CORONERS COURT

NEW SOUTH WALES

Inquest:	Inquest into the death of Vijay Singh
Hearing dates:	18 June 2015
Date of findings:	19 June 2015
Place of findings:	Coroner's Court, Glebe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-Cause and manner of death-Death in workplace-Death in course of police operation
File number:	2013/130661
Representation:	I Fraser, Counsel Assisting instructed by D McMullen, Crown Solicitors Office M Spartalis representing NSW Police Force D Dinnen representing Workcover NSW Mr O'Neil representing Laurent D Pty Ltd A Brand representing Mr P Beaumont
Findings:	I find that Vijay Singh died on 28 April 2013 at St George Hospital, NSW as a result of complications of hypothermia that developed while he was trapped in an industrial freezer.

IN THE STATE CORONER'S COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This inquest concerns the tragic death of Vijay Singh who died after a workplace accident. He was only 23 years of age at the time of his death.

2. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

   (a) the identity of the deceased;

   (b) the date and place of the person's death;

   (c) the physical or medical cause of death; and

   (d) the manner of death, in other words, the circumstances surrounding the death.

3. The Police became involved in his rescue when the work accident occurred and accordingly the Act requires a Coroner to conduct an inquest as the death occurred "*in the course of police operations*". (s.23, s.27).

> *"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police ..... have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and*

warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."[1]

4. It should always be borne in mind that inquests are not criminal investigations, nor are they civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. This Inquest has been a close examination of the circumstances around Mr Singh's death with a focus on whether there should be any changes that might prevent similar deaths.

Mr Singh

5. Mr Singh is a much loved son and brother.
6. He was born 2 February 1990 in India. He arrived in Australia in 2009, joining his sister who had immigrated to Australia in 2007 with her husband. Vijay lived with his sister and her husband in Western Sydney up until his death. He was only 23 years of age when he died.
7. His parents remain in India. He worked hard to send them money, on which they relied, as they did not qualify for an aged pension. He also contributed money to his sister's household.
8. Mr Singh was employed to work at Laurent D Pty Ltd at its Matraville site. He appears to have been liked and respected by his co-workers. His supervisor Mr Beaumont had identified him as an intelligent and able young man, and was apparently training him for a more senior position at the facility. One co-worker described him as "a very hard worker [who] was always very helpful and would never say no when asked for help."

Laurent D Pty Ltd

9. Laurent D Pty Ltd ("Laurent"), a company registered in Victoria, is the trustee for the Laurent D Trust. Laurent produces and sells bread and pastry products.

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[1] Waller's Coronial Law & Practice in New South Wales 4th Edition, page 106

10. From 2004 up until the death of Mr Singh, Laurent leased three units at the Matraville site. One of those units comprised a large freezer warehouse. This is where the incident involving Mr Singh occurred.
11. The freezer is approximately 200m long and 200m wide. At the time it was maintained at a temperature of approximately minus 20 degrees Celsius.
12. Metal shelves were utilized inside the freezer to hold pallets containing boxes of bread products. The top shelf was capable of holding two full pallets. About 20 metres inside the freezer there is an alcove, which also contained the metal shelving on which pallets were stored. This is where the incident occurred. There was 2.3m between the shelves in that alcove in contrast to 3m between the shelves in the main area.
13. At the time of Mr Singh's death, 35 employees worked at the site at Matraville. It was managed by a factory manager and freezer manager. As at 27 April 2013, the acting freezer manager was Paul Beaumont. Mr Beaumont had come to Sydney from the Melbourne site and had been acting in this role since late January 2013. Mr Beaumont was responsible the freezer room, including managing work health and safety. Prior to becoming the acting freezer manager at Matraville Mr Beaumont had worked for Laurent as national logistics manager.
14. Laurent had a forklift policy which applied to work in the freezer.[2] This policy required that operators of forklifts to hold a current forklift licence . This is also a legislative requirement.[3] There was an induction booklet which included a short section in relation to health and safety.[4] There was no specific freezer safety policy, and no written policy in existence prohibiting staff from working alone the freezer, although the company has said that workers were usually rostered in the freezer in teams of two. Training records provided by the company did not indicate that Mr Singh had undertaken any health and safety training or any formal training in respect of the freezer or operation of the forklift.
15. Mr Singh had been engaged by Laurent to work at the Matraville site via a labour hire firm, Abhayaya Pty Ltd.
16. Mr Singh initially worked as a packer; however following Mr Beaumont taking over as the freezer manager, he began undertaking more senior work, including operation of the forklift, and was being trained as a supervisor.

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[2] Tab 60.
[3] Part 4.5, *Work Health and Safety Regulation 2011* (NSW).
[4] Tab 56.

17. Mr Beaumont states that when he arrived at the Matraville site he observed Mr Singh driving a forklift in the yard and he believed that Mr Singh held an appropriate forklift licence, he never asked for it to be provided, and never saw any such licence. He stated that he assumed the previous freezer manager who had left due to illness and was in hospital had examined the forklift licence.
18. I note that a WorkCover inspection had previously taken place at the site approximately six months prior to the incident. That inspection was in relation to identified issues relating to the disposal of garbage and waste at a different part of the site, and did not involve an inspection of the freezer.

Events of 27 April 2013

19. 27 April 2013 was a Saturday, and the Laurent site at Matraville did not usually operate on a Saturday. On this particular day however, Mr Singh was at work. According to Mr Beaumont, Mr Singh had said he wanted to do some work in the freezer. Mr Beaumont had also arranged for three packers to undertake some repacking of various products. Other than Vijay and the three packers, Mr Beaumont was the only one present.
20. The three packers started work at some point between 8 and 10am. Initially they were undertaking packing work in the warehouse and small freezer. Just before 11:30am Mr Singh spoke with Mr Mohammed, one of the packers, about boxes that needed to be repacked in the freezer. At about the same time Mr Beaumont had a similar conversation with Mr Iqbal, one of the other packers.
21. Mr Beaumont left the premises at approximately 12:30pm.
22. At approximately 1 or 1:30pm, the three packers were taking a break. Just before they did Mr Singh called out to the men, asking for help in the freezer as the forklift had become stuck on the ice in the alcove. All three men went in and helped to push the forklift free. This took place in the same location where the accident happened. The three packers then took their break, leaving Mr Singh working in the freezer.
23. The packers returned to work at about 2pm. They took boxes from the front of the large freezer and proceeded to repack them immediately outside the freezer. They did not see Mr Singh. Sometime shortly after 2:30pm, the three men decided that they would finish for the day. They had not seen Mr Singh since their break and went to look for him. After looking in the warehouse, Mr Iqbal checked inside the freezer. Mr Iqbal saw Mr Singh where they had previously assisted in freeing the forklift. He was trapped in between the

forklift and some shelving behind him. A pallet was on the forks of the forklift and appeared to be about to fall. There were a number of boxes that had fallen on and around the area. One of the men attempted to move the forklift, however it was stuck.

24. Mr Mohammed called '000' and requested Police and Ambulance attend. The men also tried to call Mr Beaumont and other members of Laurent management; however, they got no answer. They wanted to turn the freezer off, however, did not know how.
25. Mr Mohammed's '000' call was logged by Police VKG at 2:44pm. Police responded quickly, with the first unit being recorded as arriving four minutes later, with a second unit a minute behind. A number of other units arrived over the following minutes, including a Police Rescue Unit at 2:58pm.
26. Sergeant Murray was the first officer on the scene. The three packers took him inside the freezer to where Mr Singh was trapped. He describes Mr Singh as being wedged below a yellow metal bar that formed part of the shelving. On top of the bar was a pallet half loaded with boxes, some of the weight of which was resting on Mr Singh's head. Mr Singh was standing in the driver's well of the forklift, bent over with his torso resting on the control panel of the forklift. The prongs of the forklift had two pallets on them, which were on an angle of about 25 degrees, tilting towards Mr Singh. The top pallet was over his head.
27. Officers worked to clear the boxes and pallets over Mr Singh's head, assisted by one of the packers. Efforts to move the forklift were unsuccessful, and officers said that they could not get to the controls as Mr Singh's body was slumped over the forklift.
28. Once Police Rescue attended, the beam that was pinning Mr Singh was cut and lifted away. Mr Singh was then able to be removed.
29. The first officers on the scene stated that Mr Singh was blue when they attended, and had icicles forming on his nose. It is uncertain how long he had been in the freezer before Police arrived. He did respond to Police with small movements and some limited speech.
30. The temperature was in the vicinity of minus 20 degrees Celsius. Two police officers suffered freeze burns that required treatment. Officers were rotated out of the freezer by the Inspector at the scene, to allow officers to warm up.
31. The first paramedics arrived at 3:05pm . At that time Mr Singh was still pinned by the beam. An initial assessment found that he had icicles 5-10cm long on his face. His pupils were dilated and his skin was freezing. A pulse was not able to be located. An oxygen mask was fitted. Although initially conscious he became unconscious. An ECG monitor confirmed that he was in cardiac arrest. When he was freed the paramedics commenced

CPR. A medical retrieval team consisting of three doctors and an intensive care paramedic had been flown in by helicopter and took over treatment of Vijay. They performed a bilateral thorocostomy, and at this time, Mr Singh's heart began to beat. He was then transferred to St George's Hospital where he arrived at 4:22pm.

32. On admission to the Emergency Department, Mr Singh's body temperature was 31 degrees. He was experiencing multiple organ failure and severe acidosis. Efforts were made to warm Vijay, and various drugs were administered. Whilst Mr Singh was in the emergency department he suffered three cardiac arrests, which responded to CPR and adrenaline. He was assessed as having a poor chance of survival. He was transferred to the ICU, where his sister and brother-in-law sat with him. Unfortunately he did not recover and sadly, at 6:32pm he was pronounced deceased.
33. An autopsy was conducted by Dr Pokorny, a pathology registrar at the Department of Forensic Medicine, Glebe. The pathologist concluded that Mr Singh died from complications of hypothermia.

Events after 27 April 2013

WorkCover investigation and prosecution

34. WorkCover officers attended the scene shortly after Mr Singh had been taken to hospital, and commenced an investigation. That investigation included a site inspection, the interviewing of relevant staff, and the compulsory process requiring the production of documents and provision of answers from witnesses, as well as from Laurent. The WorkCover investigation ran in tandem with the Police investigation.
35. The brief compiled by WorkCover forms part of Exhibit 1 in these proceedings.
36. The WorkCover investigation found that the the forklift was inspected and operating normally and not to have any faults that could have contributed to the incident.
37. In 2014 WorkCover commenced a prosecution in the District Court against Laurent under ss. 19(1) and 32 of the *Work Health and Safety Act 2011*. Section. 19 creates a duty for those carrying on a business to ensure as far as is reasonably practicable for the health and safety of workers in the workplace. Section 32 makes it an offence to fail to comply with that duty and thereby expose a person to a risk of death or serious injury.

38. Laurent pleaded guilty to the charges. The statement of facts and the judge's decision are both contained within the brief. The Judge imposed a fine of $150,000. The Judge placed weight on the steps taken by Laurent following the incident, as well as its expressions of remorse and cooperation with the investigation.

Actions by Laurent D Pty Ltd since the incident

39. Since the incident, Laurent have taken a number of steps to remedy identified safety issues. They have taken steps to ensure all forklift operators have provided evidence of their licence, they ensure that no one ever works in a freezer alone, the managers have undertaken formal work and safety training. Laurent have also engaged the services of SAI Global to conduct audits of their safety systems on a six monthly basis to make sure their policies are adhered to and standards met.
40. Laurent have issued or reissued a number of policies, including policies relating to:
    a. Safe systems of work (issued May 2013)[5]
    b. Forklifts (reissued May 2013))[6]
    c. Emergency plan in freezers. (issued May 2013)[7]
    d. Occupational Health & Safety employee consultation policy (issued June 2014)[8]
    e. Work Health and Safety induction document specifically for the Matraville site (issued January 2014).[9]
41. In May 2013 Laurent outsourced its freezer operations to an independent refrigeration specialist company (Rand), and terminated its lease on the freezer at the Matraville site.
42. Existing employees were re-inducted, and there was additional health and safety training.
43. The company has stated that on 31 March 2015, Laurent ceased all operations at the Matraville site, which ended any manufacturing in NSW.

Conclusion

44. There is no question that the police response and operation was appropriate and I commend the officers and paramedics on their valiant efforts in their attempts to save Mr Singh.

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[5] Ex 1, Tab 66
[6] Ex 1, Tab 69
[7] Ex 1, Tab 70
[8] Ex 1, Tab 67
[9] Ex 1,Tab 41A.

45. I note that Laurent no longer operates in NSW and has been prosecuted and convicted of offences in the criminal jurisdiction of the District Court.
46. In all of those circumstances I do not propose to make any recommendations
47. I will now move to my formal findings.

FINDINGS

I find that Vijay Singh died on 28 April 2013 at St George Hospital, NSW as a result of complications of hypothermia that developed while he was trapped in an industrial freezer.

Magistrate C Forbes
Deputy State Coroner
19 June 2015