
FINDINGS and **COMMENTS** of Coroner Robert Webster following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Joshua John Dingjan

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Robert Webster, Coroner, having investigated the death of Joshua John Dingjan (Mr Dingjan), with an inquest held at Launceston in Tasmania, make the following findings.

Hearing Date

A case management conference (CMC) was held, pursuant to Rule 22 of the *Coroners Rules* 2006 on 4 May 2022 at which the issues that would arise at the inquest were identified. The matter was then adjourned for inquest which took place in Launceston from 5 to 8 September 2022 inclusive. Each party then made oral submissions, in addition to their previously filed written submissions, in Hobart on 30 May 2023.

Counsel

Ms Verity Dawkins and Ms Elizaveta Belonogoff appeared as Counsel Assisting the Coroner.

Mr Robert Taylor and Mr Colin Almond appeared for Mr Ralph Norton and Mr Darren Randall.

Mr Tony Dingjan, as senior next of kin and father of Mr Dingjan, appeared on behalf of himself and his family.

Notice of This Hearing

Notice in writing of the CMC was provided to Roadside Products Pty Ltd (RP) by letter of 20 April 2022. That company employed Mr Dingjan at the time of his death. A response, dated 2 May 2022, was received from the legal counsel and company secretary of Delnorth Pty Ltd (Delnorth) which indicated RP had, from 28 April 2017 been owned by Delnorth. That company was acquired by Jaybro Group Pty Ltd (Jaybro) on 31 July 2021. The letter advised neither Delnorth or Jaybro have any independent knowledge of the events leading to the death of Mr Dingjan beyond that which was provided to Delnorth by the former directors and shareholders of RP, who Delnorth understands are available to give evidence. In addition, Delnorth ended all standalone operations of RP including those at the site where Mr Dingjan passed away by October 2018. Neither Delnorth nor RP has any operations remaining in Tasmania. As a result, my office was advised Delnorth and RP have no wish to

be heard at the inquest. Accordingly, Delnorth and RP did not appear and nor were they represented by counsel at the CMC or the inquest.

Notice in writing of the CMC was provided to Mr Tony Dingjan as senior next of kin and father of Mr Dingjan and he appeared at both the CMC and the inquest.

Notice in writing of the CMC dated 20 April 2022 was provided to SeaRoad however nobody appeared on behalf of that company at the CMC. Subsequently my office received an email from Mr Phil Jones the General Manager Safety and People of SeaRoad Holdings Pty Ltd who asked that he continue to be provided with any further information about this inquest. Accordingly, he was given notice of the inquest but again nobody appeared on behalf of SeaRoad at that time.

Notice in writing of the CMC was provided to Mr Almond of HWL Ebsworth Lawyers. Mr Almond acted for Mr Ralph Norton (Mr Norton) and Mr Darren Randall (Mr Randall) in this matter. Mr Norton and Mr Randall are former directors of RP. Mr Almond appeared at the CMC and Mr Taylor and Mr Almond appeared for Mr Norton and Mr Randall at the inquest.

Preliminary matters

Introduction

1. Joshua John Dingjan died on 7 November 2013, aged 24 years, at 45-49 St Leonards Road, St Leonards in Tasmania.

2. Mr Dingjan's death is subject to the *Coroners Act* 1995 (the Act). In this State a coroner has jurisdiction to investigate any 'reportable death'.[1] A 'reportable death' includes a death where the death occurred in Tasmania, and it was unexpected, unnatural or violent.[2] Mr Dingjan's death meets that definition. Because this death occurred while Mr Dingjan was at work s24(1)(f) of the Act provides an inquest is mandatory unless the senior next of kin, pursuant to s26A, requests I not hold an inquest. In this case in conversations between staff of my office and Mr Tony Dingjan it was clear he wanted an inquest to be held.

[1] See section 21 of the *Coroners* Act 1995.
[2] See section 3 of the *Coroners Act* 1995.

3. At approximately 3:45pm on 7 November 2013 Mr Michael Jones, who was employed by Sea Road Logistics Pty Ltd (SeaRoad), drove his employer's delivery truck north along St Leonards Road and up the incline of the driveway at RP which was situated at 45 – 49 St Leonards Road, St Leonards. His job was to deliver 2 packs of steel sheets, weighing approximately 1.9 tonnes each, to RP. The 2 packs of steel had been placed over the rear axle of the flat bed light rigid truck Mr Jones was driving by SeaRoad staff, after being delivered to SeaRoad's Youngtown depot from Melbourne. RP were to supply a forklift truck and operator in order to unload the packs of steel. RP's factory was situated parallel to the roadway on a rise approximately 2.5 m above St Leonards Road. RP's premises had 2 access points both from the roadway with one from the northern end and the other, which is the steepest, situated at the southern end of the site. The southern access was made of concrete and commences at street level for a distance of approximately 25 m up to the doorway of the factory. The access from the northern end was a lot longer, sealed in asphalt, and it is not as steep as the southern access.

4. RP had finished production for the day and there was only Mr Diprose, Mr Jacobson, Mr Sharp, Mr Randall and Mr Dingjan left working inside. Mr Jones found Mr Dingjan and arranged for him to unload the packs of steel. As Mr Dingjan was unloading the initial pack of steel from the truck, the load shifted on the forks of the forklift truck as he began to swing the load down the slope causing the forklift to overturn. Mr Dingjan was fatally injured when he received crush injuries to his neck and chest as the forklift truck impacted with the ground.

5. On the basis of the evidence tendered at the inquest I make the following formal findings pursuant to section 28(1) of the Act:

   (a) The identity of the deceased is Joshua John Dingjan;

   (b) Mr Dingjan died as a result of the load on the forklift he was operating shifting, causing it to topple onto its right side thereby causing fatal injuries.

   (c) The cause of Mr Dingjan's death was blunt trauma to the head, neck and chest sustained when the forklift toppled onto its right-hand side in the circumstances described in (b); and,

   (d) Mr Dingjan died on 7 November 2013 at the premises of RP situated at 45 – 49 St Leonards Road, St Leonards in Tasmania.

A Coroner's jurisdiction and functions

6. In Tasmania, a coroner's functions are set out in section 28(1) of the Act. By this section, a coroner is required to find the identity of the deceased, how death occurred, the cause of death and when and where death occurred. By section 28(2), a coroner may make comment on any matter connected with the death; and by section 28(3), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter the coroner considers appropriate.

7. Coroners complete their written findings pursuant to section 28(1) of the Act in respect of a reportable death after receiving documentary evidence in the investigation. In a small proportion of reportable deaths, the coroner will hold a public inquest, which almost always involves the calling of oral testimony to further assist the coroner in investigating the death and in making findings. Many of the public inquests held by coroners in Tasmania are made mandatory by the Act.[3] The remaining inquests are held because the coroner considers that a public inquest is desirable in the particular circumstances of the investigation[4].

8. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial; whereas in criminal or civil proceedings the proceedings are adversarial; that is one party against another. In these proceedings I am required to thoroughly investigate the death and answer the questions (if possible) that s28 of the Act asks. Those questions in s28(1) include who the deceased was, how he died (that is the circumstances surrounding Mr Dingjan's death), what was the cause of his 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. A coroner is required to make findings of fact from which others may draw conclusions.

9. A coroner does not have the power to charge anyone with a crime or an offence. In this case I have no power to charge anyone with any breach of the *Work Health and Safety Act* 2012 arising out of the death the subject of the investigation. I note charges have previously been filed against RP and subsequently not proceeded with so to be clear there will not be any further charges laid arising out of the inquest process. Nor

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[3] S24(1) of the Act.
[4] S24(2) of the Act.

is it my role to review what the Director of Public Prosecutions did or did not do or how the charges which were laid were dealt with by the Court. A coroner also does not have power to determine issues associated with an inheritance or other matters arising from the administration of deceased estates.

10. As noted, one matter that the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. 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.

11. A coroner may comment on any matter connected with the death into which he or she is enquiring. The power to make comment *"arises as a consequence of the [coroner's] obligation to make findings ... It is not free ranging. It must be comment "on any matter connected with the death" ... It arises as a consequence of the exercise of the coroner's prime function, that is, to make "findings".*[5]

12. The standard of proof applicable to a coronial investigation 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 investigation reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.[6]

Issues at this inquest

13. The scope of this inquest was settled at the CMC as follows:

    1. The circumstances of Joshua Dingjan's death including:

        a. His job at his employer.

        b. What he was doing on the day of his accident.

        c. How he was using the forklift to unload the truck on the day of his accident.

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[5] See *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[6] (1938) 60 CLR 336 per Latham CJ at 347 and Dixon J at 362 and 368-9.

d. The location where the unloading was taking place.

2. What caused the forklift to rollover, including whether there were any mechanical issues.

3. Any training, instruction and supervision given to employees of RP, including Mr Dingjan, in order to safely operate forklifts as part of their work, and in particular policies and procedures about the use of forklifts to load and unload materials such as those being unloaded on the day of the accident.

4. An assessment of adherence to safe work practices, particularly as they related to loading and unloading of materials by forklift, at the workplace.

Evidence in the Investigation

14. The documentary evidence at this inquest comprised exhibits C1 to C40. The exhibit list is annexed to this finding.

15. Mr Michael Jones, Mr Bruce Webb, Constable Joshua Hayes, Mr Allan Baker, Mr Kris Sturmer, Mr Lee Tennick, Mr Brendan Sharp, Mr Gerald Fraser, Mr Nicholas Jacobson, Mr Mark Diprose, Mr John Sindorff, Mr Darran Randall and Mr Ralph Norton provided oral testimony at the inquest.

Background

16. Joshua Dingjan was born on 3 January 1989 in Launceston to Tony Dingjan and Susan Dingjan. Mrs Dingjan passed away from an auto-immune illness in 2010. He had one sister, Keisha, and a brother, Rhys. Mr Dingjan was raised with his siblings in Swansea and went to Swansea Primary School. The family left Swansea in late 1995/early 1996 and moved to St Leonards after which Mr Dingjan attended St Leonards Primary School and Queechy High School. He was a keen participant in basketball and roller hockey, and he played junior football while in primary school.

17. Mr Dingjan left school at the end of year 10 in 2005 and then he completed a prevocational training course in automotive studies. Thereafter he obtained employment and he then moved out of home with four friends. He returned to live at home in 2009 and after his mother's passing, he moved to Queensland where he resided for 3 years. On his return to Tasmania, he resided with his family who had moved to Karoola while he had been in Queensland.

18. At the time of his death Mr Dingjan was employed as a blow moulder operator by RP which was located at 45-49 St Leonards Road, St Leonards. That company was registered as a propriety company with three directors namely Ralph Norton, Darren Randall and Roger Trethewie. The St Leonards Road address has a north-south aspect and RP's factory was situated parallel to the road.

19. Each issue identified in the scope will be considered in turn.

The circumstances of Mr Dingjan's Death

a. His job at his employer

20. Mr Dingjan commenced work at RP's warehouse in Queensland in 2010.[7] He was initially employed as a casual assembly line labourer, however subsequently his employment was converted from casual to full time employment, and his position morphed into being an all-rounder and a back-up supervisor.[8] He was required to operate a forklift which is classified as high-risk work that requires a licence. RP funded Mr Dingjan's training which enabled him to obtain his forklift licence and a Certificate III in Warehousing and Logistics whilst he was in Queensland.[9] While the Certificate III in Warehousing and Logistics covered a range of matters relevant to warehouse operations, picking and packing it also included the safe operation of forklifts.[10]

21. Mr Dingjan's forklift licence was first issued on 19 November 2010 and was due to expire on 19 November 2015. He was granted that licence in Queensland, and it was valid in Tasmania, as licensing arrangements in all Australian jurisdictions are consistent with the relevant National Standard.[11] The training Mr Dingjan undertook in Queensland was equivalent to the training he would have to undergo in Tasmania to obtain the same licence, and the same unit of competency and assessment instrument would have been applied.[12]

22. Mr Sindorff was the production supervisor of RP at its factory at St Leonards and was Mr Dingjan's direct supervisor, when he moved to Tasmania from Queensland.[13] Mr

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[7] Exhibit C12 – Affidavit of Mr Randall.
[8] Exhibit C12 – Affidavit of Mr Randall.
[9] Exhibit C12 – Affidavit of Mr Randall.
[10] Exhibit C12 – Affidavit of Mr Randall.
[11] Exhibit C40 – Affidavit of Mr Parker.
[12] Exhibit C40 – Affidavit of Mr Parker.
[13] Transcript (T) page 221 [line 8].

Sindorff indicated he was aware Mr Dingjan was an employee of RP when he, that is Mr Sindorff, was in Queensland and he had seen Mr Dingjan at work in Queensland on about four occasions. He saw Mr Dingjan unloading trucks with a forklift at the national distribution centre, which is on level ground.[14]

23. Mr Randall, the Production Manager at RP, said he had seen Mr Dingjan working at RP in Brisbane a day or two a year and thought he was a good worker.[15] He could not remember seeing Mr Dingjan using a forklift in Queensland.[16]

24. Mr Dingjan commenced work at RP at St Leonards in Tasmania in late February or early March 2013.[17] Mr Randall offered him the position after he had tendered his resignation in Queensland.[18] Mr Dingjan was employed in Launceston to operate the blow moulder.

25. Mr Sturmer was also employed to use the blow moulder at RP. He gave evidence at the inquest the blow moulder is a machine that makes plastic products, including guideposts, and it melts plastic and forms it into a shape. He said the plastic goes through the machine, melts, is extruded at 90 degrees and the blow pin blows it into the shape required.[19] Mr Sturmer advised the machine is 4 metres high, 6 metres long and three metres wide, and the operator climbs up a ladder in order to access the top of it. He noted when it is running the operator stands in a safe zone, but when the cycle is finished, the operator uses grippers to retrieve the plastic, put it on the stand, fold it up, cut it into shape, trim it and stack it. [20] He said the machine would run continuously for 12 hours straight and each operator would relieve each other for lunch and a break, although the machine gets turned off on a break.[21] One cycle starts when the plastic injects to the mould and finishes when the product is grabbed, and then the machine will start another cycle automatically. He stated it runs all day by itself, but the operator can control the speed of the cycles.[22]

26. Mr Sturmer said he would either work from 5 a.m. to 3p.m. or 11 a.m. to 9p.m. and he may do some extra hours, with the other qualified person (Mr Dingjan) on the other

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[14] T224 [15] – [20].
[15] T290 [10].
[16] T315 [29].
[17] Exhibit C12 – Affidavit of Mr Randall.
[18] Exhibit C12- Affidavit of Mr Randall.
[19] T168 [1]-[5].
[20] T168 [29].
[21] T168 [41].
[22] T169 [24].

shift.[23] He noted that he and Mr Dingjan learned to use the machine together. Mr Sturmer indicated the blow moulder was near the centre roller door by the northern end of the factory, 10 metres from the back wall[24].

27. Mr Dingjan was described by his colleagues in Launceston, as *'a hard worker'* with a *'great work ethic'*,[25] and a *'good operator'*.[26] He was considered a safe worker.[27]

28. The documentary evidence indicates Mr Dingjan performed a significant amount of overtime in the weeks before his death due to the factory being behind in its schedule.[28] The records show Mr Dingjan completed 63 hours overtime in the 5 weeks prior to his death. The evidence indicates he was willing to work overtime as he was saving money.

29. There was evidence about his forklift use from his colleagues that he was a *'confident operator'*,[29] *'used a forklift every day'*[30], *'competent'*[31], operated it *'pretty well'*[32], was *'quite good'*[33] and 'he knew what *he was doing'*.[34]

30. Mr Sindorff said he observed Mr Dingjan use a forklift to unload trucks: "*I had on one occasion. I actually walked beside him because they were one-tonne pallets of plastic that had to go onto shelving. I walked beside the forklift to make sure that he was you know competent, even though I knew that he'd done a course, a warehousing course in Queensland, which included more forklifting, um but just to check – I like to check that you know that he was good*" and he was "*very competent*".[35] He said Mr Dingjan would be competent to unload trucks using a forklift.[36]. Mr Sindorff asked him to unload or load up onto some structures some one tonne pallets of plastic that he thought would be a bit of a test, and *'he did that with flying colours'*.[37]

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[23] T169 [35].
[24] T171 [1]-[6].
[25] Mr Sturmer T170 [25].
[26] Mr Randall T316 [31].
[27] Mr Sturmer T170 [34].
[28] Exhibit C21 – Affidavit of Mr Sindorff.
[29] Mr Tennick T134 [16].
[30] Mr Tennick T134 [12].
[31] Mr Sturmer T172 [18].
[32] Mr Sharp T179 [39].
[33] Mr Fraser T195 [4].
[34] Mr Diprose T269 [2].
[35] T227 [32]-[40].
[36] T228 [20].
[37] T251 [43].

31. The evidence indicates Mr Dingjan was a licensed forklift operator and was experienced in using a forklift on a level surface in Queensland. He also operated a forklift at RP's premises at St Leonards including its sloping driveway. The evidence establishes Mr Dingjan was supervised in some tasks and considered competent by his colleagues.

Requirement to use a forklift

32. As indicated above, Mr Dingjan was employed to use the blow moulder. Mr Randall noted that it was not expected Mr Dingjan would use a forklift in the course of his employment, but it could happen occasionally.[38] Mr Sindorff said he would have expected Mr Dingjan to use the forklift in his role '*internally*', that is moving pallets from one area to another inside the factory, and to unload trucks if Mr Sindorff was not there.[39]

33. The operation of forklifts at RP was predominantly carried out by Mr Sindorff who indicated he would do about 95% of the unloading, with the other 5% undertaken by Mr Diprose and anyone who had a forklift licence.[40] This was confirmed by other employees namely Mr Jacobson,[41] Mr Fraser (who also would unload as part of the 5%),[42] and Mr Diprose.[43]

34. Mr Diprose said Mr Sindorff was the main forklift driver especially for deliveries and "*Josh obviously had a forklift ticket didn't use it very often, used it a couple of times I think beforehand. Darran[44] had a fork ticket and I don't think I'd seen him move before or not.*"[45] With respect to Mr Dingjan Mr Diprose said he "*wouldn't have expected Mr Dingjan to unload trucks, it wasn't part of his normal operation, so he would normally have been busy... he would not even be the number 2 or 3 backup if John or myself were unavailable, being Kerry or one of the other guys more than likely to jump on it to unload a truck*".[46]

b. What he was doing on the day of his accident

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[38] T316 [19].
[39] T227 [9], [15].
[40] T226 [41-42], T227 [2]-[6].
[41] T217 [11]-[17], [24]-[28].
[42] T203 [9]-[21].
[43] T267 [35].
[44] That is Mr Randall.
[45] T267 [32]-[37].
[46] T268 [10]-[15].

35. On 7 November 2013, Mr Dingjan commenced work at 7a.m. with his usual knock off time being 3.30p.m. As previously indicated, it was usual for Mr Dingjan to work overtime and finish at around 5.00-5.30p.m.[47] Also at work that day were Mr Diprose, Mr Randall, Mr Jacobson, Mr Sharp and Mr Fraser. At around 3 p.m. a number of employees were finishing work, including Mr Fraser and Mr Sharp.

36. Mr Randall said the night before, on the 6 November 2013, he had turned off the blow moulder and had forgotten to turn it back on. [48] The machine takes three hours to warm up, so Mr Dingjan spent the morning doing odd jobs and cleaning up.

37. After the machine had warmed up Mr Dingjan operated the blow moulder.

38. At approximately 3.45 p.m. Mr Jones, a truck driver employed by SeaRoad arrived at the St Leonards site to deliver some steel in a Volvo medium flat tray truck. [49] The delivery was two 1.9 tonne packs of steel from SSAB Swedish Metal which was delivered to RP from time to time.

39. SeaRoad did not often deliver to RP at St Leonards, with the main delivery company being Toll. Mr Jones says it was the first time he had delivered that particular load.[50] He also indicated he had only been to the St Leonards site once before 5 or 6 years previously when he was with a different trucking company and on that day, he delivered roadside guideposts.[51]

40. He gave evidence that when the steel packs were loaded onto his truck at the SeaRoad depot they were too heavy at the back end of the truck, so they were loaded at the front.[52] He had a full load, including the pallets of steel plate.[53]

41. Mr Jones parked perpendicular to the factory with the front of his truck facing the factory. When he arrived at the site Mr Jones "*walked inside. I went through the door, and I walked up a bit. I seen no one was there and I heard this cement mixer going and I seen him up the far end of the – the building so I went and asked him if he could come*

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[47] Exhibit C21- Affidavit of Mr Sindorff.
[48] Exhibit C12- Affidavit of Mr Randall.
[49] Exhibit C11 – Affidavit Mr Jones.
[50] T20 [30].
[51] T21 [2-16].
[52] T20 [20]-[24]. In his affidavit he says the packs of steel were reloaded from the rear of the flat tray to a position where they were sitting over the rear wheels and second row from the back. The photographs at exhibit C27 support this version of events and I so find.
[53] Exhibit C11- Affidavit of Mr Jones.

out unload the steel for me. He said he'd come out and do it for me."[54] He says Mr Dingjan turned the mixer off, walked down and went and got the forklift. I infer the mixer was the blow moulder machine.

42. Mr Jones said his usual practice when he arrives at a site is to *"[h]ave a look around, unstrap and then go and get someone to unload the truck for you because we're not allowed to do it."*[55]

43. Mr Jones stated he used the entrance to RP nearest to Tyres 4 U[56]. Mr Jones then said *"I seen the slope but um as I thought to myself oh well – will I get it unloaded or not, that's what I just thought to myself"*[57]. When he arrived, he says he unstrapped the load which involved *"Ah we got load binders on one side of the truck. Then you've got to get another – what do you call it – a wrench to undo your straps. Then you've got to walk around the other side, undo your clips and come back around the other side and wind them up and put them on the bar of your truck."*[58]

44. Mr Jones could not recall seeing a sign which read: *'Notice. All visitors report to the office"* on the day[59]. This sign is captured in the photos from immediately after the accident.[60] Mr Jones says he went to the site office, [61] talked to a lady in the site office and she told him to go out and see the young man in the shed [that is Mr Dingjan] .[62] This was the first time he ever said this as this evidence does not appear in his statements (Exhibits C11 and C11A) or interview (Exhibit C11B). He also did not say he spoke to a lady in the office when questioned earlier about that.[63] Nothing turns on this discrepancy and it does not need to be resolved. The plain fact of the matter is Mr Jones spoke to Mr Dingjan who agreed to unload the packs of steel.

45. Mr Diprose was the leading hand in 2013. At the time Mr Jones came into the factory he was in the site office which was next to the roller door against the corner of the warehouse, about six or seven metres from the blow moulder.[64] He stated he did not

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[54] T23 [28]-[32].
[55] T21 [33]-[34].
[56] This is the northern entrance with the slope.
[57] T22 [39]-[40].
[58] T23 [6]-[11].
[59] T37 [31]-[32].
[60] Exhibit C38, WorkSafe Tasmania File, Volume 1, page 89.
[61] T37 [32].
[62] T38.
[63] T37 [32]-[34].
[64] T265 [2]-[9].

see the truck pull up or the truck driver come in.[65] He also said Mr Dingjan and Mr Sharp were the only two people working, but there were also staff "*Cheryl, Linda, Libby receptionist and Ross...* [and] *Darran was upstairs...*".[66] His evidence was that they were not in the site office but in a separate office unit. Mr Diprose confirmed he was in the site or dispatch office at the time the truck driver came in.[67] This evidence is contrary to Mr Jones' evidence that he went to the site office. Further if Mr Jones had walked to the other office location it is likely he would have walked past Mr Diprose. Mr Diprose notes if he had seen the truck driver, he would have been the person to take the delivery.[68] Again this discrepancy need not be resolved as it is clear Mr Jones spoke to Mr Dingjan who indicated he would obtain a forklift to unload the packs of steel.

46. Mr Diprose, Mr Randall, Mr Jacobson and Mr Fraser heard a bang and came from different areas of the factory to help. The forklift was observed on the left side of Mr Jones' truck, when viewed from the rear, and the forklift was on its right-hand side with its mast and the tynes pointing down the slope of the driveway towards St Leonards Road. Mr Dingjan was observed on the ground but in the confines of the cabin of the forklift however his head was below, but adjacent to the steering wheel. He was facing the rear of the forklift and his left leg was trapped under the rear right hand pillar of the frame of the cabin of the forklift. Emergency Services were called at 3.53 p.m. Mr Ryan and Ms Dahlvid were driving along St Leonards Road and pulled over to assist. Mr Baker, who was an employee of Tyres4U, which is next door to RP, gave evidence. He noted his employer's loading dock faces RP's building and they have a forklift.[69] He says he heard two bangs, and a person ran in and said there had been an accident and they needed a forklift and so he drove his forklift over. The possibility is the first bang was the pack of steel hitting the driveway followed by the forklift as it toppled over. Mr Randall, Mr Jacobson and Ms Dahlvid performed CPR on Mr Dingjan while waiting for an ambulance.

47. One ambulance arrived at 3.59 p.m. followed by a second ambulance one minute later. After Mr Dingjan was examined by paramedics, it was determined his injuries were incompatible with life, and they did not continue with CPR after initially taking over that task from the people who had assisted Mr Dingjan prior to their arrival. Mr

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[65] T265 [12]-[18].
[66] T265 [36]-[39].
[67] T266 [20].
[68] T268 [21].
[69] T97.

Dingjan was pronounced dead at 4.05 p.m. Police and members of Tasmanian Fire Service also attended. Police contacted Worksafe Tasmania (WST) and two inspectors attended.

48. Dr Donald Ritchey performed the post-mortem examination on 11 November 2013. In his affidavit[70] he says Mr Dingjan's cause of death was blunt trauma of the head, neck and chest sustained when he was crushed by a forklift during an industrial accident. I accept his opinion. Toxicology results[71] obtained after testing samples taken at autopsy were negative for alcohol and illicit drugs.

c. How he was using the forklift to unload the truck on the day of his accident.

49. Mr Jones was the only witness to Mr Dingjan using the forklift to unload the delivery.

50. Prior to Mr Dingjan lifting the first pack of steel Mr Jones says he asked Mr Dingjan if he wanted to unload the steel from the other side and he said '*no he'd do the side he was on first*'.[72] He explained he asked Mr Dingjan this question because if he unloaded from the other side this would require Mr Jones to move the truck, as Mr Dingjan did not have enough room to get to the other side[73]. He said the passenger side of the truck was the side Mr Dingjan chose to unload first.[74]

51. Mr Jones said Mr Dingjan was on the other side of the truck from him. He then described what then occurred as follows:

> *"Josh went – had one bite but it was – it was tilting, and he put the steel down and had another go at it and got it level and then he told me to get out of the way just in case anything happened. So, I walked from the side of the truck to the cab side and that's when I heard a bang that hit the um truck and I come around and I seen the forklift on its side."*[75]

52. Mr Jones described the load as tilting towards the road and that the tynes were as high as the truck tray.[76] He confirmed Mr Dingjan said "*...to me to move out of the way just in case anything happened*"[77]. When Mr Dingjan said this Mr Jones walked around

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[70] Exhibit C5.
[71] Exhibit C6-affidavit of Ms Miriam Connor.
[72] T27 [4].
[73] T41 [10].
[74] T41 [3]-[4].
[75] T25 [9]-[14].
[76] T27 [32].
[77] T26 [21]-[22].

from the side of the truck to the front of the truck. He stated he heard a bang when he was near the cab of the truck, did not see the forklift topple, and then he saw the forklift on its side, and he went inside to get help.

53. The steel pack remaining on the truck was later weighed by a crane from Pfeiffer Cranes and found to weigh approximately 1.9 tonnes.[78] The measurement of the weight was witnessed by Constable Hayes who observed that when the crane lifted the pack which Mr Dingjan had attempted to unload, the pallet broke, and the sheet metal slid down the driveway.[79]

d. The location where the unloading was taking place.

54. The packs of steel had to be unloaded from the truck and deposited in the factory at the top of the driveway. A site inspection on 5 September 2022 by counsel and myself enabled us all to inspect the driveway. It appears the warehouse configuration had changed although the slope of the driveway was the same. In my view the slope was obvious to all who attended the site inspection. Constable Hayes described the slope as a noticeable slope.[80] Where Mr Dingjan was operating the forklift was measured by WST Inspectors at 9.9 degrees.[81]

55. The photographs accurately depict where the truck and the forklift were parked. [82]

56. Mr Jones said he tried to park parallel to the factory but the truck wouldn't come up the hill, as the hill was too steep for the truck.[83] However this was later clarified as something he believed from prior experience driving that truck at a different site and with other slopes; that the driveway was too steep for the truck to be reversed up.[84] He indicated he did not think about entering the site from the other entrance, or think about how the forklift would be used. [85] He said if he had been asked, he would have turned the truck around.[86]

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[78] Exhibit C30 – Affidavit of Mr Craig Pfeiffer.
[79] T114 [14]-[26]. This version of events is incorrect. There was no pallet. Constable Hayes says in his statement the ratchet straps around this pack broke and the absence of a pallet and the presence of ratchet straps is confirmed in the photographs at Exhibit C27.
[80] T111 [39].
[81] Exhibit C28 – Affidavit of Senior Constable Rybka, Exhibit C38, WorkSafe file, page 90.
[82] T36 [5]-[10].
[83] T28 [6]-[12].
[84] T29 [10]-[20].
[85] T29 [29].
[86] T29 [31]-[32].

57. Mr Jones said he was subject to a policy that SeaRoad's drivers do not unload the trucks, as that is the customer's responsibility.[87] He says he does not consider where the vehicle is parked for the person unloading it: *"[n]o it's got nothing to do with us. All we do is just their deliveries"*.[88] Mr Jones said he has a forklift licence. He was aware that forklifts need to be backed up a slope so the weight is in front of the forklift operator but he did not have any concerns about where he parked the truck.[89] He confirmed he did not have training that he should not use a forklift on a slope.[90] He said it did not occur to him there was a risk of the forklift toppling sideways.[91] This seems to be contrary to what he says at paragraph 43; that is he wondered whether his truck would be unloaded where he parked it because of the existence of the slope. He stated sometimes he used to unload trucks from a side on angle about four or five years ago and he has done that since this accident.[92]

58. Bruce Webb the Operations Manager of SeaRoad gave evidence. He had many years' experience in the trucking industry including making deliveries and he also attended RP's premises after the accident to retrieve the truck. He confirmed Mr Jones was an employee of SeaRoad and there were around 24 other employees of that business based at its Youngtown depot at the time.[93] He said most of SeaRoad's freight comes from Melbourne and once it reaches the Launceston depot at Youngtown it is consolidated into areas, that is different suburbs of Launceston called 'Locally Consolidated Loads' which would then be delivered by drivers. He indicated Mr Jones' supervisor was Christopher Marsh, however he was on leave on 7 November 2013 so his supervisor on that day was Fran Fedevolli.[94] Mr Webb said this supervisor, also called the LCL freight coordinator, is the person responsible for ensuring the loads are properly secured to the trucks and they would receive reports of any damaged freight but they do not inspect every piece of freight.[95] He indicated truck drivers were expected to identify if there was an issue with a load which was not properly secured.[96]

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[87] T29 [37]-[40].
[88] T30 [20]-[22].
[89] T31 [5]-[9], [21]-[22].
[90] T32 [27]-[29].
[91] T43 [23]-[24].
[92] T43 [26]-[37].
[93] T56.
[94] T79.
[95] T91 [10]-[31].
[96] T91 [33]-[37].

59. Mr Webb said the procedure when a driver arrives at a delivery site is that the driver is to contact a goods receivable type area to find someone that can receive the freight. SeaRoad require proof of delivery, so they have a consignment note that is signed by the person receiving the goods.[97] He confirmed the drivers are told not to operate any forklifts that are not owned by SeaRoad.[98] He advised drivers are guided by the unloading point on each particular site. He noted if drivers were concerned with the site, and where to unload, they could talk to their supervisor and a hazard identification can be done.[99] He noted hazards were communicated to employees in toolbox meetings and those occur weekly.[100] He indicated that nothing had been brought to his attention about any risks which might be encountered by SeaRoad drivers at RP's site prior to this accident. [101]

60. Mr Webb also had a forklift licence and was aware of the risks of driving a forklift across a slope as "*you don't want to have any sideways because you're already lifting up high, so your centre of gravity is obviously going to be much higher*[102]." He said he "*wouldn't be taking the forklift onto a sloping-type scenario.*"[103] He also agreed that where the forklift was in this case was not a safe place to operate a forklift to lift a load.[104] He indicated that with respect to this site:" *my initial reaction would have been seeing the slope, the site, what was carrying on it, what had happened and you know immediately you would think you know there's a danger there, there's a risk at that site.*"[105]

61. Mr Webb indicated when he would pull up to a site he would think about where the person unloading would have to unload the truck from and he would be concerned about a slope if there was a forklift used.[106] He expected his drivers to be able to identify risks and report it to him if they thought it was unsafe.[107] He said *"[a]s far as the driver's responsibility, would be to ensure that they are presenting the freight in a*

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[97] T64 [9]-[23].
[98] T64 [26]-[27].
[99] T64 [35]-[43], T65 [1]-[4].
[100] T65 [9]-[12].
[101] T66 [30]-[32].
[102] T66 [5]-[7].
[103] T66 [14]-[15].
[104] T86 [6]-[7].
[105] T67 [24]-[36].
[106] T67 [7]-[14].
[107] T67 [17]-[23].

way that can be delivered to the site safely."[108] He agreed it was quite reasonable to expect Mr Jones to say to Mr Dingjan "*you can't unload it on this it's dangerous*".[109]

62. Mr Baker said he would see trucks coming and going from RP's site quite often and the trucks would park in "*usually two different places, one where that truck is there or other times they'd come up the other side of the U-shaped driveway and park sort of parallel to the building.*"[110] He noted, as a forklift user, that the slope of the driveway would have concerned him, and he knew that from his experience.[111]

Employees

63. Some employees gave evidence that delivery trucks would usually park parallel to RP's warehouse, and they had not seen trucks parked differently:

    a. Mr Tennick said delivery trucks usually parked parallel to the building.[112] Mr Tennick gave evidence he had a forklift licence, that he would unload trucks very rarely and only when there was no one else around to do it.[113] He said he had never unloaded sheet metal.[114] He stated he had never unloaded a truck facing up and down the hill. He always unloaded when the truck was parallel to RP's warehouse.[115]

    b. Mr Sturmer, who did not drive a forklift, stated that trucks would usually be parked parallel to the building.[116]

    c. Mr Sharp also said delivery trucks would park sideways against the factory and he never saw them park in a different location.[117] He said he would unload from the factory side and then drive around to the other side and unload from that side.[118] Mr Sharp said RP's driveway "*wasn't the greatest but I didn't have a problem with it.*" He noted he would navigate the slope by going *"straight in, straight back out"* and as soon as

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[108] T86 [29]-[31].
[109] T87 [37].
[110] T102 [7]-[9].
[111] T103 [33]-[42].
[112] T120 [6].
[113] T120 [29]-[31]
[114] T122 [23]-[24].
[115] T121 [1]-[4].
[116] T173 [5]-[6].
[117] T177 [24]-[29].
[118] T177 [37]-[41].

he was back from the truck, he'd lower the load down to the ground.[119] He stated when faced with a slope forklift drivers need to be very careful and that was from *'first getting the licence'*.[120] He stated he would never unload sideways because *'it's dangerous'*.[121]

d. Mr Jacobson stated trucks would normally park at the doorway across ways and he had never seen a truck park in that direction; that is facing the factory.[122] He said trucks should be loaded across ways and where the truck was on the day of Mr Dingjan's death, the operator would be required to go downhill, and you do not normally unload them there.[123]

e. Mr Fraser said in his statement[124] that the truck was parked in a strange position on 7 November 2013; that it was parked facing towards the factory. He said in evidence *'it wasn't near the door and um the problem is...it was- when the forklift was being used it was-the forklift was at an angle sort of on a slope which is not really ideal... because... of the forklift being a bit unstable....'*[125] Mr Fraser stated that normally trucks would park across the slope and they would have to sometimes unload from the bottom side which is not ideal.[126] He indicated he had not seen trucks park in a different manner; that is otherwise than parallel to the factory, and *"[o]nly sometimes when trucks were unloaded with the coils of wire – of steel, they would – one side would be unloaded, then the truck would turn around so it was unloaded from the top side."*[127] He said he felt he could have asked the truck driver to move.[128]

64. Mr Sindorff, however, the main forklift operator had experience of trucks parking perpendicular to the factory. He said trucks would normally park at the top of the driveway facing north/south, parallel to the road, and that he would mostly unload them from the east; that is from the factory side.[129] He did unload trucks from the

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[119] T178 [12]-[13].
[120] T178 [28].
[121] T178 [38]-[40].
[122] T 216 [33]-[36].
[123] T216 [38]-[41].
[124] Exhibit C15.
[125] T190 [19]-[24].
[126] T191 [13]-[19].
[127] T192 [32]-[34].
[128] T192 [8].
[129] T236 [4]-[18].

western side, on the flat, he stated the forklift was not on the slope at that point.[130] He noted that driving forklifts on slopes should be avoided.[131] Mr Sindorff said if he was asked to unload on a sloping surface he would ask the truck driver to move[132].

65. Mr Sindorff said he had seen trucks park a different way, at the top of the driveway, facing east/west, probably twice.[133] He stated he would unload them at the top of the driveway on the level surface.[134] He said in his statement he would *"not have unloaded where I have been shown Josh was unloading"*, [135] and at the inquest he confirmed he had never unloaded in that area and had never seen anyone unload in that area before.[136] He could not recall telling Mr Dingjan about not unloading in that area, but *"would never have expected to have to tell anyone not to unload there"*.[137] Mr Sindorff said that with respect to Mr Dingjan he *"would have thought that he was capable of making that assessment on his own"* [that is the slope of the driveway was a hazard].[138] There is no evidence Mr Dingjan was not capable of making such an assessment, or that he was unfamiliar with the slope.

66. Mr Sindorff in his evidence, and his earlier affidavit, said when he unloaded the last shipment of sheet metal from SeaRoad, approximately four months before this incident, the truck was parked facing east/west or perpendicular to the factory, but that was on the flat, far from where Mr Dingjan unloaded.[139] He said *"SeaRoad were the only trucks, apart from a pallet truck, that would have ever parked facing east/west."*[140] He said he did not ask the driver to move the truck as it was on the level[141], and he thought the load would have been at the front of the truck up against its bulkhead, not down the bottom of the truck.[142]

67. Mr Diprose had also seen trucks parked perpendicular to the factory. He says he had seen trucks park differently to parallel to the building by reversing in and getting unloaded from the back, and the forklift operator would be unloading from the shed

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[130] T236 [26]-[39].
[131] T236 [42].
[132] T235 [7]-[9].
[133] T237 [7]-[17].
[134] T237 [16]-[21].
[135] Exhibit C21.
[136] T237 [30]-[31].
[137] T237 [36]-[37].
[138] T252 [24]-[27].
[139] T238 [26]-[41], T239 [11], and C21.
[140] T238 [40]-[41].
[141] T239 [1]-[2].
[142] T239 [4]-[5].

side down onto it.[143] Mr Diprose noted after the accident they did a check every time they unloaded trucks and there were *"10 or 12 different truck movements on a busy day"*.[144] Mr Diprose said usually the trucks would drive up the northern entrance and parked parallel to the factory, as close to the door as they could get.[145] He stated if he was unloading from a truck parked like that he would unload at 90 degrees to the factory and the truck so he was up and down the hill, not ever across the hill.[146] He said unloading from a truck parked in that manner from the low side or western side of the truck did occur but it was less likely as most of the Toll drivers would *"put stuff for our shed on their passenger side so we'd be loading from the shed side"*.[147] Mr Diprose said he was aware that forklifts *"[s]houldn't be operated across a slope... never across, definitely not anything steep and definitely not with anything high"* [148] He stated he would class RP's driveway as steep and described the steep section as it came off St Leonards Road and then it plateaued out on a much less angled section. He stated he *"wouldn't be unloading where that crash happened"* and *"where it was and knowing how forks are and on this –across a slope, just how unstable they feel, I don't think so"*[149].

68. Mr Randall stated he had never seen trucks parked perpendicular to the factory for unloading, and he was not aware of Mr Sindorff unloading trucks parked in that manner.[150] Mr Randall said when he undertook training to obtain a forklift licence he was given an instruction not to unload on anything but a level surface.[151] He said he had never seen a delivery truck parked on the slope of the driveway and he would not unload at that location.[152] This is because unloading a truck with a forklift on a slope creates a danger of the forklift tipping. Mr Randall said he would direct a driver to move the truck, so it was parallel to the building on the concrete surface.[153]

69. The witnesses, including the employees of RP who were questioned on this topic, recognised it was unsafe to unload the truck in the area being used by Mr Dingjan due

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[143] T271 [10]-[13], [17]-[18].
[144] T267 [28]-[29].
[145] T269 [21]-[24].
[146] T269 [26]-[29].
[147] T270 [10]-[12].
[148] T270 [20]-[26].
[149] T270 [35]-[36], T272 [36]-[37].
[150] T320 [1]-[10].
[151] T295 [36]-[38].
[152] T296 [9]-[18].
[153] T301 [18]-[25].

to the presence of the slope. All of the witnesses expressed some awareness of possible dangers around driving a forklift on or across a slope.

Unloading down the slope and Conversation

70. Mr Sindorff, Mr Sharp, Mr Diprose and Mr Fraser described a practice of unloading trucks from the western side of the truck when it was parked parallel to the factory, down or near to the slope. Mr Randall indicated that at one stage he had concerns about the loading and unloading on the western side of trucks which were parked parallel to the factory. In his interview he said:

> *"Which is the road-side of the vehicles um I, I didn't particularly like it um, from a point of view of you know the load could fall off the forklift um, I explained to John my, my concern um, and John and I went out and actually had a look at it and, and I told him why I was concerned um and I mean I'd sort of not as you know experienced I'd say on the forklift as what John is loading and unloading, using a forklift so um we had a conversation about it and ah he sort of assured me that wasn't, the issue wasn't there..."*.[154]

71. At the inquest Mr Randall was questioned about his memory of that conversation with Mr Sindorff. He said *"[a]h it's very um cloudy... I believe it was – ah we were working out driving up and down the slope, whether that was – whether it was safe or not, not across but up and down."*[155] He indicated that after that conversation he did not hold any concerns about whether loading that way was safe or not.[156] He recalled he subsequently saw Mr Sindorff unloading in that manner. He noted he did not remember if he passed on those concerns to anyone or thought Mr Sindorff should have passed them on.[157]

72. Mr Sindorff said the following about the conversation with Mr Randall: *"we had a discussion about – Darran would have said "I don't like you loading from the western side" or "unloading from the western side" and to me it was on the level, um it was – there was no risk to me because it – it wasn't – it was – western side, not – yeah. I didn't see it – have a problem with it."*[158] Mr Sindorff said he continued to unload trucks from that side as it was his responsibility, and that Mr Randall was aware of

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[154] Exhibit C12A, Record of Interview of Darran Randall at page 23.
[155] T317 [38]-[41].
[156] T318 [20]-[25].
[157] T318 [35]-[40].
[158] T239 [22]-[26].

that.[159] He said unloading on the western side of the truck where it was level was '*nowhere near where the accident happened*'.[160]

73. Mr Sindorff's and Mr Randall's evidence about this conversation is consistent so I find it occurred. I find Mr Randall did hold concerns about unloading on the western side, due to the presence of the slope, however after the conversation with Mr Sindorff those concerns were allayed, and he was aware Mr Sindorff continued to unload trucks on the western side from time to time, but on a level surface given unloading trucks was Mr Sindorff's responsibility.

74. Mr Fraser described how he would unload a truck from the western or roadside when it was parked parallel to the building. This required him to *"go back, reverse back, and you're reversing back when your load is still stable, reasonably stable because you're going back, drop my fork – drop my load down and then – nearly to the ground, then – and side shift the forklift to the right so the weight and load is to the right of your tyres and go along – and go along the slope, which is not ideal, not safe, but that's what I have done."*[161] He indicated he did have concerns about this unloading method but did not raise it because *"that's what was sort of done you know"*.[162] He said he would unload on the bottom side every four to six weeks and other senior employees were aware of him unloading in that manner.[163]

75. Although Mr Fraser (and at one time Mr Randall) held concerns about unloading from the western side when the trucks were parked parallel to the factory the unloading operation was being conducted on a flat service or, if there was any slope (which I find was in the vast minority of cases[164]), it was being conducted up and down that slope. This procedure is not directly relevant to the circumstances of Mr Dingjan's death as on that occasion SeaRoad's truck was parked perpendicular to the factory which meant when the load was lifted, and the forklift was reversed from the truck the unloading operation was being conducted across the slope. All that can be said is based on Mr Fraser's evidence, which I accept, there were other occasions when the

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[159] T240 [22]-[29].
[160] T239 [28]-[29].
[161] T191 [27]-[33].
[162] T191 [39]-[40].
[163] T195 [8]-[15].
[164] This is because Mr Sindorff did 95% of the unloading and when he unloaded a truck the unloading on the western side of the truck was conducted on a level surface. See paragraph 72.

forklift, unloading a truck from the western side had to move up and down the slope but then traverse across the slope in order to deposit the forklift's load in the factory.

The Container

76. There was evidence about a container that was parked next to the roller door of the factory. It is depicted in the photographs[165]. Mr Jones recalls seeing the container but said it did not affect his choice as to where he parked his truck.[166]

77. Mr Diprose said the shipping container was always there, that is on the northern side of the driveway pointing up and down the hill.[167] and employees would load product into it, the container was taken to Toll when full and sent to the distribution centre in Queensland and replaced with an empty one.[168] He stated the shipping container was usually in that location but not that far out from the factory, this time there was more like a metre and a half to a two metre gap between the factory and the container, rather than a persons' width.[169] He said this made it harder for vehicles to pass but a truck would be able to pull up next to it. He noted the container had been there since Friday the week before, and deliveries had occurred in that period.[170]

78. Mr Sindorff was not present at RP on 7 November 2013 as he was on leave. He said when asked about whether the container was present, when he was last at RP prior to going on leave, that he assumed it was and he probably arranged for it to be there.[171] Mr Sindorff said "*we had to have the container there to load it in a safe area – actually for me to load on the level, that's the only place we could have the container*".[172] Mr Sindorff indicated there was sufficient space between the container and the garden bed for the SeaRoad truck to pull up on the flat surface of the bitumen, and there would have been sufficient space for the forklift to unload from both sides of the tray. He said the container did not obstruct loading trucks that were parked north/south or south/north.[173]

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[165] See Exhibit C27 photograph no. 4.
[166] T22 [14]-[15].
[167] That is perpendicular to the factory.
[168] T272 [5]-[9].
[169] T272 [14]-[18].
[170] T272 [20]-[29].
[171] T249 [10]-[12].
[172] T256 [4]-[6].
[173] T256 [4]-[10], T250 [8]-[19].

79. Mr Fraser said the location of the container took away the safe unloading area.[174]

80. Mr Randall said there was plenty of room for the truck to pull up next to the container, and that it would not have been an impediment to trucks accessing the unloading area.[175]

81. The site visit revealed the dimensions of the factory had changed, so the visit provided only limited assistance in identifying whether there was any impact from the presence of the container on the room available for a truck to park parallel to the factory at the time of the accident.

82. Given the weight of evidence, I find the presence of the container did not prevent trucks from parking parallel to the factory. Further, Mr Jones gave evidence that he parked the way he did; that is perpendicular to the factory, because he believed the load on his truck was too heavy.

2. What caused the forklift to rollover, including whether there were any mechanical issues.

83. Mr Dingjan was using a Mitsubishi FG25ZNT 2004 forklift. This forklift was last serviced on 18 October 2013, and it had a 2.5 tonne lifting capacity.[176] The forklift was weighed at the scene of the accident on the day it occurred and found to weigh 3.8 tonne.[177] The load Mr Dingjan was attempting to unload from the truck, a pack of steel plate, was weighed and found to have a mass of 1.9 tonnes[178].

84. WST commissioned an engineer's report to identify the possible causes of the forklift rollover.[179] That report says the stability of the forklift supporting a load of 1.9 tonnes at a height of 2175mm[180] above the ground, required only very minimal dynamic loading effects to cause it to overturn. The engineer, Mr Neville, noted the driveway cross slope of 9.9° was potentially steep enough to overcome the static friction between the steel plate and the steel tynes which would cause the steel plate to slide

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[174] T209 [33]-[39].
[175] T300 [40], T305 [25]-[28].
[176] Exhibit C38 – WST File, Volume 2, page 102 and WST Volume 1, page 96 (photographs 9 and 10).
[177] Exhibit C30 – Affidavit of Craig Pfeiffer.
[178] Exhibit C38 – WST file, Volume 1, page 12 and Exhibit C30-Affidavit of Craig Pfeiffer. The pack of steel which was weighed was the pack which remained on the truck and was identical to the pack Mr Dingjan had attempted to lift.
[179] Exhibit C38 – WST File, Volume 2, pages 20-24.
[180] This height was the distance to the top of the fork tynes, and hence the underside of the steel pack being lifted, from the ground when the forklift rolled over.

off the tynes. In addition, Mr Neville says the steel plate should only have been lifted with the forklift when secured to the forklift by means of a pallet to which the steel was strapped. In this case it appears the pack of steel was not secured in this manner, and it was resting directly on the steel tynes of the forklift. The WST Inspector Mr Terry Hurley, says the following in his report with respect to this accident:

> *"Analysis has determined that when Mr Dingjan drove the tynes under the load of steel sheets, in preparation to lift them off the truck, the left hand tyne did not enter smoothly. This is because the differing angles involved made it higher than the right-hand side. This, in turn, caused the left-hand side of the steel sheets to slide along the tray of the truck and not load correctly on the tynes of the forklift truck. The load was askew as he picked up on the tynes. He continued to raise the load in order to clear another pallet of goods on the rear of the truck. It is clear his intention was to swing the load downhill and reverse up the slope and into the factory. He reversed back and began to turn the forklift. As he did this the centripetal force caused the load to shift on the tynes and together with the dynamic forces the combined centre of gravity (CCOG) of the forklift fell outside the perimeter of the stability triangle. This has dire consequence as once the stability triangle is compromised the forklift becomes unstable and will tip over either forwards, backwards or sideways. In this case the lateral stability was compromised, and the forklift tipped sideways. Given the conditions at the time Mr Dingjan had to swing the load down the slope.... The action of the load sliding combined with the downhill swing of the forklift caused the roll over"*[181]

85. The opinions of Mr Neville and Mr Hurley are unchallenged, and I therefore accept them. While Mr Hurley's expertise to provide opinion evidence in such matters has not been established his opinion is, in my view, reasonably open on the facts. Both opinions explain the cause of the rollover of the forklift being operated by Mr Dingjan.

86. Warnings with respect to turning on a ramp or gradient and picking up loads while the forklift is not level, amongst many others, are provided in the forklift's manual.[182]

Packaging of the pallets

87. Employees of RP gave evidence that the manner in which the packs of steel arrived on the day of this accident was unusual. Mr Sharp said he had previously unloaded packs of steel and they would usually arrive on two pieces of wood with some sort of plastic packaging around them. He had never seen them arrive in a different way, or flat on the truck without something under them.[183] Mr Fraser said he had unloaded sheet metal in the past, and it would usually arrive on pallets, but on the day of the accident

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[181] Exhibit C38, WST File, Volume 1, page 25-26.
[182] Exhibit C38, WST File, Volume 1, pages 388-394.
[183] T180-181.

it was not on pallets, and he had not seen sheet metal delivered like that before.[184] Mr Randall said RP received deliveries of that steel about four times a year, and generally they were on dunnage.[185]

88. Mr Sindorff said he had unloaded the sheet metal on numerous occasions and it would normally arrive in 1.9 tonne packs with bearers attached and with four straps and plastic sheeting.[186] Mr Sindorff stated "*when I arrived back from America both – well both – the pack that I observed, which wasn't the pack that came off the truck, was attached – there were no bearers attached, um and they were just strapped, not with metal strapping.*" [187]

89. Mr Sindorf said he would have concerns about lifting the sheet metal in that form rather than how it was usually packaged because "*it could slip. I mean if they had the bearers – if the load has slipped with metal on metal, the bearers stop against the tynes of the forklift.*"[188] Mr Sindorff however said he would still have unloaded the pack of steel which was packaged in the manner it was on the day of this accident or in the manner he observed when he returned from leave but on a level surface.[189]

90. There was some questioning of the witnesses about how something left on the truck and depicted in the photographs appeared to be dunnage or a bearer.[190] In this case the evidence establishes, dunnage or bearers should be attached to the packs of steel which was not the case with this delivery. I accept though, that the bearers discussed by the witnesses and depicted in the photographs, were positioned under the pack of steel lifted by Mr Dingjan because otherwise he would not have been able to place the tynes of his forklift under the pack of steel in order to lift it off the truck. It appears however they were not secured to the pack, given they were separated from it.

91. Mr Jones gave evidence that the pallets usually come from Melbourne to the SeaRoad terminal in Launceston the way they were packaged on this occasion.[191] He said he knew steel on steel did not work.[192]

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[184] T 189 [40]-[41], T190 [1]-[8].
[185] T297 [16]-[27]. Dunnage is inexpensive or waste material such as wooden railings used to load and secure cargo during transportation.
[186] T240 [31-[41], T241 [1]-[2].
[187] T241 [10]-[13].
[188] T241 [18]-[20].
[189] T241 [25]-[38].
[190] Mr Randall T297 [29]-[36], Mr Fraser T207 and Mr Sindorff T248 [20]-[28].
[191] T48 [23]-[29].
[192] T49 [14].

92. However Mr Webb, the operations manager of the Youngtown depot of SeaRoad in November 2013, said he believed the steel came to his depot on skids with dunnage-type bearers underneath them with metal strapping and these would also prevent the load from moving in transit.[193] In addition he said *"[o]bviously if you're moving these things with forklifts you need the space underneath to be able to get the tynes in, pick it up, so that sort of weight, packs of steel, would be on some form of cradle and strapped together as – to hold it together as one bundle."*[194] He said there did not appear to be dunnage or other timber on the steel, but that it may have been on the truck and not strapped to it.[195] He indicated he was aware that steel on steel would be very slippery and not good.[196]

93. Mr Baker who worked at premises next door to RP saw the steel delivery to RP that day and noticed the steel was not packaged on a pallet. His immediate thought, when he saw the steel was not sitting on a pallet, was that was stupid because *"trying to pick up metal with metal tynes on the forklift, it's very slippery and it doesn't take much at all to get it to slide"*[197] and he would *"assume that it would be strapped to a pallet myself"*.[198]

94. The relevant oral and documentary evidence, including the report of Mr Neville, leads to a conclusion that it was both the existence of the slope and lack of packaging on the steel, that led the steel to slip and the forklift to overturn. Evidence of a number of witnesses show an awareness of the risks associated with lifting steel whereby it sits directly on the steel tynes of the forklift.

Mechanical issues

95. There were no identified mechanical issues with the forklift. Mr Sharp said in his experience the forklift was in good working order.[199] Mr Fraser stated it was *"quite a new forklift and everything to me was operating quite well"*. It was in good working order.[200] Mr Diprose stated it was in good condition with no faults.[201]

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[193] T69 [5]-[13], T72 [1]-[2].
[194] T71 [26]-[30].
[195] T72 [37]-[41], T73 [1]-[4].
[196] T73 [18]-[21].
[197] T101 [27]-[38].
[198] T104 [11]-[12].
[199] T179 [22]-[23].
[200] T208 [9]-[10], T208 [16]-[18].
[201] T273 [4]-[8].

96. Mr Tennick gave evidence there were faulty locking pins on the forklift that had been brought up in toolbox meetings and with John Sindorff.[202] However, no other employee identified this as an issue.[203] Further the forklift was inspected on 18 November 2013 by Mr Wayne Rice who is a transport inspector and who, at that time, had over 20 years' experience in the automotive industry. Mr Rice says the forklift was in good working order before the accident involving Mr Dingjan and it was fully operational and did comply with all safety features. [204] He was specifically asked outside of Court about the locking pin, given Mr Tennick's evidence, and he advised Counsel Assisting that he *"inspected the locking pin and was aware that it was working without fault"*.[205] This was agreed as a fact by the parties, and I so find.

97. Mr Tennick also gave evidence that he saw Mr Diprose adjust the tynes of the forklift on the day of the accident as he was leaving and just prior to when the truck was to be unloaded. He explained if someone was nearby that person would adjust the tynes so the operator did not have to get off the forklift.[206] However this was something not contained in his prior interview with WST[207]. Mr Diprose said he very frequently adjusted the tynes, and he would have adjusted the tynes multiple times a day, but cannot recall adjusting them with Mr Dingjan, and certainly not after the truck driver had arrived.[208] Mr Diprose did say that he remembered there was one locking pin that was a little bit bent at the top, but it did not stop it locking in. He said he had problems with the tynes themselves not moving very well, and he'd have to kick them, but when he cleaned and greased them, they would slide much more nicely.[209]

98. I accept Mr Diprose's evidence in preference to the evidence of Mr Tennick about whether the tynes were adjusted prior to Mr Dingjan's attempt to unload the truck. Mr Diprose's evidence at the inquest was consistent with both his statement and interview with WST in that he was attending to duties in the dispatch office for approximately 45 minutes prior to the accident. He was still in that office when he heard *"an almighty bang"*.[210]. His statement was taken shortly after the accident, and he was interviewed approximately 6 weeks thereafter. In his interview Mr Diprose says

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[202] T118 [19-36], T140 [25]-[39].
[203] Mr Sindorff T258 [11]-[14], Mr Sharp T182 [9]-[27] and Mr Diprose T276 [23]-[27].
[204] Exhibit C9 – Affidavit of Mr Wayne Rice.
[205] T160 [14]-[15].
[206] T123 [26-[41], T135 [16]-[20].
[207] Exhibit C34.
[208] T273 [15]-[30].
[209] T276.
[210] Exhibits 13 and 13A.

he had no idea the truck had arrived nor where it was parked prior to the accident[211]. In those circumstances it is not consistent with that evidence that he then, just prior to the accident, adjusted the tynes as alleged by Mr Tennick. By contrast Mr Tennick had never advised anyone, in the almost 9 years since the accident, that Mr Diprose adjusted the tynes just prior to the truck being unloaded until he gave evidence at this inquest. In addition, given the unchallenged evidence of Mr Rice to the contrary, that the forklift was in proper working order, and the agreed fact he inspected the locking pins, and they were working without fault, it is not open to accept Mr Tennick's evidence that the forklift was not in proper working order.

99. There was some evidence about the document 'Forklift Safety Driver's Daily Checklist' which on 19 October 2012 was signed by Mr Tennick. This was a document which was to be completed daily prior to the use of the forklift in order to ensure the forklift was safe to use. Mr Tennick said we *'did it for a little while and then- but it wasn't pushed upon us...'.*[212] While what Mr Tennick says in that regard may be so other witnesses gave evidence that checks of the forklift were made prior to its use however those checks were not documented. For example, Mr Sindorff said he performed checks of the forklift prior to using it, everything was in a working condition and that was something required of him as a forklift operator.[213] Mr Fraser said he would make visual checks of the forklift.[214] Mr Diprose said he could not remember doing daily checks on the forklift and not doing a check sheet, but he checked oil and water every now and then.[215]

100. The unchallenged evidence of Mr Rice is the seatbelt provided for use by the operator of the forklift was fully functional and in good order.[216]

101. Given the evidence which I have outlined I find there were no mechanical issues with the forklift that contributed to this accident.

3. Any training, instruction and supervision given to employees of Roadside Products, including Mr Dingjan, in order to safely operate forklifts as part of their work, and in particular policies and procedures about the use of forklifts to load and unload materials such as those being unloaded on the day of the accident.

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[211] Exhibit 13A at page 24.
[212] T126 [28]-[42].
[213] T242 [23]-[31].
[214] T194 [14]-[16].
[215] T269 [5]-[18].
[216] Exhibit C9.

102. There was limited training, instruction and supervision given to employees in order to safely operate forklifts. The evidence established there was a reliance by RP on the training an individual employee received as part of the course they participated in to obtain the forklift licence. A review of the WST file at Exhibit C38 does not reveal any relevant written safety policies or procedures with respect to the safe operation of forklifts. In the absence of any such documents on the WST file, and in the absence of evidence relating to those documents at the inquest, I find there were no written safety policies or procedures with respect to the safe operation of forklifts.

103. At the inquest, the existence of any verbal policies was explored with the witnesses.

104. Mr Randall gave evidence that Mr Dingjan had an induction in Brisbane.[217] Mr Randall also said this was an over-arching induction and he received a site induction at the factory at St Leonards from Mr Sindorff.[218] In his WST interview, he indicated Mr Dingjan's induction records were not able to be located and that Mr Dingjan was inducted verbally in Launceston.[219]

105. Mr Sindorff said he could not recall inducting Mr Dingjan but assumes he would have done.[220] He indicated he would usually do inductions with new staff "*telling them when their breaks were, where all the exits were, fire exits, ah what their role was.*"[221] He stated that would include information about safe work procedures and operating forklifts, but not where trucks should be parked, although it could have been.[222] Mr Sindorff said he cannot recall telling Mr Dingjan where trucks ought to have been parked at any time.[223]

106. Mr Randall said Mr Sindorff would conduct the induction and it was Mr Sindorff's responsibility to show a new employee the driveway, but he cannot remember if it was his or Mr Sindorff's responsibility to advise the employee about the loading or unloading of trucks.[224]

107. Employees of RP gave the following evidence about verbal instructions received with respect to forklift safety and use:

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[217] T290 [37]-[38].
[218] T291 [4]-[21].
[219] C12A at pages 6-7.
[220] T224 [32]-[42].
[221] T225 [8]-[9].
[222] T226 [11]-T227 [19].
[223] T226 [29]-[30].
[224] T322 [5]-[11].

a. Mr Tennick gave evidence he had had a forklift licence since 2009 which he obtained while working for RP. He used a forklift as part of his job nearly every day to move bins around. He would only unload a truck when there was no-one else present to do it[225]. As to instructions and training he received, it was verbal and it was provided to him by Mr Sindorff: "*John had given me some instruction, just to take it easy and keep the load low when you were coming back up the driveway*". [226] He noted he was not aware of any written procedures[227]. He said he received general safety instructions, with respect to operating a forklift, when he acquired his licence[228].

b. Mr Sturmer said the following about whether there were any changes in unloading policies after the accident: "*Not that I was aware of... I didn't have a forklift document – licence, but there's normally only two or three people used to unload the um - the trucks um but we did have um meetings regarding more forklift safety but as I wasn't involved in driving forklifts-*" and that he was stuck on the blow moulder all day so he "*missed a lot of that stuff*".[229]

c. Mr Sharp also had a forklift licence and would use the forklift to unload trucks.[230] When asked about guidelines or training on how to unload in relation to the driveway he said "*I'm not aware but I imagine when I first started John would have taken me out and shown me how to unload the truck.*"[231] He also said he could not recall any training about safely operating forklifts, but believes he was supervised the first few times he unloaded a truck.[232]

d. Mr Fraser said he did not receive any training about how to use the forklift at RP and could not recall anything communicated to him from other employees about operating on the slope.[233] His training about how

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[225] T120 [15]-[31].
[226] T123 [1]-[2].
[227] T123 [12]-[13].
[228] T124 [7]-[9].
[229] T174 [10]-[21].
[230] T177 [16].
[231] T179 [1]-[5].
[232] T180 [7]-[16].
[233] T190 [38]-[42]- T191[1]-[5].

to use the forklift at RP's site came from his own experience.[234] He also said prior to him operating a forklift there were no policies or procedures put in place by RP about operating the forklift.[235]

e. Mr Diprose said that when he started at RP in mid-2013 he recalls the induction processes being *"shown around, taught everyone* [sic], *shown the office area"*.[236] Mr Diprose stated he could not recall any information being given to him about loading and unloading of trucks, about where the trucks should park and he was not given any information about how the forklift should be used in the driveway of RP[237], or any recollection of Mr Sindorff, Mr Randall or any other representative of the company telling him to avoid loading on the slope.[238] With respect to loading from the western or road-side when a truck was parked parallel to the factory he said he recalled being told to be a bit more careful *"coming around as we come up the slope"* but he could not recall who said that.[239]

108. Employees of RP also gave evidence about the information they received from RP about where trucks should be unloaded:

a. Mr Sharp said there was nothing formal that would stipulate where trucks ought park, but the practice was they would park sideways against the factory; that is parallel to it.[240]

b. Mr Fraser says he was not sure whether employees were told where trucks should park, but it seemed like the best idea to him for trucks to park parallel to the factory. He also said *"I don't know whether the drivers were told. I think they may have been told to park like that way yeah."* [241]

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[234] T191 [7].
[235] T194 [10]-[12].
[236] T266 [29]-[32].
[237] T267 [5]-[13].
[238] T273 [32]-[35]
[239] T273 [37]-[42].
[240] T179 [9]-[14], T177 [24]-[26].
[241] T192 [38]-[40], T194 [1]-[5], T193 [35]-[39].

c. Mr Sindorff said there was no written procedure about where trucks should park but *"I know there was a verbal – a verbal you know 'This is how we should load trucks', but I think it was done after the accident."*[242]

d. Mr Sindorff said with respect to how trucks were to be unloaded *"[t]here was instruction given by Darran. Ah we had a toolbox meeting every fortnight"*[243]. He indicated these meetings which were safety meetings would be every fortnight and all employees would be present.[244] He said he did not have a specific memory about anything in respect of where trucks were to be unloaded, or with respect to forklifts, being raised in those meetings because *"[n]o because pretty muchly I was the one that unloaded the trucks.'*[245]

e. Mr Sindorff said there were no policies in place about where trucks should park prior to the accident.[246] He noted this changed after the accident with loads to be unloaded inside the factory, a checklist was to be completed, nothing was unloaded outside the factory so trucks were backed into the factory, the driver was standing in a safe area with the wheels chocked, and the truck couldn't move and was parked on a level surface.[247]

f. Mr Diprose stated he could not recall any information about the loading and unloading of trucks or where trucks should park.[248] He said there were no written policies on where trucks should park, or a verbal policy *"but best practice was near the building because that's where all the trucks would go"*.[249]

109. Mr Randall said his opinion was that trucks should be parked parallel to the factory to be unloaded, that he had communicated that to Mr Sindorff and to the other forklift operators, but he did not know if he communicated that to Mr Dingjan.[250] He would have communicated that information at a toolbox meeting, but he does not

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[242] T226 [32]-[36].
[243] T225 [17]-[20].
[244] T225 [35]-[42].
[245] T226 [4]-[9].
[246] T241 [40]-[42].
[247] T242 [5]-[14], T245 [33]-[36].
[248] T267 [5]-[10].
[249] T271 [33]-[39].
[250] T320 [12]-[29].

remember if there were any written procedures about where trucks ought park prior to the accident.[251] Mr Randall could not remember if Mr Dingjan had been made aware of where trucks were to be unloaded.[252] He said there were no incidents relating to the unloading of materials prior to the 7 November 2013.[253] Mr Randall stated there was a distinct directive given to all forklift operators not to operate a forklift outside that preferred unloading zone.[254]

4. An assessment of adherence to safe work practices, particularly as they related to loading and unloading of materials by forklift, at the workplace

110. Mr Randall gave evidence that at the time of this accident RP was an ISO9001 accredited company.[255] Mr Norton also said *"...my awareness of safety procedures in the factory were ah of a general nature I suppose. We were ISO[256]9001 accredited. We ah were – took our safety procedures very seriously, um we'd implemented you know huge amounts of changes to that machinery and how it was operated in any way in that factory when we took over in 2002... we were always extremely serious about safety"*[257] before the accident.

111. ISO9001 is an international standard with respect to quality business management systems. Ms Dawkins submitted no evidence was lead, or provided to me, as to what safety systems this standard required to be in place. However, Mr Taylor did not contend this standard related specifically to workplace safety matters, nor did he suggest accreditation under that standard meant that RP's workplace safety system had been approved by the international accrediting body. I agree with Mr Taylor. This standard was simply mentioned by Mr Norton during his WST interview.

112. Mr Sindorff sighted all employees forklift licences in late October 2013.[258] At that time there was evidence Mr Sindorff did not have a current forklift licence, because he had overlooked its renewal and he believed he did not need to renew it. He accepted he was incorrect in that regard.[259] This oversight is not, in my view, relevant to the circumstances of Mr Dingjan's death.

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[251] T320 [31]-[39].
[252] T305 [19]-[23].
[253] T305 [30]-[34].
[254] T325 [1]-[5].
[255] T301 [29]-[33].
[256] International Standards Organisation.
[257] T335 [25]-[30], T336[2].
[258] Exhibit C21, Affidavit – Mr Sindorff, at page 2.
[259] C21A- WST Interview, Mr Sindorff, at page 5.

Location of the unloading zone

113. The most common zone where trucks were unloaded was when trucks were parked parallel to the factory, and unloading and loading took place within the factory (eastern side) and on the other side of the truck, which was the road or western side. With respect to this zone, the following exchange took place between Mr Randall and his Counsel: "*[s]o the understanding, at least between you and ah John, was that that was where trucks got unloaded and it was safe to unload trucks there. Yes?..... Correct*" [260] I note however, trucks also parked perpendicular to the factory and were unloaded while parked in that position, as indicated by Mr Sindorff, Mr Diprose and Mr Baker in their evidence.

114. Mr Randall said his opinion was that trucks should be parked parallel to the factory, that he had communicated that to Mr Sindorff and the other forklift operators, but he did not know if he communicated that to Mr Dingjan.[261]

115. There is therefore a conflict between Mr Randall thinking that trucks should always be parked parallel to the factory and unloaded from that position, and Mr Sindorff unloading trucks parked perpendicular to the factory from time to time. Given this conflict it is clear the communication between them was not sufficient enough to ensure Mr Randall's expectations about where trucks were unloaded or loaded from were reflected in the work practice which was actually implemented by Mr Sindorff. That is clear given Mr Randall says he was not aware unloading of some trucks took place when those trucks were parked perpendicular to the factory[262].

116. The insufficient communication also suggests it is likely the message about the location of the loading zone, while being passed on successfully to Toll, was not passed on successfully to SeaRoad. Mr Randall said at the inquest he did not remember having a conversation with any Toll drivers or SeaRoad drivers about where trucks should be parked on the site.[263] Mr Randall said he had communications with management of Toll Transport about where trucks should be parked.[264] He said he could not remember if he had a similar conversation with the managers at SeaRoad.[265] He also said he could not remember if there were any signs erected at the site about

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[260] T305 [10]-[12].
[261] T320 [12]-[29].
[262] T320 [1]-[10].
[263] T319 [26]-[34].
[264] T321 [5]-[6].
[265] T321 [8]-[11].

where trucks should be parked.[266] The photographs suggest there were no such signs[267].

117. WST, by notice[268] dated 14 November 2013, sought amongst other things a copy of the traffic management plan with respect to RP's site at St Leonards and details of the immediate corrective actions taken by RP in order to prevent a recurrence of this accident. A traffic management plan and photograph were provided[269] whereby:

- a loading zone was identified by paint markings at the site; and
- a loading exclusion zone was identified on the traffic management plan.

118. In addition, a requirement to complete a load assessment risk form was implemented and that form was required to be completed before any loading or unloading occurred. Point 2 of the General Requirements in the form stated, *"Is the truck/trailer correctly positioned and level?"*. In addition, a Freight Loading and Unloading Company Procedure (P-OHS—024) was implemented and the training of all staff with respect to that procedure was conducted. These controls were implemented in order to prohibit the loading, or unloading, by the use of forklifts on ground other than the area defined in the traffic management plan as the loading area. That area has a flat surface and accordingly loading and unloading was not permitted on sloping ground.

119. The following exchange took place between Ms Dawkins and Mr Norton at the inquest:

> *"So are you aware of what was done after um the accident to improve safety in the driveway?.... The only thing that I was aware of that changed was an actual delineation line was painted on the concrete.*
>
> *Um so that's a physical line?..... Yes.*
>
> *And what what did that line indicate?..... It indicated an area for loading and unloading".*[270]

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[266] T321 [13]-[15].
[267] See Exhibit C27 and Exhibit C38, WST file, Volume 1, pages 80-108.
[268] Issued pursuant to s171 of the *Work Health and Safety Act* 2012.
[269] These documents and those described in paragraph 119 can be found in exhibit C 38, WST file, Volume 2, pages 45 to 52.
[270] T338 [6]-[14].

120. A photograph of the new loading/unloading zone appears at page 138 of Volume 2 of exhibit C38. The new company procedure (P-OHS-024) was issued on 22 November 2013.[271] The employee manual was also updated on 24 November 2013.[272]

121. Mr Webb noted in his experience that *"[t]here's a lot of sites these days, you would pull up into what's a designated unloading zone and then the driver would wait....- in driver's safety zone"*[273] while arrangements are made to unload the truck.

Wearing of seatbelts

122. At the time of the accident Mr Dingjan was not wearing a seatbelt[274].

123. Some employees gave evidence about seatbelt use. Mr Sturmer said he saw Mr Dingjan using a seatbelt and employees would use seatbelts, but he did not take much notice.[275] Mr Sharp stated he used a seatbelt but could not remember if others used the seatbelt when using the forklift.[276] Mr Fraser said he would use a seatbelt when operating the forklift, and he observed others wearing the seatbelt when using the forklift.[277]

124. Mr Randall stated he would operate the forklift very, very rarely, but when he did, he would always use a seatbelt. He always expected other employees to use a seatbelt and he always saw other employees using a seatbelt. In addition, he says there was a directive that employees use a seatbelt.[278]

125. Other employees gave evidence that they did not always use a seatbelt. Mr Tennick said he did not use a seatbelt when using the forklift, and he was sure some employees did not and maybe some did.[279] Mr Diprose stated that he wore a seatbelt *"[a]t times. Sometimes I did, sometimes I didn't"*.[280] He said he could not recall whether other employees used the seatbelt.[281]

126. Exhibit C38 contains a photograph of the seatbelt of the forklift used by Mr Dingjan. Under the photograph the caption says *"Photograph depicting the seatbelt as pulled*

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[271] Exhibit C38, WST File, Volume 2, page 130.
[272] Exhibit C38, WST File, Volume 2, page 281.
[273] T87 [27]-[31].
[274] Constable Joshua Hayes - T112 [9].
[275] T172 [22]-[36].
[276] T179 [25]-[34].
[277] T194 [26]-[27], [36]-[37].
[278] T316 [37]- T317[4], T325 [7]-[10].
[279] T124 [20]-[25].
[280] T268 [24]-[25].
[281] T268 [27]-[28].

directly out from the retractable housing. The seatbelt was creased from being wound up in a twisted state for an amount of time'. [282] The inspector's conclusion in his report was the seat belt had not been used for some time.[283]

127. Even if the evidence of Mr Tennick and the evidence in paragraph 126 is put to one side there is still evidence of two employees, namely Mr Diprose and Mr Dingjan, on the day of his accident, who did not wear a seatbelt. This can only lead to the conclusion the directive mentioned by Mr Randall that employees were to use a seatbelt when operating a forklift was either not given, or, if it was, not enforced.

128. Counsel Assisting submits it is not known whether if Mr Dingjan had been wearing a seatbelt, he would have died. Given this, she says the lax culture around seatbelt wearing is only relevant to adherences to safety practices at the site. There are no submissions on this point from either Mr Taylor or Mr Tony Dingjan. I agree, given the evidence, wearing of the seatbelt was not enforced by RP however I do not agree that it is not known had Mr Dingjan been wearing a seatbelt he would have died. The evidence with respect to this issue is as follows. Dr Ritchey says the cause of death was blunt trauma to the head, neck and chest[284]. This included a compressive subarachnoid haemorrhage of the cerebellum and occipital hemispheres, a transverse fracture of the vertebral column at C5 and a complete transection of the vertebral column and spinal cord[285], multiple rib fractures and a transverse fracture of the sternum. These are all very serious injuries. Mr Jones observed Mr Dingjan to be under the forklift after it had toppled over[286]. Senior Constable Rybka says Mr Dingjan's body was trapped between the frame and the concrete[287]. Mr Randall at first thought Mr Dingjan was trapped underneath the forklift. He observed him lying on the ground in the cab, with his neck at an acute angle to his chest. His head was hard up against the roof, which pushed his chin into his chest. One of his legs looked to be severely broken under the rollover protection system.[288] Mr Diprose says he could see Mr Dingjan's legs underneath the body of the forklift and his body was pushed up against the roof of the forklift which pushed his head forward so his chin

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[282] Exhibit C38, WST File, Volume 1, page 94. The seatbelt is also photographed in C27, photographs 22 and 23.
[283] Exhibit C38, WST File, Volume 1, page 21.
[284] Exhibit C5.
[285] These injuries may have occurred as a result of Mr Dingjan's head hitting the concrete driveway and/or the roll over protection system of the forklift.
[286] Exhibit C11.
[287] Exhibit C28.
[288] Exhibit C12.

was on his chest.[289] This is very similar to what Mr Randall says he saw. Similar evidence is given by Mr Jacobson[290], Ms Dahlvid[291] and Mr Ryan[292]. The photographs depict a badly broken left leg which is trapped under the rollover protection cage of the forklift with Mr Dingjan's body lying on the concrete but facing towards the chair in which the operator of the forklift sits when operating the forklift[293]. The weight of the evidence favours a finding that Mr Dingjan's left leg was trapped under the forklift, not his whole body, and that he was lying on the concrete of the driveway in the manner described by Mr Randall, Mr Diprose, Mr Jacobson, Ms Dahvlid and Mr Ryan but facing towards the operator's chair; and I so find. The weight which Mr Dingjan was attempting to lift with the forklift was substantial and as it toppled over significant force resulted in Mr Dingjan being ejected from the operator's chair with his body rotating so that his left leg became trapped under the right-hand side rear pillar of the rollover protection system. The force had to be very significant, given the various serious injuries described by Dr Ritchey. I am satisfied, to the requisite standard, Mr Dingjan would not have been ejected from the operator's chair of the forklift and he would not have sustained the very serious injuries, which were sustained, had he been wearing the seatbelt. In those circumstances he would not have died.

Who was responsible for unloading when Mr Sindorff was on leave?

129. Mr Sindorff went on one month's leave a few days before this accident. When asked who was going to do the unloading in his absence he said *"[t]here were no specifics. I assumed that – well I assumed that Mark was doing my role. We trained Mark up to do my role."*[294] Mr Randall said when Mr Sindorff went on leave, it was intended that Mr Diprose be responsible for unloading trucks and this was communicated to Mr Diprose and to other employees.[295] Mr Diprose was asked, when Mr Sindorff went on holiday, whether it was discussed about who would be the main operator of the forklift in his absence. Mr Diprose said, *"no discussions but I basically jumped into his role"*.[296]

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[289] Exhibit C13.
[290] Exhibit C14.
[291] Exhibit C16.
[292] Exhibit C17.
[293] Exhibit C27 and the WST file, Exhibit C38, Volume 1 pages 105-106.
[294] T 227 [20]-[28].
[295] T319 [10]-[16].
[296] T268[1]-[3].

130. Given the state of this evidence it is not clear Mr Diprose was told directly he would assume Mr Sindorff's duties in the latter's absence however given Mr Diprose's position within the work force at RP it is clear he was aware he would assume those duties[297]. It was submitted by Counsel Assisting that these arrangements are unclear and tentative, with the relevant employee, Mr Diprose, not advised by RP that he would be responsible for unloading in Mr Sindorff's absence. Even if Mr Dingjan was unaware of these arrangements there is no evidence, had he known, that he would have asked Mr Diprose to unload the truck rather than unloading it himself.

Further submissions

131. Counsel Assisting submits had there been training or communication on where trucks were to park, and a direction that the forklift was not to be operated on the slope of the driveway when loading or unloading, this may have prevented the accident. Although she does not say so, given what I have said in paragraph 128, it might also be said had there been enforcement of the requirement of forklift operators to wear the seatbelt when loading and/or unloading then this may well have prevented Mr Dingjan from sustaining fatal injuries. Further training, policy or communication in these areas, it is submitted, would have promoted a safer workplace by ensuring all employees were aware of these particular risks and safety protocols that some employees considered assumed knowledge. No records of toolbox meetings or specific details of these matters being raised with employees were able to be identified.

132. Counsel Assisting also submits if the action of marking a designated loading/unloading zone after the accident had been undertaken prior to the accident then this would likely have prevented Mr Dingjan's death, as it would have clearly indicated to Mr Jones, the truck driver, and Mr Dingjan where the unloading was expected to take place.

133. While I agree with Counsel Assisting's submissions from a common sense point of view the question is whether the employer, in this case, ought be criticised for failing to provide directions and training to Mr Dingjan not to operate a forklift on a slope and to wear the seatbelt provided? Should RP also be criticised for failing to provide a designated loading/unloading zone prior to this accident?

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[297] Mr Diprose was the leading factory hand who worked under Mr Sindorff: Exhibit C13 and C13A at page 2.

134. Work, health and safety law around Australia casts a duty on an employer to ensure, so far as is reasonably practicable, the health and safety of its workers while they are at work[298]. At common law, with respect to the tort of negligence, a duty of care arises on the part of a defendant to a plaintiff when there exists between them a sufficient relationship of proximity, such that a reasonable man in the defendant's position would foresee that carelessness on his or her part may be likely to cause damage to the plaintiff[299]. Such a duty is owed by an employer to its employees.

135. The duty imposed by work, health and safety law is qualified by the use of the expression "so far as is reasonably practicable". After considering a number of authorities Porter J in *Kent v Gunns Limited* [2009] TASSC 30 said, amongst other things, *"the primary element of the offence is the failure to ensure so far as is reasonably practicable that each employer is safe from injury and risk to health. The obligation created is not an absolute one..., 'reasonably practicable' means something narrower than physically possible or feasible... what is reasonably practicable is to be judged on the basis of what was known at the relevant time... foreseeability of risk of injury is likely to be a subject for consideration in reaching a determination as to whether the element of ensuring safety so far as was reasonably practicable has been made out. However, such a consideration does not import common law requirements... as an element of the offence."*[300]

136. His Honour continued by saying when considering the issue of foreseeability and the broader issue of practicability, the dangers of the use of hindsight must be taken into account; that is the question of whether reasonable care was exercised is to be judged prospectively and not by retrospectively asking whether a defendant's actions could have prevented the plaintiff's injury.[301] Allowance must also *"be made for the fact that inattention or misjudgement are common features of everyday work, and the chance of haste, carelessness, inadvertence, inattention and even unreasonable or disobedient conduct, must be recognised."* [302]

137. At common law the position is, as enunciated by Mason J, as follows:

> *"In deciding whether there has been a breach of the duty of care the tribunal of fact must first ask itself whether a reasonable man in the defendant's position*

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[298] See for example s19 of the *Work Health and Safety Act* 2012 (Tas).
[299] *Wyong Shire Council v Shirt* [1979-1980] 146 CLR 40 at 44 per Mason J; as he then was.
[300] *Kent v Gunns Limited* [2009] TASSC 30 at [44].
[301] *Kent v Gunns Limited* (supra) at [45]. This principle also applies in the common law context.
[302] *Kent v Gunns Limited* (supra) at [46].

would have foreseen that his conduct involved a risk of injury to the plaintiff or to a class of persons including the plaintiff. If the answer be in the affirmative, it is then for the tribunal of fact to determine what a reasonable man would do by way of response to the risk. The perception of the reasonable man's response calls for a consideration of the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have. It is only when these matters are balanced out that the tribunal of fact can confidently assert what is the standard of response to be ascribed to the reasonable man placed in the defendant's position.

The considerations to which I have referred indicate that a risk of injury which is remote in the sense that it is extremely unlikely to occur may nevertheless constitute a foreseeable risk. A risk which is not far-fetched or fanciful is real and therefore foreseeable. But, as we have seen, the existence of a foreseeable risk of injury does not in itself dispose of the question of breach of duty. The magnitude of the risk and its degree of probability remain to be considered with other relevant factors." [303]

138. It is clear from cases such as *Baiada Poultry v The Queen* [2012] 246 CLR 92 and *DPP v JCS Fabrications Pty Ltd and Anor* [2019] VSCA 50 employers have relied on the expertise of their employees or subcontractors engaged by the employer to carry out work for the employer. That argument as explained by the joint judgment of the High Court in *Baiada Poultry v The Queen* (supra) is relevant only to the question of what was reasonably practicable for an employer in the circumstances. That is the employer sought to argue the prosecution had not proved beyond reasonable doubt that the employer had not ensured the health and safety of their employees or subcontractors as reliance on an employee or subcontractor's expertise was a step which was reasonably practicable to have taken to provide and maintain a safe working environment[304]. In addition, *"demonstration that some step could have been taken does not, without more, demonstrate that to fail to take that step was a breach of the*

[303] *Wyong Shire Council v Shirt* [1979-1980] 146 CLR 40 at 47-48.
[304] *Baiada Poultry v The Queen* [201] 246 CLR 92 at [11]-[16].

obligation so far as was reasonably practicable to provide and maintain a safe working environment"[305]

139. Mr Dingjan was a highly qualified, competent and diligent forklift operator. Contrary to his training he has attempted to unload the pack of steel on a slope when not wearing a seatbelt. As I have already said my role is to make findings of fact from which others may draw conclusions. This process requires the making of various findings, but without apportioning legal or moral blame for the death. In those circumstances it is not for me to say whether RP has breached its workplace health and safety obligations or been negligent. However, in the circumstances of this case, I can say RP was entitled to rely on Mr Dingjan's expertise given his work history. While re-enforcement of training that loads were not to be unloaded on the slope of the driveway and seatbelts were to be worn, may well have reduced the risk of this accident occurring, my view is RP ought not be criticised for failing to provide these directions. Likewise requiring RP to implement the traffic management plan, which was imposed after this accident, prior to it occurring when the evidence does not reveal any previous accidents or near misses on the slope or indeed a delivery being unloaded that far down the driveway where Mr Dingjan chose to unload it, would involve the application of retrospectivity.

Conclusions

140. Although Mr Dingjan's position at RP was to operate the blow moulder, he would be required to operate a forklift to unload trucks from time to time. Mr Dingjan was a hardworking and safety conscious employee who was a good forklift operator. He was experienced in operating forklifts and was licensed to do so.

141. Trucks would usually park parallel to RP's factory to be loaded and/or unloaded, however they had, less frequently, parked perpendicular to the factory. On those occasions, the load was usually at the head of the truck, or the truck was reversed up the driveway enabling the forklift operator to unload on the flat section of the driveway.

142. The presence of the container at the top of the driveway and to the left-hand or northern side of the factory did not prevent trucks being parked parallel to the factory in the usual loading/ unloading area.

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[305] *Baiada Poultry v The Queen* (supra) at [38].

143. There was no designated loading/unloading zone or signage identifying where loading and unloading was to be carried out at the site on the day of this accident. The communication to delivery drivers about where trucks should park was given to Toll as that company's drivers tended to park parallel to the factory. That same message did not reach the drivers who were employed by SeaRoad given the evidence of Mr Jones.

144. There was no formal procedure, or other written communication, provided to employees of RP about where trucks should park. Whether or not it was communicated informally by oral means to employees as to where trucks should park, trucks occasionally did park perpendicular to the factory.

145. There was a reliance on an individual employee's training by RP and there was an absence of policies or procedures on the safe use of the forklift. Mr Randall and Mr Sindorff were aware of safe unloading of forklift procedures but did not communicate or train employees on this topic. Although Mr Sindorff did most of the unloading of trucks using a forklift (95%) there were other employees trained in forklift use and expected to use the forklift to unload trucks, including Mr Dingjan.

146. There were no identified written or formal polices on forklift use tendered at the inquest and Mr Randall had a lack of memory on these and other matters. In fact, the quality of the evidence in this case generally from a number of witnesses was materially affected due to the lapse of time between the accident, the institution of a work, health and safety prosecution and the notification provided to my office by WST on 22 April 2021 that the prosecution would not proceed.

147. Mr Webb, the operations manager of the Youngtown depot of SeaRoad was somewhat critical of Mr Jones for not evaluating the site for the forklift user. Mr Jones, in my view, contemplated the risk which unloading on the slope created because his evidence was that he wondered if he would be unloaded where he had parked the truck.[306] Mr Dingjan also recognised the risk that something might happen because he advised Mr Jones to get out of the way just in case.[307]

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[306] See paragraph 43. Mr Jones' operations manager, Mr Webb, also recognised the risk; see paragraphs 60 and 61.
[307] See paragraph 51.

148. In addition, those loading Mr Jones' truck at SeaRoad and Mr Jones himself should have identified the difference in packaging on the steel, in that the pack was not attached to dunnage or a pallet, and accordingly when the steel was lifted by the forklift there was a risk of the steel slipping because the steel would be resting on the steel tynes. SeaRoad, in my view, had an obligation to ensure the steel was properly packaged so it could be safely loaded onto its delivery truck and so that it could also be safely unloaded at its destination.

149. I agree with the statement made by Mr Tony Dingjan, in his written submissions, that his son made an error of judgement on the date of this accident to unload the pack of steel from SeaRoad's truck on the slope of RP's driveway. His error was compounded by the fact he failed to wear the seatbelt provided. Both these errors were contrary to the training he had received when he obtained his licence.

150. Finally, Mr Tony Dingjan says in his written submissions *"... I am convinced if Josh had been told not to unload in that zone that he would have not wilfully disregarded that instruction."* The same can be said if he had been given an instruction to always use the seatbelt provided in the forklift. There is no reason, given the evidence in this case, to think that Mr Dingjan would have unloaded the truck, in the position on the driveway where he chose to unload the truck, without using the seatbelt if he had been told not to unload it on that slope while not using the seatbelt. Mr Dingjan was after all a reliable, hard-working and conscientious employee who was skilled in his job. The question is whether RP were obliged to tell him what was plainly obvious, and which was consistent with the training he had received when he obtained his licence. In the absence of any evidence which put RP on notice Mr Dingjan could not be relied upon to take the precautions which he had learned during his forklift operation training, because he made rash decisions, was intemperate, careless or inpatient, then the answer to that question is RP were not so obliged.

Comments and Recommendations

151. As the business operated by RP no longer exists there are no recommendations that need to be made with respect to that business or that site. However, it is appropriate that some general recommendations be made with respect to the transport and logistics industry. The first two recommendations are made in order to reinforce training which is received by those who successfully obtain a forklift operator's licence. I therefore **recommend**:

- all drivers of forklifts use any seatbelt provided when operating a forklift[308];
- an operator of a forklift ought not load or unload a truck on a slope or gradient or turn. These manoeuvres should always be carried out on a level surface; and
- all packs of steel should be attached to a pallet or dunnage so a pack of steel can be safely loaded onto, and unloaded from, any truck without slipping.

152. I extend my appreciation to investigating officer Constable Joshua Hayes for his thorough investigation and report.

153. I thank counsel namely Ms Dawkins, Ms Belonogoff and Mr Taylor for their assistance in this matter. I also thank Mr Tony Dingjan.

154. Finally, I convey my sincere condolences to the family and loved ones of Mr Dingjan.

Dated: 15 February 2024 at Hobart in the State of Tasmania.

Magistrate Robert Webster
Coroner

[308] The failure of an employee to wear a seatbelt can be avoided if when buying or replacing a forklift the employer purchases a forklift which can only be operated when the seatbelt is fastened. Alternatively, an employer might consider fitting an interlock switch to the seat belt to prevent operation of the forklift when the seat belt is not worn.