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

Guy Redman Clark

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Simon Cooper, Coroner, having investigated the death of Guy Redman Clark with an inquest held at Launceston in Tasmania make the following findings.

Hearing Dates

23-25 September 2019 at Launceston and

27 September 2019 at Hobart in Tasmania

Representation

P Zeeman, Counsel assisting the Coroner;

S Thompson for the Regulator, WorkSafe Tasmania (WST); and

T Cox for Pyengana Dairy Company Pty Ltd and Pyengana Trading Company Pty Ltd.

Introduction

1. Guy Redman Clark died when he was electrocuted at work shortly after 9.00am on 20 October 2015.
2. Mr Clark was working as the facilities manager at the Pyengana Dairy, Pyengana in Tasmania. Pyengana Dairy Company Pty Ltd was the owner of the premises and Pyengana Trading Company Pty Ltd ran the businesses conducted on the site including a dairy and the Holy Cow Café. At the time of his death, Mr Clark had been employed by Pyengana Dairy Trading Pty Ltd for about 10 months. A capable and skilled man, Mr Clark was obviously well liked by his colleagues and valued by his employer.
3. He is survived by his wife Lesley Anne, daughters Natasha and Mieke and grandchildren Lennox, Ada, Noah and Indigo, as well as his brother Dennis and sister Jan. His death was undoubtedly a shock to all who knew and loved him.
4. A big man physically, his medical records indicate he was in reasonable health. At the time of his death, he was prescribed medication for high blood pressure

and depression. I am quite satisfied that no pre-existing health condition caused or contributed to his death.

What a coroner does

5. Before looking at the circumstances surrounding Mr Clark's death it is necessary to say something about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. Because Mr Clark died as the result of an accident which occurred whilst he was at work the *Coroners Act 1995* (the *Act*) makes an inquest mandatory, subject to one exception.¹ That exception is that a coroner may dispense with an inquest if the Senior Next of Kin of the deceased person requests the coroner not to hold an inquest.² In this case, the Senior Next of Kin, Mr Clark's widow, Mrs Lesley Clark, did not make such a request.
6. An inquest is a public hearing.³ The public aspect of any inquest is particularly important so that any lessons learned can be better understood by the wider community.
7. When investigating any death, whether or not an inquest is held, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Act* asks. Those questions include who the deceased was, how he or she died, what was the cause of the person's death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death.⁴ A coroner is required to make findings of fact from which conclusions may be drawn by others.⁵ A coroner may also, if he or she thinks fit, make comments about the death being investigated or, in appropriate circumstances, recommendations with a view to preventing similar deaths in the future. This is a particularly important function in the context of workplace deaths.

¹ Section 24(1)(ea).

² See section 26A generally.

³ Section 3.

⁴ See *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7.

⁵ See *Keown v Khan* [1998] VSC 297; [1999] 1 VR 69, Calloway JA at 75 – 76.

8. A coroner does not impose punishment nor award monetary compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner have the power to charge anyone with crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that she or he thinks someone is guilty of an offence.⁶
9. As noted above, one matter that the Act requires is that a finding be made about how death occurred.⁷ It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.⁸ 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.
10. Finally, it should be noted that the standard of proof at an inquest is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an enquiry reaches a stage where findings being made may reflect adversely upon an individual the standard applicable is that set out in the judgment in *Briginshaw v Briginshaw*.⁹ That case stands for the proposition that it is particularly important to bear in mind the seriousness of any allegation when deciding whether that allegation is true or not. Put another way, the task of deciding whether a serious allegation is proved should be approached with great caution.

The issues at inquest

11. A number of issues were identified in advance of the inquest as particular matters that required closer consideration. Those issues were circulated to all interested parties. The issues identified were as follows:
 - a) The adequacy of the approval, construction and/or the inspection of construction of the Holy Cow Café at 163 St Columba Falls Road

⁶ Section 28(4) of the Act.

⁷ Section 28(1)(b).

⁸ See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.

⁹ (1938) 60 CLR 336 (see in particular Dixon J at page 362).

Pyengana (the café), particularly in relation to the installation of the Residual Current Devices (RCDs).

- b) The installation and/or adequacy of the installation of and servicing history of the dishwasher at the café particularly in relation to the appropriate wiring of the dishwasher.
- c) The adequacy and appropriateness of the staff training and instruction given to staff at the café, particularly with respect to:
 - defining their roles and duties;
 - first aid; and
 - the removal of the coffee machine and the dishwasher.
- d) The adequacy and appropriateness of any instructions given to the deceased on the removal of the coffee machine.
- e) The adequacy and appropriateness of the first aid/medical care provided to the deceased at the café including but not limited to the response and training of any attending police officer or other third parties.
- f) The adequacy and appropriateness of the investigation of the Department of Justice (WST) represented by Inspectors pursuant to the *Work Health and Safety Act 2012* and the subsequent disclosure of the same to the Office of the Coroner.

Evidence at the inquest

12. A number of witnesses gave evidence at the inquest. In order those witnesses were:

- a) Ms Nicole Blair;
- b) Mr Greg Gibson;
- c) Mr Damus Fry;
- d) Mr Jamie McKimmie;
- e) Ms Amanda Cropp;
- f) Ms Lara Bishop; and
- g) Ms Tahnee Williams – all work mates of Mr Clark at the time of his death; and
- h) Mr Ian Ransley – an appliance technician;

- i) Constable Allison Ward – Tasmania Police;
 - j) Sergeant Rob King – Tasmania Police;
 - k) Mr Bradley Pfundt – an electrician;
 - l) Mr Paul Kitchener – formerly an inspector with WorkSafe Tasmania;
and
 - m) Ms Robyn Pearce – Director, Industrial Safety, WorkSafe Tasmania.
13. In addition to the witnesses set out above evidence in the form of affidavits, records and reports was received from a number of other witnesses who were not called to give evidence at the inquest. That evidence included:
- a) An affidavit of Dr Marcus Yong confirming life extinct;
 - b) An affidavit of Mr Michael Laherty dealing with identification;
 - c) The Post-Mortem report of Dr Donald Ritchey, Forensic Pathologist;
 - d) Toxicological and Biological analysis reports from Forensic Science Service Tasmania;
 - e) The medical records relating to Mr Clark held by Dr Julian Henley, General Practitioner;
 - f) Ambulance Tasmania Patient Care Records;
 - g) An affidavit of Mr Jack Metham – a colleague of Mr Clark’s;
 - h) An affidavit of Senior Constable Chris Richardson – one of the attending officers; and
 - i) An affidavit of First Class Constable Bridget Tyson, a Forensic Officer, (which included a bundle of 87 photographs she took at the scene).

Circumstances of Mr Clark’s death

14. Mr Clark went to work as normal on Tuesday 20 October 2015. A number of other people were at work that day including Ms Nicole Blair, Mr Jamie McKimmie, Mr Greg Gibson, Mr Damus Fry, Mr Jack Metham, Ms Amanda Cropp, Ms Tahnee Williams and Ms Lara Bishop.
15. Mr Clark’s first job for the day was to remove the coffee machine in the café. The evidence was that the machine had been operating in a less than satisfactory way and needed to be taken to Launceston for inspection, repair and servicing. In fact, it had been intended to carry out the job the day before

but early starting staff had switched on the machine (presumably to make coffee) and it was too hot to be able to be moved.

16. Several witnesses described the machine as being a large industrial type machine, typical of the models seen in cafés throughout the country. Ms Nicole Blair said that it was of such a weight as to require a two person lift in order for it to be moved safely. The general size and nature of the coffee machine was clear enough from some of the photographs taken by Constable Tyson, the Forensic Officer.¹⁰
17. The coffee machine was located on a bench in the café. Directly under the coffee machine was a 'Norris' brand industrial glass washing machine. The machine was variously described as a dishwasher or glass washer by witnesses in their evidence – but I am satisfied that each witness was talking about the same machine, regardless of what they called it. The glass washing machine is depicted in a number of photographs taken by Constable Tyson.¹¹ I will return to the machine shortly.
18. Mr Clark's job was to remove the coffee machine and replace it with a spare machine. The spare was kept in a storage shed on the property. The shed was apparently known to staff as 'George'.
19. Mr Jamie McKimmie swore an affidavit, which was tendered, and he gave evidence at the inquest. He said that shortly after he started work at the Dairy at 9.00am he was approached by Mr Clark who asked for his help with the coffee machine. Mr McKimmie said that when he and Mr Clark moved the coffee machine water 'started to go everywhere'. The two men put the coffee machine down and moved the glass washer to attempt to find the tap to which the coffee machine water hose was attached so it could be turned off. They were unable to locate a tap behind the glass washer. As they moved the glass washer, a water pipe attached to it was dislodged.
20. Mr McKimmie looked behind a refrigerator (next to the glass washer) but could not see a tap there either. Mr Clark went to the cellar where he located, and turned off, the tap that supplied water to the coffee machine. He returned

¹⁰ See exhibit C20 generally and in particular photographs 941130_21.JPG and 25.JPG.

¹¹ *Supra*, photographs 941130_7.JPG and 55.JPG.

to the café where he and Mr McKimmie disconnected the coffee machine and moved it onto a bench in the kitchen.

21. Mr McKimmie went with Ms Nicole Blair to the storage shed 'George' to get the spare (replacement) coffee machine. Mr Clark laid two black plastic garbage bags on the floor (presumably to protect his clothing from the water which had accumulated on the floor).
22. Ms Amanda Cropp was working nearby in the kitchen. She described hearing a 'bang' and rushed to the kitchen door to look into the café. She could see Mr Clark, lying down on his right side. She said he 'appeared to be looking at something under the dishwasher'. Ms Cropp then realised Mr Clark had been electrocuted and called for help. She told other staff that something was wrong with Mr Clark and asked Ms Lara Bishop to call an ambulance.
23. Ms Bishop notified Mr Gibson, the manager, by phone, and then rang 000. Ms Blair and Mr McKimmie also rushed back to the café to help. Ms Blair turned off the power to the café at the switchboard.

Response of Emergency Services

24. At approximately 9.30am Tasmania Police Radio Dispatch Service (RDS) contacted the nearest Police Officer on duty, Constable Ward (at the time Constable Rolls – she has since the date changed her name as a consequence of marriage), at St Helens and tasked her to attend the dairy. Constable Ward arrived shortly before the Ambulance. Having been told by RDS that someone had been electrocuted, she took a portable automated defibrillator (AED) from the police vehicle with her when she went into the dairy. Constable Ward saw Mr Clark's body lying on the floor behind the counter in the general area of the kitchen. She described him as lying flat on his back, with his head facing the rear sliding doors and his feet facing into the café. She saw Mr Jack Metham and Mr McKimmie performing CPR on Mr Clark. Mr Greg Gibson was also involved in efforts at CPR, as was a visitor to the café, apparently a qualified nurse. Using the AED, and following the instructions provided by it, she assisted with CPR. The CPR performed by Constable Ward continued. She was assisted by Senior Constable David Richardson who arrived shortly after

her. Upon their arrival at 10.09am Ambulance Tasmania personnel took over resuscitation efforts.

25. The relevant Ambulance Tasmania electronic records (tendered at the inquest) indicate that the 000 call was received at 9.23am.¹² An ambulance was dispatched immediately and was en route to Pyengana 3 minutes later from St Helens. The ambulance arrived at the scene at 10.09am.
26. Unfortunately, despite the efforts of Mr Metham, Mr McKimmie, Mr Gibson, Constable Ward, Senior Constable Richardson and Ambulance Tasmania paramedics, Mr Clark could not be revived.
27. I have set out in some detail the above timeline because it is necessary to consider carefully the response of the emergency services, particularly in light of the evidence of Mr Greg Gibson as to his perception of the adequacy of that response. In his evidence at the inquest, Mr Gibson said that the ambulance took over 2 hours to arrive. He claimed he personally performed CPR on Mr Clark for 110 minutes. I do not accept that this was so. The electronic, contemporaneous, records kept by Ambulance Tasmania in relation to Mr Clark's matter indicate that the response time was in the order of 40 minutes. These records are consistent with the tenor and substance of Constable Ward's evidence. Conversely, the records are inconsistent with the tenor and substance of Mr Gibson's evidence. I do not doubt that Mr Clark's death was a terrible experience for everyone directly concerned – including Mr Gibson who was very much at the centre of things – and that experience no doubt effected the accuracy of recollections of times and sequences of events.
28. Mr Gibson also said in his evidence at the inquest that Constable Ward seemed incapable of correctly operating the AED. Again, I do not accept that this was so. Constable Ward explained that the AED was brand-new and had never been used before. She said that as a consequence of the fact that the AED was new the packaging had not been removed from the unit's battery. Once Constable Ward identified that, and quickly unwrapped and reconnected the battery, she was able to proceed to use the defibrillator in accordance with her training, and the instructions that the unit gives. Her training in first aid enabled her to identify and rectify the difficulty with the AED.

¹² Exhibit C7, see in particular page 5.

29. I have set these matters out in some detail because I think it important to correct the impression given by the evidence of some witnesses at the inquest that there was in some way a less than adequate, or timely, response by emergency services to the tragedy. In fact, I am quite satisfied that the response was both timely and professional. To the extent that Mr Gibson's evidence in this regard was inconsistent with the evidence of emergency services personnel, and objective records tendered at the inquest, I reject that evidence.
30. It follows from this conclusion that in terms of the scope of the inquest set out above I am satisfied that the first aid/medical care provided to Mr Clark at the café, including but not limited to the response and training of any attending police officer or other third parties, was both adequate and appropriate.

The Investigation – an overview

31. After formal identification, and after it had been photographed, Mr Clark's body was removed from the scene and transported by mortuary ambulance to the Royal Hobart Hospital (RHH).¹³ At the RHH highly experienced forensic pathologist Dr Donald Ritchey performed a *post-mortem* examination upon Mr Clark's body. He found two thermal electrical burns on the palmar surface of Mr Clark's right hand as well as multiple thermal electrical burns on the left upper arm, left elbow and left hand. Dr Ritchey interpreted these findings as suggesting that Mr Clark came into contact with a live electrical source that produced a current that flowed through his right arm, central chest and neck, through the left arm resulting in seizure activity and a cardiac arrest which caused his death. I accept Dr Ritchey's opinion. It is clearly consistent with the objective evidence, to which I will turn shortly.
32. Samples taken at autopsy were analysed at the laboratory of Forensic Science Service Tasmania (FSST) for two purposes. First, DNA forensic biology profiling was undertaken to endeavour to prove, or disprove, the theory that Mr Clark had touched the inside of the glass washer by matching DNA with hair found in the dishwasher. That biological DNA profiling showed beyond

¹³ Exhibits C3 and C4.

question that Mr Clark had come into contact with the inside of the dishwasher.¹⁴

33. Second, toxicological analysis of samples taken at autopsy was also undertaken at FSST. The result of that testing showed clearly that Mr Clark did not have any alcohol or illicit drugs in his body at the time of his death.¹⁵ Thus, I am satisfied that neither drugs nor alcohol caused or contributed to Mr Clark's death.
34. The scene was comprehensively photographed. Forensic testing and collection of samples also occurred. Two (2) WST investigators arrived to commence the investigation under the *Work, Health and Safety Act 2013* at 12.32pm, while police were still on site. One of those investigators, Mr Paul Kitchener, gave evidence at the inquest.
35. Finally, given the fact that it was very clear that Mr Clark's death was either caused, or contributed to, by electricity, inspectors from Techsafe attended the scene and carried out enquiries. The report produced by Techsafe was provided to WST and also tendered at the inquest, as part of the WST file.¹⁶ Techsafe is an ASX300 company, contracted to carry out electrical inspections by Electrical Standards and Safety, part of WST's Consumer Building and Occupational Services, which is responsible for compliance with the *Electricity Industry Safety and Administration Act 1997*. Mr Thompson, for WST submitted, and I accept, that Techsafe is a subject matter expert in relation to electrical compliance. As such WST contracting out that particular function is, in my view, appropriate.

The removal of the coffee machine

36. It is necessary now to consider the circumstances in which Mr Clark came to be removing the coffee machine. The evidence was that Mr Clark had initially been employed at the café as a cook. Mr Gibson gave evidence that he promoted Mr Clark to the position of facilities supervisor. It is evident that Mr Clark was a skilled cook and had an understanding of machinery and business

¹⁴ Exhibit C6.

¹⁵ *Supra*.

¹⁶ Exhibit C32.

operations. The decision to promote him to facilities supervisor seems logical. The position description for that role indicates that the position involved, *inter alia*, being available to assist with breakdowns of equipment and the commissioning of new equipment. Mr Gibson said that when each new employee commenced work they were provided with what he described as a formal induction. He said he had a recollection of providing Mr Clark with that induction. The induction involved being familiarised with the site's amenities, procedures with respect to fires, how to use a payroll logon and log off system and generally advising Mr Clark as to where things on the premises were located. Mr Zeeman submits, and I agree, that the induction played no role at all in Mr Clark's death.

37. I do note that Mr Clark was given no training as to the use of any of the equipment in the café. Mr Gibson said that this was because Mr Clark had told him that he, Mr Clark, was familiar with the facilities and equipment in the café. It is inferred from this evidence that Mr Gibson was satisfied that Mr Clark knew how to use the coffee machine. It seems clear enough that he was, in a general sense, familiar with its operation. The fact that there was confusion in respect of the water supply to the coffee machine indicates to me at least that he may not have been completely familiar with all aspects of the machine's operation.
38. Returning to the issue of repairs, the evidence was that the general position seems to have been that any requests for repairs, maintenance and the like had to be referred to Mr John Healy, one of the directors of the trading company (it will be remembered that the trading company was responsible for the operation of the café, including the employment of staff). However, in the particular instance of the removal of the coffee machine the evidence was that no request for a repair of the machine was in fact referred to Mr Healy. The decision appears to have been made at the café that the machine needed to be removed and replaced with a spare in order that it could be serviced.
39. The evidence was that Mr Clark and Mr McKimmie were identified as the persons who would carry out the task. In advance of carrying out the task, Ms Blair turned the coffee machine off at its power point the night before (i.e. 19 October 2015). Ms Blair said in her evidence she spoke to both Mr Clark and

Mr McKimmie about undertaking the task. She told them to unplug and remove the coffee machine. She said in her evidence at the inquest that while she was aware of how to unplug the coffee machine from the power she did not know how to disconnect the hose. Self-evidently, she did not brief Mr Clark or Mr McKimmie as to how to go about disconnecting the hose. In fact the evidence seems clear enough that the job was regarded as straight forward and that neither man was told how to carry it out.

40. In the event, Mr Clark and Mr McKimmie started to remove the coffee machine. In doing so, the water supply to the machine (a rubber hose joined to the back of the machine) was dislodged. Water was spilt on the floor as a result. Some confusion followed as to the location of the tap to which the hose was connected. Both men initially thought it was located under the bench, behind the glass washer. In an attempt to find the tap, the glass washer was moved. This in turn dislodged the glass washer's wash pipe.
41. As I have already mentioned, Mr Clark then went to the cellar, located the tap to which the coffee machine water supply hose was attached and turned it off. The evidence is that he then went back upstairs to the café's kitchen. It seems he attempted to fix the glass washer; that is reconnect that machine's wash pipe. Having placed two large green garbage bags on the floor of the café near the glass washer, Mr Clark lay on the floor, one assumes to get access to the rear of the glass washer, in order to re-attach the wash pipe. He removed the washer's front glass panel, placed his hand and arm inside the machine, touched a 'live' terminal and was electrocuted.
42. I note that the power to the glass washer was not turned off. I also note that the power to the glass washer was not protected with an RCD. Finally, I observe that the problems which led to Mr Clark's death arose from the fact that he seems to have been unaware (or perhaps forgot) where the water supply for the coffee machine was. Had he been briefed, reminded or instructed as to the location of the water supply before he and Mr McKimmie carried out the job it is reasonable to conclude the chain of events which led to his death may not have ensued.

Electrical issues

43. Fundamental to the issues for consideration at the inquest was how it was that Mr Clark came to be exposed to an electrical shock of in excess of 240 volts. I have already explained how and why he came into contact with a live terminal. Another issue is, of course, why the terminal was live. The obvious answer is that the power to the glass washer had not been turned off. But this is only part of the answer. I turn now to consider the evidence in relation to the wiring and safety of the glass washing machine.
44. Mr Bradley Pfundt, an electrical practitioner, made an affidavit and gave evidence at the inquest.¹⁷ He said that he was called to look at an ice cream machine, coffee machine and the glass washer on 2 February 2016. He said that he went 'right through the café's electrics' at the request of Mr Gibson to 'ensure that it was safe for people to work in' after Mr Clark's death.
45. In carrying out the inspection, Mr Pfundt found at least two (2) anomalies. First he said that he found that the coffee machine had a 15 amp plug, which had been ground down to enable it to fit a standard electrical socket plug. Second, he found the plug on the glass washer was wired in reverse polarity i.e. positive from the cord flex was wired into the negative terminal on the plug and the negative from the cord was wired into the positive terminal on the plug. He said, and I accept, that the result of this was that when the machine's standby switch was turned off, power was still running throughout the machine. In other words, it was live, but that would not be apparent to anyone. In fact the fact that the machine was still 'live' would likely be obscured by the situation with the standby switch. However, the evidence in relation to Mr Clark's death is that the glass washer was not turned off at the standby switch when he suffered his fatal shock.
46. Because Mr Pfundt was unable to determine whether the glass washer had been inspected by TechSafe he left the plug as it was. He said he did this because (understandably) uncertain whether TechSafe had inspected, he wished to leave the machine as he found it so that their investigation was as accurate as possible in order to ensure they would get the 'right answer'.

¹⁷ Exhibit C36.

47. Two weeks later, on 16 February, Mr Ian Ransley, an appliance technician, was called by Mr Gibson to the café to inspect the glass washer. He found a number of things wrong with the glass washer such that he advised Mr Gibson that it was uneconomic to repair. At the inquest he said that the principle problem was that the glass washer's main pump was not operating and required replacement – and a replacement would, he said, cost roughly half the price of the glass washer. In addition, he found the heater element wires were burnt and damaged. He also found that a detergent solenoid was incorrectly wired. But of most concern was the fact that Mr Ransley found that whoever had installed the water pipe to the glass washer had done so in such a way that it was leaking water into the unit's electrical motor. Mr Ransley said that he recommended that the pipe be re-aligned and described the installation as 'very poor'. I accept Mr Ransley's evidence generally, and in particular that the installation was poor. The significance of a water leak into an electrical motor is obvious. As Mr Ransley said it was a dangerous situation which could lead to an electrical short occurring.
48. Mr Ransley also said that it was common to find bare terminals inside the inner cabinet of the glass washer as it is a part of the machine not normally accessible. That was certainly so in this case – Mr Clark removed a panel to obtain access to the inner part of the glass washer, and received his fatal shock as a result.
49. Notably, like Mr Pfundt, Mr Ransley said he saw that the plug was wired the wrong way. Mr Ransley actually corrected the plug's wiring by changing it around. He said in evidence that the particular type of glass washing machine 'always come with a moulded plug' but the machine at the Holy Cow Café did not have the original moulded plug on it.
50. Mr Ransley was obviously very experienced with glass washing machines of the type in the café, as well as the actual machine which caused Mr Clark's death. He was, like Mr Pfundt, a careful and impressive witness. The evidence of both men was particularly helpful to me in determining why Mr Clark died.
51. Insofar as the glass washer is concerned, I am unable to say, on the evidence, that the poor state of it actually was the cause of Mr Clark's death, but it is likely to have been a contributing factor.

Residual Current Devices

52. Residual current devices (RCDs) or, as they are sometimes known ‘safety switches’, are cheap safety devices that instantly break an electrical circuit to prevent death (or serious harm) from an ongoing electric shock. In summary, the evidence was that at the time the café was built, RCDs were not mandatory for commercial premises in Tasmania, but became mandatory shortly after. The evidence was that no RCDs were fitted at the café (and particularly not to the socket outlet into which the glass washer was plugged).¹⁸ While Mr Clark may still have received a shock, had an RCD been fitted it may not have been fatal. I am satisfied that the absence of an RCD may have contributed to Mr Clark’s death.
53. It follows from the fact that the regulatory position was that at the time the structure of the café was approved RCDs were not mandatory, no issue in fact arose with respect to the adequacy of the approval, construction and/or the inspection of construction of the café, particularly in relation to the installation of the RCDs.
54. Thus, the absence of any RCDs at the café should not, on the face of it at least, attract criticism. I do observe though that the *Work, Health and Safety Regulations 2012* provide that a person conducting a business or undertaking at a workplace must manage risks to health and safety associated with electrical risks at the workplace.¹⁹ The same regulations impose an obligation upon persons operating workplaces to take all reasonable steps to ensure the regular testing of RCDs actually present in the workplace.²⁰ The premise of the regulations concerned with electrical risk seems, in part at least, to be that properly operating RCDs are a proper response to such a risk. It seems something of an anomaly, to me at least, that there is a requirement to regularly test RCDs, but no requirement to actually have them fitted, if a building is older – just the sort of building which might be thought to have increased electrical risk, by reason of age alone.

¹⁸ Exhibit C41, Annexure 8, Techsafe Report, page 5.

¹⁹ See Regulation 147.

²⁰ See Regulation 165.

WST

55. I have already touched upon the commencement of the WST investigation. Mr Paul Kitchener and Ms Robyn Pearce both gave evidence in respect of different aspects of WST's investigation. Mr Kitchener is no longer employed by WST; and Ms Pearce was not employed by WST at the time of Mr Clark's death. Nonetheless the evidence from both witnesses was relevant, important and helpful.
56. Mr Kitchener's evidence both in his affidavit and at the inquest dealt with the actual investigation itself.²¹ He said he was notified at 9.55am on Tuesday 20 October 2015 of the incident and very shortly after departed for Pyengana, with Senior Inspector Robert Buchanan.
57. He and Mr Buchanan carried out enquiries over the next few days, and re-attended the café on Thursday 22 October and, as has been mentioned, interviewed various witnesses.
58. Mr Kitchener gave evidence that the WST investigation was comprehensive. I accept that in general it was. I do note, however, that WST does not appear to have ever actually identified, let alone interviewed, anyone responsible for the electrical work associated with the glass washer. In my respectful view, given the circumstances of Mr Clark's death that is something that ought to have been done. This is particularly so given that the Techsafe report (dated 21 October 2015) identified there was a live (244.8 volts), bare, uninsulated spade terminal in the glass washer, with which physical contact was possible.
59. The same report identified that the glass washer was not protected by an RCD. Both factors warranted further investigation in my view.
60. As part of the coronial investigation an order was made on 10 May 2017 directed to the Regulator, pursuant to section 59 of the Act, requiring production of the WST file in relation to Mr Clark's death. WST expressly accepted that it did not comply with that order (and through its counsel apologised to the court for the failure) because it provided an incomplete file – something not apparent when the file was examined. Nor did it advise the

²¹ Exhibit C41.

Coroner's office that it had not complied with the order. The complete file was only provided after a second section 59 order was issued.

61. It seems that the reason WST decided not to provide the full report was based on the Regulator's claim of client legal privilege.²² I observe that no such claim was made when the second section 59 order was served. Indeed, there was no evidence, at all, that the withheld materials were confidential communications or documents made or prepared for the dominant purpose of a lawyer providing legal advice, or that any lawyer had actually even been consulted by WST.²³ I also note that where any such claim of privilege is made the fact that existence of the privilege is claimed actually has to be identified.²⁴ A party is not permitted to fail to produce material in obedience to a court order in secret, as it were. Mr Thompson was quite right to describe WST's failure to comply with the section 59 order of 10 May 2017 as regrettable.
62. Ms Pearce's evidence took the form of a detailed and comprehensive affidavit.²⁵ She also gave verbal evidence at the inquest and answered questions from Mr Zeeman. Ms Pearce's evidence was concerned with an overview of the role of WST. In addition she dealt with the changes that had been made to WST internal procedures to endeavour to ensure that there is no repeat of the unfortunate failure to comply with the section 59 order (which I have dealt with immediately above).
63. It follows from my findings above that in some identified respects I consider that the investigation of Mr Clark's death by WST was inadequate. Furthermore, I consider that the subsequent failure on the part of WST to comply with the terms of a court order to produce its complete file was wrong and served to delay the coronial investigation. I acknowledge that WST has taken steps to ensure that there is unlikely to be a repeat of such a failure in the future.

²² See par 37 of the Affidavit of Robyn Pearce, exhibit C38.

²³ Section 118 *Evidence Act 2001*.

²⁴ *Supra*.

²⁵ Exhibit C38.

One other issue

64. The submissions of Pyengana Dairy Company Pty Ltd and Pyengana Dairy Trading Pty Ltd focussed upon why it was contended that no person should be identified as having contributed to Mr Clark's death. It is unnecessary to say anything about that submission, based as it appears to have been upon a misunderstanding of the statutory role of the coroner. The requirement for a coroner to make a finding, if possible, as to 'the identity of any person who contributed to the cause of [Mr Clark's] death' was repealed on 15 May 2015.²⁶

Formal Findings

65. On the basis of the evidence at the inquest I make the following formal findings in accordance with section 28 (1) of the Act:
- a) The identity of the deceased is Guy Redman Clark;
 - b) Mr Clark died in the circumstances set out in this finding;
 - c) The cause of Mr Clark's death was electrocution; and
 - d) Mr Clark died at the Holy Cow Café, Pyengana in Tasmania on 20 October 2015.

Recommendations

66. The unequivocal evidence is that RCDs save lives – and one may have saved Mr Clark's life. In my respectful view, it is time for their installation to be mandated, and not just prospectively. Accordingly, I **recommend** that the appropriate authorities commence the necessary steps to ensure the installation of RCDs in all workplaces, regardless of when the workplace was constructed.
67. Mr Clark's family suggested that AEDs be made either compulsory or at least more widely available for businesses remote from ambulance services. I note in this case the evidence was that the shock suffered by Mr Clark was not survivable and thus the availability or otherwise of an AED would not have

²⁶ See *Coroners Amendment Act 2015*.

changed the tragic outcome. I do however consider that there is considerable merit in such a suggestion. I also note that the Act, section 28 (2) permits me to make recommendations with respect to ways of preventing further deaths and on any other matter that I consider appropriate. Section 28 (3) authorises comment on any matter connected with the death. In my view, consistent with authority²⁷, the issue of the availability of AEDs in businesses, especially those such as the Holy Cow Café frequented by members of the public, falls within the permitted areas of both recommendation and/or comment for a coroner. I am satisfied in all of the circumstances that it is appropriate to **comment** that it is important for AEDs to be as widely available as possible, particularly in isolated workplaces and tourist venues.

68. In conclusion I convey my sincere condolences to the family and loved ones of Mr Clark.

Dated 21 January 2020 at Launceston in the State of Tasmania.

Simon Cooper
Coroner

²⁷ See for example *Harmsworth v The State Coroner* [1989] VR 989.