IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4693

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**CHAD ANDREW LYNCH**
Date of birth:	17 August 1977
Date of death:	16 October 2013
Cause of death:	BLUNT HEAD INJURY
Place of death:	Alfred Hospital, Commercial Road, Melbourne, Victoria

HER HONOUR:

Background

1. Chad Lynch was born on 17 August 1977. He was a truck driver who lived with his wife Greta Boyd and three young children in Kerang in country Victoria. He was 36 years old when he died on 16 October 2013 from head injuries sustained in a workplace accident.

2. Mr Lynch was very close to his parents and brother. His death was devastating to his family.

The coronial investigation

3. Mr Lynch's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

5. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. As Mr Lynch's death occurred in a workplace it was investigated by WorkSafe Victoria and Victoria Police. A criminal prosecution ensued. I received a coronial brief of evidence at the conclusion of the criminal proceedings. I then obtained a copy of the remarks of the

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

sentencing Judge and the Court of Appeal decision in relation to that sentence (*DPP v Frewstal Pty Ltd* [2015] VSCA 266).

8. Coroners are also obliged under the Act to avoid unnecessary duplication of inquiries and investigations (section 7). Further, if charges are laid in respect of a reportable death, as here, Coroners are not required to make the usual findings if they do not hold an inquest and the making of findings would be inappropriate in the circumstances (section 71 of the Act).

9. After perusing all the material I was satisfied that the circumstances of Mr Lynch's death were clear and that an inquest was not necessary. However, as a result of correspondence received from Ms Boyd I determined that I should make findings as there was a public interest in exploring possible prevention opportunities arising from the circumstances of Mr Lynch's death.

Identity of the deceased

10. Mr Lynch was formally identified by Ms Boyd at the Alfred Hospital on 16 October 2013. Identity was not in issue and required no further investigation.

Medical cause of death

11. On 22 October 2013, Dr Noel Woodford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Lynch's body after reviewing a post mortem CT scan.

12. Dr Woodford completed a report, dated 27 November 2013, in which he formulated the cause of death as 'blunt head injury'. I accept Dr Woodford's opinion as to the medical cause of death.

Circumstances in which the death occurred

13. On 14 September 2013 Mr Lynch delivered a load of sheep to an abattoir in Stawell operated by Frewstal Pty Ltd (Frewstal). Mr Lynch had previously attended the abattoir and was familiar with its layout, although he had not received any formal training or induction by Frewstal.

14. On this occasion Mr Lynch was driving a 2013 Kenworth Prime mover with trailer. He reversed his truck to an unloading ramp and raised the ramp to the trailer to begin unloading

the sheep into holding pens. The ramp was approximately 9 metres long and was raised by depressing a 'U' button which operated a hydraulic hoist. On the side of the ramp was a clear sign with operating instructions stating in part 'WHEN RAMP IS AT REQUIRED HEIGHT MAKE SURE SAFETY BAR HAS STARTED TO ENTER SLOT BUT HOIST CAN STILL CARRY THE WEIGHT OF RAMP' followed by two explanatory diagrams. In essence the safety bar was intended to rest on a vertical steel ratchet and thereby provide additional support for the ramp.

15. Soon after the sheep started unloading Mr Lynch stepped onto the ramp from his trailer presumably to deal with congestion of sheep in the narrow ramp, which was a common occurrence. When he did this a lug welded to the top of the hoist mainframe above the ramp broke and the hoist fell approximately 3 metres striking Mr Lynch on the head. Nearby workers heard the incident and found Mr Lynch unconscious on the floor of the ramp.

16. Ambulance attended and treated Mr Lynch before transporting him to Stawell Hospital. He was then airlifted to the Alfred Hospital where CT scans revealed severe head injuries. Mr Lynch died in hospital on 16 October 2013.

17. Investigations revealed that Mr Lynch had not engaged the safety bar in accordance with the instructions and therefore the secondary safety ratchet system was not in use. This meant that the whole weight of the ramp and livestock was held by the electric hoist, which in turn was held by a single lug. This lug was poorly designed for its purpose. It had a maximum rated capacity well short of that required to lift even the unladen ramp and structural failure was inevitable.[2] Further, subsequent inspection revealed that at the time of the accident it was exhibiting fatigue damage and corrosion.

18. On 15 May 2015 Frewstal pleaded guilty in the County Court to three breaches of its obligation under s 23 of the *Occupational Health and Safety Act 2004* (**OHSA**) to ensure the safety of non-employees, being delivery drivers. Specifically, the charges related to failures with respect to the design (Count 1), maintenance (Count 2) and instructions for use (Count 3) of the ramp.

19. As to Count 1, Frewstal had constructed and installed the ramp but had never sought independent advice as to the suitability of the design and in particular the hoist lug, which

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[2] *DPP v Frewstal Pty Ltd* [2015] VSCA 266 at [15].

failed to comply with structural integrity requirements of the applicable Australian Standard. As to Count 2, Frewstal did not comply with the applicable Australian Standard which required annual structural inspections of the hoist (including the lug), nor conduct independent testing and inspections at any other appropriate interval, or indeed, at all. As to Count 3, whilst there was a sign on the hoist, Frewstal had never provided training or induction to delivery drivers as to safety procedures and in particular the need to engage the safety bar.

20. Frewstal was convicted and fined an aggregate of $250,000, which sentence was appealed by the Director of Public Prosecutions on the ground of manifest inadequacy. The appeal was dismissed for the reasons set out in the Court of Appeal judgment, *DPP v Frewstal Pty Ltd* [2015] VSCA 266.

21. It is important to highlight that Frewstal was not charged with causing the death of Mr Lynch. However, the Court of Appeal acknowledged that attachment of the safety bar would have prevented the collapse of the ramp[3] and further that *'had a competent independent inspection been undertaken at any stage'* the defects in the design and maintenance of the ramp would have been discovered and *'the accident would in all probability have been avoided.'*[4]

22. There is no doubt that appropriate training and induction is the best way to optimise compliance in any situation. It is logical that if people understand the reason to do something they are more likely to do it. Nevertheless, I acknowledge that training does not ensure compliance and it is possible that a driver might have chosen not to engage the safety bar despite adequate instruction. However, in that situation a properly designed, maintained and inspected hoist should have been able to withstand the weight of the otherwise unsupported ramp.

Opportunities for future prevention

23. In correspondence with the Court, Ms Boyd expressed her concern that although Frewstal had been quick to address the safety issues in its workplace there remained a risk of a similar incident to workers within the livestock transport industry generally.

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[3] at [6] and [30].

[4] at [28] and see [23].

24. Following the death of Mr Lynch the Australian Livestock and Rural Transporters Association in cooperation with various stakeholders, including the Livestock and Rural Transporters Association of Victoria (of which Ms Boyd was a member) and WorkSafe Victoria developed a '*Guide For Safe Design of Livestock Loading Ramps and Forcing Yards*' published in June 2015 (**The Guide**). Whilst acknowledging the Guide, Ms Boyd remained concerned that there were no compulsory standards for the design and construction of loading ramps or yards, nor any laws providing for ongoing maintenance of equipment. She also noted that most livestock facilities do not have site inductions and drivers simply obtain a key to gain access.[5]

25. In its introductory sections the Guide emphasises that it is just that - a guide. Readers are advised to refer to relevant legislation to ensure compliance with their legal obligations. Examples of statutory or accreditation requirements that may apply are set out in an Appendix and include various Australian Standards and other guides and codes of practice.

26. The Guide makes it clear, as does the OHSA, that the responsibility for maintaining a safe workplace rests on the employer. Relevantly, the Court of Appeal observed *'[a]t a minimum, the discharge of this obligation requires the employer to inform itself of the applicable safety standards and to ensure that everything reasonably practicable is done to comply with them'*[6] and further *'[e]nsuring adequate training and instruction is a foundational safety obligation of employers'*.[7]

27. In her sentencing remarks Her Honour Judge Cannon noted that *'ramps are an unusual species of equipment for which there is no specific set or list of standards, but rather a hotchpotch of standards which must be drawn from information and requirements of other more commonplace pieces of equipment'*.[8] Her Honour opined that the fact ramps were constructed by individual abattoirs rather than in factories heightened the need for expert design, construction and periodic inspection, before stating *'it is also to be hoped that*

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[5] Ms Boyd contrasted this situation with that of the Upper Hunter Shire Council which has a compulsory induction for all users of its livestock selling centre and truckwash facility.

[6] *DPP v Frewstal Pty Ltd* [2015] VSCA 266 at [17].

[7] Ibid at [32].

[8] *DPP v Frewstal Proprietary Limited* [2015] VCC 731 at [60].

specific standards in the one document can be compiled to better facilitate appropriate design and construction, as well as monitoring of livestock ramps'.[9]

28. I endeavoured to ascertain from WorkSafe the prevalence of workplace injuries from loading and unloading livestock, however was advised that the level of detail in the incident description of reported injuries in the livestock industry did not permit of this analysis.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Chad Andrew Lynch born 17 August 1977;

(b) Mr Lynch died on 16 October 2013 at the Alfred Hospital, Melbourne, from blunt head injury; and

(c) the death occurred in the circumstances described above.

Comments

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

1. There is no doubt that Frewstal breached its obligations to ensure, as far as reasonably practicable that 'persons other than its employees' were not exposed to safety risks. The law is clear that it an employer's responsibility to inform itself of applicable safety standards and to comply with them. However, where the relevant standards come from a variety of sources, consolidation into a single document would obviously assist in that process. I therefore agree with the comments of Judge Cannon as to the desirability of bringing together the various standards applicable to livestock ramps into a single set of Australian Standards. I also agree with Ms Boyd that a compulsory induction process for non-employees using the facilities of an abattoir or yard would be the best method of ensuring their safe use of plant and equipment.

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[9] Ibid at [61].

Recommendation

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation connected with the death:

1. That Standards Australia consult with relevant stakeholders as to the feasibility and desirability of developing a single Australian Standard applicable to the construction, inspection and maintenance of livestock ramps and the induction to premises containing such ramps.

Publication

Given that I have made a recommendation I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

I convey my sincere condolences to Mr Lynch's family.

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

Greta Boyd, Senior Next of Kin;

Nola Hinch;

Standards Australia;

Worksafe Victoria;

Frewstal Pty Ltd;

Senior Constable Carolyn Kronberg, Coroner's Investigator, Victoria Police;

Other interested parties.

Signature:

ROSEMARY CARLIN
CORONER
Date: 20 June 2017