QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Adam Douglas Forster**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2011/3658
DELIVERED ON:	6 March 2014
DELIVERED AT:	Cairns
HEARING DATE(s):	4 September 2013
FINDINGS OF:	Alan Comans, Coroner
CATCHWORDS:	Coroners: work-place accident, small business, ball-mill.

REPRESENTATION:

Counsel Assisting:	Ms S Williams, i/b Office of the State Coroner, Northern Region
Mrs L Forster:	Mr B K Gillan, B K Gillan Solicitors
Mr S Catalano Director, Pacific Mineral Developments	Mr D McKinstry, Williams Graham Carman Lawyers

Identity of the deceased – Adam Douglas Forster

Place of death – 1111 Palmerston Highway Coorumba QLD 4860

Date of death– 25 October 2011

Cause of death – Torn aorta due to crushing accident

How he died –

Mr Forster was employed as the sales and marketing Manager at Pacific Mineral Development Pty. Ltd. (PMD) located at 1111 Palmerston Highway, Coorumba from May 2011.

PMD was owned and operated by Mr Salvatore Catalano.

PMD had two other employees: Ms Basso, administration officer and Mr Stoddart, a general hand.

PMD produced MinPlus which is the product of grinding volcanic rock in a ball mill situated within the plant at 1111 Palmerston Highway, Coorumba.

The ball mill consisted of a large rotating steel cylinder with bolts protruding from the surface and was situated in a large room at the plant.

There were no guards, barriers or other apparatus restricting access by any persons to the ball mill.

Mr Forster's official duties did not include working in the mill room, however he did at times assist with bagging the mill product in another part of the plant.

Mr Forster had also assisted with the repair of a dust extractor and on two occasions assisted Mr Catalano and Mr Stoddart with some repairs to the ball mill when it was not operating.

Mr Forster did not know how to turn the ball mill on or off.

On 25 October 2011, Mr Forster was sweeping up spillage from the floor of the mill room to which he had unrestricted and unsupervised access.

Mr Forster had not been requested to sweep up the spillage by either Mr Catalano or Mr Stoddart, however Mr Stoddart knew he was there.

At a time unknown between about 9.30am and about 1.00pm on 25 October 2011, whilst alone in the mill room, Mr Forster came close to the rotating ball mill, then accidently became ensnared by the protruding bolts and was dragged

underneath the ball mill which continued to rotate, thereby causing his fatal injuries.

No one saw this incident happen and it cannot be ascertained how or why Mr Forster came to be so close to the rotating ball mill as to be accidently ensnared by the protruding bolts.

There is no evidence that Mr Forster was adversely effected by the very low level of the active constituent of cannabis (tetrahydrocannabinol “THC”) present in his body at 0.006mg/kg.

Comments and recommendations under section 46 Coroners Act 2003

The focus of the inquest was on the immediate circumstances surrounding the death of Mr Forster.

Unfortunately, the circumstances of exactly how Mr Forster came to be accidently ensnared in this large piece of unguarded rotating machinery (the ball mill) could not be found at the inquest.

What is known is that whilst Mr Forster was not employed to work with this piece of machinery, he had ready and unsupervised access to the area where it was operating.

Also there were no guards, barriers or other apparatus restricting access by any persons to the ball mill.

These known circumstances speak for themselves and there was really very little that could be submitted by the employer or Workplace Health and Safety Qld (WHSQ) that could shed any more light on the immediate circumstances of Mr Forster’s death.

However, Mrs Forster has made her own personal submission to the inquest which has raised a pertinent point that may be commented on under section 46 *Coroners Act 2003.*

That point is workplace health and safety education in the very small business area.

PMD was certainly a very small operation comprising the owner and three employees.

The owner, Mr Catalano and his general hand, Mr Stoddart had a long association with the ball mill. Both were very familiar with all aspects of its operation and were the persons solely concerned with its operation.

Mr Forster was a sales manager and not concerned with the day to day operation of the ball mill. However, during his short period of employment he had been known to assist in some operational duties but never whilst the ball mill was rotating.

This was an operation that, because of its size and location, was not generally open to the scrutiny of officials, unions, passers-by or others who might have raised concerns about the level of safety measures around the ball mill.

It has taken this fatal incident to focus attention on this particular workplace.

The recommendation made now is for the policy makers and advisors of WHSQ to consider the circumstances of Mr Forster's death to see what else may reasonably be done or done better to educate very small business operators in order to foster a culture of workplace health and safety into their operations.

Accordingly, I direct a copy of these findings and comments be forwarded to the Attorney-General and Minister for Justice and the Chief Executive, Workplace Health and Safety Queensland.

I close the inquest.

AJ Comans
Coroner
Cairns
6 March 2014