers. The Coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Act* asks. Those questions include who the deceased was, how he or she died, what was the cause of the person's death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[2] A Coroner is required to make findings of fact from which conclusions may be drawn by others.[3] A Coroner is also able, if he or she thinks fit, to make comments about the death or, in appropriate circumstances, recommendations with a view to preventing similar deaths in the future. This is a particularly important function in the context of workplace deaths.

7. A Coroner does not impose punishment nor award monetary compensation – that is for other proceedings in other courts, if appropriate. Nor does a Coroner have the power to charge anyone with crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that she or he thinks someone is guilty of an offence.[4] As noted above, one matter that the *Act* requires is that a finding be made about how death occurred.[5] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[6] Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the Coroner.

8. Finally, it should be noted that the standard of proof in coronial inquests is the civil standard. This means that where findings of fact are made a Coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an enquiry reaches a stage where findings being made may reflect adversely upon an individual it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw.*[7] That case stands for

---

[1] Section 24(1)(ea).
[2] See *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7.
[3] See *Keown v Khan* [1998] VSC 297; [1999] 1 VR 69, Calloway JA at 75 – 76.
[4] Section 28 (4) of the *Act*.
[5] Section 28(1)(b).
[6] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[7] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

the proposition that it is particularly important to bear in mind the seriousness of any allegation when deciding whether that allegation is true or not. Put another way, the task of deciding whether a serious allegation is proved should be approached with great caution.

The issues at inquest

9. A number of issues were identified in advance of the inquest as particular matters that required consideration. Those issues were circulated to all interested parties. The issues identified were as follows:
    a) Why the section of roof was not safety meshed when work was being performed by Kurt Gorrie and others on 8 December 2014
    b) When and why packs of roofing iron sheets were lifted onto the roof, apparently in an area that had not been meshed
    c) Why the roofers, including Kurt Gorrie, were permitted to be on the roof without harnesses in circumstances where the roof had not been fully meshed
    d) Whose responsibility it was to prevent falls from occurring and whether their methods and practices were adequate to prevent it
    e) Whether the non-laced shoes worn by the deceased in any way was a factor that contributed to the fall from the roof and
    f) Whether there was any dew/moisture on the purlins or roofing iron on the morning of the fall
10. I will return to these issues later in this finding.

Kurt Gorrie's background

11. Mr Gorrie was born in Burnie to Mrs Tania Gorrie and Mr Michael Gorrie. At the time of his death he was in a relationship with Ms Mikaela Richards. Together he and Ms Richards had a daughter who was less than two years old when her father died. He was physically fit and was not suffering from any illnesses either physical or mental. As at December 2014 he was not taking any prescribed medication or using illicit drugs.
12. Mr Gorrie was a self-employed, qualified roofing plumber. He traded as Kurt Gorrie Roofing. His brother Luke was similarly self-employed, trading as L G Roofing. The brothers frequently worked together. Although they ran separate businesses in that each sourced their own work and quoted for their own jobs a

loose partnership arrangement (or understanding) was in place between the brothers whereby they would work together on jobs each paying the other dependent upon who had obtained the work in the first place.

The Airport Extension works

13. On 8 December 2014 the brothers were working together on the airport extension at Currie, King Island. They had an apprentice with them, Mr Jacob Brown. Although Luke Gorrie in an affidavit tendered at the inquest[8] described Mr Brown as "our" apprentice (suggesting that Mr Brown was apprenticed to both brothers) records held by Skills Tasmania indicate that he was apprenticed to Luke Gorrie.
14. De Jong and Sons Constructions Pty Ltd (De Jong) had been engaged by the King Island Council to build an extension to the terminal at the airport near Currie. The council leased the airport from the Commonwealth Government.
15. The terminal extension was in the order of 500m² and the roof height roughly 6 metres from the ground at the centre span. The extension had a concrete slab floor. As well as constructing the extension De Jong was contracted to complete renovations of the existing structure and carry out some ground work relating to the airport's car parking area.
16. The evidence was that the brothers were engaged to roof the extension as a result of contact initiated by Mr Stuart Winwood on behalf De Jong. Both brothers had worked for De Jong in the past and were well known to, and well regarded by, Mr Winwood. The evidence was that the job they were engaged to carry out was for labour only. In other words, all the material and equipment necessary to install the roof was furnished by the principal contractors De Jong. It was the role of the brothers to put the mesh, insulation and iron sheeting in place.
17. Mr Winwood was one of two supervisors working for De Jong on the airport construction site. He shared that responsibility with Mr Tim Mitchell. De Jong operated a rotating shift from Wednesday to Wednesday which meant that Mr Mitchell supervised for one week and Mr Winwood the next. Mr Mitchell was the supervisor when the Gorrie brothers first arrived on the island on Monday, 3 November 2014. Mr Winwood was the supervisor on the island on Monday, 8 December 2014, the day of Kurt Gorrie's fatal fall.

[8] Exhibit C19 –Sworn 13 September 2017.

18. Kurt and Luke Gorrie were not the only contractors used by De Jong at the airport. The evidence was painters and plumbers had both been on the site to carry out the tasks associated with their particular trades as part of the construction of the extension.
19. The design of the extension was that the roofing was held in place by large steel sections running north to south. The steel sections had steel purlins attached running east to west. The sheets of roofing iron were affixed to the purlins. Pine battens were attached to the underside of the purlins. The battens were in place to enable ceiling sheeting to be affixed when the roofing was complete. The battens were not designed to be weight bearing, something that was known to Kurt and Luke Gorrie, and the apprentice Jacob Brown.
20. The Gorrie brothers and Jacob Brown first worked on roofing the terminal extension between Monday, 3 November and Thursday, 6 November 2014. When they arrived at the work place they completed a site induction with Mr Mitchell, De Jong's foreman on site at the relevant time. Mr Mitchell gave evidence about that induction. He said that it involved familiarising the Gorrie brothers with the area, explaining the evacuation plan and dealing with the particular issues associated with the site being a working airport. In addition he said that he ensured that their Safe Work Method Statements (referred to throughout the inquest as SWMS) had been completed.
21. Mr Mitchell said that as roofing contractors both Kurt and Luke Gorrie had separate SWMS. He simply checked that they had a SWMS and took the matter no further. He described viewing a SWMS on an iPad. No hard copy was provided to De Jong by either of the Gorrie brothers. In fact there was evidence at the inquest, from Mr Winwood, that after they left King Island on 7 November 2014, and before their return on 8 December 2014 he had exchanged text messages with Luke Gorrie on 18 November 2014[9] about the need to bring a hard copy of the SWMS when they returned to King Island.
22. The time of the brothers working on King Island was cut short by reason of the death of their grandfather. When they returned to the mainland of Tasmania (flying there on the morning of Friday, 7 November 2014) they had only roofed approximately three quarters of the extension.[10] Relevantly the roof had not been fully fitted with safety mesh by the Gorrie brothers as there was insufficient mesh available to them to complete the job. This was because there

[9] Exhibit C14, Annexure F – screenshot of text messages.
[10] Exhibit C19, Annexure A, line 316 – 317.

was insufficient mesh on the island, which in turn was caused, at least in part, by a shipping delay (although I observe that if enough mesh had been delivered in the first place then obviously a shipping delay on account of poor weather would have not made any difference). The importance of the safety mesh is that, once in place, it provides complete protection against falling. Kurt and Luke Gorrie both knew that the installation of the safety mesh had not been completed when they left the island on 7 November 2014.

23. As the installation of safety mesh is the responsibility of the roofers nothing further was done by De Jong to install any more of the safety mesh (which the evidence suggests did not arrive on the island until Monday, 9 November 2014 – after Kurt and Luke Gorrie had left the worksite for the first occasion).

24. The evidence in relation to safety mesh is that "it is designed to prevent internal falls through a roof. If securely fixed, safety mesh provides fall protection for roof installers and offers long-term protection against falling for maintenance and repair workers".[11] The applicable industry Code of Practice lists safety mesh as a fall prevention device, along with temporary work platforms and perimeter guard rails - neither of which were provided for the use of the roofers on 8 December 2014. The evidence was that fall prevention devices in the form of harnesses were available for use by the roofers and had been used by Kurt Gorrie, Luke Gorrie and Jacob Brown on their earlier trip to the site in November 2014. However they were not used on the day Kurt Gorrie fell to his death. I will return to this issue later in this finding.

25. All evidence was that packs of roofing iron were lifted into place on the roof of the extension by a crane. According to Mr Mitchell this occurred initially on the afternoon of Tuesday, 4 November 2014 although Luke Gorrie recalls it occurring on Monday, 3 November 2014. Little if anything turns on the difference. It is clear that at least some of the roofing iron was in position earlier in the week commencing Monday, 3 November 2014 when Luke and Kurt Gorrie and Jacob Brown were first on the site. It may be thought more likely that this was on Monday, 3 November 2013 than the following day, if only because it would be inefficient for the material required by the roofers not to be positioned as they started the job they were engaged to do. On the other hand the evidence was quite clear that it was the responsibility of the roofers to install the safety mesh. Mr Mitchell said that the first load of roofing iron was

[11] Annexure A, Exhibit C21, affidavit of workplace inspector D Langerak.

lifted into place by the crane only after some safety mesh had been installed by Luke and Kurt Gorrie. This is equally plausible. However as I say little, if anything, turns on the difference.

26. I am satisfied that the rest of the roofing iron was placed in position by the crane on Friday, 7 November 2014. Mr Winwood said this occurred[12] and both Luke Gorrie and Jacob Brown confirmed that this was so. I am also satisfied that the roofing iron was placed on the roof at Mr Winwood's direction (who had taken over as site foreman) and actually occurred as the Gorrie brothers were flying off the island at about 9.00am. A principle consideration in determining where the packs of roofing iron where placed was the need for them to be positioned near steel purlins so as they could be safely secured (i.e. tied off) pending installation.
27. I am also satisfied that Luke and Kurt Gorrie were aware, when they left the island, that additional roofing iron packs had been placed on the roof and that they were also aware, at least in a general sense, where those packs of roofing iron had been placed. I accept that neither brother gave any direction or made any request of either Mr Winwood or the crane driver as to where the packs should be positioned.
28. The roofing iron remained on the roof until the return of the Gorrie brothers. It was secured on the roof by ratchet straps. Some of it was outside the meshed area. Mr Winwood knew this; Kurt and Luke Gorrie also knew this.
29. I am also satisfied that, wherever on the roof the packs of roofing iron were placed, at least some would need to be moved to enable the roofing job (including the installation of the rest of the mesh, as well as the iron sheeting) to be completed. Obviously there is no other way the job could be finished.
30. The evidence was that the Gorrie brothers and Jacob Brown had worn safety harnesses whilst installing the safety mesh. Mr Mitchell said that he insisted upon this at the direction of the De Jong head office. Mr Winwood, in an interview with inspectors from WorkSafe Tasmania, confirmed that this was so. He also said that he had seen Kurt and Luke Gorrie wearing harnesses during the week in November, when they were working on the roof of the airport extension.[13] Harnesses as a form of fall prevention or arrest devices were provided by De Jong irrespective of whether contractors such as the Gorrie brothers provided their own. Mr Winwood said that he had actually purchased

[12] Exhibit C14, annexure B, line 167 -168.
[13] Exhibit C14, annexure B, line 140, line 189 – 149.

the harnesses after De Jong had had some type of incident with harnesses in Launceston (although he did not say what) and that three harnesses were available on King Island to be used by anyone working on the roof.

31. Mr Mitchell said in his evidence at the inquest that harnesses were available in a shipping container which was used as a temporary storage facility at the site. He described the harnesses as being "all checked and stamped". He said that neither Luke or Kurt Gorrie or Jacob Brown brought harnesses with them in November 2014.

32. Mr Mitchell also said, so far as he was aware, during the initial stage of preparing the roof and installing the safety mesh both Kurt and Luke Gorrie and Jacob Brown were all wearing harnesses.

33. For various reasons, none of which have any bearing on Kurt Gorrie's death, the Gorrie brothers did not return with Jacob Brown to King Island to complete the roofing job until the morning of Monday, 8 December 2014. They arrived on a flight from the mainland of Tasmania at about 8:30am less than 40 minutes after their arrival, Kurt Gorrie had fallen from the roof and landed on the concrete slab. How and why that occurred will now be examined in detail.

Circumstances of Kurt Gorrie's Fall

34. What occurred after the arrival of Kurt and Luke Gorrie and Jacob Brown, and before Kurt Gorrie's fatal fall, was the subject of some dispute at the inquest. Mr Winwood said that whilst he was aware Luke and Kurt Gorrie and Jacob Brown had arrived he only spoke to Kurt Gorrie. He said that he remembered "making eye contact with Luke [and] sort of giving him the thumbs up [whilst] he was waiting at the baggage collection". He said that he spoke to Kurt and they discussed the manner in which a ladder (which was to be used to access the roof by Kurt and Luke Gorrie and Jacob Brown) was tied off. He and Luke Gorrie then had a brief chat about the roofing plan and walked together to the shipping container to get a copy of that plan. Mr Winwood then said that he returned to the job he had been undertaking which involved working with other employees of De Jong and putting some eaves sheeting in place. He claimed that he was unaware that Kurt Gorrie, Luke Gorrie and/or Jacob Brown had gone on to the roof before Kurt Gorrie fell. It was submitted by Counsel Assisting that it is unlikely that this is so. I agree. Mr Winwood was working at the time of Kurt Gorrie's fall with Mr Jak Youd, Mr Dion Marshall and Mr Jacob

Beamish. Mr Youd and Mr Beamish, both of whom gave evidence at the inquest, said that they heard the roofers on the roof. Mr Youd said (and I accept) that he was at ground level and close to the area in which Mr Winwood was working. Mr Beamish was standing on a scaffold nearby where Mr Winwood was cutting eave sheets, to be passed to Mr Beamish and Mr Marshall. I do not accept Mr Winwood was unaware that the roofers had climbed the ladder and gone onto the roof.

35. Even if he was unaware that they were on the roof, Mr Winwood should have known because it was his responsibility to ensure the safety of every person on the site. Whilst Kurt and Luke Gorrie were obviously experienced roofers, (which is why they had been engaged to carry out the task), they had not been on the site for a month and the physical condition of the site had changed since they had last been there. Mr Winwood must have known that. Also, Mr Winwood must have known (or should have known) that some of the packs of sheet iron that were on the roof needed to be moved.
36. Mr Winwood also knew that the safety meshing had not been completed. He knew that safety harnesses were provided by De Jong constructions for use by any employees or contractors working at height (after all he had bought them and he knew De Jong insisted on harnesses being used for work at heights). In the circumstances he should have at least considered what was reasonably required in safety terms to undertake the task of completing the roofing.
37. In assessing the reasonable actions of the supervisor or foreman Mr Winwood's conduct in the immediate lead up to Kurt Gorrie's death can be contrasted with the actions of Mr Mitchell who insisted upon the wearing of harnesses by Luke and Kurt Gorrie when they were present at the work site in early November 2014.
38. Luke Gorrie gave evidence at the inquest that he spoke to Mr Winwood shortly arriving at the worksite on 8 December 2014 about getting the crane back to the airport to move the roofing iron packs on the roof (which he said were in the wrong place). He said Mr Winwood made a phone call to De Jong's office, in his presence, and the request was refused by Mr John De Jong (the principal of De Jong's), apparently because of the cost associated with using the crane.
39. I reject Luke Gorrie's evidence about this. Mindful of the standard of proof required by *Briginshaw*[14], I am affirmatively satisfied that Luke Gorrie was

[14] Supra.

deliberately untruthful about this conversation. I have not reached this conclusion lightly. However there are a number of compelling reasons for the conclusion.

40. First, in no statement, record of interview or affidavit did Luke Gorrie ever suggest that this had occurred. The first time he seems to have suggested that there was such a conversation was when he gave evidence at the inquest.

41. Second, Mr Winwood was recalled to be questioned about this issue at the inquest and had no recollection whatsoever of any such conversation occurring. It is also completely consistent with the account he gave to WorkSafe investigators in a record of interview conducted on 23 March 2015.[15]

42. Third, and more persuasively, evidence was called on behalf of De Jong showing that no telephone call was made from Mr Winwood's work mobile phone at the time Luke Gorrie claimed the call had been made to De Jong (or indeed any number). This strongly suggests Luke Gorrie's account is not correct.

43. Fourth, after Luke Gorrie gave evidence about this issue Mr De Jong was called at short notice to be questioned about the allegations. He said no such telephone call was made to him and he gave no such instructions to not recall the crane. I had the advantage of seeing and hearing from Mr De Jong. I found his evidence on the point impressive. It was supported, as I have already said, by the telephone records. It is also significant that Mr De Jong was not challenged about his evidence, at all, by Luke Gorrie's lawyer in cross examination.

44. Fifth, I am satisfied that Luke Gorrie was not truthful because admitted to having lied in an affidavit sworn by him on 13 September 2017.[16] In that affidavit he told a deliberate and conscious lie about Jacob Brown's whereabouts at the time Kurt Gorrie fell from the roof. The lie was about a material fact. It was, as I have said, quite deliberate. Luke Gorrie admitted he lied, but only after Jacob Brown had made a second affidavit in which he told the truth about his whereabouts. In my view this demonstrates a propensity to telling untruths, at least in the context of this inquest.

45. Sixth, Luke Gorrie admitted at the inquest to having persuaded Mr Jacob Brown to lie in his affidavit as to his whereabouts at the time of the fall. In my

[15] Exhibit C14, Annexure B lines 325 – 334; 415 – 418.
[16] Exhibit C19.

view this also demonstrates a propensity on the part of Luke Gorrie to telling untruths, at least in the context of this inquest.

46. Finally, I had the advantage of seeing and hearing Luke Gorrie give his evidence. I recognise that is critical to keep in the forefront of one's mind when assessing evidence at an inquest that the proceedings are highly emotional and stressful. This is particularly so for a witness such as Luke Gorrie who have lost someone close to them (and in Luke Gorrie's case saw him die). Even allowing for all this his evidence was unimpressive and not at all persuasive.
47. For all these reasons I reject any suggestion that Luke Gorrie asked Mr Winwood to recall the crane and that his request was refused.
48. I am satisfied that having tied the ladder off Luke and Kurt Gorrie and Jacob Brown climbed onto the roof and moved the roofing iron to where they wished it to be positioned so that they could proceed with the job. When they did that Luke and Kurt Gorrie knew that the safety mesh was not in place. When they did that both Luke and Kurt Gorrie chose not to utilise safety harnesses which both knew were available.
49. I reject Luke Gorrie's argument advanced in evidence that safety harnesses are dangerous. The suggestion is nonsense, and unsupported by any evidence and completely inconsistent with all industry codes of practice. It also defies common sense. Plainly, if Kurt Gorrie had been wearing a safety harness he would not have fallen to his death. He fell because while unsecured he stood on a batten in area of the roof yet to be safety meshed (which he and his brother knew). The batten gave way and allowed him to fall the 6 or so metres onto the concrete slab below.
50. When Kurt Gorrie fell both Luke Gorrie and Jacob Brown were on the roof. Jacob Brown was not, as it said in his original affidavit, in the shipping container. He admitted he was on the roof and admitted having lied in his first affidavit.

The initial response

51. Several people saw Kurt Gorrie fall including Luke Gorrie and Jacob Brown, a school teacher from Victoria Mr Ben Wilkinson (who was picking people up from the airport). Mr Youd and Mr Beamish were working on the site and also witnessed the fall. Mr Youd, Mr Beamish and Mr Winwood all ran to Kurt

Gorrie's side. So did Mr Victor Cook and Mr Shane Day, both employees of the King Island Council. An ambulance was called and local volunteer ambulance officers were quickly on the scene. Effective first aid was performed during the short time between Kurt Gorrie's fall and the arrival of the ambulance.

52. Kurt Gorrie was rushed by ambulance to the King Island Hospital where he quickly succumbed to the massive injuries he had sustained. After formal identification his body was transported to the mortuary at the Royal Hobart Hospital where an autopsy was subsequently carried out.

Initial Investigation and Forensic Pathology Evidence

53. In the meantime Sergeant Stephen Shaw of King Island Police commenced an investigation into the circumstances surrounding Kurt Gorrie's death. He organised for the scene to be secured. He took photographs, seized exhibits (including the broken pine battens upon which Kurt Gorrie had stood and Kurt Gorrie's shoes). Sergeant Shaw commenced interviewing witnesses. The inquest benefited enormously from the manner in which Sergeant Shaw conducted the investigation at the scene. This is particularly so because neither Forensic Services Officers nor Criminal Investigation Branch detectives were available to assist him and no WorkSafe Tasmania investigators attended the site until two days later, on 10 December.

54. An autopsy on Kurt Gorrie's body was carried out by Dr Donald MacGillivray Ritchey, a very experienced forensic pathologist. Dr Ritchey expressed the opinion that the cause of Kurt Gorrie's death was multiple traumatic injuries sustained during the fall from height. He found that Kurt Gorrie had suffered severe traumatic injuries particularly involving his head. He found a large contusion of the posterior scalp overlain a stellate fracture of the occipital skull which appeared to him to represent the impact site. In other words Dr Ritchey's findings at autopsy suggest that Kurt Gorrie landed on his head (something consistent with the evidence from Mr Wilkinson and Mr Youd). Dr Ritchey found severe traumatic injuries of the bilateral cerebellar hemispheres and the ventral surfaces of the brain that suffered extensive bruising. Dr Ritchey said the head injuries would have rendered Mr Gorrie immediately unconscious (again something consistent with the observations of witnesses at the scene). Finally, Dr Ritchey said that the injuries were sufficiently severe to be fatal irrespective

of the remote location of the worksite on King Island. I accept Dr Ritchey's opinion as to the cause of death.

55. Samples taken at autopsy from Kurt Gorrie's body were subsequently analysed at the laboratory of Forensic Science Service Tasmania. No drugs of any type, legal or illicit, were found to have been present in those samples. No alcohol was found to be present in the samples. Nothing was found as the result of toxicological analysis which helped cast any light on the reason for Mr Kurt Gorrie's fatal fall.
56. The reason why Kurt Gorrie stepped onto a batten over an un-meshed area will never be known for certain but it is most likely inattention on his part.

Particular issues

57. Some of the issues identified for consideration at the inquest have already been addressed earlier in these findings. However for the sake of completeness it is appropriate to deal with them again.

Why that section of roof was not safety meshed when work was being performed by Kurt Gorrie and others on 8 December 2014?

58. I am satisfied, on the evidence, that when the first stint of roofing work was undertaken, there was insufficient safety mesh to enable the entire roof to be meshed.
59. It is clear that Mr Winwood knew that the entire roof had not been meshed. He described in his evidence of being involved in directing the crane to lift packs of iron onto the roof after (or at about the time) Luke and Kurt Gorrie had left King Island on 7 November.
60. I am satisfied that Mr Winwood knew that Luke and Kurt Gorrie would need to mesh the rest of the roof when they returned to complete the roofing on 8 December 2014.
61. As I have already said, the roofing work contract for the performance by Kurt and Luke Gorrie was a labour only job with De Jong supplying all materials required for the roofing as well as coordinating the materials with the labour.
62. It is apparent that the mesh would have prevented Kurt Gorrie from falling onto the slab had it been in place.
63. I am satisfied that the reason the roof had not been fully meshed before the packs of roofing iron were placed on the roof on 7 November 2014 was:

a. There was insufficient mesh available to mesh the entire roof before Kurt and Luke Gorrie left the island on 7 November 2014; and
b. One additional roll was ordered on 19 November 2014 and arrived on the island on 9 December 2014.

64. I find that De Jong had not arranged for sufficient mesh to be available during the week of 3 November 2014, when it was required.
65. I find that when Luke and Kurt returned on 8 December 2014, no instructions were issued by De Jong employees (Mr Winwood in particular) about how the roofing work was to continue. Instead, Kurt and Luke Gorrie, along with Jacob Brown began moving roofing iron around on the unmeshed section of roof.

When and why packs of roofing iron sheets were lifted onto the roof, apparently in an area that had not been meshed?

66. I am satisfied on the evidence that there were two occasions when the crane lifted roofing iron onto the roof. First on either 3 or 4 November, when this was organized by Mr Mitchell. And second on 7 November 2014, when it was arranged by Mr Winwood.
67. It seems clear from the evidence that convenience, cost and time saving were likely reasons for placing the roofing iron on the roof and on the unmeshed area in the region of Kurt Gorrie's fall.
68. That there was a logical practicality to putting the sheets up on 7 November is clear from Mr Winwood's evidence. It appears however that little consideration was given to how the rest of the mesh would be applied and no instructions were given by De Jong (particularly Mr Winwood) about how the sheets on the unmeshed area would be moved and where to, to permit the meshing to be completed.
69. I am satisfied that Luke Gorrie was not involved in directing where the stacks of sheet iron were placed on 7 December 2014. This is clear from the evidence of both Mr Winwood and Luke Gorrie.

Why the roofers, including Kurt Gorrie were permitted to be on the roof without harnesses in circumstances where the roof had not been fully meshed?

70. As has already been mentioned earlier in this finding Mr Winwood said in his evidence at the inquest that he was unaware of Kurt and Luke Gorrie or Jacob Brown going onto the roof before Kurt Gorrie fell. As I have already said, I do

not accept this was so, as Mr Youd and Mr Beamish who both gave evidence stated that they heard the roofers on the roof. Mr Youd was at ground level and in a similar area to Mr Winwood. He was passing eaves up to Mr Beamish and Mr Marshall who were on a scaffold in fairly close proximity to where Mr Winwood was working.

71. As I have already said even if Mr Winwood was unaware of the roofers on the roof before the fall, it was a failing on his part. Their safety (like everyone else on the site) was his responsibility. It was also his responsibility to know who was on site, who was working on site, and to supervise their work. It was his responsibility to ensure that those working on site carried out that work in accordance with the SWMS that governed the work they were to do.

72. Mr Winwood told investigators from WorkSafe in an interview conducted 2 days after Kurt Gorrie's death that he didn't think the Gorrie brothers would get on the roof until 'smoko' and that the fact they were on the roof, more or less straight away after their arrival on site surprised him.[17]

73. I note that although Luke and Kurt Gorrie were experienced roofers (and had a clear responsibility for their own safety, and that of each other and Jacob Brown), they had not been on site for a month and the physical condition of the site had changed. Mr Winwood knew this. He also knew, or ought to have known, some sheet iron would need to be moved. Even though he knew they had arrived at the work site, he had no discussion with either Luke or Kurt Gorrie (other than to get a hard copy of the roofing plan for Luke) at all, and certainly not about safety.

74. Mr Winwood told WorkSafe investigators he was unsure whether the Gorrie brothers had their own harnesses on 8 December 2014.[18] However he also said, in effect, that it did not matter whether they had their own harnesses as they would rely on using the De Jong safety harnesses. As I have already mentioned he knew that there were safety harnesses available for any work at heights.

75. While it is accepted that Mr Winwood did not have control over ensuring there was enough mesh to cover the entire roof, knowing that it had not been entirely meshed, he was reasonably required to address what method of work would be undertaken to complete the roofing once Luke and Kurt Gorrie returned to the site and how that method would be rendered reasonably safe.

---

[17] Exhibit C14, Annexure A, Line 263 -265.
[18] Exhibit C14, Annexure A, Line 386 -387.

Whose responsibility it was to prevent Kurt Gorrie and other roofers from working on the roof without harnesses?

76. Kurt and Luke Gorrie both had as much responsibility for their own safety as De Jong who were in effective control of the building site.
77. I am satisfied on the evidence that Kurt Gorrie did not pay adequate regard to his own safety, in failing to wear a harness, which was a requirement of the SWMS under which he was working, which would have been a requirement known to him due to his training and qualification and which given the absence of safety mesh common sense dictated was necessary.
78. I am also satisfied that Luke Gorrie did not pay adequate attention in regard to his own safety or that of his brother or Jacob Brown by either allowing work to be done on the roof without safety harnesses or failing to even raise the issue. I have already dealt earlier in this finding with his attempt to justify not wearing a harness on safety grounds.
79. De Jong equally had clear responsibilities under the *Work Health and Safety Act* 2012. The evidence permits comment that the responsibilities were likely breached.

Footwear or moisture to blame?

80. The evidence was that Kurt Gorrie was wearing Dunlop Volley sand shoes, unlaced, on the roof at the time of his fall. Those shoes were recovered by Sergeant Shaw as part of his investigation and tendered as exhibits at the inquest.[19] The evidence was that wearing of footwear of that type was (and is) extremely common amongst roof plumbers. This is because sand shoes provide better grip and were less likely to damage the roofing than conventional workplace safety boots. Even though the shoes Kurt Gorrie was wearing at the time of his fall were unlaced and strictly speaking were not safety footwear in any proper sense of the word I am quite satisfied that they played no role in his fall.
81. Equally there was no evidence whatsoever of any moisture or dew present on the roof which caused or contributed to Mr Kurt Gorrie's fall.

[19] Exhibit C25.

Comments and recommendations

82. The evidence given by all those who gave evidence about the Safe Work Methods Statements - Mr Winwood, Mr Mitchell, Mr Beamish, Luke Gorrie amongst others - demonstrated they are regarded as a piece of paper work or process to be completed, even a “box to be ticked”, but seemingly having no practical applicability to the task at hand. The SWMS tendered at the inquest were without exception of a generic nature.
83. The attitude that seemed to emerge from the evidence was that, by and large, personnel at this worksite seemed either not to understand the purpose and importance of SWMS or if they did were largely indifferent to them. The evidence of all witnesses was characterised by a distinct lack of clarity about what is to be done and by whom in a workplace to ensure compliance with the safe methods of work documented in them.
84. A stark example of this was the attitude that seemed to emerge from Mr Mitchell and Mr Winwood’s evidence that because contractors had their own SWMS then the responsibility to comply with them was entirely vested in the contract. Such an attitude ignores the overlay of duties recognized by the law under the *Work Health and Safety Act* 2012, or as it was put very eloquently by one witness, that everyone on a worksite has safety responsibilities.
85. I am satisfied on the evidence in this case that both De Jong and the Gorrie brothers’ SWMS relating to work at height all contemplated a need to use harnesses in work at heights. Tragically, no one took any steps, except for Mr Mitchell on one occasion, to ensure that that aspect of all relevant SWMS was complied with. At the risk of repetition had a harness been worn by Kurt Gorrie then he almost certainly would not have died.
86. In the same way the evidence at the inquest demonstrates that Kurt and Luke Gorrie and Jacob Brown all knew that the harnesses ought to have been worn on 8 December 2014 for the work to be done, but there was an apparent willingness to ignore the requirement and adopt behaviours that were plainly exposing themselves to serious injury from a fall from the roof.
87. Mr Winwood would appear to have omitted to turn his mind to what Kurt and Luke Gorrie and Jacob Brown were doing on the site for about half an hour. I am satisfied on the evidence, in particular his own, that he was either complacent about, or distracted from, ensuring they conducted the work they were to do safely. The evidence also demonstrates that De Jong processes

and safety documents, particularly SWMS were found to be deficient by WorkSafe and this was said to be the result of being unaware of the current health and safety requirements.

88. It is difficult to escape the conclusion that poor safety awareness and culture was a significant factor in Kurt Gorrie's death. It is acknowledged that in the aftermath of Kurt Gorrie's death and as a consequence of the WorkSafe investigation De Jong seems to have given attention to the various failings identified in respect to their compliance at the time with the then requirements of the *Work Health and Safety Act* 2012. Nonetheless, the fact that the various identified deficiencies were not all rectified until after Kurt Gorrie's death tends to suggest that rather than a proactive approach to safety De Jong's approach was reactive. I **comment** that De Jong needs to take steps to ensure that it fosters a proactive approach to safety amongst its workers and contractors on any sites for which it has responsibility.

89. I observe that no proceedings whatsoever were taken against De Jong with respect to any of the apparent deficiencies identified in respect of their safety practices identified in the WorkSafe report tendered at the inquest. Ms Taglieri SC submitted that this may serve to reinforce the undesirable behavioural elements and risk of dismissive culture towards proactively taking measures to reasonably identify, manage and hopefully reduce the risk of death in workplaces conducted by the company. I accept this submission. I **comment** that failures to prosecute apparent breaches without adequate explanation or justification is highly undesirable and may rob the workplace safety legislative regime in this State of its deterrent effect.

90. Finally, the evidence at the inquest made it clear that while some degree of training and instruction is given during various apprenticeships in the construction industry about precautions to be taken when working at heights, the evidence demonstrates a lack of clear understanding about:

    a) what is safe practice in particular given situations;
    b) how to apply generic instructions to particular situations; and
    c) how to ensure compliance with the content of SWMS, by all those involved in the particular at risk work, including how to address the behavioural influences that affect whether known at risk conduct is undertaken.

91. As this case so tragically demonstrates, failures to adhere to basic safety precautions means workers die. It seems unlikely that the attitude articulated

by several of the workers who gave evidence at the inquest toward safety is an isolated example. In my respectful view the matter needs to be addressed by the appropriate authorities. I therefore **recommend** that a review be undertaken in relation to the adequacy of training and instruction delivered within the construction industry apprenticeships schemes for SWMS, particularly for working at heights.

92. Finally Ms Taglieri SC submitted that there is merit in considering whether persons involved in work involving reasonable risk of death from falls from heights ought to be required to undertake regular "refresher training" regarding SWMS preparation, compliance and enforcement. This would be consistent with what is now a commonly accepted practice in a number of occupations that continuing education and training occur over time. I agree and consider it can be appropriately considered as part of the recommendation set out immediately above.

Formal findings

93. The evidence enables me to make the following formal findings pursuant to section 28 (1) of the *Coroners Act* 1995 this with respect to Kurt Gorrie's death:

    a) the identity of the deceased is Kurt Joshua Gorrie;
    b) Kurt Gorrie died in the circumstances set out earlier in this finding, namely as a consequence of injuries sustained in a fall from height whilst at work;
    c) the cause of Kurt Gorrie's death was multiple traumatic head injuries;
    d) Kurt Gorrie died at the King Island Hospital, Currie, King Island in Tasmania on 8 December 2014.

Conclusion

94. Kurt Gorrie's death was a completely avoidable, tragic accident. Had even the most simple and obvious safety precautions been taken then he would have returned home to his partner and young daughter at the end of his week on King Island.
95. I wish to extend my appreciation to Sergeant Stephen Shaw for the manner in which he conducted the difficult and challenging investigation and his assistance when the inquest heard evidence at Currie on King Island.

96. I extend my thanks to counsel who appeared at the inquest and in particular Ms Taglieri SC for her assistance.
97. The contribution of Constable Stephen Anderson, Launceston Coroner's office, to the smooth running of the inquest also should be acknowledged.
98. In conclusion I extend my condolences to the family, loved ones and friends of Kurt Joshua Gorrie on their loss.

Dated 3 August 2018 at Hobart in Tasmania

Simon Cooper
Coroner