Submission No 56

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

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Please find below a brief outline of the incident that resulted in the suicide death of my partner of 20 years Davern.

On 24th May 2018 an incident occurred at Norske Skog which resulted in the deaths of Ben and Lyndon.

Davern was a senior lead operator and had asked Ben to go up to the top of a tank and check where water was coming from which they always did when the tank was being filled after a shut (3-5 days of maintenance which occurred on a regular basis)

Davern was unable to do this as he was recovering from having a kidney removed due to kidney cancer. He had just returned to work and was on light duties at the time and could not have bent down to check the tank.

After a few minutes when Ben hadn't returned, Davern went up the ladder to find Ben laying on the top of the tank, presuming he had hit his head he called Lyndon for help to check on him.

Lyndon then asked Tom Johnson (contractor) to help him as he thought he might need help getting Ben down.

During this time Davern went to get a scissor lift just in case they needed it.

Davern then climbed up the ladder to see what was going on and saw that Lyndon and Tom were also laying on the top of the tank. He was then overcome by fumes and made his way back down the ladder just reaching the floor before collapsing. I am unsure how long it took for him to get his bearings, but I don't think it was more than a few minutes

Realising that something was wrong he managed to get out to another worker that they needed help.

Turned out it was a suspected Hydrogen Sulphide gas leak.

Emergency response were called into to go up the tank to get Ben, Lyndon and Tom

An ambulance was called during this time and from Daverns observations it looked like Ben had already passed away and the first aid team were trying to revive Lyndon and Tom.

Davern, Ben, Lyndon and Tom were all transported to Albury Base Hospital where it was confirmed that Ben had passed away and Lyndon and Tom were in a critical condition.

When I arrived at the hospital, they had Davern sitting in a room (more like an unused office) on his own. He then informed me that Ben had passed away and that Lyndon wasn't good.

Davern was discharged from hospital around 9pm, but was called back around 10.30pm as they found irregularities in his heart. While he was in emergency he was obviously still worried about Lyndon and remarked to me "that's my boy in there" They kept him. I will never forget the look on his face, he looked so powerless, they kept him in the hospital overnight for observation. I left about 2.30am and told him to call me when he was ready to come home. They were going to send him home during the night but they decided to let him sleep which was a good thing, because he would not have slept at home.

Davern's main concern then was Lyndon. Davern had worked with Lyndon's father for approx. 20yrs and when Lyndon came to work at Norske Skog approx. 15yrs ago, Davern took him under his wing. It was like mutual admiration that Davern and Lyndon had for each other. Since the Incident I have become very close with Lyndon's wife Jacci. We often talk about the boys and remark on how alike they were, and they both had sung each other's praises. Seeing that they worked on a rotating 4-day roster working night shifts as well as days and weekends, unfortunately they didn't socialise with each other outside of work as they both enjoyed time they had free with their family.

The counsellor that they had given Davern straight after the incident in the workplace, was not a trauma counsellor so really didn't know how to help him with his grief. He should have seen a trauma counsellor straight away, but unfortunately the forensic psychologist arrived on the 5th June, Lyndon's funeral was on the 6th June and Davern took his own life on the 7th June. Maybe if this was organised on the day of the incident.

The day after (Friday 25th May) the incident I went to work but ended coming home to check on him after I got a call from one of his workmates, when I arrived home, he asked me what I was doing home and I said that I was worried about him, his reply was "I am not going to do myself in" that should have told me something then, but Davern never lied to me, and usually what he said he meant. Not realising that he had changed his mind on the Monday after the boys had passed away. I found this out a few months after he passed away when I checked his internet searches, only to find that he had looked sites like: 10 easiest ways to commit suicide. I didn't even know these sites existed.

Over the next two weeks he suffered a lot, he couldn't get it off his mind that he had killed Ben and Lyndon. I tried to do what I could, but I had no idea how to help him. He would stand and look out the window a lot and didn't know what to do. I tried to keep busy, but he didn't know how to do that, he seemed to have lost all of his energy. It seemed that he had to use all of his energy to get out of bed every day in the beginning. There was no psychological intervention offered to Davern in this time.

I would come home from work and ask him what he had been doing each day and he would tell me he had been for a drive out to the Hume weir. This wasn't unusual as he was a fisherman with his own boat and would often go out there for a drive to have a look at the water level. But he wasn't looking at the water level. Davern was looking for somewhere to die. He was going out to the weir wall. There was weir wall maintenance being undertaken at this time and the locks to the ladders were left unlocked after the workers had left. These ladders take you to the top of the wall.

So, what we think he did was. Walked across the wall to the other side and waited until the workmen had gone off to do something else, climbed up to the top, he either had a drink of Wild Turkey before going up the ladder or on top. As they found the bottle up the top where he had etched Ben, Lyndon, Dav into the top of the wall and then ……, in order to take his own life. (sorry I can't write the word)

There are direct links between these tragic workplace deaths and Davern taking his own life two weeks later (he had not returned to work). Amongst is a lack of health psychological support and monitoring of Davern after the deaths. Davern was these boys senior lead operator and he was the person who had requested they undertake the check when the problem was found. His decision to take his own life was as a result.

These are my considered recommendations;

- That workplace related suicides be recognised as part of a workplace incident.
- A recommendation be made by the coroner to Safe work when handing down findings that they are to be included in any legal proceedings that may occur.
- To determine whether any suicide is due to the workplace.
- Despatch of the coroner's report be a "flagged system". The report should be sent by registered mail. Recipient is then notified that the report has been despatched. I believe the coroner's office should contact a counsellor to meet with the recipient at an appointed time to open and give support when the report is received.
- The coroner's report stated that Davern's suicide was due to a workplace incident. Has the criteria for suicide death being declared as a direct result of a workplace incident, been reviewed in recent times.

Thanking You

Noeline Bridge