



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



Record of Investigation into Death (With Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Simon Brown, Coroner, having investigated the death of Leigh Anthony Reaney with an inquest held in Launceston in Tasmania make the following findings:

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

- The identity of the deceased is Leigh Anthony Reaney;
 - Mr Reaney died as a result of the blunt trauma to the head he suffered in the fall the subject of these findings, that fall having occurred at the Devonport Homemaker Centre on 6 August 2012;
 - Mr Reaney died on 7 August 2012 at the Royal Hobart Hospital, Hobart;
 - Mr Reaney was born on 3 April 1992; he was aged 20 years at the time of his death, was single and was then employed by W & A Sherwood Enterprises Pty Ltd.
1. The deceased, Leigh Anthony Reaney, was born on 3 April 1992 and lived at 12 McRae at Prospect. As at the date of his death, 7 August 2012, he was employed by W & A Sherwood Enterprises Pty Ltd (“Sherwoods”) as a roofer. He had been employed by that organisation for a significant period and had obtained a number of qualifications in relation to his employment which were in evidence. Sherwoods is a company who was engaged in roofing contracting. It did work on commercial and residential jobs. It has been involved in work of that sort for many years. As at the date of the deceased’s death it was run by Mr Ashley Sherwood who is a director of that company, although on the evidence it was owned jointly by Mr Ashley Sherwood and his father who had formerly owned and run the business but who no longer played an active part in the day to day operations of the business.
 2. In mid-2012 Sherwoods signed a contract to be the roofing contractor for Fairbrother Pty Ltd (“Fairbrothers”) the principal contractor constructing the Devonport Homemaker Centre adjacent to the Bass Highway at Devonport.
 3. On 6 August 2012 Mr Reaney was working for Sherwoods at the site when he fell from a roof under construction and suffered injuries. He died a day later.

The Devonport Homemaker Centre Development

4. The Devonport Homemaker Centre is a “big box” type retail development outside Devonport’s central business district adjacent to the Bass Highway. The principal contractor for the construction of the centre was Fairbrother Pty Ltd (“Fairbrothers”). The development was built to house a number of separate retail tenancies.

5. The development is, essentially, a series of stores which was constructed as a single storey development of pre-fabricated concrete “tilt up” design. The deceased’s employer, Sherwoods, was awarded the contract by Fairbrothers to roof the buildings in the development.
6. The evidence before me was that Sherwoods placed a tender in order to win that contract with Fairbrothers after the principal contractor issued an invitation to do so at the end of May 2012. The bid was a “fixed price” one to do all the roofing for the development.
7. As part of the contract awarding process Sherwoods needed to supply what I would term “references” about the quality of their work and, amongst other things, their occupational health and safety record, systems and performance on other jobs. The evidence before me is that these were provided and Fairbrothers performed a “reference check” on Sherwoods based on those materials. The unchallenged evidence given to me was, essentially, that the referees provided gave Sherwoods a very favourable report generally and as to their OH&S performance. OH&S was very much the focus of the references and the reference check as far as Fairbrothers were concerned.
8. In any event Sherwoods were awarded the contract. What they were to do and the manner in which it was to be done are evidenced by a number of documents. Most importantly amongst those was the “Safe Work Method System” (SWMS) which they submitted to Fairbrothers on 23 July 2012.
9. That document set out, in considerable detail, the precise manner as to what Sherwoods were to do to the roofing work and how it was to be completed.
10. Essentially that document sets out the plan as to the method which Sherwoods agreed to adopt to roof the buildings which was broadly as follows:
 - a. The pre-cast concrete walls and RSJs (purlins) holding them together and forming the base on which the roof was to be affixed were put in place by other contractors.
 - b. The first task to be undertaken by Sherwood’s employees was for gutters and drains for downpipes (“sump” sections as part of the gutters for downpipes) were to be affixed along the inside of the concrete walls using a scissor lift and/or portable scaffold. These were themselves supported by brackets affixed along the walls. These formed a “box gutter” on the “inside” of the walls of the structure.
 - c. Once the gutters and sumps were put in place and riveted together then wire mesh was to be rolled out across the span of the roof from one side right across to the other, again either using a mobile scaffold and/or scissor lifts. This mesh would cover the entire roof area from gutter to gutter and was to be tied off along the gutter line using the above equipment on each side of the roof.
 - d. Once the gutters and drains and mesh were completed then the employer’s workers would then work from the roof area itself for the first time and affix sections of roofing iron (over a layer of insulation) “clip lock” style across the roof.

- e. By utilising this method workers had no need to be near or work at any “live edges” when working on any step of the roofing process, save in very limited areas where access was to be gained to the roof area through the mesh. In essence they would either be on a scissor lift, on a mobile scaffold or on the roof area, but guarded there from falling by wire mesh.
11. The above method was plainly a systematic, sensible, orderly and safe one. However, it was essentially abandoned as the job developed.

The mode of work actually used

12. As noted above the mode of work set out above was what the employer Sherwoods undertook to comply with in its contract with Fairbrothers. The SWMS was submitted by Fairbrothers on 23 July 2012, the first day Sherwoods started work at the Homemaker Centre. It was reviewed and accepted by Fairbrothers, in accordance with the agreement entered into between the parties, on that day. This document was considered and evaluated by Fairbrothers’ employee, Mr Warwick Jones, that day.
13. The evaluation of the SWMS involved:-
- a. Assessing whether the SWMS was current;
 - b. Whether it complied with the legislative requirements;
 - c. Assessing whether the risk involved in the work had been evaluated;
 - d. Fairbrothers, the principal contractor, had a pro-forma checklist in existence for this purpose.
14. The evaluation process for the SWMS also involved a second evaluation to be conducted during works, but at a time which was unspecified. I will return to that aspect of the matter later.
15. However, as it turned out, this second evaluation of the SWMS, and necessarily therefore the matter of Sherwoods compliance with it, did not occur prior to Mr Reaney’s death. The reasons why the SWMS was departed from was central to the conduct of the inquest. I note that those reasons – as suggested by Sherwoods – were also central to the mitigation it relied on when it pleaded guilty to charges brought against it in relation to Mr Reaney’s death.
16. On the evidence the SWMS was initially complied with on site. However, when work started in the area comprised of tenancies 5 and 6 (“T5-6”) of the development the SWMS was entirely abandoned. Mr Ashley Sherwood said in evidence during his first appearance before me (he appeared on two separate occasions) that the roofing iron sheets to be used in this part of the development were delivered early and ground conditions were bad – wet – so the sheeting was put down on the roof purlins in packs essentially, as I understand it, for want of a better and dry place to store them. The evidence from Fairbrothers’ employees was to the effect that this was raised with Sherwoods and Sherwoods simply acquiesced in this and raised no issue about that occurring – despite the fact that it rendered compliance with the SWMS impossible or at least difficult in most areas of the tenancy in question.
17. It was the evidence of Fairbrothers’ employees that if Sherwoods insisted that the packs be moved or placed elsewhere to start with they would have done so. The evidence is that they were at no time ever asked to do that. I accept that evidence.

For reasons I will return to, I do not accept Ashley Sherwood's evidence that the placing of the packs of roofing iron in bundles over the roofing area was something which was foisted on him unwillingly. I accept Mr Sweeney's for Fairbrothers submission that initially Mr Sherwood said he did not want the roof packs put on the purlins, but that when David Parker from Fairbrothers said he did not want to leave the packs sitting on the wet, muddy ground. I also accept that Mr Parker then asked Mr Sherwood if he would like delivery of the sheeting to be delayed. That suggestion, which would have rendered compliance with the SWMS readily achievable, Mr Sherwood said no and words to the effect that "she'll be right, we'll still get it and be ready for it."

18. Whilst Sherwoods' employees were plainly unhappy with this development, the fact of the matter was that the significant change to the work methods which this caused was simply worked around by them at the behest of Mr Sherwood.
19. Importantly this major change resulted in no planned or systematic approach being taken to do the job being done in a different way from that planned. Rather an entirely piecemeal approach was adopted - or more accurately simply developed - by way of a response. Mr Ashley Sherwood also said that the SWMS could not be complied with because the concrete floor slab inside the area of the T5-6 tenancy was "green" at the time of Mr Reaney's death, i.e., it had not "gone off" and could not weight bear things like mobile scaffolds and scissor lifts and this meant that up to the day of Mr Reaney's death they could not use those items of equipment to work at heights. Again, for reasons that I will return to, I simply do not accept that as being accurate.
20. In any event by the time roofing work on the T5-6 area commenced an entirely different method of doing the work, utterly different from the SWMS, had developed. The process which actually took place in this area was as follows:-
 1. A mobile scaffold was used to affix brackets along the outer walls of the development. These were installed before the floor slab was poured in T5-6. These were to hold up the gutters and sumps.
 2. Then mesh was laid out across the roof space along the purlins using the "endless rope" technique that I heard evidence about.
 3. Because of the placement of the packs of roofing iron sheets around the roof space this meshing was necessarily incomplete across spans of the roof leaving significant stretches of the roof span unwired and therefore leaving "live edges" (unprotected drops) across the roof's span in numerous places.
 4. With the mesh partially across parts of the roof only workers worked on the gutter boards themselves using them as a working platform to complete the fitting off of the gutters and sumps and also to tie off mesh. They accessed the gutters via a ladder which was placed in the many gaps in the wire mesh. Harnesses were worn by workers in the process of doing so. I have some doubts as to whether that was a universal practice. These were attached at foot level (or gutter board level) along the line of roof purlins wherever a person was working. Of course, had the SWMS been complied with there would have been no need to use harnesses and workers would have worked from the safety of mobile scaffolds or scissor lifts at all times prior to fixing the roofing sheets

themselves, which work would have been done from the roof area but with wire mesh acting as an effective safety net for workers.

21. The non-compliance with the SWMS that Sherwoods themselves had authored and which Fairbrothers had approved therefore resulted in a far less safe and more complex method of working on the development. Had the SWMS been complied with the Sherwoods' workers on site would essentially never have been exposed to live edges. Nor would they have ever had to work on and from the gutter boards.
22. As it turned out, of course, the Sherwoods' workers including Mr Reaney were forced to work from the gutter boards and sumps and at numerous live edges left along the gutter boards by virtue of the gaps in the wire meshing stretched across the roof.
23. This method adopted by Sherwood's at T5-6 was observed by a Fairbrothers employee, a Mr Phillip Riley. His evidence was that on Friday 3 August 2012 he saw Sherwoods' employees working on the gutter boards in question with safety harnesses on and affixed to the roof purlins at their feet. Unsurprisingly he was unhappy with that. He saw this when taking a regular tour around the site as Fairbrothers' QSE Coordinator for the site.
24. Mr Riley's job involved inspections and conducting audits of work processes on the site. Mr Riley suggested that a different method of tying off should be adopted. Clearly on his evidence Mr Riley was concerned that tying off at foot level was less than optimal – ground (i.e. earth or slab) level below only being some five metres beneath the workers. Mr Riley felt that affixing the harnesses over the shoulder at a higher point was desirable. Bearing in mind the method of work that had developed Mr Riley's advice was doubtlessly good. His inspection resulted in a brief discussion whereby it was agreed that rather than affixing harnesses to the purlins at foot level the harnesses would be affixed over the shoulder (effectively from above) by the method of tying them off over the parapet wall behind the workers and down the outer side of the external walls to some I-beams or "canopy" steel work along the exterior wall of the premises.
25. On the evidence Mr Riley reported that conversation to another Fairbrothers employee – a Mr Brett Coombes who is the site manager and foreman for Fairbrothers. Both Mr Coombes and Mr Riley gave evidence that they had no knowledge of Sherwoods' SWMS but accepted that the work that they were doing was high risk in terms of this development. At that point the SWMS was plainly not being complied with and there was no system in place whereby the Fairbrothers' employees inspecting and in charge of the site were made aware of that non-compliance. Of course in accordance with its SWMS the primary responsibility to advise Fairbrothers of this non-compliance was on Sherwoods. They at no stage did so. This was a significant lapse by them. Had they done so there was, at the very least, a prospect that a more coherent and safe work method could have been developed.
26. Whilst Mr Riley's suggested changes to the method of tying off represented an improvement on the method in place, it was frankly an unwieldy one. It required workers to unhook and re-attach harnesses as they moved along the gutter boards. The process of doing so was necessarily complicated by virtue of where it was that the harnesses were to be tied off, i.e., on the far side the parapet wall and down the other side. This method plainly did not lend itself to persons being able to make their way along the gutter boards safely without laboriously going through the motions of detaching their tie off lines and re-tying off their harnesses lines on numerous occasions.

27. Following Mr Reaney's death charges were brought against both Fairbrothers and Sherwoods. The charges against Fairbrothers were not proceeded with. Eventually Sherwoods pleaded guilty to the charges. The essence of the complaint against Sherwoods (and one they pleaded guilty to) was that they were negligent in not establishing a static line along the inside of the parapet wall behind on the gutters which would have allowed workers such as Mr Reaney to more easily detach and reattach their harnesses lines from a static line just behind them so that they could more easily and conveniently work along the gutter boards and sumps while still safely harnessed and attached to a safety line.
28. Whilst that method of securing the harnesses would have been a significant improvement over the method which was adopted at Mr Riley's behest, it is plain that even that would not have been necessary had the SWMS been complied with. The simple expedient of moving the craned up roof packs out of the way would have allowed that to occur. However, Mr Ashley Sherwood never asked for that to occur and, on the evidence, all the employees at Sherwoods simply accepted (albeit it seems quite unhappily in the case of at least some of them) that the situation had changed and that they would just have to work around it.

The events surrounding Mr Reaney's fall on 6 August 2012

29. On 6 August 2012 the deceased continued to work on the installation of the guttering and sumps along the parapet wall at T5-6. Two other Sherwood's workers were present and assisting him – Mr Wilson and Mr Smith. Mr Smith worked from a scissor lift and the deceased and Mr Wilson worked from the gutter boards. They accessed them via a ladder. Obviously pursuant to the system described they should have been wearing harnesses secured "over the shoulder" in accordance with the system discussed above. Up until lunch their work involved fixing off the wire mesh where it was in place across the roof.
30. Just before lunch Mr Ashley Sherwood told the group that after lunch they should work fitting off the sumps and gutters. Mr Smith alone was to continue fixing off the wire mesh. After lunch the evidence is that at about 1.30 Mr Reaney and Mr Wilson put their harnesses on. Using the scissor lift driven by Mr Smith he took them to start work on the gutter boards. Mr Smith himself returned to fixing mesh and was working about half way across the roof span at about the apex of the roof line at the relevant time. It was Mr Wilson's evidence that the fitting off of sumps and gutters started at the western end of the T5-T6 tenancy and that affixing of the roofing sheets themselves was to start at that end of the tenancy.
31. The evidence before the inquest supports a finding that Mr Reaney, once up on the gutter boards, went to fetch his power drill to use in this fitting off work. The evidence supports a finding that the drill had been left on the gutter boards before lunch, but at the eastern end. The deceased, although wearing a harness, plainly did not connect it at any point on the far side of the parapet wall as had been agreed between his employer and Mr Riley.
32. As he made his way along the gutter boards, harnessed but not tied off, he fell through the gutter boards. He probably fell through a sump which had not been fitted off. This sump was later found on the ground near Mr Reaney. He fell about 4.7 metres to the slab below. He suffered severe injuries as a result of his fall. Assistance was offered by his distressed workmates and an ambulance was called. The deceased was eventually taken to the Mersey Hospital and was then transferred to the ICU at the

Royal Hobart Hospital. He was pronounced dead the following day as a result of his injuries.

Discussion and findings

a) Harness connection, lack of a static line etc.

33. Several issues fall for comment arising out of the evidence I heard on the inquest which are relevant to my findings. Firstly, I turn to the issue of the system of connecting harnesses used for those working on the gutter boards. The system discussed between Mr Ashley Sherwood for the employer and Mr Riley for Fairbrothers was plainly a better system than the one it replaced i.e. tying off at foot level. However, it was also I find sub-optimal. It was cumbersome in the sense that connecting up to it – especially if one was required to move along any length of the gutter boards (i.e., to fetch a tool or similar) rather than if one were working for a sustained period in a single area. Experience suggests strongly that such a system led to the obvious temptation to detach ones harness and not go through the business of reattaching over the parapet wall behind if one needed to move along the gutter boards. On the evidence Mr Reaney did exactly that.
34. Clearly a static line on the inside of the parapet wall and immediately behind the backs of the workers would have meant that the process of tying on and off would have been quick and easy and would have been able to be done by each worker alone and without assistance from the gutter boards. The failure to provide such a system against the back drop of the system of work which had developed on the gutter boards was a very significant one. In this regard I refer to Windeyer J in *Sungravure Pty Ltd v Meani* [1963-64] 110 CLR 24 at 37:-
- “When a worker in a factory is alleged to have been wanting in care for his own safety the jury may have regard to such things as inattention bred of familiarity and repetition, the urgency of the task, the man’s pre-occupation with matters at hand and other prevailing conditions. They may consider whether any of these things cause some temporary inadvertence to danger, some lapse of attention, some taking of a risk or other departure from the highest degree of circumspection, excusable in the circumstances because it is not incompatible with the conduct of a prudent and reasonable man”.
35. It is plain that, while Mr Reaney was wearing his harness at the relevant time, he did not attach its safety line. The system which was in place lent itself to exactly that type of failure. As Windeyer J said above Sherwood’s, like all prudent employers, should have been mindful of the risk – even the likelihood – of such a lapse when they directed how their employees were to do their jobs. They failed to do so.
36. In all this it should not be forgotten that the primary responsibility for the deceased’s safety on the site rested with his employer effectively in this case Mr Ashley Sherwood. He directed that the tying off harness system which was in place be used on the job. The evidence before me is that Sherwoods had no static line available to use on the job in any event. It was pointed out that the affixing of such a line was not without its difficulties. While that may be the case the affixing of the harnesses over the parapet wall was also not without its difficulties and was itself a system which was unwieldy and liable to non-compliance.

37. Once the system tying off safety harness lines which Mr Sherwood agreed to was adopted it was never reviewed. The cumbersome nature of the system simply begged for it to be reassessed. However, that was not done.

b) Mr Reaney's lapse

38. Secondly, it must be accepted that the deceased himself clearly played a role in the fall. He moved along the gutter boards without his harness safety line affixed. Had his harness been affixed his fall would have been arrested. In so finding I accept that his failure to do so was explicable, some might say even predictable, in all the circumstances. As noted above, the words of Windeyer J come readily to mind in that regard.

c) The sumps and gutter boards as a work platform

39. Thirdly, I turn to the matter of the sumps themselves. The sump through which Mr Reaney most likely fell had not yet been affixed albeit that they were put in place ready to be fixed off. The evidence does not allow me to say with certainty how the deceased came to fall through the sump. However on the balance of probabilities, the deceased simply trod on one of those as he made his way along the gutter board to retrieve his drill. It is also, of course, possible that he may have somehow stumbled and placed his foot on the sump in question accidentally rather than intentionally. In any event the unsecured sump represented a plain danger. In all this it must be remembered that the sumps and gutters had become a work platform. No system of covering or somehow marking or fencing off unfixed sumps was in place. The failure to cover off unfixed sumps (or indeed unfixed off gutterboards) with something as simple as a sheet of plywood for example was a significant lapse. No system or training was in place to address this issue. This was another failure by the employer.

d) Non-compliance with the SWMS and legislative changes since 5.8.2012

40. Finally there is, of course, the failure of the employer to comply with the SWMS which it had authored and which had approved by Fairbrothers. The failure to comply with the SWMS was central to the inquest and, at base, central to the deceased's death. There are a number of aspects to that failure.
41. Firstly in this regard I repeat my observations above as to Mr Sherwood's rejection of the offer to delay delivery of the roofing iron sheet packs and his assertion that "they will be ready for it". Plainly not accepting that offer was a significant failure by Sherwoods. Had it been accepted the work at T5-6 could and should have been done in accordance with the SWMS and Mr Reaney would not have had to use the gutterboards as a work platform. Further no effort seems to have been made, at the T5-6 site at least, to "be ready" in accordance with the SWMS – i.e. have the gutters, sumps and mesh in situ - before the roof packs were put in place.
42. Secondly, I also repeat my observation concerning the wholly inadequate appraisal of the system of work undertaken by the employer once the roof packs were placed in bundles across the roof space. Not only did Mr Ashley Sherwood simply acquiesce in the new situation, not only did he not "get ready" for the delivery of the sheeting onto the roof in any effective way but he and his workers worked around its delivery in an entirely piecemeal, unsystematic and reactive way.
43. Thirdly in this regard Mr Ashley Sherwood suggested in his evidence before me on the first occasion that the untimely pouring of the slab inside tenancies 5 and 6 meant that

workers could not work from scissor lifts or mobile scaffolds as work platforms rather than the gutter boards because the slab was too “green” to bear the weight of those devices. This assertion, along with the suggestion that the craning up of the roof packs being foisted unwillingly on Sherwoods, had been relied upon by them in mitigation when they pleaded guilty to charges under the *Workplace Health and Safety Act 1995* relating to the deceased in August 2014. That assertion was wrong. When recalled to give further evidence after it became plain that this assertion was incorrect Mr Sherwood conceded under skilful questioning by counsel assisting that by 6 August 2012 the slab was not in fact “green” at all and that machines were available and could have been used to work on the gutter boards on the day in question.

44. There is a fourth aspect to the non-compliance with the SWMS which is relevant to my finding. Working at height doing roofing work is plainly a high risk activity. In the circumstances of this case and because of the nature of the work a new SWMS should have been submitted by Sherwoods and assessed by Fairbrothers before this high risk work was undertaken pursuant to an entirely different system, or what perhaps should be described as what passed for a system. The change from the SWMS submitted was not formally made known to any of Fairbrothers’ employees, certainly not those to whom it was given and evaluated by. Mr Riley – who saw the original method of tying off – was unhappy with that. He was unfamiliar with the SWMS and did not have recourse to it after making his recommendation. Likewise Mr Coombes – the person to whom Mr Riley reported – did not have recourse to the SWMS. For that reason nobody at Fairbrothers became aware that the approved SWMS had been affectively abandoned by Sherwoods. So there was a failure by Sherwoods to not only comply with the SWMS, but also to advise Fairbrothers it had been abandoned and also to effectively develop a new one. Further, there was no system in place whereby Fairbrothers reviewed compliance with the SWMS before the accident. I accept that not all of Fairbrothers’ employees on site could not have intimate knowledge of the SWMS so as to have suspected or realised that Sherwoods were not doing their work as had been agreed. I also accept that primary responsibility for advising Fairbrothers of those changes lay with Sherwoods. I also accept that Fairbrothers had, effectively “got the experts in” to do this high risk work and most if not all of their workers were entitled to rely on that expertise. However, they were plainly a number of opportunities for Fairbrothers to review the actual situation on the job in the light of the SWMS as approved prior to the accident. Roofing is high risk work. No review was done. It seems no one averted to the desirability of doing so. As Mr Nicholson submitted, had the Part B evaluation of the SWMS been conducted earlier then Sherwood’s lapses may well have been apparent and the unsatisfactory situation on site reconsidered. It would not have been unreasonable to undertake the Part B evaluation earlier in the work schedule rather than later bearing in mind the nature of Sherwoods role on site.
45. Fifthly, I accept Mr Nicholson’s submission that the SWMS submitted was basic and, it seems, somewhat generic in nature. Its provenance was uncertain.
46. As to this issue under the *Work Health and Safety Act 2012* (which replaced the 1995 Act in force as at Mr Reaney’s death) and the regulations made thereunder (see Regulations 299-303 especially) the obligations of those employing workers in high risk construction work to author far more detailed SWMS, review and record same has been enshrined in legislative form. Under the legislative regime now in place, non-compliance with Sherwoods SWMS would now itself be an offence, absent any accident or injury. Further, their failure to formally review it before work continued would similarly attract a sanction (see Reg 300(2)).

47. The existence of this new regime is an important advance in industrial safety, health and welfare in this state. It is to be hoped that this change has been widely disseminated and that it is known to principal contractors, subcontractors and their employees alike. SWMS in these high risk areas must not be seen as a simple “pro forma” step that, once completed, can be largely forgotten. Rather industry at all levels must recognize these documents as central to safe work practices being followed.

In Closing:

48. I express my condolences to the family of Mr Reaney. Their conduct at the inquest was dignified, patient and respectful throughout what must have been a very difficult process for them. I regret that other duties have delayed the publishing of these findings. I thank counsel assisting in particular for his thorough and fair conduct of the inquest and for his considered submissions and approach to the matter generally. I also thank counsel for Fairbrothers and for the Reaney family. The manner in which they assisted in the economical and sensible conduct of the inquest was much appreciated.

Dated: 13 February 2018 at Launceston in the State of Tasmania.

**SIMON BROWN
CORONER**