IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2006 0101

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: DALLAS ALISTER ANDERSON

Hearing Dates:	2-6 May 2011, 9-13 May 2011, 28 June 2011
Representation:	• Mr J.E. Goetz on behalf of WorkSafe Victoria[2] • Mr J Murphy on behalf of Energy Safe Victoria • Mr J McCristal on behalf of Mrs Alicia Anderson
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 Kavanagh 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 Dallas Anderson should be taken to by synonymous with the organisation now known as WorkSafe Victoria (WorkSafe).

I, AUDREY JAMIESON, Coroner having investigated the death of **DALLAS ALISTER ANDERSON**

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 DALLAS ALISTER ANDERSON

born on 17 March 1975

and the death occurred on 9 January 2006

at 70 Greens Road, Bena, 3946

from:

1 (a) ELECTROCUTION

in the following summary of circumstances:

1. On 9 January 2006, Dallas Alister Anderson was electrocuted whilst acting in the course of his employment, and was tipping a consignment of lime at a farm in Bena, Victoria when the trailer of his truck came into contact with overhead power lines.

BACKGROUND

2. Mr Anderson was 30 years of age at the time of his death. He lived in Giffard West with his wife, Mrs Alicia Anderson.

Background driving experience

3. Mr Anderson was raised on a broad acre farm at Giffard in Gippsland, Victoria where he gained experience operating a wide range of farm machinery. He moved to Western Australia where he was employed as a truck driver carting grain under a Heavy Combination Licence. He was later employed by a company in Heyfield as an interstate semi-trailer driver, then returned to the property in Giffard. purchased his own semi-trailer and commenced running a contracting business carting stock and various farming freight throughout Gippsland. In April 2005, he commenced employment as a truck driver with Calcimo Lime & Fertilizers Pty Ltd of 76 Princes Highway, Sale (Calcimo).

BACKGROUND CIRCUMSTANCES

4. Ms Jillian Green was the sole owner of the farming property located at 70 Greens Road where she ran sheep and dairy cattle. Ms Green also owned a farming property at 125 Greens Road where her parents John and Margaret Green resided.

5. In December 2005, Ms Green spoke with Mr Matthew Whiteside[3] from Rodnmar Pty Ltd (trading as Korumburra Lime & Spreading) and organised to have 200 tonne of lime[4] delivered to her property at 70 Greens Road. Korumburra Lime & Spreading were also to organise spreading the lime on Ms Green's property.

6. Ms Green had not had bulk quantities of lime delivered by a tipper trailer prior to this day[5] and due to the fineness of the lime particles, aerial spreading of lime was not a practical method of placement. Ms Green had input in the selection of the dumpsite but her preferred site was ultimately not considered suitable due to the presence of ground debris such as rocks and sticks.[6] The site instead chosen ran parallel with the gravel driveway near the boarder of the property at Greens Road. Ms Green assumed that Korumburra Lime & Spreading would hold discussions with the contractor as to a dumpsite.[7]

7. On Friday, 6 January 2006, Mr Stephen Hibberson, sales representative at Calcimo, received a telephone call from either Mr Matthew Whiteside or Mr Rod Abbott at Korumburra Lime & Spreading requesting 200 tonne of lime. Mr Hibberson stated that he then:

> *..prepared a Calcimo Lime & Fertilizers Customer Order Form No: 5366, remove the 'white' and 'pink' copy from a carbon copy order book, hole punched and placed in a blue folder. The white copy is used for invoicing once the job is completed and the driver takes the 'pink' copy, if there are delivery instructions written on the Order Form. If there are no delivery instructions written on the Order Form, the driver gets his instructions via phone or it is written on the white board in the office.*[8]

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[3] In her *viva voce* evidence, Ms Green stated that she had spoken to Mr Rod Abbott about her order; (Transcript (T)@ p6, 16-17).

[4] Lime was to be used for the purposes of reducing the aluminium content detected in the soil. According to Ms Green, she used the lime to *break down the acidity in the paddocks to make the grass grow better for feed for the cow;*. (Exhibit 1 – Statement of Jillian Green dated 9 January 2006).

[5] T @ p22.

[6] T @ p 8.

[7] T@ p18.

[8] Exhibit 8 - Statement of Stephen Hibberson dated 22 March 2006.

8. The order of lime for Ms Green's property specified:

3 loads dropped from Monday

Quad dog only

Balance when ready

Instructions at depot on way past

9. On 6 January 2006, Mr Joshua Whiteside and Mr Nicolas Jones from Korumburra Lime & Spreading attended Ms Green's property for a site inspection for the purposes of establishing a suitable dumpsite as Ms Green's property was undulating and a large dump area was required to accommodate the delivery. Mr Jones stated that he was "looking for a flat area with a reasonable amount of room to manoeuvre the truck."[9] During the inspection, while Ms Green, Mr Whiteside and Mr Jones travelled around the property together in the same vehicle for approximately 30 minutes, they drove underneath the power lines that run close to the property boundary.[10]

10. On returning to Korumburra Lime & Spreading, Mr Jones informed either Mr Matthew Whiteside or Mr Rod Abbott of the location of the dumpsite he had selected and that an electric fence would need to be removed by the farmer to enable access and egress for the delivery truck.[11]

11. Two days prior to the delivery, Ms Green and her father, Mr John Green, removed an electric fence to allow the delivery truck access to the designated dumpsite.[12]

SURROUNDING CIRCUMSTANCES

12. At approximately 10.15am on Monday, 9 January 2006, Mr John Green received a telephone call from Mr Abbott from Korumburra Lime & Fertilizer, advising Mr Green that the first 33 tonne of lime was scheduled to be delivered at 10.30am.

13. At around the same time, Mr Anderson arrived at the farming property at 70 Greens Road to deliver the load of lime after which he was scheduled to drive to North Melbourne to collect a load of pallets. Mr Anderson was driving a 2000 model Freightliner rigid truck, measuring

[9] Exhibit 9 – Statement of Nicolas Jones dated 19 January 2006.
[10] T @ pp7-8.
[11] Exhibit 9 – Statement of Nicolas Jones dated 19 January 2006, T @ p79.
[12] T @ p 21.

nine metres in length,[13] towing a Hercules dog trailer (Quad dog trailer), measuring 10 metres in length,[14] loaded with 33 tonne of the 200 tonne ordered lime. Mr Anderson was working alone.

14. The ground at the farm that morning was described as somewhat wet or slippery from a fall of dew/mist.[15] Mr Green described it as "a bit greasy on top" because it was raining slightly at the time of the delivery[16] but otherwise the surrounding district had been experiencing one of its' driest years.[17]

15. Mr Green met Mr Anderson in his truck at the fork of Greens Road,[18] where the right fork represents the entrance to the farm.[19] According to Mr Green, he and Mr Anderson rode Mr Green's quad bike[20] onto the property and he showed Mr Anderson where to turn and the position of the designated dumpsite for the purpose of unloading the truck. According to Mr Green, he showed Mr Anderson the power lines[21] and drove Mr Anderson back to his truck.[22] Mr Green positioned himself near a hay shed where he expected Mr Anderson to drive his truck. There was no official 'spotter' used to guide Mr Anderson.

16. Mr Anderson drove his vehicle into the property and positioned his vehicle approximately 100 meters from the hay shed,[23] on sloping ground with the cabin facing uphill. He parked the vehicle underneath live 22,000 volts power lines that ran parallel with the ground across the property. Mr Anderson then commenced to unload the lime by raising the tipper.

17. Ms Green, her mother and Ms Green's 10-year-old daughter were standing approximately 100-200 metres from the truck and observed the unloading process. Ms Green saw Mr Anderson attempt to pull the truck forward but from her position, it appeared to have no traction. Ms Green then witnessed Mr Anderson starting to raise the tipper from the cabin. Ms Green stated to her mother, "If he's not careful he'll hit the lines with the tipper." Mr Anderson was then seen to alight from the cabin and walk to the rear of the trailer and then

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[13] Exhibit 24 – Statement of L/S/C Michael O'Brien dated 9 October 2009.
[14] *Ibid.*
[15] T @ p82, 85.
[16] Statement of John Green dated 9 January 2006 – (contained within Exhibit 30 – balance of the Brief).
[17] DPP v Calcimo Lime & Fertilizers Pty Ltd and Rondmar Pty Ltd, CR-08-0418; CR-08-0419 (CC), T @ p387.
[18] CC: T@ p360.
[19] CC: T @ p364.
[20] A four wheel motorbike.
[21] Statement of John Green dated 9 January 2006 – (contained within Exhibit 30 – balance of the Brief), CC: T @ p366.
[22] CC: T @ p378.
[23] Exhibit 16 – Statement of Ross Clayton dated 14 February 2006.

walk back to the cabin of his truck, open the driver side door and step onto the side step and reach into the cabin. At this point, Ms Green saw a flash of sparks coming from the top of the rear tipper and Mr Anderson was thrown off the truck cabin step and onto the ground.

18. Ms Green drove to the location with her mother Margaret and then returned to the house to call an ambulance. Margaret, a former nurse, rendered assistance to Mr Anderson. Approximately 10 minutes later,[24] an ambulance from Korumburra arrived at Ms Green's property.

19. Leading Senior Constable (L/S/C) Michael O'Brien from Loch Police Station arrived at Ms Green's farm at approximately 11.00am. Ambulance paramedics were continuing with their resuscitation attempts. L/S/C O'Brien appraised the scene and spoke to the power company worker that was already at the Green farm and ascertained that the power had been cut off. L/S/C O'Brien then contacted the WorkSafe communications centre for notification of the incident, Wonthaggi Crime Investigation Unit (CIU) and the Office of the Chief Electrical Inspector.[25]

20. A number of WorkSafe inspectors attended Ms Green's farm that day. Upon lowering the trailer, WorkSafe Investigator Mr Ross Clayton observed a burn mark on the tarpaulin where it appeared to have contacted the power line.[26] On examination of the truck, it was apparent that its front tyre had exploded. Representatives from Energy Safe Victoria (ESV) also attended.

21. At approximately 11.45am L/S/C O'Brien was advised that Mr Anderson had not responded to resuscitation attempts. It appeared that Mr Anderson was electrocuted as a consequence of his trailer coming into contact with a distribution power line. He died at the scene.

JURISDICTION

22. At the time of Mr Anderson'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[27]

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[24] *Ibid.*
[25] Exhibit 24 – statement of L/S/C O'Brien dated 9 October 2009.
[26] Exhibit 16 – Statement of Ross Clayton dated 14 February 2006.
[27] Section 119 and Schedule 1 - *Coroners Act 2008.*

23. 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.[28]

24. 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.

25. 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.[29] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

26. 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.[30] 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.[31]

INVESTIGATION

Identification

27. The identity of Dallas Anderson was without dispute and required no additional investigation.

Medical Investigation

28. On 11 January 2011, a post mortem examination was performed at the Latrobe Regional Hospital by Dr Stephen Chan under the supervision of Dr Patrick Van Der Hoeven. Dr Chan

[28] See for example, sections 67(3) and 72 (1) & (2).
[29] Section 67(1).
[30] Section 67(3).
[31] Section 72(1) & (2).

formed the opinion that the cause of Mr Anderson's death was electrocution. In his report, Dr Chan made the follow observation relating to the external examination of Mr Anderson:

> "There is a burn mark on the middle sternum measuring 36mm. There is a small punctate exit wound on the medial aspect of the right ankle measuring 2mm."

29. Toxicological analysis of post mortem blood was performed at the Victorian Institute of Forensic Medicine (VIFM). No alcohol or common drugs or poisons were detected.

Police Investigation

30. Detective Senior Constable (D/S/C) David Reynolds from the Wonthaggi CIU undertook the investigation and compilation of the Inquest Brief on behalf of the Coroner.

WorkSafe Investigation

31. WorkSafe undertook an investigation into Mr Anderson's death. As part of their investigation, WorkSafe engaged Mr Henry Bleeck, a Training and Facilities Manager with the Department of Defence to provide an expert opinion.[32] On 3 September 2009, Mr Bleeck attended the Green farm at 70 Greens Road, Bena with WorkSafe Inspector, Mr Ross Clayton. Mr Bleeck and Mr Clayton were met by Mr John Green at the farm entrance and were escorted by Mr Green to the site of the incident. Mr Green also indicated to Mr Bleeck and Mr Clayton where Mr Anderson's truck left the gravel driveway.[33]

32. A prosecution was authorised and charges laid against the supplier and distributor for breaches of the *Occupational Health and Safety Act (2004)* (Vic) (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.

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[32] Exhibit 21 –Report of Henry Walter Bleeck dated 11 May 2011.

[33] Exhibit 22 – Contemporaneous notes of site visit of Mr Bleeck; T @ pp243-245.

[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)(e) 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.

Energy Safe Victoria Investigation

33. 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 each of these three incidents. In Mr Anderson's case, ESV Compliance Officer Mr Michael Leahy attended the incident scene and compiled a Fatal Electrical Incident Report.

34. Mr Leahy measured the conductors in the vicinity of the incident to be 7.87 metres above the ground at the point of contact. There were two lines with 22,000 volts between them – 12,700 volts between one of the lines and earth/the ground.[35] The span of the line was approximately 340 metres from pole number 6544 and pole number 6545. Mr Leahy estimated that Mr Anderson's vehicle contacted the line approximately 60 metres from pole 6545. which was the last pole on the line.[36]

35. In his report, Mr Leahy concluded that the contact point of the truck's trailer to the power line would be live at 12.7kV with respect to earth, that is, the tyres in contact with the ground. He said that this would cause a voltage difference to exist across various parts of the truck and between the truck and the ground. Mr Leahy said that based on witness accounts that Mr Anderson was standing on the metal step of his truck and operating controls in the truck cabin, "a voltage difference between the metal steps and conductive material in the cabin could have been high enough to allow a current flow of sufficient intensity to cause death." Mr Leahy said that it was also possible that Mr Anderson was still in contact with the ground when he reached into the truck in which case "there could be a voltage difference between the truck and the ground to allow a current flow of sufficient intensity to cause death."[37]

Other deaths

36. In 2006, two other men lost their lives in circumstances similar to those surrounding Mr Anderson's death. On 19 April 2006, truck driver Mr Brian Baker died whilst delivering fertiliser to a property in Woorak.[38] On 28 April 2006, farmer Mr John Jones died whilst assisting a truck driver to deliver lime to his property in Mudgegonga.[39] The deaths of Brian

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[35] T @ p109.
[36] Exhibit 12 – ESV fatal Electrical Incident report compiled by Mr Michael Leahy dated 22 March 2006.
[37] *Ibid.*
[38] COR 2006 1427.
[39] COR 2006 1546.

Baker and John Jones were also investigated by WorkSafe and in each case, a decision made not to proceed with a prosecution.

37. 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 the other two matters);

    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;

    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.[40]

INQUEST

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

39. I determined that the deaths of Mr Anderson, Mr Baker 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 Anderson, Mr Jones and Mr Baker 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.

40. 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

[40] 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.

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.

41. In addition to the specific circumstances of Mr Anderson's death, a number of circumstantial similarities were identified in the three deaths requiring further examination,

***Viva voce* evidence at Inquest**

42. *Viva voce* evidence was obtained from the following witnesses in relation to the death of Mr Anderson:

    a. Ms Jillian GREEN – dairy farmer at 70 Greens Road, Bena as of 2006;

    b. Mr Joshua WHITESIDE – spreader/ truck driver for Korumburra Lime & Spreading;

    c. Mr Stephen HIBBERSON – former sales representative for Calcimo;

    d. Mr Nicholas JONES – former spreader driver for Korumburra Lime & Spreading;

    e. Mr Michael LEAHY – Compliance Officer for ESV;

    f. Mr Graeme O'CONNOR – Manager, Calcimo;

    g. Mr Ross CLAYTON – WorkSafe Investigator;

    h. Mr Bruce GIBSON – WorkSafe Manager Agriculture Safety Program;

    i. Mr Craig NEWTON – WorkSafe Former Team Leader Investigations;

    j. Mr Henry BLEECK – expert engaged by WorkSafe;

    k. Leading Senior Constable Michael O'BRIEN - Coroner's Investigator; and

    l. Mr Phillip WALTERS – Manager Electricity Infrastructure Safety, ESV.

43. Statements from Mr John Green and Dallas' father, Mr Alister Anderson were also tendered as evidence as part of the balance of the Inquest brief.[41]

44. Dallas' mother Susanne addressed me on 11 May 2011 on behalf of herself and Alicia Anderson.

[41] Exhibit 30.

Issues investigated at Inquest

45. 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 37.

46. 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.

The incident

47. At the time the trailer contacted the line, Mr Anderson was either attempting to get back into the truck cabin or was standing on the truck cabin's metal step in an attempt to operate (or was operating) the tipper controls. There was speculation that Mr Anderson's truck experienced slippage on the damp/wet grass[42] but WorkSafe Inspector, Ross Clayton stated that there were no signs of the truck having skidded on the grass[43] and no indication that the truck had moved.[44]

Mr Anderson's training and knowledge

48. According to Mr Graeme O'Connor, Manager at Calcimo, Mr Anderson received induction training which included "highlighting all aspects of working safely", upon his commencement with the company in April 2005.[45] As a part of the induction, Mr Anderson drove a vehicle

[42] See above paragraph 17.
[43] Exhibit 16 – Statement of Ross Clayton dated 14 February 2006.
[44] T @ p170.
[45] Exhibit 15 – Statement of Graeme O'Connor dated 30 March 2006, T @ p124-125.

under the direction of Mr O'Connor and "was instructed in all aspects of operating and loading and unloading and all maintenance and operating issues."[46]

49. Mr Stephen Hibberson Sales Representative at Calcimo at the time said that on Mr Anderson's first day at Calcimo he had provided him with training by getting Mr Anderson to perform a difficult manoeuvre of backing a truck and dog quad trailer[47] into the superphosphate shed, using only the left hand mirror to guide him into the load and unload bay to tip a load off.[48] As part of this training procedure, Mr Hibberson stated that before Dallas was permitted to tip the load off, he was asked "What's above you?"[49] as a prompt to always stop and look before commencing to unload. Mr Hibberson stated that this was not a one off exercise and that he observed Mr Anderson until he felt that he was competent in tipping and in watching, looking and checking for what was above him.[50] Mr Hibberson however conceded that he had not seen the diagrams depicting the '*No Go Zone for Overhead Electrical Power lines*' such as in the '*Look Up and Live*' pamphlet[51] but he was aware of other trucks touching power lines and had seen advertisements on television from time to time in relation to this issue.[52] According to Mr Hibberson, he also provided Mr Anderson with ""the whole basics" of working with tipper trucks.[53]

50. According to Mr O'Connor, whilst employed at Calcimo, Mr Anderson also underwent a two day course at DECA[54] where he obtained his B-double licence. Thereafter, Mr Anderson operated Calcimo's B-double tip truck on various occasions.[55]

51. According to Mr Anderson's father, Mr Alister Anderson, his son gained extensive qualifications, knowledge and truck driving experience through his membership with the Country Fire Authority (CFA), and this included training in respect of the dangers associated with working near power lines and the need to maintain a minimum distance from the power

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[46] *Ibid.*
[47] The same truck he was driving on the day of the incident.
[48] T @ p56.
[49] T @ p57.
[50] *Ibid.*
[51] A safety campaign undertaken by Energy Safe Victoria, which dates back to 1995 (see *Office of the Chief Electrical Inspector Annual Report 1995/1996*, p 7)and provides information and publications directed at truck drivers, rural property owners and their families about the risks of electrocution from trucks contacting power lines on rural properties. The publications are prefaced with the phrase: "LOOK UP AND LIVE – BE ALERT, BE AWARE – OVERHEAD POWER LINES ARE ALWAYS THERE." (Exhibit 4). This campaign had commenced prior to these three deaths.
[52] T @ pp59-60.
[53] T @ p58.
[54] Driver Education Centre of Australia.
[55] Exhibit 15 – Statement of Graeme O'Connor dated 30 March 2006.

lines. Alister Anderson described his son as a careful and competent truck driver, having driven from an early age. Mr Alister Anderson was supportive of the training and instruction that his son had received and stated:

> *"It is my view that Dallas had all the necessary experience and understanding of the risks associated with power lines and that there was nothing more that could have been told to him that he did not already know and understand."*[56]

52. On the other hand, according to Mr Anderson's mother, Mrs Susanne Anderson, her son's experience as a tipper driver was being a *"little overstated"*[57]. Mrs Anderson stated that her son was a *"wonderful truck driver"*[58] but his main job was farm work, driving livestock and hay, and he had never been a full time truck driver until he commenced with Calcimo in April 2005.[59] She said that even when he was working full time with Calcimo he did not do tipping every day. He also drove the spreader for Calcimo.[60] Mrs Susanne Anderson also stated that she did not believe that the experience her son obtained in the CFA had much to do with the circumstances of his death. She was also a member of the CFA and had the same training as her son and she could not recall receiving any training on tipper trailers or about overhead power lines other than how to deal with power lines that had come down across a vehicle or a road in a storm.[61]

53. WorkSafe's expert Mr Henry Bleeck was scathing in his report about Mr Anderson's lack of training for the delivery on 9 January 2006. His views were not dissimilar to those of Mrs Susanne Anderson. Mr Bleeck stated that Mr Anderson's driving profile indicated that Mr Anderson was experienced in operating heavy trucks in farm environments but that he had no history of operating tip trucks with trailers. Mr Bleeck stated:

> *"There is no* evidence *of Dallas Anderson receiving the required training to tip the quad dog trailer involved in the incident in off road conditions."*[62]

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[56] Statement of Alister Anderson – dated 18 November 2009 (contained within Exhibit 30 – Balance of the Brief – Inquest into the death of Dallas Anderson).
[57] T @ p288.
[58] *Ibid.*
[59] T @ p288-289.
[60] *Ibid.*
[61] T @ p289.
[62] Exhibit 21 - Report of Henry Walter Bleeck dated 11 May 2011 @ paragraph 96.

Organisation of delivery

54. In his *viva voce* evidence, Mr Joshua Whiteside stated that *"a site inspection was the exception to the rule"*[63] and not a usual task however, he also stated that most new sites would get an inspection. Mr Whiteside said that the issues he considered at a site inspection related to his job as a spreader. The ease of the spreading task and accessibility for vehicles to the paddocks was his primary focus but the site for dumping the lime or fertiliser would also be checked.[64] Mr Whiteside stated that at the Green property:

> *"Considering the farm is mostly vertical we discussed the best location to dump the 200 tonne of lime, the location of the dump site was made with myself, Nicolas Jones and Jillian Green."*[65]

55. Mr Whiteside stated that he did not consider power lines at the Green property during the site inspection. He stated that he did not see them because he was looking at the terrain and condition of the land.[66] At the time of the site inspection, he did not think of the power lines as an issue and considered it more related to the driver's discretion.[67] Mr Whiteside stated that the information obtained from the site inspection including the agreed upon dumpsite,[68] was transmitted back to the office through a discussion or verbal debriefing with Rod Abbott and his brother, Matthew Whiteside.[69] There was no map or other document created to depict the selected site for dumping the lime.[70] In relation to communication of the site information to the delivery contractor, Mr Whiteside stated that:

> *"I presumed that they'd have someone either go out with him or the farmer would be notified and ..that'd be all between the farmer and the two companies, there'd be some discussion made."*[71]

56. Mr Nicholas Jones stated that he probably played a bigger role in the selection of the dumpsite[72] than that of Joshua Whiteside predominately because he had more experience at the company. Their respective *viva voce* evidence regarding the selected dumpsite and

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[63] T @ p25.
[64] T @ p25.
[65] Exhibit 3 – Statement of Joshua Whiteside dated 1 June 2006.
[66] Exhibit 3 – Statement of Joshua Whiteside dated 1 June 2006.
[67] T @ p27, 33.
[68] T @ p39.
[69] T @ p30.
[70] T @ p31.
[71] T @ p39.
[72] Mr Jones' selected preferred dumpsite is depicted in Exhibit 10.

communication back to Korumburra Lime & Fertiliser was not however dissimilar. Mr Jones stated that he too could not recall turning his mind to any risk posed by power lines as he could not recall seeing them. He did however reflect that if he did see them on the day he "did not think they were going to be coming into the equation block."[73] He agreed with Mr Goetz that if his selected dumpsite had been used by Mr Anderson, the power lines would have not been an issue[74] however he could not say that he had indeed provided his employer with any specific details of the selected dumpsite other than an electric fence needed to be removed. Similarly, he could not recall if he had told his employer that the site might be difficult to access if the conditions were wet.[75] He said "it was a difficult job".[76] Mr Jones also agreed that there was no documentation or diagrammatic depiction of the selected dumpsite given back to his employer to pass onto the driver and he had no knowledge of how the selected preferred dumpsite would be passed onto the delivery truck driver other than he too presumed that someone from Korumburra Lime & Fertiliser would be attending the farm at the same time as Calcimo delivery truck.[77] In fact, none of the people present when the dumpsite was selected following their inspection of the conditions of the land, were present when Mr Anderson arrived with the consignment of lime.

57. Mr Hibberson from Calcimo stated that it was the role of the company taking the order from the farmer to "identify with the customer what hazards might be on the site"[78] If they did not do this he believed they were not doing their job properly. In this case he had not spoken to the farmer Ms Green directly and had no personal knowledge of the Green farm. As the contractor to perform the delivery, he had an expectation that Korumburra Lime & Fertiliser would provide any information they had about hazards to his driver, Mr Anderson, when he called into their depot as instructed. The information Mr Hibberson expected to be given to Mr Anderson would be in the form of written instructions "on where to go, where to drop".[79]

58. Mr Bleeck stated in his report to WorkSafe that it was unclear if Mr Anderson had received any information from the site assessment and opined that there did not appear to be any system of communication in place for passing on the information gained from the site assessment to the delivery driver, Mr Anderson. Mr Bleeck stated that such a communications

[73] T @ p86.
[74] *Ibid.*
[75] T @ p90.
[76] T @ p94.
[77] T @ pp87-88.
[78] T @ p53.
[79] T @ p50.

breakdown might be because there is a "system problem", being a lack of procedures or checklists.[80]

59. Mr Hibberson like Mr Joshua Whiteside said that ultimately the decision about "the safety of the delivery drop site rests with the driver."[81] He stated that the practice in place at Calcimo was that the truck drivers knew to ring into the company to make alternative arrangements if they were not happy with the drop site, regardless of any information the driver may have previously received. Mr O'Connor's views were not dissimilar when he stated:

> *"Our drivers are instructed prior to delivery to do an inspection of the delivery site and it is left up to the driver to inspect the site and make a call as to whether or not he can successfully deliver to that site."*[82]

Changes to Staff Training

60. Mr Joshua Whiteside agreed with Counsel for ESV and WorkSafe that since Mr Anderson's death he was now more aware of the location of power lines on the properties he inspects and that it had taken this incident for him to improve his awareness.[83] Mr O'Connor said that he was not as aware of the *Look Up and Live* campaign in 2006 as he is now.[84] Mr Hibberson's level of awareness and attitude to the dangers of overhead power lines for truck drivers was similarly enhanced by Mr Anderson's death.[85] He candidly stated:

> *"Because until it touches you personally, you know what can happen but you don't know the devastating effects it has on everyone around you and all the family."*[86]

61. Mr Whiteside stated that he had never seen the Korumburra Lime & Spreading "Work Instructions Fertiliser Lime Delivery Bulk Sites" dated 16 January 2006.[87] Whilst he was aware of the *Look Up and Live* campaign[88] as of 2006, he not aware of the *No Go Zone* campaign[89] in relation to power lines. He had not heard the term 'spotter' prior to 2006.[90] He

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[80] Exhibit 21 – Report of Henry Walter Bleeck dated 11 May 2011 @ paragraph 95; T @ p258.
[81] Exhibit 8 – Statement of Stephen Hibberson dated 22 March 2006.
[82] T @ p127 and p132.
[83] T @ p37, 39.
[84] T @ p 129.
[85] T @ p60, 70.
[86] T @ p60.
[87] Exhibit 3 – Statement of Joshua Whiteside dated 1 June 2006, T @ p26.
[88] Above no 51.
[89] The "No Go Zone for Overhead Electrical Power lines" campaign similarly highlights safety issues related to working near overhead power lines 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

had no formal qualifications, however since Mr Anderson's death, he and everyone else at the company had undergone training in relation to site inspections.[91] The company now also has a dumpsite or "mud map" check sheet[92] to be completed by those undertaking inspections of the properties, which is used to depict the location for dumping the delivery and for highlighting any identified hazards and features about the terrain[93] relevant to facilitating the delivery. The company also now utilises "No Go Zone" stickers which are attached to all of their vehicles and loaders with the aim of helping to remind and alert their drivers to power lines.[94]

62. The recording of driver training at Calcimo has undergone some changes since Mr Anderson's death. Mr Hibberson stated there was no recording of the training that was supplied including that given by himself to Mr Anderson. He said that all drivers' training was now recorded because "you don't appreciate the importance of it until something like this happens."[95] The Calcimo Lime & Fertilizers Driver Manual has been developed and implemented and "*...contains safety instructions for unloading/loading and selecting dumpsite at delivery location, which has specific guidelines for working near overhead power lines.*"[96]

63. Mr Hibberson also indicated that the lines of communication between Calcimo and the sub-contractor, Korumburra Lime & Spreading, had improved since the death of Mr Anderson. He stated that Calcimo were now getting significantly more information from Korumburra Lime & Spreading about conditions at the farm where a delivery is to occur, including anything relevant to getting a truck in and out of a property and notice of any obstructions.[97]

64. In relation to the risk of hitting power lines whilst unloading and the use of spotters to minimise the risk, Mr O'Connor was strongly of the belief that spotters were not needed in his industry. He intimated that the whole process was really quite simple. He said that "you pick a better site".[98]

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surrounding overhead power lines. It is incorporated within the "Look Up and Live" publication and a number of WorkSafe publications and training programs.(Exhibit 28). The minimum clearance distances/heights are prescribed in the *Electrical Safety (Network Assets) Regulations 1999* (Vic).

[90] T @ p33.
[91] T @ p25.
[92] T @ p32.
[93] T @ p 40.
[94] T @ p32.
[95] T @ p58.
[96] Exhibit 8 – Statement of Stephen Hibbberson dated 22 March 2006.
[97] Exhibit 8 – Statement of Stephen Hibbberson dated 22 March 2006, T @ p49.
[98] T @ p129.

65. In relation to whether more could have been done to prevent Mr Anderson's death, Mr O'Connor stated:

> *"...I believe there was no more as the employer of Dallas Anderson that I could have done to prevent this terrible accident."*[99]

66. I am cognisant of the date on which Mr O'Connor made his statement and its proximity to Mr Anderson's death and I am cognisant of why an employer might express such a belief and why he maintained a somewhat defensive approach throughout his *viva voce* evidence, however, the weight of the evidence is to the contrary of his stated belief(s). Regardless of Mr O'Connor's expressed belief, the weight of the evidence enables me to accept and acknowledge the responses of both Korumburra Lime & Spreading and Calcimo to Mr Anderson's death by their respective acknowledgements that there were shortcomings in training and communication and documentation/recording of the same. I am satisfied that the changes implemented by both companies have been undertaken with the aim of providing greater support to their employees, preventing like incidents and generally with a concern for their employees' occupational health and safety. I am also satisfied that there has been a general improvement in awareness of the presence and risks associated with working near overhead power lines by all who were affected by Mr Anderson's death. The *ad hoc* approach that existed at both companies to potential hazards and communication of the same appears to have been definitively addressed.

Submissions

67. 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.

General observations of the themes emerging in the three deaths

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

Overhead power lines

69. 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

[99] Exhibit 15 – Statement of Graeme O'Connor dated 30 March 2006.

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". [100] Mr Jones' and Mr Baker's cases involved a single 12,700 SWER line.[101]

70. 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"* however the bare wires are live and are only protected by an Expulsion Dropout Fuse or EDO.[102]

Procedures around taking orders for bulk deliveries, including site inspections

71. 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

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[100] T @ p109.

[101] In the inquest into the death of Brian Baker, ESV Compliance Officer Mr Terence 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, they will exceed the height that the SWER lines are installed above ground (Investigation into the death of Brian Baker, Exhibit 7, ESV Electrical Safety Investigation Report dated 28 June 2006).

[102] Exhibit 6 - Statement of Terence Patrick Clement dated 30 June 2006 (Inquest into the death of Brian Baker). 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).

identifying safety issues for the driver, which should be ranked above the customer's preferences.[103]

Use of pre-delivery information

72. 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. 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

73. There was a general lack of knowledge of the minimum 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 knowledge and instructions is insufficient for delivery drivers working alone and does not enable them to make proper assessments and identify risks.

74. 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.[104]

Use of appropriately qualified spotters

75. 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. Mr Hibberson 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

[103] T @ pp328-328.
[104] T @ p330.

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".[105]

Other safety measures

76. 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 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.[106]

Occupational Health and Safety responsibilities of employers

77. 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.

78. 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.[107]

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[105] T @ p69. (Dallas Anderson Transcript of Proceedings).
[106] T @ p330.
[107] Exhibit 18 – Statement of Bruce Gibson and attachments dated 9 May 2011.

79. 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.*[108]

80. 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.[109] 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 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.[110]

De-energising power lines

81. 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 Inquest into the death of Brian Baker. 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

[108] T @ p337.
[109] T @ p345.
[110] T @ pp344-345.

as according to Mr Ray QC on behalf of Powercor,[111] "*de-energising ordinarily doesn't isolate simply one farm it may isolate instant areas.*"[112]

82. 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

83. 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*[113] 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.[114] 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.*[115]

84. The Royal Commission made 67 recommendations, of which eight (Recommendations 27 – 34) relate to reducing the likelihood of power lines starting catastrophic bushfires. The

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[111] Mr Ray QC appeared on behalf of Powercor, who was an Interested Party in the Inquest into the death of Mr Brian Baker. Mr Ray QC also appeared on behalf of Powercor for the purpose of providing submissions at the conclusion of all three Inquests.
[112] T @ p360.
[113] 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.
[114] T @ pp345- 347.
[115] Victoria, 2009 Victorian Bushfires Royal Commission, *Final Report: Volume II, Fire Preparation, Response and Recovery* (2010), p154.

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[116] 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 Anderson, Mr Baker 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

85. 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 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.*[117]

86. 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.

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[116] 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.
[117] T @ p330.

Framework promoting safety

87. 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

88. WorkSafe outlined their agricultural safety program[118] 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.

89. 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 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.[119] The distribution of this information from the electricity provider is currently in the vicinity of 26,000 landowners/occupiers of land.[120]

90. 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".[121] Farming is not a concentrated industry such as the construction industry whose participants might acknowledge the existence of like occupational health and safety issues.

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[118] Exhibit 18 – Statement of Bruce Gibson dated 9 May 2011, T @ pp177 – 203.
[119] T @ pp204-205.
[120] T @ p205.
[121] T @ p112.

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

91. 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 Anderson, Mr Baker and Mr Jones.

92. ESV contributed some funding[122] 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 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.[123] 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.[124] Mr Walters gave the same indication when speaking of one such device, "ProxyVolt®",[125] a product whose use appears to be confined to plant in the mining industry.[126] 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.[127] 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.

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[122] T @ p295.
[123] T @ p295.
[124] T @ p343.
[125] Other products discussed in the course of Mr Walters' evidence included "Wilsave" and "Sigalarm™"– Exhibit 27.
[126] T @ p302.
[127] T @ p301.

93. 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[128] 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).[129] 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.

94. 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.

FINDINGS

1. I find that the identity of the deceased is Dallas Alister Anderson.

2. I accept and adopt the medical cause of death as ascribed by Dr Chan and find that Dallas Alister Anderson died from electrocution in circumstances where his tipper trailer contacted overhead power lines on a farming property while he was acting in the course of his employment.

3. It is not possible nor necessary to make a finding on the route Mr Anderson drove once he entered the Green property as the evidence on the same was speculative and Mr Green's evidence was not able to be tested at the Inquest.[130] Similarly, it is not possible to make a finding on why Mr Anderson chose the particular site to unload save that I am satisfied that he was not given prescriptive instructions either in writing, diagrammatically or by way of a simple marker in the ground indicating the "stockpile site"[131] by his employer, the supplier or the farmer. If there was a system of communication in place at the time, I find that it was ineffective and it let Mr Anderson down.

4. It is not necessary for me to make any findings on whether or not slippage of the wheels on damp ground led to the trailer's contact with the overhead power lines, because it is sufficient to find that in the first instance, Mr Anderson positioned his truck and trailer

[128] A height detection device that was presented on "The Inventors" program on the ABC in 2007.
[129] T @ p313.
[130] Mr Green was excused from giving evidence on the grounds of ill health.
[131] T @ p210.

inappropriately close to the overhead power lines and in the second instance, commenced to tip his load whilst his truck and trailer were so positioned. Mr Anderson's reason(s) for adopting this course of tipping his load was the subject of relatively consistent speculation by a number of witnesses and predominantly related to the evidence that Mr Anderson's truck had become stuck. The grass was damp and the trailer was positioned on a steep incline. Lessening the weight off the trailer would have increased his prospect of gaining greater traction and enabling or at the least improving the chances of Mr Anderson being able to drive out of his stuck position.[132] In the absence of definitive evidence of Mr Anderson's reason(s) for adopting the course of action that he did, it is possible that he inadvertently found himself in this "stuck" position, with his vehicle unable to gain traction. Similarly, there remains the possibility that Mr Anderson did not see the overhead power lines when he positioned his truck and trailer or indeed, came to be in that position. According to Mr Clayton, the power lines were not very obvious and would not have been easy to spot from the truck's cabin.[133]

5. The scenario of inadvertent positioning/becoming 'stuck', while compelling on the evidence is difficult to reconcile with Mr O'Connor's evidence that there was a practice in place at Calcimo at the time of the incident that would have seen Mr Anderson telephoning his employer to advise him of his predicament before attempting to lessen the load in his trailer. Mr O'Connor's evidence in this regard, however, was not convincing. He may have a belief that the practice was in place but there were no prescriptive instructions of such a practice to support his belief and the fact remains that Mr Anderson did not telephone him which indicates that if it was in place it had been ineffectively communicated or indeed implemented.

6. I acknowledge that there has been a range of restorative and preventative changes and measures implemented by individuals and to employer's practices since Mr Anderson's death and I also acknowledge that WorkSafe and ESV have been and continue to utilise a number of mediums and activities in respect of the dangers associated with operating machinery or plant in close proximity to overhead power lines. I accept that all these measures are and have been utilised with the aim of preventing like deaths.

7. The evidence indicates that the actions of Mr Anderson on 9 January 2006 were contrary to his experience in driving heavy vehicles. There was no evidence to suggest that he was not

[132] For example see T @ p175 (Mr Ross Clayton).
[133] T @ p212.

considered proficient in his job or that he adopted unsafe practices. Nevertheless, it remains necessary to find that the death of Dallas Alister Anderson 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 Anderson, Mr Baker 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[134] 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.*[135]

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

[134] Mrs Alecia Anderson's letter of suggestions was distributed to all Interested parties and summarised by Counsel assisting in closing submissions – T @ pp331-334.
[135] T @ p354.

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.*[136]

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 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)[137] 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

[136] T @ p355.

[137] 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.

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 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[138] 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.[139]

I commend the publications of WorkSafe and Energy Safe Victoria in this regard and encourage all

[138] *Harmsworth v The State Coroner* [1989] VR 989.
[139] Exhibit 18 – Statement of Bruce Gibson dated 9 May 2011, T @ p179.

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. 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.[140] 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 Up and Live" campaign. Three deaths is a clear indication that, at that time, the message was not being 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.[141]

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

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[140] T @ p291.

[141] This recommendation recognises that first, there remains a possibility that Mr 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 provided in the inquest into the death of Brian Baker, 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 no 101). 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.

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 collaboration with WorkSafe develop a farm safety accreditation program as suggested by Alicia Anderson.[142]

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.

[142] Exhibit 33 – letter from Mrs Alicia Anderson addressed to the Court, T @ pp331-334.

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

- Mrs Alicia Anderson
- Mr John McCrystal, Maurice Blackburn Lawyers on behalf of Mrs Alicia Anderson
- WorkSafe Victoria
- Mr John Murphy on behalf of Energy Safe Victoria
- Powercor Australia Pty Ltd
- Farmsafe Australia Inc
- Calcimo Lime & Fertilizers Pty Ltd
- Korumburra Lime & Fertilizer
- Transport Workers Union
- Australian Workers Union
- Detective Senior Constable David Reynolds

Signature:

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