IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2006 1427

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: BRIAN MAXWELL BAKER

Hearing Dates:	2-6 May 2011, 9-13 May 2011, 28 June 2011
Appearances:	• Mr J.E. Goetz on behalf of WorkSafe Victoria[2] • Mr J Murphy on behalf of Energy Safe Victoria • Mr R Ray SC with Mr Sam Stafford of Counsel on behalf of Powercor Australia Pty Ltd
Police Coronial Support Unit:	Leading Senior Constable Remo Antolini, Assisting the Coroner
Findings of:	AUDREY JAMIESON, CORONER
Delivered on:	13 March 2015
Delivered At:	Coroners Court of Victoria 65 Kavangh Street, Southbank 3006

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal representatives and counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.
[2] Any reference to the Victorian WorkCover Authority throughout the course of the investigation into the death of Brian Baker should be taken to by synonymous with the organisation now known as WorkSafe Victoria (WorkSafe).

I, AUDREY JAMIESON, Coroner having investigated the death of BRIAN MAXWELL BAKER

AND having held an inquest in relation to this death on 2-6 May 2011, 9-13 May 2011 and 28 June 2011

at the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was BRIAN MAXWELL BAKER

born on 7 June 1961

and the death occurred on 19 April 2006

at 1940 Nhill-Netherby Road, Woorak West, Victoria, 3418

from:

1 (a) ELECTROCUTION (HIGH VOLTAGE)

in the following summary of circumstances:

1. On 19 April 2006, Brian Baker was electrocuted whilst acting in the course of his employment when the trailer of his truck came into contact with overhead power lines when he was tipping a consignment of super-phosphate fertiliser at a farm in Woorak West, Victoria.

BACKGROUND

2. Brian Maxwell Baker was 44 years of age at the time of his death. He was married to Janine Baker and they lived in Nhill, Victoria.

3. Mr Baker was the sole employee truck driver employed by Marra Farms, a bulk haulage company located at Netherby Lorquon Road, Netherby, which delivers grain, stockfeed and super-phosphate to farmers around the Nhill district. Mr Baker drove a 1997 Kenworth prime mover, registration TA1559, towing a 2004 Barber tipper trailer that was 10.35 metres in length and had the capacity to carry 30 tonne of super-phosphate.[3] The tipper can be raised to angle of approximately 85 degrees and is raised by *a 4 stage hoist driven by the hydraulics on the prime mover.*[4] The tipper controls are located inside the prime mover's cabin and can be operated from within the cabin or from standing on the ground outside the cabin with the truck door open.[5]

[3] Exhibit 2 – Statement of Robert Picone dated 11 July 2006.
[4] *Ibid.*
[5] *Ibid.*

4. Mr Baker's truck driving routine in or around April 2006 involved driving to Melbourne on Monday, Wednesday and Friday to drop off grain and pick up fertiliser in Geelong before returning home. On Tuesday and Thursday, he would drive to Ballarat with grain then onto Geelong to pick up fertilizer before driving home. On his return from Geelong, he would usually drop the fertilizer at Jason Marra's depot. On occasion, he would deliver the fertilizer directly to the farmer.[6]

5. Mr Bruce Deckert owned and lived on a property at Deckerts Road, Woorak West, and leased a property at 1940 Nhill-Netherby Road, Woorak West. Both properties are broad acre cropping mixed with sheep rearing.[7] In March 2006, Mr Deckert ordered 65 tonnes of fertiliser mix called 22-15 from Landmark Operations Limited (Landmark), an Australia-wide chemical and fertiliser dealership, to be delivered to his Woorak West leased property sometime in April 2006. Marra Farms was engaged to undertake the delivery by J&A Spreading, a local business in partnership with Landmark. The owner of J&A Spreading, Jason Marra, contacted Mr Deckert in early April 2006 to arrange a suitable date for delivery, which was agreed to be Wednesday, 19 April 2006.

SURROUNDING CIRCUMSTANCES

6. On 19 April 2006, Mr Baker was tasked with the delivery of the load of super-phosphate fertiliser to Mr Deckert's leased property at 1940 Nhill-Netherby Road, Woorak West. He had travelled to Melbourne in the morning with a load of grain then onto Geelong to pick up Mr Deckert's fertilizer which he was to deliver direct to the property.[8] There was no site visit conducted prior to delivery. Prior to his arrival at Mr Deckert's farm at approximately 2.00pm, Mr Baker had been driving for approximately 12 hours.

7. Mr Deckert had placed a petrol engine auger and mobile/field storage bin at the intended dumpsite, which was in close proximity to a power line of 12,700 volts (a Single Wire Earth Return [SWER] line). The auger was running at the time of the delivery. Mr Deckert offered to re-locate the auger, however Mr Baker apparently declined. Under the direction of Mr Deckert, Mr Baker reversed the truck and parked it in position for unloading. The SWER

[6] Exhibit 12 – Statement of Ricky Marra dated 4 June 2006.
[7] Exhibit 1 – Statement of Bruce David Deckert dated 21 April 2006.
[8] Exhibit 12 – Statement of Ricky Marra dated 4 June 2006.

line directly adjacent to Mr Baker's truck was at a height of 7.855 metres.[9] Mr Deckert did not volunteer to act as a spotter for the purposes of unloading but the presence of the power line was reportedly acknowledged by both Mr Baker and Mr Deckert during the unloading process when the trailer had been elevated to approximately two thirds of its' final position.[10] Mr Deckert at that stage offered to keep a look-out.

8. Mr Baker elevated the trailer to an angle that placed it within 1.5 metres of the power line. Most of the fertiliser left the trailer as it tipped up however, an amount of fertiliser remained in the trailer. In an effort to remove the remaining fertiliser from the trailer, Mr Baker exited the vehicle cabin to observe the process as he further elevated the trailer. He stood on the ground, elevating the trailer from this position using the controls inside the vehicle cabin.

9. Mr Deckert continued to act as look-out. He noticed fertiliser starting to move, held up his hand and yelled out to 'stop'. The centre bar which runs along the length of the trailer and acts to hold the roll top tarp over the trailer top contacted the power line. Mr Deckert saw a small arc and simultaneously heard Mr Baker scream and a loud bang. As Mr Deckert looked over at the truck he saw an arc go from the front driver's wheel to the ground. Mr Baker fell away from the truck onto the ground onto his hands and knees. Mr Deckert's wife, Lisa, had recently arrived at the farm and she went to Mr Baker's side to render assistance while Mr Deckert attempted to put out grass fires that had ignited next to the truck's tyres. Mr Baker's condition however deteriorated and Mr Deckert returned to his side and commenced cardio-pulmonary resuscitation (CPR) while Lisa telephoned '000'. Approximately ten minutes later, Police arrived and assisted Mr Deckert with ongoing CPR until the arrival of Ambulance paramedics.[11] Mr Baker could not however be revived. It appeared that Mr Baker was electrocuted as a result of the trailer contact with the power line. He died at the scene.

10. Representatives from Rural Energy Pty Ltd[12] attended soon after. The SWER line was identified as one carrying 12,700 volts, the standard voltage for a SWER line in Victoria. Mr Graeme Janetzki from Rural Energy Pty Ltd identified that the fused control point was two

[9] According to Terrence Clement from ESV this height is 2.35 metres above the statutory minimum set under Regulation 13 *Electricity safety (Network Assets) Regulations* 1999, Table 13.2.
[10] Transcript (T) @ p17-18.
[11] Exhibit 1 – Statement of Bruce David Deckert dated 21 April 2006.
[12] Rural Energy Pty Ltd provide 24 hour fault response service to Powercor Australia Ltd. (Exhibit 3 – Statement of Graeme Janetzki dated 11 July 2006.)

poles away from incident and noted that the fuse, known as Expulsion Drop Out Unit (EDO Unit) had operated, resulting in a break to the electrical circuit, isolating the line. The line was then earthed, rendering the scene safe[13] and the ignition on the truck turned off.

11. WorkSafe Inspector, Mr Leslie Ferguson, arrived at the scene at 9.05pm that evening and was met by Worksafe Investigator Mr Greg Wait and Leading Senior Constable (L/S/C) Richard Shiells. Due to failing light, they returned the following day. Representatives from Energy Safe Victoria (ESV) also attended the Woorak West property on 20 April 2006.

12. Mr Ferguson issued Mr Deckert with an Improvement Notice[14] as he had formed the opinion, based on his observations of the scene and his discussions with ESV representatives that Mr and Mrs Deckert *"had failed to make arrangements for ensuring, so far is reasonably practicable, safety and the absence of risk to health in connection with the use, handling, storage or transport of plant and substances"*[15] in contravention of section 21 (2)(b) *Occupational Health and Safety Act 2004* (Vic) (OH&S Act). Mr Ferguson also raised concerns with Mr Deckert contemporaneous to the issuing of the Improvement Notice that there was a Chain Harrow situated to the north of the incident scene, which was itself under the power line. Mr Ferguson asked Mr Deckert to relocate the Chain Harrow away from the power line.[16]

13. Mr Ferguson subsequently met with Mr Ian Marra of the family business, Marra Farms and confirmed that Mr Baker was their sole employee. Mr Ferguson issued an Improvement Notice to Marra Farms as he had formed the opinion as a result of his preliminary investigations *"that Marra Farms did not have an adequate training process in place in relation to safe work in the vicinity of overhead power lines"*[17] in contravention of section 21(1) and 21(2)(e) of the OH&S Act.

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[13] Exhibit 3 – Statement of Graeme Janetzki dated 11 July 2006.

[14] WorkSafe Inspectors have legislated powers to enter workplaces during working hours, or when there is an immediate risk to anyone, to assess compliance with occupational health and safety laws. Improvement notices are written directions requiring a person to fix an issue within a specified time. The Inspector will include information on the notice about what must be done to comply with the law. The person who receives the notice is responsible for achieving compliance with legislation or dealing with the immediate risk.

[15] Exhibit 10 – Statement of Leslie Ferguson dated 8 June 2010.

[16] *Ibid.*

[17] *Ibid.*

JURISDICTION

14. At the time of Mr Baker's death, the Coroners Act 1985 (Vic) (the old Act) applied. From 1 November 2009, the Coroners Act 2008 (Vic) (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[18]

15. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety is found in other sections of the new Act.[19]

16. Section 52(1) of the new Act enables a Coroner to exercise their discretion to hold an Inquest. Section 54 of the new Act states that a Coroner may hold an Inquest that investigates two or more deaths and enables a Coroner to hold simultaneous Inquests into deaths where for example, like circumstances or issues have been identified.

17. Section 67 of the new Act describes the ambit of the Coroner's Findings in relation to a death investigation. A Coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[20] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

18. A Coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[21] A Coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death, which the Coroner has investigated including recommendations relating to public health and safety or the administration of justice.[22]

[18] Section 119 and Schedule 1 - *Coroners Act 2008*.
[19] See for example, sections 67(3) and 72 (1) & (2).
[20] Section 67(1).
[21] Section 67(3).
[22] Section 72(1) & (2).

INVESTIGATION

Identification

19. The identity of Brian Maxwell Baker was without dispute and required no additional investigation.

Medical Investigation

20. In response to the Coroner accepting an application pursuant to section 28 *Coroners Act 1985* (as it then was) objecting to an autopsy being performed, Dr Noel Woodford, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed only an external examination on the body of Brian Baker. Dr Woodford also reviewed a post mortem CT scan and reviewed the circumstances as reported in the Police Report of Death for the Coroner, Form 83 and reported to the Coroner that his findings were in keeping with high voltage electrocution. Injuries seen on Mr Baker's right hand and right foot were consistent with electrical burns. Dr Woodford stated that in the absence of an autopsy, the possible contribution of occult natural disease processes to the ultimate mechanism of death would be unable to be properly assessed but opined that a reasonable cause of death in the circumstances could be ascribed to electrocution (high voltage).

21. Toxicological analysis of post mortem blood did not detect the presence of alcohol or any common drugs or poisons.

Police Investigation

22. L/S/C Richard Shiells from Nhill Police Station undertook the investigation and compilation of the Inquest Brief on behalf of the Coroner. Statements were obtained from a number of witnesses.

ESV investigation

23. Section 7(f) of the *Electricity Safety Act 1999* (Vic) enables ESV to investigate events or incidents that involve electrical safety. ESV participated with WorkSafe in investigating Mr Baker's death.

24. An ESV Electrical Safety Investigation Report (the ESV report) based on an on-site investigation conducted on 20 April 2006, was authored by ESV Compliance Officer, Mr

Terence Clement.[23] The ESV Report identified and confirmed the observations of Mr Graeme Janetzki from Rural Energy Pty Ltd on the day of the incident that the electricity assets on Mr Deckert's property belonged to Powercor Australia and consisted of a SWER system operating at a nominal voltage of 12,700 volts with respect to earth. A pole located inside the boundary fence was fitted with a 10 Amp Expulsion Drop Out (EDO) high voltage fuse which had operated appropriately at the time of the incident resulting in the removal of electricity supply from the SWER line at the incident site. Mr Clement stated in the ESV Report that the EDO "*is designed to provide electrical safety protection of network assets and to isolate parts of the network when a fault is detected, it is not intended to protect a person from injury or death.*"[24]

25. The Electricity Safety (Network Assets) Regulations 1999 require that the minimum height of a SWER line above ground traversable by vehicles to be 5500mm and in the ESV Report Mr Clement stated that the overhead electric line at the site of the incident complied with the minimum height above ground requirements when measured on 20 April 2006. In the ESV report, Mr Clement noted that it was probable that the SWER line had been installed during 1965 and that *the size of many of the tipper trailers in use today is such that when elevated to their maximum height(sic) will exceed the height that the SWER lines are installed above the ground.*[25] Mr Clement commented on information obtained from Mr Deckert on 20 April 2006 that Mr Baker raised his tipper trailer to within 1–1.5 metres of the overhead electric line that:

> *When the tipper trailer was elevate to this height, and within 2000mm of the overhead line, the operator of the truck was in breach of Regulation 40 of the Electricity Safety (Network Assets) Regulations 1999.*[26]

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[23] Exhibit 7 – ESV Electrical Safety Investigation Report dated 28 June 2006.

[24] *Ibid.* In the Inquest into the death of Mr John Jones, Mr Clement explained that an EDO is used to protect the electrical system, not a person, and even if had been operational at the time of the fatal incident in relation to Mr Jones, would not have prevented his death; (transcript in the Inquest into the death of John Jones, @ p52). Mr Clement later explained that he had mistakenly identified an expulsion fuse/EDO, and the device was in actuality an over current relay (OCR) device, which is operated electrically, monitoring how much current is going through the system, and has a predetermined level which, when the system surpasses, automatically trips the system and turn the lines off. Mr Clement considered that the predetermined level may not be such that the incident involving Mr Jones may have caused it to trip (transcript in the Inquest into the death of John Jones, @ p56 &72). Mr Clement opined that neither an EDO nor an OCR would have protected Mr Jones (or Mr Baker); (transcript in the Inquest into the death of John Jones, @ p74).

[25] *Ibid.*

[26] Exhibit 6 – Statement of Terence Clement dated 30 June 2006.

26. There was evidence of significant pitting and burn marks on the central support for the load cover, which confirmed that it was this centre bar which runs along the length of the trailer that made contact with the power line.[27] The centre steel bar sits 15 centimetres higher than the sides of the trailer.[28]

27. The ESV report identified four contributing factors to the fatality at Mr Deckert's farm as:

    a) not understanding the fatal consequences that can result from a truck making contact with an energised high voltage electric line;

    b) placement of the mobile auger and storage bin in close proximity to the energised overhead electric line;

    c) the size of the many tipper trailers in use today; and

    d) not being able to see the load cover support structure from the ground when elevating the tipper trailer and attempting to estimate the closeness of the tipper trailer to the overhead electric line.[29]

WorkSafe Investigation

28. On 26 May 2006, WorkSafe Inspector Mr Ferguson returned to Marra Farms and met with Ian and Rick Marra. Mr Ferguson was shown a copy of a safety manual that had been revised since the date of Mr Baker's death and included a copy of ESV's "No Go Zone" pamphlet. Marra Farms were also able to show Mr Ferguson that they had introduced a training register with new employee records reflecting their training on commencing work at Marra Farms. Mr Ferguson was also shown a "No Go Zone" sticker and was advised that these had been placed on the dashboards of all of Marra Farms' mobile plant. Mr Ferguson formed the opinion that the Improvement Notice issued to Marra Farms on 20 April 2006 had been complied with.[30]

29. On 31 May 2006, Mr Ferguson attended the Deckert property at 1940 Nhill-Netherby Road Woorak West and met with Mr and Mrs Deckert. Mr Ferguson formed the opinion that the Improvement Notice issued on 20 April 2006 had been complied with after he observed in particular, that a sign warning of the presence of overhead power lines had been erected

[27] T @ pp131-132.
[28] Exhibit 11 – Statement of Senior Constable Richard Shiells dated 3 May 2011.
[29] Exhibit 7 – ESV Electrical Safety Investigation Report dated 28 June 2006.
[30] Exhibit 10 – Statement of Leslie Ferguson dated 8 June 2010.

under the power line at the southern side of the entrance track and accepted Mr Deckert's information of having erected a number of other signs in other areas on his farms where roads travel under overhead power lines.[31]

Other deaths

30. In 2006, two other men lost their lives in circumstances similar to those surrounding Mr Baker's death. On 9 January 2006, Mr Dallas Anderson died from electrocution whilst tipping a consignment of lime at a farm in Bena, when the trailer of his truck came into contact with overhead power lines.[32] On 28 April 2006, farmer Mr John Jones died whilst assisting a truck driver to deliver lime to his property in Mudgegonga.[33] The deaths of Dallas Anderson and John Jones were also investigated by WorkSafe. In Mr Jones' case, a decision was made not to prosecute any party in relation to his death. In Mr Anderson's case, a prosecution was authorised and charges laid against the supplier and distributor of lime for breaches of the OH&S Act.[34] The matter proceeded to trial in the County Court of Victoria. On 24 June of 2010, the trial jury delivered verdicts of not guilty on all charges in respect of each of the defendant companies.

31. The common threads linking these deaths were as follows:

    a. the bulk ordering of either lime or fertiliser to farms;

    b. the order was to be delivered by a tipper truck to the farm;

    c. the deliveries in each case had a dumping site that required the tipper truck to be in close proximity to power lines (two lines in Mr Anderson's case and Single Wire Earth Return (SWER) system in Mr Jones' and Mr Baker's case);

    d. the three incidents resulted in the death of a person due to the tipper trailer contacting overhead transmission lines on the farming properties;

    e. it was apparent that all parties were aware of the power lines;

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[31] *Ibid.*

[32] COR 2006 0101.

[33] COR 2006 1546.

[34] The charges against Rodnmar Pty Ltd formerly trading as Korumburra Lime And Spreading and Calcimo Lime & Fertilizers Pty Ltd included:

1. OH&S Act 2004 - s 21(1) & (2)(a) Employer failed to provide & maintain so far as was practicable for employees a safe working environment - plant & systems of work [1800 penalty units individual 9000 penalty units body corporate] Indictable offence triable summarily.
2. OH&S Act 2004 - s 21(1) & (2)(c) Employer failed to provide & maintain so far as was practicable for employees a safe working environment - information instruction training & supervision (1800 penalty units individual 9000 penalty units body corporate) Indictable offence triable summarily.

f. a qualified spotter was not used at any of the sites; and

g. the drivers were not familiar with the properties that they were attending.[35]

INQUEST

32. Direction Hearings were held on 2 February 2010, 4 August 2010 and 5 November 2010.

33. I determined that the deaths of Mr Baker, Mr Anderson and Mr Jones individually warranted the exercise of my discretion pursuant to section 52(1) of the new Act to hold Inquests into their deaths. The investigations into the deaths of Mr Baker, Mr Anderson and Mr Jones identified similar features including matters related to public health and safety, and I accordingly determined that there was some utility to collectively addressing these similarities and collectively exercising my role to contribute, where possible, to the reduction of preventable deaths. I thus determined to hold an Inquest into multiple deaths pursuant to section 54 of the Act.

34. The Inquest commenced with the investigation into Mr Baker's death with evidence heard on 2, 3 and 4 May 2011. The Inquest into the death of Mr Jones was held on 5 May 2011. An Inquest into Mr Anderson's death was held on 9, 10, 11 and 13 May 2011. Closing submissions in relation to the three inquests were heard on 28 June 2011.

***Viva voce* evidence at Inquest**

35. *Viva voce* evidence was obtained from the following witnesses in relation to the death of Brian Baker:

a. Mr Bruce Deckert – farmer;

b. Mr John Picone – truck driver;

c. Mr Graeme Janetzki – linesman, Rural Energy;

d. Mr Jason Marra – owner, J & A Spreading, Nhill;

e. Mr Robert Cole – Branch Manager, Landmark, Nhill;

f. Mr Terrence Clement – Compliance Officer, Energy Safe Victoria;

g. Mr Leslie Ferguson – Inspector, WorkSafe Victoria;

[35] However it was subsequently revealed in the Inquest into Mr Baker's death that according to the evidence of the land owner, Mr Deckert, that Mr Baker had previously delivered fertilizer to his property and that the earlier delivery had been within 30 metres of the site of the fatal incident.

h. L/S/C Richard Shiells – Coroner's Investigator; and

i. Mr Ricky Marra – farmer, Marra Farms.

Issues investigated at Inquest

36. At the opening of the Inquest into the three deaths, Leading Senior Constable (L/S/C) Antolini, Assisting the Coroner, noted the common threads linking the incidents included the points outlined above in paragraph 31.

37. The issues identified involving bulk delivery of farm supplies requiring further exploration included:

a. the order taking method/procedure;

b. Safety Assessment made by the Company receiving the order;

c. Safety Assessment made by the customer placing the order;

d. evidence of consideration given to the selection of a dumpsite;

e. evidence of consideration given to attending for a site inspection;

f. procedure by which this is communicated to the driver;

g. training provided to drivers regarding tipper trailers and power lines; and

h. the use of appropriately qualified spotters.

Mr Baker's training and knowledge

38. Mr Baker had been working at Marra Farms for approximately 3 years.[36] According to Ricky Marra, the training for drivers prior to Mr Baker's death consisted of handing out and discussing the contents of, pamphlets produced by Vic Roads. He said:

> *We went through those and that were their training at that time.*[37]

39. There was no formal induction program but an informal one that included discussing the "dos and don'ts"[38] of what to do with the tipper and where not to unload including where it was not safe to unload. Mr Ricky Marra believed that discussion would have included power lines.[39]

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[36] T @ p193.
[37] T @ p188.
[38] T @ p189.
[39] T @ p189.

40. According to Mr Ricky Marra, Mr Baker *was an excellent and reliable truck driver who worked well without supervision.*[40] He knew two to three of Mr Baker's previous employers and hence knew that he had experience with tippers and that he did his job very well.[41]According to Mr Picone, Mr Baker was honest, reliable and thorough and he found it difficult to comprehend that Mr Baker would have unloaded under the power line if he had known it was there.[42] Mr Jason Marra expressed a similar sentiment and believed that Mr Baker would have told Mr Deckert to move the bin if he had know it was placed under the power line, as it was.[43]

Organisation of delivery

41. General Manager at Landmark, Nhill at the time of the incident, Mr Robert Cole, stated that Landmark never requested details of the delivery site at the time of taking an order. He however agreed with Mr Ray QC that it would be a relatively simple enquiry to ask the farmer placing an order whether there were any site hazards that should be disclosed. As Landmark had a system of providing written confirmation of the order back to the farmer, Mr Cole agreed that the confirmation letter was an opportunity either to confirm any site hazards or to ask the farmer for disclosure at that time.[44]

42. Mr Picone stated that Jason Marra took orders and would provide him details of the delivery including the farm address and the farmer's telephone number. After picking up the consignment, Mr Picone would telephone the farmer approximately one hour prior to arriving at the farm to determine whether anyone was going to meet him. Ninety percent of the time he was working alone[45] and on the other occasions, one of the *"Marra boys"* may have been available to help load or unload or act as a spotter,[46] however this usually only occurred on one of the Marra family's own farms.

43. In relation to the dumpsite, Mr Picone stated that generally no details of the dumpsite were known to him prior to arrival at the farm[47] wherein the farmer would direct him to the designated dumpsite. On occasion, Mr Picone has assessed a farmer's designated dumpsite

[40] Exhibit 12 – Statement of Ricky Marra dated 4 June 2006,
[41] T @ p190.
[42] Exhibit 2 – Statement of Robert Picone dated 11 July 2008.
[43] Exhibit 4 – Statement of Jason Marra dated 20 June 2006, T @ p80.
[44] T @ p109.
[45] T @ p47.
[46] T @ pp47-48.
[47] T @ p29-30.

as unsafe due to unlevel ground[48] and an auger being too close to overhead power lines.[49] He said that moving an auger was *"not that hard"*[50] a task and *"two blokes can move it easy enough"*[51] in about 15 minutes.

Designated dumpsite

44. In the three years that Mr Deckert had been working these properties, he had approximately seven bulk deliveries involving trucks of similar size. He stated that this was the third time that this particular truck had delivered at his farm. Mr Deckert stated that he spoke to Jason Marra about the delivery site and told him that the consignment of fertiliser was to be dumped in the "same yard".[52] The dumpsite for the deliveries on each of the other occasions occurred approximately 20-30 metres away from the dumpsite used on 19 April 2006.[53]

45. No official/designated spotter had ever been provided with any of the other bulk deliveries to Mr Deckert's farm. The delivery truck driver worked alone and Mr Deckert would act as the spotter.[54] According to Mr Deckert, Mr Baker had been at his farm on one other occasion to make a delivery with the Marra Farms truck.[55]

The Incident

46. According to Mr Deckert, Mr Baker was facing towards him as he was standing at the side of his truck and reaching in the driver's side door to operate the lever that caused the tray of the truck to elevate.[56] Mr Deckert had eye to eye contact with Mr Baker but was looking at the power line and the tray not Mr Baker once the tray started to move.[57] Mr Deckert said that there was nothing obstructing Mr Baker's ability to see that he was holding his hand up to stop, he had yelled "stop" as loud as he could and he believed that Mr Baker should have been able to hear him.[58]

47. WorkSafe Inspector Mr Ferguson stated that the information Mr Deckert provided to him about his and Mr Baker's awareness of the power line was consistent with what else he saw

[48] T @ p30.
[49] T @ p32.
[50] T @ p44.
[51] *Ibid.*
[52] T @ p20.
[53] T @ p13.
[54] T @ p26.
[55] T @ p23.
[56] T @ p22.
[57] T @ p23.
[58] T @ p25.

on the site.[59] He stated that he had observed burn marks on the ground where Mr Baker's foot was, which was besides the cabin and:

> *He would have been able to see the line but he wouldn't have had the perspective to know how close it was and neither would the farmer from what he told me.*[60]

48. Mr Ferguson stated that this was because Mr Baker was positioned at the front of the truck and Mr Deckert was positioned down the back of the truck whereas a spotter *would have been expected to stand well to the one side so you could actually see the line and the tray coming close together.*[61]

Mr Deckert's training and knowledge.

49. Mr Deckert was not a qualified "spotter" and although he was aware of the *Look Up and Live* campaign,[62] he had no knowledge of the specific "No Go Zones"[63] or minimum safe distances prescribed for approaching equipment at the time of the incident. He said that if he had known of them he:

> *..would have placed the bin slightly further north and it wouldn't have been anywhere near the power line.*[64]

50. Mr Deckert said that since the incident, he no longer places the mobile bin anywhere near the overhead power lines.[65] He did not consider the lack of a trained spotter as being the main issue, rather that it was more about staying away from the power lines.[66]

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[59] T @ p161.
[60] T @ p162.
[61] T @ p162.
[62] A safety campaign undertaken by Energy Safe Victoria providing information and publications directed at truck drivers, rural property owners and their families about the risks of electrocution from trucks contacting powerlines on rural properties. The publications are prefaced with the phrase: "LOOK UP AND LIVE – BE ALERT, BE AWARE – OVERHEAD POWERLINES ARE ALWAYS THERE." This campaign had commenced prior to these three deaths.
[63] The "No Go Zone for Overhead Electrical Powerlines" campaign similarly highlights safety issues related to working near overhead powerlines on poles and prescribes acceptable and unacceptable distances for working unaccompanied, with a spotter and that of the "no go zones" which are defined distances for safety clearances surrounding overhead powerlines. It is incorporated within the "Look Up and Live" publication and a number of WorkSafe publications and training programs. The minimum clearance distances/heights are prescribed in the *Electrical Safety (Network Assets) Regulations 1999* (Vic).
[64] T @ p25.
[65] T @ p26.
[66] T @ p27.

Improvements to work practices

51. Mr Robert Picone took over Mr Baker's job at Marra Farms in May 2006 and gave evidence about his role as the sole driver for the company that is, the role that Mr Baker had occupied prior to his death. Ricky Marra had given him a rundown on tipper truck's function and shown him how to use the tipper truck's controls. Mr Picone had extensive experience in driving car carriers and flat top trucks[67] and although he had not driven tippers full before he started with Marra Farms, he had previously "*done a fair bit of tipper work*".[68] Mr Picone considered tipper trailers to be "*pretty straightforward*".[69] Mr Picone stated that the day he started at Marra Farms he also received awareness training that included occupational health and safety management systems and workplace hazards[70] as well as information on working near overhead powerlines.[71] He received a "WorkSafe kit" which included stickers for putting inside the cabin of the truck – one *"to go near where the hoist control was about no go zone and power lines and a "Look Up and Live" sticker"*.[72] Mr Picone stated that prior to receiving this kit there were no stickers inside the truck cabin.[73] He was required to sign off that he had read and understood the information he had been given at his induction.[74] In the two years that he worked for the Marras he did not receive any additional or refresher training.[75]

52. WorkSafe Inspector Mr Ferguson was satisfied with the erection of signage at Mr Deckert's property alerting to overhead power lines such that he was satisfied that the Improvement Notice issued to the Deckert's had been complied with. Although not subject to the Improvement Notice *per se*, Mr Ferguson was however disappointed on his return to Mr Deckert's property to observe a Chain Harrow in the same position in close proximity to the overhead power line as it had been on 20 April 2006, with its wings folded up *so they stuck up in the air which could have, you know, been the source of a similar incident, if they come close to the power lines and the power had jumped over.*[76]

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[67] T @ p34.
[68] T @ p35.
[69] T @ p35.
[70] T @ pp40-41.
[71] T @ p41.
[72] T @ p44.
[73] T @ p44-45, Mr Clement also stated that there were no stickers in the truck at the time of the incident – T @ p123.
[74] T @ pp193-194.
[75] T @ p46.
[76] T @ p153.

53. Mr Ferguson was similarly satisfied with the steps taken at Marra Farms in response to the issuing of an Improvement Notice. They had created a document called "Marra Farms Policy & Procedure Manual'.[77] Mr Ferguson did however make further suggestions to them that their revised manual include more specific information about minimum distances and how to measure them.

Submissions

54. Closing submissions in relation to all three inquests were heard on 28 June 2011. Counsels acting on behalf of the Interested Parties and Counsel Assisting the Coroner provided final submissions, which I have considered for the purpose of this Finding. A number of facts had been agreed upon by the Interested Parties in respect of each of the deaths.

General observations of the themes emerging in the three deaths

55. A number of common elements were identified in all three deaths as follows:

Overhead power lines

56. Mr Baker's and Mr Jones' cases involved a single 12,700 SWER line. In Mr Anderson's case there were two overhead power lines called a 'two-phase 22,000 volts system' that according to Mr Michael Leahy from ESV involves "22,000 volts going out to a transformer and then returning through the other conductor". The difference in the SWER line according to Mr Leahy is that "12,700 volts that return through the conductor, down through the transformer and then return through the ground itself".[78]

57. According to Mr Terence Clement from ESV, the SWER line is a common way of distributing electricity throughout rural Victoria because it is more economical to install than other systems. The SWER line consists of three bare strands of wound steel wire that enables it to be strung for longer distances between poles because it can be pulled very tight. Mr Clement states that the SWER lines are *"rendered safe by installing them at a height that makes them hard to access"*[79] however the bare wires are live and are only protected by an Expulsion Dropout Fuse or EDO.[80]

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[77] T @ p190.
[78] Inquest into the death of Dallas Anderson, T @ p109.
[79] I note paragraph 25 in this regard.
[80] In the Inquest into the death of Mr John Jones, Mr Clement explained that an EDO is used to protect the electrical system, not a person, and even if had been operational at the time of the fatal incident in relation to Mr Jones, would not have prevented his death; (transcript in the Inquest into the death of John Jones, @ p52). Mr Clement later explained

Procedures around taking orders for bulk deliveries, including site inspections

58. Counsel Assisting submitted that there should be definitive procedures in place by companies taking bulk orders for farm supplies. These procedures should include an obligation on their part to ask the farmer/property owner about site hazards and if a safety assessment of the site has been done. Accepting the order and agreement to delivery should be contingent on the safety assessment having been undertaken by the farmer/property owner. In addition and where possible, farmers/property owners should be required to provide maps of their properties to the supplier that identifies hazards such as power lines and dams. The provision of property maps would enable the supplier to carry out their own safety assessment and in the absence of a map, a site inspection should be undertaken by the supplier with the emphasis on identifying safety issues for the driver, which should be ranked above the customer's preferences.[81]

Use of pre-delivery information

59. In all three matters the evidence indicates there was little to no information passed to the drivers regarding safety hazards at the tipping sites. In most instances, the delivery driver was only given the address and contact details of the farmer prior to the delivery, such as in Mr Baker's case. In Mr Anderson's case, a site inspection was undertaken but it was completed by spreaders whose focus was on choosing a site for spreading purposes and not necessarily with a focus on the safety of the tipper trailer driver. I accept that the provision of property maps and/or details of the safety assessments to the drivers would help the drivers to be fully informed of the hazards at the delivery site, thereby assisting to minimise risk and prevent harms.

Knowledge of No Go Zones

60. There was a general lack of knowledge of the miuimum distance tipper trucks ought to be away from power lines in order to operate safely. There were general instructions to stay away from power lines but these three deaths have demonstrated that having only basic

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that he had mistakenly identified an expulsion fuse/EDO, and the device was in actuality an over current relay (OCR) device, which is operated electrically, monitoring how much current is going through the system, and has a predetermined level which, when the system surpasses, automatically trips the system and turn the lines off. Mr Clement considered that the predetermined level may not be such that the incident involving Mr Jones may have caused it to trip (transcript in the Inquest into the death of John Jones, @ p56 &72). Mr Clement opined that neither an EDO nor an OCR would have protected Mr Jones (or Mr Baker); (transcript in the Inquest into the death of John Jones, @ p74).

[81] Inquest into the death of Dallas Anderson, T @ pp328-328.

knowledge and instructions is insufficient for delivery drivers working alone and does not enable them to make proper assessments and identify risks.

61. There was and remains no mandatory education about the risks of driving and/or unloading near overhead power lines. Counsel assisting submitted that such education should form part of the endorsed heavy vehicle licence training requirements.[82]

Use of appropriately qualified spotters

62. In each of the deaths, the farmer or property owner acted as a spotter for the delivery driver when they were not appropriately qualified to do so. Where a tipper driver is required to make a delivery in close proximity to power lines, common sense dictates they ought to be accompanied and directed by a qualified spotter. In the Inquest into the death of Dallas Anderson, Mr Stephen Hibberson, sales representative at Calcimo Lime & Fertilizer Pty Ltd acknowledged that a second person might be beneficial for drivers, however might not be economically practical for employers in most tipping jobs. Similarly, coordinating the attendance of, for example, the spreader at the same time as the delivery was not always practical or achievable. He said that "you wouldn't send a spotter out unless there's a particular problem".[83]

Other safety measures

63. These cases have highlighted that there has been complacency and a general lack of consideration to the directing of time and resources to the risk associated with the delivering of bulk farming supplies in close proximity to overhead power lines by farmers, employers and subcontractors who supply and distribute these products to the agricultural sector. The risk associated with this task has been clearly demonstrated by these three deaths. Counsel assisting submitted that there are a range of safety measures which could be implemented to mitigate this risk including:

    a. imposing an obligation on farmers/property owners to erect warning signs at all access gates to paddocks that have power lines travelling through them;

    b. the use of a job safety analysis on the delivery docket, requiring the driver and customer to sign off on before unloading the ordered farming supplies. This would

[82] Inquest into the death of Dallas Anderson, T @ p330.
[83] Inquest into the death of Dallas Anderson, T @ p69.

ensure that both the driver and customer are turning their minds to the risks contemporaneously to the unloading process;

c. general safety campaigns targeting rural communities; and

d. placing overhead power line warning stickers inside trucks to provide constant reminder of the risks to drivers.[84]

Occupational Health and Safety responsibilities of employers

64. Mr Goetz submitted on behalf of WorkSafe Victoria that, pursuant to section 21 of the OH&S Act, it is the primary responsibility of individual employers to provide and maintain a working environment for its employees that is safe and without risk to health so far as is reasonably practicable.

65. It is the role of WorkSafe to provide guidance on how the duties of employers are to be met. In these matters, WorkSafe demonstrated their execution of this role through the material tendered to the Court through witness Mr Bruce Gibson.[85]

66. Mr Goetz submitted that:

> .. *in conjunction with the plethora of written and audiovisual material emphasising the need to look up and live and work at safe distance*[s] *or set distances from power lines, a warning sign on a farm access gate (sic), a safety checklist incorporated into a delivery invoice, a verbal directive to look up, could all indeed be appropriate recommendations arising out of these inquests.*[86]

67. In Mr Murphy's submissions on behalf of ESV he said that it is everybody's responsibility to warn others of the danger of overhead power lines.[87] There is a chain of responsibility commencing with the person placing the order to advise of the presence of power lines proximate to the drop off site and to advise the order taker of any other feature relevant to the power lines. Second, the person receiving the order should question the customer regarding power lines in the vicinity of the drop site. Such information should be included

[84] Inquest into the death of Dallas Anderson, T @ p330.
[85] Inquest into the death of Dallas Anderson, Exhibit 18 – Statement of Bruce Gibson and attachments dated 9 May 2011.
[86] Inquest into the death of Dallas Anderson, T @ p337.
[87] Inquest into the death of Dallas Anderson, T @ p345.

on the delivery docket to alert the driver. Finally, a driver should orient themselves upon arriving at the site to the lines and the adjacent areas to the drop off zone, even though the driver has already received warnings about the area.[88]

De-energising power lines

68. De-energising power lines for the purposes of accommodating the delivery of farming supplies was raised as a possible risk minimisation strategy by witnesses Mr Clement and Mr Ferguson during the course of the evidence in Mr Baker's case. De-energising of power lines requires an additional level of pre-planning by the farmer/landowner, involving arranging a qualified electricity work crew to be on-site to de-energise the line at or about the time of the delivery and available on-site to re-energise the line once the delivery is complete and risk of contact with power lines removed. To adopt such a course for the purposes of the delivery of farming supplies, the farmer/landowner must also consider the inconvenience of the interruption of the power supply not only to their own farm but possibly to adjoining farms as according to Mr Ray QC on behalf of Powercor,[89] *"de-energising ordinarily doesn't isolate simply one farm it may isolate instant areas."*[90]

69. This suggested risk minimisation strategy thus appears to require a level of additional planning and inconvenience such that I consider it could only be described as practical if the *only* suitable dumpsite for the farming supplies is under overhead power lines. If an alternative dumpsite can be identified, I do not consider that it would be practical to implement such a risk minimisation strategy.

Placing power lines underground

70. The issue of replacing rural power lines underground was not a focus of my investigation. At the time of the Inquests I was aware that the *Power line Bushfire Safety Taskforce*[91] was underway. Any inquiries of my own into the feasibility of placing power lines underground would have arguably been a duplication of inquiries and investigations contrary to section 7 of the new Act. Nevertheless, it was appropriate of Mr Murphy to address me on the issue.[92]

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[88] Inquest into the death of Dallas Anderson, T @ pp344-345.
[89] Mr Ray QC also appeared on behalf of Powercor for the purpose of providing submissions at the conclusion of all three Inquests.
[90] Inquest into the death of Dallas Anderson, T @ p360.
[91] The Power line Bushfire Taskforce (the taskforce) was established in August 2010 to consider how the Victorian Government should implement the recommendations of the 2009 Victorian Bushfire Royal Commission.
[92] Inquest into the death of Dallas Anderson, T @ pp345- 347.

Three deaths from contact with overhead power lines in rural Victoria in one year necessitates at the very least an acknowledgement that many have advocated for the placing of all power lines underground particularly following the identification of the involvement of overhead power lines in the 7 February 2009 Victorian "Black Saturday" bushfires that claimed 173 Victorian lives. The 2009 Victorian Bushfires Royal Commission concluded that five of the major fires that it investigated were started by power lines. In its July 2010 Final Report, the Royal Commission concluded that:

> *The SWER and 22kV distribution networks constitute a high risk for bushfire ignition, along with other risks posed by the ageing of parts of the networks and the particular limitations of SWER lines.*[93]

71. The Royal Commission made 67 recommendations, of which eight (Recommendations 27 – 34) relate to reducing the likelihood of power lines starting catastrophic bushfires. The Victorian Government accepted all of these recommendations. The *Power line Bushfire Safety Taskforce* (the Taskforce) was established to recommend to the Victorian Government how to maximise the value from the two electricity-related recommendations to Victorians – that is, recommendations 27, which related to power line replacement and recommendation 32, which related to disabling or adjustment of power line reclose functions on the automatic circuit reclosers on all SWER lines for the six weeks of greatest bushfire risk in every fire season. The Taskforce's Final Report[94] was published on 30 September 2011 and acknowledges the risk of bushfires could be reduced by placing power lines underground, however considers the cost of undertaking such a project to be prohibitive. Conversion to an underground rural network, would also function to prevent like deaths to those of Mr Baker, Mr Anderson and Mr Jones, however, I defer to the findings of the taskforce that such a project would be financially prohibitive. Accordingly I make no further comment or recommendation regarding placing power lines underground.

Enhancing truck driver awareness

72. VicRoads was not an Interested Party to these proceedings so I do not propose to make formal recommendations with respect to how to enhance truck driver awareness at the time

[93] Victoria, 2009 Victorian Bushfires Royal Commission, *Final Report: Volume II, Fire Preparation, Response and Recovery* (2010), p154.
[94] Power line Bushfire Safety Taskforce, *Final Report* (2011), available at http://www.esv.vic.gov.au/About-ESV/Reports-and-publications/Victorian-Bushfires-Royal-Commission/Power line-Bushfire-Safety-Taskforce.

of obtaining a licence. Nevertheless, I did receive sufficient information during the course of these Inquests to form the view that consideration should be given to incorporating into the heavy vehicle knowledge test a section on the *No Go Zones* in all applications for a heavy vehicle licence. Counsel Assisting identified shortcomings in the licence training requirements and made suggestions for improvements. He submitted that:

> *..delivery drivers should be made aware of the safe minimum working distance from power lines and in my view, if the drop off site is in close proximity to the power lines but outside the 6.4 metre spotter zone, then this distance should be clearly identified with markers.*[95]

73. The Victorian Bus & Truck Drivers' Handbook is the reference material referred to on the VicRoads website for people preparing for an application for a heavy vehicle licence. Currently there is an absence of reference to *No Go Zones* or the *Look Up and Live* campaign in this material.

Framework promoting safety

74. In the course of the Inquests I have been referred to the *Accident Compensation Act 1985* (Vic), the OH&S Act and its Regulations, the *Electricity Safety Act 1998* (Vic) which sets out some objectives of Energy Safe Victoria, *Electricity Safety (Network Assets) Regulations 1999* (Vic) which involve minimum distances, and the *Electricity Safety (Installations) Regulations 2009* (Vic).

Public education and awareness initiatives

75. WorkSafe outlined their agricultural safety program[96] comprising agricultural field days, an advisory service, routine visits by inspectors, agricultural conferences and distribution of guidance material through rural and regional Victoria. In addition, WorkSafe officers distribute ESV resources such as the "Look Up, Look Down and Live" DVD and vehicle stickers, to owners of rural properties. Both organisations also have had and continue to have an abundance of safety information on their websites.

76. I accept that there is indeed an abundance of occupational health and safety information and support available to the farming and agricultural sector which is readily accessible to them. I

[95] Inquest into the death of Dallas Anderson, T @ p330.
[96] Inquest into the death of Dallas Anderson, Exhibit 18 – Statement of Bruce Gibson dated 9 May 2011, T @ pp177 – 203.

also accept that Powercor annually undertakes a mail out to all owners of private overhead electric lines, enclosing a brochure which contains information reminding owners of their inspection and maintenance obligations, to plan farm roads for tall equipment so they do not pass under electricity lines as well as other electrical safety information.[97] The distribution of this information from the electricity provider is currently in the vicinity of 26,000 landowners/occupiers of land.[98]

77. I accept that there is a collaborative approach between WorkSafe and ESV to safety education and I further accept and acknowledge that a considerable amount of work has been done in this area before these three fatalities and continues to be done since the deaths. The power companies also play a role. The challenge particularly for ESV and WorkSafe is in effectively educating farmers of the dangers of electricity on farms and "getting the message across on safety".[99] Farming is not a concentrated industry such as the construction industry whose participants might acknowledge the existence of like occupational health and safety issues. Farming and associated businesses working within the agricultural sector appear to be a disparate group with disparate views. Assuming the witnesses I heard from in these Inquests are generally reflective of the views of the agricultural sector, I would consequently assume there is also a general antipathy or resistance to change. Any antipathy to acknowledging risks and genuinely considering implementing measures to improve safety is unfortunate and yet another hurdle for WorkSafe and ESV.

Height detection devices

78. At the time of the Inquests, there was no product on the market that has the engineering capacity to shut down an engine or a hydraulic system upon detection of an electrical field within a calibrated height. In his evidence Mr Walters, Manager of Electricity Infrastructure Safety at ESV indicated that in theory such a device could be made but none have and/or are available that could be fitted to tipper trailers such as those seen in the deaths of Mr Baker, Mr Anderson and Mr Jones.

79. ESV contributed some funding[100] to a private business for the development of a height detection device that omits an audible sound upon detection of an electrical field within a

[97] Inquest into the death of Dallas Anderson, T @ pp204-205.
[98] Inquest into the death of Dallas Anderson, T @ p205.
[99] Inquest into the death of Dallas Anderson, T @ p112.
[100] Inquest into the death of Dallas Anderson, T @ p295.

calibrated height but this particular device does not have the capacity to shut off hydraulics or engines when it is detected. The development of this device was last reported to making slow progress and not performing as expected.[101] In his closing submissions, Mr Murphy on behalf of ESV confirmed that no height detection devices had been fitted to tipper trailers and he indicated that a limitation on all height detection devices is that they rely on the operator resetting the device on every occasion.[102] Mr Walters gave the same indication when speaking of one such device, "ProxyVolt®",[103] a product whose use appears to be confined to plant in the mining industry.[104] He said that he thought they were more suited to plant that is set up in an established place of work/controlled environment whereas a truck may only visit a site with a particular above height risk once and would likely encounter a different height risk at the next delivery site.[105] Such is the scenario for contractors delivering large volume farming products to different farms and the need to reset the voltage detection device on each occasion could be cumbersome for the drivers.

80. The evidence indicates that there are a number of impediments to high voltage proximity warning systems being embraced in the heavy transport sector. One of those impediments appears to be lack of product development. Wilsave power line detectors[106] had not gone into production at the time of these Inquests, Sigalarm™ was a product not available in Australia and ProxyVolt® was being used in a restricted capacity in the mining industry only and had not been developed to attach to the hydraulic systems such as used in tipper trailers (according to Mr Walters).[107] ProxyVolt® report that their product is capable of being applied to tipper trucks but that it does require recalibration of the device for each location.

81. If there are devices in the making or have in part been developed that have the potential to prevent tipper truck trailers being inadvertently elevated into overhead power lines, it would be unfortunate if they could not be made available to the transport industry.

[101] Inquest into the death of Dallas Anderson, T @ p295.
[102] Inquest into the death of Dallas Anderson, T @ p343.
[103] Other products discussed in the course of Mr Walters' evidence included "Wilsave" and "Sigalarm™"– Exhibit 27, Inquest into the death of Dallas Anderson.
[104] Inquest into the death of Dallas Anderson, T @ p302.
[105] Inquest into the death of Dallas Anderson, T @ p301.
[106] A height detection device that was presented on "The Inventors" program on the ABC in 2007.
[107] Inquest into the death of Dallas Anderson, T @ p313.

FINDINGS

1. I find the identity of the deceased is Brian Maxwell Baker.

2. It is difficult to reconcile the evidence of Mr Deckert that Mr Baker was aware of the SWER line at the time he commenced unloading his trailer of Mr Deckert's order of fertilizer. The evidence of those who personally knew Mr Baker indicated their belief that he would have never unloaded if he had been aware of the power lines. Nevertheless, in the absence of specific evidence that contradicts Mr Deckert, I find that Mr Baker was aware of the SWER power line's close proximity when he commenced the tipping process. I am not however able to make a finding about why he departed from what is considered his usual practice on that day save to say that he was unloading at the site designated and identified by the farmer through his positioning of the auger and mobile bin.

3. I accept and adopt the medical cause of death as ascribed by Dr Noel Woodford and find that Brian Maxwell Baker died from electrocution from high voltage electricity wires in circumstances where his tipper trailer contacted overhead transmission lines on a farming property while he was acting in the course of his employment.

4. AND I further find that the death of Brian Maxwell Baker was avoidable and preventable.

CONCLUDING COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

Risk minimisation in any workplace is the responsibility of all and the deaths of Mr Baker, Mr Anderson and Mr Jones demonstrate that a number of people can be involved in the surrounding circumstances leading up to a fatal incident, albeit that their involvement can be somewhat peripheral and unwitting of the consequences. Each individual, however, can play a role in risk minimisation.

The entirety of the process from the farmer/property owner placing an order to delivery by the employee/contractor truck driver necessitates that risk minimisation is front and foremost in each and every participant's mind. The process clearly starts with the farmer/property owner who requires the supply of materials and has the most intimate knowledge of their property that, if conveyed accurately, can minimise risk and indeed prevent harms. It is the farmer/property owner

that knows the layout of their land, knows where overhead power lines are situated and has the time either before placing the order or between placing the order and delivery to identify and prepare a safe delivery site. Mrs Alecia Anderson[108] suggested that consideration should be given to the implementation of a farm safety accreditation program through Farmsafe or WorkSafe and that a levy could be charged to farmers who did not go through accreditation, creating a pool of money that could be put back into training and safety programs. She also suggested that as part of such an accreditation program, farmers could seek certification for a nominated dumpsite. Mrs Anderson's vision for the future was that companies would not deliver to a site that had not been certified as safe. Mr Ray QC supported Mrs Anderson's suggestion for certified dumpsites which he described as:

> *..a practical farm person's recognition of ensuring that the locality is safe and free of the over head hazard.*[109]

In the absence of the identification of risks by the farmer/property owner, communication of the same and preparation prior to the arrival of the delivery, all risk minimisation responsibility transfers to the driver. The offer by a farmer/property owner to clear a different site or move some other structure to provide a safer site at this point in the process unnecessarily creates decision-making and time impost on the driver. The driver cannot and should not divest themselves of the risk minimisation responsibility, but such an impost seems inequitable when the farmer/property owner starts from a greater knowledge base and as such is at the head of *the hierarchy of risk management where the first thing you do is engineer out the risk.*[110]

Employers have common law and statutory obligations to their employees to provide them with a safe system of work. This responsibility is not divested merely by the mobile nature of the workplace encountered by for example, delivery drivers. The employer has a range of measures open to them to ensure that their drivers are not arriving at farming/rural properties uninformed and unsupported in the process of discharging their work duties in the safest possible environment. Such measures include the most basic of risk assessments, such as seeking appropriate information from the farmer at the time of the order to identify the relevant hazards/risks, and the effective communication of this information to the driver as well as providing the driver with physical support in the form of a spotter where appropriate. The driver is then in the position to employ risk

[108] Inquest into the death of Dallas Anderson, senior next of kin Mrs Alecia Anderson's letter of suggestions was distributed to all Interested parties and summarised by Counsel assisting in closing submissions – T @ pp331-334.
[109] Inquest into the death of Dallas Anderson, T @ p354.
[110] Inquest into the death of Dallas Anderson, T @ p355.

minimisation strategies in a considered approach, the most fundamental, and manageable one being the elimination of the risk by opting for the safest dumpsite, away from overhead power lines.

In 2009 the Coroners Prevention Unit (CPU)[111] analysed ESV's data on the number of mobile plant contacts with power lines and this demonstrated that between 2002 and 2009, 101 tippertrucks contacted power lines in Victoria which represents an average of one contact incident per month. Tipper trucks accounted for 15% (n=16) of all contact incidents reported to ESV in a one-year period (July 2008- June 2009). The analyses of the data indicated that at that time the "Look Up and Live" awareness campaigns and mandatory minimum clearance distances established by WorkSafe and ESV had not demonstrated a reduction in the number of mobile plant contacts with power lines.

Since then, I understand that in 2012, ESV undertook a "reach and recall" survey of the Look Up and Live campaign. I understand that the survey found that the "Look Up and Live" advertising was recalled by one in two regional Victorians, and that it was considered that the message of awareness around power lines was well received. The summary of the report stated that "in terms of behaviour change and awareness, there were very strong likelihoods of regional Victorians making conscious efforts to be more aware and cautious of overhead power lines as a result of seeing the advertising".

I commend this review and anticipate the ESV will conduct periodic evaluation of the "Look Up and Live" campaign to monitor long-term effectiveness.

RECOMMENDATIONS:

A number of the safety measures intended to reduce the risk of death from contact with overhead power lines that were discussed in the course of these Inquests do not lend themselves to Recommendations pursuant to section 72(2) of the *Coroners Act 2008*, as they are not recommendations that can be made to a Minister, public statutory authority or entity.

I commend the submissions for the improvement to order forms to include a checklist with details of overhead power lines, the signing of the Order Form by both driver and farmer/property owner prior to unloading and farmers providing a mud map to the supplier for the driver's use. These submissions however are arguably all directed at improving the consciousness of individual farmers/property owners and distinct businesses. There were no submissions made by the interested parties as to whom I could direct these broad risk minimisation recommendations. As far as I am

[111] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

aware, Order Forms/dockets are neither in a prescribed form nor mandated by any legislation/regulations for private businesses. I could thus only make recommendations to the suppliers the subject of these three investigations which would not achieve the far-reaching preventative outcome arguably envisaged by the submissions. I do not have the jurisdictional scope[112] to make recommendations with respect to the ordering processes that I could expect to reach beyond the three suppliers and result in a uniform approach to this discreet aspect of risk minimisation. Furthermore, I do not have the jurisdictional scope to recommend, for example, that all farmers in Victoria provide a mud map to a supplier before taking delivery of farming supplies or indeed that they and other related employers should inform themselves about the risks associated with working near and contacting overhead power lines. I can merely encourage them to adopt at the very least, the risk minimisation strategies that were identified in these Inquests including utilising documents that have been prepared by WorkSafe and contained in their publications to help with these tasks including the "15 Minute Farm Safety Checklist" which has been available since July 2001.[113]

I commend the publications of WorkSafe and Energy Safe Victoria in this regard and encourage all farmers/landowners and suppliers to familiarise themselves with these publications, but I cannot extend that encouragement to recommendations with regard to these particular risk minimisation strategies.

I commend WorkSafe and Energy Safe Victoria for their efforts to disseminate information and provide education to rural Victorians on the risks associated with working near and contacting overhead power lines and the Regulations in respect of the same. I support the continuation of such educational forums and where possible, including with reference to the recommendations below, the expansion of educational programs/forums to rural Victorians. Mr Dallas Anderson's mother, Mrs Susanne Anderson, herself a farmer, also expressed her support for the educational measures adopted by WorkSafe and ESV asking of WorkSafe: "*please don't give up*". She said you just have to "*keep batting into farmers*" about safety issues and eventually they will adopt them.[114] However as with all educational programs or campaigns their effectiveness needs periodic evaluation. The evidence in each of these Inquests reflects that the individuals did all look up and were all aware of the overhead power lines yet proceeded in behaviours contrary to the message of the "Look and Live" campaign. Three deaths is a clear indication that, at that time, the message was not being

[112] *Harmsworth v The State Coroner* [1989] VR 989.
[113] Inquest into the death of Dallas Anderson, Exhibit 18 – Statement of Bruce Gibson dated 9 May 2011, T @ p179.
[114] Inquest into the death of Dallas Anderson, T @ p291.

effectively conveyed.

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the three deaths I have been investigating:

1. With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc, Powercor and other relevant electricity power suppliers, produce signage which alerts a visitor/contractor to the presence and risks of over head power lines on a given property. [115]

2. With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc, Powercor and other relevant electricity power suppliers, undertake a feasibility study on how to best implement and roll-out a program for introducing the said signage including whether financial assistance can be provided or whether embodiment in legislation could be achieved to ensure the provision, construction and maintaining of said signage at all access gates on farming and rural properties where overhead power lines run through them.

3. With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc, Powercor and other relevant electricity power suppliers, hold an educational campaign in farming and rural communities on the roll-out of the said warning signage.

4. With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the safety signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and

[115] This recommendation recognises that first, there remains a possibility that Mr Dallas Anderson did not see the overhead power line and relevant signage could have alerted him to its presence, secondly, as pointed out in evidence adduced during the Inquest into the death of John Jones, some farm deliveries occur after dark, rendering on site-risk assessments ineffective at identifying the risk of overhead power lines, and thirdly, that similar signage appears to have been widely accepted and effective nationally and internationally in the identification of hazardous chemicals by the use of the 'Hazchem' signs. The recommendation also recognises the evidence of ESV Compliance Officer Mr Terence Clement that rural SWER lines were installed in around 1965, and that the size of many of the tipper trailers currently in use is such that when elevated to their maximum height, they will exceed the height that the SWER lines are installed above ground (see above paragraph 25). This recommendation recognises the impracticality and economic burden associated with changing the entire rural SWER network, and rather offers an arguably more economically viable option to help minimise this hazard.

collaboration with WorkSafe develop a farm safety accreditation program as suggested by Alicia Anderson.[116]

5. With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the warning signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a process for obtaining Dumpsite Certification, either separately or as an element of the farm safety accreditation program.

6. With the aim of minimising contact incidents with overhead power lines by tipper truck trailers, I recommend that WorkSafe and Energy Safe Victoria invest in the evaluation of proximity warning devices to determine their efficacy, applicability and practicability to tipper trucks.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published on the internet.

I direct that a copy of this Finding be provided to the following individuals and agencies:

- Ms Janine Baker
- WorkSafe Victoria
- Mr John Murphy on behalf of Energy Safe Victoria
- Powercor Australia Pty Ltd
- Farmsafe Australia Inc
- Transport Workers Union
- Australian Workers Union
- Victoria Police Sergeant, Nhill Police Station

[116] Inquest into the death of Dallas Anderson, Exhibit 33 – letter from Mrs Alicia Anderson addressed to the Court, T @ pp331-334.

Signature:

AUDREY JAMIESON
CORONER
Date: **13 March 2015**