The Work-Related Liaison Service presents:

WORK**WISE**

WORK-RELATED DEATH PREVENTION: **THE CORONIAL APPROACH**

A combined State Coroner's Office and Victorian Institute of Forensic Medicine publication.

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EDITORIAL

Welcome to the first edition of WorkWISE for 2009. We hope our readers had a safe and happy holiday break.

This February edition presents four separate worker deaths where previous similar events could have served as examples to avoid tragic outcomes. A 2002 worker death in the house re-stumping industry and a subsequent death in 2004 prompted the repeated recommendation for an industry standard by a coroner. It was third time unlucky for a self-employed paint stripping business owner who failed to modify a hazardous work practice following two near-misses.

A short piece by Professor Joan Ozanne-Smith on a systems approach to injury prevention, and the shortcomings of individual behaviour change alone as a prevention measure, is also provided.

SNAPSHOT: WHEN WORK TAKES A TOLL

Case Number: 0642-05

Incident Circumstances

Mr C was driving his car to work with two passengers. At approximately 1:20am he was observed to be driving erratically on the road and then swerve onto the wrong side of the highway, into the path of a four wheel drive vehicle. Mr C was critically injured in the collision and died in hospital later that night.

Coronial Investigation

A coronial investigation revealed that Mr C, aged 29, worked as a baker at a bakery that he and his wife had just recently purchased. Due to his work commitments, Mr C had only been sleeping one or two hours per night. On the day prior to his death, Mr C had only three hours sleep during the day.

DISCLAIMER: All cases that are discussed in WORKWISE have been formally closed by a coroner. Every attempt has been made to de-identify individuals or groups.

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ON OVER-COMING ERROR

Much is known about preventable work-related deaths, yet deaths continue to occur under similar circumstances. While historically a focus on the victim's behaviour and victim-blaming, may have limited progress in injury prevention, in recent times the public health approach, with its focus on data and a systems approach to prevention has come to the fore.

Using this approach for the cases presented in this edition of WorkWISE, one must ask:

> Are there under-pinning imperatives to cut-corners on sleep requirements and work practices? Do errors of the types represented here result from ignorance, financial pressures, over confidence and/or other factors? Can these underlying risk factors be addressed with current knowledge? Is enhanced data and research required on these fundamental questions to change the circumstances that pre-dispose to such deaths and injuries?

Are approaches that take some of the pressure off individual behaviours and potential resulting errors, such as regulatory or design approaches, feasible and enforceable? Would they be acceptable to those affected: industry, workers, regulators, unions?

While behaviour change is often a key step in the implementation of workplace safety, it is an active measure, requiring ongoing action and the potential for errors by workers persists. The passive approach to injury prevention tends to be favoured by many injury prevention experts. Using this approach, design or organisational change is the favoured approach, supported by regulation and enforcement where necessary to achieve implementation and compliance.

Design or organisational change, once implemented, is protective over time and individual action is not generally required each time a worker needs to be protected. Importantly, the protection is cumulative so that it may be in place for many workers over a long period of time.

In reality educational and behavioural approaches are needed in a systems approach to complement and support design and organisational interventions and to ensure compliance with these measures.

Prof Joan Ozanne-Smith
Head, Prevention Research Services, VIFM

HOUSE RESTUMPING – LESSONS TO BE LEARNED NUMBER 01

Case Number: 0802-02

Incident Circumstances

Mr N, an experienced restumper, was involved in the re-stumping of an old weatherboard house with three co-workers.

The house had been raised and was being supported by hydraulic bottle jacks as the old stumps had been removed. Identifying that the house level was slightly uneven, the workers planned to raise a corner of the house. Before this was done, Mr N was positioned underneath the house re-measuring the lengths of the stumps that would be required. Suddenly, the house slipped forward and Nr N was crushed beneath.

Coronial Investigation

WorkSafe Victoria investigated the death. The house was situated on a sloping block and slipped down the slope. What precisely caused the house to fall was undetermined.

A number of unsafe work practices were identified, including: inadequate timber used as a base plate for the jacks, an absence of ground surface preparation to ensure the jacks were operating from a solid and level base, and most significantly, no secondary support system was in place.

Investigators commented that the re-stumping industry has a high turnover of staff who often work with little or no supervision and require no qualifications to undertake the work.

Finding & Recommendations

The coroner concluded that a fail-safe system or secondary support system of some kind should be used on all re-stumping works once a house has been lifted onto jacks and before any person is permitted under the house.

The coroner recommended that a standard be introduced in the restumping industry to set-out appropriate guidelines to be followed.

HOUSE RESTUMPING – LESSONS TO BE LEARNED NUMBER 02

Case Number: 2710-04

Incident Circumstances

Mr A, aged 24 years, had recently commenced working as a labourer for a restumping business. Mr A was working at a house that had been raised using hydraulic jacks whilst the old stumps were removed. The next day, he returned to the site to remove the remaining old stumps. No secondary support systems had been put in place.

While Mr A and a co-worker were working beneath the house, another worker adjusted the levels of individual jacks to ensure the house was level prior to inserting the new concrete stumps. The house collapsed whilst both men were working underneath. Mr A received fatal injuries and his co-worker suffered a broken shoulder and other injuries.

Coronial Investigation

WorkSafe Victoria investigated the circumstances of death. The company was charged for failing to provide a safe workplace and fined $100,000.

At the time of this incident, the re-stumping industry remained unregulated and no specific trade qualifications were required. Persons involved in the work required adequate experience, or were required to work under close supervision of a competent person.

A Guidance Note for re-stumping of buildings was produced by WorkSafe to alert those engaged in re-stumping activities of the potential risks and ways to minimize them.

Finding & Recommendations

The coroner commented that although the Guidance Note was sufficiently comprehensive, the re-stumping industry remained unregulated. Given the number of similar deaths and the benefits of consistency, uniformity and the portability of the workforce, the coroner recommended that an Australian Standard for restumping be sponsored.

Additional Resources

WorkSafe Victoria's Guidance Note and Checklist for Re-stumping Operations can be accessed using the following link:

http://www.worksafe.vic.gov.au/wps/wcm/connect/WorkSafe/Home/Forms+and+Publications/Guidance+Notes/import_Re-stumping+of+Buildings

Although there are existing standards in relation to the residential construction industry, there is currently no national standard that encompasses the entirety of house restumping operations as recommended by the coroner.

CHEMICAL FUMES CAN QUICKLY OVERCOME

Case Number:. 1341-04

Incident Circumstances

Mr Q, a small business owner, was working alone at his antique furniture and paint stripping business where he was stripping paint from a piece of furniture over a dipping tank. The dipping tank contained Dichloromethane (Methylene Chloride), and the deceased was last seen working above the tank not wearing any respiratory equipment. Mr Q was found by a customer sometime later slumped over the dipping tank. A number of attending emergency personnel involved in emergency resuscitation were also affected by fumes and required hospitalization. Symptoms included dizziness, shortness of breath, palpitations, headaches and nausea..

Coronial Investigation

An inquest was held. In the process of the investigation it was found that Mr Q often worked alone and that standing over the tank of volatile substance while stripping paint from furniture was the predominant method used. There had been two previous occasions where Mr Q had been overcome by fumes and lost consciousness while working over the dipping tank. On the first occasion he required hospital treatment for chemical burns, and the last incident occurred just eight days before his death. Despite collapsing, Mr Q did not change this work practice.

The issue of material safety data sheets was raised, and although the supplier indicated that they supplied them, these safety documents had not been displayed at Mr Q's factory. In addition to lack of mechanical ventilation and lack of suitable respiratory equipment, the WorkSafe investigation also revealed lack of a safe system of work, lack of protective clothing, lack of mechanical dipping cage, failure to provide an emergency alarm and a failure to follow legislative and regulatory requirements.

The coroner found that Mr Q's death was due to dichloromethane toxicity in a man with coronary artery disease, and that the death could have been avoided had he not ignored the immediate risks.