IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 003862

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: RAYMOND DURRAN

Delivered On:	26 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	17-19 December 2013
Findings of:	PHILLIP BYRNE
Representation:	Mr Andrew Halse of Counsel for Retreev P/L, Venturoni Bros P/L, Messrs John and Dean Venturoni and Mr Ted McCarthy Ms Karen Argiropoulos of Counsel for WorkSafe
Police Coronial Support Unit	Leading Senior Constable John Kennedy

I, PHILLIP BYRNE, Coroner, having investigated the death of RAYMOND JEFFREY DURRAN

AND having held an inquest in relation to this death on 17 – 19 December 2013
at Coroners Court MELBOURNE
find that the identity of the deceased was RAYMOND JEFFREY DURRAN
born on 15 August 1953
and the death occurred on 6 October 2010
at Appleton Way, Docklands

from:

1 (a) HEAD INJURIES – STRUCK BY HEAVY LOG OFF TRUCK

in the following circumstances:

1. I make some preliminary comments with a view to outlining my broad approach to the coronial role.

2. I view the judgment of Calloway J.A in *Keown v Kahn*[1] as the watershed judgment pertaining to the role of the coroner post the 1985 Act. I sat as a coroner under the 1958 Act from 1983-5 in what I will call the "old" coronial jurisdiction which in effect was a quasi criminal jurisdiction. Save for investigations involving suspected crime, many of the coronial investigations undertaken were limited. Even after the 1985 Act was promulgated it took some time for the "new" coronial jurisdiction to evolve. For instance in *Keown v Kahn* the contentious issue that went to the Supreme Court, and ultimately the Court of Appeal, was whether the act of shooting Ms Richman by a police officer was in self defence - justifiable homicide - or not. In a timely reminder to the coroners, His Honour stated it was not part of the coroner's role to lay or apportion blame; he drew a dichotomy between causal factors in a death and "background circumstance". The nub of the judgment is, in my view, encapsulated in the following observation:

   "In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was a breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report,

[1] *Keown v Kahn* (1999) VR 69

Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame: the proceeding is inquisitorial."[2]

Justice Callaway observed it was the coroner's role to seek to establish the facts, set them out and for others, if they wish, to draw legal conclusions. The amendment to the 1985 Act repeals the requirement to make a finding as to persons/other entities who "contributed" to the death was, due to the connotation that had attached to that concept, a connotation of fault, blame or culpability. In short, I have assiduously sought to follow His Honour's direction.

3. Furthermore, I have consistently sought to apply the broad principle stated by Justice Nathan in *Harmsworth.*[3] He reminded coroners the powers of investigation are not "free ranging" and observed that unless restricted to pertinent issues an inquest could become wide, prolix and indeterminate. He stated:

   "Such an inquest would never end, but worse it would never arrive at the coherent, let alone concise, findings required by the Act..."

   The relevant principle was recently re-stated in the Full Court of the Supreme Court of the Australian Capital Territory in *R v Coroner Maria Doogan; ex-parte Peter Lucas-Smith.*[4]

4. As I reflect on the evidence led over the three days of the formal inquest, I feel to some extent the matter proceeded almost as an adversarial proceeding rather than a purely inquisitorial proceeding. I suspect this may have been due to the nature of the significant amount of material that resulted from the incident being investigated by WorkSafe as well as police. The WorkSafe investigation, by its nature, is primarily focussed on considering whether breaches of the *Occupational Health and Safety Act 2004* (OHS Act) were committed. I interpolate that no charges were laid; I do not know whether having heard the evidence WorkSafe propose to revisit that incident; that is not a matter for me. Upon formal application by Mr Halse I excused Mr Dean Venturoni, Mr John Venturoni and Mr Edward McCarthy from giving evidence on the basis of them exercising their privilege against self incrimination. I add I did not invoke section 57 of the *Coroners Act 2008.*

---

[2] *Keown v Kahn* (1999) VR 69 C p.76

[3] *Harmsworth v State Coroner* (1989) VR 989

[4] (2005) ACTSC 74 (8 August 2005)

5. I add that, as was their right, all major players – the brothers Venturoni and Mr McCarthy – declined to be interviewed by WorkSafe investigators. These matters may also have impacted on the feeling I had that the matter proceeded as somewhat adversarial. I stress that this is not a criticism, it is just the nature of this particular matter with the WorkSafe Brief of Evidence being such an integral part of the coronial investigation.

6. Having made those opening comments I turn to seeking to establish the facts surrounding the untimely death of Mr Durran, after which I am required to consider whether the facts, as found, represent causal factors in his death.

7. This is a 2010 matter I "inherited" in 2013. Not having had carriage of the matter from the outset, not having had management of the investigation, brings with it additional complications. In the event, when I did take over carriage of the matter I sought to progress it to conclusion as soon as possible.

8. The inquest ran for two and a half days, 17-19 December 2013. Present throughout the proceedings was Mrs Ann Durran, wife of the deceased, accompanied by one, other or both of her sons. In response to a query from me, Mrs Durran indicated she did not wish to play an active direct part in the proceedings but would put any questions she had through Mr John Kennedy, of the Police Coronial Support Unit, assisting the coroner. Mr Andrew Halse, of counsel, instructed by Lander & Rogers represented Retreev P/L, Venturoni Bros P/L, Messrs John and Dean Venturoni and Mr Ted McCarthy, their employee. Ms Karen Argiropoulos of counsel represented WorkSafe.

   I heard *viva voce* evidence from the following witnesses:

   - Scott Kimberley
   - Ian Wright
   - James Chasser
   - Anthony Newton

9. In very broad-brush terms, Mr Durran worked for Venturoni Bros transporting logs from a coupe at Strath Creek to the West Melbourne site of Westgate Ports and JNC, the consignee. The harvesting and loading of the logs was performed by Retreev P/L who employed Mr Ted McCarthy to load the logs onto the truck for transit to West Melbourne, some 130 kilometres away.

10. Between 4:00am and 4:30am on 6 October 2010, Mr McCarthy loaded Mr Durran's combination trailers with logs. Mr Durran drove the vehicle to West Melbourne where, after a short delay at the boom gates which are operated by Westgate Ports, he entered the JNC site and was directed to an area by Mr Anthony Newton, the yard operator employed by JNC whose job it was to unload the logs from the trailers. Another truck was already at the site awaiting unloading; Mr Durran pulled up where he was directed some 10 metres behind the other truck. Mr Newton said the expectation is that while the first truck is being unloaded the driver of the second truck will remain in the cabin. Although that is common knowledge throughout the industry, I suspect that expectation is "more honoured in the breach than in the observance".[5] Mr Newton related how he observed Mr Durran in his cabin after the truck pulled up but did not see him get out of the cabin. Mr Newton further stated that Mr Durran had been bringing loads to that site for the period he had worked there; approximately one year. He further stated that Mr Durran who while waiting would usually get out to "ready the load"; by that he said he meant "remove the straps". He added "most drivers would".[6] Mr Newton claimed that in terms of "pulling up" drivers for exiting the cabin prematurely he considered that to be an issue for someone higher up the hierarchy than himself.

11. It has to be constantly borne in mind that the actual incident when a log fell from the trailer striking and killing Mr Durran was unwitnessed.

12. In relation to the height of a load above the stanchions, Mr Newton, in answer to a question from Mr Kennedy as to safety generally, said Mr Durran's approach was "reasonable. His loads were generally really good, loaded correctly".[7] He did, however, maintain that he had cause to "have a chat"[8] with Mr Durran in relation to load heights on two or three occasions. He described these "chats" as a "gentle reminder".[9] Although some aspects of Mr Newton's evidence were to some extent confusing with inconsistencies, importantly he opined, examining Mr Durran's load after the incident that, "it was well over height".[10] Having examined a photograph (which became "Exhibit J") Mr Newton said what was depicted on the front trailer (from where the log fell that resulted in Mr Durran's death) accorded with his

---

[5] Shakespeare – Hamlet, Act 1 Scene 4

[6] Transcript of Inquest p.210

[7] Transcript of Inquest p.214

[8] Transcript of Inquest p.246

[9] Transcript of Inquest p.246

[10] Transcript of Inquest p.219

recollection. That photo clearly shows a number of logs, of varying diameters, well above the stanchions. I suspect because logs loaded at the Strath Creek Coupe were light, loads went higher to seek to get the weight of the load as near as possible to the maximum allowable.

13. When examined by Ms Karen Argiropoulos for WorkSafe, Mr Newton conceded it was, to his knowledge, "common practice" for drivers to leave the cabin, inspect their load and undo the straps "ready to go"; again a guideline only honoured in the breach. He indicated that after the death of Mr Durran the operation moved to premises in Brooklyn where the stay in the cabin policy was better enforced by management.

14. In response to a question put by Mr Halse, Mr Newton advised he had received no information whatsoever by his employer JNC about WorkSafe Industry Standards or VicRoads Standards[11] as to load heights. The thrust of Mr Halse's questions was that it was only his clients who were investigated by WorkSafe, not JNC. Had I carriage of the matter from the outset that may well have been another focus of attention.

15. Mr Ian Wright was engaged by WorkSafe to provide a report into aspects of the circumstances surrounding Mr Durran's death. He also provided a statement. For all intents and purposes Mr Wright's report titled "Log Loading/Unloading Opinion – Independent Information Analysis" was treated as an expert opinion. When that opinion was to be tendered, Mr Halse sought to examine Mr Wright as to the issue of his expertise to provide the various opinions he proffered in his report. After considering evidence on the challenge to Mr Wright's expertise and listening to Mr Halse's submission, I indicated that I would accept Mr Wright as an expert in light of his extensive involvement in the industry and his further involvement in the development of industry guidelines, but indicated that ultimately it would be up to me as to what weight I attached to Mr Wright's evidence on various issues.

16. I am unaware whether Mr Wright had previously given evidence in court where his expertise was challenged. Being cross examined by competent experienced counsel was no doubt an interesting experience for Mr Wright. Whilst Mr Halse's cross examination was measured he systematically deconstructed aspects of Mr Wright's report, resulting in a number of concessions on important issues. As to Mr Wright's evidence, in written submissions Mr Halse claimed:

[11] Transcript of Inquest p.242

"It is submitted that, the utility of any of Mr Wright's evidence is significantly confined. The most helpful information provided by Mr Wright was the various concessions he made during his evidence as to the problems with his report."[12]

One may well agree with the first sentence of the excerpt, but the second is perhaps a bridge too far.

17. In paragraph 36-41 of his submissions Mr Halse refers to matters which he claims impact upon the value of Mr Wright's report. I do not propose to allow those, what I will call technical deficiencies, to diminish all Mr Wright's opinions, however in areas where he demonstrated, or conceded a lack of expertise that of course impacts upon the weight one attaches to that evidence. I think it fair to say, as a broad principle, that expert evidence (opinion evidence) is generally only permissible where the opinions provided go to areas outside the knowledge and understanding of the finder of fact, whether it be judge, jury, magistrate or coroner. A Coroner is afforded further latitude due to the Act providing that a Coroner is permitted to inform him/herself in any manner the Coroner thinks fit. I believe that a number of critical issues for resolution in this matter do not require expert opinion, but are matters I conclude can be resolved by applying good old fashioned common sense to the evidence presented.

18. Mr Scott Kimberley, at the time of this incident, drove a logging truck for a company sub-contracted to Venturoni Bros to take logs from the Strath Creek coupe to the JNC facility at Enterprise Road. His loads were also loaded by Mr Ted McCarthy. In his statement,[13] Mr Kimberley stated:

    "Before the incident to Ray Durran I had been warned by JNC staff that loads were starting to get a bit high and I have had the JNC staff put the loader mainly on the front bay when the strapping was being removed to steady the load. I have asked Ted McCarthy to remove logs from the load as the load was too high."

    In relation to the height of the load Mr Kimberley in evidence stated:

    "Raymond used to push the boundaries a bit with heights. There's no doubt at that."[14]

---

[12] Paragraph 30 Outline of Submissions

[13] Exhibit A

[14] Transcript of Inquest p.14

and added that this occurred "60-70% of the time". Mr Kimberley maintained that as a general rule his load would involve half a log above the stanchion on the outside (i.e. resting on the stanchion) and the bottom of the top log of the crown approximately two feet above the stanchion. Interestingly, when one looks at the load depicted in Exhibit J (photographs of Mr Durran's truck and trailer at the site after the accident) that is precisely what one sees. Another point of particular interest in Mr Kimberley's evidence was his comment that in terms of how high the truck was to be loaded the "ultimate call" fell to Mr McCarthy, but "he relied on the drivers to be honest with him". One of the reasons for that reliance was that at this particular site the loader was below the level of the truck which may make it more difficult for the loader to observe precisely how high above the stanchion to the top of the crown was. Another interesting observation made by Mr Kimberley was that occasionally at the point of delivery if he was concerned that a log may fall off the top of the load he would get the loader operator to hold the load with the "grabs" while he undid the straps. It was clear, however, that this again was the exception rather than the rule, at least at JNC.

19. Mr Kimberley said JNC personnel never refused to unload due to a load being too high, but he claimed that Mr Newton had advised him on occasions:

"Don't touch the straps. I'm coming over to hold the load."[15]

I found aspects of Mr Kimberley's evidence interesting for a number of reasons, one of which is that he was speaking from the perspective of someone "at the coalface" so to speak. I suspect he had never previously given evidence in a court; he, in my view, spoke frankly and objectively; he impressed as a witness of honesty and reliability.

20. Mr Kimberley gave evidence of his observations of Mr Durran's load on the day in question; he maintained that in his opinion, claiming to have had a good oncoming view of the vehicle as they passed each other on the Ring Road, the load was "dangerously high"[16]; higher than usual. In response to a question from Mr Halse, Mr Kimberley conceded he did not raise that issue with Mr Durran over the two-way radio.

21. The issue of crowning was canvassed at various times and with various witnesses. When examined by Mr Halse, Mr Kimberley stated that while crowning of logs makes transportation safer he was not suggesting it made unloading safer; in his view on the contrary. He said:

---

[15] Transcript of Inquest p.39

[16] Transcript of Inquest p.33

"I'm saying it's safer for transport. I'm not saying it's safer to be unloaded. There's more of a chance of that log rolling, being crowned. There's no doubt about that. But for transportation purposes, I think it's perfect."[17]

For balance I include several other statements made by Mr Kimberley. He said that Mr McCarthy was "one of the older and wiser loader operators"[18] he had worked with. Mr Kimberley also acknowledged if Mr Dean Venturoni saw "too many logs" on a truck he would have no hesitation in directing that they be removed.[19]

22. Mr James Chasser, a Victorian Workcover Authority Investigator, gave evidence. Much of his statement relates to what I will call technical and procedural matters that flowed from the incident in which Mr Durran was killed. His 11 page statement constitutes Exhibit D. Mr Chasser's *viva voce* evidence was far more relevant from my perspective, especially as he had been present in court for the entirety of the inquest. At the outset Mr Chasser confirmed WorkSafe issued improvement notices, but no prosecutions were launched. Mr Chasser advised that his organisation had published compliance codes or industry standards (which for all intents and purposes are the same thing) which he advised were "advisory documents" only.

23. Mr Chasser conceded in examination by Mr Halse that the half log above the stanchion is a standard, as distinct from a legal requirement.

24. I was assisted in my endeavour to understand the status of the WorkSafe Industry Standard (contained in the Brief of Evidence) by Mr Wright's response to a question from Ms Angiropoulos. He said he was consulted and played some role in its development. Ms Angiropoulos put the following propositions to Mr Wright with which he agreed:

    "What those paragraphs essentially describe is the status of this industry standard, namely that it is designed to be a reference document so that people who are trying to comply with their obligations under the Occupational Health and Safety Act can benchmark their procedures against what is set out in this industry standard. Do you agree with that summary of the role of it?---Yes.

[17] Transcript of Inquest p.41

[18] Transcript of Inquest p.46

[19] Transcript of Inquest p.49

Certainly it doesn't prevent employers or other persons from adopting different standards, but it really places the onus on those people to ensure that if they don't comply with this standard, the processes that they introduce should be at least as good as or better in terms of safety, safe practice? --- Yes – I agree"[20]

25. The maximum height a load can be in Victoria is 4.3 metres. As far as I recall there is no evidence as to precisely what height Mr Durran's load was on this day; I have proceeded on the basis it was less than 4.3m. However, little turns on that; it is not the issue. The focus of my investigation is, was the load at the top of the crown at a safe height above the stanchion so as not to have a log or logs fall when the load was unstrapped. In considering that issue the prospect that in spite of restraints (even with self-tensioners) logs may move during transit has to be taken into account. The fact that during transit although restrained logs are apt to move should be taken into account when loading. Also, the weight and nature of the log has to be considered.

26. Mr Wright's evidence took a good part of the inquest hearing; the transcript of his evidence is contained in 100 of the 249 page transcript. I raise this because in the final analysis it is somewhat ironic that his evidence had limited bearing on the core finding I propose to make. I make it clear this is no reflection on him, he was obviously a witness of honesty.

27. The evidence of Messrs Kimberley and Newton, together with pictorial evidence, leads me to what I consider to be an inescapable conclusion; this load was inherently unsafe in that the logs crowned above the stanchion were too high by quite a margin. There was, as turned out to be the case, an appreciable danger that when unstrapped a log or logs would be dislodged and fall from the trailer; this is whether or not they may have moved in transit. When one compares the loads depicted in the exhibits "J", "F" and "G" with those depicted in exhibit "H" the comparison is stark.

28. The load being too high to be safely unstrapped is, in my considered view, a causal factor in the untimely death of Mr Durran; whether that fact is a breach of recognised duty or a departure from a standard, or both, is of little consequence.

29. What flows from that finding is more problematic because I have to consider who was responsible for the crown of the load being too high above the stanchions. Mr McCarthy loaded the trailer, albeit in the dark and from a position below the top of the load. Mr Durran

---

[20] Transcript of Inquest p.84-5

himself was able to request some of the top logs be removed if he considered it may be too high to safely unload. Mr Durran, upon arrival at the JNC site, had the opportunity to observe the load as depicted in exhibits “J”, “F” and “G” before he commenced to unstrap.

30. Mr Durran, by unstrapping what was obviously a potentially hazardous load, unwittingly put himself in harms way with a tragic consequence. It would have been prudent, after examining the load at the JNC site, to request Mr Newton to put the grabs over the load before unstrapping.

31. Management have an obligation to ensure a safe workplace; part of the responsibility goes to adequately inducting and training employees. It is imperative if industry standards and guidelines exist (albeit advisory) that employees are acutely aware of them. If an employee is non compliant with those standards/guidelines then it is the responsibility of management to re-educate, reinforce, and if necessary discipline, that employee for non-compliance/breach. Mr Dean Venturoni was the face of Retreev at Strath Creek, although he was not at the Strath Creek site at the time Mr Durran’s truck was loaded and departed on the 6 October 2008. I have concluded that a significant number of potentially unsafe loads left the Strath Creek Coupe during the period prior to Mr Durran’s death. If Mr Dean Venturoni was aware of that he should have acted to prevent it occurring; if he was not aware he should have been; one way or another his failure to act or make appropriate enquiries represents, not a background circumstance, but a causal factor in Mr Durran’s death.

32. Although it was not a focus of the WorkSafe investigation, JNC personnel at the site of unloading surely had some responsibility to warn a driver with an obviously unsafe load not to unstrap his load. In these circumstances, it would have been appropriate for Mr Newton to advise Mr Durran that to unstrap may have been hazardous and to stay in the cab of the truck until he secured the load with his unloader and not to unstrap until he had done so. This also was not an isolated case at the JNC facility and its management was aware of the potential problem. JNC management, whoever and wherever they be, should have taken action to ensure hazardous, unsafe loads were either rejected (as was their power) or at least instructed Mr Newton to take a tougher line with the driver; once again these are causal factors in the untimely death of Mr Durran.

33. While I have stressed it is not my role to lay or apportion blame or culpability, the IMPLICIT attribution of blame may be unavoidable in order for a Coroner to explain how death occurred in the wider events that were the causal factors in the death.

34. Furthermore, while it may appear obvious, the fact that a log dislodged, struck and killed Mr Durran is the final compelling piece of evidence that confirms that the load, whether there was movement in transit or not, was too high to be safely unloaded.

COMMENTS

1. I refer to myself as a "Harmsworth" Coroner; I do not see it as my role to investigate too far beyond the parameters relevant to the particular death under investigation. I only make formal detailed recommendations if several criteria are met; including being satisfied that I have sufficient factual information/material to make some reasoned contribution to public health and safety. I am more inclined to be general, non-specific, as to an issue that requires attention. In this case it became clear that some of the advisory materials, call them industry standards, advisory codes of practice or guidelines, however titled were in some respects deficient, they did not demonstrate best practice and require review; as much was conceded by both Mr Wright and indeed Mr Chasser.

2. Although in his submission Mr Halse was highly critical of many aspects of Mr Wright's report, and as I have observed aspects of it were deconstructed during cross examination, his clients would do well to heed a number of observations and comments made by Mr Wright in that report.

3. The implementation of practices and procedures in Venturoni Bros Safe Work Procedure Manual in relation to health and safety management was less than optimal. I make this observation – it is one thing to have adequate policies and procedures documented, but too often <u>in practice</u> the implementation, compliance, oversighting and review of those policies and procedures by management is not as robust as it could and should be.

4. As to unloading, Mr Wright, in answer to a question from Mr Kennedy, made a pertinent comment. I include a short excerpt from the transcript of evidence (it contains the question posed and the answer given). It may provide food for thought for a WorkSafe review I anticipate may follow this inquest.

   "Your Honour, the key is for the site routine not to let the driver take his straps off until that loader authority has given him a clearance and he's in the right position to do it safely.

   It seems to me this is pretty fundamental stuff..."

"We did hear Scott Kimberley give evidence that when the load is high, he's had times where Anthony Newton will restrain the load with the loader to make sure nothing comes loose when the straps are released?---Yes.

It is a case, is it, that this isn't something that has to be done in Victoria?---That's right. It's not the case that it has to be done in Victoria?---That's right. It's not the case that it has to be done, but it's talking about best practice. If you're too high-risk small logs over the top of the stanchions, then it becomes good practice to not allow the driver to drag his straps, risking the logs to roll off before the loader has clamped on top of them."[21]

My only observation at this time is, if it is "best practice" it should be formalised in a revised standard.

RECOMMENDATION

1. I don't propose to be prescriptive, but <u>recommend</u> WorkSafe Victoria undertake a review of its Industry Standard/Safety in Forest Operations - Harvesting and Haulage July 2007, particularly to address aspects of the present standard shown and conceded during the running of this matter to be deficient and/or confusing.

---

[21] Transcript of Inquest p.80

I direct that a copy of this finding be provided to the following:

Mrs Ann Duran

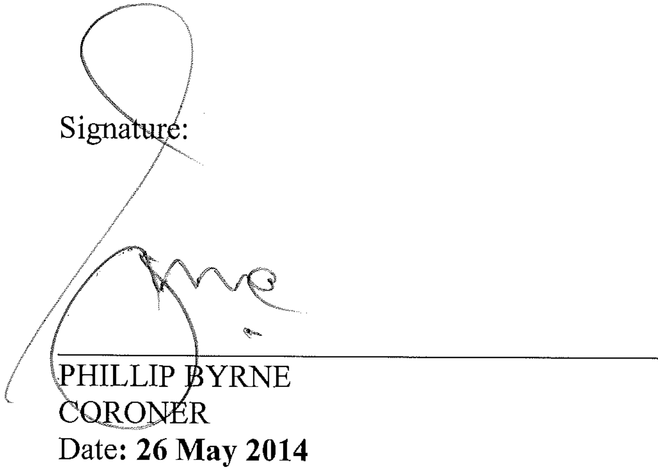
WorkSafe

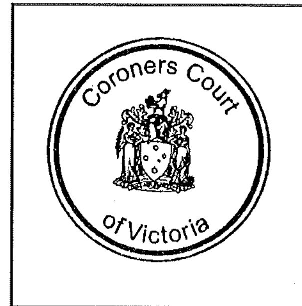
Mr Stephen Greenham

Ms Penny Stevens

Constable Lorelle Ross, Victoria Police

Signature:





PHILLIP BYRNE
CORONER
Date: **26 May 2014**